South Gloucestershire Alcohol Needs Assessment 2019

Contents

Recommendations

There is need in South Gloucestershire **to work in partnership** to provide evidence-based approaches to:

1. Prevent and reduce underage drinking through education, campaigns and enforcement; and through our specialist children and young people's service reduce consumption or promote abstinence among those already drinking.
2. Reduce the numbers of people locally drinking more than 14 units of alcohol (approximately 10 small glasses of low strength wine or 6 pints of average strength beer) per week; using multi-media campaigns, early interventions in a variety of settings including healthcare, workplaces and online, and throughout the life-course; and lobbying for national legislative interventions such as minimum unit pricing of alcohol.
3. Reduce the consumption of those drinking more than 14 units per week, and particularly reduce binge drinking (where more than 6 units for women or 8 units for men are drank on a single occasion), using campaigns and early interventions.
4. Reduce alcohol-related crime, road traffic accidents and fires; and support safer and responsible drinking through effective licensing and enforcement.
5. Normalise abstinence for those choosing it.
6. Reduce the numbers of pregnant women and those planning to conceive from drinking alcohol during their pregnancy.
7. Increase the numbers of higher risk and dependent drinkers accessing advice, support, treatment and stable recovery; including how to overcome barriers to accessing these services and building capacity in the treatment services.
8. Encourage those accessing alcohol treatment also to stop smoking and support their identified needs for a holistic approach to greater wellbeing.
9. Develop joined up pathways particularly for those between early intervention, treatment, mental health, and social services; and for those transitioning from children and young people to adults services, from criminal justice to community services, and from hospital to community services.
10. Through strategic leadership and implementation of integrated care systems, aim for joint commissioning of, and/or a pooled budget for, campaigns, early interventions, and services – and particularly for those with complex needs.
11. Offer equitable, available and accessible interventions universally but proportionally target groups at increased risk of alcohol harms such as those experiencing socioeconomic deprivations, LGBTQ+ communities, care leavers, people with learning difficulties and older adults.
12. Aim for reductions in alcohol-specific hospital admissions, particularly for females and females aged under 18 years.
13. Ensure the Needs Assessment is informed by regular updates of new and emerging data analysis and this is communicated effectively across the partnership to mitigate the wider harms of alcohol to families and communities.
14. Ensure clarity of individual partner roles and responsibilities in agreeing and achieving identified outcomes and to develop processes for evaluating progress.

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Executive summary

Our vision is to make South Gloucestershire a great place to live and work. Alcohol is used responsibly by most adults and is associated with positive experiences like celebrations and socialising with family and friends. Social contact is important for mental health and wellbeing and alcohol may have a part to play in this for many people. Drinking alcohol is however not without risk. It risks causing harm to individual drinkers, their families, communities and workplaces, and the babies of pregnant women. This needs assessment looks at the importance of reducing these harms across the life course, and for communities and individuals with particular needs. There was a 15% reduction in the total Drug and Alcohol Programme budget between 2016/17 to 2019/20 resulting in some reductions to service provision. This needs assessment aims to identify interventions which provide value for money and together with prioritising the needs identified will form the basis for our new alcohol strategy. To identify the needs epidemiological, comparative and corporate methods was used. Data, evidence, economic evaluation, stakeholder feedback and partner contributions were synthesised.

Risky drinking in South Gloucestershire and likely awareness of the risks

Public Health England (PHE) estimate that 29% of adults in South Gloucestershire drink at more than lower risk levels, compared with 26% nationally – although this is deemed statistically similar. Only 12% of our local population are estimated as choosing not to drink at all compared with 16% in England. South Gloucestershire has the highest estimated rate of binge drinking (23%) in the Avon & Somerset police force area, and a higher (albeit statistically similar) rate than that for England (17%). Similar to the national picture, men in South Gloucestershire typically drink more than women, but women are more vulnerable to the effects of alcohol. The effect of alcohol on their health, weight and money are the top three concerns for people in the UK.

Younger people and those with lower socioeconomic status are less likely to know about units and lower risk guidelines; and 28% of females are likely to be unaware of the need to stop drinking when pregnant. The UK is the worst out of eight groups globally for women continuing to drink during pregnancy, with more than 40% of pregnant women in the UK estimated to be drinking alcohol during their pregnancy. Drinking in pregnancy can result in the development of foetal alcohol spectrum disorders, low birth weight babies or a miscarriage, the effects of which might be exacerbated by also smoking in pregnancy. There is a strong association between sudden infant death syndrome and alcohol if a mother shares her bed or sofa with the baby after drinking, and a risk of neglect if the mother has been binge drinking.

Risks and harms to our children and young people

Nationally alcohol consumption among young people has declined since 2002 and more young people are choosing to abstain from drinking altogether. Local data suggests that in South Gloucestershire self-reported infrequent (monthly) alcohol use among younger teenagers (years 8 and 10) may have increased between 2015 and 2019. 10% of those in year 8 (aged 12-13) reported drinking sometimes (monthly), and 3% frequently (weekly or most days). For those in year 10 (aged 14-15) 27% reported drinking sometimes, and 14% frequently.

Young people often feel that the messages that they receive from school, the media and home assume that young people will want to drink alcohol and that risks need to be minimised. Research has identified a strong link between young people's alcohol use and both the level of use by their parents and the extent to which their alcohol use is monitored at home. Locally, 72% of year 8s who

reported drinking alcohol said that they gained it from home with parental permission. For 14% of those in year 10, their friends gave it to them; 7% obtained it from a local shop, supermarket, off-licence, pub or club; and for 9% someone buys it for them. It is illegal for licensed premises to sell alcohol to children or young people under 18 years; and Trading Standards are responsible for the enforcement of this legislation. It is especially concerning if adults are buying it for them because alcohol can make children and young people vulnerable to exploitation or abuse.

Local and national data demonstrates the correlation between levels of drinking and particular vulnerabilities and characteristics such as looked after children, young people with SEND, those experiencing mental health issues and those who identify as LGBT. Levels of deprivation are also linked to the increased harm caused by alcohol to young people living within poorer communities. Underage drinking is likely to result in worse educational outcomes, and particularly for those in low income families could worsen their health and social inequalities.

Rates of alcohol specific admissions to hospital for under 18s have increased in South Gloucestershire in contrast with decreasing rates nationally. Young women and girls are of particular concern accounting for 66% of alcohol specific admissions in the last 5 years in this age group.

Risks and harms to our adults, families, communities, and inequalities

Risks to adults include health harms such as breast cancer, liver and cardiovascular disease, and alcohol dependency– a recognised mental illness. Approximately 1% of adults in South Gloucestershire are estimated by PHE to be alcohol dependent. Parental drinking can cause Adverse Childhood Experiences (ACEs) which result in permanent detriments throughout a child's life course.

Drinking alcohol is associated with domestic violence, violent and sexual crime. Alcohol related crime and disorder impacts on community cohesion and wellbeing. The three hotspots for crime and public order resulting from the night time economy in South Gloucestershire are in Kingswood, Staple Hill and Chipping Sodbury. A *'Behave or Be Banned'* scheme has recently been launched in South Gloucestershire with the agreement of some licensed premises. Decisions around granting or revoking a license for on or off-sale consumption is a permissive regime and is legally dependent on the licensee's compliance with the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm. There is an association between density of on-trade licensed premises and licensed convenience stores, and hospital admissions for conditions wholly attributable to alcohol, particularly amongst older people. We need also to remember that 76% of our residents prefer to drink at home; (82% of those who live in our Priority Neighbourhoods – Cadbury Heath, Kingswood, Patchway, Staple Hill, and Yate and Doddington). PHE estimated that treating people for whom alcohol has caused a problem in the Avon and Somerset Police Force area would have saved over £7 million in preventing the social and economic costs of violent, sexual and non-violent crime. The health and wider harms from drinking have costs to our local economy and are a factor in widening health and social inequalities.

There is a harm paradox whereby people from more affluent groups might drink more than those in less affluent groups, but it is those who are less affluent who suffer the greatest health harms. If you live in one of the areas with most deprivations in South Gloucestershire you are up to four times more likely to be admitted to hospital because of alcohol than if you live in an area with less deprivations. We have increasing rates of alcohol-specific hospital admissions in South Gloucestershire; and a higher rate than that for England, particularly for females. Men aged 60-69 and women 50-54 are the age groups most likely to be admitted.

Adults who identify as LGBT are at a greater risk of drinking alcohol in a problematic way than those who identify as heterosexual. Over 4,000 adults in South Gloucestershire have a learning disability, and alcohol is more likely to place them at greater risk of accidental injury, and risk-taking behaviour such as unplanned or unprotected sex, than the general population. People with a learning disability might be less likely to use alcohol but if they do, they are more likely to drink at a higher risk level. Anxiety and depression are associated with alcohol use, and alcohol can worsen the symptoms of depression. Self-harm and suicide are more common in people with alcohol problems. Over £7 billion is lost in UK workplaces by hangovers and other sickness related to alcohol use, and to wider society in terms of benefits paid out due to alcohol-related incapacity and disabilities.

Prevention and early intervention

The greatest value for money would be delivered from population wide primary prevention such as legislative interventions including licensing and restricting the availability of alcohol, lobbying for minimum unit pricing and increased taxation; and education and support for people to change their drinking behaviour before harms have been caused. Targeted secondary and tertiary prevention such as identification and brief advice (IBA) in primary care settings and secondary care alcohol teams have a lower cost than the treatment of people for whom alcohol has caused a problem. IBA in primary care saves the NHS £27 per patient per year and the return on investment for hospital alcohol care teams can be nearly £4 for every £1 invested. An estimated one in five people admitted to hospital in the UK drink at harmful levels and one in ten are estimated to be alcohol dependent.

The public health division promotes some national alcohol campaigns but currently this is not planned and co-ordinated with all of our stakeholders. Although we have previously piloted IBAs in GP practices and pharmacies these interventions were discontinued. Local sexual health services informally ask patients about their alcohol use and refer people worried about their use to local specialist alcohol and drug services but there is no local data about the effectiveness of this approach. The South Gloucestershire Prevention and Self Care Network are keen to support awareness raising campaigns, the sharing of data and providing more brief interventions particularly in pharmacies.

The University of the West of England (UWE) funded a full-time drugs and alcohol worker but ownership of the data has not yet been agreed and it cannot therefore be reported in this needs assessment. Through the drugs and alcohol worker, students can also access an online treatment and recovery app.

This year we launched the *'One You South Gloucestershire'* (OYSG) healthy lifestyles and wellbeing service which includes online resources and signposting to sources of support to reduce or stop drinking alcohol. The OYSG service provides a holistic approach for service users to also make other behaviour changes such improving nutrition, managing stress or increasing physical activity, to improve their wellbeing. We have trained over 452 council, voluntary sector and other staff to provide *'Making Every Contact Count'* behaviour change interventions but it has not been possible to evaluate whether or how this has impacted on drinking behaviours.

From 2016/17 to 2017/18 we provided over 13,000 NHS Health Checks, of which at least 67% were screened for an alcohol use disorder but less than half the patients eligible for brief intervention(s) or signposting for further support were recorded as receiving it. There are plans to improve the alcohol component of this service. We are joint funding an alcohol specialist nurse at Southmead Hospital and the alcohol team there had 2,028 individual patient contacts in 2018/19.

Treatment

The total cumulative social and economic return on investment of alcohol treatment services commissioned by South Gloucestershire Council is estimated as £4.1million over 10 years; with community treatment and relapse prevention cheaper than residential treatment. Alcohol dependency is a mental illness where relapses can occur and some service users respond better to community or residential treatment than others. It is likely that service users with more complex needs such as those with dual diagnosis experiencing severe mental illness, those who have low social support and/or who are homelessness would benefit from residential treatment and find it difficult to make changes through community treatment alone. Currently residential rehabilitation is funded using a person-centred approach from the Drug and Alcohol Programme budget.

Drug and alcohol treatment services were recommissioned in 2017/18 and are delivered through an integrated service led by the charity *'Developing Health and Independence'* with flexibility over numbers treated for drugs or alcohol. There is a greater proportion of people in the service being treated for drugs than alcohol, than is the case for England and the South West. For 2016/17 we reported a significantly worse estimated unmet need of 94% of alcohol dependent individuals not in treatment compared to 82% for England. Although we managed to increase the numbers of alcohol only clients in treatment during 2018/19, this has put a strain on capacity in the system with a reduced rate of successful completions compared to the previous year and reported increased waiting times for components of the service.

From 2013/14 to 2017/18 the proportion of those treated in South Gloucestershire who successfully completed their alcohol treatment was higher than the average for England or the South West. Part of this success might be due to the wraparound services that our providers offer. For people who drank alcohol in a problematic way who also had a housing issue, the housing issue was best resolved by completing the course of alcohol treatment alongside receiving the wraparound support. This year we successfully secured external capital funding for the purchase of a 4 bedroom Recovery House, which is planned to provide temporary accommodation for those struggling to access alcohol treatment due a lack of suitable housing or homelessness. There is some evidence that completing treatment has increased service users' ability to work more productively. Family-focussed interventions are likely to enhance the effectiveness of alcohol treatment and recovery. In South Gloucestershire we appreciate the necessity of also supporting the family members of dependent drinkers and therefore share with Bristol and BANES joint commissioning of the Families Also Matter Service (FAM).

Despite our lead provider being in an integrated service with the Avon Wilshire Mental Health Partnership NHS Trust, the evidence found that we might not be meeting the needs of some of our alcohol clients who need community mental health services. We might also not be meeting the needs of people who drink alcohol in a problematic way locally and who have contact with the criminal justice system, and similar to the national situation those who are transitioning from prison back into the community. In 2016/17 a higher than the national average and an increasing proportion of South Gloucestershire service users were dying whilst in treatment. Although the numbers dying whilst in structured treatment reduced in 2018/19, our local review system indicates the deaths of those not in structured treatment drastically increased. The local system is in place to review deaths where alcohol is suspected to have caused the death of someone known to our provider services or where it has been flagged by the Coroner's Office or Police. This is to assist our Clinical Governance Group (CGG) to use the learning from these cases to reduce the risk of similar occurrences.

Additionally, many who recover from alcohol dependency who also smoke tobacco subsequently die because their tobacco addiction has not been treated. Smoking cessation often has a positive influence on substance use outcomes. To date the uptake and success of alcohol service users referred to our smoking cessation service appears to be disappointing. Embedding stop smoking services in drug and alcohol treatment appears to be best practice and what we should be aiming for in the next commissioning round, whilst looking for all opportunities to improve outcomes for people currently in treatment to stop smoking in the shorter term.

Research indicates that barriers which prevent dependent drinkers from accessing treatment include perceived stigma and not wanting to ask for help, lack of awareness that their drinking is causing them or others a problem, and concerns about childcare for those who are parents. There is also need for awareness raising and training for healthcare and social services professionals within the challenging environment of pressure on resources.

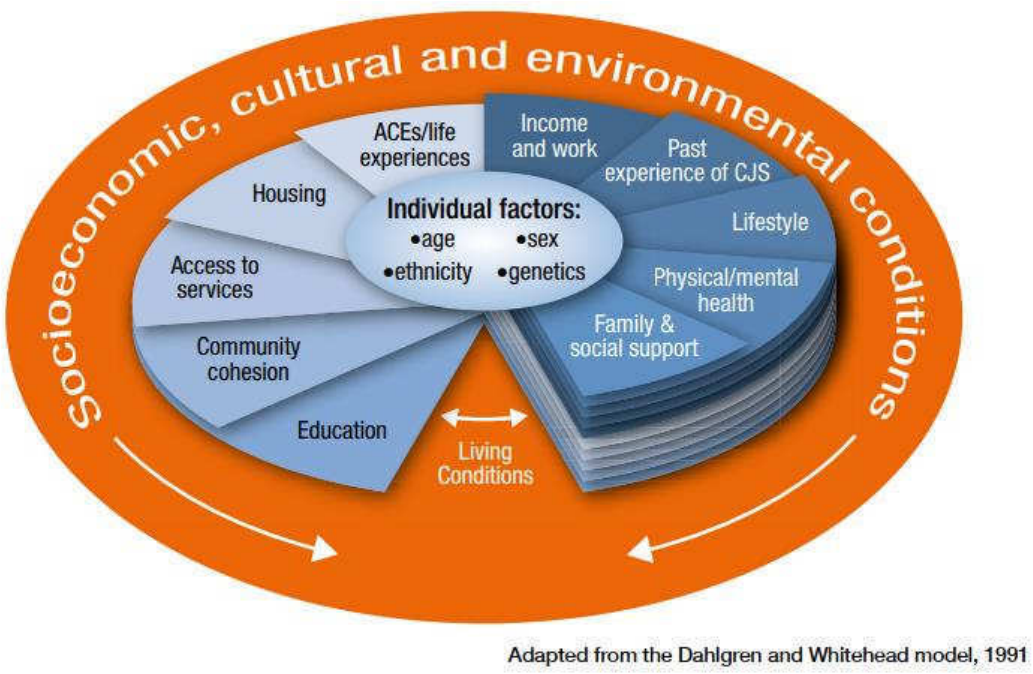
1. Introduction and aims

Although there is no completely safe level for consuming alcohol, it is acknowledged most adults drink responsibly at social occasions, in their home or at a licensed premise. A public house is often seen as a hub for community cohesion and it can prevent social isolation particularly amongst older men[1]. For some people however their drinking puts them at risk of physical and mental illnesses including alcohol dependency. Drinking alcohol can lead to premature death, and it can adversely affect drinkers' families and communities. Underage drinking is associated with school and educational problems, other risk-taking behaviours, and the development of drinking problems in later life. Alcohol consumption can be a causative factor in crime, antisocial behaviour and disorder, road traffic accidents and house fires. Alcohol has a large cost to the economy in terms of hospital admissions, crime, lost productivity at work and other societal costs.

This needs assessment aims to assess the level of need within South Gloucestershire for interventions to prevent and reduce the risks of drinking alcohol, and to treat those who are alcohol dependent. It aims to identify interventions which provide value for money. It looks at the level of need across the life course, and for communities and individuals with particular needs. The influence of some environmental, individual and social factors known to impact on health and how they might relate to drinking locally are considered based on Dahlgren and Whitehead's (1991) social determinants of health which are shown in Figure 1 below.

Following on from and including the recommendations from our CLeaR peer assessment in 2018, this needs assessment describes and reviews current service provision and its effectiveness. It identifies gaps in provision and actions to consider; and makes recommendations to be included in a new Alcohol Strategy for South Gloucestershire.

Figure 1: Social Determinants of Health



Source: PHE and College of Policing[2]

Where available, local and national data for prevalence of drinking at different risk levels, amongst different demographic groups (particularly those known to be more at risk), its associations with inequalities, and its harmful effects on health and the wider community is examined. The project team aimed to co-produce this needs assessment with all relevant organisations, partners and stakeholders in South Gloucestershire. A comprehensive stakeholder engagement process was therefore undertaken to discover their strategic priorities, and some sections have been written by our partners or developed through conversations with them and subsequently endorsed.

1.1. References

[1]University of Bristol (2018) Beermats to boost conversations in pubs and tackle loneliness in older men, Available at https://www.bristol.ac.uk/sps/news/2018/loneliness-older-men.html

[2]PHE and College of Policing (2019) Public health approaches in policing: A discussion paper, Available at https://www.college.police.uk/What-we-do/Support/uniformed-policing-faculty/Documents/Public%20Health%20Approaches.pdf

2. Method

2.1. What is a health needs assessment?

Health needs assessment (HNA) is a systematic approach which reviews the health problems of a population with a view to ensuring resources are efficiently allocated to improve health[1].

Bradshaw's taxonomy of social need[2], categorises needs as:

1. **Normative** – defined by a professional(s) as good practice
2. **Felt** – discovered by asking a population what they want. People can however be clouded by unrealistic desires, and/or prior knowledge of what is available, and/or reticence to admit a problem.
3. **Expressed** – felt needs translated into action such as accessing services. One measure of an unmet expressed need could be numbers on a waiting list.
4. **Comparative** – identified by comparing populations receiving a service with similar populations not in receipt.

NHS Health Scotland[3] categorise needs assessments as:

1. **Epidemiological** – where data is used to estimate the size and demography of the population; incidence and prevalence of disease within it; the social determinants of health; and to review current provision and effectiveness of provided services.
2. **Comparative** – the population receiving services are compared with those receiving services in a different area or time or to a population with different characteristics.
3. **Corporate** – a qualitative method to elicit stakeholder views about current needs and priorities for future improvements.

2.2. Methods used in this needs assessment

This needs assessment blends an epidemiological, comparative and corporate approach. The methods used to capture each need are listed in Table 1 (below):

Table 1:

Need	**Method**
Normative	Literature review. Engagement with partner organisations and key local professionals. Mapping against recommendations made by the peer reviewers during our 2018 CLeaR assessment process. CLeaR good practice standards are informed by National Institute for Health and Clinical Excellence (NICE) guidance.
Felt	Engagement with partner organisations; providers; key local professionals; our residents/the public; groups with protected characteristics; and service users
Expressed	Review of service performance data.
Comparative	Comparison of population and service data to the 'nearest neighbours' (16 similar Local Authorities (LAs) such as Bath and North East

Need	Method
	Somerset, Swindon and Wilshire), as defined by The Chartered Institute of Public Finance and Accountancy (CIPFA); regional; and national data.

2.3. References

[1]Wright, J., Williams, R., and Wilkinson, J. R. (1998). 'Development and importance of health needs assessment', *BMJ (Clinical research ed.),* vol. 316, no. 7140, pp1310-3. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113037/

[2]Bradshaw, Jonathan (1972) Taxonomy of social need. In: McLachlan, Gordon, (ed.) Problems and progress in medical care: essays on current research, 7th series. Oxford University Press, London, pp. 71-82. Available at http://eprints.whiterose.ac.uk/118357/1/bradshaw_taxonomy.pdf

[3]NHS Health Scotland (2018) *Improve policy and practice, Carry out a needs assessment,* Available at http://www.healthscotland.scot/improve-policy-and-practice/carry-out-a-needs-assessment (Accessed 12 November 2018)

3. Background

There is no current published national alcohol strategy and we are not expecting one in the foreseeable future. We have therefore taken the decision to develop a local one based on local needs. Our last Substance Misuse Needs Assessment (SMNA) was completed in 2016. A refreshed Alcohol Harm Reduction Strategy 2014-17 was developed from it, which now needs to be reviewed. In 2018 South Gloucestershire became a priority area of focus for alcohol for Public Health England (PHE) because the Public Health Dashboard ranks South Gloucestershire in the worst quartile for alcohol treatment as measured by a number of indicators (waiting times, numbers in structured treatment, estimated unmet need and mortality) providing a clear rationale for us to focus on better understanding alcohol related harm in South Gloucestershire. Due to the different approaches needed to tackle alcohol and drug harm, and their different places on key stakeholder's agendas, the decision was made to complete separate needs assessments for each to ensure due time and consideration is given to both. The documents will however connect with each other.

3.1 South Gloucestershire Drug and Alcohol Programme

The South Gloucestershire Drug and Alcohol Programme (DAP) was established in October 2017 when the previous Drug and Alcohol Action Team (DAAT) and the Young People's Drug and Alcohol Service joined together. The change of name reflected the aim for drugs and alcohol to be dealt with

in a strategic fashion across the life-course. The DAP vision is "To provide a **strategic**, **preventative** as well as **treatment** based, **life-course** approach to **drug** and **alcohol** harm in South Gloucestershire that meets the **needs** of the **population, including those most vulnerable** for the best **value for money**." Historically we have been, perhaps necessarily, very focused on treatment and we know that if you are in treatment, whether as a young person or an adult, you tend to do well in South Gloucestershire. However, our unmet need and hospital admissions suggests that there are a large amount of people in our population who are not getting the treatment they need and we are not being successful in our aim of preventing people from needing treatment in the first place.

3.2 CLeaR Review

The Alcohol Stakeholder group that oversaw development of the South Gloucestershire 2014-17 Alcohol Harm Reduction Strategy was disrupted during 2016/17 due to a divisional restructure, change in leadership of the Drug and Alcohol Programme (DAP) and recommissioning of community drug and alcohol services for adults. It was reconvened in 2018, when members contributed to an Alcohol CLeaR self-assessment and peer review process. CLeaR is a Public Health England (PHE) service improvement tool which is about:

- *"Challenging services - looking at key aspects of local delivery against the evidence base, identifying local innovation and learning*
- *Leadership - reviewing the local vision and governance supporting this, planning and commissioning arrangements and evidence of collaboration between partners*
- *Results - examining outcomes achieved locally and considering progress against local priorities"*[1].

It not only focuses on public health and treatment but also on alcohol harm across all domains, such as its place in criminal justice, social care and licencing[1]. We completed the self-assessment in the summer of 2018. We then took part in a peer review in September 2018, where commissioners from a different local authority, along with independent reviewers and members of PHE came and met with over 20 representatives from South Gloucestershire to discuss our self-assessment findings and rate our scores and evidence. We then received a peer review report in December 2018.

The CLeaR review report contained some positives, particularly around treatment for Young People and Adults[2]. However, it also suggested significant opportunity for improvement across all three domains[2]. Recommendations made by the CLeaR reviewers for consideration by strategic leaders in South Gloucestershire were[2]:

- All relevant organisations should be involved in the development of the new local alcohol strategy bringing a perspective on how this can contribute to wider agendas and outcomes
- Senior strategic leaders within the council are encouraged to use contact with their counterparts in other local partner agencies to increase engagement and ensure appropriate representations and commitment to the development and implementation of the updated strategy

- The content of the updated alcohol strategy and local improvement/delivery plan should make the partnership vision and ambition for reducing alcohol harm in South Gloucestershire explicit
- The proposed strategy and action plan should seek to clarify individual partner roles and responsibilities in achieving the identified outcomes, develop processes for evaluation progress against these and strengthen governance arrangements.

Further recommendations[2] made by the CLeaR reviewers are included in the relevant sections of this needs assessment. The work done to bring partners together to discuss how we tackle alcohol related harm across the partnership has enabled us to draw on other's expertise to develop this needs assessment. Our ambition was for this to be not just a Public Health needs assessment and strategy, but rather to be developed and held in partnership with other agencies and departments for whom alcohol use and its related harms is important to their work as well as ownership and oversight by the Health and Wellbeing Board.

Despite the obvious harms that alcohol can cause, we also recognise that for many people, alcohol is something they associate with pleasure, socialising and celebrating. It can help people to form friendships and has a place in our culture. We therefore need to ensure that the strategy focuses on reducing alcohol harm and helping people that choose to drink to do so as safely as possible being fully informed of the risks and potential consequences of drinking and where to get support should they want to cut down or get support or treatment

3.3 Why we are concerned about alcohol?

3.3.1 Making South Gloucestershire a great place to live and work

'*The South Gloucestershire Sustainable Community Strategy 2016*' was developed by the South Gloucestershire Partnership[3]. Members of this partnership include Avon and Somerset Police and Crime Commissioner, South Gloucestershire Clinical Commissioning Group, City of Bristol College, Airbus, and The Care Forum[3]. The strategy articulates a strategic vision for the next twenty years to make South Gloucestershire a *"great place to live and work"*[3]. For this purpose, it includes ambitions to[3]:

- Give children the best start in life
- Improve educational standards in schools
- Reduce the level of crime and disorder
- Reduce health inequalities
- Ensure health needs of residents are met
- Help people to make healthy choices

Drinking alcohol during pregnancy does not give children the best start in life. It can result in spontaneous abortion, premature and/or low birth weight babies, and babies born with a collection of conditions termed foetal alcohol spectrum disorder (FASD)[4]. Reducing drinking could reduce crime and disorder. For example, it has been estimated that in two-thirds of domestic incidents reported to the police at least one partner was under the influence of alcohol[5]. 40% of victims of violent incidents in 2016 believed their perpetrators were under the influence of alcohol[6]. Reducing alcohol consumption amongst people suffering multiple deprivations could reduce health

inequalities. We know that although in Great Britain people who are poorer do not necessarily drink more alcohol than those in higher socioeconomic groups (and might drink less), they suffer the greatest health harms from alcohol[7]. We also know there is no safe level of alcohol consumption. The UK Chief Medical Officers suggest pregnant women abstain and non-pregnant adults drink no more than 14 units of alcohol per week[8]. Furthermore, for people on a low income, money spent on alcohol could exacerbate their struggles to pay their household bills and to afford a healthy diet. One of the four themes of 'The South Gloucestershire Council Plan 2016/2020' is to *"promote personal well-being, reduce health inequalities and deliver high quality physical and mental health and social care services which protect our most vulnerable"*[9]. Key measures of success in the plan include:

- Alcohol specific admissions to hospital per 100,000
- Standardised premature (<75) all-cause mortality per 10,000 (all South Gloucestershire) and (all Priority Neighbourhoods)
- Children subject to a child protection plan for a second/subsequent time
- Key Stage 2 attainment (Level 4 and above in Reading, Writing and Maths)

For English people aged 15 to 49 years, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability[4]. For all ages it is the fifth most important risk factor[2]. Alcohol is a causal factor in more than 200 diseases including high blood pressure, breast cancer, liver cirrhosis, and depression[4]. Parental alcohol misuse impacts on the whole family and can result in their children needing child protection plan(s), suffering serious harm or even death[10,11]. *"Children who start drinking early are more likely to become more frequent and binge drinkers and underage drinking is associated with school and educational problems, unprotected sex, consumption of illicit drugs, violence and drinking problems in later life"*[4]

'The South Gloucestershire Joint Health & Wellbeing Strategy 2017-2021' promises "*The Health and Wellbeing Board will:…Commit to continued investment in evidence-based programmes that promote the physical and mental health and wellbeing of children and young people, and minimise the use of …alcohol*[12]*.* The South Gloucestershire Health and Wellbeing Board have prioritised four areas for collective action. These are to:

"1. Improve educational attainment of children and young people, and promote their wellbeing and aspirations.
2. Promote and enable positive mental health and wellbeing for all.
3. Promote and enable good nutrition, physical activity and a healthy weight for all.
4. Maximise the potential of our built and natural environment to enable healthy lifestyles and prevent disease."[12]

The health and social harms caused by alcohol are proportional to the amount of alcohol consumed and frequency of consumption[4]. Approximately 1 in 4 adults in England could benefit from reducing their drinking[13].

3.3.2 Adverse childhood experiences

We acknowledge that alcohol services in South Gloucestershire and the information surrounding alcohol and its impact on health, both short term and long term, need to be accessible for all

residents in order to prevent ACEs in future generations. The term Adverse Childhood Experiences (ACEs) identifies and includes those experiences that directly harm a child (e.g. physical, sexual or emotional abuse) or affect them through the environment they live in. This includes: growing up in a household where there is alcohol misuse, drug misuse, parental separation/loss, mental illness, domestic abuse or where someone has been incarcerated.

In South Gloucestershire we understand that stressful experiences in childhood can have an impact throughout people's lives. As a result of this, we are working towards having an ACE-informed approach with our work. We recognise that ACEs have a profound impact on an individual's life chances and are working to develop a holistic ACEs approach that aims to:

- Prevent ACEs in future generations, including breaking the cycle of ACEs within families
- Support and build resilience in families and children who are at risk of exposure to ACEs
- Recognise the signs and symptoms of ACEs to enable appropriate early intervention
- Recognise the impact of ACEs on adults.

Research has shown that people with ACEs are at greater risk of a range of negative health, social and economic outcomes. The research also shows that the more ACEs people have, the greater the risk. It is important to understand that those outcomes are not inevitable, but for many people those outcomes may be more likely.

From a service user perspective, an ACE-informed approach asks: 'What happened to you?' rather than, 'What's wrong with you?' and goes on to ask, 'How has this affected you?' and 'Who is there to support you?' It is a change in culture away from a system that labels people as symptoms or behaviours. Instead, it is about being aware and responsive about recognising that what happened in childhood can impact the journey of people's lives today. It is also about taking the time to listen and understand.

3.4 References

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4. Alcohol consumption

One unit of alcohol equates to 10ml in volume (or 8g in weight) of pure alcohol[1]. Alcohol by volume (ABV) describes the proportion of pure alcohol contained in the drink measured in terms of volume and expressed as a percentage[1]. For example a bottle of wine described as 14% ABV contains 14ml pure alcohol per 100ml of wine, and 100ml (less than a small 125ml glass) of this wine would therefore contain 1.4 units. Similarly a single measure (25ml) of typical vodka (ABV 40%) contains one unit, as does less than half a pint (250ml) of lager, beer or cider of ABV 4% strength[1].

The Chief Medical Officers' guideline for both men and women is that[2]:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.

For women who are pregnant or think they could become pregnant the recommendation is not to drink alcohol at all.

Children and their parents and carers are advised that an alcohol-free childhood is the healthiest and best option. Alcohol consumption during any stage of childhood can have a detrimental effect on development and, in particular, alcohol use during teenage years is related to a wide range of health and social problems. Vulnerability to alcohol-related problems is greatest among young people who begin drinking before the age of 15. The recommended safest option for children and young teenagers up to and including the age of 14 years is not to drink at all[3].

4.1.1. Categorising alcohol consumption

Lower risk drinking – is considered to be following the UK Chief Medical Officers' guidance for adult males and non-pregnant females of not regularly drinking more than 14 units per week[2,4]. This level of consumption and/or a score of between 1 and 7 in the screening tool *'Alcohol use disorders identification test'* (AUDIT) is likely to indicate a lower risk of experiencing harms from drinking alcohol, although any alcohol consumption cannot be considered as totally safe[2,5]. It has also been called 'sensible' or 'responsible' drinking.

Increasing risk (hazardous) drinking – is defined as the regular consumption of between 14 and 35 units per week for women and of between 14 and 50 units for men[4,6]. Drinking at such a level would be expected to increase the risk of adverse health and social consequences[4]. This level of drinking could result in a score of 8-15 in the AUDIT screening test, whereby the World Health Organisation (WHO) recommended advice would be to reduce drinking levels[5].

Higher risk (harmful) drinking – applies to women regularly drinking more than 35 units per week or men regularly drinking more than 50 units[4,6.] It is defined by NICE as a pattern of alcohol consumption causing health problems directly related to alcohol[4]. Such problems include depression, alcohol-related accidents and acute pancreatitis[7]. Continued higher-risk drinking can result in developing disease conditions such as breast cancer, oral cancer, high blood pressure and liver cirrhosis[7]. For higher risk drinkers scoring 16 to 19 in the AUDIT, the WHO recommend brief counselling and continued monitoring[5].

Binge drinking – is defined by the Office for National Statistics as when more than 8 units (for men) or 6 units (for women) are consumed on a person's heaviest drinking day in the week previous to partaking in a survey[8]. NICE define it as drinking a lot of alcohol in a short timescale which raises their risk of harm (such as injury, toxicity, misjudging risky situations and/or loss of control) on that occasion[4].

Long term higher risk or binge drinking can result in alcohol dependency.

4.1.2. Alcohol dependency and severity of dependency

Dependent drinking – an AUDIT score of 20+ indicates the possibility of alcohol dependence[5]. Alcohol dependence is a diagnosable disease listed in the 'Diagnostic and statistical manual of mental disorders' (DSM-V) published by the American Psychiatric Association and the 'International statistical classification of diseases and related health problems – 10th revision' (ICD-10) published by the World Health Organization[4,9]. It manifests as the presence three or more diagnostic markers which include compulsion to drink, experience of withdrawal symptoms, tolerance, continued drinking despite evidence of harm, and neglect of other interests[10].

Although a diagnosis of dependence or its absence is useful for diagnostic and statistical purposes, the reality is that it exists on a continuum of severity[7]. To assist with treatment, alcohol dependence can be subdivided into mild, moderate or severe. These categories can be assessed using the *'Severity of Alcohol Dependence Questionnaire'* (SADQ)[7].

Mild dependence – people scoring ≤15 on the SADQ scale are assessed as suffering mild dependence. They do not usually require assisted alcohol withdrawal[7].

Moderate dependence – those with a SADQ score of 15- 30 indicating moderate dependence usually need assisted alcohol withdrawal. In the absence of other risk factors, they can generally be managed in a community setting[7].

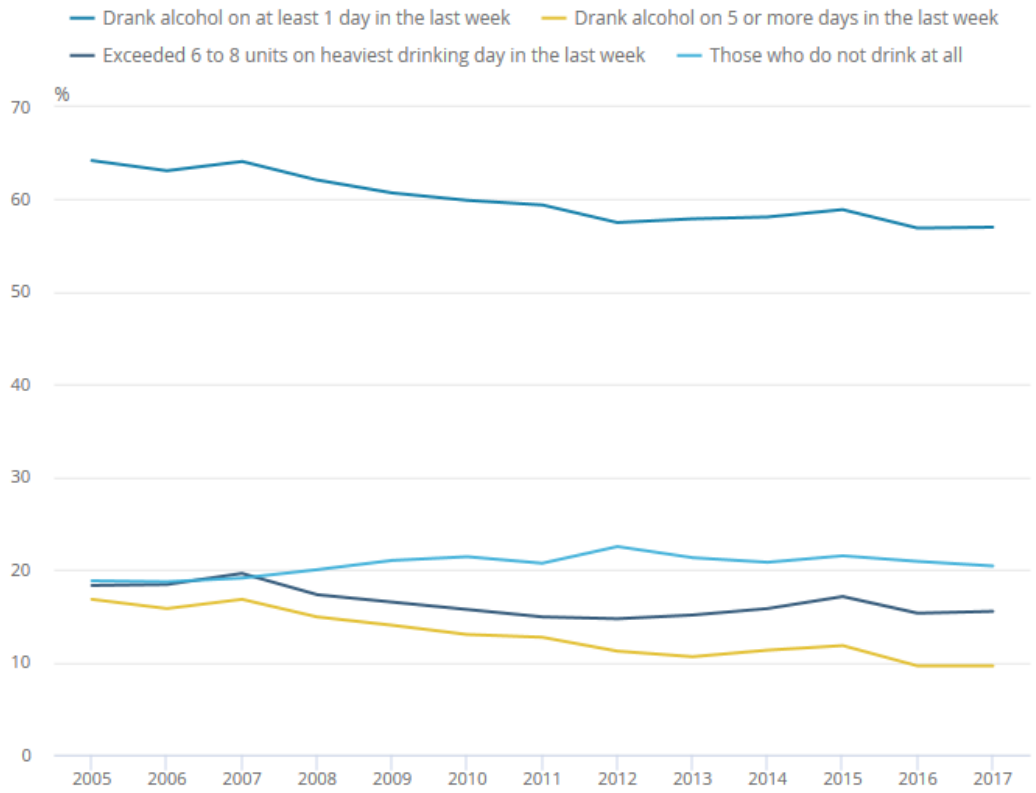
Severe dependence – (SADQ >30) need assisted alcohol withdrawal and are normally managed as a hospital inpatient or within a residential treatment centre[7].

4.2. National adult drinking behaviour

The 2017 Office for National Statistics (ONS), Opinions and Lifestyle Survey reports on drinking behaviour in the week before interview[8]. The sample size for the survey is approximately 7,100 people, and the results are weighted to represent the population of Great Britain[8]. Great Britain is comprised of England, Scotland and Wales.

57% of respondents aged 16+ reported drinking alcohol in the week before the survey in 2017, compared with 61% in 2009 and 64% in 2005[9]. People exceeding 6 to 8 units (indicating binge drinking) on the heaviest drinking day in the week before being surveyed in 2017 was 15.5% - a decrease from 16.5% in 2009 and 18.3% in 2005[8]. This downward trend in drinking amongst adults in Great Britain is illustrated in Figure 2 below. It also shows some increase in those abstaining from alcohol – 20.4% in 2017 when compared to 18.8% in 2005.

Figure 2: Self-reported drinking habits in the week prior to interview, Great Britain, 2005 to 2017



Source: Opinions and Lifestyle Survey, General Lifestyle Survey and General Household Survey; Office for National Statistics

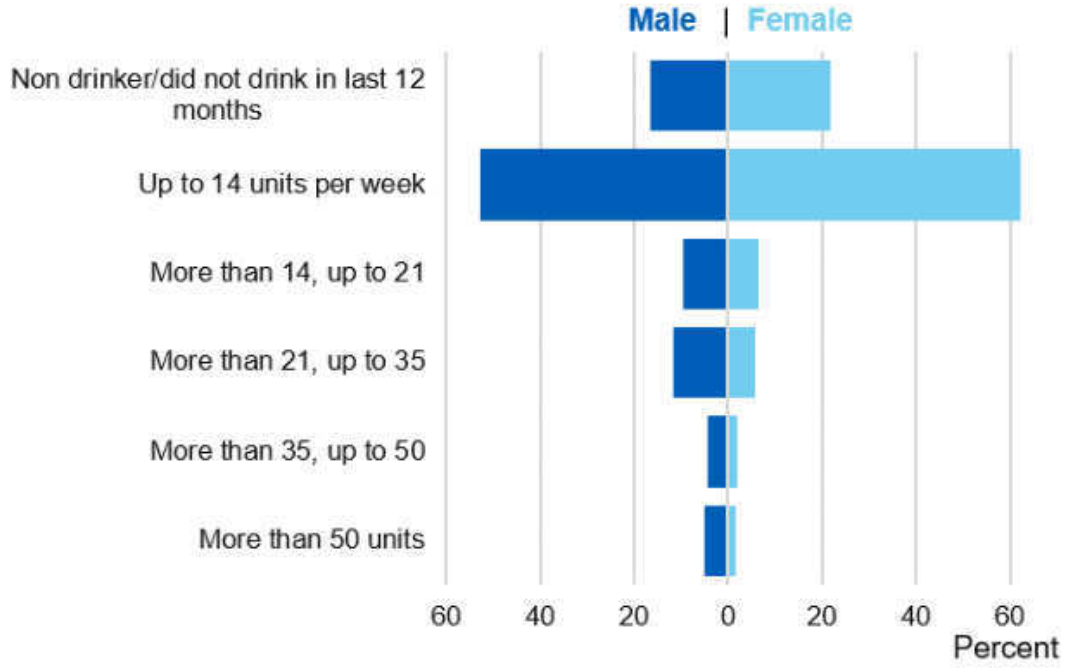
Source: ONS[8]

4.2.1. Effect of gender and age

Men in Great Britain were found to drink more than women, with the highest consumption being in males aged 45 to 64 years[8]. The lowest consumption of alcohol was among those aged 16 to 24 years, although when they did drink, they were the age demographic (both males and females) most likely to binge drink – although probably mainly only at the weekend[8]. Drinkers over 65 years were least likely to binge drink but for those that did, the proportion of males doing so was almost twice that for females[8]. The most harmful drinking was stated to be amongst middle aged drinkers who are most likely to drink every day[8].

The number of units consumed per week by gender from data collected in the 2016 Health Survey for England is shown in Figure 3 below and those binge drinking is shown in Figure 4:

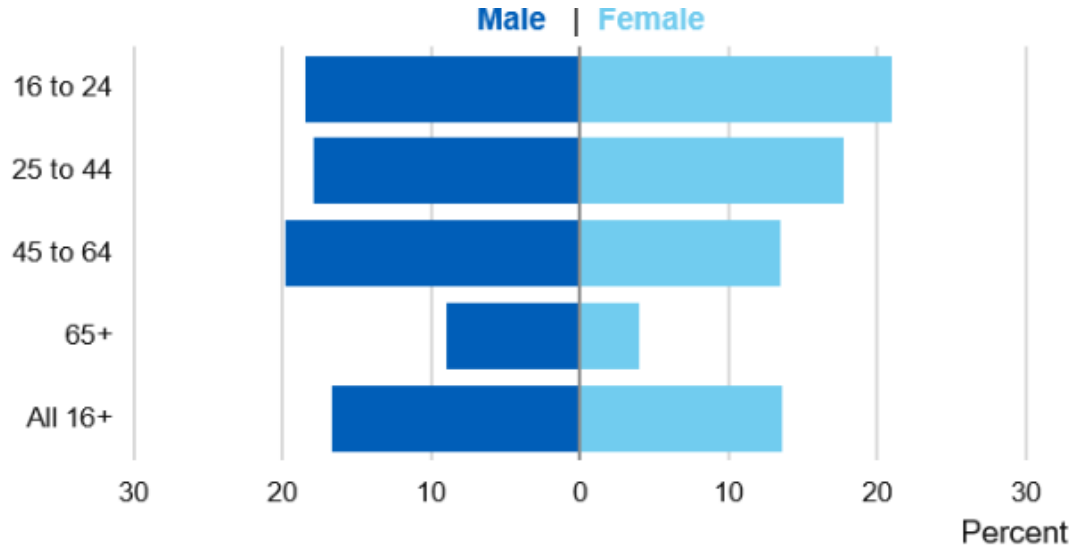
Figure 3: Weekly consumption of alcohol in England by gender



Source: ONS[11]

Men are more likely than women to drink more than 14 units per week (indicating increasing or higher risk drinking)[11].

Figure 4: Drinking more than 8/6 units on heaviest drinking day in the last week by sex and age

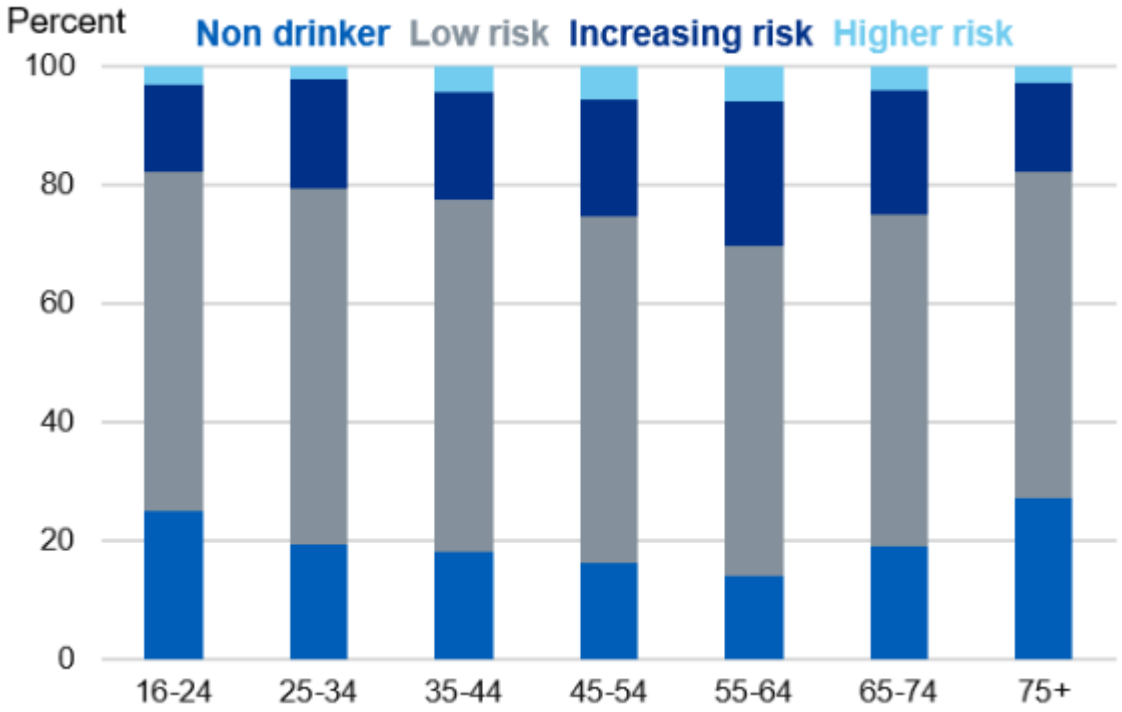


Source: ONS[11]

Binge drinking is most prevalent in young people aged 16-24 (particularly young females) and declines with age[11].

Figure 5 below shows younger and older adults were most likely to be abstainers and those aged 55 to 64 as most likely to be drinking at increasing or higher risk levels.

Figure 5: Weekly consumption of alcohol in England by age



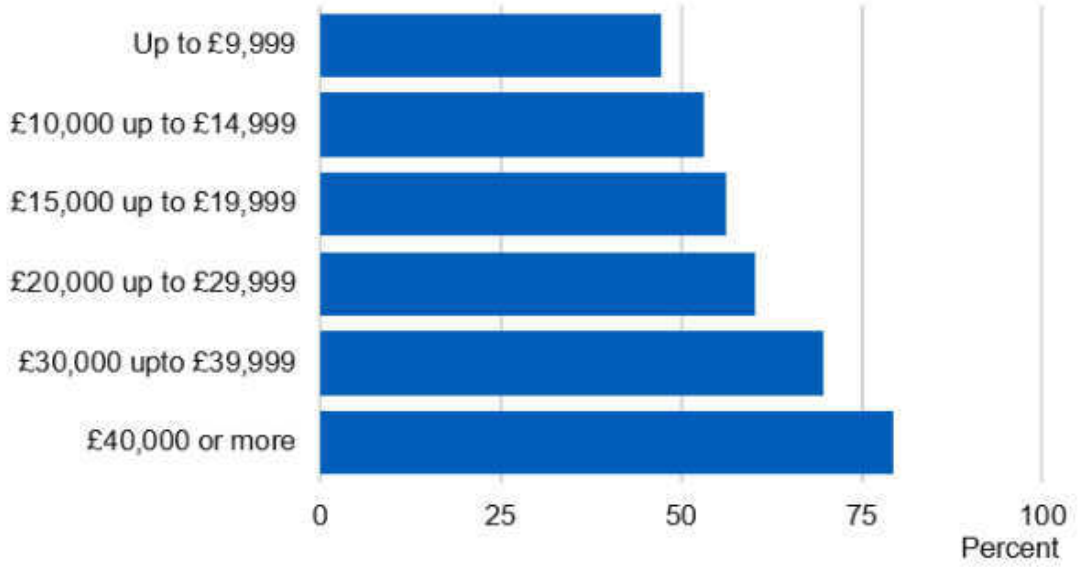
Source: ONS[11]

A more detailed analysis of this survey reported that men are more likely to drink beer, stout, lager or cider (including the strong versions) and women are more likely to drink wine or champagne on the heaviest drinking day in the week before interview[11].

4.2.2. Effect of socioeconomic status

High earners in England were more likely to drink alcohol; whereby 79% of those surveyed earning over £40,000 drank alcohol in the week before their interview compared to 47% of those earning up to £9,999. This is illustrated in Figure 6 below:

Figure 6: Drinking by annual income



Source: ONS[11]

Similarly those in higher as opposed to lower socioeconomic groups drink more often[8]. Approximately 7 in 10 working in managerial and professional occupations (includes doctors, nurses and teachers) reported drinking in the week before interview, as opposed to only approximately 1 in 2 working in routine and manual groups (such as care workers, bar workers, labourers and lorry drivers).

A study from Scotland shows that less affluent, moderate alcohol drinkers have a higher risk of harm than more affluent, heavy drinkers[12]. There are thought to be a number of complex reasons for this; alcohol use combined with other health-challenging behaviours, such as smoking or having a poor diet, has been found to multiply the risk of developing alcohol related conditions compared to doing them separately or not at all. In 2016, a paper came out that showed how less affluent drinkers are more likely to have more health-challenging behaviours at the same time, compared to their more affluent counterparts[13]. Multiplied risk may explain the difference in harm, despite the different groups drinking similar amounts or possibly more affluent people drinking more. Another explanation could be that people living in less well-off areas drink alcohol in more harmful ways, for example, binge drinking and therefore suffer more injury from alcohol than more affluent people. People with a lower socioeconomic status have to deal with more barriers in accessing health services than people with a higher socioeconomic status, for example transport costs and being on waiting lists (not affording quick access through private healthcare). On top of that, stigma around alcohol dependence seems to be particularly high for less affluent people. Together, these barriers mean that less affluent drinkers are less likely to receive, or look for, professional help with alcohol-related diseases and disorders[14]. Another explanation could be that alcohol harms have caused people to move down the socioeconomic gradient, and thus there is a higher concentration of people who drink alcohol in a problematic way living in areas of socioeconomic deprivation.

Actions to consider

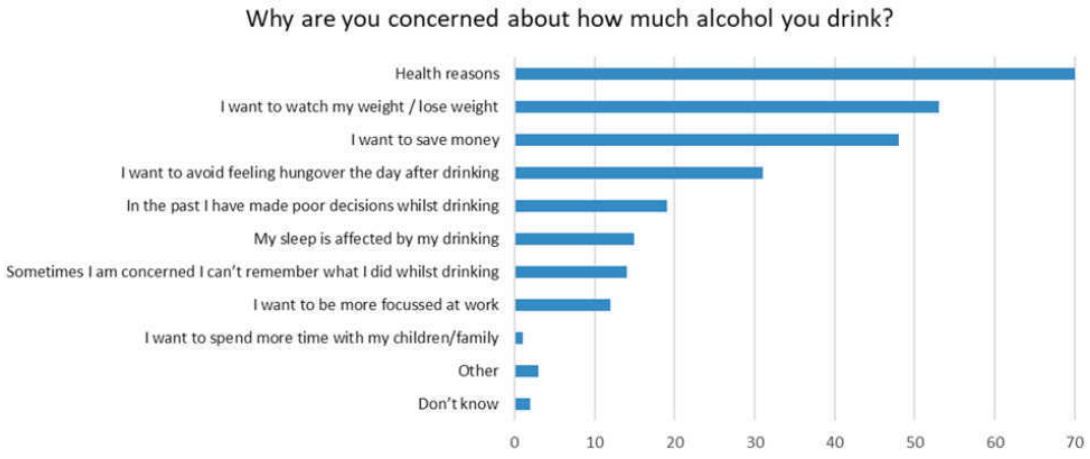
1. Targeted messages for those in different socioeconomic groups; for example for professional and managerial occupations to reduce consumption, and for those in routine and manual groups; non-stigmatising and sensitive messages aimed at reducing all health harming behaviours and binge drinking.
2. Plan how services can be made more accessible to people working in routine and manual groups and for people on a low income.

4.2.3. Effect of gender, age and socioeconomic status on the awareness of drinking guidelines, and perception of drinking in the UK

The 2018 Health Alliance survey entitled *'How we drink, what we think, Public views on alcohol and alcohol policies in the UK'* found that only 19% of people in the UK are aware that low risk drinking equates to drinking 14 units per week; and 28% of men and 14% of women self-reported drinking more than this[15]. They also found that people with higher socio-economic status and older (especially those aged 50-64) rather than younger (especially those aged 18-24) are more likely to know about units and the lower risk guidelines[15].

Furthermore they found that less 18-24 year olds (58%) than 50-64 year olds (71%) considered the UK has an unhealthy relationship with alcohol; and only 14% of all drinkers who were surveyed reported being concerned about how much alcohol they drank[15]. Reasons expressed for their concern are detailed in Figure 7, below. The top three reasons were health, weight and money.

Figure 7: Why are you concerned about how much alcohol you drink?



Source: UK Health Alliance survey, 2018[15]

Actions to consider

1. Education to transmit the message about low risk drinking and units, particularly for those aged 18 to 24 and people in lower socioeconomic groups.

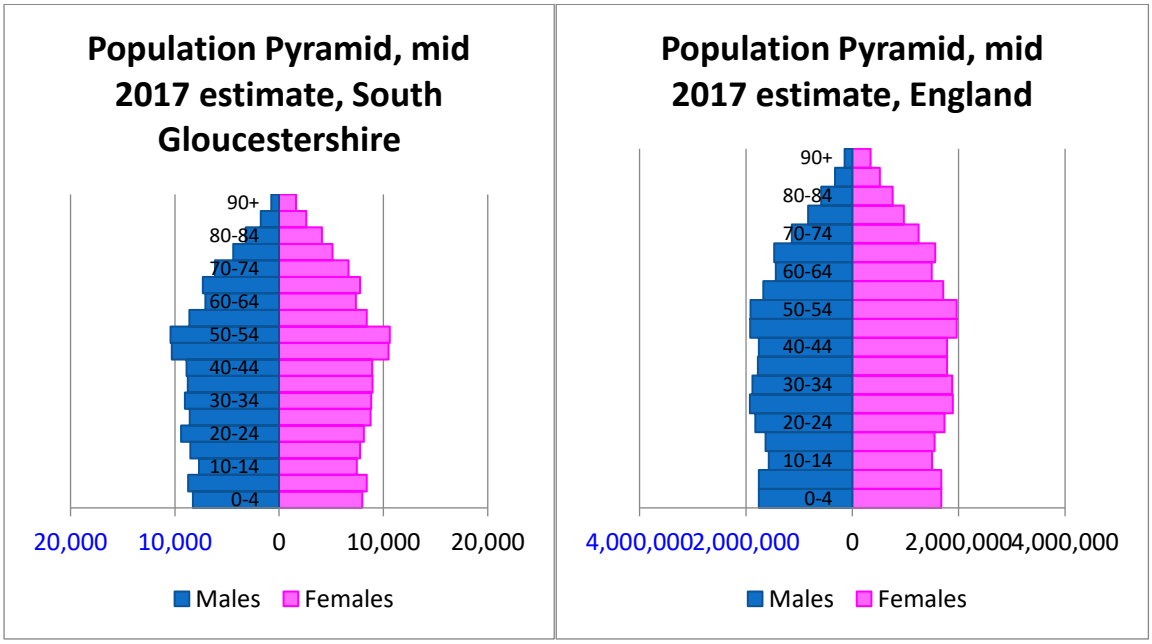
2. Adapt campaigns to target the issues that people are concerned about around alcohol use, particularly health, weight and money.

4.3. South Gloucestershire demographics

South Gloucestershire is situated in the South West region of England and has a total resident population estimated (ONS, 2017), mid-year population to be 279,000, of which 138,400 (49.6%) are described as male and 140,600 (50.4%) as female[16].

The population structure of South Gloucestershire is similar to the national average, albeit with a slightly larger proportion of middle aged people[17]. Approximately 19% of the population are children aged 0-15 years; 63% are broadly of working age (16-64 years) and 18% are older people aged 65+[18]. The distribution of ages and genders in 2017 compared with the pattern in England is shown in Figure 8 below.

Figure 8:



Source: South Gloucestershire Council (2018) BNSSG Demographics[17]

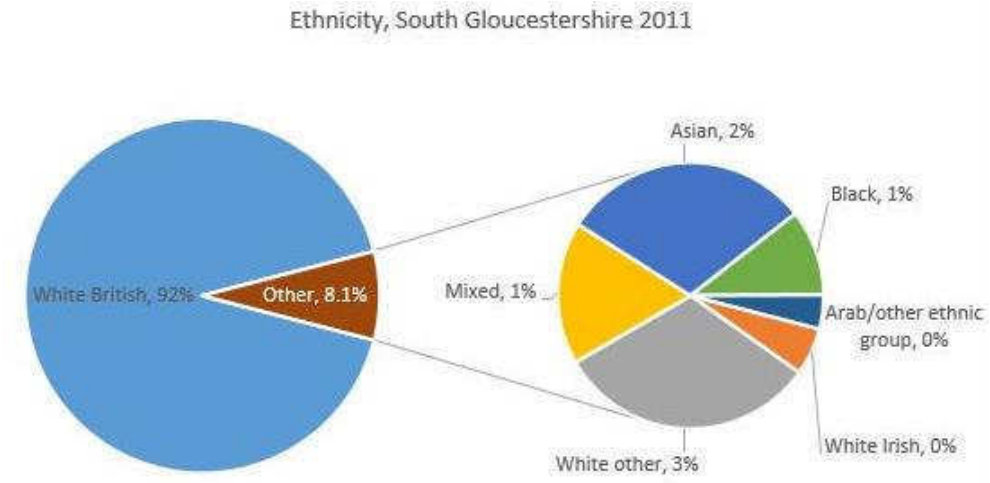
South Gloucestershire is mainly a relatively affluent area. It is ranked as 274 out of 326 local authorities, where 326 is the least deprived and 1 the most[19]. 68% of the local population are among the 40% most affluent, although there are pockets of deprivations[17]. These pockets are mainly concentrated in what were (until May 2019) the wards of Staple Hill, Kings Chase, Patchway, Parkwall and Woodstock[19].

Six areas were designated as Priority Neighbourhoods. These were the wards previously known as Patchway, Staple Hill, Kingswood, Cadbury Heath, Yate and Dodington, and Filton[21]. Staple Hill contained the most deprived Lower Super Output Areas (LSOAs) in South Gloucestershire; and is the most deprived in terms of income, employment, health and disability, and living environment[21]. The highest level of crime deprivation was found within nine LSOAs in Kingswood and three LSOAs within Staple Hill[21]. Filton was the least deprived priority neighbourhood (and was therefore renamed as an area of focus)[21].

From the 2011 Census, it is estimated 5% of residents living in South Gloucestershire identify as in a Black and Minority Ethnic (BAME) grouping, which is approximately one third the proportion for England and Wales[19,20]. As shown in Figure 9 below a further 3% of residents identify as White

Other[19]. The largest ethnic groups are Asian (2%), Mixed (1%) and Black (1%)[19]. Data from the 2011 census estimates the white gypsy or traveller population in South Gloucestershire to be in excess of 270 (0.1%)[19].

Figure 9:



Source: Office for National Statistics, Census 2011, cited in South Gloucestershire Council (updated 2017) Joint Strategic Needs Assessment[19]

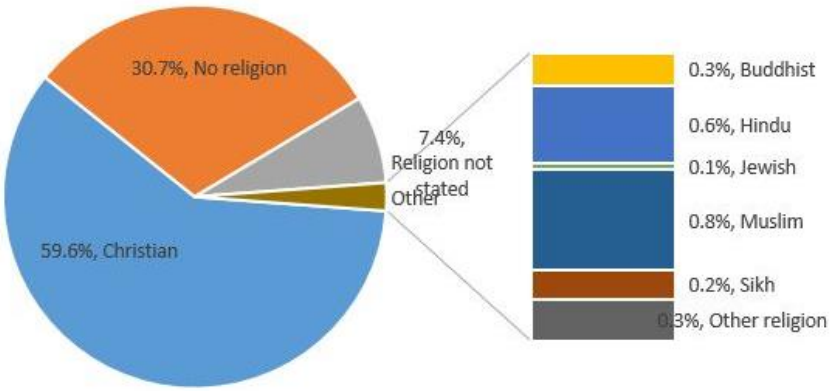
Gypsy and Traveller communities suffer some of the worst health outcomes in the UK[22]. Limited evidence indicates variations in alcohol use between different Gypsy, Romany and Traveller communities, with some communities being abstinent[22]. There is some weak qualitative evidence that indicates alcohol consumption is used to self-medicate bereavement and depression amongst Gypsies and Travellers [23]. There are anecdotal reports that premature deaths amongst young Gypsies and Travellers due to road traffic accidents are associated with alcohol use and high speed driving[22]. When we spoke with three members of a local gypsy and traveller community as part of our 2019 stakeholder engagement exercise, their comments were:

- Alcohol is not a problem in the traveller community
- Women only drink on special occasions
- Men drink socially – maybe once per week
- Hadn't heard of services and didn't know where to go if they needed help
- Educates children through watching programmes with them and then and discussing it.

NICE state *"…some Black and minority ethnic groups are less able to metabolise alcohol than Caucasians"*[4]. It may therefore be that people from these BAME groups drink less alcohol due to being more sensitive to its effects including hangover. The prevalence of alcohol dependence is likely to be lowest amongst South Asian men living in the England[24]. The prevalence of alcohol dependence amongst Black men might be lower than that of males from White or Other ethnicities living in England[24]. South Asian women had either the lowest or second lowest prevalence possibly sharing this ranking with Black women but the evidence for this was very weak[24].

At the time of the 2011 census, the majority of South Gloucestershire residents described themselves as Christian (60%), Muslim was the second most common religious group (0.8%) followed by Hindus (0.6%)[19]. Over a third of the population did not disclose their religion or stated they had no religion[19]. This is illustrated by Figure 10 below.

Figure 10: Religion 2011 of South Gloucestershire residents



Source: Office for National Statistics, Census 2011, cited in South Gloucestershire Council (updated 2017) Joint Strategic Needs Assessment[19]

For some faiths including Muslims and Sikhs the consumption of alcohol is proscribed, although not all who identify as of a certain faith practice its commands or follow its guidelines. A 2006 Brazilian review of international studies stated higher levels of religiosity are associated with less alcohol use or dependence[25].

Actions to consider

1. To reduce health inequalities, provide outreach to known Gypsy and Traveller communities in South Gloucestershire to raise awareness of OYSG and discover how such services could best meet the needs of this community.

4.3.1. Licensing, availability, consumption of alcohol

Under the Licensing Act 2003 all premises that sell alcohol have to have a premises licence and persons authorised to sell alcohol. South Gloucestershire Council is the Licensing Authority for South Gloucestershire. The Licensing Act 2003 stipulates four statutory obligations which must be considered before granting a license. These are:

1. The prevention of crime and disorder
2. Public safety
3. The prevention of public nuisance
4. The protection of children from harm.

As part of the application process the applicant has to explain what procedures are in place to ensure that children are protected from harm and plans are stated (such as the use of CCTV and/or employment of security officer(s)) for how to meet the other three obligations. Licences will not be granted unless that can be demonstrated. Licenses might be granted subject to certain conditions, but this information is not currently online for easy accessibility to the public. Risk based visits to premises are also made, particularly when the Designated Premises Supervisor (the person responsible for the premises) is changed.

Trading Standards enforce many pieces of legislation relating to under age sales and alcohol is one of these. They will provide advice and guidance to retailers, both physical and online, and where necessary undertake test purchasing operations. In addition they are a 'responsible authority' under

the Licensing Act 2003 and will review all applications to try and ensure that the objective to protect children from harm is being met. This could include introducing policies such as age checking, refusal logs and others. Public Health are not currently represented on the Licensing Enforcement Group. Our CLeaR peer reviewers recommended Public Health gain representation at the Licensing Enforcement Group.

As estimated by our local police force, there are currently approximately 700 licensed premises in South Gloucestershire. These include pubs, clubs, supermarkets, convenience stores, off licences restaurants and café/bars. New licensing applications received by South Gloucestershire Council for the sale of alcohol since May 2012 is shown in Table 2 below. Without knowing how many licensed premises close or stop selling alcohol, we are unsure whether the number is increasing each year.

Table 2: Number of new licensing applications from premises in South Gloucestershire

Year	New Applications
4 May 2012 to 31 Dec 2012	17
1 Jan 31 Dec 2013	43
1 Jan to 31 Dec 2014	22
1 Jan to 31 Dec 2015	12
1 Jan to 31 Dec 2016	25
1 Jan to 31 Dec 2017	24
1 Jan to 31 Dec 2018	16
1 Jan to 9 Sept 2019	18

Directors of Public Health are deemed a responsible authority in the Licensing Act 2003. The public health division currently responds to applications for new licenses and variations upon existing licenses, relating to the sale and/or supply of alcohol, the provision of regulated entertainment and/or late night refreshment. The South Gloucestershire Public Health division make recommendations to the Licensing Sub-Committee of the Regulatory Committee in response to the measures proposed by the applicant to meet the four licensing objectives. They provide information on which ward the premises are located in; the distance from other licensed premises and schools; whether it is a Priority Neighbourhood; and whether alcohol-specific admissions, alcohol-attributable hospital admissions and emergency admissions are higher, lower or not significantly different from the South Gloucestershire average. There is however currently no licensing obligation to protect adults from alcohol-related health harms.

Public Health does not routinely receive feedback on the impact of this information on licensing applications, and although Public Health are a responsible authority, legally decisions around granting a license can only be considered and influenced by compliance with, or lack of compliance, with the four licensing objectives and the objectives don't directly relate to health. For the future our CLeaR reviewers suggested it might be useful to obtain data from the ambulance service to map where there might be issues with licensed premises.

Alcohol Research UK conducted a geographical analysis using databases for 2003, 2007, 2010 and 2013 which were estimated to contain 98% of all outlets selling alcohol in England[26]. Calculations on outlet density were calculated at the Lower Super Output Area (LSOA) level. Hospital Episode Statistics from 2002/3 to 2013/14 were cleansed according to PHE practice, scrutinised to identify alcohol-related (narrow measure) hospital admissions. From this data four outcome categories of alcohol related harm were chosen[26]. Their findings were:

- "*A higher density of on-trade outlets is associated with higher hospital admissions for conditions wholly attributable to alcohol.*
- *A higher density of licensed convenience stores is also associated with higher hospital admissions for conditions wholly attributable to alcohol.*
- *The relationship between outlet density and hospital admissions is largely the same for men and women, though appears more pronounced for older people.*
- *The overall relationship between outlet density and hospital admissions appears to be the same in deprived areas and affluent areas."* [26]

Furthermore exposure of children to the marketing of alcohol increases the risk children will start to drink alcohol or if already drinking they are more likely to increase their consumption[27]. Restricting and enforcing the hours particularly for on-trade alcohol sales in the most densely populated areas has been found to be cost-effective[27].

PHE estimated that in 2016/17 there were 1.3 premises licensed to sell alcohol per square kilometre in South Gloucestershire. This is identical to the average density in our CIPFA nearest neighbours and statistically similar to that for England (1.4)[28]. Although the density in South Gloucestershire does not appear to cause concern, our population is mainly situated in urban areas surrounded by large rural areas. It is likely therefore that our licensed premises are concentrated in relatively small, densely populated areas.

The DAP team continues to build links with the Licensing and Safer and Stronger teams. As recommended by the CLeaR peer reviewers, we are currently considering how best we can influence the availability of alcohol in the local population. Kingswood High Street is located in one of our most densely populated areas. It is also in one of our Priority Neighbourhoods. It has a high density of alcohol on-trade, off-trade, and late night refreshment establishments. It has therefore been designated as a Cumulative Impact Zone (CIZ). In a CIZ the collective effect of granting additional licenses on the promotion of the four licensing obligations is considered.

In 2014 the estimated total volume of pure alcohol sold in South Gloucestershire through off-sales such as a supermarket or convenience store (4.6 litres per adult) was less than that estimated as an average for our CIPFA nearest neighbours (5.5 litres per adult), and that for England (5.5 litres per adult)[28]. Similarly South Gloucestershire on-trade sales figures such as that sold in a pub or restaurant in 2014 (1.58 litres per adult) were estimated to be lower than the national average[29]. In 2014 more alcohol in South Gloucestershire and nationally was sold through off-trade outlets than on-trade outlets[29]. This suggests that more alcohol is being consumed in people's homes than in pubs and bars.

Estimates of volume sold however are 5 years old and were calculated from 2014 commercial alcohol sales data designed to estimate sales per TV region[28]. Furthermore sales from discount retailers or online sources were excluded[28]. The method to estimate local authority level data was to calculate average sales volume per sales outlet per region by drink type, multiply that by the number

of outlets in the local authority and then divide it by the population to produce rates per adult[28]. This method would not show if there were above average sales per outlet in South Gloucestershire when compared with the region.

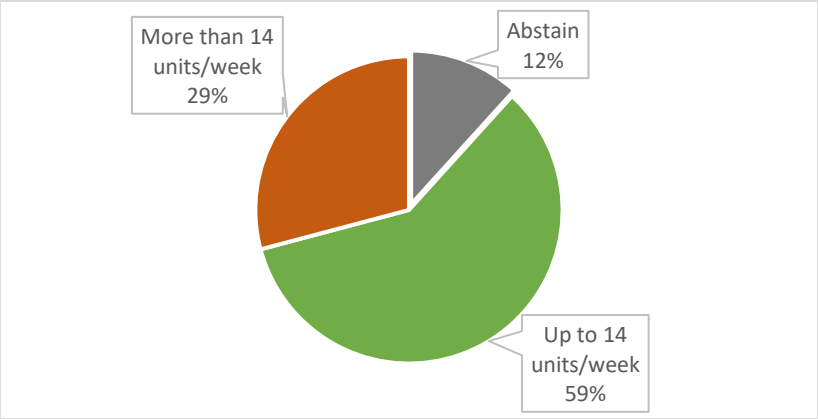
Actions to consider

1. Request that Public Health gain representation at the Licensing Enforcement Group.
2. Investigate if and how health considerations could be tailored to fit the current four licensing objectives, and/or whether to lobby for a fifth licensing objective such as restricting the availability of alcohol in areas known to suffer a higher proportion of alcohol-specific and/or attributable hospital admissions and/or emergency admissions.
3. Contact the ambulance service to request relevant data and analyse it to see if there are associations with certain licensed premises or geographic areas; and provide this information to the Regulatory Committee.
4. Meet with our digital team to discuss the feasibility of mapping all the alcohol on-trade, off-trade, and late night refreshment establishments; and making available all licences and conditions online to provide public transparency.

4.3.2. Adult drinking risk levels

The proportion of adults drinking alcohol above or below the lower risk levels currently recommended by the UK Chief Medical Officers, or abstaining from alcohol in South Gloucestershire, is shown in Figure 11 below. Public Health England estimated that 29% [α]of our population drink more than 14 units of alcohol per week[30], which places them in a category of increasing risk, higher risk or dependency. The proportion in such risk categories is higher than that estimated for England (26%)[30], albeit deemed by PHE to be statistically similar[28]. The numbers in South Gloucestershire drinking up to 14 units/week is the same as that for England (59%)[30].

Figure 11: Estimated adult consumption in South Gloucestershire



Source: Weighted estimate of data from the Heath Survey for England cited in PHE[30]

The difference might be at least partially explained due to a larger proportion abstaining from alcohol in England (16%) than in South Gloucestershire (12%)[30]. This could be because South Gloucestershire has a lower than average proportion of BAME residents from cultures where alcohol abstinence is normative, and also because we are a relatively affluent area with a slightly higher

[α] Lower Confidence Interval 22.2% - Upper Confidence Interval 37.2%

proportion of middle aged people – a demographic known to drink more. Unmet needs (whereby we are failing to engage with those who are alcohol dependent to motivate and support them into in treatment and recovery; and/or failing to prevent and/or reduce increasing and higher risk drinking) would also be likely to keep our proportion of people drinking more than 14 units per week higher.

PHE estimate a higher level of binge drinking in South Gloucestershire (23%)[29] than in other local authorities within the Avon and Somerset police force area[31], and higher than that in England (17%)[29]. Although the percentage of adults binge drinking is higher in South Gloucestershire than that in England it is deemed to be statistically similar[28].

The estimated percentage of adults with alcohol dependence in South Gloucestershire is 0.99% (AUDIT score 16-19 and SADQ score of 16+ or AUDIT score over 20 and SADQ score of 4+.) This is lower than the England average (1.39%), but not significantly so[28].

Actions to consider

1. Provide a range of evidence-based, effective, equitable and accessible interventions aimed at reducing the drinking behaviour of the 29% of adults in South Gloucestershire who drink more than 14 units per week. Measurable outcomes to be achieved within a set timeframe would need to be agreed with our partners.

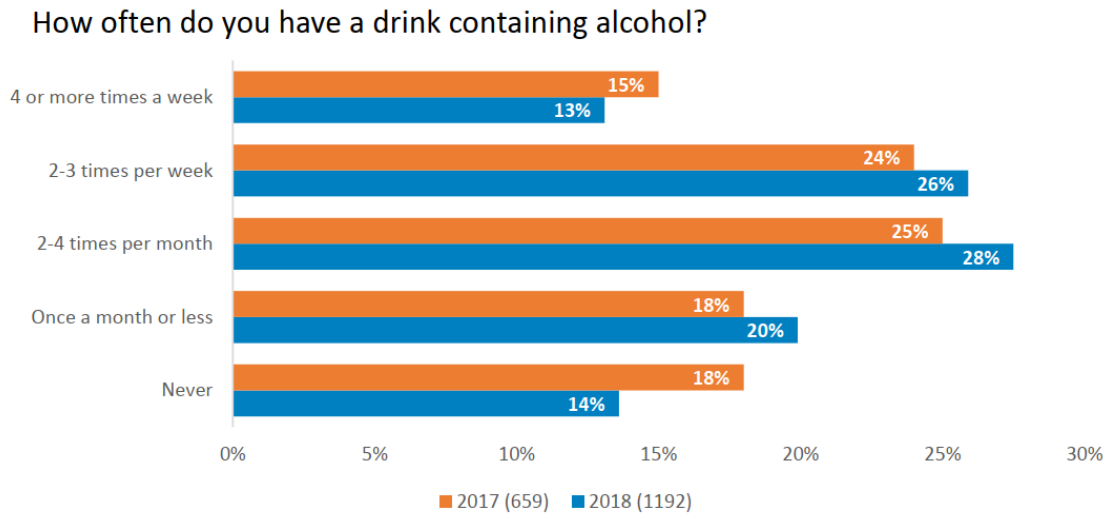
4.3.3. Viewpoint survey

Viewpoint is a panel of people which in October 2018 comprised of 2,290 South Gloucestershire residents who volunteer to be consulted on a range of topics[32]. The survey which included questions about drinking alcohol and other health behaviours such as smoking was sent to all members of the panel either by post or email[32]. 52% responded[32]. The results were weighted by age, gender, ethnicity and geographic location with the aim of representing these categories of diversity in our local population[32] and gives further insight in to drinking patterns in South Gloucestershire. There is however likely to be recall and response bias in a self-reported survey with reluctance to admit drinking heavily when asked about health behaviours. It has been estimated that alcohol surveys are likely to underestimate alcohol consumption by approximately 40% to 50% particularly for young men and middle-aged females[33]. The results therefore need to be interpreted with caution.

4.3.3.1. How often and how much alcohol is reported as consumed

82% of the South Gloucestershire Viewpoint respondents declared drinking alcohol; this compares to 88% estimated by PHE data described in Figure 11 above. 15% said they consumed alcohol 4 or more times a week as illustrated in Figure 12 (below)[32]. The majority (49%) however reported drinking less frequently – either 2 to 3 times a week (24%) or 2 to 4 times a month (25%)[32].

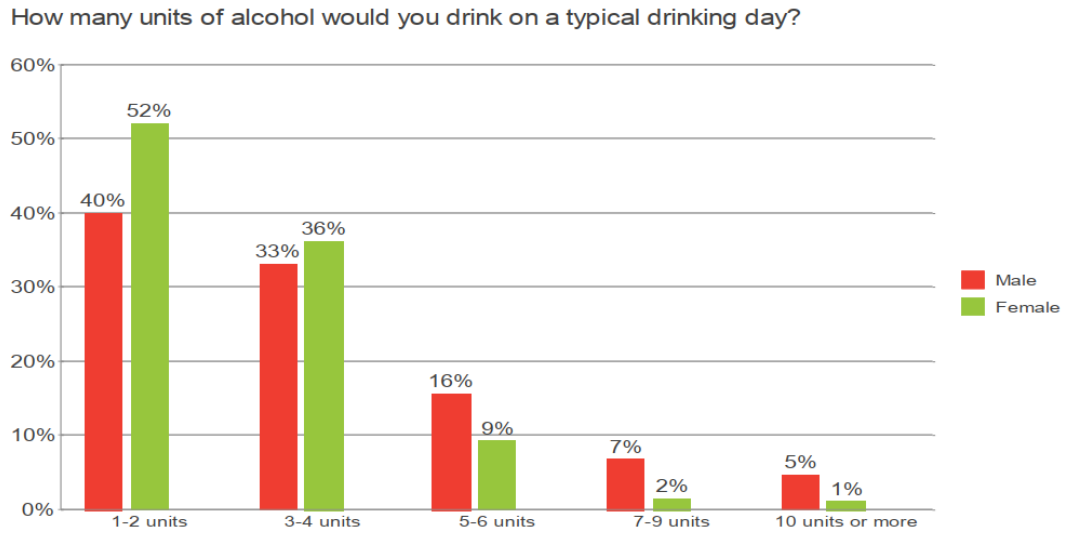
Figure 12: Frequency of drinking



Source: South Gloucestershire Viewpoint[32]

Similar to national data, Viewpoint survey data shows that South Gloucestershire men drink more than women. Figure 13 below shows 88% of female respondents versus 73% of males declared drinking less than 4 units on a typical drinking day, whereas 28% of men versus 12% of women declared drinking more than 5 units on a typical drinking day. Table 3 illustrates that South Gloucestershire men are more likely than women to drink more than 6 units on a single occasion and to do so more frequently. Although the women are drinking less than men, they are generally more vulnerable to its effects[4].

Figure 13: Alcohol consumption and the difference between males and females



Source: South Gloucestershire Viewpoint[32]

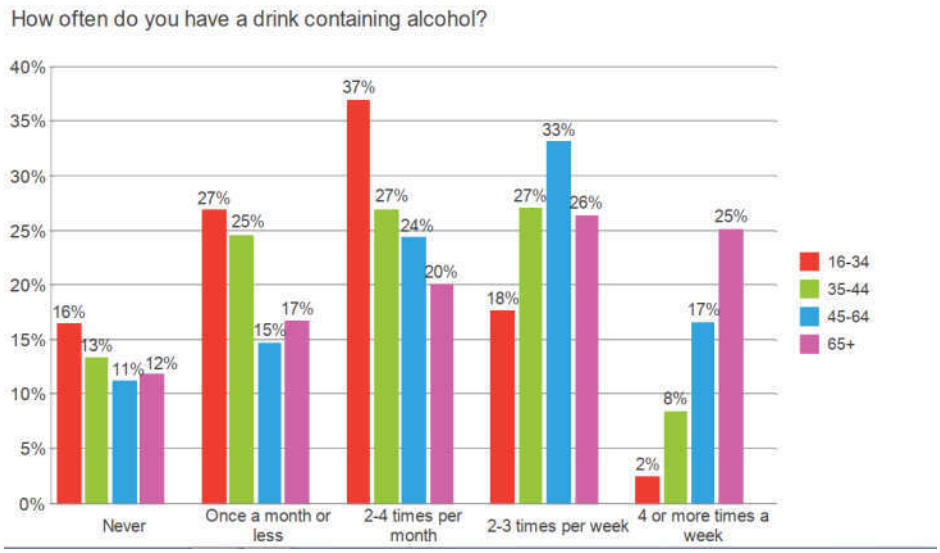
Table 3: Number of occasions where 6 or more units were consumed

	A. Male	B. Female
Base	514	498
Never	31%	39%
Less than monthly	41%	49%
Monthly	16%	9%
Weekly	12%	3%
Daily or almost daily	2%	0%

Source – South Gloucestershire Viewpoint[32]

The Viewpoint survey reported that whilst respondents aged 65+ were more likely to drink regularly (as shown in Figure 14), they were more likely to drink less on each occasion[32]. Younger and older people tend to be more vulnerable to the effect of alcohol than those who are middle-aged[4].

Figure 14: Frequency of drinking by age group

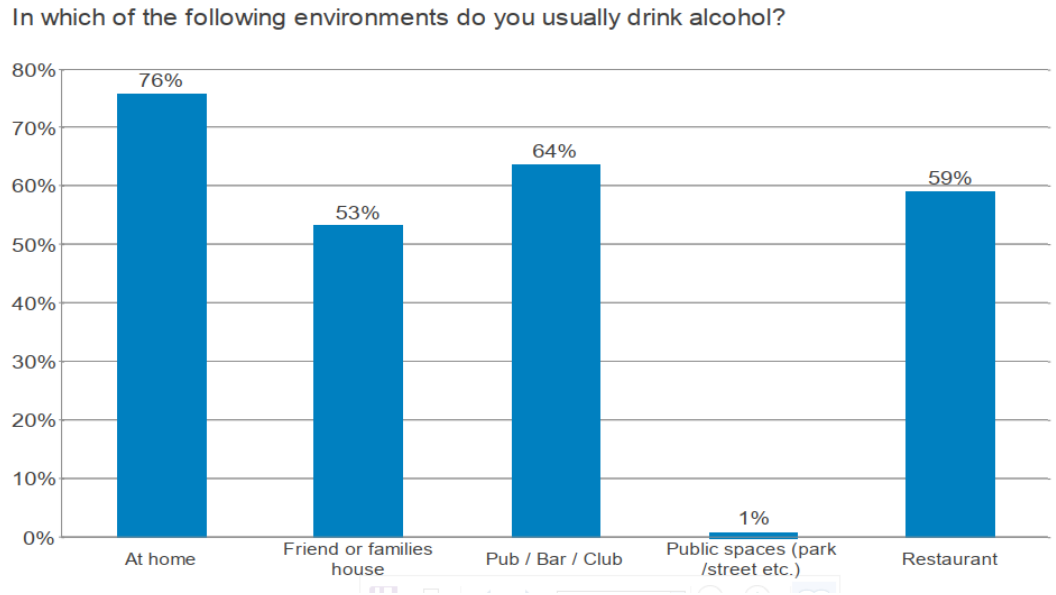


Source: South Gloucestershire Viewpoint[32]

4.3.3.2. Where they report drinking

As shown in Figure 15, amongst Viewpoint survey respondents the preferred environment for drinking alcohol was at home (76%). Drinking in licensed premises such as a pub, bar or club (64%) or restaurant (59%) were also popular choices. It was reported that respondents aged 16-34 were significantly less likely to drink at home (65% compared to 79% 35-44, 79% 45-64, 81% 65+) and significantly more likely to drink in pubs/bars/clubs (73% compared to 67% 25-44, 58% 45-64, 53% 65+)[32]. Respondents living in South Gloucestershire Priority Neighbourhoods were more likely to drink at home (82% compared to 75%) and significantly less likely to drink in a restaurant (49% compared to 67%)[32].

Figure 15: Places where people drink alcohol



Source: South Gloucestershire Viewpoint[32]

Actions to consider

1. Consider conducting another Viewpoint survey and including questions:

    (a) To discover how many are drinking more than 14 units per week or use an alcohol use screening test to discover our resident's risk levels. Include information regarding where to access support to reduce drinking for those who are concerned about their drinking.

    (b) To discover how many drink in South Gloucestershire licensed premises, and how many regularly travel further afield to drink – for example to Bristol.

4.4. Other influences on alcohol consumption in adults

4.4.1. Sexual orientation

It has been estimated that 5-7% of the UK population are lesbian, gay, or bisexual[19]. Using the 2017 population this equates therefore to at least 13,950 – 19,530 South Gloucestershire residents who might describe themselves as lesbian, gay, bisexual, questioning, transgender or other sexuality apart from heterosexual (LGBQT+).

LGBT individuals are identified as an at-risk group for drinking alcohol in a problematic way. A large 2013 national US health survey found 35% of adults between 18-64 years who identified as gay or lesbian and 42% bisexual of those who identified as bisexual reported binge drinking (defined as five or more drinks consumed on a single occasion) at least once in the last year in comparison to 26% who identified as heterosexual[34]. Analysis of a US survey of 452 trans adults found that 10% of these individuals reported a life-time substance use disorder (alcohol or drugs) treatment history in comparison to 1% of the general population[35].

Actions to consider

1. Develop targeted alcohol harm reduction campaigns and interventions for people in our LGBTQ+ communities, including those relating to binge drinking.

4.4.2. People with disabilities

The 2011 Census found 18% of local residents aged 16+ have a long term health problem or disability[19]. Of those aged 18-64, it is estimated that approximately 16,900 have a moderate or severe physical disability, and approximately 23,000 people aged 65+ have a long term illness that limits their day to day activities[19]. Analysis in 2013 of nine years data from the US National Survey on Drug Use and Health found significantly lower levels of alcohol misuse amongst people with disabilities but higher levels of drug use, particularly increasing levels of marijuana and oxycodone[36].

Approximately 4,100 adults aged 18-64 years live with learning difficulties in South Gloucestershire, and approximately one third of these also have an autistic spectrum condition[37]. In 2017, it was estimated 1,086 adults had moderate or severe learning disabilities with 260 being in residential or nursing homes[38].

Substance misuse in people with intellectual disability carries risks to personal safety due to the association with impaired judgement and excessive risk-taking. This can increase the potential for accidental injury, unplanned and unprotected sex, and violence or criminal behaviour[39,40]. A recent review (based on 2016 data from NHS Digital) found weak evidence that people with intellectual disability might have a lower prevalence of current alcohol use (1.9-55% vs. 62.5%) and a higher prevalence of alcohol misuse (22% vs. 4.5%) compared to that in the general population[41]. Data from two large, Swedish population-based twin cohorts suggested that autistic-like traits increase the risk of substance use disorder[42,43]. It has also been suggested that once alcohol use is initiated, progression to alcohol misuse is quicker for individuals with autistic traits than the general population[43].

A large 2017 Swedish cohort study found that people with autism spectrum disorder (ASD) are twice as likely to develop a substance use disorder in comparison to their non-ASD relatives, with such disorders highest amongst those with ASD and attention deficit hyperactivity disorder (ADHD)[44]. Findings also showed that parents and siblings of people with ASD have a higher risk of substance use disorders[44]. A smaller qualitative study found people with ADHD were more likely to develop substance use disorders than those with ASD[45].

Actions to consider

1. Ensure that appropriate services are available that are accessible and equitable for people with all types of disability.
2. Raise awareness amongst those with, or caring for people with, learning disabilities ASD, ADHD about possible associations between their condition(s) and alcohol (and/or substance) misuse disorders; and the risks involved for people drinking alcohol who have intellectual disorders.
3. Develop targeted alcohol harm reduction campaigns and interventions for people with learning disabilities, ASD and ADHD.

4.4.3. People with mental illness

In the UK at least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time[46]. In 2012 and using data from the 2007 Adult Psychiatric Morbidity Survey, Public Health England produced synthetic prevalence estimates of common mental health conditions[46]. They estimated 8.1% of the South Gloucestershire population suffered with mixed anxiety and depressive disorder, 3.6% with generalised anxiety disorder, 1.1% depressive episode, 1.6% phobias, 0.7% obsessive compulsive disorder, 0.5% panic disorder. 6.7% eating disorders and 3.0% post-traumatic stress disorder[46]. This equates to approximately a prevalence of 25% mental illness amongst adults in South Gloucestershire.

Mental and physical wellbeing are closely linked. People with mental health problems are more likely to smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system[47]. It is therefore crucial that mental health is given equal priority to physical health in order to improve health and reduce inequalities in the population[47].

Self-harm and suicide are much more common in people with alcohol problems[48]. This may be because they regularly drink too much, making them feel depressed (after the original mood boost) or because they self-medicate with alcohol to relieve anxiety or depression[48]. Alcohol affects brain chemistry increasing the risk of depression and can cause symptoms which appear similar to dementia in older people such as memory loss, hearing voices and confusion[48,49]. Alcohol can result in dependency, which is a recognised mental illness[50]. Alcohol dependency and other mental illnesses can also be found as separate co-morbidities within an individual. The condition of experiencing both problems with alcohol (and/or another drug) plus another mental illness is termed dual diagnosis[46].

The prevalence in South Gloucestershire of increasing risk or higher risk drinkers who also have a mental illness is unknown. To estimate prevalence in the future a protocol has been written for a useful study. It is entitled: *'The prevalence of alcohol misuse in those with and without a common mental health disorder in the adult general population: a systematic review and meta-analysis protocol'*, available at http://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42019126770 and although due for completion in September 2019 the study has not yet been published.

In comparison to the national picture, clients who entered alcohol treatment in South Gloucestershire in 2017/18 with a co-occurring mental health condition appear to be over-represented, but this could be an anomaly of the small number of individuals in this dataset. 76%, n=34 (69% of the males and 84% of the females) in South Gloucestershire self-reported a mental health treatment need[30]. This compares to 41% (38% of males, 46% of females) nationally[30]. The high rate of reporting clients with dual diagnosis in South Gloucestershire might be due to better data recording or increased confidence of service users in reporting[46]. Alternatively it could be because only the most serious cases and/or those who initially present at their GP with a mental illness are identified for alcohol treatment.

The majority (65% in South Gloucestershire, 53% nationally) were receiving mental health treatment from their GP[30]. Less (15%) were already engaged with the Community Mental Health Team/Other mental health services, compared to 21% nationally[30]. The lowest proportion (n<5) which was the same as that nationally, were engaged with '*Improving Access to Psychological Therapies'* (IAPT)[30].

As part of a piece of work scoping whether there were issues in the joined up approach between drug and alcohol services and mental health services (see section 9.1, and Appendix 2 for the questions asked) a link to an online survey was sent via email to a total of 54 professionals regarding clients with dual diagnosis. The professionals comprised 9 mental health service mangers, 27 social care managers and 18 substance misuse workers. 11 practitioners (8 substance misuse workers, 1 social worker, 1 alcohol specialist nurse, and 1 mental health service worker) responded. 7 reported having had referrals rejected due to the client having the dual diagnosis of a mental health and a substance misuse disorder and 3 had not experienced this. One practitioner commented:

"Mental health service state that they are not able to accept…risky/dependent alcohol users. Mental health services decline…without completing their own triage assessment, stating it is primarily an alcohol addiction issue and not mental health".

*A*nother practitioner affirmed this issue by saying:

"…assessment of and working with mental ill health was not possible while client was drinking".

Multivariate modelling of a 2018 nationally representative cohort study of 45,971 US adults (≥18 years) and young people (12 to <18years) found that when people used both alcohol and cigarettes (rather than alcohol only or cigarettes only) they were associated with a significantly higher risk of mental or substance use problems[51].

Actions to consider

1. Ensure all local alcohol services are available, accessible and equitable for people with mental illnesses.
2. South Gloucestershire DAP and South Gloucestershire Drug and Alcohol Services (SGDAS) to work with MH colleagues and commissioners to ensure everyone across the life-course with a dual diagnosis is offered a package of concurrent mental health and substance misuse treatment.
3. Conduct a review of those self-reporting mental illness; to ensure that they have received a referral to specialist mental health services to ascertain if an official diagnosis and treatment course is required.
4. People presenting for treatment or advice about mental wellbeing or illness, or for smoking cessation advice, should be routinely asked about their use of alcohol and given appropriate advice or referral to specialist service(s).

4.4.4. Smoking and alcohol associations

There has for a long time been a known link between smoking and drinking. A large national survey conducted in the USA showed people dependent on alcohol were three times more likely to be smokers than the general population[52]. Similarly dependent smokers were four times more likely to also be alcohol dependent [52]. People who both drink and smoke are at a higher risk of contracting certain cancers such as those of the mouth, throat and oesophagus[52].It is likely that smoking tobacco increases the craving for drinking and vice versa and there is cross tolerance to both drugs[52].

Many who successfully recover from alcohol dependency with the support of treatment services continue to smoke and subsequently die because of their untreated tobacco dependency[30]. PHE recommend alcohol treatment services offer support to stop or reduce harm from smoking, or alternatively work with their local smoking cessation services[30].

A 2017 narrative review of 24 studies published from 2006 to 2016 reported the impact of smoking cessation treatment or quitting smoking, on substance use or substance disorder treatment[53]. The authors concluded smoking cessation often has a positive effect on substance use outcomes. No studies reported increased substance use[53].

55% (n=21) of South Gloucestershire clients in treatment (from a cohort of 38) during 2017/18 were identified as smoking tobacco at the start of their treatment[27]. This compared with 42% nationally[30]. The number in South Gloucestershire identified as abstinent from tobacco at review was 38% (n=8/21), compared to 34% nationally[30] – which appears to be encouraging. Unfortunately however there were a much higher proportion locally (albeit a small number of individuals, n<5) than the national proportion (13%), who were identified as having started to smoke tobacco at review despite abstinence from tobacco at start of treatment[30]. A small number of clients (n<5) and a higher proportion than those identified nationally (3%) were recorded as receiving smoking cessation interventions in South Gloucestershire[30]. The numbers are too small to draw any conclusions apart from to note the risk of people in alcohol treatment starting to smoke and identifying an opportunity to support those in treatment to stop smoking.

From April 2018 to March 2019 our specialist alcohol provider (DHI) referred 36 of their drug and/or alcohol clients to the South Gloucestershire smoking cessation service, 9 agreed in principle to receiving the service, 22 were unable to be contacted and 1 declined. Only 2 set a quit date and both of these were recorded as lost to follow-up, so it is unknown whether or not they quit smoking. These referrals were done on an 'opt-out' basis (i.e. if they were identified as smoking tobacco they were automatically referred) and so might have lacked motivation and/or confidence to stop smoking. Additionally it would have meant engaging with a different provider to treat their tobacco dependence from that where they had an existing relationship for their alcohol or drug dependency or problematic use. It is clear that more needs to be done to gain meaningful access to stop smoking support for those in alcohol treatment.

In the past year, we have been working with our provider to make the treatment centre at Tower Road North a smoke free site. Whilst there had been no smoking in the building since before the smoking ban, staff and people who used the service would be permitted to smoke outside the kitchen area. This had the potential for people who did not smoke to inhale passive smoke due to its close proximity to the building. It also sent a message about the acceptability of smoking compared to, for example, alcohol. Also due to the statistics detailed above and to follow the example of hospitals and the prison estate which have gone totally Smoke Free, we aimed to do the same at the Tower Road North site in making it completely Smoke Free. However, after feedback from service users about them feeling marginalised by the ruling and concerns about people having to congregate outside at the front of the building on the road, we reached a compromise where there will now be a smoking area at the top end of the garden at the site, as far away from the building as possible and away from the vaping site. This should minimise any risk from breathing in passive smoke because there would be no need for them to access that part of the garden unless they wanted to smoke. Signs to highlight the area as well as a cigarette bin will be installed and we will review its use and whether people are complying with the new ruling.

Actions to consider

1. Within the Public Health Division, the DAP should work with the smoking cessation team to ensure their service users (where appropriate) are offered support for both smoking and alcohol consumption.

2. Stop smoking services should be embedded within drug and alcohol services in future commissioning rounds. Ideally our alcohol specialist provider would be incentivised to offer structured courses of smoking cessation additional to alcohol treatment. Meanwhile all alcohol service users should at least be signposted to information about smoking cessation support on the new One You South Gloucestershire website.
3. Engage with our providers and service users about how to reduce the risk of people abstinent from smoking at the beginning of treatment from starting during treatment.
4. Review all sites where people use the service as non-smoking sites and continue dialogue with people who use our service, both smokers and non-smokers on how this affects them.

4.4.5. Carers

It is estimated that 10.5% of the population of South Gloucestershire is a carer, and this is slightly higher than the national average of 10.3%[54]. Currently the use of alcohol amongst carers or their experience of alcohol use in the people they are caring for, does not feature in the South Gloucestershire Carers strategy[54]. The strategy does however recognise that carers include young carers caring for a relative who *"misuses alcohol"*, or adult carers who might be caregivers for friends, neighbours or relatives[54]. 82% of carers report that caring has a negative impact on their health and their mental wellbeing[54]. They are vulnerable to experiencing stress loneliness and isolation[54]. It is possible therefore that some carers might self-medicate such feelings with alcohol. A US survey and qualitative study of caregivers found 10% report more frequently misusing alcohol or prescription drugs, with the prevalence being higher amongst those under 45 years[55].

Actions to consider

1. Provide targeted alcohol harm reduction campaigns and brief interventions for carers.
2. Collect more data and analysis on alcohol use by people who are carers.

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5. Children and young people

5.1. Patterns of alcohol consumption in England

In 2009, the Chief Medical Officer of England published the first official guidance on alcohol aimed specifically at children and young people[1]. It recommended that the healthiest and safest option was for children to remain alcohol free up to age 18. If they did drink alcohol it should not be at least until the age of 15. For young people aged 15 to 17, it was suggested they should only drink in a supervised environment, and no more than once a week. The guidance was based on a body of evidence that drinking at a young age, and particularly heavy or regular drinking, can result in physical or mental health problems, impair brain development, and put children at risk of alcohol-related accident or injury. More broadly it is also associated with missing or falling behind at school, violent and antisocial behaviour, and unsafe sexual behaviour[1].

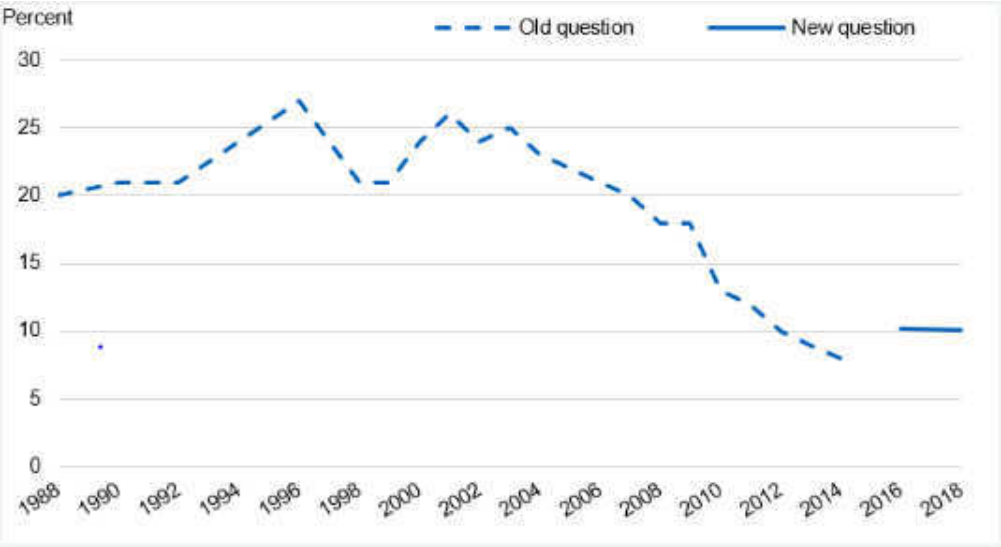
5.1.1. England prevalence 11-15 year olds

'Smoking, drinking & drug use among young people in England'[2] is a biennial survey of secondary school children aged 11-15 which began in 1982 providing comprehensive data around prevalence, attitudes and behaviours. The data below is from the survey's 2018 summary report.

5.1.2. Had an alcoholic drink in the last week

Between 2002 and 2014 (Figure 16) there was a decline in the percentage (25% to 8%) of young people who reported that they had consumed an alcoholic drink in the last week (part of the question relating to this was reworded in 2016 meaning that previous data is not comparable). In 2018 9% of boys and 11% of girls aged 11-15 reported that they had consumed an alcoholic drink in the last week with the proportion increasing by age from 2% of 11 year olds to 23% of 15 year olds.

Figure 16: Young people reporting having had an alcoholic drink in the last week



5.1.3. When 11-15 year olds drink and how much they drink, by age

Young people reported that they were most likely to drink at weekends and consumed an average (mean) of 10.3 units a week. Mean consumption was lowest among 11-13 year olds and highest among 14 year olds. 21% of pupils who drank in the last week were estimated to have drunk more than 15 units.

5.1.4. Breakdown of alcohol type for 11-15 year olds

Pupils who drank in the last week were most likely to have drunk beer, lager or cider, with boys more likely than girls (87% of boys, 65% of girls). Girls were more likely than boys to have drunk spirits (67% of girls, 52% of boys), alcopops (39% and 27%) or wine, martini or sherry (55% and 27%).

Beer, lager and cider accounted for 60% of the alcohol units consumed by pupils in the last week. Beer, lager and cider made up 73% of boys' consumption, compared with just under half (46%) of girls' consumption.

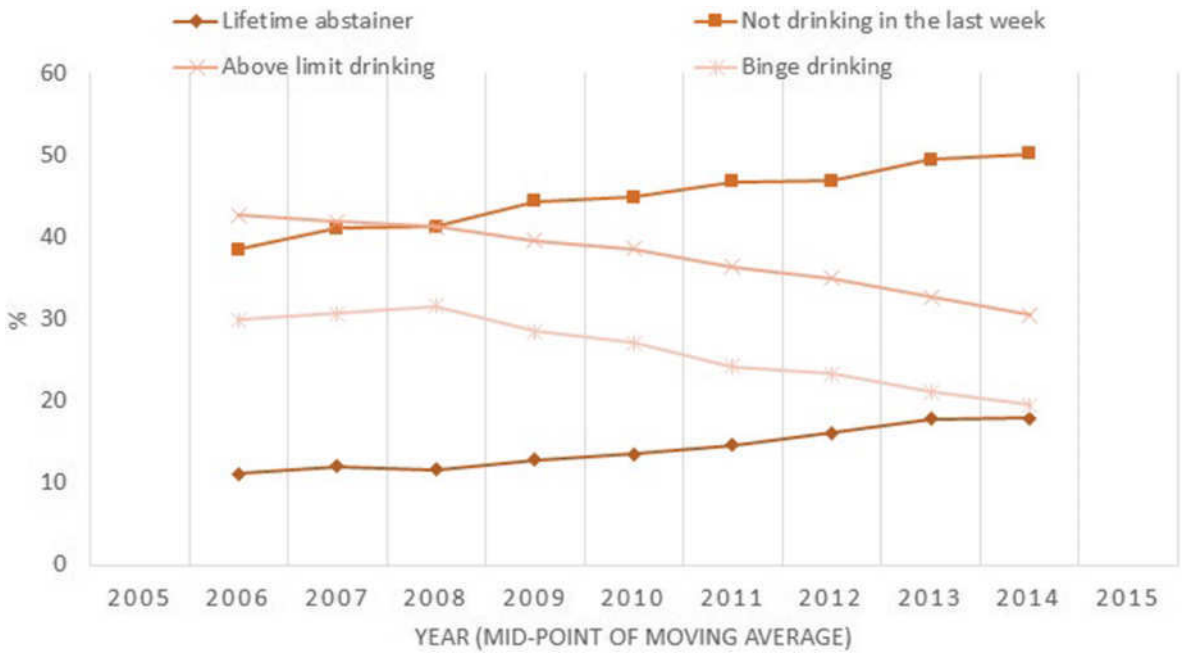
5.1.5. Prevalence of drunkenness

9% of pupils said they had been drunk in the last four weeks, including 6% of pupils who had been drunk once or twice, and 2% more often. Girls (11%) were more likely to have been drunk in the last four weeks than boys (7%). The proportion of pupils who reported having been drunk in the last four weeks increased with age. 22% of 15 year olds reported having been drunk in the last four weeks, compared with 1% of 11 and 12 year olds.

5.1.6. England prevalence 16-24 age group

Figure 17 illustrates the analysis of cross-sectional surveys in England between 2005 and 2015[3] and shows the decline in alcohol use across four measures for 16-24 year olds; lifetime abstinence, weekly drinking, binge drinking and above limit drinking. Among those aged 16 to 24 years, the proportion of non-drinkers increased from 18% in 2005 to 29% in 2015. The increase was largely attributable to an increase in the proportion of lifetime abstainers (9% to 17%), rather than ex-drinkers (remaining at 2%). There were also increases in the proportion whom had not drunk any alcohol in the last week, from 35% in 2005 to 50% in 2015, and from 22% to 33% among drinkers only. There were significant decreases in the proportion who drank above limits (43% to 28%), or binge drank (27% to 18%) but no differences in the proportion drinking within limits (remaining at 22%).

Figure 17:



The evidence from these cross-sectional surveys suggest that there is less stigma around non-drinking and that this has contributed to a reduction in use across almost all subgroups of which geography, levels of deprivation, levels of education and employment, health & socio-economic status have been considered. Non-drinking remains higher among ethnic minorities than the white population. In 2017 23% of 16-24 year olds reported not drinking alcohol at all, this was higher than older adults. Of those who did drink, the level of units consumed was higher for 16-24 year olds than older adults[4].

Actions to consider:

1. Further develop support to all schools (primary, secondary, colleges & special) to deliver alcohol education in line with best practice and NICE guidance NG135.
2. Ensure that the above support is also offered to those Young People who are not in education.

5.2. Patterns of alcohol consumption in South Gloucestershire

Public Health England Profile data for 2014/15 contained in the *What About YOUth (WAY) survey*[5] shows the percentage of regular drinkers aged 15 was 9.3% in South Gloucestershire. This is equal highest for the South West region where the average was 7.4% and significantly worse than the England average of 6.2%. The percentage of young people who had reported being drunk in the last four weeks was 16.2% which is slightly lower than the regional average of 17.5% but is interpreted by PHE as statistically similar to the England average of 14.6%.

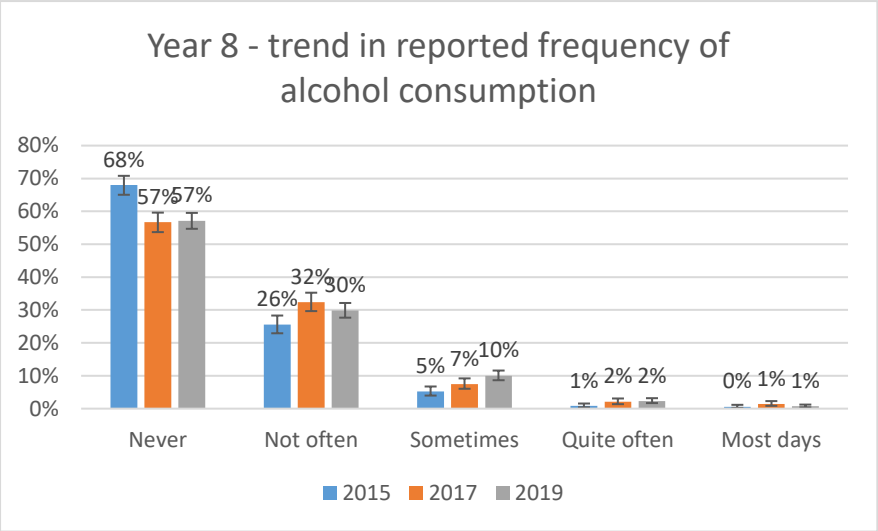
Regular drinking appears to be more prevalent amongst 15 year olds in South Gloucestershire than regionally or nationally; and although there is less evidence that there is a problem with regular drunkenness, there is a risk that this could develop with age.

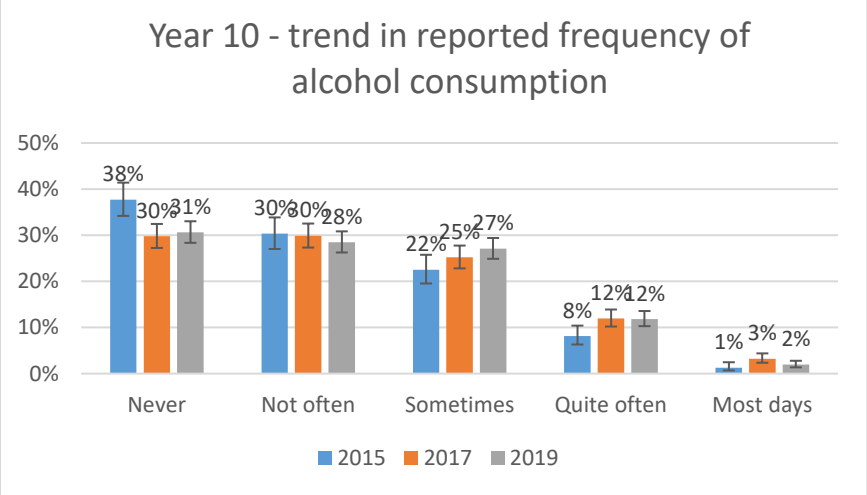
5.2.1. Online Pupil Survey

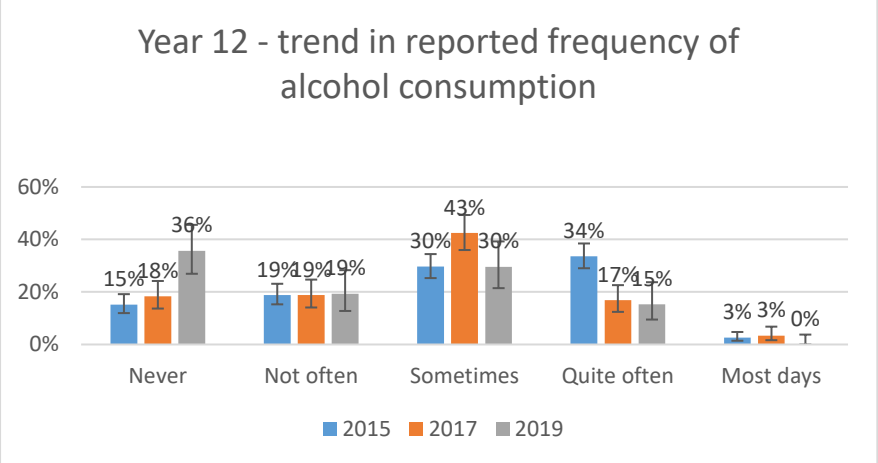
Young people in South Gloucestershire have completed three Online Pupil Surveys (OPS) in 2014, 2017 & 2019 totalling almost 20,000 children and young people from year 4 to post 16. The surveys have included specific questions around alcohol use identifying how often young people drink and get drunk alongside where they get their alcohol from. The results from these surveys provide useful data to explore patterns of substance use among specific groups. The CLeaR peer reviewers stated ”The online pupil survey is a useful source of information for identifying issues and may be used in future to measure impact of some measures”.

Prevalence data from the 2019 survey of young people within secondary and post 16 settings has been split by year group (8, 10 & 12). Figure 18 shows how the pattern of use changes with age in relation to the survey question *Do you drink alcohol?*

Figure 18:


Year 8 - trend in reported frequency of alcohol consumption
80%
70%
60%
50%
40%
30%
20%
10%
0%
68%
57%
57%
26%
32%
30%
5%
7%
10%
1%
2%
2%
0%
1%
1%
Never
Not often
Sometimes
Quite often
Most days
2015
2017
2019


Year 10 - trend in reported frequency of alcohol consumption
50%
40%
30%
20%
10%
0%
38%
30%
31%
30%
30%
28%
22%
25%
27%
8%
12%
12%
1%
3%
2%
Never
Not often
Sometimes
Quite often
Most days
2015
2017
2019


Year 12 - trend in reported frequency of alcohol consumption
60%
40%
20%
0%
15%
18%
36%
19%
19%
19%
30%
43%
30%
34%
17%
15%
3%
3%
0%
Never
Not often
Sometimes
Quite often
Most days
2015
2017
2019

Very few young people in year 8 (n=1599)[i] report frequent use (weekly/most days) however 10% report that they drink sometimes (monthly). This compares to 7.5% in 2017 (n=1079) and 5.2% in 2014 (n=1014) suggesting infrequent alcohol use has increased in this age group.

By year 10 (n=1488) around 14% of young people are reporting that they drink frequently (weekly/most days) which compares to 15% in 2017 (n=1189) and 9% in 2014 (n=694). The data suggests an increase of frequent use for year 10s since 2014 although the number completing the survey was significantly smaller in 2014.

Around 55% of year 12s reported that they never drink or do not drink often. The sample size for the year 12 cohort was smaller than previous years (n=98). The 2017 (n=208) survey reports 37% of year 12s never or not often drinking alcohol and 33% in 2014 (n=398). The data collected from the 3 surveys suggests therefore that alcohol is not a lifestyle issue for between a third and a half of year 12 students.

Action to consider:

1. To continue to invest in the OPS and work with colleagues to ensure relevant questions are asked about alcohol use in YP.

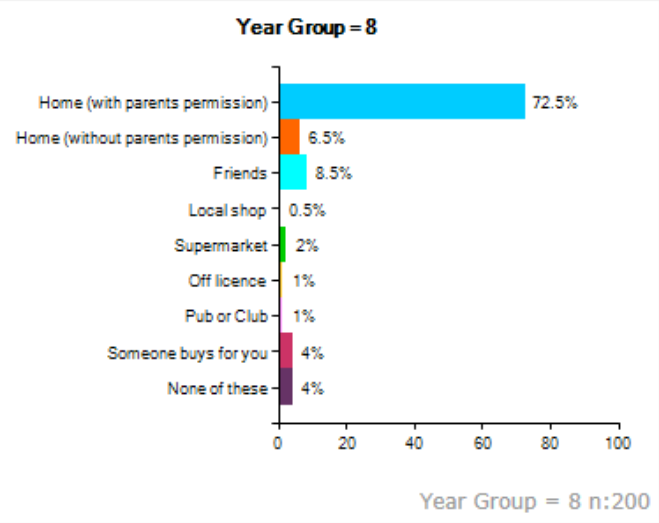
5.2.2. Gender

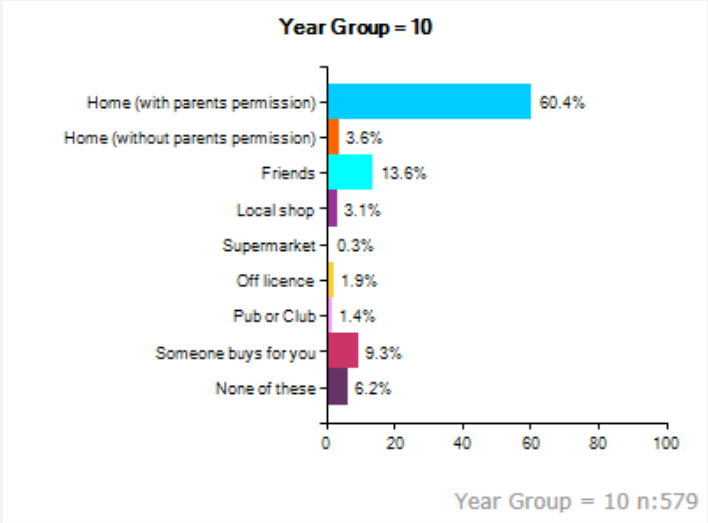
Young people who indicated that they drink alcohol went on to answer the question *Do you ever get drunk?* Getting drunk quite often (weekly/most days) can be termed as problematic alcohol use and the 2019 survey showed equal numbers of males and females reporting this level of use. Higher numbers of females reported that they drink sometimes (monthly) with more males reporting that they never/not often drink.

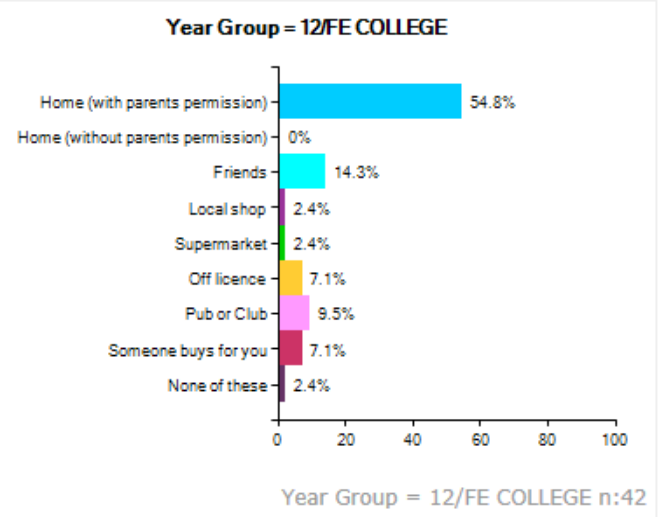
5.2.3. Obtaining alcohol

Young people who indicated that they drink alcohol went on to complete the question *Where do you normally get your alcohol from?*

[i] (n=) refers to the number of respondents within the year group who answered the question.







72% of year 8s who reported drinking alcohol within the 2019 survey stated that they get it from home and with their parent's permission. 9% of year 10s obtain it by someone else buying it for them with 60% getting it from home (with parental permission). This reduces to 55% of year 12s obtaining it from home with a greater number getting it from an off licence, friends or from someone else buying it. Year 8s were more likely to take it from home without parental permission. As a comparison with the 2017 survey with all year groups (8, 10 & 12) 53% obtained alcohol from home (with parental permission) compared to 63% in 2019. More young people obtained alcohol from someone else buying it (12%) in 2017 than in 2019 (9%).

Actions to consider:

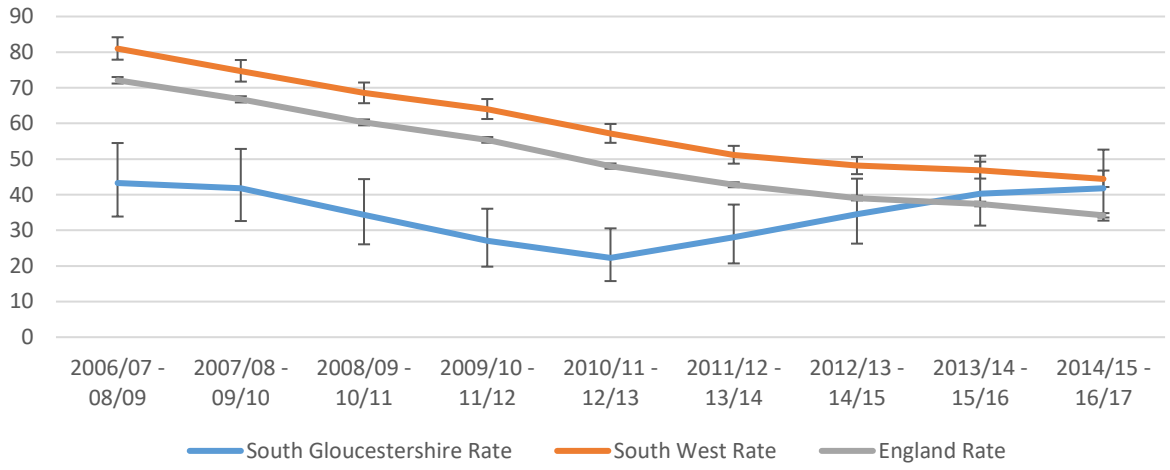
1. Include within alcohol education the promotion of non-drinking/infrequent drinking among young people.
2. Include within alcohol education a greater emphasis around different drinking patterns and how these impact on young people.
3. Develop ways of communicating with parents around choices in providing young people with alcohol.

5.3. Effects of alcohol on health

Admission episodes for alcohol-specific conditions from 2015/16 to 2017/18 for South Gloucestershire residents aged under 18 years (38.1 per 100,000) were considered to be statistically similar to that for England (32.9 per 100,000) and are not dissimilar to the average value for our CIPFA nearest neighbours (37.9 per 100,000). For our young people however there were more females (53 per 100,000) admitted than males (23.8 per 100,000).

Rates of alcohol specific admission among under 18s (birth to 17yrs) in South Gloucestershire have increased year on year between 2010/12 and 2014/17[π].This contrasts with decreasing rates among under-18s nationally and regionally (Figure 19)[6].

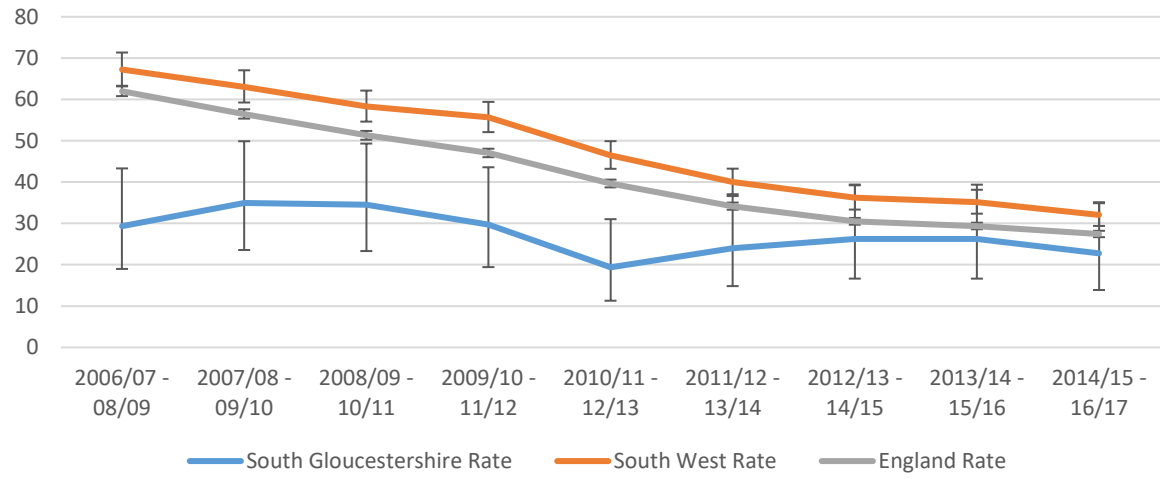
Figure 19: Hospital admissions for alcohol specific conditions, crude rate per 100,000 persons (u18), 2006/07 – 2016/17 – South Gloucestershire, South West and England



Rates of alcohol specific admission among males under 18 in South Gloucestershire have not changed significantly in recent years (Figure 20)[6].

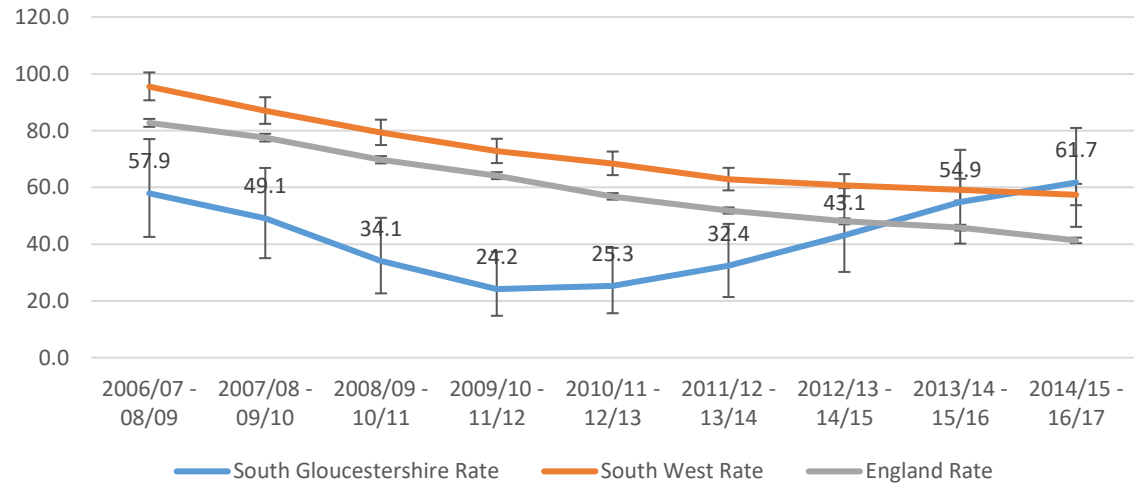
[π]*due to the small numbers involved, data is pooled over 3 years to increase the confidence we can have in the trends observed*

Figure 20: Hospital admissions for alcohol specific conditions, crude rate per 100,000 males (u18), 2006/07 – 2016/17 – South Gloucestershire, South West and England



Rates of alcohol specific admission among females under 18 in South Gloucestershire have undergone significant increases since 2010 – 2013. This contrasts with the decreasing rates that can be observed at a regional and national level (Figure 21)[6]. Among under 18s females have accounted for 66% of all alcohol specific admissions over the 5 years since 2012/13. Although '*all persons under 18 admissions*' is similar to the national trend it is concerning that over twice as many South Gloucestershire females under 18 years are admitted to hospital than males in the same age group. Furthermore there appears to be a local issue with a higher than expected rate of alcohol-specific hospital admissions amongst females.

Figure 21: Hospital admissions for alcohol specific conditions, crude rate per 100,000 females (u18), 2006/07 – 2016/17 – South Gloucestershire, South West and England



Over the 5 years between 2012/13 and 2016/17, the most common alcohol specific cause of admission was *mental and behavioural disorder due to use of alcohol* which accounted for 62% of admissions. This was followed by *toxic effect: ethanol*, which accounted for 29% of admissions. Analysed over 5 years, there has not been a notable increase in any one cause, though analysed at this level numbers are small.

When analysing under-18 data, disaggregation to electoral ward, priority neighbourhood or deprivation quintile does not provide any statistically significant results due to the small numbers involved.

Actions to consider:

1. Alcohol harm-reduction interventions need to be provided at a younger age particularly for females.
2. Scrutiny of the data for under 18 years female alcohol-specific hospital admissions would be useful in order to check whether there are repeat admissions or from the same ward(s) or LSOAs etc. enabling interventions to be targeted.

5.4. The impact of vulnerability on drinking

Vulnerable young people are individuals who are more exposed to risk taking behaviour than their peers. They can be vulnerable in terms of deprivation (food, education, and parental care), exploitation, abuse, neglect, violence, and mental and physical ill health.

The 2019 Online Pupil Survey enables data to be collated around the alcohol use of young people who have specific vulnerabilities. However, as it only takes place in schools, it could be missing some of the most vulnerable young people who may have been excluded or not in mainstream education.

5.4.1. Looked after children

Young people who stated that they were or had been in care reported that they were more likely to 'drink more often' (11%) than those who were not or had not been in care (8%). Young people in care or who had been in care reported significantly more experiences of being drunk with 41% getting drunk quite often compared to 14% of those young people not within the care system. The sample size for young people who have indicated that they are currently or have been in care for this set of data is small (n=22).

5.4.2. Young carers

Those young people who indicated that they have a caring role at home reported both a higher frequency of drinking and of getting drunk compared to those who did not. Almost 13% of young carers drink often (weekly/most days) compared to 8% who do not see themselves as having a caring role.

5.4.3. Levels of wellbeing

Young people who scored average to high for levels of wellbeing reported lower levels/frequency of drinking, 5.9% of this cohort reported weekly/daily use compared to 14.7% of those scoring low and very low for wellbeing.

5.4.4. Smoking

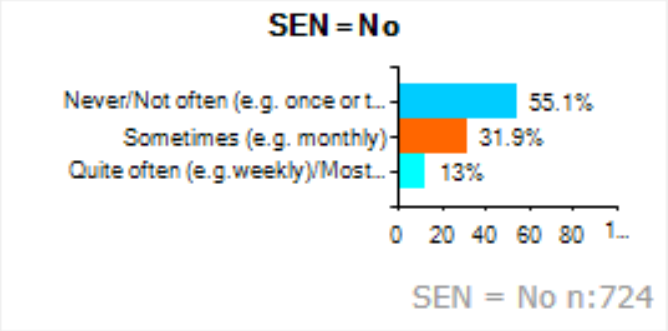
Young people who reported that they smoke quite often (weekly/most days) were significantly more likely to drink often (weekly/most days) than those who reported that they never or not often

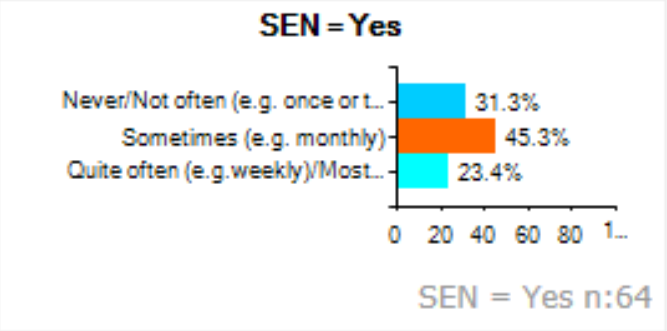
smoked. 48% of smokers drank often compared to 6% who did not smoke. Similarly 48% of smokers reported being drunk quite often compared to 9% of non –smokers.

5.5.5. SEN

Young people who indicated that they had Special Educational Needs reported similar frequency of drinking to those young people without additional needs. There is however an increased frequency of 'getting dunk' among the SEN participants with 45% getting drunk monthly and 23% weekly/most days. Those without SEN reported 13% and 32% respectively.

How often do you get drunk?





5.5.6. Alcohol from home

Young people were asked within the Online Pupil Survey how they obtained their alcohol. The data from the 2019 survey suggests that some young people who are drinking and getting drunk more frequently (the cohort identified as having a vulnerability) are less likely to obtain alcohol from home (with permission) than those who are not:

- 64% of young people who are not or who have never been looked after obtained alcohol from home compared to 33% who have been in care.
- 64% of young people who do not have SEN obtain alcohol from home compared to 54% who have SEN.
- Almost 71% of young people who scored average to high for their wellbeing score obtained alcohol from home compared to 55% who had low to very low scores for wellbeing.
- 70% of non-smoking young people obtain alcohol from home compared to 33% who are smokers.

Young people who do not obtain alcohol from home are more likely to get someone else to buy it, get it from friends or get it from a local shop.

5.5.7. Parental alcohol misuse (PAM)

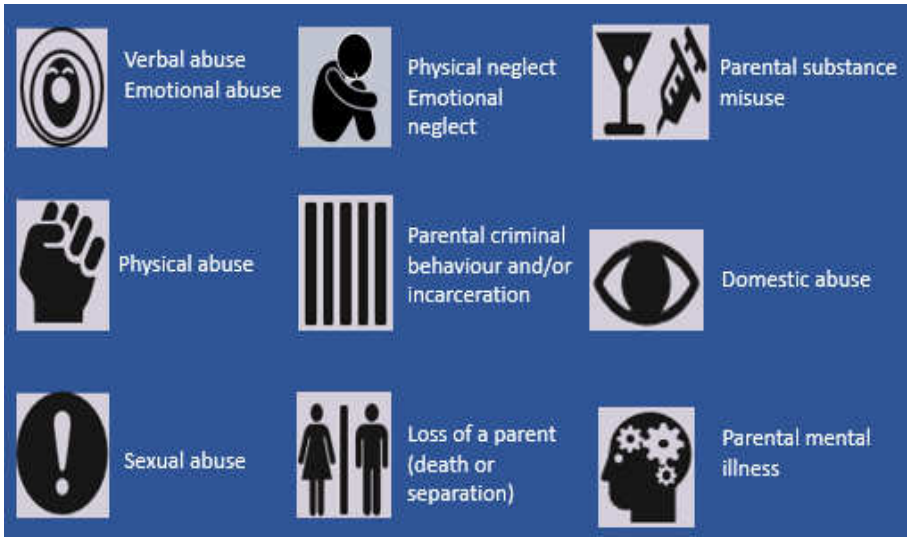
A recent rapid evidence review by the Children's Policy Research Unit[7] into parental alcohol misuse and the impact on children showed that between 14% and 26% of fathers with children aged 9-12 months and 14 years drink at levels classified as increased risk drinking, and between 5% and 18% of mothers drink at levels classified as increased risk drinking (defined as 15 units a week or more).

Prevalence of parental drinking increases with the age of the child with the highest levels of use recorded for children aged 12-14.

In comparison to birth cohort studies, PAM was substantially under-recorded by all services across health and children's social care although the recording was higher for services providing substance use interventions. Potential reasons for under-recording include failure to record parental status for presenting adults, under-recording of alcohol misuse throughout healthcare, and failure to consider and ask about PAM when children present with emotional and behavioural problems. The review found that between 2.1% and 9.8% of all mothers who gave birth in 2011 had an alcohol or drug-related admission up to 5 years before and 5 years after the child's birth (2006-2016) and that at least 1 in 17 children live with a mother with recorded alcohol misuse up to 5 years before and 5 years after birth.

5.5.8. Parental alcohol misuse and Adverse Childhood Experiences (ACEs)

Research into the impact of ACEs has established a set of data that links traumatic and stressful events with increased ill health and health harming behaviours. The infographic below summarises the 9 adverse experiences that have been identified (there are others) within key studies. It is estimated that currently over 200,000 children in England live with at least one parent, carer or adult who is alcohol dependent[8].



The figure below illustrates the health harming behaviours experienced by people who have experienced ACEs including an increased rate of binge drinking. Parental alcohol use is therefore both a result of and a contributor to ACEs and demonstrates how drinking alcohol in a problematic way can become inter-generational.

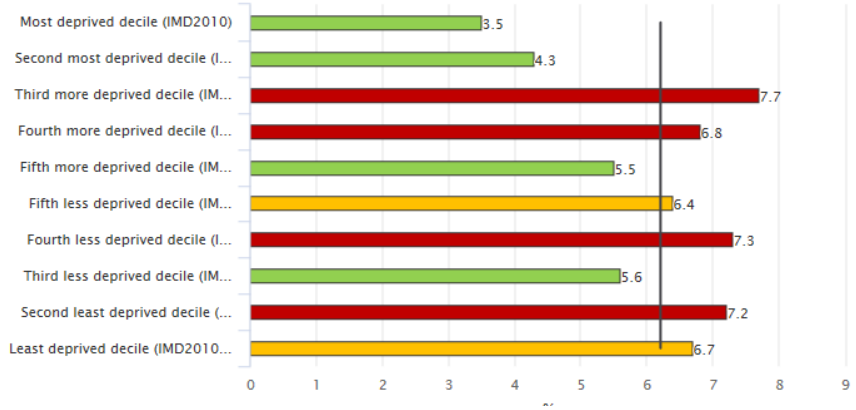
5.5.9. Alcohol and socio economic status

A number of studies (e.g. Makela et al., 1999 and Deacon et al. 2011) have identified a gradient in the risk of alcohol related ill health among people with a low socioeconomic status compared to those with high socioeconomic status despite the consumption of similar amounts of alcohol. This is what is known as 'the alcohol harm paradox'. For further explanation see section 4.2.2. This research is useful when looking at the relationship between alcohol harms and deprivation for young people.

PHE data from the What about YOUth survey[5] shows the levels of alcohol use among 15 year olds who report to be regular drinkers according to levels of income deprivation. The most deprived deciles have the lowest rates of alcohol use (Figure 22 below).

Figure 22:

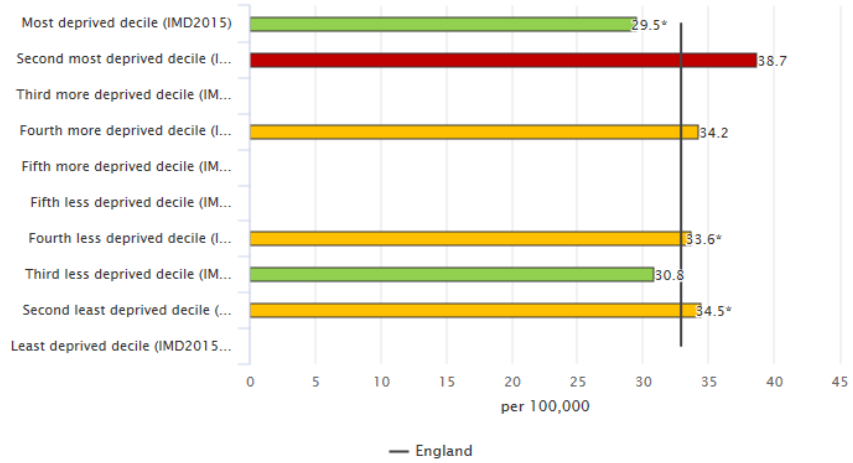
Percentage of regular drinkers by deprivation decile



When examining admission episodes for alcohol specific conditions in under 18s by levels of deprivation it is the second most deprived decile that shows the greatest number of episodes (Figure 23 below).

Figure 23:

Admission episodes for alcohol specific conditions in under 18s

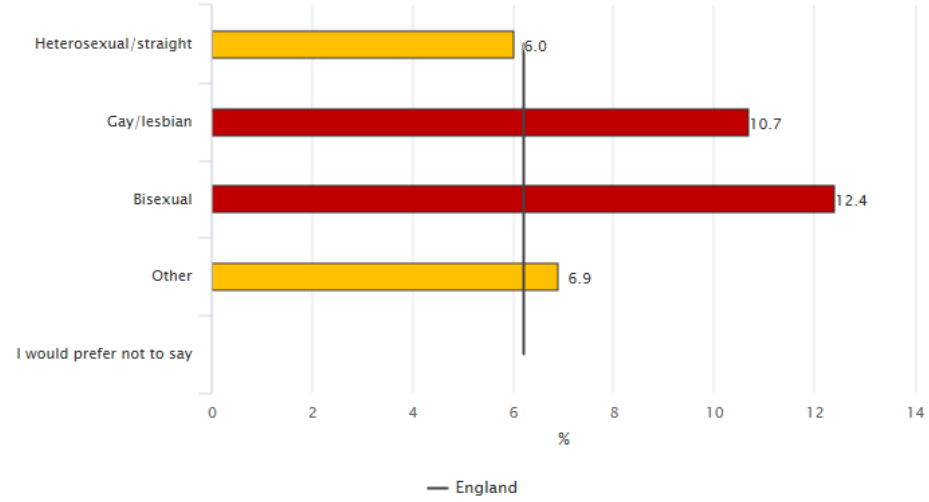


Local data on the drinking behaviours of young people in South Gloucestershire does suggest that the 'alcohol harm paradox' may be impacting on those young people experiencing deprivation.

5.5.10. Sexual orientation

Public Health England Profile data for 2014/15 (*What About YOUth (WAY) survey*[5]) shows the percentage of regular drinkers at 15 within South Gloucestershire according to sexual orientation. There is a greater percentage of young people who identify as Lesbian, Gay or Bisexual who report drinking regularly.

Percentage of regular drinkers by sexual orientation



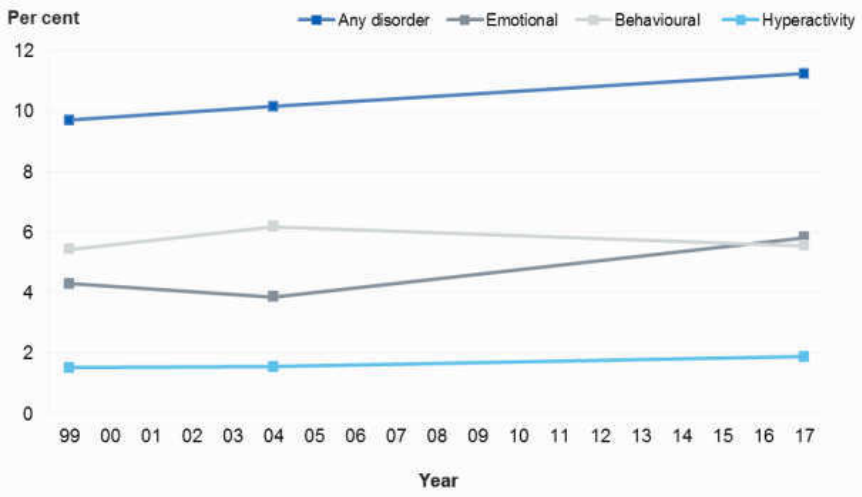
Other research has identified that LGBTQ+ young people report earlier initiation and steeper drinking trajectories into young adulthood than heterosexual youth[9]. In one meta-analysis, LGB adolescents (no transgender included) were 190% more likely to use substances than heterosexual adolescents within some subpopulations of LGB youth (340% higher for bisexual youth, 400% higher for females).[10] Additionally, there is evidence that bisexual

young people drink at the highest rates compared with both exclusively gay/lesbian and heterosexual youth[11].

5.5.11. Mental health

The *Mental Health of Children & Young People in England (2017)*[12] survey provides a comprehensive set of data covering emotional, behavioural and hyperactivity disorders in children and young people. Figure 24 illustrates prevalence of disorders in 5 to 15 year olds between 1999 and 2017.

Figure 24:



In 2017 one in seven (14.4%) 11 to 16 year olds were identified with a mental disorder. And one in sixteen (6.2%) met the criteria for two or more mental disorders. Emotional disorders were the most common type at this age, present in 9.0% of 11 to 16 year olds. This was followed by behavioural disorders (6.2%).

While at this age boys and girls were equally likely to have a disorder, they tended to have different types of disorder. Girls were more likely than boys to have an emotional disorder (10.9% compared to 7.1%), while boys were more likely than girls to have a behavioural disorder (7.4%, compared with 5.0%) or a hyperactivity disorder (3.2% compared with 0.7%).

Prevalence increases with age. In 2017 one in six (16.9%) 17 to 19 year olds had a mental disorder and one in sixteen (6.4%) met the criteria for more than one mental disorder. Emotional disorders were the most common type in this age group, present in 14.9% of 17 to 19 year olds. 13.1% were identified with an anxiety disorder and 4.8% with depression.

Among boys, the likelihood of having a disorder was highest at age 11 to 16. In girls, however, the disorder rate was highest in those aged 17 to 19. These differences in the pattern of association between age and presence of disorder were due in part to differences in the types of disorder boys and girls had.

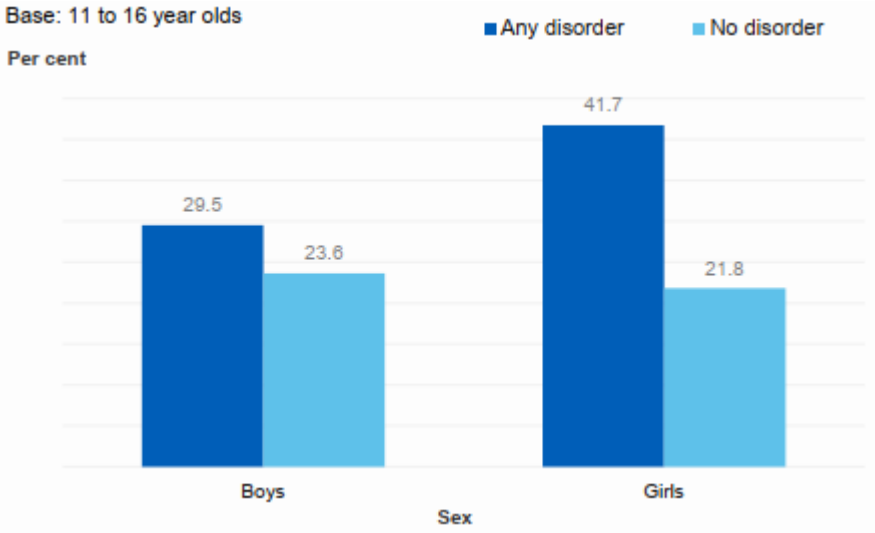
5.5.12. Mental health and alcohol use

Overall rates of drinking are higher in young people with a mental disorder although this varies with gender and age. More than a third (36.3%) of 11 to 16 year olds with a disorder who took part in the

Mental Health of Children & Young People in England (2017) survey[12] had tried an alcoholic drink compared to about a quarter (22.7%) with no disorder.

The proportion to have tried an alcoholic drink was similar in boys with a disorder (29.5%) and boys without a disorder (23.6%). However, girls aged 11 to 16 with a disorder were more likely to have tried an alcoholic drink (41.7%) than girls without a disorder (21.8%):

Ever tried an alcoholic drink by any disorder and gender



Among 17 to 19 year olds the proportions to have ever tried an alcoholic drink were similar in those with and without a disorder and there was no difference between boys and girls.

Children aged 11 to 16 with a disorder were more likely to drink on a monthly or less frequent basis (31.7%) than children without a disorder (19.4%), however they were not more likely to drink on a weekly basis. Girls aged 11 to 16 with a mental disorder were more likely to drink on a monthly or less frequent basis (38.2%) than girls without a disorder (19.7%), however this was not true for boys aged 11 to 16.
In 17 to 19 year olds, drinking on a weekly basis was not associated with a mental disorder nor was drinking on a monthly or less frequent basis; this was also true for boys and girls in this older age group.

High risk groups for alcohol were identified among young people in specific cohorts: girls aged 17-19, those with a non-heterosexual identity, White British children, those from lower income households, those with poor physical health, developmental disorders and educational needs, those experiencing ACEs and those with families who score low for healthy family functioning.

Actions to consider:

1. All young people who become looked after would benefit from receiving some targeted education around alcohol use.
2. Young people who are known to be regular smokers would benefit from some targeted education around alcohol.
3. Young people identified with SEN would benefit from targeted education around alcohol.
4. Education that is targeted at parents and foster carers needs to give consistent messages around the potential risks of giving alcohol to young people.

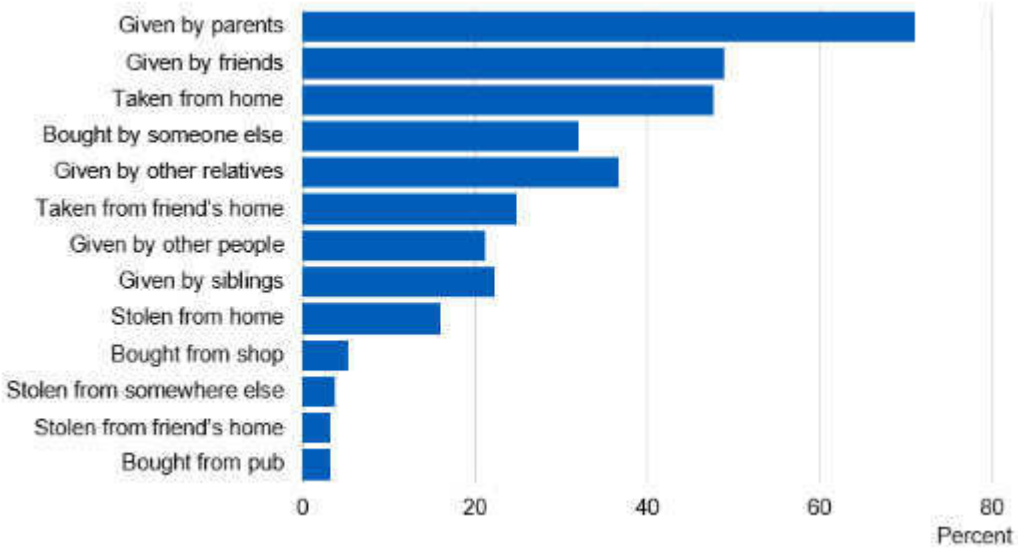
5. To develop a strategic approach which will encourage practitioners across health & social care to ask questions around parental alcohol use when both adults and young people present with emotional and behavioural issues.
6. To explore at a local level the experiences of LGBT young people in relation to alcohol use and unmet need.
7. To explore whether treatment interventions can be broadened to meet the needs of young people presenting with a range of mental health behaviours alongside using alcohol in a problematic way.

5.5. Influences on drinking

5.5.1. Where 11-15 year olds get alcohol

'Smoking, drinking & drug use among young people in England'[2] surveyed young people in 2018 to identify how they obtained alcohol:

Of pupils who obtained alcohol in the last four weeks, they were most likely to have obtained it from parents or guardians (71%). Other common sources were from friends (49%), or from home with permission (48%). 9% of pupils said they had bought alcohol from a shop or pub in the last 4 weeks, with 15 year olds the most likely to have done so.



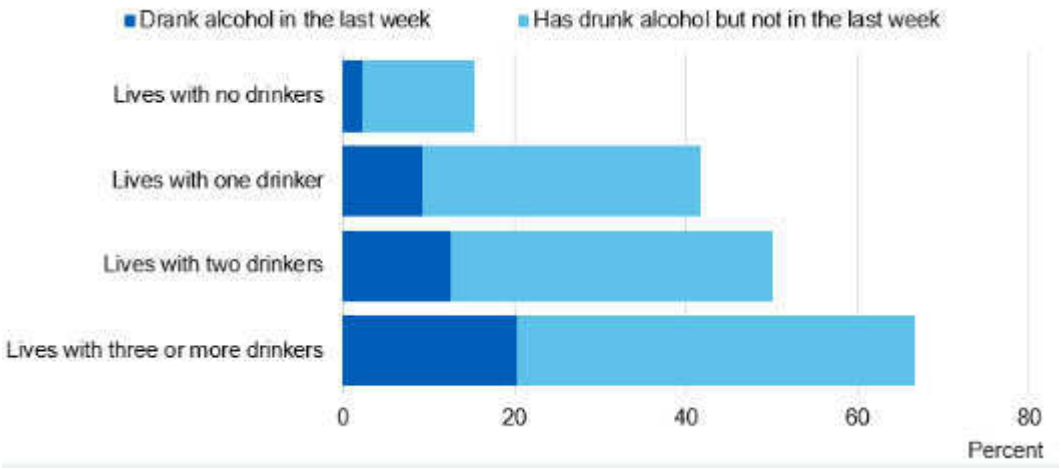
5.5.2. Where young people usually drink and with whom

Young people who drank alcohol were most likely to do so in their own home (66%), at parties with friends (40%), or at someone else's home (41%). Drinking at home was the most common location for all ages. Drinking at parties with friends and at someone else's home became more common as age increased. Young people who drank alcohol were most likely to report that they drank with friends (58%) or parents (66%), few said that they usually drank alone (3%). Younger pupils who

drank were most likely to say that they usually drank with their parents. Older pupils were more likely to say they usually drank with friends.

5.5.3. Alcohol consumption related to drinking in the home and parental attitude

11-15 year olds who lived with people who drank alcohol were more likely to drink alcohol themselves. Only 2% of young people who lived with only non-drinkers had drunk alcohol in the last week, and 85% had never drank alcohol. Among young people who lived with three or more people who drank, the proportion who had drunk alcohol in the last week rose to 20%, whilst the proportion who had never drunk fell to 33%.



49% of young people said that their parents 'did not allow', or 'would not like' them to drink alcohol. Perceived parental disapproval of their drinking decreased as the age of young people increased. Those who lived with people who drank alcohol reported less parental disapproval. Only 23% of those who lived with three or more drinkers reported parental disapproval compared to 80% who lived with non-drinkers. A cohort study into the effect of parental drinking & monitoring concluded '*Young adults whose parents have moderate or high-risk alcohol consumption are more likely to consume alcohol than those with parents with lower alcohol consumption. This association appears to be partly accounted for by earlier alcohol use initiation and higher prevalence of association with deviant peers*'.[13]

5.5.4. Young people's attitudes to drinking and sources of information

Following a general decline in tolerance of drinking and getting drunk since 2003, the most recent surveys (*Smoking, drinking & drug use among young people in England – 2014, 2016 & 2018*) indicate a slight relaxing of attitudes in recent years. In 2018, 27% thought that it was OK to drink alcohol once a week, up from 24% in 2014 (though still down from 46% in 2003). 9% of pupils thought it was OK to get drunk once a week, up from 7% in 2014 (though down from 20% in 2003). 47% of 15 year olds thought it was OK to drink alcohol once a week, and 19% thought it was OK to get drunk once a week.

52% of 15 year olds believed that most people their own age drink alcohol, with a further 21% saying about half of them do. 18% of pupils significantly underestimated how many people their own age drink, believing that only a few or none did so.

The most commonly held belief among young people was that pupils of their own age drank to look cool in front of their friends (74%). Other common beliefs were because their friends pressured them into it (62%), to be more sociable with friends (61%), and because it gave them a rush or a buzz (60%).

A large proportion of young people (77%) considered their parents to be a source of helpful information about drinking alcohol. Teachers were the most commonly identified helpful source of information outside of the family setting (by 62% of pupils). In relation to different forms of media, TV and the Internet were the most popular sources of helpful information about drinking, with both identified by 57%. Social media was mentioned by 45% of pupils. Some sources, like friends, TV, the Internet and social media became more common as pupils got older.

5.5.5. Young people and drinking behaviours

A study[14] by the Joseph Rowntree Foundation into the alcohol choices of 16-25 year olds considered how understanding the decisions not to drink or drink lightly could be used to change the prevailing drinking culture in the UK. Young people felt that messages about alcohol at school and in the media reinforced the belief that alcohol use is normal among teenagers and that too much emphasis was placed upon long term harms rather than immediate benefits. It was identified from the cohort within the study that those young people who chose not to drink or drank lightly had very busy and active lives where alcohol did not have a big role. Much of the decision by those who chose not to, was due to observations of those around them (either non-drinkers or drinkers who experienced negative impacts). Young people felt that the option to not drink needs to be promoted as a valid choice with strategies promoted that enable this such as more social activities for young people which do not involve alcohol.

A literature review around the influences of alcohol on young people[15] provides a summary of research into what influences young people's choices around alcohol. We know that attitudes and knowledge are developed in childhood and these are influenced by family, peers, the media and wider society. There are many aspects of family processes and structures which have an impact such as modelling behaviour (of alcohol), responsive parenting, communication, boundaries, monitoring, expectations, family cohesion & bonding, sibling behaviour and the extent to which young people want to emulate parents. As complex as these aspects of family functioning, are the peer relationships that gain importance during the maturation process. There is a significant interconnection between peer selection and peer influence. Young people choose like-minded peers who fulfil a number of roles key to adolescent development, these relationships provide mutual influence with the idea of 'peer pressure' now seeming to be too simplistic an explanation for the shift of influence from family to friends.

The extent to which and the type of media (indirect or direct advertising) that children and young people are exposed to does have an impact although research in this area provides a mixed picture. Research by Eysenbach[16] (2018) identified that alcohol posts on social media depict alcohol in a positive social context and part of young adults everyday social lives. The study showed that alcohol posts were more often placed on the participant's timeline than posted by the participants themselves and that social posts also received more likes than non-social posts. Eysenbach concludes that '*Potential intervention strategies could involve making young people aware that when they post about social gatherings in which alcohol is visible and tag others, it may have unintended negative consequences and should be avoided*'.

Actions to consider:

1. Parents would benefit from clear messages around buying alcohol for and drinking with young people.
2. Parents would benefit from consistent messages around their role in modelling drinking behaviours and how these can impact on the attitudes to drinking by young people.
3. Review the messages provided within much of alcohol education that normalise alcohol use. Identify new messages that can be promoted by C&YP workforce, community and parents that promote non-drinking. Explore with young people their experiences on social media and the appropriateness of posting alcohol-related images.

5.6. Preventative and treatment services

5.6.1. Public health nursing

The public health nursing service, commissioned by the Public Health and Wellbeing Division provides information and support to children, families and communities including schools and early years settings. The aim of this universal service is to empower families, children and young people to make healthier choices for themselves by providing evidence based information, supporting behaviour change and facilitating access to services available in the local community. The service is easily accessed at any time by children aged 0-19 and their family. Public health nurses use advanced communication skills to work in partnership with children and their families to assess their health strengths, needs and risks to future outcomes and to identify opportunities with parents and children for health improvement. It is currently not known whether they regularly hold conversations about drinking behaviours with the families they work with and more work needs to be done to provide support for staff working in these settings to help reduce alcohol harm

5.6.2. Early help

The importance of Early Help has been a common theme in a number of government reviews over the past decade such as the Graham Allen Report[17], the Munro Review[18] and the Marmot Review[19]. The cost of late intervention to children, families, communities and public resources is well documented through research into ACEs and in the figure of 17 billion pounds in England and Wales[20]. '*The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during those early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational and economic achievement. Later interventions, although important, are considerably less effective if they have not had good early foundations.*'[19]

The Early Help Strategy (2019-24) sets out the vision and strategic priorities for partners within South Gloucestershire to enable all young people to have the best start in life, thrive and be prepared for a successful adult life. Early Help is a provision that works across the stages of childhood and adolescence to build resilience in individuals and families and in doing so work to prevent the educational and health harms of risky behaviours such as using alcohol in a problematic way. In practice support can be accessed across universal, targeted and specialist services from

pregnancy until young adulthood providing where needed a lead professional and a team around the child.

5.6.3. Children's Social Care

Children's Social Care supports family members who have additional needs beyond what health, education, early help and preventative services can provide. They also have a duty to safeguard children who may be at risk of harm, whether from family members or others. Levels of support can vary according to need but the law defines what the duties are and the 'thresholds' as to when they will provide a service. South Gloucestershire Council provides the following services:

- Referral, Assessment & Review
- Child Protection & Care Proceedings
- Children Looked After & Care Leavers
- Corporate Parenting
- Private Fostering
- Fostering and Adoption
- 0 - 25 SEN and Disability Service

NICE[21] and governmental guidance recognises the increased likelihood of problematic alcohol use among young people within the care system and an annual health assessment with access to advice, information and support forms part of best practice.

Young people who are looked after are recognised as being vulnerable to risk taking behaviour, including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. These early risk-taking behaviours are very often indicators of poor emotional health and well-being and may be the forerunner of wider social exclusion such as homelessness and unemployment. [22]

South Gloucestershire Council has a nurse for Looked After Children (LAC) who provides an annual health assessment and who works closely with paediatric staff to support health and medical needs. The nurse is able to screen for alcohol use and to seek guidance and onward referral to specialist services as required.

The CLeaR peer reviewers noted an opportunity for Public Health to work with South Gloucestershire children's services to agree an approach which supports the early identification of families affected by parental alcohol misuse and both encourages dependent adults to take action to address their drinking and supports affected children to achieve their full potential. The CLeaR peer reviewers suggested that South Gloucestershire "Incorporate alcohol and procedures for signposting/assessment of alcohol needs into safeguarding documentation."

Actions to consider

1. Work with South Gloucestershire children's services to ensure appropriate interventions are made for families affected by drinking.
2. Incorporate into safeguarding documentation issues around alcohol and procedures for assessment and signposting of alcohol needs.

5.6.4. Schools and other settings for young people

South Gloucestershire has 94 Primary, 17 Secondary, 2 post 16 colleges and 7 Special schools which are supported by many partner organisations to promote health & wellbeing and develop resilience in children and young people. The Health in Schools programme (HiSP) is an award scheme open to all primary, secondary and special schools which brings together the best evidence based health promotion practice and sets achievable challenges to improve the health and wellbeing for everyone within the school community. It starts with a health and wellbeing self-review capturing what is working well and identifying areas for further development and seeks to enable school settings in South Gloucestershire to be health promoting and engage in healthier behaviour change projects. With the introduction of the new PSHE curriculum in 2020 schools will be expected to teach drug and alcohol education in both primary and secondary schools. It will be a separate theme as well as incorporated into Relationships & sex education, Physical & mental health & wellbeing the Law. YPDAS and the HiSP will support schools to audit current provision, identify gaps and put in place plans to enable schools to become compliant.

5.6.5. Alcohol specific school based interventions

NICE NG135 *Alcohol interventions in secondary and further education*[23] provides guidance around delivering a whole school approach to alcohol education and prevention advocating best practice when working with external organisations to support both the curriculum and pastoral care. In line with this the Young People's Drug and Alcohol Service (YPDAS) provide a core offer of prevention, treatment and Continuing Professional Development (CPD) interventions to schools which begins in primary school and continues to post 16 students. YPDAS encourage schools to use the offer to develop and compliment the curriculum, to facilitate timely support to vulnerable young people and to offer guidance around policy and best practice around alcohol. Data around the number and type of interventions delivered highlight the variation in take up of targeted and preventative education across the schools.

5.6.6. Youth activity offer

More than 2000 young people per year benefit from youth services in South Gloucestershire which are delivered by four lead organisations: Creative Youth Network, Southern Brooks Community Partnership and Learning Partnership, West and Diversity Trust CIC (LBGTQ+ provision). Centre based youth provision (open access) is available in each of the five priority neighbourhoods - Patchway, Yate, Kingswood, Staple Hill and Cadbury Heath, weekly sessions for young people with learning difficulties and/or disabilities in Kingswood, Yate and Little Stoke and provision for LGBTQ+ young people across the area. There are also additional centre based and some detached youth work sessions outside of priority neighbourhoods. These services support young people to access advice and guidance, to take part in positive activities, to build trusting relationships with adults who know their communities well and to develop life skills and resilience all of which act as protective factors in relation to the early onset of drinking by young people.

5.6.7. Mental health & wellbeing

Young people who need support for their mental health and emotional wellbeing can self-refer to counselling which is provided by Off the Record and Kooth. Young people with more complex needs can be referred to NHS Child and Adolescent Mental Health Services via a GP. Waiting lists for CAMHS have a direct impact on the levels of complexity that some young people present to drug and alcohol services with and the amount of time needed by drug & alcohol specialists to support this wider need. South Gloucestershire has a specific website called 'Mind You' which is a mental health and emotional wellbeing hub for young people. Young people who would benefit from mentoring can receive this where there is available funding to purchase an individual package. There is currently no coordinated local offer and mentoring is delivered by a number of providers.

5.6.8. Alcohol interventions for young people

Alcohol treatment[ϖ] for young people is provided by a partnership of agencies; the Youth Offending Service (YOS), The Young People's Substance Misuse Treatment Service (YPSMTS) and the Young People's Drug and Alcohol Service (YPDAS). YPDAS works with young people across the community and engages the largest proportion of young people within treatment. The YOS supports young people who are engaged within the Youth Justice system providing non- treatment interventions and YPSMTS provides specialist treatment interventions to young people who have complex mental, emotional or behavioural issues alongside alcohol use.

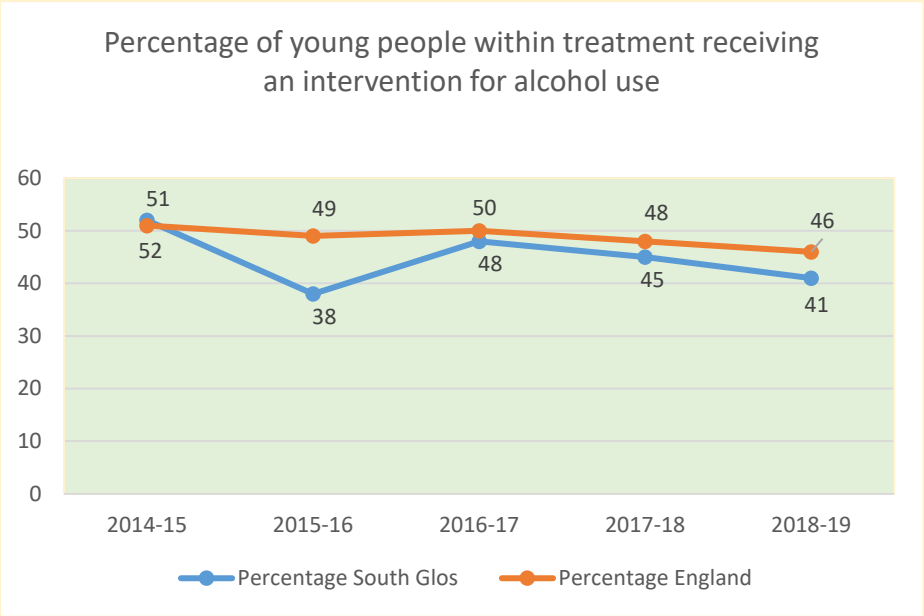
In 2017 PHE completed a performance report on South Gloucestershire Young People's Treatment Services in which it concluded that most young people 'receive an exceptional service locally compared to that in other parts of the country'[24]. They also made a number of recommendations one of which was related to the length of time that young people were spending in treatment where it stated "the range of substances does not necessarily merit, at first consideration, the length of time on average a young person spends in treatment and, although there are significant vulnerabilities cited, it can be argued that these issues might be better supported through multi-agency approaches". It also recommended that transitions and pathways to other services were maximised, in particular looking at interventions for sexual health and smoking cessation services.

5.6.9. Young people in treatment

Figure 25 shows the percentage of young people within treatment who are receiving an intervention for alcohol; the figures for South Gloucestershire are slightly below those for England.

[ϖ] Treatment is as a care-planned and goal orientated intervention using specific techniques and approaches designed to reduce harm and promote behavioural change

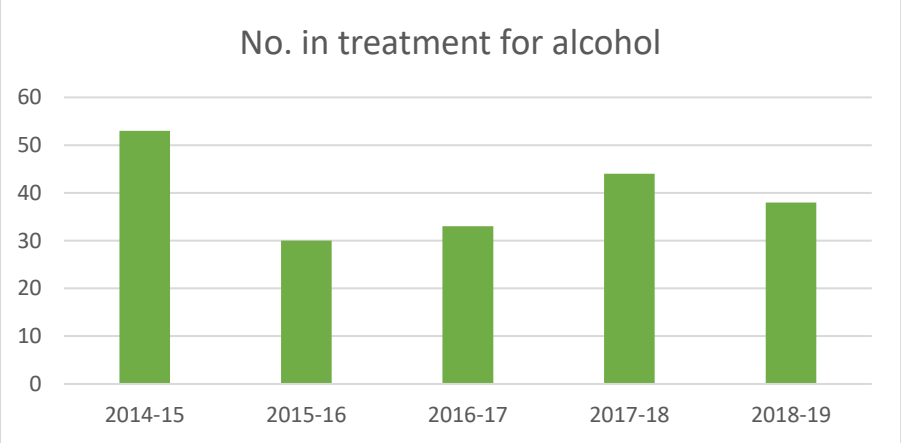
Figure 25:



For the year 2018-19 38 young people received a treatment intervention for problematic alcohol use.

Figure 26 shows the numbers of young people who received an intervention for problematic alcohol use from 2014-15 to 2018-19. Alcohol clients as a percentage of those in treatment and actual numbers have fluctuated within the last five years.

Figure 26:



NDTMS[25] data provides outcome measures related to young people with problematic alcohol use. 2% of young people within treatment in South Gloucestershire report high risk drinking[ω] compared to 3% for England. The average number of units consumed by a young person at the start of treatment in South Gloucestershire is 14 a week which is slightly higher than the national average of 12; at treatment exit the average number had reduced to 9 units, the same number of units as nationally. The mean age of first use for drinking among South Gloucestershire young people

[ω] Young person is drinking 27 or 28 days out of the previous 28 days (regardless of unit intake) or YP is drinking 13-26 days out of the previous 28 days and drinking more than 6 units (females) or 8 units (males)

accessing treatment is 12.9 years of age. Young people presenting with problematic alcohol use are likely therefore to have started drinking alcohol at a younger age than their peers reinforcing the importance of early identification and support.

Treatment data is collected by NDTMS via a monthly submission and released quarterly in the form of partnership and provider reports. It is not possible using this data to extract alcohol specific information for demographics such as additional vulnerabilities, age, gender, ethnicity and comorbid behaviours. A detailed exploration of treatment data across the substances will be completed as part of the Drugs Needs Assessment which will be completed at a later stage.

5.6.10. Young people receiving a non-treatment intervention within the YOS

The YOS provides non-treatment interventions to young people whose alcohol use is risky or linked to an offence (drunk driving, common assault, shoplifting (for alcohol) and drunk and disorderly). For the period April 2018 to March 2019 a number less than 5 young people presented with alcohol use as their primary substance and 28 as a secondary substance. Young people supported by the YOS are not recorded on NDTMS as they are mandated to attend an intervention as opposed to those accessing YPDAS & YPSMTS who do so on a voluntary basis. They therefore do not feel that this should be defined as "treatment".

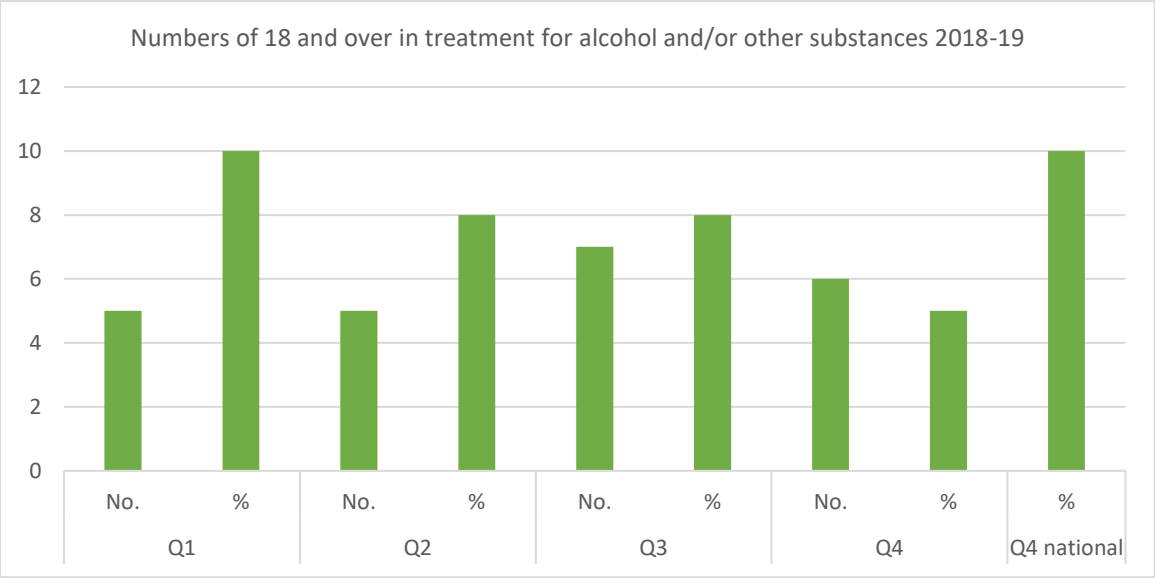
5.6.11. Transition between young people and adult services

NICE guidance NG43 *Transition from children's to adults' services for young people using health or social care* services[26] sets out best practice for the transition of young people across services within health and social care. Within South Gloucestershire we have a transitions protocol which uses these overarching principles to set out in practice how young people can make the transition from young people's drug and alcohol services to adult treatment services. YPDAS works with young people who have been in service prior to turning 18 through their 18th year which means that most young people complete treatment and do not have a need to access adult services. Young people who have been receiving treatment from YPSSMTS who are becoming 18 can be transitioned to either YPDAS or adult services as appropriate. No young people have been transitioned into adult services within the last 3 years. The flexible approach delivered by YPDAS towards transitions allows vulnerable young people to continue to access young people's services. Where there is a complexity that requires an intervention not offered by YPDAS then transition to adult services is required.

YPDAS can support care leavers up to the age of 25, in reality however young people do not generally access the service over the age of 20. YPDAS can have a role of supporting young people who are 18 or over and care leavers to access adult services where these are most appropriate.

Figure 27 below illustrates the numbers of 18-19 year olds in treatment within 2018/19 in South Gloucestershire. These numbers are slightly below the national average for treatment of around 10%.

Figure 27:



5.6.12. Working with parents of young people who are using substances

We know from research that family relationships and interactions can play a large part in perpetuating young people's substance use (Cohen 2014)[27], (Henggeler et al 2009)[28] and that engaging parents or caregivers in addressing young people's behaviours can be highly effective (Asmussen 2011)[29]. However, despite recommendations from NICE (2007), statistics from the National Drug Treatment Monitoring Service (NDTMS) suggest that only 2% of young people referred to specialist drug services in England receive 'structured family interventions' (NDTMS Quarter 4 2018-19).

YPDAS and YPSMTS co-deliver a Non Violent Resistance (NVR) programme which has been successfully adapted to address a wide range of violent, aggressive, coercive or self-destructive behaviours alongside problematic substance use. Many of these behaviours which are embedded in complex cross generational stresses which we now refer to as ACEs require specifically adapted trauma informed methodologies. NVR is one of these, a family-based intervention that teaches parents actively to resist rather than attempt to control their child's behaviour. It enables drug and alcohol services to work with families even when young people themselves are refusing to engage with support.

Adolescent substance misuse is increasingly being viewed as a systemic problem and several studies have shown the benefit of increased parental involvement. Atwood et al, (2019)[30] recently published an evaluation of the South Gloucestershire NVR group parent training programme. Eighteen participants completed questionnaires before and after the programme, and at follow-up. Parents reported experiencing the programme as unique and helpful. Measures of parental self-efficacy and goal-based outcomes showed significant improvement at the end of the programme, and improvement in parental self-efficacy remained significant at follow-up, suggesting that by equipping parents with the means to address problematic substance use we may be able to reduce levels of harm.

Actions to consider:

1. Ensure that Public Health Nurses are involved in the development of wider alcohol harm reduction plans and are given any necessary training and support.
2. Look into the feasibility of a specific alcohol component/award as part of the HiS programme which could support schools to develop interventions that deliver targeted work around alcohol harm.
3. To explore ways in which all secondary schools & colleges can be encouraged to take up the offer of targeted and preventative education.
4. YPDAS to further develop links with youth providers to promote joint working.
5. To use the findings of this needs assessment to further explore how treatment services in South Gloucestershire can be developed to better meet the needs of young people.
6. Young people who go on to develop problematic alcohol use are likely to start drinking in the first few years of secondary school. Interventions within school need to recognise the vulnerability of some young people to early drinking.
7. Scope opportunities to recruit volunteer mentors for young people accessing support for substance use.
8. Further evaluation of the NVR scheme to assess value for money.

5.7. References

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6. Effect of alcohol on our local population

Whilst it is acknowledged most people drink responsibly; alcohol causes detriments to some individuals, families, communities, and to society. These harms can manifest as crime, nuisance or disease. Such harms could be exclusively or partially caused by alcohol. Alcohol-attributable harm is where the harm is partially contributed to by alcohol[1]. Those partially attributed to alcohol are termed alcohol-related. Alcohol-specific harm is where the resultant harm is caused exclusively by alcohol[1].

6.1. Health harms

There is no level of regular drinking that can be considered completely safe[2]. The health harms from regular drinking of alcohol can develop over many years. This occurs either from the repeated risk of acute harms (e.g. alcohol-related accidents) or from long term diseases caused by alcohol, which may take ten to twenty years to develop. These illnesses, including various cancers, strokes, heart disease, liver disease, and damage to the brain and nervous system, can develop despite drinking for years without any apparent harm[2].

The health harms associated with alcohol can be explored and understood through analysis of disease incidence and prevalence data as well as health care activity data such as hospital admissions and mortality data.

Disease conditions or deaths can either be wholly or partially caused by (or attributed to) alcohol. Box 1 (below) illustrates how attributable fractions are used to calculate alcohol-related hospital admissions and alcohol-related mortalities.

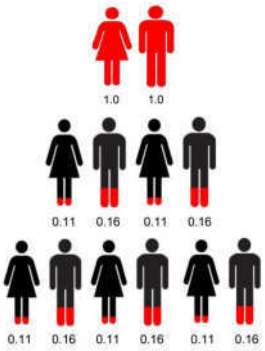
Box 1: Method of calculating alcohol attributable fractions

An alcohol-attributable fraction is the proportion of a condition caused by alcohol.

An alcohol-attributable fraction of 1.0 = 100% of cases are caused by alcohol.

An alcohol-attributable fraction of 0.25 = 25% of cases are caused by alcohol.

The total alcohol-related admission/mortality episodes for an area are the sum of episode-specific data. An illustration of this summation is given below.



The alcohol-attributable fraction for alcoholic liver disease is 1.0 (Appendix 1). Summing two people admitted for ethanol poisoning will give a total of 2.0 alcohol-related admission episodes.

The alcohol-attributable fraction for colorectal cancer for the population aged 16 to 24 years is 0.16 for males and 0.11 for females (Appendix 1). Summing five males and five females aged 16 to 24 years admitted for colorectal cancer will give a total of 1.35 alcohol-related admission episodes.

Source: PHE[3]

Alcohol-specific conditions are those where alcohol is the only cause and are thus 100% caused by (wholly attributable to) alcohol[3]. These conditions are listed in Table 4, below and could result in disease or death[4].

Table 4: Alcohol-specific conditions for disease or mortality

ICD-10 code	Description of condition
E24.4	Alcohol-induced pseudo-Cushing's syndrome
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol induced chronic pancreatitis
Q86.0	Fetal induced alcohol syndrome (dysmorphic)
R78.0	Excess alcohol blood levels
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

Source: International Classification of Diseases, Tenth Revision (ICD-10) cited in ONS[5]

However in 2017 PHE decided to align itself to the definition used by the Office for National Statistics and record deaths where alcohol poisoning (ethanol poisoning, methanol poisoning and the toxic effect of alcohol) were listed on a death certificate as an alcohol-related death[3]. This is because these causes of death were mainly found to co-exist with drug poisoning on a death certificate[3]. Alcohol poisoning conditions are now therefore recorded as an alcohol-related death, albeit with an attributable fraction of 1.0[3].

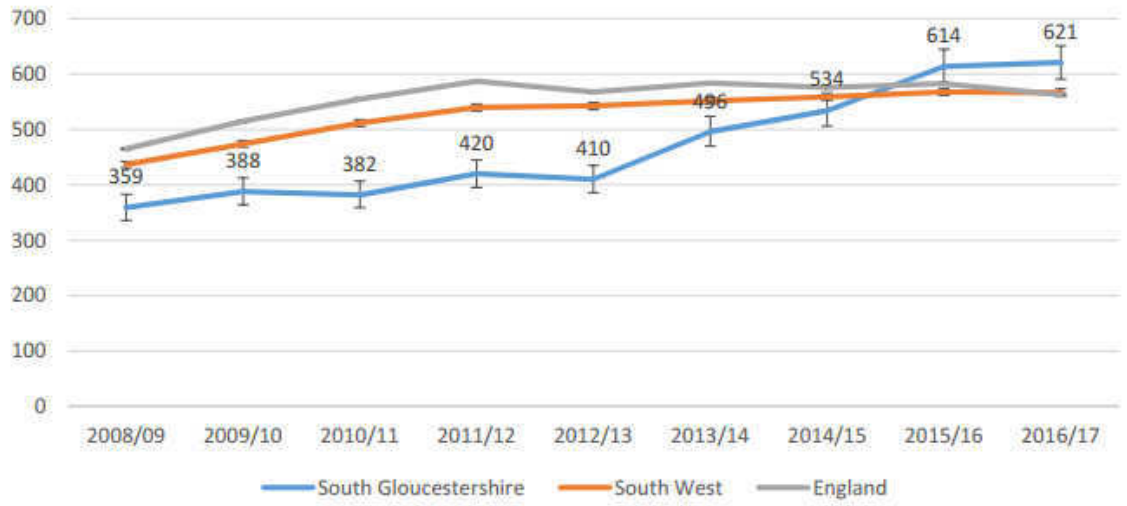
6.1.1. Alcohol-specific hospital admissions

Hospital admissions are deemed by PHE to be alcohol-specific if the primary diagnosis or any of the secondary diagnoses are a condition which is wholly attributable to alcohol[3]. They are expressed as a directly age standardised rate per 100,000 population[3]. The directly age-standardised rate refers to a method of calculation which adjusts the rates found in local populations to that expected if they contained the same proportion of people in different age groups as those in the European Standard Population[6]. The 2017/18 directly age standardised rate of hospital admissions for alcohol-specific

conditions in South Gloucestershire is 624 per 100,000. This is significantly higher than that for England (570 per 100,000)[6]. The average value for our CIPFA nearest neighbours is unknown.

Since 2012/13 the age standardised rate has been rising in South Gloucestershire whereas those for England and for the South West region have been fairly stable[6,7]. This trend is illustrated in Figure 28 below.

Figure 28: Directly standardised rate of alcohol-specific admissions, per 100,000 persons 2008/9 - 2006/17 – South Gloucestershire, South West and England



Source: Coleborn, S, Alcohol Admissions in South Gloucestershire[7]

Reason(s) for the increasing rates of alcohol-specific hospital admissions is uncertain. Possible reasons include there are a greater number of people who drink above 14 units/week in South Gloucestershire, although PHE data suggests that numbers are not significantly higher than the England average. It might also be there was a greater number who did so in the past and it has taken a while for the alcohol to damage their health. As described previously, high earners in England are more likely to drink alcohol. Because South Gloucestershire is predominantly an affluent area, it is likely there are a greater number who previously drank and/or are currently drinking at the highest risk levels. Increasing waiting list pressures for elective admissions might also be contributing to this trend[7]. However, it is also possible that in South Gloucestershire, more work has been done in hospitals to highlight alcohol specific issues and therefore code correctly.

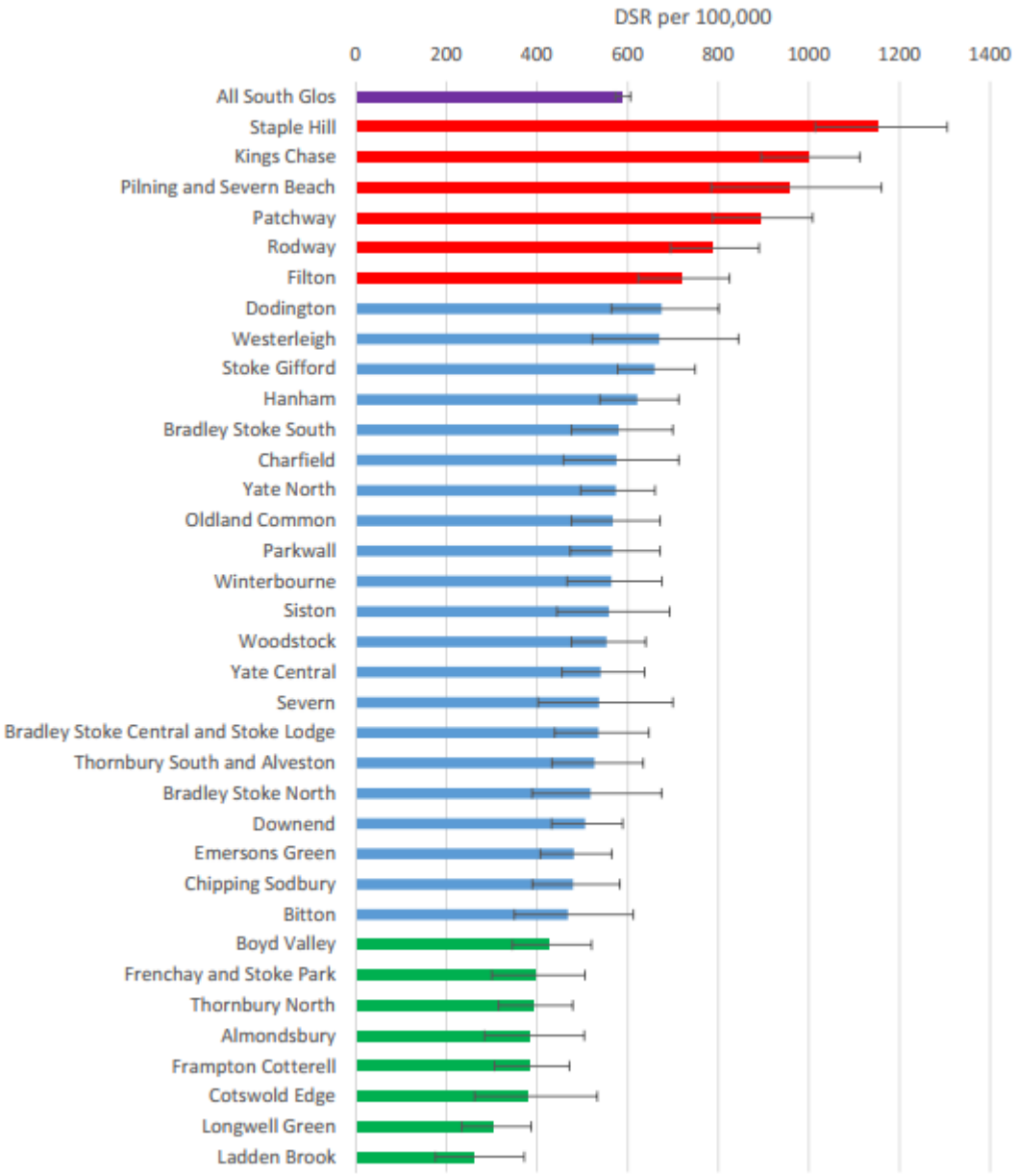
From 2012/13 to 2016/17 there was a 151% increase in admission rates for men aged 60-64, a 55% increase in men aged 65-69, and a 136% increase for those aged 70 to 74. Similarly the increases for women was 211% for those aged 40-44, 82% for those aged 50-54, 85% for those aged 55-59, and 131% for those 60-64[7].

As is the case nationally, for all ages approximately twice as many men as women are admitted to hospital for alcohol-specific conditions[7]. The highest rates of admissions amongst men in South Gloucestershire is for those aged 60-69 and that for females is 50-54[7]. The overall rate for females from 2015/16-2017/18 has however been worse than the rate for England[6].

As can be seen from Figure 29 (below), the wards (until boundary changes in May 2019) of South Gloucestershire with the highest rates of alcohol-specific hospital admissions were Staple Hill, Kings

Chase, Pilning and Seven Beach, Patchway, Rodway and Filton. Three of these wards (Staple Hill, Kings Chase and Patchway) were designated as priority neighbourhoods, and Filton was an area of focus.

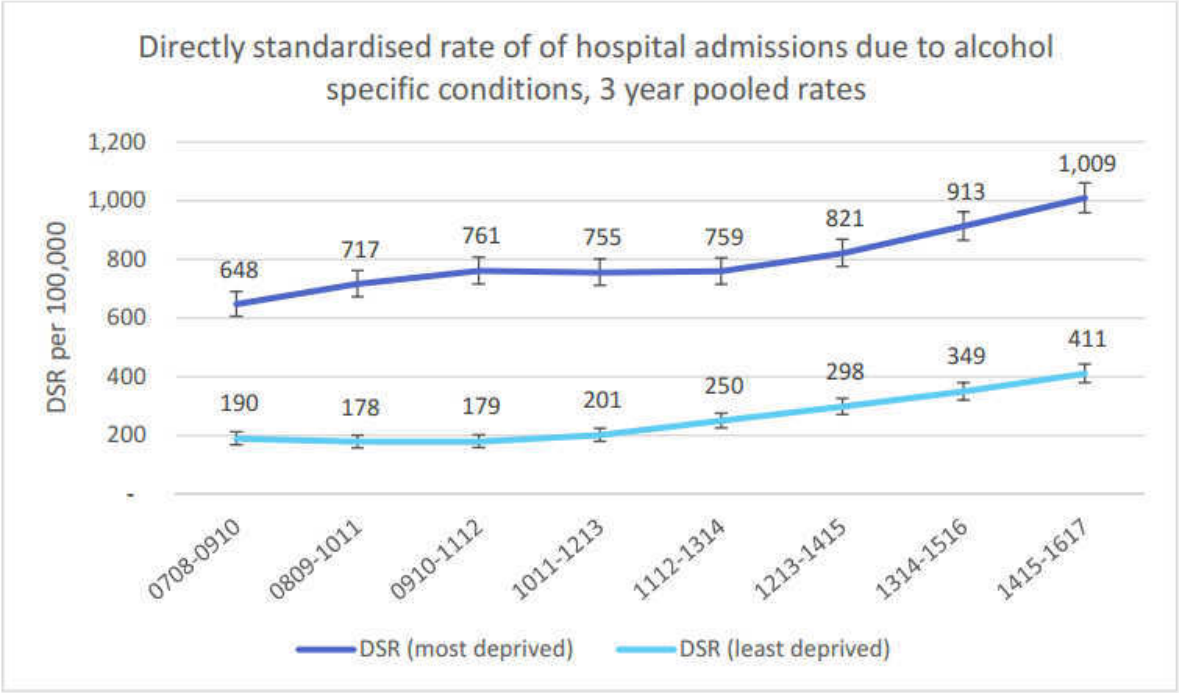
Figure 29: Directly standardised rate (DSR) of alcohol-specific admissions per 100,000 persons by South Gloucestershire electoral ward, 2014/15-2016/17 pooled.



Source: Colborne, S, Alcohol Admissions in South Gloucestershire[7]

South Gloucestershire alcohol-specific hospital admissions rates have risen significantly in quintiles experiencing both the most and least deprivation, as measured by the 2015 Indices of Multiple Deprivation[8]. Despite larger proportional increases in the least deprived quintile, the inequalities gap between the most and least deprived quintiles in South Gloucestershire has increased since 2008/09-2009/10[4]. This is illustrated in Figure 30, below and is similar to the national situation[8].

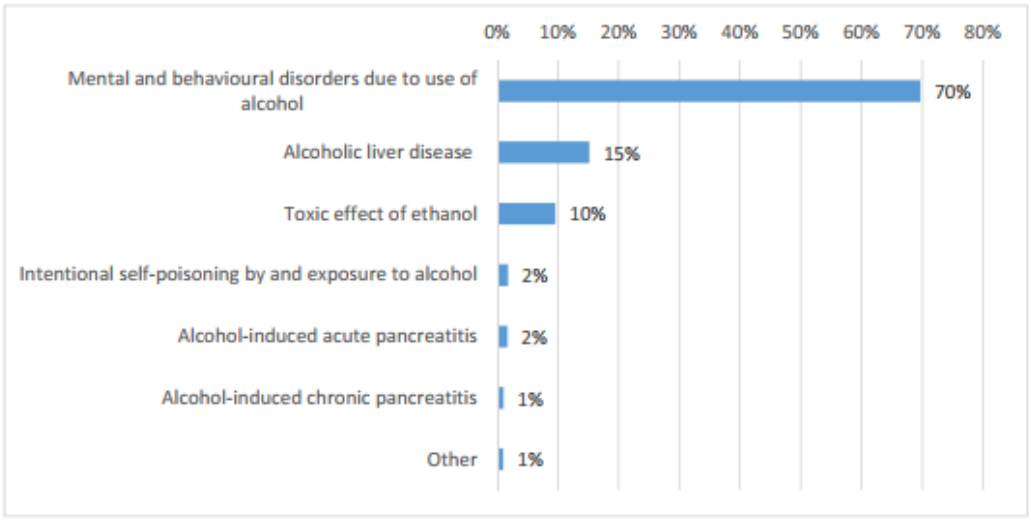
Figure 30: Alcohol-specific hospital admission rates in the most deprived quintile of South Gloucestershire compared with the least deprived quintile



Source: South Gloucestershire Council[8]

The causes for alcohol-specific hospital admissions in South Gloucestershire are shown in Figure 31 below. It can be seen that 70% of admissions were for mental and behavioural disorders due to the use of alcohol (MBDA). This category includes acute drunkenness, alcoholic dementia, Korsakov psychosis, delirium tremens, and other symptoms of withdrawal in an alcohol dependent individual[9]. 15% of admissions were as a result of alcoholic liver disease and 10% due to alcohol toxicity. The proportion resulting from MBDA are higher in South Gloucestershire (70%), than in the South West (65%) or England (65%)[7].

Figure 31 – Alcohol-specific admissions by cause 2012/13 -2016/17 – South Gloucestershire



Source: Colborne, S, Alcohol Admissions in South Gloucestershire[7]

Although there has been some increase in the proportion of MBDA cases in South Gloucestershire since 2013/14, none of these causes have increased disproportionately and it is therefore unlikely that a particular cause is responsible for the increasing rate of alcohol-specific admissions[7].

The majority of alcohol-specific admissions in South Gloucestershire are emergency admissions (68% in 2016/17) such as those through A&E, rather than elective admissions (31% in 2016/17)[7]. The trend since 2012/13 has shown a 27% increase in the directly standardised rate of emergency admissions, and a 160% increase in elective admissions[7]. Elective admissions include those which are controlled by a waiting list, are planned, or are booked[7]. Elective admissions admitted through the waiting list system in South Gloucestershire have increased by over 200% in the last 5 years[7].

The data for these hospital admissions refer to the number of admissions, but in 2016/17, 35% were repeat admissions[7]. Repeat admissions are where the same individual has been admitted previously during that year. From 2012/13 to 2016/17 the proportion of repeat admissions increased by about 5-6%[7].

Furthermore a systematic review, meta-analysis and meta-regression published in July 2019 estimated one in five UK hospital in-patients drink at harmful levels and one in ten are alcohol dependent[10]. The method used for this review was to extract data from 124 studies (1,657,614 UK patients) who had been diagnosed with one of the 26 conditions defined by ICD-10 as wholly attributable to alcohol, such as a mental and behavioural disorder due to the use of alcohol or alcoholic liver disease[10]. It was already known that the prevalence of alcohol-related conditions are higher amongst hospital in-patients than amongst the general population[10]. Knowledge that a patient is drinking at a higher risk level could enable clinicians to more appropriately diagnose the patient's condition and potential comorbidities[10]. Hospital clinicians however often report lacking confidence in managing alcohol use disorders[10]. The authors of this review therefore recommend considering the use of dedicated in-patient specialist alcohol care teams, and improving the training provided to clinicians about alcohol-related conditions[10].

Actions to consider

1. Target particularly men in South Gloucestershire for alcohol interventions as soon as possible before they reach the age of 60, and for women before they reach 40; and people living in areas experiencing the worst multiple deprivations. Provide similar interventions to older age groups whose health might already have been damaged so as to prevent further deterioration.
2. Take a proportional universalism approach whereby all adults in South Gloucestershire are offered interventions aimed at reducing their drinking but with a greater provision for those in the target groups such as men living in areas experiencing multiple deprivations.
3. Analyse the ICD codes especially for the approximately 70% with MBDA, those on waiting lists and the repeat admissions to discover what precisely is leading to their increased admissions' and consult with local clinicians about this.
4. All hospital inpatients and emergency admissions should be screened to gauge their alcohol use and the results used to inform the patient's treatment. The patients should also be given appropriate interventions (including if necessary referral to, or contact by, specialist alcohol treatment services). Training for these tasks should be provided for all hospital clinical staff.

6.1.2. Alcohol-related hospital admissions

As is the case with alcohol-specific conditions, alcohol-related disease could be physical such as heart disease, or mental such as depression[1]. Disease conditions partially attributed to alcohol are termed alcohol-related. An alcohol attributable fraction is the proportion of a health condition such as hypertensive diseases or an external cause such as road traffic accidents that is calculated as apportioned to exposure to alcohol in a population[3]. For example the alcohol attributable fraction for cancer of the oesophagus in males aged 25-34 is 0.61, which means that alcohol is the causative factor in 61% of cases[3]. Similarly hypertensive diseases are deemed to be caused by alcohol in 25% of cases of women aged 35-44, and 40% of falls which result in death in males aged 45-54[3].

*"The **broad** measure for alcohol attributable [alcohol-related] hospital admissions gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. It counts the sum of alcohol attributable fractions in both primary and secondary diagnostic positions and in 2016/17 was reported to account for 7% of all hospital admissions in England."*[8]

The overall broad age-standardised measure rates in South Gloucestershire for all persons (2,182 per 100,000) and females (1,572 per 100,000) in 2017/18 were not deemed as statistically significantly different than those for England (2,224 per 100,000 persons, 1,513 per 100,000 females), and that for males was better[6]; although the rates have risen significantly both at local authority level and in the least deprived quintiles[8].

Looking in detail at the broad measure of admission episodes in South Gloucestershire is interesting. During 2017/18 for MBDA (429 per 100,000 persons, the England value is 371 per 100,000), it reveals a statistically significantly worse rate than that for England, caused by a high value for females (312 per 100,000, England 212 per 100,000)[6]. The value for MBDAs in South Gloucestershire compared with England has been higher for women since 2015/16[6]. The broad admissions episode measures for alcohol-related cardiovascular disease (1,036 per 100,000 persons) and alcoholic liver disease (100.6.2 per 100,000) in 2017/18 are better than the rates for England[6]. The incidence rate of alcohol-related cancer for South Gloucestershire as measured in 2014-16 (36.98 per 100,000) was similar that for England[6].

*"The **narrow** alcohol attributable [alcohol-related measure captures the relevant proportions of all those admitted to hospital with an alcohol attributable cause as their primary diagnosis, or an alcohol attributable external cause (for example intentional or unintentional poisoning) as a secondary diagnosis. The narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions, which at a national level have changed little over the last ten years and account for approximately 2.1% of all hospital admissions."*[8]

For the narrow alcohol-related measure of hospital admissions in 2017/18, South Gloucestershire (667 per 100,000) was statistically significantly worse than the rate for England (632 per 100,000)[6]. Similarly the rate for females (541 per 100,000) was significantly worse than that for England (473 per 100,000)[6]. The worst age group is females 40-64 where the rate in South Gloucestershire is 873 per 100,000 compared to 682 per 100,000 in England[6].

South Gloucestershire was significantly worse than the rate for England in 2017/18 for the narrow measures of admission episodes for alcohol-related unintentional injuries (159.2 per 100,000

persons in South Gloucestershire and 144.3 per 100,000 in England). We also had worse admission rates for this measure in 2016/17.

Intentional self-poisoning by, and exposure to alcohol is also significantly higher (58.5 per 100,000 persons in South Gloucestershire and 46.2 in England). Intentional self- poisoning by, and exposure to alcohol is significantly higher amongst females in South Gloucestershire ((77.1 per 100,000) than is the case in England (53.0 per 100,000[6]. This has been a trend for our females since 2015/16[6].

High levels of diagnosed alcohol-related unintentional injuries, and intentional self-poisoning by, and exposure to alcohol could indicate a future problem in South Gloucestershire, which has not yet revealed itself in the longer-term effects of alcohol-related cancers, cardiovascular and liver disease.

The gap in admission rates between the least deprived and the worst deprived quintiles in South Gloucestershire has increased since 2007/8 -2009/10 for both the narrow and broad measures of alcohol-related hospital admissions[8].

Actions to consider

1. Investigate what is happening amongst females in South Gloucestershire that is causing them to experience worse rates of admissions for MBDAs (which include drunkenness); alcohol-related unintentional injuries; and intentional self-poisoning by, and exposure to alcohol.

6.1.3. Mortality

In South Gloucestershire life expectancy for a man at birth is 81.1 but their healthy life expectancy is 63.6 (below the current stage pension age of 65). For women life expectancy is 84.6 and healthy life expectancy 66.4[11,12]. The ONS found that in 2017 alcohol-specific death rates in the UK were highest among 60 to 64 year olds, with the highest age specific death rate for males being 60-64 and that for females being 55 to 59[5].

PHE estimated that in 2017 the directly age-standardised potential years of life lost in South Gloucestershire adults aged below 75 years due to alcohol-related causes was 491 per 100,000[6]. The number of years lost being worse amongst males (685 per 100,000) than females (301 per 100,000)[6]. This was the case for most of its CIPFA nearest neighbours such as Bath and North East Somerset, North Somerset, and Wiltshire, for both males, females and all persons. Rates for males and females were statistically similar to the England averages in value to that for England[6].

Alcohol-specific directly age standardised mortality rates for South Gloucestershire females (4.4 deaths per 100,000) and all persons (8.3 deaths per 100,000) in 2015-17 were better than that for England. For males (12.4 deaths per 100,000) it was similar to that for England[6]. As explained in Box 1, section 6.1 these deaths will have been identified as wholly caused by a condition (listed in Table 4 section 6.1) attributable to alcohol.

Alcohol-related mortality estimated for 2017 (41.7 persons per 100,000, 61.2 males per 100,000 and 25.5 females per 100,000) was similar to that for England [6]. Mortality from chronic liver disease (9.9 persons per 100,000, 13.4 males per 100,000 and 6.6 females per 100,000) in 2015-17 was similar to that for England[6]. These indicators are also calculated using age standardised data and are not therefore equivalent in value to people known by our local services to have died due to alcohol.

6.1.3.1. Local records for case reviews of known alcohol-related deaths and deaths in service

Whilst there is no statutory requirement to review drug and alcohol related deaths, it is seen as good practice by PHE. The South Gloucestershire Drug and Alcohol Programme (DAP) keep a secure database containing details relating to people who have died and who are known to our commissioned drug and alcohol treatment service(s) (these may be people receiving support on a non-structured pathway or seen in structured treatment), and/or those whose details have been sent to us by the Coroner's Office or Police. Only people who have died whilst in structured treatment (deaths in service/DISs) will be recorded by NDTMS and therefore be shown in the national figures, although DISs might not have died from an alcohol-related cause. The ONS however, gets their data from the coroner so this will be a more realistic picture, although there is a significant lag in the data. Because of our relatively low numbers in South Gloucestershire we are able to review each case where the person has died rather than only cases where drugs and alcohol has been the immediate causal factor i.e. through overdose or alcohol toxicity. This would be much more difficult in an area with a larger population. It is deemed important to review every case where the person died to enable lessons to be learnt and also to try and act as a risk management process for those at highest risk of these kinds of deaths. Such deaths are often premature, preventable and suspected to be caused by their alcohol use, even if the cause of death is not recorded as such. These cases are reviewed at the South Gloucestershire DAP Clinical Governance Group meetings, where it is decided how to record their cause of death and what lessons can be learnt.

Criteria considered for recording a person as an alcohol-related death (ARD) include their cause of death e.g. alcoholic liver disease and drinking history. Over the years causes of death have varied but common causes noted are liver failure/cirrhosis/alcoholic liver disease, cardiac failure, multi-organ failure and gastrointestinal bleeding. Unlike the PHE definitions of alcohol-related deaths, attributable fractions are not used and instead clinical judgement is used to decide whether alcohol for that person was likely to be a clear contributory cause of death. In practice what we call ARDs are closer to alcohol-specific deaths. This data is an under-estimate of all ARDs in South Gloucestershire but includes more than are recorded by the National Drug Treatment Monitoring System (NDTMS) system.

Table 5: South Gloucestershire Alcohol-Related Deaths (ARD) and Deaths in Alcohol Service (DIS)

Year	Number of ARD and DIS - All	Males	Females	Average (mean) age at death - All	Age range at death - All	Average (mean) age at death - Male	Average (mean) age at death - Female
2015/16	7	7	0	53	28 -71	53	N/A
2016/17	6	R	R	47	36-56	54	40
2017/18	8	R	R	48	37-67	50	37
2018/19	16	11	5	49	30-66	52	43
TOTAL	**37**	**28**	**9**	**49**	**28-71**	**52**	**40**
		R=redacted due to low numbers of <5)					

Year	Estimated mean duration of harmful drinking (years) -All	Estimated number of harmful drinking years (range)	Estimated mean duration of harmful drinking for Males (years)	Estimated mean duration of harmful drinking for Females (years)
2015/16	14	2-40+	14	N/A
2016/17	19*	8-32*	24	16
2017/18	16	3-41	17	9
2018/19	14**	<1-45	18	4
TOTAL	**16**	**<1-45?+**	**18**	**10**
*5 responses to this question out of 6 deaths in 2016/17 (?M or F),				
**14 responses to this question out of 16 deaths in 2018/19 (?M or F)				

Tables 5 above describes the average age at death and age range for ARDs or DIS in this cohort, and length of self-reported or professionally estimated harmful drinking before death where known. The average age of death is 49 years (52 for men and 40 for women), which is younger than might be expected from considering the highest UK alcohol-specific death rates occur in those aged 60 to 64 (males) or 55 to 59 (females)[5]. This also compares to a life expectancy of 81 years for men and 85 for women born in South Gloucestershire[11]. This means alcohol is likely to have deprived this cohort of men on average approximately 29 years of living, and 45 years for the women.

Furthermore the figures show that they were drinking at harmful levels for an average of 16 years (18 for men and 10 for women) before dying – years that gave opportunity for a change in outcome. However, some were only drinking harmfully for a much shorter period.

Although the data is from a small sample size and thus we are unable to draw firm conclusions, it appears to show women die younger and with less years of harmful drinking than do men. The data shows a large increase of alcohol-related deaths in 2018/19 from that in the previous 3 years. This might be due to more cases being reported to us by the Coroner's Office because NDTMS data does not currently show any deaths in service for 2017/18 (see section 8.14) although there were a number less than 5 who died whilst in treatment during the nine months from 1 April to 31 December 2018[13]. This data is revealing people who died, who were not in a structured treatment programme.

The differences in gender could be seen as an unexpected finding because directly aged standardised PHE estimates for years lost due to alcohol-related conditions, alcohol specific mortality and alcohol-related mortality both in South Gloucestershire and in England are all worse for men than for women. It is however known that generally women are physiologically more vulnerable to the effects of alcohol than are men.

Actions to consider

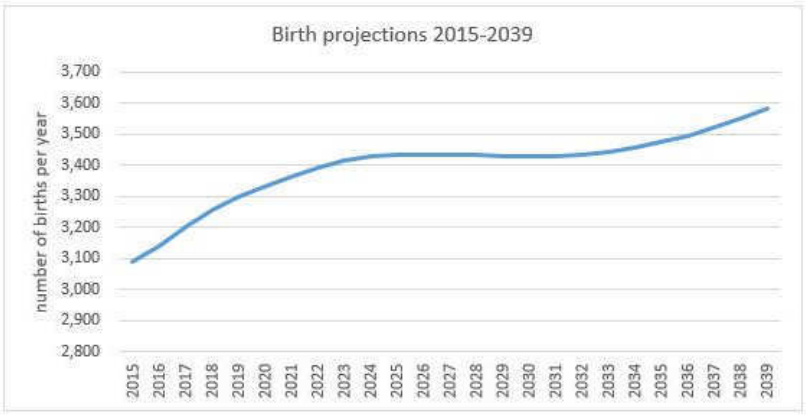
1. The local review of people known to the Integrated Drug and Alcohol Service and the DAP Clinical Governance Group who have died because of their drinking or whilst in treatment for it should be continued. This is primarily to gain information to enable risk assessments of people known to be at risk and to develop plans to mitigate the risk and a risk flagging system should be developed to try to achieve this.
2. Provide education about alcohol harms to young adults, particularly females.

3. Identify as soon as possible people who are drinking at higher risk levels. Motivate and support them to reduce their alcohol consumption and where appropriate to complete a course of structured treatment.

6.1.4. Pregnancy and foetal alcohol syndrome

Approximately 3,000 births occurred amongst South Gloucestershire residents in 2016[14]. A rise in births is expected as shown in Figure 32 below.

Figure 32: Projected number of births in South Gloucestershire 2013 to 2037



Source: Office for National Statistics 2014, cited in South Gloucestershire Council (updated 2017) Joint Strategic Needs Assessment[14]

Drinking in pregnancy can lead to long-term harms to the baby, with the more consumed the greater the risks. The Chief Medical Officers' guidance is for pregnant women or those planning a pregnancy, the safest approach to minimise risks to the baby is not to drink alcohol at all[2]. This guidance has been included in *'NICE (CG 62) Antenatal care for uncomplicated pregnancies'*. It suggests such antenatal information be given to women at their first contact with a healthcare professional[15]. NICE CG 62 also recommends woman-centred care whereby healthy pregnant women are treated with respect and given the opportunity to make informed decisions about their care in partnership with their healthcare professional[15]. NICE Guidance relating to foetal alcohol spectrum disorders (FASD) is due to be published in July 2020, and it will include information about alcohol consumption in pregnancy, and the diagnosis and assessment of people affected by FASD[16]. NHS England have included in their *guidance "Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality"* advice for pregnant women to avoid alcohol[17].

As part of the NHS England Maternity Transformation Plan[18] and roll out of the Saving Babies Lives Care Bundle[17] there are bi-monthly Local Maternity System' meetings facilitated by Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG). A primary aim of these meetings is to deliver safer care to pregnant women across the BNSSG area. For uncomplicated pregnancies the normal pathway is for a minimum of 10 maternity care contacts with a healthcare professional. At their booking appointment pregnant women attending services provided by North Bristol NHS Trust are asked about their intake of alcohol. If any disclose continuous consumption at high quantities they are referred to the Specialist team for substance misuse and are placed under Consultant care for closer screening. The procedure in other maternity

services commissioned for South Gloucestershire residents and across BNSSG is as yet unknown. Additionally there is concern for those who do not disclose continued alcohol consumption, and it is uncertain what advice (if any) is given for those who disclose lower level consumption.

A recent (2017) meta-analysis and systematic review estimated that in 2012, over 40% of women in the UK drank (any amount) of alcohol during pregnancy[19]. This place the UK in the worst out of eight groups globally[19]. Awareness of the UK guidelines to avoid drinking alcohol when pregnant was known by 67% (72% females, 63% males) of those asked in a 2018 YouGov online poll[20] , which means that 28% of females are likely to be unaware of the need to stop drinking when pregnant.

Drinking one or two units per day in pregnancy is a risk factor for premature or low-birth weight babies[19,21]. 2.3% of babies carried to term and born in South Gloucestershire are considered to be of low birth weight, which is similar to the proportion for England[6]. Alcohol will be a causal factor in some but not all of these cases. Drinking more than 1.5 units per day in the first trimester is associated with an increased risk of miscarriage[21].

Drinking in pregnancy can also result in a range of FASDs, which include low intelligence, poor co-ordination and problems with seeing and hearing[19]. There is evidence which shows prenatal exposure to 4 to 5 units of alcohol per occasion and no more than 9 units per week is associated with an increased probability of childhood behavioural problems[21]. Foetal alcohol syndrome (FAS) is the most severe and visibly identifiable manifestation of FASD[19]. Children born with FAS have facial abnormalities e.g. small eyes, thin upper lip), restricted growth, and learning and behavioural disorders which can be severe and lifelong[21]. The prevalence of FAS in the UK is estimated to be 61.3 cases per 100,000 of the population[19]. It could be therefore that there are approximately 171 people living with FAS in South Gloucestershire. Because the prevalence ratio of FAS to FASD is believed to be about one to nine or ten[19], it is likely there could be approximately 1,710 people living in South Gloucestershire with at least one symptom of foetal alcohol spectrum disorder.

Vulnerability to the effects of FASDs may be enhanced by maternal smoking[19]. There is an established opt-out pathway for all pregnant women who smoke. Particularly in young people there is often a cluster of unhealthy behaviours such as smoking, drinking and/or using other drugs. South Gloucestershire Public Health Division, aiming to reduce smoking and promote breastfeeding in young mums commission a Family Nurse Partnership (FNP) programme[22]. It is a voluntary, evidence-based, home support visiting programme which has been commissioned for first-time young parents aged under 19 years. The details of all pregnant women under 19 years at their first maternity appointment in Bristol or South Gloucestershire are referred to the FPN supervisor. As there is a capacity limit of 25 families in South Gloucestershire, the parents will be assessed and prioritised for the offer of a place on the programme according to their vulnerability. The programme is delivered to the young mothers and their partners by a specially trained nurse usually until the child is aged 2 years. The FNP programme is designed to improve the mother's self-efficacy and give their child the best start in life.

The NHS Website suggests that whilst an occasional drink consumed by a breastfeeding mum is unlikely to harm the baby, if more is likely to be consumed breastfeeding could be avoided for 2 to 3 hours for every drink consumed[23]. This is because alcohol passes into breast milk and therefore time is needed to metabolise that in the mother's body. Furthermore there is a strong association of sudden infant death syndrome (SIDS) if a mother shares a sofa or bed with her baby after drinking alcohol, and a risk of neglect if binge drinking has occurred[23]. Early post-natal care is provided by a midwife and then transferred to a health visitor.

Structured alcohol treatment is available to pregnant women who need support to stop drinking and is delivered by specialist drug and alcohol staff as described in sections 8.2.2 and 8.2.3. No pregnant women in South Gloucestershire were identified as a new presentations in need of alcohol treatment in 2017/18[24]. Nationally, 1% of new female presentations to alcohol treatment were pregnant and for 3% of new female presentations the data on pregnancy status was incomplete[24]. The context of having 31 females in treatment for alcohol only problems in South Gloucestershire in 2017/18 has to be considered. A further 84 females started drug treatment in 2017/18, some of whom would also be receiving treatment for alcohol[25]. Of the 84 new presentations for drug treatment, a number smaller than 5 were pregnant[25]. Details of how to access specialist or less intensive support or self-help to reduce drinking can be accessed through the One You South Gloucestershire website https://oneyou.southglos.gov.uk/ (see section 7.5).

Actions to consider

1. Implement NICE Guidance relating to foetal alcohol spectrum disorders (FASD) once published (July 2020).

2. The DAP should develop working relationships with maternity services commissioners and providers across BNSSG through the 'Local Maternity System' meetings.

3. Train and upskill all Maternity Healthcare Providers to ensure key messages, support offered and referrals to services are in line with NICE Guidance and the Saving Babies Lives Care Bundle (V2).

4. Work in partnership with the BNSSG Trusts to develop informational content on alcohol intake before, during and after pregnancy for patient apps and websites, leaflets and posters etc.

5. Audit current practice across the local system to identify priority areas for development and help with effective planning.

6. Work towards developing and sharing agreed protocols and evidence-based pathways for pregnant women who disclose continued alcohol consumption at their booking appointment and any other contact with a maternity healthcare professional.

7. Discuss with midwifery services screening of pregnant women for continued drinking, binge drinking or an alcohol use disorder, and providing a brief intervention or referral to a specialist service.

8. Discuss with midwifery services the provision of information about the One You South Gloucestershire website/ service for pregnant women who do not disclose continued alcohol consumption, and/or for those who disclose lower level consumption but would like some advice and support on alcohol intake in pregnancy

9. Educate pregnant women to avoid drinking alcohol and target messages to their partners for supporting this.

10. Provide pre-conception education about the risks of drinking alcohol in pregnancy including within schools and sexual health settings.

11. Develop partnerships with post-natal services, e.g. health visitors for minimising the risk of alcohol use and breastfeeding. Train and upskill health visitors, and collaborate on the development of patient information leaflets and apps etc.

12. Request data for pregnancy status on presenting for specialist alcohol treatment for the last five years and compare it with the national proportion.

13. Monitor improvements and outcomes regularly over time.

6.2. Wider harms

The damaging effects of alcohol are not limited to the health of the drinker and in the case of pregnant women their unborn child. Alcohol also impacts on families, communities, workplaces and the wider society in terms of safeguarding issues, crime and disorder, accidents, and lost productivity.

6.2.1. Effect on families

Although most families who drink alcohol do not harm, abuse or neglect their children, parental drinking can impact on them. Nationally, approximately 18% of children in need of support from social services are affected by alcohol misuse, and alcohol 'misuse' was identified as a factor in 37% of cases where a child was seriously hurt or killed.[26,27]. Research has however shown referrals to social services are often made only when the level of concern has reached that for child protection rather than for early support[27]. Other impacts of parental drinking include an increased risk of children experiencing injuries or health concerns in their early years necessitating medical care, conduct disorders, the development of Adverse Childhood Experiences (ACE's), and earlier use of alcohol and/or to develop dependency themselves.

PHE estimated that from 2014/15 to 2016/17 there were 455 alcohol dependent adults in South Gloucestershire who lived with children, and 811 children who lived with an alcohol dependent adult[24]. In 2016/17 alcohol 'misuse' was identified as a risk factor in 15.1% of children in need assessments[24]. This compares with 21% in the South West region, 18% nationally and 14.9% locally where drugs were identified as a risk factor[26].

For the years 2014/15 to 2016/17, PHE estimated only 12% (n=56) of alcohol dependent adults in South Gloucestershire who were living with children received treatment, as shown in Table 6, below[27]. This is less than the national proportion (21%). It is also less than the proportion of parents estimated as receiving treatment for opiate dependency in South Gloucestershire (52%) –the same as the estimated national proportion for parental opiate treatment (52%)[27].

Table 6: Estimated treatment needs for alcohol dependent parents

Adults with an alcohol dependency	South Gloucestershire			Benchmark	National
	Prevalence	*Treatment*	*% met need*	%	%
Total number of adults with a dependency who live with children	455	56	12%	26%	21%
Total number of children who live with an adult with a dependency	811	74	9%	26%	21%

Source: PHE[27]

In 2017/18 there were 17 children who were living with South Gloucestershire clients entering treatment for alcohol[24]. Box 2 below illustrates that 20% (n=9) of alcohol clients were living with children when they presented for alcohol treatment. This is lower than the national proportion (24%). Additionally the proportion of females living with children is lower than the national proportion[24].

16% were parents but were living apart from their children at assessment and 64% were not parents or had no contact with their or their partner's child/children[24].

Box 2: Parental status of alcohol clients entering treatment

	Local		National	
	n	Proportion of new presentations	n	Proportion of new presentations
Living with children (own or other)	9	20%	11,967	24%
Parents not living with children	7	16%	12,906	25%
Not a parent/no child contact	29	64%	25,468	50%
Missing / incomplete	0	0%	315	1%

Source: PHE[24]

In 2017/18 less than 5 client's children were receiving early help, designated as a child in need, had a child protection plan in place, or were a looked after child[24]. Box 3 below shows the proportion nationally. As the number of clients assessed locally was 45, it is not known whether there is a lack of social care provision for alcohol only clients or whether there is only a lack of data. It is however likely that parents would find it more challenging to access treatment than non-parents (see section 8.16).

Box 3: National proportions of alcohol client's children receiving early help or in contact with children's social care

	National		Proportion by gender	
	n	Proportion of clients with child contact	M	F
Early Help	779	3%	2%	5%
Child in need	734	3%	2%	4%
Child protection plan in place	1,434	6%	4%	9%
Looked after child	573	2%	1%	4%

Source: PHE[24]

Actions to consider

1. Aim for families to receive early interventions and support before the child has need for a child protection plan, and to protect against the development of alcohol-related childhood injuries or Adverse Childhood Experiences.
2. More prominence needs to be given to identifying and treating alcohol dependent parents. There is therefore need to develop greater partnership working with other agencies such as the early intervention and social services teams.
3. Obtain data for the last five years relating to the number of children identified both by local alcohol treatment services and by local children's social care services where parental alcohol use has been identified as an issue.
4. Consult with local higher risk and dependent drinkers and/or previous service users with children over potential barriers to treatment.

6.2.2. Domestic violence and abuse

Domestic violence and abuse (DVA) can be defined as

"Any incident or pattern of incidents of controlling, coercive, or threatening behaviour, violence, or abuse between those aged 16 years or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional."[28]

It is estimated that alcohol could be involved in anything from 17% of perpetrators up to two thirds of domestic violence incidents known to the police, with it being mainly the perpetrator under the influence of alcohol[28,29].

During 2015/16 the South Gloucestershire Safer and Stronger Communities Strategic Partnership estimated there were approximately 3,275 reported cases (and possibly more than twice as many which were not reported) of domestic and sexual violence cases[28,30]. Data for reported cases in 2016/17 or 2017/18 is not available[30]. In 2017 however there were 169 cases reported to the Police in South Gloucestershire where the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment score showed the victims to be at high risk, although not all cases are reported to the police[30]. In 2016/17, 300 victims with a high DASH score were considered by the Multi-Agency Risk Assessment Conference (MARAC)[30].

MARAC referrals capture whether the victim or perpetrator have alcohol (and/or drug) issues. Up until 2014 an annual report was produced by the South Gloucestershire Safe and Strong Communities team, which included alcohol-related data. In 2014 responsibility for MARAC was returned to the police and the last known data collated was for 2015/15. It showed that current or previous alcohol and/or drug use by the victim was identified in only 19% of cases but was relevant for 66% of the perpetrators[28]. Responsibility for MARAC was returned to SG Council in April 2019 and now sits within the Children and Adult Health (CAH) Directorate.

Next Link is the provider for supporting victims of DVA but their current administration system does not have the facility to report alcohol and drug information. The South Gloucestershire Senior Community Safety Project Officer will raise this issue with the Joint Commissioning Group and propose this as information we require for future reports.

The way that the police gather statistics around crime and crime recording does not adequately enable us to analyse and assess alcohol as a contributory factor. However a keyword search of a log of domestic abuse incidents reported to the police shows that there had been 4,465 DV incidents reported across Avon and Somerset in the 12 months prior to May 2019. Of these 2,349 showed up alcohol through a keyword search. This is a rate of over 50%. It has been pointed out that this is likely to be an underestimate. For example, the keyword search was for the word "alcohol" not "drunk" so it will not have captured all cases.

Actions to consider

1. Contact the MARAC lead in South Gloucestershire CAH services and request that data be extracted for the numbers and proportions of victims and perpetrators where alcohol (and/or drugs) is mentioned to have featured in DVA cases; and how many (and what) alcohol (or drug)-related referrals have been made.
2. Next Link to begin recording alcohol data for their service-users.
3. The police and the DAP should work together on developing more robust processes for collecting statistics around how alcohol acts as a contributory factor in domestic violence cases.

6.2.2.1. Support for DVA victims and perpetrators with problematic drinking behaviour

Although there is no evidence that alcohol causes DVA, it is likely to be a trigger factor. An intention to support families to reduce trigger factors for DVA such as drugs and alcohol, unemployment, debt and housing is stated in the South Gloucestershire Domestic Violence and Abuse Strategy[31].

Our alcohol treatments services are flexible and sensitive to the needs of those experiencing DVA and staff have received training on identifying domestic abuse and violence, completing standard screening and onward referral. Referrals are made to the Multi Agency Risk Assessment conference (MARAC) from DHI and one of our Specialist Health Improvement Practitioners in the DAP is our MARAC representative, processing referrals and attending meetings where appropriate. They also sit on the MARAC steering group.

Next Link as the provider for DVA services in South Gloucestershire offer support ranging from telephone support and advice to a place in a safe house. Next Link provide the Freedom Programme which is a 12 week course which examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help them to make sense of and understand what has happened to them. There is currently a waiting list for the programme however and it is not known whether people using drug and alcohol services are regularly sign posted to the programme.

In 2014/15 a small amount of community safety funding was secured by DHI to provide a perpetrator programme. Named the *Reducing Substances and Violence Programme (RSVP),* it aimed to work with perpetrators of domestic abuse and violence who also had substance misuse issues on a voluntary basis. Perpetrators were identified from Probation or from DHI. They entered the programme which offered 8 structured 1:1 sessions to support people to make changes in their behaviour. It worked in partnership with Survive, the commissioned provider of Domestic Abuse Services in South Gloucestershire at that time, to enable a joined up approach to working with these kinds of issues in families.

The project showed merit and had some success after a slow start, primarily caused by how long it took to recruit a staff member to work on the project. There were also a low number of referrals at the start of the project as stakeholders in other services were informed what was on offer. By the end of the third quarter, momentum was increasing. The number of referrals increased by the fourth quarter. Unfortunately, the funding was discontinued and so the project was forced to end ahead of the planned timescale. The total number of referrals received over the period from July 2014 to the end of March 2015 was 19, of which 10 actually commenced working with the programme; Of the 10 clients who commenced the programme, 8 successfully completed it and 2 dropped out in the early stages of the programme. All who completed the programme reported a reduction in their domestic abuse tendencies in terms of severity and frequency, although regrettably, 1 did get involved in a domestic abuse incident several weeks after completing the programme, which contributed to the ending of the relationship. The project therefore showed some promise in working in this way with perpetrators of domestic abuse but no full evaluation was ever done of the project due to the short timescales and the funding being terminated.

Colleagues in Safer and Stronger are currently exploring the response to and provision available for perpetrators that will include enforcement and holistic remedies. Perpetrators of domestic violence and abuse must be challenged and brought to justice. Domestic Violence and Abuse Prevention Programmes are well placed to help perpetrators recognise that their actions have an impact on

their home life. We believe that a proactive approach should be adopted when targeting perpetrators along with the use of appropriate tools and powers to target those who are not willing to change their behaviour, helping to protect the most vulnerable.

Those who are willing to change their behaviour will be signposted or referred to appropriate perpetrator interventions such as:

Reprovide: this programme is RESPECT accredited and recognised by the Family Courts. Furthermore the programme not only works with the perpetrator, but includes a family support worker that works with the perpetrators partner to help build self-esteem and develop safety plans. Respect accredited programmes are trauma informed. Any professional can refer to this programme although up to the time of report, all referrals have come from the police or from social care with no one being referred from drug and alcohol services.

CARA Project - These workshops designed by The Hampton Trust, provide opportunities for offenders to be held accountable for their actions and reflect on their behaviour and has set a precedent in its approach to working with perpetrators nationwide. Police officers who identify offenders suitable for the CARA programme will refer them to the Constabulary's new ASCEND (Avon and Somerset Constabulary Engage Navigate Divert) service, which has been created to assess the offender's need and support them through the programme. This is a PCC funded service for A&S force area).

Building Better Relationships (BBR) – This is a 29 week accredited Programme. Referrals come from the courts or from social care and are mainly for offenders sentenced to this as a requirement following a conviction for a DV offence. It can also be a licence requirement following a custodial sentence. Our Community Rehabilitation Company (CRC) also offer the intervention for men working with CAFCASS and referrals can be made by Social Workers however there is a fee for those not required to attend the programme as part of sentence or licence.

Respectful Relationships: This intervention is designed for individuals whose behaviour is linked to relationship issues and who do not meet the criteria or eligibility for Building Better Relationships (BBR). It is a 10 week programme and delivered as part of a RAR (court ordered Rehabilitation Activity Requirement) or for those on licence. CRC also accept referrals via social workers or GPs but there is a fee for those not required to attend the programme as part of their sentence or licence.

In conclusion, although there are perpetrator programmes available in South Gloucestershire, there is limited provision for those outside of the criminal justice or social care system. However, the lack of referrals from drug and alcohol services to the ReProvide scheme suggests that enough has not been done to publicise or create adequate pathways between these services and more could be done to ensure that those who may be supported to change their behaviour given the right intervention can do so.

Actions to consider

1. Explore whether a Freedom Programme could be run from Drug and Alcohol services.

2. Develop stronger links between drug and alcohol services and perpetrator programmes to ensure adequate provision.

2. Work with the Safer and Stronger Communities team to obtain data on numbers of people from South Gloucestershire attending DVA perpetrator programmes and their outcomes.

6.2.3. Effect on communities

A consensus statement was issued in 2018 by the Association of Directors of Public Health, the Association of Police and crime Commissioners, PHE, the Local Government Association and others[32]. It acknowledges and supports *'The New Policing Vision 2025'* which aims for a new approach to policing which works collaboratively across organisations including public health to develop whole place approaches to commissioning and developing preventative services to manage sexual and violent offenders and those with alcohol dependencies; and to support troubled families, victims of DVA and children subject to Child Protection Plans [32].

A 2019 study *'Alcohol-related harm to others in England: a cross-sectional analysis of national survey data'* estimated approximately 1 in 20 adults aged 16+ experienced alcohol-related aggressive harm whereby they felt physically threatened; were physically assaulted; or felt forced or pressured into sex or a sexual act[33]. Using 2017 estimates of our local population aged 16+ (226,942)[34] it is therefore estimated that 11,342 adults in South Gloucestershire have experienced alcohol-related aggressive harm.

The Alcohol Toolkit Survey data used in this study had an original sample size of 5,068 with a 96.3% fully completed response rate, and the fully completed sample was then weighted to improve its representativeness[33]. The full results of the study including non-aggressive alcohol-related harm are shown in Table 7 below.

Table 7: Prevalence of alcohol harm to others in the previous 12 months (2015/16), weighted data

Harm type	Number of respondents who experienced harm	Percentage of respondents who experienced harm	95% CI
Been kept awake due to noise or disruption	390	8.0	7.2 to 8.9
Felt uncomfortable or anxious at a social occasion (eg, a party)	331	6.8	6.0 to 7.6
Had a serious argument that did NOT include physical violence	275	5.7	5.0 to 6.4
Been let down by someone due to them failing to do something that I was counting on them to do because of their drinking	174	3.6	3.0 to 4.2
Been emotionally hurt or neglected	170	3.5	3.0 to 4.1
Felt physically threatened	164	3.4	2.8 to 4.0
Had to stop seeing or being in contact with someone because of their drinking	120	2.5	2.0 to 3.0
Had to contact the police	117	2.4	2.0 to 2.9
Had someone break or damage something that mattered to me	95	1.9	1.5 to 2.5
Been physically hurt due to them assaulting me or acting violently	92	1.9	1.5 to 2.4
Been put at risk in a car when someone was driving after drinking	75	1.5	1.2 to 2.0
Felt genuinely concerned that they may cause harm to my children or someone else's children	61	1.2	0.9 to 1.6
Had to spend my personal time caring for a person with a long-term health condition or disability that resulted from their current or previous drinking	57	1.2	0.9 to 1.5
Been physically hurt due to them accidentally injuring me (eg, by falling on me)	53	1.1	0.8 to 1.5
Had money that would have improved the quality of my life spent on their alcohol-related purchases	50	1.0	0.8 to 1.4
Drank alcohol myself in order to cope with the problems caused by their drinking	33	0.7	0.5 to 1.0
Felt forced or pressured into sex or something sexual	33	0.7	0.5 to 1.0
Had to move out of my usual place of residence and stay somewhere else	25	0.5	0.3 to 0.8
At least one reported harm	980	20.1	18.9 to 21.4
At least one aggressive harm	225	4.6	4.0 to 5.4

Weighted n=4874.

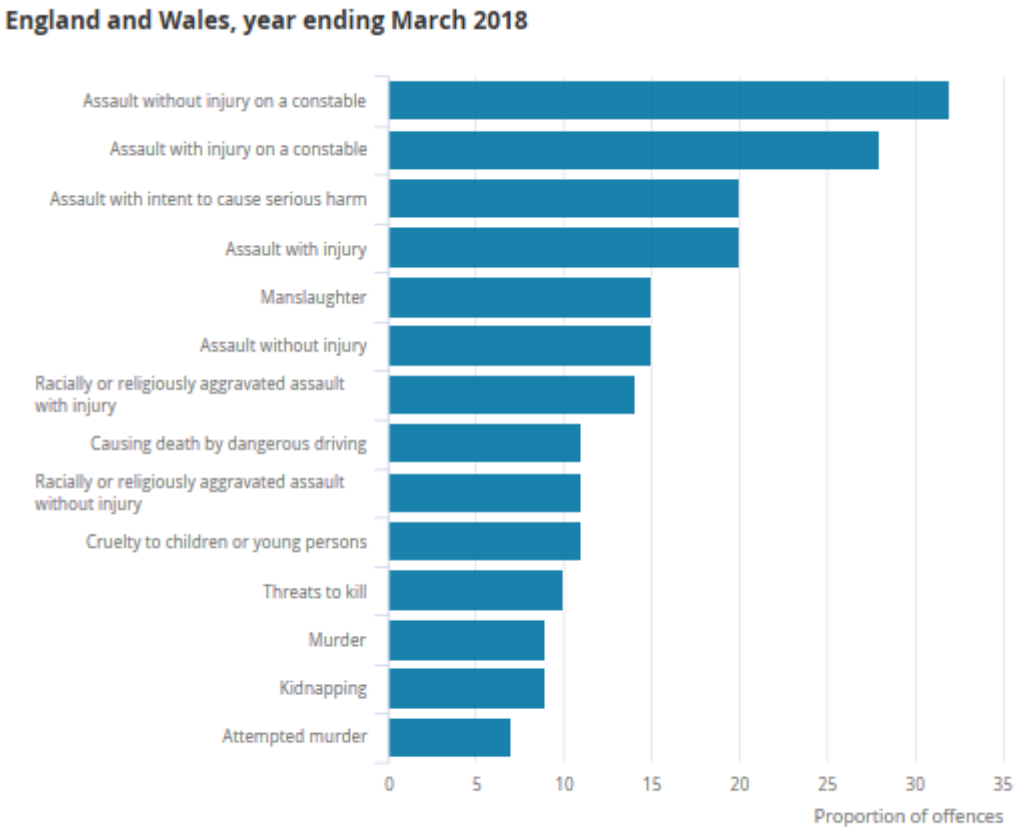
Source: Beynon C, et al[33]

Those most likely to experience alcohol-related harm were those who are of White British ethnicity, stated to be drinking at hazardous or harmful (increasing or higher risk) levels of drinking, having a disability, being educated and living in private rented accommodation (compared with being an owner occupier[33].

6.2.4. Violent and sexual crime

The 2019 Office for National Statistics (ONS) publication *'The nature of violent crime in England and Wales: year ending March 2018'* reported on violent crimes estimated by the 2018 Crime Survey for England and Wales[35]. The Crime Survey data showed in 39% of violent incidents, victims believed their perpetrators to be under the influence of alcohol[35]. The violent incidents comprised of wounding, assault with minor injury, and assault without injury[35]. A lower proportion however of violent crime was flagged by 35 police forces in England and Wales as alcohol-related, with the most common offence being assault without injury on a constable (32%); and manslaughter (15%), causing death by dangerous driving (11%) and murder (9%) as shown in Figure 33 below[35].

Figure 33: The proportion of selected violent offences recorded by 35 police forces as "alcohol-related".



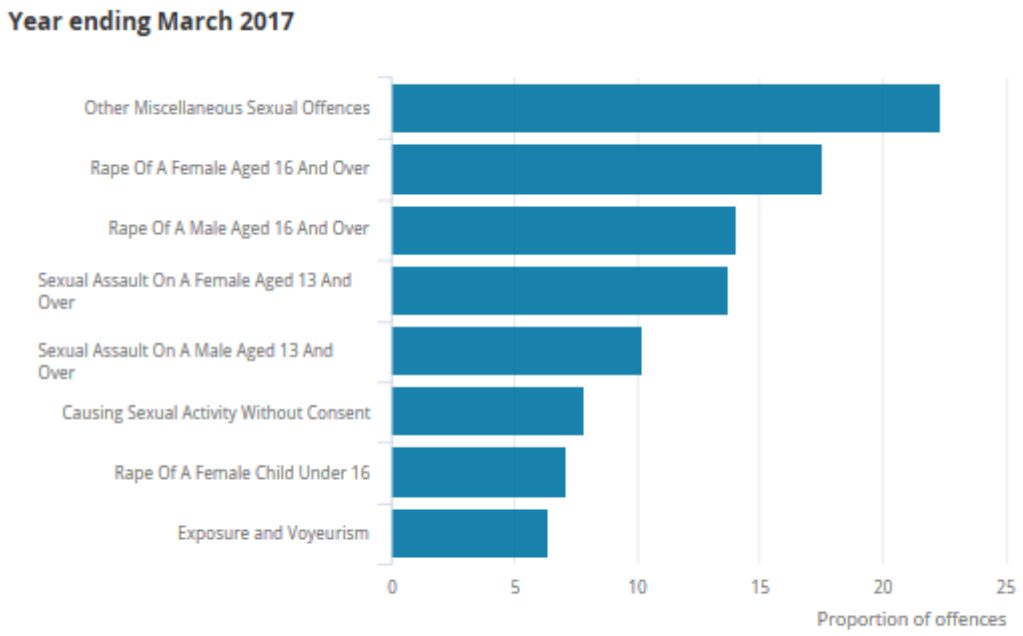
Source: Home Office Data Hub

- Cited in ONS[35]

Sexual offences include the rape and sexual assault of adults or children, sexual grooming and indecent exposure[35]. In the 2017 '*Crime Survey for England and Wales'*, respondents (aged 16-59) who had experienced rape or sexual penetration (including attempted penetration) aged 16+ when the most recent incident occurred were asked whether they thought the perpetrator was under the influence of alcohol or drugs at the time of the incident and also whether they were[36]. 38% reported they believed the perpetrator to be under the influence of alcohol and a similar proportion (38%) reported they too had drunk alcohol at the time of the incident[36]. This is a higher proportion than those who reported their perpetrator (8%) or themselves (2% drugs they had chosen to take, plus 6% drugged) to be under the influence of drugs[36]. More victims were under the influence of alcohol when the perpetrator was a stranger (65%) compared with when the offender was a partner or ex-partner (19%)[36].

The proportion of sexual offences committed in 2016/17 and recorded by 31 police forces in England and Wales which were flagged as alcohol-related is shown in Figure 34 below.

Figure 34 – The proportion of selected sexual offences recorded by 31 police forces as "alcohol-related".



Source: Home Office Data Hub

- Cited in ONS[36]

There was no South Gloucestershire data available for child sexual exploitation – the more severe cases being included in the reporting of sex offences[30]. An approximation for childhood sexual abuse in South Gloucestershire was calculated using the NSPCC national prevalence estimate of 1 in 20. The rate estimated was 3,406 victims per annum in South Gloucestershire[30].

The South Gloucestershire Strategic Assessment of Crime and Disorder 2017/18 used the national Management of Risk Assessment in Law Enforcement (MORILE) risk management process to prioritise activity and resources[30]. From this it was decided to prioritise for 2018/19:

- Serious Organised Crime (incorporating Modern Slavery)
- Rogue Trading and Mass Marketing Fraud
- Child Sexual Abuse / Child Sexual Exploitation and Serious Sexual Offences
- Anti-social behaviour
- Domestic Abuse
- Hate Crime[30]

From the beginning of February 2017 to the end of January 2018, there were 124 rapes and 186 serious sexual offences excluding rapes reported in South Gloucestershire[30]. It could be estimated that in 38% of these rapes (n=47) either the victim and/or the perpetrator had drunk alcohol at the time of the incident[30,36].

Reducing alcohol consumption (including where appropriate with treatment) could reduce the numbers of violent and sexual crimes. Across the Avon and Somerset police force area (which includes South Gloucestershire) PHE estimated that in 2017/18 alcohol clients would have committed 116 offences of violence against the person and 23 sexual offences before entering

treatment[37]. Furthermore PHE estimated that treating alcohol clients in the Avon and Somerset Police area 2017/18 would save over £7 million in terms of the social and economic costs of violent, sexual and non-violent crime crimes[37].

Actions to consider

1. Prevent vulnerable intoxicated people from becoming the victim of a rape or other sexual crime through education, campaigns and maximising night time support such as taxi marshals and street pastors.
2. Perpetrators of violent and sexual crimes with alcohol dependency or who are drinking alcohol in a problematic way should be identified by the criminal justice system and encouraged to enter alcohol treatment.

6.2.5. Non-violent crime

From 2017/18 Across the Avon and Somerset police force area a total of 5,481 non-violent and violent crimes were estimated to have been committed by clients before they entered treatment for alcohol[37]. The crimes included 4,901 shoplifting offences, 39 drink/drug driving, 71 domestic burglary, 75 other thefts, 40 non-domestic burglaries, 32 criminal damage and arson, and 26 robberies[37].

In South Gloucestershire there were 1,702 reported cases of shoplifting from the beginning of December 2016 to the end of November 2017[30]. PHE estimated that alcohol treatment reduced numbers of alcohol only clients reoffending by 58%[37]. It is possible therefore that up to 987 of the shoplifting cases in South Gloucestershire (and similar proportionate reductions for other crimes could have been prevented by the identification and recruitment into treatment of people who drink alcohol in a problematic way.

Actions to consider

1. Perpetrators of non-violent crimes with alcohol dependency or who drink alcohol in a problematic way should be identified by the criminal justice system and encouraged to enter alcohol treatment.

6.2.6. The night time economy

Around 62% of South Gloucestershire's population live in the built up areas which border Bristol such as Kingswood, Staple Hill and Filton, 18% live in the towns of Yate, Chipping Sodbury and Thornbury[38]. The remaining 20% live in more rural areas[38].

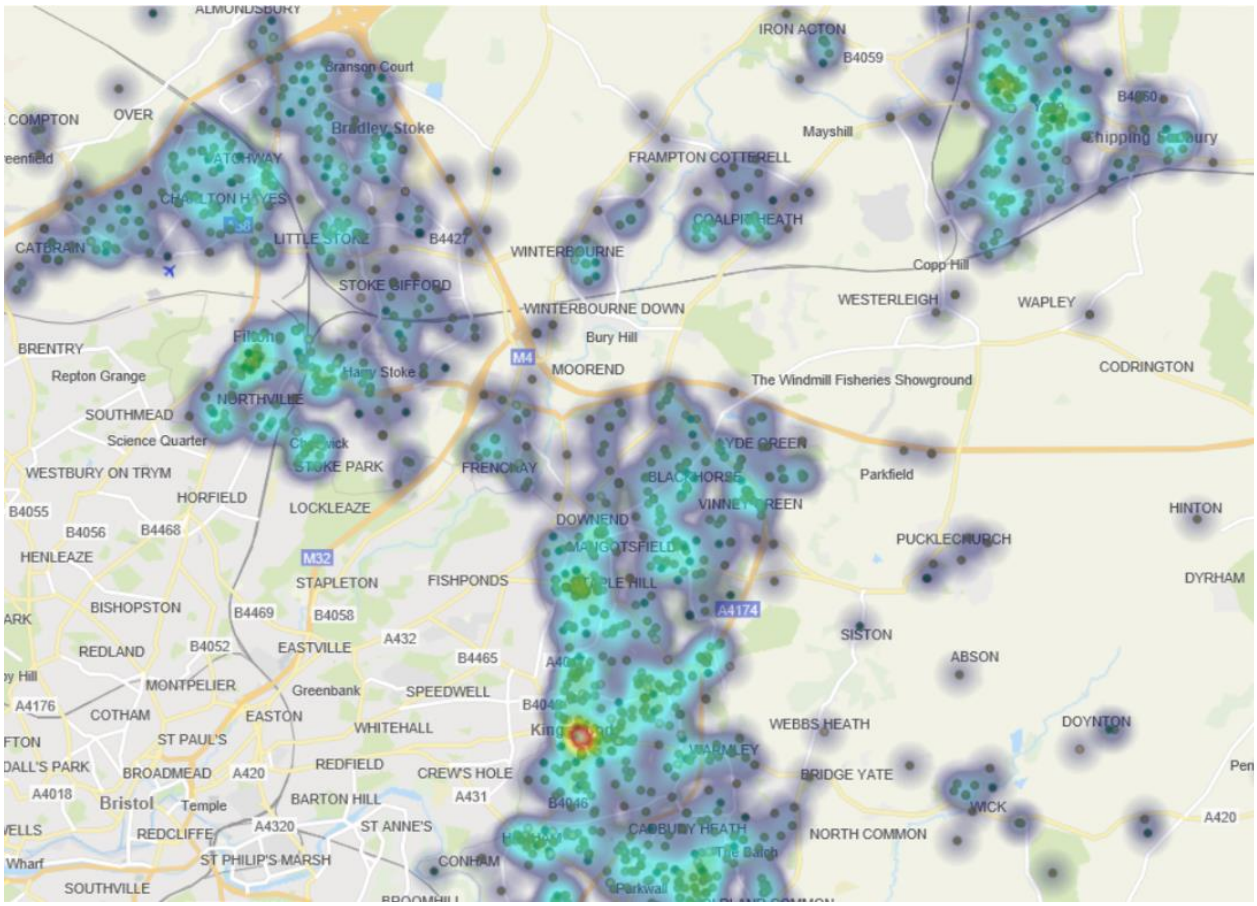
Figure 35: South Gloucestershire towns and villages

Source: South Gloucestershire Safer and Stronger Communities Strategic Partnership Delivery Plan 2019/20[39]

There were 1,100 incidents out of 48,398 that were flagged as alcohol related in a snapshot of the previous rolling 12 months prior to May 2019. However, this is likely to be a large underestimate because this is only taken from comments added by a call taker to a computerised record of a call into the Police, on a system known as STORM, which documents all 999 and 101 calls. All incidents and crimes where the victim (or any other person) perceives that the effects of alcohol consumption on the offender or victim was an aggravating factor, should have the alcohol Local Qualifier (Niche) or Qualifier (STORM) applied to them. Using Qualifiers is a mandatory Home Office requirement.

The map (Figure 36, below) shows local public order crime hot spots. Furthermore mapping by the police also identified a concentration of offences against the person (mainly assaults) in the Kingswood and Staple Hill areas.

Figure 36: Public Order 12M Crime hot spots in the 12 months prior to May 2019



Source: *Avon and Somerset Constabulary*

There are three "hot spots" identified in South Gloucestershire for police officer deployment. These are:

- Regent St, Kingswood
- High St Staple Hill
- Chipping Sodbury High St

These are closely correlated to issues around the NTE and alcohol consumption.

Responding to these incidents is time consuming and costly. For example, in a snapshot of the previous 12 months prior to May 2019, officers spent 327 hours dealing with 263 incidents at Regent St, Kingswood, at a salary cost of approximately £8826.00.

South Gloucestershire Local Policing Area (LPA) within Avon and Somerset has 50 Problem Solving Plans across all areas of Neighbourhood policing. 10 are related to problems with the NTE and licensing.

Therefore you could say that 20% of problem solving work is related to the NTE.

<u>Incidents at Licensed Premises April 2018 to March 2019</u>

There were 452 incidents at licences premises in South Gloucestershire in 2018-19. Figures do not include supermarkets and off licenses. Therefore we can see that the police are having to respond to a large number of incidents taking place in pubs and bars where alcohol is likely to be a primary factor in many of these incidents.

Street marshals are based in Kingswood and Chipping Sodbury, our two busiest night-time economies. Their role is to help the licensed premises in that area ensure that the streets are safe, prevent or minimise altercations and help by getting people in to properly licensed transport such as Taxis and Private Hire vehicles and back home.

6.2.7. Antisocial nuisance and disorder

There were 5,146 reports of anti-social behaviour (ASB) in South Gloucestershire over the 12 months to the end of November 2017, and there was a 28% increase over the same period in 2015/16[30]. The general trend is for increasing reports of ASB. Although there is a high volume of ASB, it is often low level in severity and examples include noisy and rowdy behaviour especially that associated with drinking in public places or after leaving a licensed premise, littering, disputes with neighbours, and criminal damage to property or vehicles[30]. Some local issues with street drinkers have been identified. The top three locations for reporting of ASB to the end of November 2017 were:

- The Downend/Emersons Green/Siston/Rodway Police Beat area
- Yate and Yate Central/Dodington Yate
- Kings Chase/Kingswood and Woodstock/Kingswood[30]

The hotspots for ASB are however not static. A recent *'Behave or Be Banned'* scheme has been launched in South Gloucestershire with the agreement of some licensed premises. This scheme is intended to ensure the safe enjoyment of the majority of people using these premises[40]. Our ASB team together with pubs who are members of the local PubWatch (a voluntary organisation for licensed premises) will target and ban repeat offenders from pubs and venues where they have caused a troublesome incident[40]. Furthermore if they are banned in one PubWatch venue, they will be banned from them all[40]. Enforcement powers from serving such a Community Protection Notice (CPN) could result in a fine, remedial or forfeiture order being issued if compliance is breached[40].

Actions to consider

1. Map episodes of ASB (and other crime hotspots) with the number and type of licensed premises in an area.
2. Liaise with PubWatch to evaluate the implementation of the '*Behave or Be Banned*' scheme.

6.2.8. Road traffic accidents

Alcohol-related road traffic accidents in South Gloucestershire for 2014 -16 (24.7 per 1,000) is similar to that for England (26.4 per 1,000) and is less than the average value for its CIPFA nearest neighbours (30.2 per 1.000)[6]. However any alcohol related traffic accident is preventable and therefore we should aspire for zero incidents. Evidence demonstrates the effectiveness and cost-effectiveness of enforcing legislative measures to prevent drink-driving[21].

Actions to consider

1. The road safety and the DAP teams should work collaboratively to develop any campaigns they are running around drink driving.

6.2.9. Fires

Where it was suspected alcohol and/or drugs were a factor, Avon Fire and Rescue Service (AFRS) report that there were an average (mean) 7 (range 5 to 9) fire incidents per year during the years January to December 2012 – 2018. The peak number of such fires was during summer months.

Actions to consider

1. South Gloucestershire DAP team to work with the AFRS Vulnerable Adult Manager to share ideas which could be implemented to reduce the risk of alcohol consumption in causing fires.
2. To develop training for fire service staff who attend people's homes to provide Alcohol IBAs and MECC

6.2.10. Other impacts

If someone of low income is drinking heavily they are likely to be spending money on alcohol rather than on essentials such as their rent or mortgage, food, heating and lighting. South Gloucestershire Food Plan 2018-21 identifies people who are currently using or recovering from alcohol dependency as an at risk group for poor nutrition[41]. Furthermore alcohol is high in sugar and empty calories, and 61% of adults in South Gloucestershire are classified as overweight or obese[12]; although conversely alcohol-related liver disease can cause weight loss[42].

If drinkers are experiencing frequent hangovers their performance at or ability to work is likely to deteriorate, which in the worst cases could lead to disciplinary action or dismissal. They could become homeless. Due to lack of money or lack of control when drunk they could commit crime. Their relationships with family and friends are likely to suffer, as will their health. This paints a picture of sliding down the socioeconomic scale, thus alcohol can worsen social and health inequalities. Such effects are not easily visible in South Gloucestershire as the number of claimants of benefits (88.8 per 100,000) in South Gloucestershire due to alcoholism in 2016 were lower than the value for England (132.8 per 100,000) and is less than the average number for its CIPFA nearest neighbours (114.1 per 100,000)[6].

The direct costs of problematic alcohol use to taxpayers are composed of those which are needed for health and social care, the police and the criminal justice system, and for unemployment and other welfare benefits[21]. Hangovers and other effects of drinking for example those which result in sickness absence or accidents at work reduce the productivity and profitability of business[21]. For individuals their earning potential may be reduced, they may experience pain and suffering and have their lives cut short[21]. Money is spent on alcohol which could be used more productively[21]. These costs will be discussed further in the Economic Evaluation (chapter 10).

Actions to consider

1. Dependent and high risk drinkers need a holistic approach to wellbeing which includes education about healthy nutrition and wraparound services for housing, debt advice and budgeting.
2. The impact of alcohol to businesses through absenteeism, lost productivity, and decreased staff wellbeing could be used to incentivise workplace initiatives.

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7. Services available for prevention and early intervention

71% of our adult population are estimated to drink alcohol at the lower risk level of ≤14 units per week – which includes those who abstain from drinking[1]. 29% (61,500) are estimated to be drinking more than 14 units per week[1], which places them in the categories of increasing risk, higher risk or risk of dependency. PHE estimate that 1% (2,202 people) of our population are likely to be alcohol-dependent and are in need of specialist alcohol treatment[1]. For some it will be too late to reverse the damage caused from their drinking.

Most resources are currently spent on treating people once they have become alcohol dependent. Additional to these downstream interventions, which we must keep investing in as people need specialist support and often affect some of the most vulnerable people in our population; we need to provide evidence-based upstream interventions throughout the life-course in a range of settings aiming to reduce the risks of developing alcohol-specific (such as dependency) and alcohol-related harms (such as certain cancers and cardiovascular disease). It is likely the costs of prevention and early intervention are cheaper than treatment. Aside from the financial argument, there is also an ethical responsibility to attempt to stop people from reaching the point where they need specialist treatment, are unwell or have suffered trauma related to problematic alcohol use. The challenge for the DAP is how we continue to provide a wide range of treatment options for those most acutely affected by alcohol harm, whilst ensuring that work to prevent people from becoming dependent or drinking at levels which significantly risk damaging their health is also invested in, with limited funds.

This chapter will consider what preventative and early interventions have been provided or are currently provided in South Gloucestershire and will make further recommendations for what could be improved.

7.1. Education and campaigns

The 2016 PHE evidence review of effectiveness for different alcohol policies concluded education campaigns were not cost effective, albeit they increased public support for more stringent and effective changes of policy[2]. The review therefore recommends information and education be

included as components of an overall policy approach. There is some evidence that school-based programmes might be more effective than a standard curriculum in reducing measures such as binge drinking, or the frequency or quantity of alcohol consumed[2]. They note the delivery of messages by the alcohol industry to have no significant public health effects[2].

Currently South Gloucestershire Public Health Division promote some national campaigns – mainly Dry January (which encourages people to give up alcohol completely for the whole month) and Alcohol Awareness Week in November, (which aims to increase awareness and spark conversations about alcohol and its related harms). Resources used include alcohol wheels, AUDIT scratch cards and unit cups. There is currently no coherent or co-ordinated message regarding alcohol harms from all stakeholders. Messages are not generally targeted to particular demographics nor are campaigns focussed on local issues and social media is not used to its full potential. The CLeaR peer reviewers suggested we could develop communications between partner organisations and with local communities especially those who have increasing risk of alcohol harm whilst not requiring hospital or service interventions. They suggested this could include traditional campaigns and social media.

Actions to consider

1. Draw up a multi-agency agreed strategic communications plan that clearly sets out who will be targeted and when and who will be included and responsible.
2. Communicate messages considered as important using universal and targeted campaigns.
3. Social media should be used more effectively to support local and national campaigns.
4. Ensure there is a budget to provide tools such as alcohol wheels, AUDIT scratch cards and unit cups to facilitate brief interventions in the community.

7.2. Students

South Gloucestershire is home to the University of the West of England (UWE), and their main campus, Frenchay Campus, with other campuses situated in surrounding local authorities. UWE provide higher education to over 27,000 students and accommodate over 3000 first year students on site at Frenchay Campus.

In the past few years, there has been growing concern and focus on the use of alcohol by students and an Alcohol Impact Group has been set up, with representatives from various agencies in attendance. However, this is an area where continued work is required and needs to be handled in a sensitive manner. This is due to the impact that needing to have a group like this this can have on the perception of the university and its reputation.

UWE has taken a proactive approach and signed up to the Alcohol Impact Programme, run by the National Union of Students (NUS) achieving full accreditation in December 2017. The programme aims to tackle cultures of irresponsible drinking, ultimately reducing harm to students, improving welfare, well-being and academic achievement, creating more inclusive spaces, enhancing the student experience and helping to foster top-down institutional change. UWE had to evidence various responsible approaches and initiatives in numerous categories, which equate to points, to achieve accreditation, exceeding the accreditation threshold by 90 points.

As part of the South Gloucestershire Drug and Alcohol Service, DHI were providing an engagement worker to provide support for half a day a week. As it became apparent that increased support

would be utilised, UWE funded a full time Drug and Alcohol worker, through DHI, who sits within the Wellbeing Team at UWE. This position has been in place since September 2018 and has been well utilised, so has been extended for a further year. However, the data gathered is not entered into NDTMS and ownership of the data is not yet agreed.

Another useful tool in monitoring UWE students' alcohol use, is the Breaking Free Online app. Access to the app is funded by South Gloucestershire DAP and is currently only available for use through the UWE Drug and Alcohol worker. It allows individuals access to a comprehensive online treatment and recovery programme, that supports them to resolve the psychological and lifestyle issues that drive their use of alcohol from their phone or computer. Access to the app means 24/7 support is available and may encourage more people to access support or think about their alcohol consumption and behaviours, who do not feel traditional community support is appropriate for them.

Actions to consider:

1. DHI and UWE to agree ownership of data and for data to be entered into NDTMS for monitoring purposes.
2. Continued funding of a specific drug and alcohol post at UWE.
3. Continued multi-disciplinary approach to alcohol use by students, and promotion of responsible drinking habits.
4. Increased access to Breaking Free online for the student population.

7.3. Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is an approach to behaviour change that supports staff to make the most of the everyday interactions that they have with people. MECC is endorsed by NICE (National Institute for Health and Care Excellence)[3].

MECC encourages staff and volunteers who have contact with the public to use these opportunities to engage in brief conversations. The practitioner uses Open Discovery Questions (ODQ) to ascertain how the member of the public might make positive changes to their health or wellbeing, such as reducing their alcohol consumption, looking after their mental wellbeing, stopping smoking, eating more healthily and increasing physical activity.

MECC training was rolled out across South Gloucestershire Council in September 2016. By March 2019, over 452 people had accessed some form of MECC training. An online follow-up survey was sent via email to all attendees who completed the MECC training between October 2018 and March 2019. The purpose of the follow-up survey was to obtain information about the attendees' perceptions of the benefits of the training and how useful it had been for their practice and everyday life after 3-months of attending MECC training. In total, 58 online surveys were sent to attendees with 21 responses received (36.2%). Over 65% of respondents agreed or strongly agreed that they utilise the MECC approach in their day to day work. 43% of respondents found that the training was very helpful or helpful in increasing their confidence to have a 'healthy conversation' and supporting someone to make a lifestyle change with 47% giving a neutral response. It is possible that some participants felt that they were already giving healthy lifestyle information to their clients but not referring to this as MECC. Recommendations from the survey included an acknowledgement that 'without the continual support for MECC or healthy lifestyles being championed, MECC can fall off of

the agenda and staff can be left feeling unable to make a change in their own practice' and 'One of the issues with MECC is demonstrating its impact. Collecting data on referrals to the One You service through sustaining a 'healthy conversation' would be one way of measuring its impact.'

The South West region of England use the Wessex model of MECC, but there are a number of other MECC models across the country. Public Health England coordinate the roll out of MECC across the region and it is their vision that all health and social care organisations and relevant partner agencies will be aware of, adopt and embed MECC principles. This means that every appropriate opportunity should be used for MECC conversations. An important focus of MECC is the aim of making prevention a core part of everybody's business. South Gloucestershire Public Health and Wellbeing Division have led the approach and staff working in social care settings, public facing roles in the health settings (health care assistants and pharmacists) were among the first to be trained in the MECC approach.

Staff are trained to use ODQ's which prompt people to talk and help them to reach their own conclusions about changes they want to make. The MECC approach moves away from telling people what to do. It addresses the person's own concerns with their health by helping people make informed choices which can be evaluated and readjusted after they have set specific goals. A MECC conversation may sometimes be simply about 'planting a seed' so that a person makes a small step towards thinking about change. Where people need further support to make a change, they can be signposted towards the relevant services.

Reasons for MECC implementation:

- MECC supports people to make the first steps towards leading healthier lives – this should reduce demand on health and social care services over the medium to long-term;
- MECC offers a different way of interacting with people which may help to bring up different issues and provide staff with different options for supporting people.

Due to the way in which behaviour change and people's reasons for wanting change vary from person to person, it is impossible to tell which contact had the effect of helping people to change their behaviour, therefore it is difficult to evaluate the MECC programme directly regarding reducing alcohol consumption. NICE guidance 'Behaviour Change: individual approaches' highlights however that the delivery of brief interventions is well below the NICE cost per quality-adjusted life-year (QALY) thresholds[4]. NICE reached this decision following review of evidence that included systematic reviews and meta-analyses[5].

Our CLeaR peer reviewers recommended alcohol identification and brief advice (IBA) training should be linked to the rollout of MECC, and a monitoring system be devised for observing the quality of IBA sessions.

Actions to consider

1. IBA training should be offered to those attending MECC training and with capacity for full evaluation built in at the beginning.
2. Evaluation of IBA sessions should include observations of the quality of delivery.

7.4. South Gloucestershire Prevention and Self Care Network

The South Gloucestershire Prevention & Self Care Network was established in October 2017 to help develop a strategic and co-ordinated approach to prevention and self-care activities in South Gloucestershire. The Network's objectives centre around gaining an overview of the range of prevention and self-care activities across South Gloucestershire; developing relationships between partners, and sharing and promoting good practice; advocating for joint working; and linking into the work being undertaken at a Bristol, North Somerset and South Gloucestershire level through the Healthier Together Prevention Plan Implementation Groups, one of which is on alcohol.

The Network meets every six months. At each meeting partners receive an update on national prevention policies; latest work of the Healthier Together Prevention Plan Implementation Groups; and 'showcases' relating to specific South Gloucestershire prevention and self-care initiatives.

Alcohol was showcased at the Network meeting in November 2018 and the update included:

- The Public Health Drugs and Alcohol Programme had undertaken a PHE CLeaR review and peer assessment, and preliminary findings included good pockets of work in South Gloucestershire, but not a coherent overall vision.
- The Team had reviewed the alcohol elements of the 2016 Substance Misuse Needs Assessment.
- It was recognised that the programme had been very focused on treatment but there was an ambition to extend its focus on prevention as this was seen as ethical and cost effective.
- A new alcohol health needs assessment and strategy, taking a life-course approach, would be developed. It would include a review of the evidence base and good practice guidelines; and there would be engagement and consultation with the public and stakeholders.

Partners were keen to help reduce alcohol harm and highlighted the following measures:

- Alcohol harm awareness raising campaigns
- Sharing alcohol treatment referral data
- More brief interventions, for example in pharmacy
- Online training for pharmacy staff
- Roll out Making Every Contact Count (MECC) training with pharmacy Health Champions.

Some of these measures are being progressed. In May 2019 the Network received the Public Health Campaign Calendar for 2019-20 and were encouraged to support initiatives throughout the year, which include 'Alcohol Awareness Week' in November and 'Dry January'. It was also agreed that the Network would adopt three or four priorities to focus on during the year. In addition, MECC training is now being rolled out to all primary care staff, which includes pharmacy Health Champions. MECC training includes an element of online learning on healthy lifestyle topics, including alcohol.

Finally, in May 2019 the Network received an update on the latest work of the Healthier Together Alcohol Group, which included:

Activity	Outputs/Outcomes
Agree on and conduct a baseline assessment informed by NICE recommendations for alcohol	Completion of the CleaR alcohol assessment tool across BNSSG partners
Work in collaboration with the CCG and WAHSN to assess how community-based mobile fibroscanners can identify those at risk of alcohol-related harm	Feasibility assessment of use of fibroscanners in primary care / community services and input provided to shape pilot project work
Review provision of Alcohol Care Teams across BNSSG	Greater identification and signposting of patients to services Engagement with Blue Light project to develop alternative approaches and care pathways for treatment-resistant drinkers

Actions to consider

1. Continue working with the partners on campaigns, MECC and other brief interventions, and alcohol awareness training and include this in communications plan.

7.5. One You South Gloucestershire

One You South Gloucestershire (OYSG) is a healthy lifestyles and wellbeing service for adults to help make important, lasting improvements to their health. The service is for all adults over the age of 18 who are a South Gloucestershire resident or registered with a GP practice in South Gloucestershire.

OYSG services include access to information to help residents stop smoking, eat healthier, move more, sleep better, stress less, address weight concerns and drink less alcohol.

OYSG is delivered in a stepped approach offering support through -

- Prevention and self-care information with downloadable resources and digital self-care tools. This information and contact details can be found at https://oneyou.southglos.gov.uk/
- Light touch support which may offer face to face sessions , telephone support or ongoing self-care advice
- Enhanced support to make multiple lifestyle changes including one to one support with a health coach.

The alcohol service element of OYSG begins with an assessment using the Alcohol Use Disorder Intervention Tool (AUDIT) compact section (AUDIT-C). Dependant on their score, the service user will be offered advice on reducing their alcohol consumption, a series of brief interventions to assist in this process or be signposted to more intensive support through DHI.

The OYSG service aims to provide residents with an explanation of the harms associated with a variety of risky behaviours as well as services available to them and information about how they can reduce their risk of various health harms by making some changes to their lifestyle.

Actions to consider

1. Promote OYSG service to ensure individuals are aware of the alcohol early intervention support available.
2. Evaluate the effectiveness of the OYSG service for reducing increasing and higher risk drinking and signposting to specialist support.

7.6. Healthcare settings

A 2018 Cochrane review studied 69 trials internationally whereby brief interventions were provided by doctors or nurses in GP practices or emergency care with the aim of reducing drinking[6]. The interventions studied were typically face-to-face or by telephone; of 5 to 15 minutes duration with a doctor, or 20 to 30 minutes with a nurse. Interventions of between one and five sessions were included in the study. The authors concluded there was moderate quality of evidence to support the effectiveness of these brief interventions. Reductions of approximately a pint of beer or a third of a bottle of wine per week at one-year follow-up were achieved.

7.6.1 GP practices

A 2016 meta-regression analysis and systematic review concluded that alcohol brief interventions play a small but significant role in reducing alcohol consumption and that in primary care settings nurses were most effective in reducing the quantity (but not the frequency) of alcohol consumed[7]. The study compared different types of brief intervention such as FRAMES (feedback of client's alcohol risk, responsibility for change belongs to the client, advice when requested, menu of options, empathy and self-efficacy), motivational interviewing, or brief advice [7]. They concluded a lack of evidence to demonstrate one type of brief intervention used as being more effective than another [7].

The PHE (2016) review of the effectiveness and cost effectiveness of alcohol control policies recommended the use of alcohol identification and brief advice (IBA) to every patient at their next registration with a new GP practice and during NHS health checks [2]. IBA is part of the NHS Health Check (see section 7.6.2 below) PHE cite strong evidence which states IBA delivered in primary care is a cost effective option for reducing alcohol misuse [2]. The University of Sheffield estimated if IBAs were delivered to every patient at their next registration with a new GP in England, there would be almost 2,400 fewer alcohol-attributable deaths and 125,000 fewer hospital admissions (broad measure); and net savings of £282 million for the NHS alone [2]. For a five year cycle of NHS Health Checks they estimated the benefits to be almost 1,900 fewer alcohol-attributable deaths and 86,000 fewer hospital admissions (broad measure); and net savings of £262 million for the NHS [2]. Furthermore the CLeaR peer reviewers recommended opportunities for IBAs in South Gloucestershire are maximised, and that this be a focus of the new alcohol strategy. They also stated *"It would also be good to see the Clinical Commissioning Group…more actively engaged in the*

routine identification of alcohol related harm and delivery of information and advice or onward referral as required"

In 2014/15 to 2015/16 a pilot was commissioned by the Public Health and Wellbeing Division whereby 2 GP Alcohol Liaison Nurses were employed by the Avon and Wiltshire Mental Health Partnership to provide alcohol interventions such facilitating IBAs, one-to-one keywork, supporting GPs in providing community detoxifications and relapse prevention for dependent drinkers[8]. This service was provided in Thornbury Health Centre, Courtside Surgery (Yate) and Kingswood Health Centre[8]. 346 IBA were provided in 2014/15. In this first year 84 referrals for specialist alcohol treatment were identified, with peak numbers in Quarter 4 after Christmas and New Year. Of those identified 56 service users started alcohol treatment with the nurse and 40 successfully exited their treatment as alcohol-free or an occasional user[8]. GP's confidence questionnaires revealed satisfaction that the nurse (only one was in post during the first year) alleviated their time pressures and gave them greater confidence in working with alcohol clients; and feedback from the service users was positive[8]. The pilot was not formally evaluated in 2015/16 but was discontinued when the service was recommissioned due to the remodelling of the service to mean that drugs workers would also work with people around their alcohol issue. The DAP received feedback from some people accessing alcohol treatment that they would prefer a non-healthcare professional as a keyworker. This was stated as being because it was perceived that the nurse(s) focussed on their health more than the psychosocial aspect. As there were only two nurses it is unknown whether this was typical of the profession or a characteristic of particular practitioner(s). It was felt that similar work could be done by non-medical staff, with the notable exception of administering community detoxes. In the new commissioning model, generic DHI keyworkers meet with their treatment clients in several GP practices and will work with them on their alcohol and drug issues together, as appropriate.

When patients first register with a GP practice an AUDIT-C test or other alcohol screening checklist could be completed and an appropriate brief intervention provided. There is currently no standardised protocol for this in South Gloucestershire, and it is unknown how many might offer alcohol identification and brief advice (IBA) for their new patients. A few years ago there was a Local Enhanced Service agreement in which some practices were paid to offer IBA to their patients. When the funding was withdrawn it is likely most or all practices stopped providing the service. One GP stated "*Very few problem drinkers were identified. And those that were [sic] often university students bingeing once in a blue moon*"[9]. Therefore despite the evidence backing up the use of IBA's in this way, there may be some difficulty in encouraging practitioners to roll out the intervention again.

Actions to consider

1. Whether alcohol identification and brief advice (IBA) interventions should be provided to every patient at their next registration with a new GP practice. Support for funding this should be discussed with the CCG.
2. Run an IBA pilot using nurses, with capacity for full evaluation built in at the beginning and ensure their training includes the use of evidence based brief intervention techniques.

7.6.2. NHS Health Checks

South Gloucestershire Local Authority (LA) is responsible for commissioning and monitoring the offer of an NHS Health Check to eligible individuals aged 40-74 years once every five years. Individuals

with pre-existing heart disease, stroke, diabetes, kidney disease, high blood pressure or other vascular disease are not eligible. The NHS Health Check programme has a crucial role to play in tackling cardiovascular disease (CVD) because it provides a systematic mechanism for identifying and managing people with the common risk factors driving CVD, stroke, type 2 diabetes, kidney disease and dementia. The LA is responsible for ensuring those receiving the NHS Health Check receive information on their identified risks, and if necessary are signposted to and offered either lifestyle or clinical interventions.

In South Gloucestershire the NHS Health Check programme is delivered currently only in GP Practices. Patients are provided with a 20 to 30 minute appointment in which the health professional, generally a Health Care Assistant or Practice Nurse, will carry out an eleven component risk assessment. These components include asking the patient questions about lifestyle and family history; measuring blood pressure, cholesterol levels, height and weight for a BMI calculation; and calculating a cardiovascular risk score.

The risk assessment component relating to alcohol is the AUDIT test. If a patient scores 5+ in the first three questions (AUDIT C) the remaining seven questions should be answered to complete a full AUDIT test. Before the soft launch of the One You South Gloucestershire (OYSG), Healthy Lifestyles and Wellbeing Service in April 2019, the NHS Health Check Practitioners were trained in the following pathway. If the patient scored 0-7 (indicating lower risk drinking) in the full AUDIT test, their alcohol consumption should have been affirmed. If the AUDIT score was 8-15 (indicating drinking at an increasing risk level) they should have given brief advice aiming to reduce the patient's drinking. For an AUDIT score of 16-19 (indicating higher risk drinking) they could have either given extended brief advice, or referred the patient to our specialist alcohol provider (DHI) or their GP. If the patient scored 20+ indicating the possibility of dependency, they should have been referred to DHI or to their GP. OYSG was launched formally in September 2019. Following this launch, the pathway is as follows. A full AUDIT score: 0-7 brief intervention, 8-15 refer to OYSG, 16+ refer to DHI.

In the two years 2016/17 - 2017/18 the number of NHS Health Checks completed at GP surgeries within South Gloucestershire was recorded by the practitioners using an online template as 13,497. Of those, 9,096 (67%) had an AUDIT C score recorded. Due to issues with coding and data extraction it is uncertain how many of these patients also went on to complete the full AUDIT test. Available data suggests that 1,395 (15%) of patients who had an AUDIT-C test recorded, scored over 8 for AUDIT, indicating at least an increasing risk of alcohol-related harms. As AUDIT is a self-reported test, this is however likely to be an under-estimate of the numbers drinking at these increasing and higher risk levels[10]. This likelihood of under-estimation is indicated when comparing NHS Health Check data showing 15% drinking at levels indicating at least an increasing risk of developing adverse health and social consequences, whereas PHE estimated 29% of our population are drinking at such levels.

Unfortunately less than half (595, 42%) of the 15% eligible for a brief intervention and/or signposting were recorded as having received it. Furthermore 116 (1.3% of those completing the AUDIT-C) scored over 20 in the full AUDIT (indicating possible dependence) but only one patient was recorded as referred to DHI (although that one person was recorded as having declined the referral).

To start investigating the barriers to completing the alcohol section of the NHS Health Check, a survey (Appendix 1was trialled on a convenience sample of eight practitioners. Six surveys were returned, including one which was not completed due to the practitioner not yet having completed training for the role. At least one other was also known by the facilitators not to have completed the training. Out of the five completed surveys, the key points were:

- It appears currently (albeit from a very small sample size) the preferred referral was to GPs rather than DHI and it is unclear which GP's are providing specialist support rather than referring patients to DHI;
- There was some confusion over the referral criteria among practitioners delivering the NHS Health Check as the local referral criteria differs from that in the national Best Practice Guidance. National Best Practice Guidance requests referral to a specialist alcohol service only if the AUDIT score is 20+;
- NHS Health Check practitioners could benefit from more training on referral criteria and knowledge of what DHI provide.

Anecdotal feedback from the NHS Health Check practitioners to the South Gloucestershire Public Health and Wellbeing Division revealed doubts that practitioners offer more than very brief advice to their patients due to time pressures, unless the client requests it. Practitioners have also reported confusion with the 2015 Bristol, North Somerset and South Gloucestershire (BNSSG) locally developed template. Work is therefore currently underway on the development of a new local template.

South Gloucestershire Public Health and Wellbeing Division in 2019 completed a local Health Equity Audit (HEA), this was carried out on data extracted from the NHS Health Check programme between 2013 and 2018. The HEA compared the characteristics of the eligible population with the characteristics of who was being invited for an NHS Health Check and who took up their invitation. They found that although people from high risk groups were being invited, for example smokers and people with mental health conditions, they were less likely to attend. Although drinking status was not investigated there are strong associations between drinking and smoking, therefore those drinking at higher risk levels might also be less likely to attend an NHS Health Check.

National data extraction of the NHS Health Checks programme has been carried out by PHE and NHS Digital, the findings of which were made available at LA level in September 2019. There has not been time to include it for this needs assessment but it is hoped that analysis will give a more comprehensive picture of activity.

Actions to consider

1. Clinical signoff of a local pathway for NHS Health Check Programmes that includes local referral criteria, and further training for the new pathway.
2. A retrospective investigation of the pathway for 116 patients who had an NHS Health Check in 2016/17 - 2017/18 and scored over 20 for their AUDIT test but appear not to have been referred for further support; in particular looking at the two surgeries where most of these patients were identified.
3. Investigations to be made as part of the next Health Equity Audit cycle looking at alcohol risk assessment and management, in particular any barriers to raising the issue of alcohol. Additional investigations could be made to understand any relationship between people with a mental health status recorded and drinkers.
4. Analysis of the NHS Health Check national data extraction.
5. Partnership working between the NHS Health Check team and the DAP team to increase the numbers of those likely to be at higher risk of more than lower risk drinking to attend an NHS Health Check.

7.6.3. Pharmacies

NHS England commissions pharmacies to provide essential services such as the dispensing of prescriptions. Another of the essential services which is mandatory for the pharmacies to provide is entitled *'Promotion of Healthy Lifestyles (Public Health)'*[11]. Their service specification states the requirement to participate in up to six public health campaigns, and leaflets and information relating to the campaigns are provided by NHS England[10]. Alcohol is scheduled as a campaign in January 2020[11].

Pharmacies have a higher footfall of people than is the case in other primary care settings. It was therefore decided in 2014 to pilot IBA interventions in three South Gloucestershire community pharmacies. This was then rolled out to Healthy Living Pharmacies. The IBA intervention consisted of a member of the pharmacy team offering their patients an AUDIT-C test in the form of a scratch card and giving appropriate brief advice depending on the resulting score. Because the scratch cards were completed anonymously patients revealed to be drinking higher than lower risk levels could not be followed up to discover whether their drinking had reduced post-intervention. There was therefore no way to evaluate the effectiveness of this intervention and the pilot was discontinued in 2016.

PHE (2016) *'The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review'*[2] reported the outcome of a randomised controlled trial in 16 London community pharmacies. It failed to demonstrate any reductions in AUDIT score for their study cohort three months post-intervention when compared with the control group who were only given a leaflet. The trial did however report this might have been due to the pharmacists receiving insufficient training for the intervention, as only a single 3.5 hour training session was provided.

Actions to consider

1. If pharmacy IBA interventions are commissioned in the future, more intensive training should be provided to the pharmacy team member(s), and a method to follow up the patients for evaluation of effectiveness devised where possible.

7.6.4. Dentists

It is unknown what interventions (if any) are made by dentists to their patients. Oral cancer is however an alcohol-related disease. NICE Guideline *'Oral health promotion: general dental practice'*[12] recommends dentists and dental care professionals should give advice about alcohol consumption to their patients.

Actions to consider

1. Work with dentists to encourage and equip them to provide alcohol brief interventions and referrals for specialist treatment.

7.6.5. Secondary care and emergency admissions

Payment is available through the Commissioning for Quality and Innovation (CQUIN) scheme, for including certain indicators to prevent ill health[13]. Indicators which can be provided for 2019/20 include the interventions of screening and brief advice for alcohol and tobacco[13]. These can be provided in acute (hospital), community and/or mental health settings[13]. Our CLeaR peer reviewers said

"It would also be good to see… NHS acute /mental health trusts more actively engaged in the routine identification of alcohol related harm and delivery of information and advice or onward referral as required."

Currently there is no available data reported for Alcohol Screening or Alcohol Brief Advice CQUIN activity for South Gloucestershire residents or those registered with a South Gloucestershire GP. BNSSG CCG state however that CQUIN is active and is part of the acute, community and mental health contracts. The CCG state the criteria for payment are:

- Alcohol screening CQUIN – Achieving 80% of inpatients admitted to an inpatient ward for a least one night who are screened for both smoking and alcohol use.
- Alcohol Brief advice CQUIN – Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.

A 1.0 WTE Alcohol Specialist Nurse (ASN) is currently joint funded by the South Gloucestershire DAP and the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG). This post is based four days a week at Southmead Hospital and one day in the adult community service. The ASN works in a multidisciplinary Southmead Hospital Alcohol Team with a Specialist Liver Nurse and a Mental Health nurse in the gastroenterology team who are funded by North Bristol Trust and Bristol CCG.

The remit of their alcohol service includes:

- "*Ensuring the Trust has pathways to screen for problematic alcohol use.*
- *System of responding to individual patient alcohol related need*
- *Reducing re-attendence and working with High Impact Users (HIU) to develop personal support plans*
- *Ensuring patients risks are assessed and safety maintained during inpatient stay.*
- *Incident reporting review and trend monitoring*
- *Reduction Alcohol related harm in adults 18 years and older*
- *Link/liaise with Community Services/GP*
- *MDT approach with SW, Case managers, REACT, MH, Pharmacy, IDVAs, etc*
- *Physical presence at key Board Rounds*
- *Development training and training packages for staff to ensure appropriately qualified workforce*
- *Opportunistic interventions*
- *Develop specialist pathway for patients with chronic health diseases and primarily Alcohol Related Disease*
- *Supporting families*
- *Consistent point of contact and support"* [14]

Most of our residents are likely to be seen at Southmead Hospital which has an Emergency Department (ED) and is part of the North Bristol NHS Trust. Those needing emergency treatment if they were injured or taken ill whilst out drinking in Bristol would however most likely be seen at the Bristol Royal Infirmary which is part of the University Hospitals Bristol NHS Trust.

There is evidence of effectiveness for the use of IBA in ED settings. A large multicentre cluster randomised controlled trial found mean reductions in alcohol consumption of 18g per week at six month follow-up which was maintained at 12 month follow-up, although a subsequent meta-analysis of 33 RCTs of IBAs in EDs found smaller effects [15].

All patients aged 18+ attending the Emergency Department at Southmead Hospital identified as where there might be an issue with alcohol should be screened for alcohol use with the short AUDIT C tool. If they score 5 or more, they are referred to the Alcohol Team and if sober enough should be provided with a structured interview based on the full AUDIT test.

In 2018/19 the Alcohol Team at Southmead Hospital had 2,028 individual patient contacts and they aim to assess all new patients within 24 hours of referral [14]. This they stated was an increase of 587 referral from the previous year [14]. Due to increasing demands on their service in 2018/19 there were 310 entries recorded as unable to be seen within 24 hours. Patient contact events recorded on the Southmead Hospital clinical intervention system included direct ward assessments, face to face brief interventions, extended brief interventions, telephone assessments and other (e.g. letters or out-patient reviews) [14].

Achievements in 2018/19 reported by the Southmead Hospital Alcohol Team were:

- *"Choose and Book fibroscan and alcohol intervention clinic up and running*
- *2 new Peers embedded in the team. 1x recruited through NBT Volunteering and 1x previous patient now 2 years in recovery.*
- *SMART (self-management and recovery training) group running 6.30-8.00 Tuesday evenings at Gate 0*
- *CIWA online training package presented at the Think Drink conference in Birmingham 2018*
- *Addition of FAST score to ICE referral – raising awareness of alcohol screening tools in use in the Trust*
- *Established 'fast track' pathways with North Bristol DHI for complex patients and patients with established liver disease.*
- *Acquisition of Team resources for Alcohol Awareness events when the central Health Promotion lending library was shut (beer goggles, units filled glasses etc.).*
- *3 x alcohol awareness atrium events with excellent attendance and social media coverage."*[14]

The primary purpose of the ASN role is to ensure the safety of any alcohol dependent patients whilst waiting for ED treatment or if admitted as an inpatient. Such patients would be provided with medication to manage the symptoms of withdrawal. The hospital is not funded to provide a detoxification for ED patients but if they are admitted, a detoxification will be prescribed by their consultant, to ensure safe management of alcohol withdrawal. However, once they have been treated for the issue they were originally admitted for, there is no access to continued in-patient detox so many unfortunately return to their previous accommodation and start drinking immediately. If detoxification for an inpatient occurs without psychosocial/recovery support and if

the patient is not motivated to stop drinking, it can be counterproductive in terms of lost opportunity and cost-effectiveness/cost-utility. It might also be detrimental to the patient to have repeated detoxes. This is because there is some evidence which demonstrates an association between two or more alcohol detoxifications and less recovery of cognitive impairments caused by their drinking history♦. When speaking to the staff within the wider Alcohol Care Team at the hospital, it was seen as a gap that there was not 7 day coverage for the service and that there was no fast track service for those being admitted for alcohol specific reasons to access DHI, they had to phone the SPOC and go through the usual process of triage and assessment, which can sometimes take days or even over a week.

Actions to consider

1. Include the CQUIN *'Alcohol and Tobacco – Screening and Brief Advice'* indicator in all NHS provider contracts, where it is not already included.
2. Collect CQUIN data.
3. Evaluate the alcohol service provided at Southmead, to determine for example
    a. How many patients complete the AUDIT-C test?
    b. How many meet with the Alcohol Specialist Nurse and complete a full AUDIT?
    c. How many are referred to DHI or YPDAS?
    d. How many of these successfully complete treatment?
    e. Does this intervention reduce ED readmissions for alcohol-related disorders?
4. Work with CCG colleagues to maximise funding for this team to increase capacity, should the evaluation conclude this is value for money.
5. Investigate and evaluate the number of detoxifications provided without psychosocial support. [This might need help from a coder for such interventions, and BNSSG and clinical leads.]
6. Evaluate the feasibility of a fast-track pathway into treatment within 24 hours of receiving medication for withdrawal symptoms or a hospital detoxification.
7. Look at feasibility of developing a service that provides rapid access to inpatient detox, so that patients can continue their detox in a residential setting with clear pathways to their next stage of treatment, whether that be rehab for serious cases or community treatment.
8. Evaluate fibroscanning project to check feasibility in rolling this out to more than one session a week and in other community settings like pharmacies.

7.7. Older adults and adults at risk of harm

The 2018 South Gloucestershire Viewpoint survey found older people aged 65+ were more likely to drink regularly than those in other age groups although they were more likely to drink less on each occasion[16]. Older adults experience age-related physiological changes e.g., loss of lean body mass, decrease in gastric enzymes, reduced total body water content, and decreased dexterity and flexibility[17-19] that increases sensitivity and decreases tolerance to alcohol[17-19]. Even at relatively low levels of alcohol consumption, older adults are vulnerable to a number of age-related harms. For instance, alcohol contributes to 60% of falls in older adults in the US[17]. Social isolation and elder abuse are also exacerbated by alcohol misuse among older adults[19].

♦ https://academic.oup.com/alcalc/article/45/6/541/195634

As stated in section 6.1.1, the highest rates of alcohol-specific hospital admissions amongst men in South Gloucestershire is for those aged 60-69, and admission rates for older men and women are rising. The Drink Wise, Age Well organisation state that nationally alcohol-related hospital admissions and deaths are higher in older people than in any other age group[20]. The age group in South Gloucestershire on track to make the largest proportional increases are those aged 65 and over[21]. An audit conducted by a former DHI service-user showed 59% of patients referred to the Alcohol Specialist Nurse (ASN) at Southmead Hospital were aged over 50 years. The ASN suggested therefore consideration be given to the employment of an older person worker at DHI.

During a recent meeting with the ASN, she stated that with understanding of the nuances of mental capacity, alcohol-related brain injury causes impairment of executive function/loss of motivation. She therefore suggested a more assertive approach be taken which recognises that they are vulnerable adults and requested they are not removed from treatment or the waiting list after three missed appointments. Furthermore she stated *"…these people frequently fall between services as Social Work tends to close cases due to dependent alcohol use".*

In 2000, the Government defined vulnerable adults as:

"a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"[22].

This definition has since fallen out of favour, and instead the term *'adults at risk of harm'*, *'adults at risk'* or *'an adult with a care and support need'* is used instead[23]. This is because it is seen as disempowering to label people as vulnerable[23].

The Royal Society of Psychiatrists recommend the development of partnership working between services for older people and those for substance misuse[24]. Currently it is unknown whether at risk and/or older people known to adult social care are routinely asked about their alcohol consumption, and advised accordingly.

Actions to consider

1. Employ an older person worker at DHI.
2. Discuss with DHI whether an assertive approach could be taken for alcohol referrals where there is good reason to suspect vulnerability.
3. Discuss with adult social care whether alcohol use is routinely assessed for their older and/or at risk clients, and whether training for this and appropriate advice and/or signposting to specialist alcohol services is needed.

7.8. End of life care

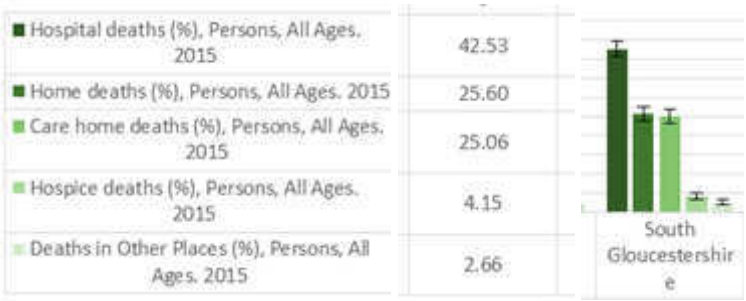
A 2019 rapid evidence assessment stated the need for greater access to palliative care and end of life services for people using alcohol and other drugs; and for prevalence studies to estimate the scale of the challenge and further research to inform the development of policies and good practice for this group of individuals[25]. They found some end of life patients were drinking large amounts of alcohol because their pain management was inadequate and noted the challenges to safe prescribing for people drinking alcohol[25]. The national End of Life Care Strategy (Department of Health, 2008) defines end of life care as:

'….care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support'[26]

Marie Curie recognises that people drinking harmfully or dependently are likely to have additional needs which are different from those for general end of life care[27]. They list particular challenges as including fear of being judged or stigmatised, difficulty managing end of life symptoms such as pain or depression due to drug-alcohol interactions, a possible absence of support from their friends and family, and being unable to access health services which permit continued drinking[27]. Additionally, harmful or dependent drinking can cause or exacerbate low mood or depression; and the patient might be feeling guilt about the role of alcohol in their diagnosis[27]. Dependent drinkers will need continued access to alcohol or medical management of their withdrawal symptoms. Marie Curie recommends that specialist palliative care and substance misuse teams should work together to provide the best end of life care for each individual[27].

The majority of deaths in South Gloucestershire in 2015 (as shown in Figure 37 below) occurred in hospital followed by, at nearly equal proportions – within their own home and within a care home. Very few died in a hospice or another place. It is unknown where those with a diagnosis of alcohol dependency died.

Figure 37: Place of death for South Gloucestershire residents, 2015



Source: South Gloucestershire JSNA[25]*.*

The 2015 VOICES survey of bereaved relatives in England however found that of those responding to the question 81% thought that the deceased would have preferred to die at home; as opposed to 8% for dying in a hospice, 7% in a care home, 3% in hospital, and 1% elsewhere[25]. These bereaved relatives also expressed greatest satisfaction for those dying in a hospice or at home, and the least for those dying in hospital[26]. The Head of Nursing in the Addictions Clinical Academic Group, South London and Maudsley NHS Foundation Trust stated in 2016 that access to end of life and palliative care services for homeless people was inequitable[28]. Currently there is no comprehensive system for recording where an individual lived or died whilst receiving treatment from our specialist alcohol service and/or where the death was reviewed by the SG Drug and Alcohol Programme Clinical Governance Group due to it being considered to have been caused by alcohol. Knowledge of such details depend on the source of information about the death. We would be informed if the individual died in hospital but we might not know where they died if for example a relative reported the death. DHI hold their own information. From July 2019 a question will be added to the death in service questionnaire to ask whether their service user was homeless when they died.

Actions to consider

1. Education for clinicians to evaluate the effectiveness of pain management in end of life care patients identified through screening as drinking at levels normally associated with problematic alcohol use; and on drug-alcohol interactions.
2. Further discussion with BNSSG to discover current pathways for provision of end of life care in alcohol dependent individuals, and how (if) their needs are met on an individual basis.
3. If not already an option, how end of life care for alcohol dependent people could be provided at home rather than in a hospital.
4. Plan where end of life care should be provided for those who are homeless.

7.9. Relationships and sexual health

Surveys in sexual health services have suggested that as many as 1 in 5 attendees consume hazardous levels of alcohol[29]. People who approach their general practitioner (GP) with problems related to sexual health may also have alcohol-related concerns. Both specialist and non-specialist providers of sexual healthcare are therefore well placed to respond to problems of both alcohol use and sexual ill health.

Currently in South Gloucestershire local sexual health services ask patients about their alcohol use, not as a formal brief intervention, but in order to refer people worried about their use to local specialist alcohol and drug services. Services have an important role in providing information and signposting and should collaborate with both sexual health and alcohol commissioners to co-ordinate this role. Further research is needed to identify the most effective interventions for those presenting with alcohol problems at sexual and other health services. Data from a 2014 randomised trial of a brief intervention for excessive alcohol use among people attending sexual health clinics suggest that there is little, if any, difference in alcohol consumption between those who are and are not offered the intervention[30].

Adults who drink at increasing or harmful risk levels are more likely to have multiple sexual partners, and there is some evidence to indicate problematic alcohol use might be associated with an increased risk of sexually transmitted infections[29]. Research indicates that people attending genitourinary medicine clinic report higher levels of alcohol consumption than the general population[29]. Sexual assault is strongly correlated with alcohol use by both victim and perpetrator[29]. Drinking can lower inhibitions, alter the perception of risk and reduce the ability of a victim to defend him or herself; additionally some perpetrators target intoxicated women[29].

Young people are a key risk group: 16–24-year-olds are the age group most likely to binge drink, and they have the highest rate of sexually transmitted infections. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use, multiple sexual partners, sexually transmitted infection and teenage pregnancy[29].

Phillips-Howard et al (2010) studied 3,641 school children aged 11–14 who were about to undertake a pilot scheme of sex and relationship education (SRE) across 15 secondary schools in the north west of England[31]. They found that 33% of 11 year olds and 66% of 14 year olds had consumed alcohol, and that there was a strong association between sexual activity and alcohol use[31]. Among 13–14 year olds, sexual activity was found to increase with the amount of alcohol consumed; if a young person was drinking alcohol more than once a week there was a 12 times greater sexual activity risk and a 10 times greater sexual intercourse risk[31]. The research concluded that the association between sexual activity and alcohol, and therefore sexual health risks, highlighted that public health

programmes integrating the two subjects and issues were needed[31]. Another more recent study showed that 6% of young people who seek alcohol and drug treatment report having been sexually exploited, the vast majority being females (14%) compared to just over 1% of males[32].

Current Personal, Social and Health Education lessons in secondary schools don't consistently include information about how alcohol use can influence sexual activity, both in relation to consent and condom use. The introduction of a new statutory Relationships, Sex and Health Education curriculum in September 2020 represents a good opportunity to address this shortcoming.

Actions to consider

1. Effective collaboration between drug, alcohol and sexual health specialists in Public Health so that schools receive the support, guidance and resources required to include education about the effects of alcohol on sexual health and relationships. Also consider how these messages can be given to those not in mainstream education.
2. Collaboration between drug, alcohol and sexual health specialists in Public Health to ensure that sexual health services are trained to provide information that highlights the link between alcohol consumption and poor sexual health outcomes, and signpost sources of useful advice on drinking sensibly. They should provide clear information about self-referral options as additional support for people wishing to reduce their alcohol intake.
3. Sexual health services should be supported to promote the One You South Gloucestershire service.

7.10. Communication and partnership working

As an outcome of our CLeaR assessment, it was noted that the voices of some key agencies were missing. The peer reviewers recommended the Alcohol Stakeholders Group or similar be reconvened. They recommended we develop a formalised agreement about data and information sharing and that senior leaders commit to sharing inter-agency protocols. They suggested providing councillor briefing sessions on alcohol-related harms to increase their knowledge and to link it with other priorities such as economic development. The peer reviewers suggested we develop a simple alcohol-specific communications strategy; with key messages and a calendar of activities, directed both internally and externally, to support the partners to carry forward the partnership's alcohol strategy more effectively. They suggested we consider jointly planned projects where benefits to South Gloucestershire partners could be released, for example targeted outreach events involving police and treatment services in areas with night time economies. They also suggested forming partnerships outside of the public sector such as workplaces to deliver targeted interventions. In the CLeaR self-assessment we identified the need for greater service user involvement in the provision and development of alcohol services.

The DAP Strategic Steering Group will monitor, review and develop implementation of an Action Plan, which will be developed subsequent to the agreement of the new alcohol strategy. It will be decided whether this should remain the group to monitor progress of the plan, whether a separate alcohol stakeholder group should be convened or whether it would be more sensible to create a series of task and finish groups for specific actions and pieces of work. Accountability and governance of the strategy and on-going action plan will sit with the Health and Wellbeing Board. The CLeaR reviewers suggested a wide range of partners be involved in monitoring progress, and an annual event centred on the strategy to maintain focus and provide opportunities for joint working.

Actions to consider

1. Reconvene an Alcohol stakeholder group and decide who the membership of this group should be.
2. Senior leaders should be invited to the next Alcohol Stakeholders Group / Strategic steering group which contains the following topics for discussion on the agenda:
    a. Development of a system to share data and information
    b. Development of a communications strategy which includes key messages and a calendar of internal and external activities which support delivery of the alcohol strategy
    c. Sharing of inter-agency protocols
    d. Co-production of projects to deliver the strategy
3. Members of the Safer and Stronger Communities Strategic Partnership could be invited annually to a Health and Wellbeing Board meeting to review progress across the range of domains in the alcohol strategy.
4. Plan councillor briefing sessions to educate and update about alcohol.
5. Request alcohol-related ward specific data from the Public Health Evidence, Performance and Intelligence team and for it to be made available for sharing with councillors.
6. Outreach to different organisations such as workplaces or the third sector to negotiate provision of universal interventions and to target groups which are more at risk of developing problematic alcohol use.

7.11. Lobbying

Evidence points to policies which reduce affordability of alcohol as being most effective and cost-effective in making population level changes, particularly minimum unit pricing (MUP) of alcohol which would proportionally target the heaviest drinkers and could raise additional taxation for social care and healthcare[2]. Increasing taxation on alcohol would enhance the effect[2]. There is some evidence to show that alcohol health warning labels on alcoholic products raise awareness of the health harms messaged, and some evidence that messages about drink-driving might be effective[2]. Advertising and marketing of alcohol is likely to increase consumption, and exposure of children and young people to alcohol advertising is associated with underage drinking[2]. Despite the current alcohol industry UK self-regulatory code, research by Ofcom in 2011 found that children saw 3.2 alcohol adverts on TV per week. Evidence has shown education messages delivered by the alcohol industry to be ineffective[2].

Actions to consider

1. Request BNSSG Directors of Public Health to lobby our councillors and local MPs to support the introduction of MUP, increased taxation on alcohol, warning labels on alcoholic products, and improved regulation of marketing.

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8. Adult treatment services

"Treatment" in this section refers to a course of structured treatment delivered by specialist drug and alcohol staff. It includes triage, assessment, brief interventions and biopsychosocial interventions. Interventions are delivered in a community setting, either on a one-to-one basis or as part of a group session. Treatment is commissioned by the South Gloucestershire Drug and Alcohol Programme and provided by a specialist provider. Currently the lead provider for community-based treatment is the charity 'Developing Health & Independence' (DHI) who sub-contract to other providers to deliver different elements of the service. The contract with DHI was for 3 years from April 2017 with an optional 2 years extension (3 years plus an optional one year plus another optional year). The decision has recently been approved to extend the contract for the maximum term of two years, up until the end March 2022. The treatment centres are in Warmley, Yate and Patchway – which is where the groups would normally be accessed. The treatment centres are all able to be accessed by wheelchair users.

8.1. Accessing treatment

There is a single point of access for clients to access treatment staffed by DHI during working hours (9:00 – 17:00, Monday to Friday), and a message can be left on their answerphone at any time. The contact information including a Freephone number is available online on the DHI website and on the One You South Gloucestershire Website. Our CLeaR peer reviewers suggested the single point of contact (SPOC) for treatment services could be better promoted and suggested it would be helpful to determine the demand outside working hours. However, in 2018/19 there has been a 39% increase in people newly presenting to the service, which suggests that people are now more aware of the SPOC and how to get support. DHI has a community development worker who has been increasing the profile of SGDAS in the local community by attending outreach events, community stalls and advertising through social media. They also take an Asset Based Community Model approach which is delivered by Southern Brooks. There is a balance in trying to advertise services but also being aware that services may already be under pressure in terms of capacity and to encourage more people to make contact with services with no more resources may be counterproductive.

50.1% of the population in South Gloucestershire are rated as amongst the 40% most deprived nationally in terms of physical access to services[1]. This is likely to be due to the rural nature of much of South Gloucestershire[1]. Travel is an issue in South Gloucestershire. The urban (most densely populated) areas of South Gloucestershire are not all geographically close together. This makes it

less effective and less equitable to have a central hub for services. Locality alcohol clinics would be helpful to overcome the barrier of travel to accessibility, however lack of financial resources may limit this. The availability of reliable and affordable transport, particularly for those living in the rural areas will be an influence on service uptake. Furthermore there are some South Gloucestershire residents who are provided with medical care or alcohol treatment in Bristol and vice versa. The commissioning team provides a ring-fenced budget to the provider for client subsistence which includes the client activities and travel budget. This is essential for supporting access to treatment. Many clients would not be able to access support if DHI were unable to reimburse bus fare.

Actions to consider

1. Develop a plan with DHI on how the SPOC could best be promoted whilst bearing in mind service capacity.
2. DHI to audit the number of messages left on their answerphone outside of working hours to determine the demand for service(s) at the weekend/evenings.

8.2. What do we provide?

Service-users who are ambivalent about changing their drinking behaviour can access up to four one-to-one sessions. As part of the treatment offer, service-users who are assessed as well-motivated to change are offered four to six, one-to-one sessions fortnightly plus attendance at group session(s) until the agreed goal(s) are achieved. Current group sessions offered include preparation for change, into action, and relapse prevention. One-to-one sessions can be provided at several "Super surgery" GP practices by a DHI worker. The treatment centres are in Warmley, Yate and Patchway – which is where the groups would normally be accessed.

Groups are of mixed gender and age, except for a pilot women's only 'Self-Management and Recovery Training (SMART) Recovery' group. They are attended by both alcohol service-users and drug service-users. Discretion is used and the group programme can be offered on a one-to-one basis if for example the service-user has literacy issues or has the diagnosis of a significant mental health need.

8.2.1 Throughcare

The Throughcare Team at DHI are made up of 4 team members (one of whom is funded by the West of England Works contract and the rest commissioned by the DAP as part of the commissioned service). The team provides a wraparound and aftercare service for service users who are both abstinent and non-abstinent from alcohol in order to achieve or maintain their recovery. They provide support in three main areas:

1. Work, training and volunteering;
2. Benefits and housing; and
3. Recovery support, peer support and mutual aid.

The Throughcare Team aims to enable and empower service users to be independent and offers support to assist with work placements, both paid and voluntary, advice on housing and benefit related problems and encouraging attendance at mutual aid and recovery support groups. Both

SMART and AA meetings are available across the three hubs. The Throughcare team are able to work with clients whose recovery capital may have been jeopardised by the challenges to daily life which some people may be unable to overcome without a supportive person to help them.

One important barrier to recovery for someone with housing issues can be the lack of a deposit for a rented property. There is therefore an access scheme to an interest free loan to support individuals to secure a tenancy. The loan can be used to pay a deposit and the first month's rent, and can be used for both private rental and social housing tenancies. The loan must be paid back, in full, within three years. To be eligible for this scheme, an individual must:

- Be homeless, threatened with homelessness, or live in unsuitable accommodation or in a hostel
- Be unable to obtain housing in any other way
- Be engaged or recently engaged (in the past 3 months) in drug/alcohol treatment services
- Be regularly turning up to scheduled appointments with Key Worker
- Be able to demonstrate how they will repay the loan within 3 years.

The deposit portion of any money loaned must be registered with a tenancy deposit protection scheme; therefore the Landlord must be appropriately registered. Applications can be submitted at any time and all applications will be reviewed within 2 weeks by the Throughcare Team Leader and Service Manager. If an application is successful, it remains valid for 12 months. If the applicant does not find a suitable property within this time frame, they are able to submit a new application. If an application is not successful, DHI will state areas that the applicant should work on to improve their score, should they wish to reapply to the scheme in the future.

The maximum amount that can be applied for through the Access Scheme is £1500. If an individual's deposit requirements are above this amount, they should continue to make an application and provide evidence as to why the additional amount is required. In exceptional circumstances additional funds may be granted by a DHI Director. Further financial support may be available from South Gloucestershire Council through the Tenancy Start-up Scheme.

The Throughcare team often begin working with service users in a moment of crisis and assist them in dealing with what could potentially be an incident which causes them to fall on old coping strategies and return to misusing substances. The team will offer guidance and support to the service user so that the road to recovery is smoothed and the risk of relapse is lessened. For those service users who are not yet abstinent, the Throughcare team will work with them to identify pathways to treatment if they do not feel ready to stop. During their sessions they will identify needs and areas of support – this may include advocating with council and benefit offices, supporting and advocating at tribunals, with law agencies and with debt agencies. Other support agencies will be contacted to ensure any joined up working is efficient and client centred. Based on their individual need, pathways are identified if treatment is required for health related problems or Blood Bourne Virus (BBV) testing and treatment. If other substances are being used and there is a need for them, signposting to needle exchange services can be done through the team.

8.2.2. Detoxification

Either community or residential detoxification (dependent on assessed need and domestic circumstances) and/or specialist pharmacological interventions are offered. Community

detoxification forms part of the commissioned package administered by AWP as part of their sub-contract with DHI. Both are two week packages and require the client to be motivated to change. Community detoxifications are mainly provided from Kingswood Health Centre (KHC) with a few in Thornbury. Planned specialist detoxifications are provided on a residential basis at Broadway Lodge as part of a sub-contract with DHI. Specialist detoxes, such as those for pregnant women or those with complex needs that means they would need hospital level care, can take place at the ACER unit at Blackberry Hill hospital.

There are fortnightly detox clinic appointments in Patchway and Yate hubs to ensure that individuals can access the initial appointment and the specialist team will support them to arrange travel to KHC where appropriate. There has been a significant increase in community detoxes since the new model of services set up the clinic at KHC, 82 detoxes were completed in 2017/18 compared to an overall drug and alcohol detox target of 35. 69 of the 82 were alcohol detoxes. It also seems that the newly integrated service has worked well for people, AWP are co-located with DHI and have integrated team meetings and referral meetings, meaning that people using the service experience a smoother pathway into detox. Our provider has pointed out that they are seeing an increasing number of complex detox cases where people's needs are not able to be met either by the contracted detox service at Broadway Lodge. As mentioned above, a small amount of funding is kept aside to support those with complex care needs into the ACER unit, where people can detox in a hospital type setting, but there have been cases where the ACER unit does not feel able to meet their needs as their physical health means that they need to be in hospital. The suggestion therefore is to work on a hospital detox pathway to ensure that those with most complex needs are not deprived access to detox.

8.2.3. Complex needs

Service-users with complex needs such as pregnant women, multiple substance misuse, very poor physical health, mental ill health or with learning disabilities are referred for assessment to the 'Avon and Wiltshire Mental Health Partnership NHS Trust' (AWP). DHI has a sub-contract with AWP. AWP will then make recommendations and either refer them back to DHI, provide specialist treatment, or recommend they be assessed for residential rehabilitation by a suitably qualified member of the SGC DAP team. Residential rehabilitation funding is held in house (by SGC) and is commissioned using a person-centred approach. Currently funding for community and residential rehabilitation (but not hospital initiated detoxification) alcohol treatment is met from the public health budget and not from for example adult social care or maternity services.

Actions to consider

1. Explore opportunities for joint commissioning for people with complex needs.

8.2.4. Peer mentorship and other recovery supporting activities

At the end of their treatment a client has the option to become a peer mentor, for which they receive two-days training and six weekly supervision. There are currently 19 peers in the service, 16 of whom are active on a weekly basis. Once trained, peer mentors are able to co-facilitate a treatment group, facilitate creative activity groups or train to run SMART sessions or they may be placed in a voluntary organisation, such as Southern Brooks – to act as a bridge into treatment for

their peers. Their participation in groups provides visible recovery and valuable support for the DHI staff. Additionally they support outreach events, share their experiences at workshops and drop-in sessions in the community. A number of peers have also progressed into voluntary roles with partner organisations, or achieved paid employment through the support of DHI.

There are also other activities that people accessing the service can get involved in to aid confidence, combat boredom and increase chances of sustained recovery. These include craft club, gardening group, auricular acupuncture, reflexology and mediation.

8.3. Public health dashboard ranking

PHE Dashboard data is based on that from 2016/17, and is therefore not up to date with current performance[2]. As there are only relatively small numbers of service-users receiving alcohol treatment in South Gloucestershire, a small difference in numbers for a particular indicator can result in a large change in proportion. It therefore gives a worse impression of past performance than is in our opinion helpful. Furthermore since 2016/17 significant improvements in the indicators recorded by the PHE Dashboard have been achieved by our provider, although the estimated numbers of alcohol dependent individuals not in treatment is still a concern. The Public Health Dashboard did however rank South Gloucestershire as 123 out of 149 local authorities (LAs) in England for alcohol treatment, albeit in the top decile for people successfully completing their course of treatment once engaged[2].

The PHE Dashboard alcohol summary rank indicator is comprised of grading average z scores (number of standard deviations from the mean) of metadata[2]. The data used to form metadata for this indicator comprises of the proportions of dependent drinkers aged 18+ not also citing a problem with an opiate drug who: (a) successfully completed a course of treatment and did not re-present within 6 months of completion (b) were not in treatment (c) who died in treatment and/or (d) waited over three weeks for treatment[2]. The proportions were calculated by PHE using National Drug Treatment Monitoring System (NDTMS) data and PHE Estimates of Alcohol Dependence in England[2].

Comparing South Gloucestershire as ranked by the PHE Dashboard to 16 similar LAs (CIPFA nearest neighbours) such as Bath and North East Somerset, Swindon and Wiltshire; South Gloucestershire was in position 15 out of the 16[2]. South Gloucestershire (along with LAs which include Windsor and Maidenhead, Surrey and Hertfordshire) is in the decile for least socioeconomic deprivation as measured by the Index of Multiple Deprivation (IMD), 2015. Compared with LAs in this lowest decile for socioeconomic deprivation, for alcohol treatment South Gloucestershire is placed as 12 out of 14[2].

Once our clients were engaged into a course of structured treatment they were however reported to do very well. The indicator for successful completion of treatment ranks South Gloucestershire in position 1 out of 16 similar LAs, in position 1 out of the 14 within the same IMD deprivation group, and 4 out of all 149 LAs in England[2]. Reasons for the overall poor ranking was largely weighted by a large proportion of the PHE estimated number of drinkers in South Gloucestershire not being in treatment, and a higher proportion of those in treatment than that nationally dying whilst in treatment.

Sadly from 2014/15 – 2016/17 there were an increasing number of deaths of those in treatment (n=9 people who died) compared to 2013/14 -2015/16 (n=6) and a corresponding increased mortality ratio (from 1.23 to 1.8 respectively)[2]. More recently the number of deaths in treatment have fallen to 6 in 2015/16 – 2017/18, with there being no deaths recorded for those in treatment during 2017/18 and a number less than 5 who died whilst in treatment during the last nine months from 1 April to 31 December 2018[3].

The proportion of drinkers nationally waiting over three weeks for treatment in 2016/17 was very small (2.4%) so although the proportion in South Gloucestershire (2.1%) was statistically similar to that for England and lower than the CIPFA average (3.4%); when ranked against local authorities with smaller values (including some with 0%) the ranking appeared bad. Furthermore it is known to the South Gloucestershire DAP team that those recorded as waiting longer than three weeks were seen outside of their postcode area and thus we were not in control of the waiting times. In Q3 of 2018/19 none waited over 3 weeks[3].

When reviewing the level of unmet need it was realised a large number of clients who had been recorded as receiving unstructured treatment by the South Gloucestershire provider in 2016/17, had been receiving treatment defined as structured by other services. In April 2017, South Gloucestershire alcohol treatment services were recommissioned and started working to new contracts and models of delivery, and in August 2018 the criteria for receiving structured treatment was aligned to that for other services.

8.4. Unmet need

PHE estimated that in 2016/17 there were 2,202 alcohol only dependent drinkers and alcohol dependent drinkers who also used non-opiate drugs in South Gloucestershire[4]. Of these 134 (6%) were known to be in treatment. There was therefore an estimated unmet need of 94%[β] individuals not in treatment who were alcohol dependent but not using opiates in South Gloucestershire[4]. This compares to an estimated 82% unmet need in England[4]. The unmet need for opiate and/or crack cocaine users in South Gloucestershire is estimated at 50% (compared with 51% in England), that for opiate users is 43% (46% in England) and for crack 69% (62% England)[5]. It is expected that more opiate users would seek treatment as they are prescribed opiate substitutes which help to address their dependency whilst reducing the associated harms. Also drug users are more likely to come into contact with the criminal justice system.

In 2009/10 there were 269 individuals in South Gloucestershire receiving treatment for alcohol only, and 70 for non-opiate and alcohol combined[3]. By 2017/18 this had decreased to 72 alcohol only and 62 non-opiate and alcohol clients in treatment[3]. In 2009/10, alcohol clients may have presented to treatment and been included in the structured treatment pathway; and upon assessment were identified as not requiring structured support and were instead provided with an extended brief intervention to address their needs. In 2009/10 alcohol services were provided separately from drug services. In 2012/13 the contract included targets for alcohol only clients and there was some flexibility between drug and alcohol treatment provision. In the 2012/13 contract there were a number of agencies providing support for service users, each with a specific target for alcohol clients, and in the newest contract (2017/18) a consortium of agencies provide substance misuse

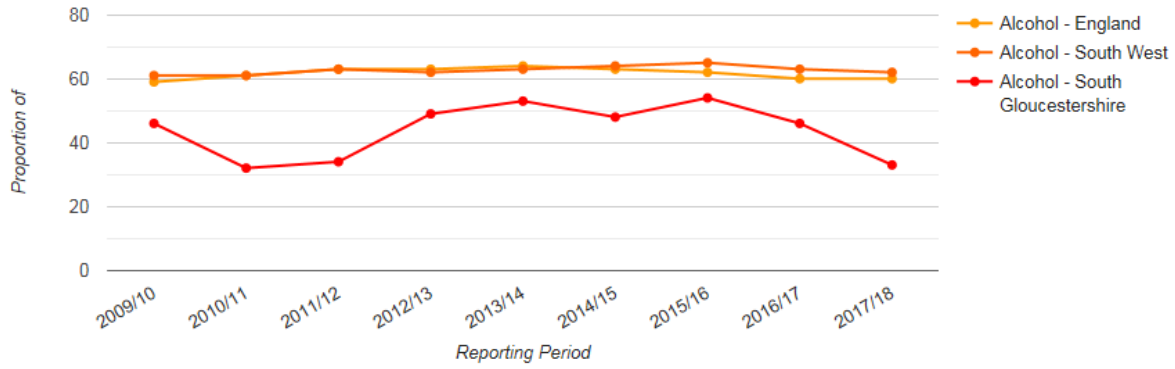
[β] Lower Confidence Interval 92% - Upper confidence interval 96%

services across South Gloucestershire. In 2017/18 an integrated drug and alcohol treatment service model was commissioned and there are no separate targets for alcohol treatment.

From April 2018 to March 2019, there has been a large increase in numbers of alcohol only clients with 155 in treatment, of which 138 were new presentations[3]. There is however evidence that the proportion of successful completions for alcohol only clients to date in 2018/19 has decreased by 17%[3], and this might be because there was little or no spare capacity in the system to treat more people.

Figure 38 (below) illustrates a long term trend whereby treatment provision for alcohol only users relative to that for drug users is below the England and South West average.

Figure 38: Adult Profiles: Alcohol only users as a proportion of all substance use categories* - South Gloucestershire compared with the South West and England - New Presentations



*Categories of substances – Opiate and crack cocaine, Opiate (not crack cocaine), Crack cocaine (not opiate), Cannabis, Cocaine, Benzodiazepine, Amphetamine (not ecstasy), Ecstasy, Mephadrone, NPS, Hallucinogen, Alcohol, Other.

Source: NDTMS[3]

Rosana O'Connor wrote in the official PHE online blog that there has been a steady decline nationally in numbers treated for alcohol dependency since 2013/14, with a fall of 17% from then until 2017/18[6]. She reports that alcohol numbers have been affected more than drug treatment numbers by financial pressures and reconfiguration of integrated drug and alcohol treatment services[6]. It was suggested that alcohol treatment might be less effective within an integrated service, along with the accessibility of services and the need for improved referral pathways also being reasons for the decline in alcohol numbers[6].

Comparing our unmet need figures for alcohol only dependent drinkers with those for England, and comparing our unmet need for alcohol against that for other drugs; it can be seen we are disproportionately not meeting the needs of people who are alcohol dependent. The CLeaR peer reviewers recommended we share knowledge of our unmet need with our partners. This information was communicated to the Health and Wellbeing Board in March 2019 and at our other main stakeholder pre-consultation events in June/July 2019.

If however we manage to identify, motivate and support more dependent drinkers to enter treatment, it would place enormous strain on our budget. Furthermore consideration needs to be given to the forecast that our population is expected to grow by over 20% to 2036[1]. The CLeaR peer reviewers recommended *"Consideration should be given to how additional demand may be met without unintended consequences of limiting treatment or excluding the most vulnerable."*

Actions to consider

1. Complete a scoping exercise to identify perceived barriers and enablers to entering treatment for South Gloucestershire people who use only alcohol (rather than also other drugs) in a problematic way. This should include consulting with potential, current and previous service-users.
2. Develop a partnership-wide plan for reducing the rate of unmet need in South Gloucestershire.
3. There is need for greater investment in reaching and treating dependent drinkers to align at least with the 2016/17 national proportion of 18% in treatment for alcohol. This would result in the need for capacity in South Gloucestershire to treat approximately 396 individuals per year for alcohol only dependency or alcohol dependency plus non-opiate drug use. It could be argued for a similar proportion (up to 50%, n=1,101) of alcohol dependent clients to be treated as is the case for some other drugs.
4. Re-introduce targets for treatment of alcohol clients and/or provide an alcohol treatment service separate to that for drugs.
5. Provision should be made to treat at least 475 (n=2,202 estimated dependent drinkers currently X 20% population growth X 18% national proportion currently treated) drinkers per year by the year 2036, some of whom might also use non-opiate drugs.

8.5. Numbers and characteristics of those in treatment

8.5.1. Alcohol only or additional drug use?

People presenting for treatment for opiates and other drugs might also be drinking at increasing or higher risk levels, or will also be alcohol dependent. Similarly people drinking in a problematic way might also be using other substances. The National Drug Treatment Monitoring System (NDTMS) artificially separate people receiving treatment into the following mutually exclusive groups:

- Opiate
- Non-opiates (e.g. cannabis, crack and ecstasy) only
- Non-opiates and alcohol
- Alcohol only

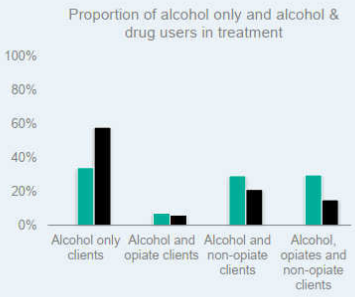
It is however possible however that those using opiates might also have problems with alcohol, and it is unclear how treatment for alcohol would be recorded for this cohort on NDTMS.

From 1 April 2017 to 31 March 2018 there were 212 clients receiving courses of structured treatment for problematic alcohol use in South Gloucestershire[4]. 34% (n=72) only used alcohol (and possibly nicotine &/or caffeine), 29% (n=62) also used a non-opiate drug such as crack cocaine or cannabis, while 30% (n=63) were identified as also using an opiate-based drug such as heroin or codeine[4]. As illustrated by the data and charts in Box 4, 59% of alcohol clients in South Gloucestershire were also using drugs other than opiates in comparison to 36% for England; and only 34% were alcohol only clients (58% for England)[4]. The most common non-opiate drugs used were crack, cannabis and cocaine. The proportion of South Gloucestershire clients in treatment using only alcohol and opiates (7%) was similar to that nationally (6%)[4].

Box 4: South Gloucestershire clients in treatment for alcohol only and alcohol plus other drugs in 2017/18.

All alcohol clients in your treatment system

	Local n	Local % of all clients receiving alcohol treatment	National n	National % of all clients receiving alcohol treatment
All alcohol clients	212		131,008	
Alcohol only clients	72	34%	75,787	58%
Alcohol and drug users in treatment				
Alcohol and opiate clients	15	7%	7,887	6%
Alcohol and non-opiate clients	62	29%	27,684	21%
Alcohol, opiates and non-opiate clients	63	30%	19,650	15%
Cited crack*	50	24%	16,394	13%
Cited cocaine*	25	12%	14,922	11%
Cited cannabis*	41	19%	19,711	15%



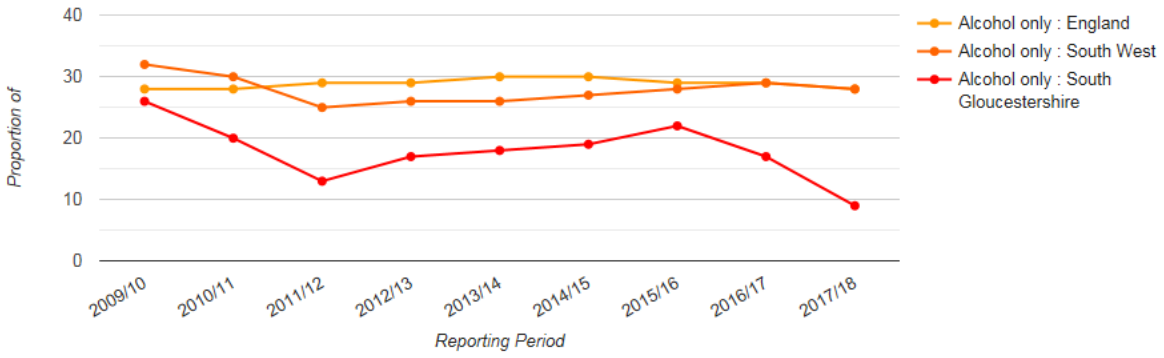
** Please note clients may cite more than one additional substance and are counted once under each relevant category*

Source: PHE[4]

Clients might be seeking treatment for opiates because they can be prescribed opiate substitution therapy, but this does not explain the higher proportion seeking treatment for other drugs.

Figure 39 below illustrates that the proportion of South Gloucestershire alcohol only clients in treatment compared to clients using other substances has been lower than the proportion for the South West and England since 2009/10.

Figure 39: Adult Profiles: Proportion of clients in treatment - South Gloucestershire, compared with the South West and England - All in Treatment - Alcohol only users



Area	Substance Category	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
England	Alcohol only	28	28	29	29	30	30	29	29	28
South West	Alcohol only	32	30	25	26	26	27	28	29	28
South Gloucestershire	Alcohol only	26	20	13	17	18	19	22	17	9

Source: NDTMS[3]

The local prevalence estimates (2014-15) for use of opiates &/or crack is lower than the rate for England[5], so it is unlikely there is a larger than average drug using population in South Gloucestershire who are also drinking in a problematic way. It is more likely we are not reaching enough of our alcohol only users whose use is high risk or dependent

Actions to consider

1. Discuss with DHI how treatment outcomes for opiate users who are also drinking in a problematic way are recorded.

8.5.2. Demography of alcohol only clients

Of the 72 alcohol only South Gloucestershire clients in treatment in 2017/18, 57% were male and 43% were female[4]. This is not significantly different for that in England – 60% male and 40% female[4]. Considering the small sample size, comparison between South Gloucestershire and England for clients in different age groups does not reveal any significant differences, except for those under 25 years[3,4]. Most clients in South Gloucestershire (60%, n=43) were aged 40-59 years with 31% (n=22) aged 40-49 and 29% (n=21) aged 50-59. 11% (n=8) were aged 18-29 , 19% (n=14) were 30-39, and 9% (n=7) over 60[4]. Of those aged 18-29, in South Gloucestershire none were aged under 25 years whereas in England they comprised approximately 2.6% of the treatment population[3]. It should be noted that DHI have secured a specific contract with UWE to provide support to this age group. We now have a full time senior practitioner in this post. Some of this could be due to the fact that most students do not require a structured treatment pathway and therefore are not counted in the numbers for NDTMS.

Of the 45 alcohol only South Gloucestershire clients who were new presentations to treatment in 2017/18, 91% (n=42) were recorded as White British[4], which is a similar proportion to that contained in our local population (92%)[7].

31% (n=14) identified as Christian, 53% (n=24) as No Religion, and the remaining 13% (n=6) were either Missing/Incomplete answers or Sikh – as the numbers for each of these categories are less than 5 they cannot be revealed[4]. Those with a faith could be under-represented amongst people in treatment for alcohol, as 60% of our population identify as Christian, 0.8% as Muslim, 0.6% as Hindu, 0.2% Sikh; with 31% stating No Religion and 7% Missing/Incomplete[7].

Gypsy, Romany and Traveller communities are a small percentage (approximately 0.1%) of our local population[7], and none were identified as accessing our alcohol service in 2017/18[4].

Most of the new alcohol only presentations were recorded as heterosexual with a small minority recorded as either Not Stated/Not Known or Missing/Incomplete[4]. None were recorded as Gay/Lesbian or Bisexual[4]. Despite the small treatment cohort sizes it is possible the LGBTQ+ community is under-represented in treatment. This is because it is estimated 5-7% of the UK population are lesbian, gay, or bisexual[7]. Training was provided to the triage team in 2019 and triage forms updated to ensure LGBT equality information was collected appropriately and fully.

67% (n=30) reported not having a disability, 29% (n=13) reported at least one disability – progressive conditions and physical health, and/or mobility and gross motor, and/or behaviour and emotional[4]. More people with at least one disability (29%) are accessing alcohol treatment than the known prevalence in the local 16+ population (18%)[4,7]. This is likely to be due to an older demographic entering adult (aged 18+) treatment services with most being aged 40 to 59. People are more likely to develop a disability as they age, particularly if their lifestyle choices are unhealthy.

Actions to consider

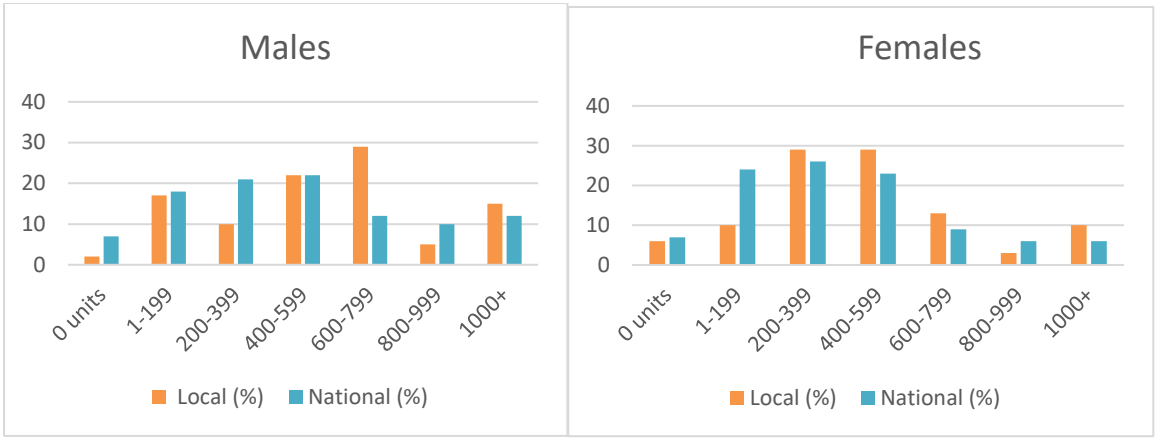
1. Plan to address unmet need for 18 to 25 year olds.

2. Additional to universal provision, ensure treatment is accessible to and sensitive to the needs of LGBTQ+ community members and consider whether specialist provision should be available.

8.6. Alcohol consumption prior to treatment

Out of 72 clients in South Gloucestershire, the majority of males reported drinking 600 to 799 units of alcohol in the 28 days before starting treatment in 2017/18[4]. This is shown in Figure 40 below, and would approximate to 150 to 200 units per week or the equivalent of up to 5 X 1 litres of vodka per week. The majority of females were drinking 200 to 599 units in the 28 days prior to treatment[4], which would equate to 50 to 150 units or the equivalent of up to 3.75 X 1 litre of vodka per week. Regular drinking at this level indicate clients at high risk of health problems directly related to alcohol and probable alcohol dependence. This suggests most people only access support when they are physically dependent or experiencing alcohol-related harm(s). Earlier interventions could have prevented them from experiencing the problems (including some which might be irreversible) associated with such drinking.

Figure 40: Self-reported units consumed in the 28 days before entering treatment in 2017/18



Source: Based on information from PHE[4]

There is a strong correlation between levels of consumption and severity of dependence but for drinkers entering treatment in South Gloucestershire, data for the majority (77% of males and 84% of females) from the 'Severity *of Alcohol Dependence Questionnaire'* (SADQ) was 'Not stated/Not known'[4]. This is much higher than was the case for national data (19% males and 20% females)[4]. The reason for this is our providers are not routinely recording the data from SADQ assessments. The provider has stated that the SADQ is often completed by the keyworker as part of a referral to the specialist team, however they are unsure whether it can be recorded on the Illy database in a way that is reportable at service level. NICE recommend SADQ be used by specialist alcohol services[8]. Assessment of dependency is recommended when deciding whether detoxification would be needed and where it should be provided[8].

DHI use the AUDIT tool. An AUDIT score over 20 identifies the possibility of dependence but is not diagnostic for dependency nor does it assess the severity of dependence. AUDIT scores for those accessing DHI would be useful to ensure resources are being used most effectively. The new One You South Gloucestershire service is set up to provide a package of brief interventions for those assessed at increasing risk (AUDIT score 8-15) (see section 7.5). For those identified as higher risk

drinkers (AUDIT score 16-19) the pathway suggests a referral is completed to DHI in order to address behaviours which may be causing health and/or other harms.

Actions to consider

1. Reach people drinking at increasing risk levels with early interventions before alcohol harms have been caused.
2. DHI to complete an audit of SADQ scores to understand reasons for omission of figures from nationally recorded monitoring systems and check whether Illy has the facility to record this information and provide data reports to show compliance.
3. Review after 12 months referrals from OYSG to DHI, to check referrals are appropriate, and the threshold for services is suitable. Check also whether other professionals understand the thresholds and pathways for DHI and OYSG.

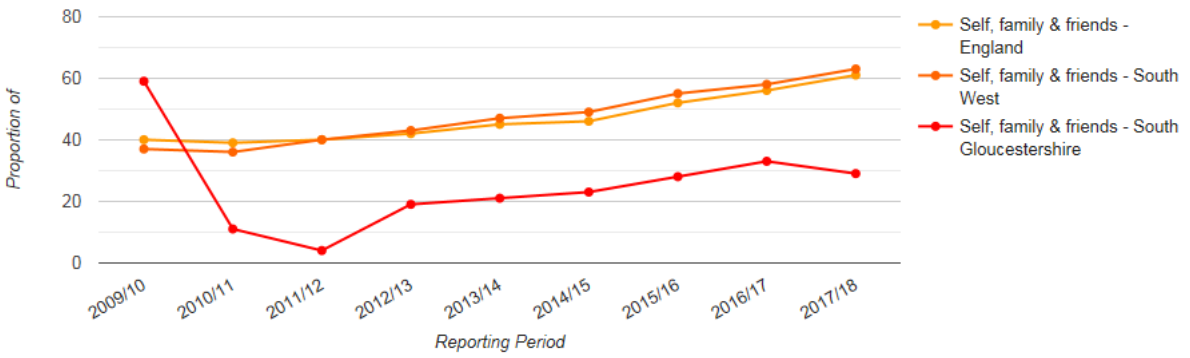
8.7. Routes into treatment

Routes into treatment identified by PHE[4] are:

- Self-referral (NDTMS[3] data includes family and friends in this category)
- Referred through criminal justice system
- Referred by GP (NDTMS data combines this category with 'Social Services' and 'Hospital/A&E' to form the category of 'Health services and social care'
- Hospital/A&E (see above)
- Social Services (see above)
- All other referral sources (NDTMS data classifies this as 'Other')

Most referrals for 2017/18 alcohol only clients into South Gloucestershire treatment were 'All other referral sources' (56%) and 'Self-referrals' (24%)[4]. For this year the proportion of 'All other referral sources' nationally is reported to be 14% and 'Self-referrals' 59%[4]. From that in 2009/10, Figure 41 shows a decline in self-referral and those from family and friends in South Gloucestershire, compared with those for England and the South West; and since 2010/11 consistently significantly lower proportions. One reason could be a lack of awareness of how to access help in South Gloucestershire. We need to understand why so many people are being coded as "all other referral sources" rather than a specific category.

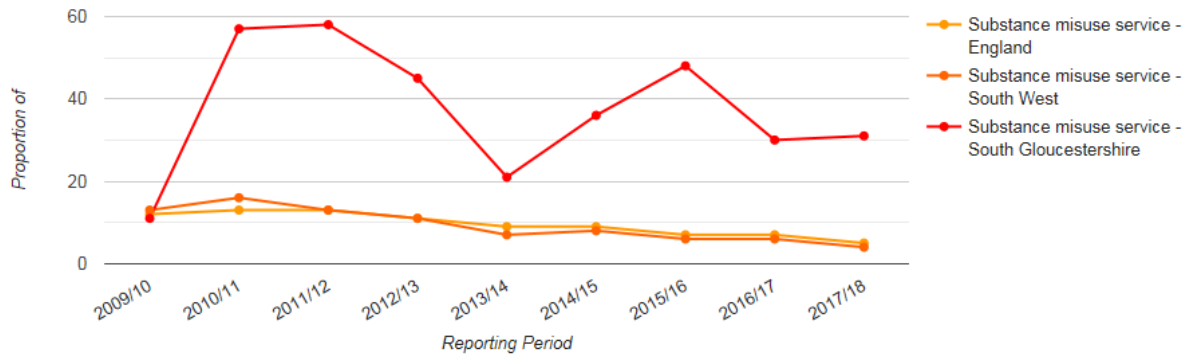
Figure 41: Adult Profiles: Proportion where referral source is self, family and friends - South Gloucestershire compared with the South West and England - New Presentations, Alcohol only users



Source: NDTMS[3]

The category of 'All other referral sources' includes those from substance misuse services[3,4], and Figure 42 (below) illustrates the trend of referrals predominantly originating from this source since 2010/11. It is not the case for opiate users and non-opiate users where the trend has been for the majority of referrals in South Gloucestershire to originate from 'Self, family and friends'[3]. This raises concern that the alcohol only clients could be mainly those recruited from the cohort for other drug use or from an out of area substance misuse provider such as Bristol Drugs Project. Alternatively it could be a data recording error.

Figure 42: Adult Profiles: Proportion where referral source is substance misuse service - South Gloucestershire compared with the South West and England - New Presentations, Alcohol only users

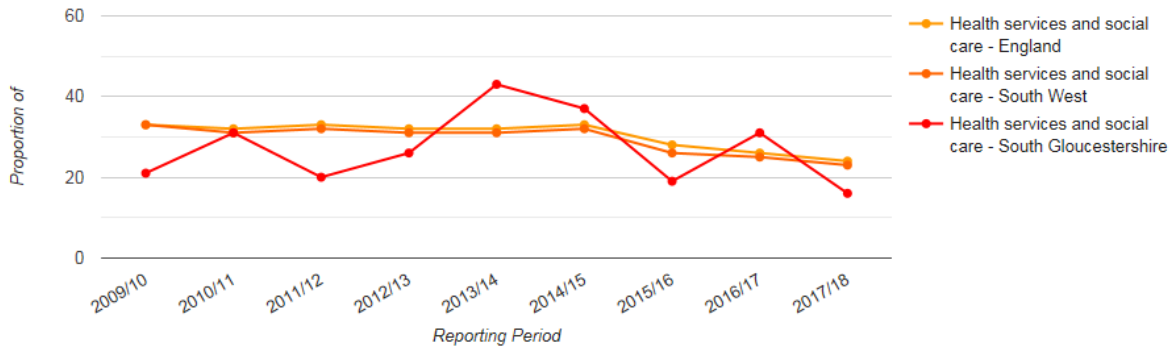


Source: NDTMS[3]

The proportion of referrals from health services and social care (Figure 43, below), and from the criminal justice system [via an arrest referral scheme, a drug rehabilitation requirement, an alcohol treatment requirement, prison or the probation service] (Figures 43 and 44, below) are also below the proportion for England and for the South West. In 2018 local Arrest Intervention Referral Services were amalgamated with the Liaison and Diversion Services to form local 'Advice, Support, Custody and Court' (ASCC). ASCC aims to assess people of all ages who pass through the criminal justice system and identify all those in need of support for mental health, learning disability, substance misuse or other vulnerability for the purpose of informing decisions about diversion, charging, case management and sentencing.

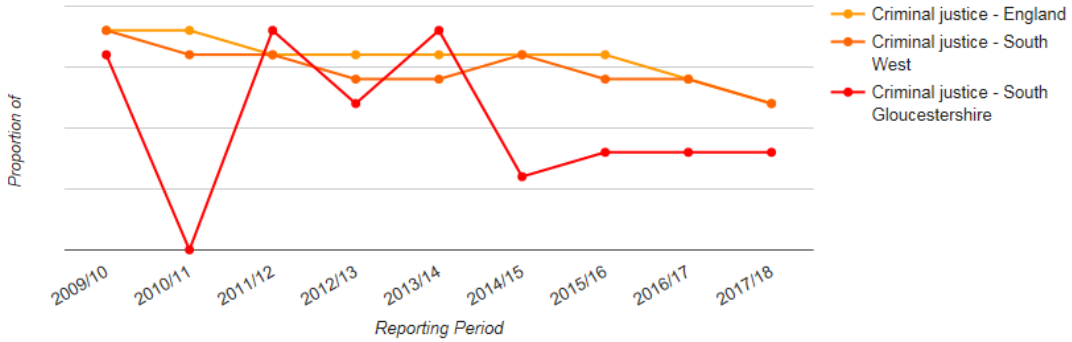
Although small numbers (less than 5 people), the proportion of referrals in 2017/18 from Hospital/A&E in South Gloucestershire were slightly higher to that for England[3]. This could indicate effectiveness of having an Alcohol team at Southmead Hospital.

Figure 43: Adult Profiles: Proportion where referral source is health services and social care - South Gloucestershire compared with the South West and England - New Presentations, Alcohol only users



Source: NDTMS[3]

Figure 44: Adult Profiles: *Proportion where referral source is criminal justice - South Gloucestershire compared with the South West and England - New Presentations, Alcohol only users



*Proportion vales redacted as in South Gloucestershire some years have client numbers of less than 5

Source: NDTMS[3]

Our CLeaR self-assessment identified the need to provide a flowchart of service accessibility to healthcare settings including GP practices, pharmacies, secondary care; and to criminal justice settings.

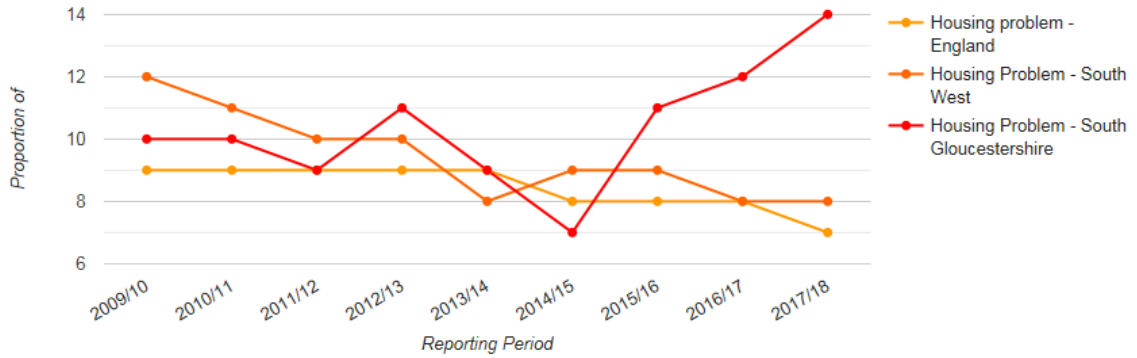
Actions to consider

1. Consult with stakeholders from primary care, adult social care, ASCC, local prisons and probation to discover what has caused the low rates of referrals and develop a collaborative action plan to address the issue(s).
2. Review pathways into treatment including the recording of referral sources.
3. Plan how community treatment service capacity will be increased to meet any increase in referrals following further promotion of services.

8.8. Housing status before and after treatment

The majority (n=38) of alcohol only new presentations for treatment in 2017/18 self-reported as having no housing problem[4]. A housing problem includes issues such as staying with friends/family as a short-term guest, using a night winter shelter, squatting or staying in a short-term hostel, B&B or hotel[9]. Figure 45 (below) illustrates however that since 2015/16 problems with housing have been growing amongst those presenting in South Gloucestershire for alcohol treatment, and is worse than the situation for those presenting in the South West and England.

Figure 45: Adult Profiles: Housing situation - South Gloucestershire, compared with the South West and England - New Presentations – Alcohol only users



Source: NDTMS[3]

Table 8 below describes the number of clients presenting for treatment with and without a housing problem.

Table 8: Adult Profiles: Housing situation - South Gloucestershire - New Presentations

Housing Situation	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
No problem	176	72	62	94	102	113	113	80	38
Housing Problem	20	8	6	12	10	9	15	11	6

Source: NDTMS[3]

A further category is clients with an urgent housing problem which includes issues such as being a rough sleeper, using an emergency shelter on a night by night basis or sofa surfing on a different friend's floor each night[9]. From the years 2009/10 to 2017/18 numbers ranging from less than 5 clients to 6 clients in South Gloucestershire had an urgent housing problem when presenting for treatment[3].

"A safe, stable home environment enables people to sustain their recovery"[4]. It is difficult for people living in unstable accommodation such as sofa surfing or who are homeless to concentrate on making effective behavioural changes or to control their environment during early recovery for example by avoiding close proximity to sources of alcohol. Not having suitable housing can also act as a barrier to detox as someone may be considered to not have enough stability to be able to sustain it on discharge. The South Gloucestershire alcohol treatment package includes wrap around housing and welfare benefits support. Accessing Housing Association and private rented accommodation has become particularly difficult since the introduction of Universal Credit. Housing

associations often require 8 weeks rent paid in advance and individuals are expected to have saved this money themselves, an impossibility for many people accessing our services. An access scheme provides loans to support individuals to pay a deposit and the first month's rent for both private rental and social landlords (see section 8.2.1).

Nationally out of the new presentations for treatment with a housing problem, 84% of those successfully completing treatment no longer reported having one[4]. In South Gloucestershire 100% of those successfully completing treatment no longer reported a housing need, albeit the number of these people was less than 5.

For all clients receiving structured treatment, providers review their clients using a Treatment Outcome Profile (TOP) report form[9]. This form is used at the start of treatment (the assessment meeting with their key worker) and again at quarterly review sessions, treatment exit and post-treatment exit. At each review the clients are asked whether they have an 'acute housing problem', live in 'unsuitable housing' or are 'at risk of eviction' [9].

Analysis of TOP planned exit data indicated that during 2017/18, out of 16 alcohol only clients reporting an acute housing problem (including 7 at risk of eviction) in the previous 28 days before starting treatment; a number less than 5 (including a proportion that developed a problem during treatment and including those still at risk of eviction) reported an acute risk at planned exit[3]. Approximately 6%[≠] nationally reported a housing problem at the start of treatment which decreased to 2% at planned exit, including 1% at risk of eviction[3].

Analysis of the TOP 6 monthly review outcomes (3 monthly review outcomes are not collated by NDTMS) indicated that in 2017/18, nationally approximately 7%[≈] reported a an acute housing risk before starting treatment, of which approximately 5%[⊄] were still at risk when partaking in their 6 month review (including approximately 3%[⊂] at risk of eviction)[3]. Locally the numbers of clients recorded as reporting a housing problem in the previous 28 days before treatment was less than 5 (all of who were at risk of eviction) and there was evidence of reductions of risks at 6 month review[3]. Although our local data comprises of small numbers, it indicates support from our treatment provider is likely to help with housing issues for people who drink alcohol in a problematic way and they are best resolved by completing treatment.

In March 2019 South Gloucestershire were successful in bidding for money from the PHE Innovation Capital Fund to be used by DHI for the purchase of a 4 bedroom Recovery House, probably in Patchway – one of our Priority Neighbourhoods. The house is planned to provide temporary accommodation (for approximately 6 – 12 months) to people who are alcohol dependent and who are struggling to access treatment due a lack of suitable housing or homelessness. It will also provide a setting for community detox. The facility is planned to be operational in 2020.

Actions to consider

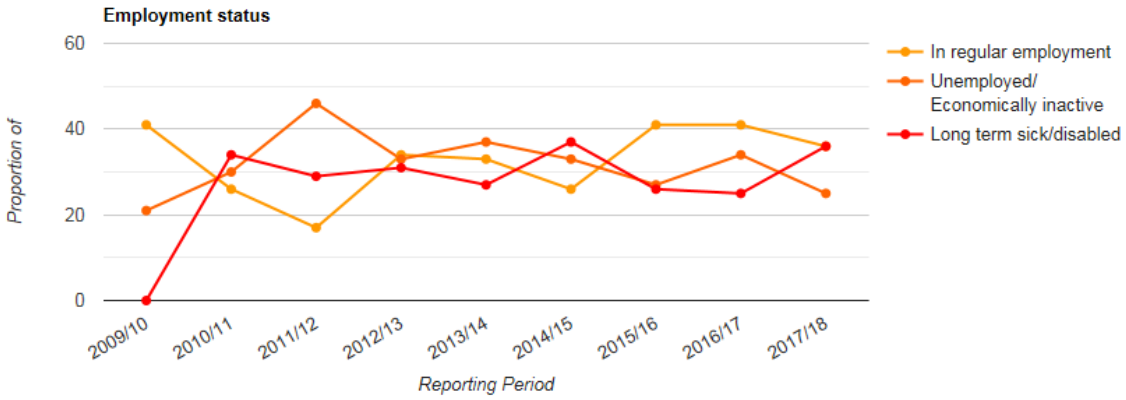
1. Aim for all people who drink in a problematic way who also have housing issues, especially urgent housing issues, to receive support to obtain safe and stable accommodation

[≠] 5.8% in Q1, 5.8% in Q2, 5.5% in Q3 and 5.3% in Q4
[≈] 7.2% in Q1, 6.9% in Q2, 6.7% in Q3 and 6.2% in Q4
[⊄] 6% in Q1, 5% in Q2,5% in Q3 and 5% in Q4
[⊂] 3.4% in Q1, 3.2% in Q2, 3.2% in Q3 and 3.2% in Q4

8.9. Employment status before and after treatment

An equal proportion of alcohol only clients presenting for treatment in 2017/18 were in employment (36%, n=16) as were long-term sick/disabled (36%, n=16)[4]. 24% self-reported as unemployed/economically inactive[4]. The trend is shown in Figure 46 below.

Figure 46: Adult Profiles: Employment status* - South Gloucestershire - New Presentations



*Those in education, unpaid voluntary work or other were redacted as the data contained numbers less than 5.

Source: NDTMS[3]

As expected from national data, at planned exits from treatment there was evidence of some shift (albeit small numbers of <5 people) in South Gloucestershire from not working to working part-time or full time hours[4]. This shift is not observed amongst those with unplanned exits from treatment[4]. Although it is only very small numbers there is indication that our alcohol clients are more likely to be employed after treatment. This should be good for their self-esteem and wellbeing, and is likely to release considerable savings on benefits which might otherwise have been needed to support these individuals.

8.10. Waiting times

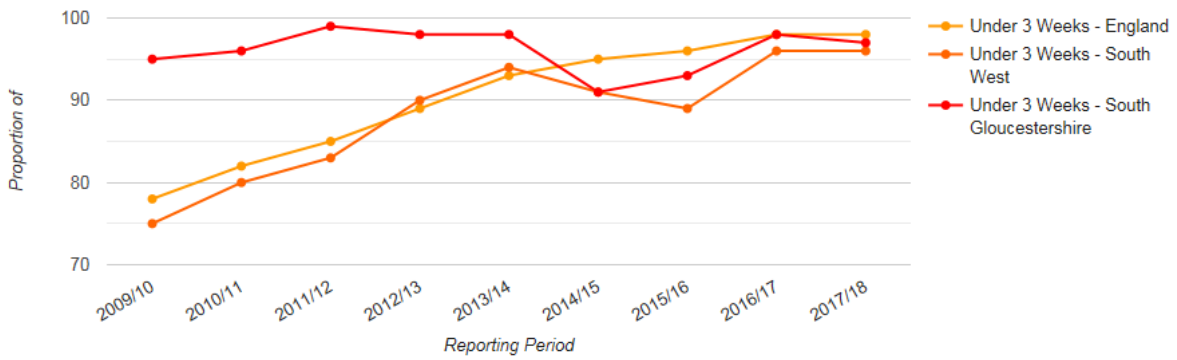
Some people with dependencies are known to be ambivalent about their feelings around wanting to change their behaviour and asking for help. People seeking support therefore need to be seen quickly to maximise their current readiness for change. It is recommended they be seen for their first appointment within 3 weeks of contacting an alcohol service. NDTMS business definitions on this topic state that the triage date should be recorded as

"The date that the client made a first face-to-face presentation to this treatment provider for structured treatment"[9].

If the client is in non-structured treatment and during this time, it is established that there is a requirement for structured treatment, the non-structured episode should be closed, and a new structured episode should be opened in which the triage date should be recorded as the date that it was agreed that they require structured treatment. This will ensure that waiting times for structured treatment can be accurately calculated"[9]

Figure 47 demonstrates an improvement in meeting this target since 2014/15 with 97% of 2017/18 alcohol only users seen within 3 weeks, and none (out of 35 clients who received a first intervention) waiting for more than 3 weeks in Q3 of 2018/19 – this exceeded the national average of 2% waiting for more than 3 weeks[3]. More recently however, DHI have informed us that they are experiencing significant pressures due to the amount of new presentations to service and some people can wait up to two weeks from their initial first contact for the triage team to call back to complete the telephone triage.

Figure 47: Adult Profiles: Proportion where waiting time was under 3 weeks - South Gloucestershire compared with the South West and England - New Presentations, Alcohol only users



Waiting Times	Area	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
Under 3 Weeks	England	78	82	85	89	93	95	96	98	98
Under 3 Weeks	South West	75	80	83	90	94	91	89	96	96
Under 3 Weeks	South Gloucestershire	95	96	99	98	98	91	93	98	97

Source: NDTMS[3]

Actions to consider

1. Extra capacity for alcohol treatment services is needed in South Gloucestershire if we are to successfully manage the demand.

8.11. Treatment interventions

The majority (94%) of our alcohol only service users in 2017/18 received a high level (pharmacological, psychosocial and/or recovery support) treatment intervention in a community setting[4]. 4% received at least one of these interventions in a hospital inpatient unit and 17% in a residential rehabilitation setting. None were recorded as delivered in primary care or in a recovery house[4].

NICE recommend a benzodiazepine such as chlordiazepoxide or diazepam be used as a pharmacological intervention for assisted alcohol withdrawal (detox) and when using a fixed dose regimen (as opposed to responding to symptoms) the initial dose should be calculated according to

the severity of alcohol dependence and/or regular daily level of consumption[8]. The dose should then be reduced over 7 to 10 days with adequate supervision when high doses are used[8]. To prevent a drinking relapse alongside psychosocial interventions, NICE recommend considering the offer of acamprosate or oral naloxone[8] – both of which may reduce cravings for alcohol. Alternatively disulfiram could be offered[8] – this acts as a deterrent because consuming alcohol whilst taking it can cause an unpleasant reaction such as experiencing flushing, palpitations and sickness or worse. These relapse prevention medications are likely to have a small effect on maintaining abstinence. Other pharmacological interventions recommended by NICE include vitamins such as thiamine for those at risk of developing Wernicke's encephalopathy[8].

Pharmacological interventions for South Gloucestershire service users were provided in community, inpatient and/or residential settings. 54% (n=20) compared to 33% (n=5,319) nationally of individuals provided with pharmacological interventions locally were to assist with alcohol withdrawal. 30% (n=11) compared to 34% (n=5,470) nationally were aimed at preventing relapse[4]. It is not known whether a lower rate of using relapse prevention pharmacotherapy in South Gloucestershire is significant or whether it is an anomaly of the small number of clients considered in this dataset. It is known that 11 people recorded as South Gloucestershire service users were prescribed naltrexone in the 12 months to October 2019, but none currently in service with DHI are receiving this medication. It is currently unknown what other (if any) relapse prevention medication is being prescribed.

Inpatient or residential assisted withdrawal is recommended by NICE to be considered if someone drinks over 30 units of alcohol per day; and/or scores more than 30 on the '*Severity of Alcohol Dependence Questionnaire'* (SADQ); and/or has a history of epilepsy, alcohol withdrawal-related seizures or delirium tremens during a previous assisted withdrawal programme; and/or needs concurrent withdrawal from benzodiazepines and alcohol; and/or regularly drinks 15 to 30 units/day and has significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or a significant learning disability or cognitive impairment[8]. NICE recommend a lower threshold for inpatient or residential assisted withdrawal be considered in vulnerable groups e.g. homeless or older people[8].

The proportion for South Gloucestershire alcohol only clients placed in residential rehabilitation (17%, n=12) albeit a small number of individuals, is much higher than the national proportion (3%)[4]. It is also much higher than the local (3%, n=24) and national (2%) proportions who attended residential rehabilitation for drug use[5]. Alcohol only clients are often not identified as needing treatment until they develop serious health harms or other complexities, and it is possible some other areas are not providing residential treatment to even their most serious cases. Alternatively it might be that our alcohol clients are being identified later than is the case in other areas. This could be linked to a paucity of IBA interventions and/or challenges with the NHS Health Check alcohol pathway. It is unknown whether the assessment criteria for residential treatment in South Gloucestershire is different from that in other areas. It could also be that our community treatment system was not, and possibly is not, meeting their needs. This is because generally alcohol clients in South Gloucestershire are provided with community treatment before residential rehab is considered for them. In 2011 NICE recommended research be conducted to appraise the effectiveness and cost-effectiveness of residential rehabilitation compared to intensive community care[8]. The Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group recommend the use of residential treatment as an option for service users at risk of disengagement including those with co-existing mental health problems[10]. There is currently no

equivalent Clinical Guidelines for alcohol treatment but one is expected at the end of 2020 (see https://www.gov.uk/government/news/uk-alcohol-clinical-guidelines-development-begins).

It has also been raised by our providers that they have been facing barriers to getting people diagnosed with Alcohol Related Brain Injury (ARBI) and getting capacity assessments for people with suspected ARBI.

Actions to consider

1. Further data on the use of relapse prevention medications in South Gloucestershire might be useful; as would be comparing a review of the evidence around relapse prevention pharmacotherapies and consulting local clinicians about their reticence to prescribe these medicines.
2. Keep up to date with and explore new evidence around medications used in the treatment of alcohol use disorders.
3. Explore the reasons why a higher proportion of residential rehabilitation is used in South Gloucestershire than is the case nationally.
4. Map our treatment interventions against those recommended in the new clinical guidelines for alcohol due to be published at the end of 2020.
5. Look into Alcohol Related Brain Injury diagnosis for people and investment in this area.

8.11.1. Evidence to support different treatment options

Comparing residential rehabilitation with inpatient alcohol withdrawal

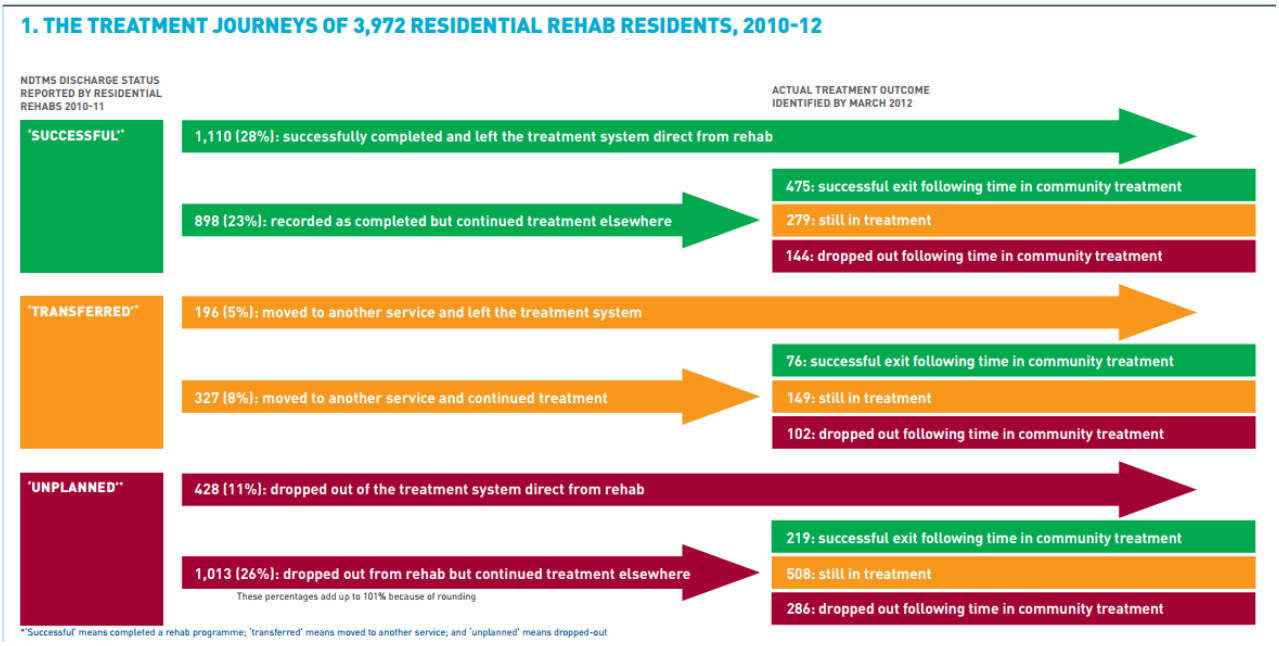
A 2018 observational cohort study analysed the NDTMS data of 3,812 English alcohol service users starting treatment and accessing inpatient withdrawal (IW) and/or residential rehabilitation (RR) from April 2014 to March 2015[11]. The primary outcome was successful completion of treatment within 12 months of commencement, with no re-presentation (SCNR) in the subsequent 6 months[11]. It should be remembered however that failing to represent within 6 months might not be a sign of continued success following the recorded cut off point.

The majority (70%, n=2,682) received IW in their index treatment 'journey'; a quarter (24%, n=915) received RR; 6% and (n=215) received both. Of treatment leavers, 59% achieved the SCNR outcome (IW: 57%; RR: 64%; IW/RR: 57%)[11]. Positive outcome for IW was associated with older age, being employed, and receiving community-based treatment prior to and subsequent to IW[11]. Patients with housing problems were less likely to achieve SCNR[11]. Positive outcome for RR was associated with paid employment, self/family/peer referral, longer duration of RR treatment, and community-based treatment following discharge. Community-based treatment prior to entering RR, and receiving IW during the same treatment journey as RR, were associated with a lower likelihood of SCNR[11].

The role of residential rehabilitation in an integrated drug treatment system

The results of a 2012 audit conducted by the National Treatment Agency (NTA) from NDTMS data for all substance users (including those who only or also used alcohol) in 2010/11 to 2011/12 are shown in Figure 48, below:

Figure 48: Treatment outcomes for a cohort of substance users who engaged with residential rehab



Source: NTA[12]

They summarised:

"That for every ten drug users who were in treatment that year and accessed residential rehab on their treatment journey:

- *Three successfully overcame their dependency directly from the residential rehab*
- *One dropped out of treatment altogether*
- *The remaining six received further structured support from the treatment system.*

Of those six:

- *Two went on to complete their treatment with a community provider and overcome their dependency that way*
- *At least two are still in the treatment system (so their outcomes have not yet been realised)*
- *At least one dropped out at a later stage."* [12]

This demonstrates a fluidity between treatment settings with both sets of providers contributing positively to recovery. They also found outcomes for the 3,881 alcohol users who spent some time in a residential rehab as part of their treatment pathway in 2010-11 were consistently better than those for drug users[12]. It has to be remembered however there is considerable variation in the quality, theoretical basis and outcomes of individual residential rehab facilities.

The effect of drinking history on the outcomes of community-based alcohol treatment

An observational cohort study analysed NDTMS data from April 2014 to March 2015 for English alcohol service users who started pharmacological and psychosocial treatment in a community

setting during this period[13]. They used the same outcome measure for success as in their other study (SCNR) and looked at the effect of community treatment on service users whose 28 day drinking history before engaging with treatment was categorised into 'Abstinent' (0 drinks per drinking day), 'Low to High' (1-15 drinks), 'High to Extreme' (16-30) and 'Extreme' (over 30)[11,13].

Over half (58%) of all these community-based service users successfully completed treatment within 12 months and did not return for further treatment in the following six months[13]. Predictors of SCNR were older age, black or minority ethnic group, employment, criminal justice system referral, and longer treatment exposure[13]. Predictors of negative outcome were previous alcohol treatment history, lower socio-economic status, housing problems, and 'Extreme' drinking at admission[13]. SCNR outcome was inversely proportional to the number of drinks per drinking day in the 28 days before treatment[13]. The addition of recovery support to psychosocial interventions alone increased the likelihood of SCNR by 80%), and had a stronger association with SCNR than the addition of pharmacological intervention(s) which showed a 35% increase[13]. The strongest association observed was with delivery of all three interventions (147%)[13]. These findings support the need for a multi-faceted approach to treatment, according to the severity of use, with a focus on maintaining recovery and improving broader aspects of wellbeing.

Which is better - community or residential treatment?

Nationally, outcomes were consistently better for the 3,881 alcohol users in 2010-11 who spent some time in residential rehabilitation as part of their treatment pathway[12]. Compared to people with drug use problems, those with drinking problems tended more often to succeed in their treatment and fewer dropped out[12]. Community treatment is cheaper than that provided in residential settings; but there is some evidence which supports residential treatment to be most useful where service users are in damaging home environments, are homeless, have low social support, are at risk of suicide, have more severe psychiatric problems, have a more severe dependency on alcohol, have low cognitive functioning, have poor employment prospects and/or severe family problems[14-16]. There is also some evidence that intensive non-residential options (but not routine outpatient care) might almost match residential settings even for severe cases[17,18].

8.12. Length of time in treatment

Retaining clients for their full course of treatment is important to increase their chances of recovery and to prevent relapse[4]. PHE state the duration of a typical full course of treatment to be just over 6 months[4].

In 2017/18 the largest proportion of South Gloucestershire alcohol clients (36%) stayed in treatment for between 3 and less than 6 months[4]. This compared to 31% nationally[4]. Similarly 28% locally stayed for 1 to less than 3 months, compared to 26% nationally[4]. A comparable proportion (8%) to that nationally (9%) exited treatment within less than a month[4]. Significantly less in South Gloucestershire (<5 people) however stayed in treatment for 9+ months compared with 20% nationally[4]. The average length of treatment in South Gloucestershire was 150 days compared with 190 days nationally[4]. Considering the small number of clients (n=50) in this data set, it is hard to draw any conclusions.

For clients prescribed acamprosate or naltrexone as a relapse prevention pharmacotherapy, NICE recommend they be monitored (and motivated with the results of improved liver function tests) at

least monthly for up to 6 months, and at regular but less frequent intervals if the medication is continued for more than 6 months[8]. For those prescribed disulfiram, monitoring should be carried out fortnightly for the first 2 months and monthly for the following 4 months and every 6 months after that[8].

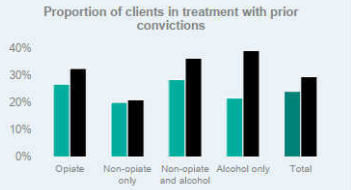
NICE recommend people who are alcohol dependent and homeless should be offered residential rehabilitation for up to 3 months, and help with accommodation provided before discharge[8].

8.13. Criminal Justice/People who have had contact with the criminal justice system

The last available relevant data collected by PHE was that for 2012. In 2012 the proportion of clients in the treatment population with at least one prior criminal conviction in the two years preceding treatment was 22% compared with 39% nationally for alcohol only clients[19]. Further information is shown in Box 5 below.

Box 5:

Clients in the treatment population in 2012 with convictions in the two-years preceding treatment	Proportion of local treatment population %	Proportion of national treatment population %
Opiate	27%	32%
Non-opiate only	20%	21%
Non-opiate and alcohol	28%	36%
Alcohol only	22%	39%
Total	**24%**	**29%**



Source: PHE[19]

Although this data is old, it indicates the possibility of failing to reach people who have offended in need of treatment for problematic alcohol use. Coupled with our low proportion of referrals from the criminal justice system from 2014/15 to 2017/18, it is likely we could do more for this vulnerable cohort. We attempted stakeholder engagement with our criminal justice partners and service users (see Section 9.1) but did not receive a reply.

Due to recent cuts in the public service budgets, our criminal justice drugs and alcohol intervention team/worker was decommissioned. Our specialist alcohol provider noted the lack of a strategic link and often fragmented communication with probation and only with individual probation workers. They also told us about the challenge when someone is given a 6-12 month Alcohol Treatment Requirement, which is outside the provider's treatment pathway.

Actions to consider

1. Obtain up to date information to fully evaluate whether treatment can meet the needs of those in the criminal justice system.
2. Consult with all stakeholders in the criminal justice system including those needing treatment, when conducting the drugs needs assessment stakeholder engagement process to discover what has caused the low rates of referrals into, and engagement with, alcohol treatment.

8.13.1. Transitions from prison

There are three adult prisons in South Gloucestershire. HMP Leyhill is a category D open prison, which in December 2015 held 511 prisoners. HMP Ashfield is a category C male prison for those serving sentences for sexual offences (397 prisoners in December 2015)[19]. HMP Eastwood Park is a female closed local prison (343 prisoners, December 2015)[19]. Prison populations are not static. The churn rate or the number of times a prison place is used each year is 1.24 for HMP Leyhill, 0.49 for HMP Ashfield, and 4.49 for HMP Eastwood Park. In 2015, the average length of stay at Eastwood Park is 49 to 60 days[19].

In 2017/18 a small number less than 5 were released from prison into the South Gloucestershire area and transferred to a community treatment provider for structured alcohol only treatment and successfully engaged with treatment[20]. Albeit with very low numbers (and less than half those identified as in need by the prisons), we appear to be statistically similar to the proportion for England (32.1%) of adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison[21]. The number of alcohol only clients is not compared.

Prisons transferring clients to South Gloucestershire treatment services in 2017-18 were HMP Bristol, HMP Exeter, HMP Guys Marsh, HMP Channings Wood and HMP Eastwood Park – all prisons within in the South West region[20]. It is unknown how many were released to other areas from prisons in South Gloucestershire in need of treatment for problematic alcohol use and their outcomes, or how many from prisons in other areas who 'slipped through the net' and were not identified as in need of treatment.

Our alcohol provider (DHI) has identified an issue with pathways and communications from prisons, citing issues with last minute alerts about releases and not receiving the necessary paperwork. There is a need to look at transition pathways from prisons into community settings to ensure a smooth transition for those leaving prison where there is an on-going treatment need. In Quarter 3 of 18/19, the provider did some analysis of prison referrals which showed that there were 47 referrals of which only 14 were appropriate. The remaining 33 were either coded as being released to the wrong area, remained in custody, or were transferred. DHI request investment and support from the South Gloucestershire DAP team and/or PHE for this.

The integrated system brought in through the recommissioning in 2017 co-located the specialist team with DHI workers. People leaving prison are able to access rapid assessment. Where timing permits in terms of having good notice of prisoner discharge, DHI will offer pre-release visits and will provide an outreach visit with 2 workers to complete triage and assessment whilst the individual is in prison.

An audit of prisoners discharged from a London prison and identified with a substance use treatment need were followed up with community treatment providers in the five highest receiving boroughs[22]. The audit found[22]:

- Nearly half the referrals were not received by the treatment providers and there was a lack of method (two-way communication) to acknowledge receipt of referrals
- Low attendance at treatment after release
- Low follow-up of those who did not attend, which was exacerbated by those with no fixed abode or where contact details were not provided

- Clients who were visited or phoned by treatment services pre-release were almost three times more likely to engage in community treatment than those who were not contacted
- Unplanned releases from court hindered the ability to make referrals and there was no joined up working with probation services during release planning.

As a result of this audit, the authors' recommendations were to develop a standard referral form, agree a referral protocol, to include in-reach by community providers, review and communicate what community treatment offers, improve links with related services, provide single point of contact details, share personal information securely, and record treatment data accurately. Guidance on how to achieve these recommendations is given in the PHE '*Guidance for improving continuity of care between prison and the community'* toolkit[22]. For example a referral form is included and provider single point of contact details can be kept up to date with prisons for example by emailing SPOC@phe.gov.uk[22]

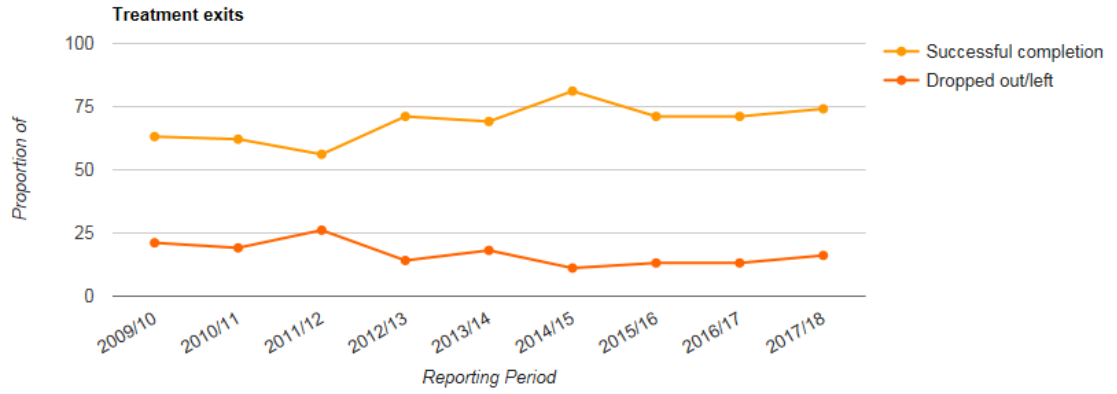
Actions to consider

1. Aim to increase the numbers of those released from prison who successfully engage with our treatment services.
2. Agree the use of a standard referral form and referral protocol between our local prisons and local service providers.
3. Review pathways between prison and the community treatment provider; and treatment for clients in contact with the criminal justice system should be maximised to ensure it meet the needs of this vulnerable client group.
4. Faxing prisoner details to providers should be discouraged and instead replaced with secure email.
5. Review the links between our treatment provider and probation services.
6. Ensure accurate recording of NDTMS data by all who provide treatment to prisoners pre- and post-release.

8.14. Treatment outcomes and successful completions

Successful completion is understood to be the completion of any care planned activity agreed with the practitioner and the service user which is then achieved. This could be a minimum of attending at least one planned treatment session (either psychosocial and/or pharmacological interventions). Planned interventions are delivered after an initial triage (which can be completed by phone) and comprehensive face-to-face assessment. It can be seen from viewing Figure 49 that between 2012/13 and 2017/18 an increasing proportion of South Gloucestershire clients have been recorded as successfully completing their alcohol treatment rather than dropping out. Unfortunately the proportion of successful completions for alcohol only clients to date in 2018/19 has decreased by 17% from that in 2017/18[3].

Figure 49: Adult Profiles: Treatment exits - South Gloucestershire - All in Treatment – Alcohol only users



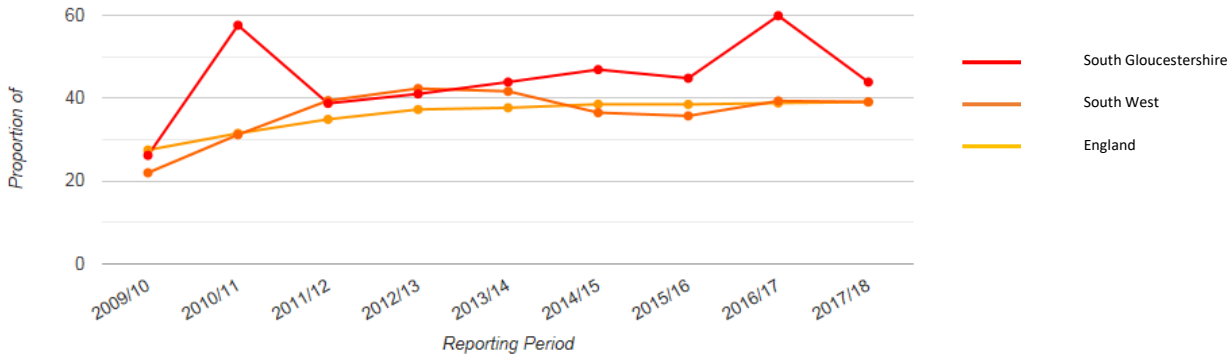
Source: NDTMS[3]

From 2009/10 – 2017/18, out of 940 alcohol only clients, 643 successfully completed, 156 dropped out or left, 71 transferred to a different treatment provider and/or geographic area, 8 were transferred and recorded as in custody, 33 declined treatment, 11 had their treatment withdrawn, 17 died whilst in treatment, and fewer than 5 went to prison or their treatment outcome was not known[3]. In 2017/18, 74% of all South Gloucestershire alcohol only clients exiting treatment left successfully compared to 61% nationally[4].

The number of alcohol only client deaths in treatment fell from 9 in 2014/15 – 2016/17, to 6 in 2015/16 – 2017/18, with there being no deaths recorded for those in treatment during 2017/18[3]. There were however a number less than 5 who died whilst in treatment during the nine months from 1 April to 31 December 2018[3].

Figure 50 (below) shows that from 2013/14 to 2017/18 a higher proportion of alcohol only clients in South Gloucestershire than in England or the South West, successfully completed treatment and did not represent within 6 months.

Figure 50: Adult Profiles: Proportion of clients successfully completing treatment and not re-presenting to treatment - South Gloucestershire, compared with the South West and England - All in Treatment - Alcohol only users



Source: NDTMS[3]

Similarly South Gloucestershire clients entering treatment since 2014/15 for all substances (opiates, non-opiates only, alcohol only, non-opiate and alcohol and non-opiate combined) was for them to

be slightly more likely to complete treatment and not re-present within 6 months than is the case in the South West or in England[3].

It is arguable however whether or not re-presenting for further treatment after attending only one or few sessions should be counted as a success. A better indicator might be the proportion becoming abstinent or managing to reduce their drinking. In 2017/18 a greater proportion (66%, n=21) of South Gloucestershire clients, compared with 51% of clients nationally became abstinent[4]. Those cutting down their drinking (n=32) fared less well with reducing from 21.9 average drinking days at the start of treatment (compared to 20.7 nationally) to 15.8 average drinking days (compared to 11.7 nationally) after treatment[4]. Although it is not known how much they drank on an average drinking day[4].

In conclusion (albeit with a caveat that for some measures the numbers compared are quite small) once alcohol only clients enter treatment in South Gloucestershire the measures of success indicate they have generally done better than is the case in England, particularly for those choosing abstinence.

Actions to consider

1. Extra capacity for alcohol treatment services is needed in South Gloucestershire.

8.15. Family members of people with alcohol use disorders

The effect of alcohol is not limited to the person with an alcohol use disorder, it can also adversely affect their family. Problems include money being spent on alcohol which is needed for other purposes, stress and anxiety about the drinker's welfare and unpredictable behaviour, stigma and isolation due to feelings of shame about the situation and possible domestic violence and abuse[23]. Furthermore evidence indicates family-focussed interventions are recognised as among the most effective approaches for treating adults and adolescents with drug problems[24.] We know that people in treatment who have supportive family members who are involved in their treatment tend to have better outcomes. The rapid evidence review conducted by the South Gloucestershire Evidence and Evaluation Support Officer in 2018 also considered the barriers for seeking help for family members of people with alcohol use disorders[24]. Key findings were nationally[24]:

- Few services were available for family members, largely because there is no requirement to do so, resources are scarce, and treatment service providers might lack the skills, knowledge and confidence for this work
- A lack of joined up working between services may prevent family member(s) receiving timely and routine information on family support services
- Lack of awareness of the need for support or a perception of not deserving it
- Fear of exacerbating domestic violence
- Shame and stigma
- Delay in seeking help.

Evidence of effectiveness for programmes for children from substance affected families is promising, especially for those of 10 week or longer duration and those which included elements on children's parenting and family skills training[24].

In South Gloucestershire, we have a dedicated Family and Carers service called Families Also Matter (FAM) commissioned as part of a tri-partite agreement between Bristol, South Gloucestershire and Bath and North East Somerset (B&NES) Public Health Teams. Prior to February 2017, each area commissioned its own Family and Carers service, delivered by DHI. In South Gloucestershire, the service had faced a considerable reduction in funding following the Public Health Grant cuts. We had worked with the provider to make these cuts in the most appropriate places which led to some very difficult decisions. It was decided that rather than cut core services, the FAM service funding would be reduced. This led to a reduction in staffing hours from a full time manager and worker to a part time worker. The worker would see people on a 1:1 basis and also run a weekly group in Warmley and Yate. In 2017, the commissioning teams above agreed to pool resources with the aim to increase family and carer provision across the three areas. Bristol, as the area contributing the largest amount of funding, led the process and the service was agreed to be commissioned as part of the ROADS scheme. ROADS stands for Recovery Oriented Alcohol and Drugs Service and is the name for the commissioned drug and alcohol treatment services in Bristol. The service was put out to competitive tender with the rest of the ROADS contract in 2018 and DHI were awarded the contract for the Family and Carers element. The service started officially on February 1st 2018 and means a continuation of the service in South Gloucestershire with a part time worker who runs groups and sees people on a 1:1 basis. DHI have also set up a new website called WebFam (https://webfam.dhi-online.org.uk/) which provides online support, resources and information for those affected by a loved one's drug or alcohol issues. DHI also run an annual conference called Reach Out, which is dedicated to family members and the issues that affect them which is always well attended and an interesting event.

Although the service has continued, we recognise that there is much less capacity in the service than previously and people who were using the service prior to the cuts have expressed dismay about how this has affected what they can access and the support they used to receive. For example, there used to be training days where guest speakers would be paid to speak to FAM service users about drug dependency but there is no longer funding available to deliver these sessions. Feedback about the need for greater service provision for family members, as well as more family support for people with drug and alcohol users was conveyed in the engagement sessions done at FAM group meetings which are addressed in more detail in the engagement section of this needs assessment.

Actions to consider

1. Ideally a whole family approach should be taken to alcohol treatment.
2. Scope if there are ways to increase provision in the FAM service.
3. Evaluate the FAM service at regular intervals to ensure it is meeting the needs of its service users and potential service users.

8.16. Barriers to accessing treatment

A rapid evidence review was conducted by the South Gloucestershire Evidence and Evaluation Support Officer in 2018 to discover the reasons which prevented dependent drinkers (particularly those with children) from accessing treatment[24]. The evidence indicated the main barriers were[24]:

- Fear of stigmatisation
- Denial or lack of problem awareness
- People preferring to cope with it on their own
- Not wanting to completely stop drinking – concern about losing the positive aspects of drinking
- Treatment is sought preferably by people with more severe dependence and a higher level of mental and physical co-morbidity
- Lack of knowledge/awareness of the range of treatment options and some perceive services are only for drug users
- Perception that treatment is ineffective
- Accessibility e.g. lack of transport, not knowing who to ask for help, perceiving services will only be available during work hours, delays receiving treatment following assessment
- Attitude of professionals – including clinician's reticence to provide screening and interventions for AUDs due to constraints on resources and/or finding it difficult to engage patients in conversations around alcohol; lack of GP knowledge; and GPs perceived as not being considerate or sympathetic to patients with AUDs
- Preferring to seek mental health treatment instead of treatment for AUDs
- Preferring to seek broader psychosocial support such as social contact, paid or voluntary work resolution of housing-related issues or gym access
- Sociodemographic characteristics - data from a national US survey found those who were younger, married, had a higher income, had higher education and did not have an adverse medical condition are less likely to perceive the need for, or seek help for, an AUD.
- Gender – conflicting results with some studies showing men are less likely to seek help for AUDs and in others women, particularly for example women with dependent children (especially lack of childcare or fear of losing their children as a condition of treatment) psychiatric co-morbidity or a history of victimisation.

Actions to consider

1. Aim to change attitudes amongst drinkers (especially around stigma, need; what treatment is available, effectiveness and how to access it; and care for children) and amongst healthcare professionals, through campaigns for the public and training for healthcare professionals.
2. Ensure local treatment provision is accessible (including some provision at weekends and/or eventing), and with effective pathways for collaborative working with mental health services and voluntary services.
3. Investigate the feasibility of providing more community detoxifications in clusters throughout South Gloucestershire.
4. Consult further on whether there should be separate services for the treatment of alcohol than for drugs and alcohol combined.

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9. What do our stakeholders think?

Aiming to build on the process of co-producing the alcohol strategy with our stakeholders, we conducted a large pre-consultation/stakeholder engagement exercise. Stakeholder mapping was

undertaken in January 2019 as part of the planning process. It was done with the support of the whole project team. Through this process a number of Boards, organisations, and named contacts were identified. Stakeholders integral to the delivery of the strategy and those who might own the strategy were highlighted, as well as those who might be interested parties and would need to be kept informed.

The objectives for our stakeholder engagement exercise were to:

- Provide our stakeholders with local information and statistics about alcohol related harms and estimated unmet needs
- Explain the purpose, roles and recent achievements of our local drug and alcohol programme
- Feedback the outcomes of our CLeaR assessment and peer review
- Inform the stakeholders about the need for a new alcohol strategy for South Gloucestershire
- Discover the normative, felt and expressed needs of our stakeholders relating to alcohol; and to request their views on what should be included and prioritised in the new alcohol strategy.

9.1. Engagement method

We split the engagement period due to purdah restrictions caused by local and EU elections. The first stakeholder event was held in March 2019. It was a 2-hour development session for the South Gloucestershire Health and Wellbeing Board and the Safer and Stronger Communities Strategic Partnership. All the remaining stakeholders (including local residents) identified by our mapping process were invited via Eventbrite to three further 2-hour large events. In June 2019, they were facilitated in three separate venues across South Gloucestershire. The format and locations of these events, and the numbers attending is described in Table 9 below. The questions asked to discover their views are described in Appendix 2. The presentations used for the Board meeting and the large events contained information tailored to those expected to attend.

We attempted to engage with our residents by promoting the three events on Facebook and Twitter. We aimed to attend three local public events in June and July 2019 but due to adverse weather the one in Page Park was cancelled and although informal conversations about alcohol were held with some attendees, it was not felt the right forum to engage the public on the strategic questions at Patchway festival. We attended Bristol Pride. During these months we met with stakeholders such as young people and service users in their venues and at a Crimestoppers event which showcased the work of primary schools. These meetings are described in Table 9. Additionally we facilitated a few one to one interviews and commissioned research from Foster and Brown. After the planned events we sent to our identified stakeholders who did not attend, and to the public, links to an online survey requesting this be completed by 9 August 2019.

Table 9: Stakeholder Engagement Events March to July 2019

Events	Method of engagement	Numbers attended
Health and Wellbeing Board (HWB) Development Session with the Safer and Stronger Communities Strategic Partnership	Presentation including background to the Drug and Alcohol Programme, headline alcohol statistics and information, outcomes of the CLeaR assessment and need for the development of a new alcohol strategy. Discussion based on *'The five strategic questions'*	15
Large stakeholder events: • Patchway • Kingswood • Yate	Presentation (similar to that for the HWB above) and discussion based on *'The four questions (a) or (b)'*	55
Residents' festivals (people attending who were engaged at a stall) • Filton	Interviews and discussion of *'The four questions (b)'*	10
Staff at the University of the West of England – the students were on holiday during the period planned for consultation at UWE	Interviews and discussion of *'The four questions (b)'*	11
Staff employed by our provider services (DHI and AWP – 2 sessions)	Interviews and discussion of *'The four questions (b)'*	18
Practitioners who see people with a dual diagnosis of mental health and substance misuse disorders	Email containing links to the *'Mental health and substance misuse survey'* (for results see section 4.4.3)	11
South Gloucestershire residents/public	Links on Facebook, Twitter and the South Gloucestershire Council website; to the Online Survey containing some information and *'The four questions (b)'*	8

Events	**Method of engagement**	**Numbers attended**
Other one to one interviews	Discussion based on *'The four questions (b)'*	4
Stakeholders unable to attend our face-to-face events	Email containing links to Online Survey containing some information and *'The four questions (b)'*	17
Gypsy and Traveller communities	Informal discussion based on the *'The four questions (b)'*	3
Families Also Matter (2 sessions, Warmley and Yate)	Discussion based on *'The four questions (b)'*	
Adult service Users	Interviews and discussion of the *'Adult service user engagement questions'*	32
Young people Attending schools/colleges: • Brimsham Green School • Digitech Studio School • Downend School • Kings Oak Academy • Pathways Learning Centre • The Concorde Learning Intervention Centre (CLIC) Attending events: • Crimestopper event • Hanham Youth Centre • The Stokes, Creative Youth Network Care leavers drop in group	Discussions based on the *'Young people group engagement questions'*	Approximately 100
Young Service Users • One to one	Interviews and discussion of the 'Young *service user questions'*	11

Events	Method of engagement	Numbers attended
Criminal Justice -questionnaires were sent however due to miscommunication in the Criminal Justice team and change in the structure no completed questionnaires were returned to the DAP despite attempts by the SHIP.	Email containing seven *'Questions for criminal justice colleagues and service users'*	No replies

For groups we were unable to engage with:

Actions to consider

1. Engage with students at the beginning of the new term in 2020 to ask them *'The four questions (b)'*
2. Engage with Criminal Justice for the Drug Needs Assessment to ask them the *'Questions for criminal justice colleagues and service users'*

Feedback from our stakeholder events was recorded on post-it notes. These were collated and an informal thematic analysis was conducted to organise and summarise the answers received. Summaries of their feedback were grouped for the Health and Wellbeing Board & Safer and Stronger Communities Strategic Partnership (section 9.2); mixed stakeholders and public events (section 9.3); family members or carers of people who drink who attend the Families Also Matter (FAM) service (section 9.4); adult users of our specialist alcohol treatment service (section 9.5); young people (section 9.6); and service users of our specialist Young People's Drugs and Alcohol Service (section 9.7).

As part of this stakeholder engagement process we also commissioned the research and consultancy firm Foster and Brown (section 9.8) to recruit South Gloucestershire residents who were not in treatment for problematic alcohol use but who were drinking at increasing or higher risk levels[1]. Furthermore, adult drug and alcohol service users were routinely surveyed by their provider, DHI in 2018 (section 9.9). The South Gloucestershire Viewpoint panel (section 9.10) were asked their views in 2017 on four topics which could be described as problematic drinking. The Healthier Together panel (section 9.11) of approximately 1,000 members is deemed to be a representative sample from the population of Bristol, North Somerset and South Gloucestershire (BNSSG). Their 2019 findings which related to NHS expenditure on alcohol interventions are also reported.

9.2. The Health and Wellbeing Board & Safer and Stronger Communities Strategic Partnership

The organisations represented by the Health and Wellbeing Board (HWB Board) and the Safer and Stronger Communities Strategic Partnership (SSCSP) are:

- Avon Fire and Rescue Service

- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- Elected Members (South Gloucestershire Councillors)
- North Bristol Trust
- Sirona Care and Health
- South Gloucestershire Community Engagement Forum
- South Gloucestershire Council, Finance and Customer Services Division
- South Gloucestershire Council, Public Health and Wellbeing Division
- South Gloucestershire Council, Safe and Strong Communities
- The Care Forum

Initial engagement with the HWB Board in February 2019 resulted in their agreeing to provide accountability and governance for the new alcohol strategy and subsequent action plan. The Alcohol Stakeholder group will monitor, review and develop implementation of the action plan and provide feedback to the DAP Strategic Steering Group. Feedback from the development session discussion group in March 2019 with both Boards/Partnerships which focussed on the '*Five Strategic Questions'* (Appendix 2) is described below:

Priorities and outcomes required from the new alcohol strategy

We asked **"***What are your organisation's priorities with respect to alcohol, and what outcomes do you want to see from the new strategy?"*

The HWB Board and the SSCSP's priorities regarding alcohol were stated as:

- An improved focus on prevention and up-stream approaches including awareness training.
- The need for collection of early intervention data from all agencies including youth services and family and young people services.
- Joint commissioning and provision of preventative and healthcare services
- For local services to be accessible; and for employers to help people improve the health and wellbeing of their employees.
- Associated links to mental health strategy improvement
- The prevention of alcohol-related crime (such as that resulting from the night time economy) especially violent crime; preventing the exploitation of children and vulnerable adults (including as a recruitment technique for involvement in drug selling/county lines); and preventing re-offending.
- Use of the licensing process to influence the night time economy and violent crime.
- A culture change for alcohol consumption.

The desired outcomes they mentioned wanting to see included were:

- An increased number of brief interventions and other behaviour change interventions provided, including the use of scratch cards.
- Reduced hospital admissions.
- Increased numbers in alcohol treatment.

NHS guidance for lower-risk drinking

We asked *"To keep your risk of alcohol-related harm low, the NHS recommends not regularly drinking more than 14 units of alcohol a week.*

- *How effectively do you think this is being done in South Gloucestershire currently?*
- *Do you see any gaps?*
- *What are the opportunities for the HWB (and SSCSP) and its member organisations to promote this message?"*

Out of 8 responses to a scale of 1 to 10 where 1 was ineffective and 10 was most effective, the median score was 4.25. This indicated an understanding amongst the HWB Board and the SSCSP that a significant number of people in South Gloucestershire are drinking above the lower risk level.

Possible reasons suggested were that the NHS guidance was not well promoted nationally, and that members of the public found the concept of units difficult to understand especially those with lower cognitive functioning or education.

Opportunities for the HWB Board and the SSCSP and their member organisations to promote this message were suggested as:

- Campaigns and social media.
  - Targeting messages for different audiences including diverse communities with different approaches to alcohol.
  - Use short You Tube videos.
  - Align health promotion messages and approaches.
- Start alcohol education early in all primary schools and encourage them to educate their parents; and continue this education at university.
- Improve the use of NHS Health Checks as an alcohol reduction brief intervention.
- Build on the reasons young people don't drink as much now as used to be the case some years ago.
- Could South Gloucestershire council be more pro-active in reducing the proliferation of *"cheap booze"* outlets?

Working together to prevent or reduce alcohol-related harm to individuals

1. We asked *"How effectively do you think we are working together to prevent or reduce alcohol-related harm to the individual e.g. accidents, liver disease, educational attainment?*
   - *What are the opportunities for the HWB (and SSCSP) and its member organisations to reduce alcohol-related harm to the individual?*
   - *Do you see any gaps?"*

Out of 5 responses, a median score of 6.5 was the result for our effectiveness in working together to prevent or reduce such alcohol-related harms to individuals. The perception was therefore that some effective health and wellbeing interventions which mitigate individual harms to adults and young people are being achieved. However, comments were made stating it was hard to group these harms.

Opportunities identified were:

- To improve the number of schools referring to the South Gloucestershire Young People's Drug and Alcohol Service; and for them to initiate other interventions.

- ❖ The need for Children and Young People's Services (not just the HWBB and SSCSP) to look for prevention opportunities through their casework.
- ❖ To maximise the use of MECC and brief intervention tools.
- ❖ Sustainability and Transformation Partnership (STP) working.
- ❖ All new or updated CCG and LA contracts to propose and resource alcohol harm-reduction work; and for community and other procurement to be used.
- ❖ For a link between licensing and the environmental health offer
- ❖ For targeting treatment at perpetrators; and finding those in domestic violence and abuse, and probation services who need support
- ❖ For the police to enforce legislation where alcohol is causing or has potential to cause harm.
- ❖ For the police to signpost to early intervention or treatment services.
- ❖ To ensure similar language is used by all frontline workers
- ❖ To share data, have joined up interventions and track individuals

Gaps identified were:

- Our higher unmet need for treatment of alcohol dependence
- Resources/funding including the need therefore to balance ideal scenarios with reality
- Joint funding to procure the delivery of services in partnership.
- The targeting of pregnant women, those with protected characteristics such as LGBTQ+.
- Knowledge about the engagement of educational systems with delivering key messages.
- Engagement with the regulatory committee that manages alcohol licences.
- Sharing data and analysis, and trusting the data (someone said *"Well the 94% Q* [sic], referring to the proportion of unmet need for treatment] *cannot be ignored ⟶ although its validity needs to be checked!"*
    - Lack of knowledge about the compatibility of different databases.
- Some lack of knowledge of levers we have, those that could be developed and what is beyond our control.

Working together to prevent or reduce alcohol-related harm to families and the community

We asked *"How effectively do you think we are working together to prevent or reduce alcohol-related harm to families and the community e.g. crime, domestic violence and abuse, antisocial behaviour?*

- *What are the opportunities for the HWB (and SSCSP) and its member organisations to reduce alcohol-related harm to families and the community?*
- *Do you see any gaps?"*

Out of 10 responses, a median score of 4.5 was obtained for assessing effectiveness. The perception of the HWB Board and the SSCSP is that we are currently not effectively working together in preventing harm to families and the community – particularly in terms of crime and DVA.

Opportunities identified were:

- ❖ More action(s) from licensing services, for example writing to licensees reminding them of the risks and their responsibilities including examples of prosecutions.
- ❖ Providing evidence for enforcement to combat underage sales.
- ❖ Develop shared responsibility across organisations – strategic leadership.

    - Engage with integrated care locality leadership group, locality provider forum, STP integrated care steering group.
    - Community health service procurement.
    - Target at joint objectives.
- ❖ Primary Care Networks/GP localities to have a localised action plan that responds to local needs and to include social care, community health, the Voluntary, Community and Social Enterprise (VCSE) and peers.
- ❖ Significant input from welfare services, adult and social care, and housing services.
- ❖ Maximising/extending the role of the Lead GP for alcohol.
- ❖ Make every contact count.

Gaps identified were:

- Education, learning and skills required including that for
    - Increased councillor effectiveness in reaching out to their residents and awareness of the DAP, the DAP team, and ward health indicators.
- Evidence for additional community impact assessments.
- Landlords serving drunk people and uncertainty over who is responsible for identifying and prosecuting them.
- Whether there was an issue with alcohol delivery services who might be breaching the terms of their license e.g. by delivering at hours outside of their license but charging for the alcohol during licensing hours.
- Working in partnership with or links with
    - South West Ambulance Service (SWAST).
    - GPs.
    - Social care.
    - The mental health strategy development e.g. Improving Access to Psychological Therapies (IAPT).
    - Youth services.
- A partnership between Children and Young People and families.
- A link with Adverse Childhood Experiences (ACEs) and a link with inequalities.
  A shared language approach across services, for example between licensing and prevention.

Perception of effectiveness of our current alcohol services across the life course

We asked *"A local authority must "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…" The purpose of the DAP is to provide a life-course, whole population level strategic approach to preventing and tackling the harms caused by drugs and alcohol in SG, rooted in a robust evidence base. This needs to be done in partnership and the NHS Long Term Plan highlights the need for more NHS action on alcohol.*

- *How effective do you think the current alcohol services we commission or provide across the life course in South Gloucestershire are?*
- *Do you see any gaps?*
- *What are the opportunities for the HWB (and SSCSP) and its member organisations to improve services"*

A median score of 3.5 resulted from the input of 3 respondents on how effective they thought the alcohol services which we currently commission or provide as a life course whole population

strategic approach were. This (albeit from a small number who responded to this question) indicates there is much need for improvement.

Additional comments to this question were made that asked us to consider the social acceptability of not drinking alcohol, and role models and their influence on others.

Opportunities identified were:

- To learn from our clients and their experiences e.g. children of service users who then become dependent.
- To link with mental health for example drinking large quantities of alcohol will most likely negate the effects of antidepressant medications.
- To educate children about alcohol at the same times as that done for smoking – possibly in Years 8 to 9:
    - About drinking tiers
    - The perception of needing to drink alcohol to have fun.
- To contract relevant services for joined up working for example by sharing key performance indicators (KPIs).
- To share individual case data.
- To obtain better data from GPs, social care, NHS Health Checks, SWAST
- To link with workplaces (large and small) and business networks such as Business West and the Chartered Institute of Personnel & Development.
- To be more proactive with using the regulatory committee, for example by considering local minimum unit pricing in South Gloucestershire.
- Verification of monitoring data obtained from providers, such as that for waiting times.

Gaps identified were:

- Promoting “cooler” soft drinks for examples schemes such as Club Soda
- Lack of choice as there is now one lead provider for treatment of all drugs and alcohol.
- Services not joined up and thus tended to be ad hoc, one off and not life course.
- People not disclosing their level of drinking; and hidden at home drinking.
- SSCSP no longer receiving data or reports about alcohol treatment services.
- Not using social media effectively.

The feedback from the Health and Wellbeing Board and the Safer and Stronger Communities Strategic Partnership were considered alongside the data and evidence when formulating the strategic recommendations for this needs assessment and the development of the new Alcohol Strategy. These included increasing the focus towards preventative and early intervention work whilst increasing capacity for treatment; Increasing partnership working, and shared commissioning and KPIs. Additionally some of the feedback was synonymous with actions to consider which were formulated for sections 4 to 8. Those not already covered specifically and which will be considered when producing the new Alcohol Action Plan are:

Actions to Consider

1. For the police to signpost to early intervention or treatment services.
2. Learn from service users.
3. Introduce choice of alcohol treatment providers into the model for commissioning.
4. All new or updated CCG and LA contracts to propose and resource alcohol harm-reduction work; and for community and other procurement to be used.

5. Primary Care Networks/GP localities to have a localised action plan that responds to local needs and to include social care, community health, the Voluntary, Community and Social Enterprise (VCSE) and peers.
6. Significant input from welfare services, adult and social care, and housing services.
7. South Gloucestershire Council being more pro-active in reducing the proliferation of "cheap booze" outlets.
8. For employers to help people improve the health and wellbeing of their employees.
9. Maximising/extending the role of the Lead GP for alcohol.
10. Link licensing work with that of environmental health.
11. In campaigns, build on the reasons young people don't drink as much now as used to be the case some years ago.
12. Ensure similar language is used by all frontline workers.

9.3. Mixed stakeholder and public events

The organisations and people who engaged with us in June to August 2019 are as listed below:

• Alcoholics Anonymous • Avon Local Medical Committee • Avon Fire and Rescue Service • Avon and Somerset Police Force • Avon and Wiltshire Mental Health Partnership (AWP) • Bristol Community Children's Health Partnership • Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group • Carers Support Centre, Bristol and South Gloucestershire • Community Alcohol Partnerships • Creative Youth Network • Developing Health and Independence (DHI) • Elected Members (South Gloucestershire Councillors) • Families Also Matter (FAM) service users • Family members of people with drug and alcohol issues • GP with Special Interest in Alcohol • LGBTQ+ attendees of Bristol Pride Festival	• Next Link • Public Health England • Residents of South Gloucestershire • School pupils • Sirona Care and Health • Service Users • South Gloucestershire Council, Children, Adults and Health, Preventative Services • South Gloucestershire Council, Children, Adults and Health, Safeguarding, • South Gloucestershire Council, Public Health and Wellbeing Division • South Gloucestershire Council, Safe and Strong Communities • South Gloucestershire Over 50's Forum • South Gloucestershire Probation Services • Staff working at AWP and DHI • The Care Forum • University of the West of England • Young people • Young service users

9.3.1. Partner organisations

Although members of the public were invited to three large stakeholder events, most attending were from our partner organisations listed above. Separate events were held with Families Also Matter (FAM) service and users of both our adult and our young people's treatment services. Additionally a survey for the public was advertised on social media. At the three stakeholder events we asked people four questions. The attendees were split up into four groups and they worked on each question for 20 minutes each and discussed each one on rotation. They wrote their thoughts down on post it notes stuck to flip chart which were collected in by the commissioning team. The questions were:

What are the three most important things to you about alcohol?

What are we currently doing well to tackle alcohol harm in South Gloucestershire?

What are the problems, gaps and challenges in tackling alcohol harm in South Gloucestershire?

What do you think we should be prioritising in our strategy?

The post it notes were grouped into themes and then the commissioning team organised these individually to group them further and to draw out what the most popular themes were.

In this section we will summarise the key themes that came out of the questions covered in the workshops. Whilst recognising that responses to the questions are subjective and could be seen as one person's opinion, there were some themes that came through strongly from a large number of people who attended the events.

We will cover each question in turn.

To the question:

What are the most important things to you about alcohol?

There were some key themes that came out from this question and these have been grouped below under their key headings.

Cultural and social aspects

Many of the discussions focused on the perceived culture around alcohol, how it was very readily available in our society and that generally drinking is seen as something acceptable to do and even encouraged. People felt that in general alcohol was seen as a positive thing and it was not questioned much of the time as to whether we should have the relationship with it that we do as a society.

Culture change was also linked in with national legislative policies which some participants supported, such as Minimum Unit Pricing (MUP), alcohol licencing regulations and alcohol labelling. Whilst it was recognised that a whole nation's drinking culture cannot be changed in South Gloucestershire, some participants felt it was important to raise these issues with people of influence and ensure that we lobbied for these interventions where appropriate and evidence based.

There was also mention of the fact that alcohol is not seen as a drug because of its legal status and that different language could be used to begin to change people's feelings about how acceptable

alcohol is. One example was about school fundraisers and alcohol being available at these types of events.

Licencing was also brought up as important and using licencing law to influence the easy accessibility and availability of alcohol to the public.

Some participants spoke about the stigma that still faces those who have issues related to alcohol and how we should be working to challenge this. Some also mentioned stigma in terms of it stopping people from seeking help when they might need it.

Many participants talked about wanting there to be a more positive culture around not drinking or having a drink free lifestyle and that rather than this being something that was seen as boring, or only to be undertaken once you had a serious issue with alcohol, that a low alcohol or no alcohol life should be promoted, encouraged and celebrated.

Some people mentioned that the most important thing to them about alcohol was the taste and the price. Also that alcohol can be a comfort and can give you confidence. We had a number of comments that pertained to the perceived positive feelings people had around alcohol and this shows that many people see drinking alcohol as beneficial in their lives, as something they enjoy and we should not forget that within our strategy.

Prevention and education

A key theme was that our stakeholders felt that people did not know enough about the harms of alcohol and that therefore the most important thing to them was around education and early intervention. This was a key theme and linked in with the thoughts above, namely that people were too accepting of alcohol's place in our lives and did not have enough knowledge about the risks or damage alcohol could do or could cause to themselves, those around them and how it could affect communities adversely. Education and talking to people, both children and adults, came through strongly as something that was important to those we spoke to.

The need to focus on prevention was brought up many times in these discussions with some participants saying that preventing people from having a problem with alcohol was very important and that education and communication campaigns to inform people of the risks were crucial.

Pathways and accessibility of services

Another key theme that was important to people was mental health and how this linked with alcohol use. Better pathways between mental health services and alcohol services were mentioned by a number of people as well as focusing on people's wellbeing as a way of addressing their alcohol use, or supporting them to address issues that alcohol might be covering up.

Discussions were held about following the SmokeFree model and that it was important to learn lessons from this as a public health success.

Accessibility of services was also raised as important, bearing in mind the rural nature of much of South Gloucestershire, as well as remembering to think about those who are infirm or elderly and unable to leave their homes easily as well as those for whom English is not their first language or who may be anxious. The lack of out of office hours provision was mentioned as something people felt needed to be addressed. Having outreach services for people with these needs was seen as important.

Transitions between services and having good pathways was a theme. Both for young people to adults but also for mental health services, prisons, hospitals etc. Some participants told us it was important to get these pathways right so that people got the support they needed at the right time and did not fall through the gaps.

Funding for services and better agreements to treat people across borders was also mentioned by participants.

Many people talked about other linking and important themes, such as mental health, domestic violence, lack of suitable accommodation and alcohol generally needing to be seen in the wider picture of where it sits. ACEs and dealing with trauma was also seen as important rather than just dealing with the surface issue of the alcohol problem. It was also raised that it would be important to link in with other relevant strategies.

Complex needs was brought up as an important theme and the role that alcohol can play in the lives of people with numerous issues affecting their lives. Dealing with these issues in the round and addressing the underlying causes of alcohol misuse was seen as important by some participants.

This contrasts with other stakeholders as mentioned about, who felt that prevention was the most important thing and it was clear that some participants wanted this to be balanced with a note of caution and felt that more important was supporting people who had complex needs now and might already be suffering from alcohol harm. The challenge is to try and do both, ensuring adequate provision for those already needing treatment and support as well as investing in interventions that can prevent people from needing that treatment and support in the first place.

Treatment and Recovery options

Offering the right treatment to the right person at the right time was a theme. Offering a wide range of interventions, support and services was seen as really important by some participants as well as giving people other things to do. Focusing on “wraparound” support, not just the core services that tackle the alcohol problem itself was seen as crucial in affecting any real long term behaviour and culture change and really changing people’s lives. Giving people something else to do, to hope for and to be part of was seen as essential for people to achieve recovery in any meaningful sense.

There were some comments about staff wellbeing as an important thing to remember, that in order to help people staff should be well trained and supportive and that roles should be manageable with reasonable caseloads. This was a reminder that when services become overstretched staff can suffer which can mean a detriment to services people receive. Although we did a specific session for workers who work in our services, so their opinions may be over represented in these comments, it was clear that staff did feel it was important to have good staffing levels to manage capacity, particularly as this had risen in the last year with no extra funding or capacity given.

Data and feedback

Using data was also seen as important to ensure that services were linking up and that we are focusing our funds in the right areas. Some participants felt it was important to respond to the needs of the population that we have rather than national targets which they felt could be politically motivated. It was also felt by some that we needed better and more consistent data to know who to target and what the best practice is to work with people around alcohol issues. The use of data to inform service delivery and what model is most effective was seen as important. Also using data to be able to identify high risk drinkers and target interventions appropriately was mentioned.

Service user feedback and involvement was also mentioned as important for us to understand what people experience when they are in treatment.

We asked the participants: What are we currently doing well to reduce alcohol harm in South Gloucestershire?

Some people engaging in the events found this question hard as they felt they did not know enough about what was happening in South Gloucestershire in order to be able to answer fully. We therefore got far fewer responses to this question than the other three. This tells a story in itself, if people are not aware of what we are doing well then this perhaps indicates that we need to advertise more of what our services provide and what is on offer in South Gloucestershire. This view is backed up by the wider findings of the needs assessment. It should also be noted that some of the positive comments about the community service may have been mostly from people who work in that service themselves as they are better placed to know what is available in South Gloucestershire compared to those who were less knowledgeable. This may therefore have led to there being an over representation of people who worked in the service commenting positively on this question.

Treatment and support

Participants felt that generally our community services were flexible and accessible and the three site access was seen as a positive. Participants commented that our treatment services were performing highly with positive outcomes. It was also felt by some participants that the staff in our services worked together well through the integrated system and that staff were approachable and non-judgemental. Throughcare and wraparound support were also mentioned by many participants as a positive as well as the triage system being comprehensive, easy and quick to access with good harm reduction advice. The groupwork programme as well as the fact that alternative therapies and other activities such as yoga are offered was also commended as well as options like the confidence course and it was mentioned that more of these types of interventions should be offered. It was also mentioned that services were good at listening to people and instilling hope.

Community detoxification and availability of the detox facility both in-patient and community was cited as something that we are doing well at, reflecting the increase in numbers for community detox. Working out of GP surgeries and having a link in A&E with the alcohol nurse was also seen as positive. Also more than one person mentioned that having a lead GP focused on alcohol was positive and provided clinical governance and assurance to our processes and supported staff in services.

Family and Carers support was mentioned as a positive part of the service. (For more detailed information on what people using our Family and Carers service said, please see section 9.4, where this is covered in more detail as part of our service user engagement section.)

It was commented on that it was good that peer support has improved in South Gloucestershire although it still needs further development. The fact that mutual aid groups are functioning and supported in South Gloucestershire and available in all three sites was also mentioned by some participants as a positive.

Partnership working and linking in with other themes

Partnership working was praised by some participants and agencies working together was considered to be something we are good at in South Gloucestershire. The integrated drug and

alcohol services that we provide was specifically mentioned in relation to this. Community support and working with other agencies was also mentioned as positive in making improved links with the community.

One participant commented on the low amount of underage sales and the work of trading standards on this.

The ACE approach was welcomed by some participants, suggesting that people are in support of us taking a trauma informed approach.

The training by the DAP was mentioned as a positive in South Glos. It was also commented that it was appreciated that the DAP were seeking people's opinions and doing this engagement and the needs assessment more widely, which is indicative of people wanting more conversations with the commissioning team about matters that affect people, as well as taking a lifecourse approach to tackling alcohol harm. It was also commented on that the DAP team are approachable and seen as part of the treatment system which is reassuring. OYSG was seen as a good start for alcohol prevention and early intervention and the fact that alcohol was higher on the agenda now than previously was also thought to be a good thing.

The Online Pupil Survey work was seen as a good thing as well as our work in schools through YPDAS and health nursing. The YPDAS service generally was commented on positively as was the Youth Offending Team (YOT).

This suggests that most of what it is considered we are doing well at in South Gloucestershire is around treatment options available in our community services.

We asked the participants: What are the gaps, problems and challenges in reducing alcohol harm in South Gloucestershire?

This question produced some very interesting and useful discussion. Again these have been themed under key headings.

Cultural and social aspects

There were many challenges discussed, many of these related to the culture of alcohol being very acceptable in society and easy to get hold of, as cited in many of the responses from the first question. Many people commented on the easy availability of alcohol in supermarkets and cafes etc and the need for more alcohol free spaces. It was mentioned that licenced premises have a role to play here and for them to be encouraged to do more alcohol free nights and initiatives etc. Whilst it was recognised that we in South Gloucestershire are not going to be able to change an entire nation's drinking culture, it was felt that we could do more to promote a healthier drinking culture in South Glos.

Stigma around people suffering from alcohol harm was also seen as a barrier for some participants in terms of people not wanting to ask for help or being able to admit they had a problem in the first place.

Prevention and Education

Many participants commented on the gap in knowledge of the public in relation to alcohol and this being a key gap and challenge in reducing alcohol harm. People raised that they don't understand unit information and are therefore unable to make an informed choice about drinking alcohol. It was

also highlighted that not enough people knew how to get help when they needed it and what services and options were available. This was seen as a key gap by many participants.

Another challenge was how to educate people who do not see themselves as being at risk or having a problem. It was felt by some participants that not everyone thought alcohol was their business or their job to tackle and this was a challenge to effectively reducing alcohol harm.

It was also commented on by some participants that they did not feel that alcohol harm was addressed early enough, for example, there was not enough done in schools to educate children about the risks.

The need for training for staff was raised as an issue, for example social workers recognising the vulnerability of alcohol drinkers and ACE training for people to better understand working with trauma and being able to ask difficult questions. It was also felt that capacity could be an issue here, as staff may not have time to have conversations about vulnerability when they have large caseloads.

It was felt by more than one participant that FASD was not known about enough and might be a hidden issue as it is difficult to diagnose and can be covered up by ADHD diagnoses.

Pathways and accessibility

Outreach was seen as a gap by some and this highlighted that as services have been cut and become more generic, outreach has become more difficult and was felt we were missing vulnerable people who are unable or unwilling for a variety of reasons to come to the treatment centres or the GP surgery. The “hidden homeless” population were felt to be neglected in this area and resources and services for this population was seen as a gap.

Leading on from this, low cost rented housing generally and the lack of appropriate dry house and specialist complex needs housing provision was seen as a gap.

Out of hours services were also highlighted as a gap, particularly for those people who need support but are in employment and it was felt by some participants that there was not enough support provided out of usual office hours, such as a helpline.

Transport and geographical issues are still seen as a problem in South Gloucestershire due to the rural nature of the authority and this was seen as an increasing challenge due to lack of funds and more people living in poverty. Although in the “things we are doing well” section above, people thought it was positive that the service operated out of GP surgeries and in three different locations, there was felt to be more to do to ensure that those living in more rural areas and with no access to affordable transport, be able to receive the support they need.

The border with Bristol was seen as a challenge and it was raised that we need to work better with Bristol colleagues to make sure we have equity of service as people tend to move back and forth across the border. The fact that we commission different services was seen as a problem for some as people will receive different treatment depending on what side of the border they are living.

Another gap was that we should be using our connections with other services that regularly go into people’s homes such as the fire service and that we don’t use the opportunities effectively at the current time.

Another gap was raised about supporting people with particular needs around alcohol, for example those with learning disabilities. It was raised that we are not specialising treatment well enough to

deal with their unique issues around this. Targeting older adults, people in the prison population or those just released and links with Domestic abuse services were all seen as gaps by some participants.

Treatment and recovery

Although services were thought of very favourably in the "what are we doing well" section, it was raised that the drop-in element of the service (in the previous commissioning round the treatment centre at Tower Road North had a drop-in daily) was missed. Participants said that there was no longer any reception area which did not make people feel welcome and that there could be a frequent change of rooms which could be unsettling. It was also raised that there was not always appropriate group and 1:1 space offered.

Some participants felt that the merging of the drug and alcohol teams within services had left a gap of specialist knowledge and dedication to alcohol and that there should be a separate alcohol team reinstated.

Support for families was seen as something that was not given enough emphasis, this may be in response to recent budget cuts for this service. Some participants made the point that the FAM service cuts were felt keenly. More information about the family and carers service feedback can be found below.

Some participants felt that there was not enough youth provision and this was therefore a gap. In addition to this, it was raised that there was a gap for Young People transitioning between YP and adult services, and that there was no provision currently for YP detox.

Although the work with UWE was seen as positive, it was still raised as a gap as it was felt it did not go far enough and that more work and time needed to be invested in this. For example attending welcome week. The issues at UWE were also seen as an issue in terms of students being scapegoated for all the alcohol problems in the area and giving better information to freshers around regrettable incidents.

Older people and end of life care was seen as a gap and something that has not been focused on enough. Some participants commented that they felt there needed to be more accessible services for older adults who are drinking, which links into the need for better outreach services for those who may not come to the treatment centre or who might struggle with mobility.

Another gap mentioned was about showing visible recovery and giving people hope and something to strive for. Alternatives to a drinking lifestyle needed to be really visible and achievable for people, was what some participants suggested.

The link between mental health and alcohol was also raised as a gap in current treatment. It was felt by some participants that support for drinkers around their mental health issues were still not working. The fact that there is no integrated strategy for working with people with complex needs was raised as an issue.

Another challenge raised was the balance between prevention and current treatment. Some participants felt that we should be concentrating far more on treatment, while another participant told us that they were concerned about the focus on prevention and a key gap was working with those with the most complex needs and those that were most vulnerable. This highlights a key challenge which is investing in prevention to ensure that people are not getting to a stage when they

need treatment, but also continuing to invest in treatment and working with those very complex people, on limited budgets.

One participant felt that there was a gap of specialist knowledge within midwifery and this needed to be addressed. This fits in with findings from the wider needs assessment and more than one participant felt that there should be more fibroscanning availability across South Gloucestershire to reduce alcohol harm.

Data and feedback

One gap that was highlighted was a risk flagging system that could identify people at risk of alcohol related harm and it was suggested that this should sit in GP surgeries and that more information and advice should be given by GPs.

Some participants felt that data sharing between agencies needed to be improved in order to tackle alcohol harm effectively.

Resources

Lack of resources was a challenge that many of our participants commented on, thinking about how we manage to tackle alcohol harm with dwindling resources. Some participants commented on how resources are split too far between different authorities and agencies and that too much gate keeping went on. Collaboration between the local authority and the CCG was seen as something that needed to improve.

Communications

Our use of effective campaigns was seen as a gap and it was raised that we should be promoting campaigns like Dry January and Stoptober to effectively promote a change in alcohol use and behaviour. Connected to this was more use of social media and websites to get effective messages out to those who need it as this was not seen as something that was done successfully currently.

Partnership working and linking in with other themes

Although joint working and multi-agency collaboration was seen as a positive in the "what are we doing well" section, it was also raised by a number of participants in this section, suggesting that we need to do more to facilitate communication between agencies and look at referral processes and pathways.

The concept of fire-fighting was seen as an issue, namely that while focusing on treatment of alcohol harm or the other factors influenced by alcohol that we are always treating the symptom rather than the underlying causes of it such as poor housing, ACEs, poverty etc. Links and influence into these different areas was seen as a gap and a challenge in how we manage to tackle harm from alcohol in any meaningful way.

Many participants felt that we were not doing enough to meet the needs of those with complex needs and a need for a complex needs strategy or policy came through strongly.

It was also felt that that there were more opportunities for joint commissioning with the CCG.

We asked participants, "What should we be prioritising in our alcohol strategy?"

Many of the answers given to this question were similar to those supplied in the first section about what was important to people. It makes sense that those issues that were most important to people were also often those they thought we should be prioritising.

Cultural and social aspects

Many answers focused on issues around culture change and cost and pressures on the system. It was recognised that there were issues around reducing funds and that this might limit what we were able to do, but that this could also mean a more focused and efficient way of working. Lobbying on national issues were seen as important by some participants, such as minimum unit pricing and taking a public health approach to limiting alcohol harm.

Creating a positive culture around non drinking was seen as a priority for some participants, recalling what was mentioned in questions about gaps above around there still being a stigma about not drinking and this was based on negative experience, i.e. having been dependant and needing to give up, or being boring or deficient in some way. Participants asked us to prioritise celebrating spaces and lifestyles that did not include drinking, to make this more acceptable in the eyes of society and something that was seen as the norm, rather than an exceptional or religious preference. Focusing on creating alcohol free spaces and encouraging mindful drinking movement with organisations like Club Soda were also mentioned.

Tackling stigma and promoting campaigns were all mentioned numerous times by participants.

It was also mentioned by some participants that we should be careful not to vilify alcohol completely as many feel that alcohol plays a positive part in their lives, for celebrations and social occasions and helping with confidence and building friendships.

Prevention and education

By far the most popular theme for this section was around education around alcohol and its harms, both for children and adults. This links into all the comments above around education in terms of what is working well and not so well. It was clear that participants felt that the strategy should have a clear education element to it to set out how we intend to raise awareness in South Gloucestershire of alcohol harm, particularly around work in schools.

Many participants were clear that we needed to have a more effective prevention focus in our strategy to stop people from developing a problem with alcohol in the first place. However, there was a word of caution from a number of participants who told us that we should not become so focused on prevention (often seen as focused at middle class “hidden” drinkers) and lose sight of those who are the most complex and in need of specialist treatment.

There were many comments about GPs being able to provide more support to reduce alcohol harm and that we should be prioritising this. Training for GPs on IBA right up to providing more community detoxes was suggested.

Treatment and recovery

Harm reduction was still seen as an important priority and it is clear that our strategy needs to focus on harm reduction and treatment for those most in need, whilst also having a section on prevention. The challenge is the balance of this with limited resources. Some participants felt we should focus on the “revolving door” of treatment and look at ways that we can tackle the “bottle neck” of more and

more people needing specialist treatment and look for ways to reduce this harm and be more pro-active about high risk users of our services. A blue light approach might be appropriate for these people.

Treatment itself was also seen as something we needed to be prioritising and to make sure that we were ensuring the best possible treatment, making it easy to access, with varied and evidence based interventions, from groupwork to detox targeted interventions for different groups and adequate wraparound support. One participant suggested the system needed to be redesigned to match demand and it was mentioned by many participants that there had been a large increase in people needing alcohol support with no extra provision. Outreach was also mentioned as a priority.

Visible recovery was mentioned by a number of people in the groups as an important priority. The need for people in treatment to be able to relate to the people around them and be inspired and have hope in their capability for change was seen as important. Handing more power and decision making over to the people that use our services or who have lived experience was suggested. Better use of mutual aid including SMART recovery and Alcoholics Anonymous (AA) was also seen as something that should be prioritised.

Older people and the theme of loneliness also came through as a priority. This was also highlighted as a gap in the earlier section and the fact that we do not have a strategy to work with an ageing population in South Gloucestershire on the subject of alcohol and our services are not well set up for the needs of elderly people. However loneliness does not only affect older people, so this may be something we need to explore in a wider context and with mental health and well-being colleagues.

Accessibility and pathways

The life-course approach was supported and it was felt strongly by a number of participants that this should we the way we are working in future. Alcohol use in pregnancy as well as older adults and end of life care were all mentioned by participants as a priority so this would support a life course approach.

Mental health and the links to alcohol were seen as a priority by many participants. They wanted us to focus on the barriers that those with mental health problems face in accessing alcohol treatment and vice versa. Pathways between services more generally was also seen as important and something that needed to be developed further through the strategy.

A number of participants felt we should be focusing more on Family support and involving people's families in treatment. Family and carers support has faced a significant reduction in funding in the last few years and this was felt keenly and felt that there was a need to look again at this in our strategy.

Data and feedback

Some participants felt we should focus on licencing and working with our licencing colleagues to see how we could better use data and influence in this area. Tackling low cost alcohol was also mentioned.

Other themes that came up as priorities were around our use of data, tying into gaps that people saw in previous sections around our effective use of data and how to use this in tackling alcohol harm and better multi agency working. Some people felt we should be prioritising crime and disorder and emergency services.

Communications

Linked to this was promotion of services and where to get help along with communication of campaigns etc. Many participants felt we should prioritise ensuring that people knew where to get help should they need it, at all stages, whether they just wanted some information about cutting down, to if they were worried they were dependant on alcohol and needed treatment.

Partnership working and linking in with other themes

Housing was also mentioned by some participants as being a priority area of focus. It was clear that without suitable, safe, secure housing, people were very unlikely to be able to make the changes necessary in their lives to be healthy and we should be doing more to ensure that housing is available for those people that need it in South Gloucestershire. Linked to this was people's views about benefits and the benefit system often acting as a barrier for people, another thing we may want to consider in terms of lobbying.

Taking an ACE approach was also mentioned as a priority for our participants.

Health inequalities came up as a theme that participants felt we should be prioritising, ensuring that we do not lose sight of the wider determinants of why people might be drinking in the first place, or why they might be more likely to have worse outcomes due to drinking.

Border issues were also raised by more than one participant in relation to disrupting treatment pathways. Participants wanted us to work more closely with Bristol colleagues and set this out in our strategy to ensure that this is a seamless as possible.

Feedback from our partners was considered alongside the feedback from the HWBB &SSCSP and the data and evidence when formulating the strategic recommendations for this needs assessment and the development of the new Alcohol Strategy. These included increasing preventative and early intervention work whilst ensuring particularly those with complex needs are provided with treatment; raising awareness of units and cultivating the acceptability of an alcohol-free environment. Additionally some of the feedback was synonymous with actions to consider which were formulated for sections 4 to 8. Those not already covered specifically and which will be considered when producing the new Alcohol Action Plan are:

Actions to consider

1. Learn lessons from the Smokefree model.
2. Increase advertising of what our services provide and what is on offer in South Gloucestershire.
3. Utilising services that regularly go into people's homes such as the fire service to give brief interventions and signposting.
4. Increase the work at UWE.
5. Increase the availability of FibroScan screening across South Gloucestershire.
6. Lobby for awareness raising of alcohol harms on alcohol labels.
7. Offer the right treatment to the right person at the right time.
8. Work towards providing, sourcing or lobbying for suitable accommodation for higher risk or dependent drinkers; and the need for low cost rented housing, appropriate dry house(s) and specialist complex needs housing provision.

9. Use a Blue Light Project approach for drinkers who are not in contact with treatment services but who have complex needs.
10. Lobby for improvements to the benefits system.
11. Better agreements to treat people across borders.
12. Provide suitable support to deal with trauma and ACEs.
13. Ensure an ACE informed approach is used in our work.
14. Better use of mutual aid including SMART recovery and Alcoholics Anonymous (AA).

9.3.2. Partners "mop up" survey

We were aware that not all stakeholders invited to the three stakeholder events were able to attend, so we sent out a survey to those people asking the four questions. 17 people responded to the survey and their answers are summarised below.

What are the most important things to you in relation to alcohol?

Many of the responses focused on education and informing people of the harms alcohol can cause before it becomes a problem. Being able to recognise the impact it has on people and ensure they get the right support was also mentioned. Some respondents didn't drink or only drank in moderation and therefore didn't think it was an issue for them. More than one respondent mentioned the need for balance between alcohol's positive elements and the negative harm it can cause, with some participants stating they enjoy drinking in moderation and would like this to continue.

What are we doing well at to reduce alcohol harm in South Gloucestershire?

Many of the responses focused on people not feeling informed enough to comment on this question. Others felt that South Gloucestershire was good at raising awareness of the issues and that holding events was a positive. A couple of respondents mentioned our Young People's Drug and Alcohol service and Adult Community provider in providing education and support to people using alcohol in a problematic way. Another respondent mentioned that OYSG tackling alcohol harm was also a good thing.

What are the issues that are stopping us from tackling alcohol harm in South Gloucestershire?

Respondents felt that the need to provide holistic care can be challenging, with particular reference to appropriate support for those with co-existing alcohol and mental health problems. Others commented on the difficulties of changing what can be entrenched and socially accepted behaviours and people not realising that they have an issue in the first place. A lack of education and prevention was seen as an issue. Another participant mentioned funding being a challenge to effectively reduce alcohol related harm. Not enough access to residential rehabilitation was seen as a problem by one participant. Licencing issues around 24 hour sales and cheap, strong alcohol sold in supermarkets was also mentioned.

What should we be prioritising in our strategy?

Education came through strongly in responses to this question. It was felt that getting the message out to people about the risks and where to get support needed to be prioritised, with hard hitting messages about alcohol harm being suggested by one respondent. Being aware of Foetal Alcohol Syndrome Disorder (FASD) was also mentioned by one participant and the need to make people more aware of this. Accessibility and appropriateness of services was also mentioned with travel

being an issue for some. Taking a multi-agency approach to tackling alcohol harm as well as seeing alcohol within its wider context (for example ACE's) was suggested as a priority. Lobbying the government about low cost alcohol was also seen as something we should prioritise.

There was another box for any further comments and two respondents completed this section. One was giving more detail about FASD, specifically concerning the possible link between FASD and offending behaviour. Another respondent commented that there is evidence to suggest that alcohol can have a positive impact at low levels on things like well-being and that socialising in a pub can tackle loneliness for example. This respondent urged us not to forget the positive impact alcohol can play in people's lives in our strategy.

Specific feedback from stakeholders completing the written survey which will be considered when producing the new Alcohol Action Plan include:

Actions to consider

1. Review accessibility to residential rehabilitation treatment.
2. Lobby the government against strong alcohol sold in supermarkets.

9.3.3. Public survey

Although members of the public were invited to the stakeholder engagement events we are aware that these were almost exclusively attended by people who were working or had some sort of professional interest in the alcohol field. We therefore also sent out a survey, advertised on social media, asking the public the four questions we asked at the stakeholder events. 8 responses were received and the answers are summarised below.

What are the most important things to you in relation to alcohol?

The answers to this were varied but mostly focused on supporting people to get help where they need it and trying to moderate drinking to safer levels. One respondent pointed out the money spent in relation to alcohol and that this was important for them.

What are we doing well at to reduce alcohol harm in South Gloucestershire?

Similarly to our stakeholder responses at the events, some of the respondents replied that they did not know what we were doing well at, which could show a need to better advertise what services and support are available in South Gloucestershire. One respondent felt we were doing well at educating young people in schools on the risks of drinking and another commented on changes in licencing and the Challenge 21 and 25 campaigns having made a difference in underage sales in the area. Another respondent felt that we were doing well at publicising the risks of drinking more widely with information about safer limits.

What are the issues stopping us from reducing alcohol harm in South Gloucestershire?

More than one participant mentioned funding challenges and money generally being an issue, stating that cut backs mean that it can be challenging to tackle alcohol harm and that wealthier people find it easier to get support for alcohol related issues. Another participant stated that there is too much of a focus on "hardcore" drinkers, when there is a wider hidden problem of socially acceptable drinking behaviours that can cause harm as well. The addictive nature of alcohol and the fact that a problem can grow over time without people realising was also mentioned.

What do you think we should be prioritising in our alcohol strategy?

Much of these comments focused on education and ensuring the message gets out to people about alcohol related harm and where to get support if they have an issue. One responder mentioned that there should be targeted interventions specific to age or group as people's needs will be different. Another responder mentioned ensuring there was support for family members and loved ones as they can be adversely affected by someone's alcohol use. Another mentioned focusing on underage drinking and sales.

There was a box for any further comments but no respondents completed this section.

Feedback from members of the public completing the written survey has already been considered in the strategic recommendations and the 'actions to consider' suggested so far.

9.4. Family and carers

Separately from the above events where we invited stakeholders to attend, the Programme Lead of the DAP attended two groups of the Family and Carers service (FAM), one in Yate and one in Warmley. The Yate group had a greater attendance and was more relevant for alcohol, whereas the Warmley group had fewer attendees and had been affected more by drugs than alcohol so requested to be involved when the drugs needs assessment was being completed. Notes were taken by the Programme Lead at both of these groups and participants were also given the opportunity to feedback individually by completing a questionnaire with the four questions on.

By far the biggest theme and opinion coming through from these sessions was the need for greater family and carers support. It was raised at both groups that the reduction in funding for the service over the last few years had been felt keenly and that although the service had continue to provide groups and 1:1's which they were clear they relied upon and felt were a huge benefit to them, they had lost really useful things like talks from relevant people on drug and alcohol related issues and social events, etc. The service was felt to be over-subscribed and the co-ordinator described that she was seeing a lot of people across the region and working over the normal working hours to try to give people the support that they needed.

The four questions were asked of participants although much of the session was more general and related to their feelings about the service and the issues impacting on them and their loved ones more widely:

What are the most important things to you in relation to alcohol?

Some participants felt the health of their loved ones, both mental and physical was really important and that there needed to be more support for family members around this.

What are we doing well at to reduce alcohol harm in South Gloucestershire?

It was felt by all participants that it was positive that a Family and Carers service existed at all and that being able to share their experiences and getting support through FAM was really important. They felt that having a professional involved in the meeting was really important, in order to guide and give advice and the particular staff member involved in these groups was clearly very highly thought of and commended for the work she was doing. Learning coping strategies and feeling heard were key to this. Getting support from other people who could understand some of the

challenges family members were facing was really important and this was felt to be a good thing in South Gloucestershire.

What are the issues that are stopping us from reducing alcohol harm in South Gloucestershire?

It was felt by participants that there was not enough support generally due to the service having faced cuts over the past few years and that not enough people knew where to go to get support if they were concerned about a family member's drinking. It was also felt that there should be better pathways into detox and more options to detox and better understanding of people who had mental health issues alongside their alcohol use problems. Tackling stigma was also raised as an issue, both for those who were drinking but also those around them who are affected. It was also raised that waiting lists were too long for other services which is a challenge.

What do you think we should be prioritising in our strategy?

Support for families and carers was seen as a key priority for these participants, perhaps unsurprisingly. They also however focused on prevention and education, with the need to try to prevent people from getting to the point where it impacted on themselves and their families and needed specialist treatment. Giving people other options other than drinking, in line with wraparound support and other activities, rather than just an abstinence approach was seen as important as well as having visible recovery and modelling of positive family behaviour. It was also felt important to continue support beyond when someone had stopped drinking, to give them support in their recovery and give them other things to do.

Other comments

There was also more general discussion around people's thoughts. One participant suggested that there should be analysis done on how much money services like FAM save the NHS and other services. It was felt that getting the support from FAM meant that people were less likely to attend at their GP surgery and that services like FAM took pressure off the system and reduced cost. It was felt that co-ordination of the service used to be better and participants were keen to have more practical support around issues such as mental health, nutrition and food, encouraging a healthy lifestyle. They also again requested more talks about the nature of addiction and more training for family members to aid their understanding.

As well as taking part in the group session, some participants also contributed afterwards by email. Most of the comments were in line with those above and concentrated on greater support and better understanding of the needs of family members, as well as better links with mental health colleagues and better pathways and joint working for those with mental health issues alongside their alcohol use problems. Better publicity of services on buses, toilet doors, and other public places was also mentioned as was better investment in rehabilitation and detox from people leaving hospital.

Specific feedback from family members and carers which will be considered when producing the new Alcohol Action Plan include:

<u>Actions to Consider</u>

1. Increase the capacity for supporting families and carers of higher risk and dependent drinkers.
2. More support for the mental and physical health of higher risk and dependent drinkers.
3. Ensuring the attendance of a professional at FAM meetings.

4. Use a wider range of sites/settings for advertising alcohol-related services such as on buses or in public toilets.

9.5. Adult service users of our alcohol treatment services

As part of the engagement process two South Gloucestershire DAP Specialist Health Improvement Practitioners carried out 1:1 interviews based on the four strategic questions with people who use our alcohol treatment services. Their feedback, captured at the time, is set out below and has been themed.

1. What are the most important things to you in relation to alcohol?

Health Theme

- Well considering I'm alcoholic/need a drink. Unfortunately, it's on a daily basis but the most important thing is getting sober for my health and family.
- Ruining health
- People don't realise how dangerous it is to come off of alcohol. Education about the effects of alcohol on the body.
- Losing inhibitions leads to poor physical health and behaviours you wouldn't normally do i.e. drink driving.
- Physical Health.
- Link to prescribed benzo's – 'I wouldn't be on benzo's if I hadn't drunk alcohol'.
- Health

Education/Prevention Theme

- Education
- Education in schools.
- Education about addiction.
- Not enough knowledge of alcohol harm in schools – start in primary school about the dangers of alcohol.
- Wasn't helped enough when I was younger – my alcohol use is linked to a traumatic childhood.
- Not taught in schools (I'm 20) – education should start in Yr 8.
- Young people and the challenges of getting information to them. Parental education linked to their supplying young people.

Challenging stigma

- Change the stigma towards drug addicts.
- Educating parents without making them feel guilty about their drinking

Treatment Approach

- How to stop!!
- Necessary stages being highlighted to client

- Other services outside of DHI, etc.
- Not thinking.
- Without DHI support wouldn't be alive.
- DHI has been brilliant. Been very supportive and hasn't had a relapse for 18 months – felt ashamed but was welcomed and not judged.
- My sobriety comes first.
- Maintain the groups like SMART, arts and craft.
- Contacting services is good and timescales into them is good.
- Boredom causes me to drink.
- My daughter, my family, my dog.
- Referral to other services is key.
- Make sure SU's can be active.
- Support – access to groups – visual sobriety is important. Need to have someone to talk to and it not be a family member.
- Available support – it's great to pick up the phone and speak to key worker. Groups are great. Local services – they are just down the road. Key worker doesn't judge.
- Habit
- Stay off of it

Advertising/Promotion

- Wish realised beforehand support was available – went to GP as had jaundice.
- Not aware of YPDAS. Advertising of services – didn't know they existed – family member informed them.
- Ban on alcohol advertising - shelves.
- Alcohol is glamourised – it shouldn't be. Soaps are all based around illness (negative) – story lines are unrealistic.
- Promotion of cheapness is a problem.

Social Aspects

- There is a cultural link to drug use, social aspect of alcohol use.
- Social aspect
- Social aspect i.e. Wetherspoons.
- Alcohol is accepted.

Links to Wellbeing/Management of emotions

- Alcohol caused break up of relationship. Domestic Abuse needs to be included.
- Gets rid of the pain for a while.
- People don't think they will be impacted by alcohol – especially binge drinkers.
- It helps me to forget.
- Relaxation
- Boredom

Licencing

- Timings of pubs – they're open too much. Licensing needs to be addressed.

- Opening times – why can you buy alcohol at 9am in a pub? Licensing conditions should be stricter – you can now drink 24 hours a day! It was different years ago – going to the pub was a social event.
- Government should take more responsibility – opening times encourage people to drink and it is too easily available – it sends the wrong message. Off licences and pubs should be managed in a much stricter way. Money made from VAT should be put toward Prevention.
- Price.
- Price – too expensive
- Access
- Price
- Price.

2. What are we doing well to reduce alcohol harm in South Gloucestershire?

Treatment

- The great service that you offer is the advice and then detox and rehab services.
- DHI is good, they treat you non-judgmentally.
- Running groups.
- SMART group helpful.
- DHI; SMART groups.
- Running plenty of groups; DHI; Good support workers; offering support with other needs.
- Support for people and signposting to other organisations. Don't just focus on alcohol, try to improve lifestyle.
- Sessions at the treatment centre. Felt comfortable and easy to access once you know about it.
- Pleased that TRN[iiϕ] have an AA meeting. DHI do a lot of things really.
- The structure of the groups is good. When people start service the process is set out well (prep for change, into action, RP, SMART). I carry cards with me in case someone says they need it.
- Support around access is good. Call back from staff. Comprehensive assessment is useful and relevant. Non-judgmental when returning to service. Digital input is useful.
- Access to treatment is good and I need to access different types of treatment – can't do AA as they only allow one person to talk at a time.
- GP access to alcohol services.
- Police letter to alcohol services meant that I became aware of services.
- Listening to others helps. Good to have somewhere to come and listen to others. Helps to have hope and relax.
- Coming to meetings is useful. Art Therapy sessions good. Ability to come back is important.
- SMART. Awareness/education.
- Groups and 1:1's. FAM service. Access to staff.
- Right staff are in place/ Right to have structure & plan in place. Good that the detox is not the end of the story.
- 1:1 sessions; don't know what else there is.
- Good access. Staff talk sense. GP refers. Found out through word of mouth.
- Helps to talk to others in the same situation/understanding – not feel alone.

ϕ TRN is the Treatment centre in Tower Road North, Warmley.

- Comfortable returning after relapses.
- Like that the approach is not 12 Step and that you don't just talk about alcohol.
- SMART
- Awareness of the damage alcohol does – not just to people who are addicted - FAM
- All I can say is you guys do a great job and keep it up. Thank you!!
- DHI is great. Can be honest and freedom. Non-judgmental.
- DHI is amazing and has helped me a lot.
- GP was my route through to services.

3. What are the issues that are stopping us from reducing alcohol harm in South Gloucestershire?

Education/Training

- Lack of education in schools.
- Secondary school advice is really needed.
- Drs should be aware of the links/signs of alcohol misuse – depression and alcohol consumption should be taught.
- No information provided by or asked by midwives.
- Educate children in schools.
- Get people with lived experience to go into schools.
- Awareness of the damage.
- Awareness of addiction if don't suffer from addiction.
- Education
- GP's record alcohol use but don't do anything about your score – they don't act on the information you give them.
- No-one understands what a unit is.
- Education needs to be better across all ages.
- SEND information – there isn't really any information available in a format accessible to SEND pupils

Advertising/Promotion

- More advertising – public transport?
- Advertising – need to do it in Wetherspoons.
- Could include alcohol services number on the legal bits of pubs – weights/measures.
- Advertise in Downend Voice/Yate version on a regular basis – not just one off specials.
- 'Drink responsibly' is not a good statement.
- Advertise in libraries.
- I didn't know DHI existed until my GP made me aware.
- General public campaigns to address health risk of alcohol.
- GP adverts.
- Advertise in Wetherspoons.
- Advertise in local papers i.e. Downend Voice – monthly paper.
- Link in with breweries around their labelling.
- Get pharmacies to display information and restock it when it has gone.
- Pub and club booklets.

- Advertising of alcohol – look into what happened with smoking and how that was influenced.
- Sponsor local events and teams.
- Consider literacy in advertising
- Advertising in GP's.
- Promotion of alcohol free events.
- No – not enough promotion of services to address alcohol – even on TV there is never any follow up to say where you can get help.
- What is out there?
- Where do you go? More advertising in Dr's surgeries.
- Social Media/Recycling boxes.
- Going into big companies to promote services.
- Didn't know where to get help.

Treatment

- The Drop-in Café, stopping has not helped people at DHI, as they have nowhere to go, especially when they get clean, they have loads of time on their hands and having nothing to do is a big trigger to relapse.
- More regular contact from support workers (appt) would be helpful. My support worker is not hands on enough.
- Lack of resources.
- Awareness – don't know about services. People not aware you can refer yourself.
- Need more things to fill time – there are different types of opportunities.
- Promotion of meetings and AA helpline would be good.
- Miss the drop-in – having a chat at different points is important and being able to is hard.
- A chat forum would be useful.
- Not being able to interrupt in group – shouldn't turn people away from all groups.
- SMART meetings can be good but depends on who is leading it. Can't butt in – can't remember.
- Family not always a good source of information as very few addicts listen to family members nagging.
- Family are useful once in treatment.
- People are blinkered about alcohol – there isn't any primary prevention.
- Need to have TRN as a drop in centre.
- Peer pressure will be difficult to crack.
- Not targeting those who need low level help – at A&E & binge drinkers.
- We need to have an alcohol nurse at GP surgeries like you have diabetic nurses.
- AA – thought it was the only way to stop and didn't want to join.
- Complaints don't get resolved quickly enough/escalated.
- GP told DVLA and lost my licence!
- More rehab.
- Funding needs to go up.
- Rehab – you need to want it and it must be a minimum of three months – keep money available for it.
- Detox in the community is difficult to manage.
- I have no idea. GP talked to me about alcohol.

- Make drop in available.
- Re-introduce music classes – i.e. give clients something to look forward to.
- Difference between YP and adult services id quite big – no transition worker

Licencing

- It's widely available.
- No bars without alcohol – why no non-alcoholic beers or wines available.
- Routes of sales – thinking about the licensing links/slap engagement in the discussion. Also the potential vendor vulnerabilities.
- No alcohol free venues – what are the options for those choosing not to consume alcohol.
- No alcohol free places to go.
- Alcohol is too freely available
- Legal status of alcohol contributes to use.
- Units are nothing – no point to them at all.
- No Community Alcohol Partnership (CAP)

Social/Cultural Aspect

- Alcohol use is pushed to the side/under the carpet.
- There are too many alcoholics in the town centre who don't care about anything.
- People are blinkered about alcohol – there isn't any primary prevention.
- Too accepted – lobby the government.
- Stigma
- Legal status of alcohol contributes to use.

Multi-disciplinary working

- Links with DV services.
- Crisis teams being able to contact DHI
- Links with MH need improving – their awareness.
- Other agencies being more proactive.
- Links between Bristol and South Gloucestershire – make surrounding areas aware of our services as there is the potential that they may be accessing GP elsewhere etc.
- No gaps from my point of view.

4. What do you think we should be prioritising in South Gloucestershire?

Treatment

- Basically you are doing good but maybe putting people who are really determined to stop in a detox asap.
- More regular contact with support workers.
- Instead of making client do the groups, give more access to courses or stuff to replace alcohol/drugs.
- How to control the amount you drink.
- Getting clients to meetings is important and could be addressed.
- Refreshments and something to eat would be good.
- Prep for Change group needs to continue.
- Make services OK for people to just come and have a chat.

- More 1:1 and more group work provision.
- Make it so peer mentors could collect SU's and take them to the treatment centre.
- More through care/aftercare services.
- Funding needs to go to people not make it so that there is 5 different bits of paperwork to complete.
- Open sessions
- Awareness of meetings
- Not enough funding – too many waiting lists
- Recovery Café – shouldn't have gone and has had a very negative effect on people.
- Messed up making treatment centre appointment only.
- Needle exchanges – all pharmacies should be needle exchanges. They should feel a duty of care to their clients.
- Somewhere to use safe – shooting galleries.
- Awareness of mutual aid sessions – get the info into social and supported housing
- Funding not enough
- More SMART groups should be about – will reduce waiting times.
- More opportunities to do groups.
- GP is a great help.
- Regular drug screening/prescribing sessions.
- FAM
- Make drop in available.
- Re-introduce music classes – i.e. give clients something to look forward to.
- Taken a lot of general support services away from places where you feel comfortable and not judged.
- Nowhere for people to drop in.
- A and E is a missed opportunity to get 18-25 year olds who need information about alcohol

Advertising

- Advertising of services – only knew through GP.
- Stop advertising on TV.
- Advertising.
- More advertising - surgeries.
- More awareness.
- Advertise on cashpoints.
- Link up with gyms and big businesses
- Local sponsorship of sports team by services
- Use social media more.
- Media links need to be improved.
- Advertising needs to be better.

Social/Cultural change

- Stopping/changing stigma about drug addicts, more education.
- Loneliness is a big issue.
- Fights tend to be caused by alcohol.
- Government lobbying – schools/surgeries.
- More openness and conversations

- Youth services and youth resources to get young people out of the mindset of alcohol only fun.
- More people should be getting help – people don't realise they have a problem
- Too accepted to drink too much.
- Stigma around drugs – people feels shamed – doesn't help you to engage. Doesn't help you get better.

Education/Groups to target

- Young people should be targeted at an early age about the danger of drugs and alcohol.
- Middle-aged people with alcohol use problems.
- Go to over 50's events, café events, legions, Wetherspoons.
- Getting the message out there about the risks.
- More awareness of health effects of alcohol.
- Education in schools – both children and the teachers. 13 year old daughter's friend was caught taking tramadol, which had been prescribed to her Mother.
- Education at secondary school.
- Senior school education is necessary 14+.
- Education for children about how much of a problem alcohol is.
- Training for GP's.
- Education/schools – start with children and give honest feedback. Educate everybody.
- Parental education – give the message that harmful to their YP.
- Educate school children to educate & call out their parents.
- Youth services and youth resources to get young people out of the mindset of alcohol only fun.
- Effects of alcohol are just not out there enough – people think it's OK.
- Start work in Primary Schools – feels children are starting younger.
- More education needed – why don't we link in with WI meetings, Rotary Clubs, PTA's, etc

Multi-agency working

- Putting in a CAP – Community Alcohol Partnership.
- Link in with Supported housing
- Relationship with police could improve.
- Relationship with Mental Health services could be a lot better and more joined up.

5. Any other comments/suggestions? (Where appropriate, I have moved responses that link with the above questions)

- SU uses 'Club Soda Together' – would be good to have something like that. It's difficult going out and the lack of choice of non-alcoholic drinks.
- Labels of health problems could be put on bottles.
- Short term effects of alcohol use could be promoted on alcohol.
- Calories could be put on the bottle to help people decide.
- Family were the first to notice I had a problem.
- Alcohol can be the default part of other illnesses.
- Sober Raves.

Specific feedback from service users (not already reviewed elsewhere) which will be taken into account when producing the new Alcohol Action Plan include:

Actions to consider

1. Develop a service user engagement plan to obtain regular service user feedback.
2. Restoring a drop-in facility/Recovery Café and/or providing more activities to combat boredom, loneliness and extra time on their hands when people are in recovery.
3. Availability of refreshments at treatment centres.
4. Work with licensing to reduce the opening hours of licensed premises which serve alcohol.
5. Education and/or campaigns to reduce the stigma of alcohol dependency and drug use/dependency.
6. Educational materials and advertising to consider people who have low levels of literacy and special educational needs.
7. Better links with crisis teams for referral to DHI.
8. Earlier access to detox.
9. Advertise the process of alcohol treatment.
10. Education of GPs in recognising the signs of drinking in a problematic way.
11. Education of GPs and non-medical prescribers regarding good practice guidance for the use of benzodiazepine medication in people who drink in a problematic way.
12. Promotion to over 50's events, café events, legions, and Wetherspoons.
13. Develop links with gyms and big businesses.
14. Sponsorship of local events or teams.
15. Think about creative places to advertise such as on recycling boxes.
16. Safe spaces for people who inject drugs and needle exchange to be provided in all pharmacies.

9.6. Young people

A summary of the feedback from the young people group engagement sessions is described below.

1. **Do you think alcohol use is a problem for your age group/in your local area? If so, what are the issues?**

Young people across South Gloucestershire report drinking with friends in community spaces such as parks. While young people do not report this is an issue socially there is a sense this places them in danger or more importantly removes safety – young people report doing things that they do not want to do, that drinking can lead to anti-social behaviour and that it impacts upon relationships within families.

2. **Is it easy for teenagers to choose not to drink alcohol? What are the pressures?**

There were conflicting messages from the young people we spoke to – while young people state it is easy to choose not to drink the normalisation of drinking in their peer groups and families is a great influence on behaviour. Young people report wanting to be the same as their friends & drinking to fit in. Alcohol is the most commonly used substance amongst the age groups interviewed. Parents drinking around children is a strong influence, as is permissive behaviour in familial settings.

When asked about messages young people receive from school, family and the media it was felt that information is inconsistent, inaccurate and not given to everyone. Information from school is negative and feels like 'nagging'. Targeting 'at risk' young people means fewer young people receive accurate information. Young people said there was not enough information about safe drinking, how to manage your alcohol consumption and that of others.

Young people felt that they are not 'told the truth'; they are given worst case scenarios which do not feel relevant, & mixed messages from families who permit drinking but give no support with how to drink safely and what is ok. Young people state they would like to be able to talk to knowledgeable people without judgement or repercussions and that effective safety messages given via social media would have more of an impact than assemblies & talks at school. Young people reflected that they did not recall assemblies in school but all remembered alcohol advertising on social media and reported buying particular brands due to this. It can be difficult to manage and balance their own experiences with the information given by school, media and parents.

3. **In what ways can drug and alcohol services reach lots of young people to give them information and help to keep them safe?**

The key message here is the use of social media – if young people saw adverts and had access to credible information this would have a great effect. Assemblies are ineffective as people skip them, lessons are better and young people feel starting harm minimisation work earlier, from years 6 and 7, would be better than starting when people are already drinking and using substances. Young people suggested a website with links – some had used Frank and gave positive reports, many had not heard of Frank.

Harm reduction information delivered across lessons by experts felt more appropriate than teachers delivering information – young people would rather approach an independent body than talk to a teacher, feeling that they may 'get into trouble' and that there is no confidentiality. Young people would like more and better education in school which is also delivered to families Young people said they would talk to a sibling or parents if they needed support.

The information delivered in school and by some media assumes that young people are naïve to drugs and alcohol – they are not and this assumption can mean young people 'turn off' during sessions. Also a lack of local knowledge can affect the reception of information. Sessions and information delivered by peers would be more appealing than teachers and outside agencies who appear much older than the young people they are speaking with. More information is needed within schools. Some felt assemblies and lessons were good for giving young people information.

4. **How do you think drug and alcohol services could help people to make changes? What would you want if you were the client?**

Several responses were for clients to be removed from their environment e.g. go to rehab.

Young people would like access to regular therapy.

Most responses asked for meetings with a professional away from school, for appointments to be a mixture of talking and practical activities, for sessions to comprise information about drugs and their effects especially when used together/mixed with real case studies which are relevant. Confidential meetings and support.

Young people feel harm reduction is an important message.

5. **Why do young people drink in South Gloucestershire?**

There is nothing else to do, alcohol is cheap, available and socially acceptable. Public transport is expensive and unreliable. More people are staying at home rather than going away to university and young people go from drinking in parks to going to the pub together. If people are not drinking they will be doing something else e.g. drugs

6. **What is the most difficult aspect of managing situations where others are using drugs and alcohol?**

Young people felt that they did not have knowledgeable people to talk to – parents give advice but they don't know what they're talking about. Adults were seen as giving bad advice, inaccurate information and having little experience of the social circumstances of their children or pupils. Some young people felt that they could challenge friends more easily than they could challenge a boyfriend/girlfriend, and it was easier to say no to friends.

Some young people said that they and their friends would broadly have the same approach to drugs and alcohol and that they wouldn't be with strangers or people out of their social group. They can rely on friends to look after them if they become unwell, most felt that they could tell parents or older siblings if they needed help – they were keen to stress alcohol information always focusses on the negative and extreme results of drinking, that there will inevitably be a dire consequence when this just isn't true.

Young people can seem resistant to accept the facts around serious alcohol related events and point to other societal risks as a way of justifying their risk-taking behaviour.

The views of some people who are in the care system were also gained at an event where the Programme Lead was present. There were recommendations made about YPDAS workers developing better relationships with social workers and for social workers to receive more training about drugs and alcohol as it was felt that they did not want to ask, or they asked at the first meeting and not again. Activities around drug and alcohol use were also mentioned as something that would be useful rather than just talking to someone about problems.

Specific feedback from young people additional to those already considered for the strategic recommendations/new strategy or identified previously, and which will be considered when producing the new Alcohol Action Plan include:

Actions to consider

1. A range of alternative activities for young people to decrease the attractions of alcohol or drugs.
2. How to make school-based alcohol education more accurate, balanced, pupil-centred and based on their current knowledge, and to include awareness of the '*Frank'* website.
3. How to educate parents to be less permissive of young people drinking alcohol.
4. Alcohol training for children's social workers including the need to ask about alcohol use during the care package/journey through the care system.
5. Stronger links between YPDAS and children's social services.
6. Rehab in an 'away from home' residential setting for young people if necessary.

9.7. Young service users' perspectives

Feedback from stakeholder engagement sessions conducted with 11 service users of the South Gloucestershire Young People's Drug and Alcohol Service facilitated in the spring/ summer 2019 is as described below:

Referral to service

- Easy to refer, via GP, had to try a few numbers
- Was positive about it as was in a bad state, did it for myself
- Good, but was nervous & required teacher to make YP attend
- Relationship with worker is key
- Was good being part of a group before 1:1
- Fine
- Had to be referred due to being caught at school
- Took a while to see drugs worker
- Really fast, a few days after speaking to my teacher
- Didn't know it would be so quick
- Didn't want mum to find out
- Didn't know I had been referred but had reasons explained; was friendly, open & honest

Meeting a drugs worker

- Felt ready & motivated to make change
- Felt excited to talk to someone, didn't feel worried although had social anxiety at time
- Having someone to talk to was what I needed
- Fine
- Was anxious but it was fine
- Was good, wasn't what I expected
- Friendly, knew I wasn't in trouble & explained didn't want my parents to know
- Met in school so easy. Worker explained why we were meeting & I felt it was my choice to work together
- First meeting was alright, you kept calling me clever and it made me smile. My drug worker listens to me
- Really good, gave me phone number and email and stayed in contact with me & other professionals. Sees me when I ask.

Working towards goals

- Easy to make progress but have reached a sticky point due to anxiety
- Used lots of practical strategies
- In long run it has helped, cut down weed although had 1 week of using other drugs. Most weeks have used less
- Quit smoking cigarettes and reduced cannabis but changes are up and down
- Have got my use more under control
- Has been good
- Have stopped using drugs & alcohol
- Helpful, don't have to change what I don't want to. Helped me understand drugs
- Talked about my goals and what they mean to me, good to look back and see what I've done
- These can change but my drug worker is there for me each step and we talk about what I want to change
- Alright, I've achieved my goals but get angrier quicker now that I'm not using

In the future, what could help?

- Hard to imagine a life when I don't smoke
- Having someone to talk to really helps, going over why you did it & how you felt afterwards

- Same level of support around drugs and lifestyle
- Being able to see my drugs worker if I need to
- Not sure
- I know I can text my worker if I need more support and she will see me
- Keep working with service, contact worker if I need to, have check ins
- Not going on my phone so not tempted to call people
- About to move into adult services and will be good if my worker can stay with me for a while

What could have been better?

- A holistic approach helps
- The decisions I've made
- Going over more safety advice
- Meet more regularly
- Nothing really
- Teachers not asking what we'd talked about
- Appointments clashed with revision sessions
- Me showing up when I was in school
- If psychiatric unit had communicated what was going on

Feedback from young service users is largely positive and has mainly been considered in the strategic recommendations and the 'actions to consider' suggested so far.

9.8. Foster and Brown survey: barriers and enablers to alcohol interventions

Foster and Brown conducted telephone interviews with individuals recruited from individual face to face approaches in Yate, Kingswood and Chipping Sodbury[1]. Those selected for the telephone interviews were screened as drinking more than 14 units of alcohol per week and were not currently in treatment for their alcohol use[1]. People drinking at this level would be putting themselves at increasing risk of developing adverse health and social consequences, or their drinking would already have caused such harm. Half hour, semi-structured telephone interviews were completed for 47 respondents who were incentivised with £20 shopping vouchers to partake in the survey[1]. They were asked questions to discover their barriers and enablers for seeking help to change their behaviour[1].

Foster and Brown sent to us a report, although we are unable to include a copy of it in the Appendices. This is because it contains sensitive information relating to numbers of less than 5 interviewees, which could self-identify them or even potentially identify them to others. Instead its contents and findings are summarised and reviewed. Characteristics of the respondents are shown in Table 10 below:

Table 10: Respondents

Demographic	Number (Total = 47)
Gender	Female = 26 Male = 21
Age	18-34 = 9 35-44 = 6 45-54 = 8 55-64 = 16 65 and older = 8
Socioeconomic group (SEG)	A/B and C1= 20 C2 = 14 D/E =13
Recruitment point	Chipping Sodbury = 10 Kingswood = 15 Yate = 22

Source: Foster and Brown, 2019

Self-reported alcohol consumption of the respondents interviewed ranged from 15 to 160 units [revised down to 130 later on reflection by respondent]. The findings of this survey need to be interpreted with caution due to the small sample size.

The most frequently mentioned reasons mentioned for excessive drinking by the respondents included stressful work and mental health issues. Socialising with friends and local pubs were mentioned frequently and serious illnesses and operations, and giving up smoking were mentioned. A number of respondents felt drinking at home was “safe”. Some of the respondents were shocked by how much they drank each week as they had not added it up before.

For the 47 respondents, the higher the amount of alcohol regularly consumed, the worse was their self-reported scores for suffering stress and anxiety. There was evidence to suggest those who drank the most alcohol had lower self-reported general health. The 8 people aged 65+ and who also on average drank the least and reported feeling the happiest and least stressed. They did not feel their alcohol consumption was putting their health at risk.

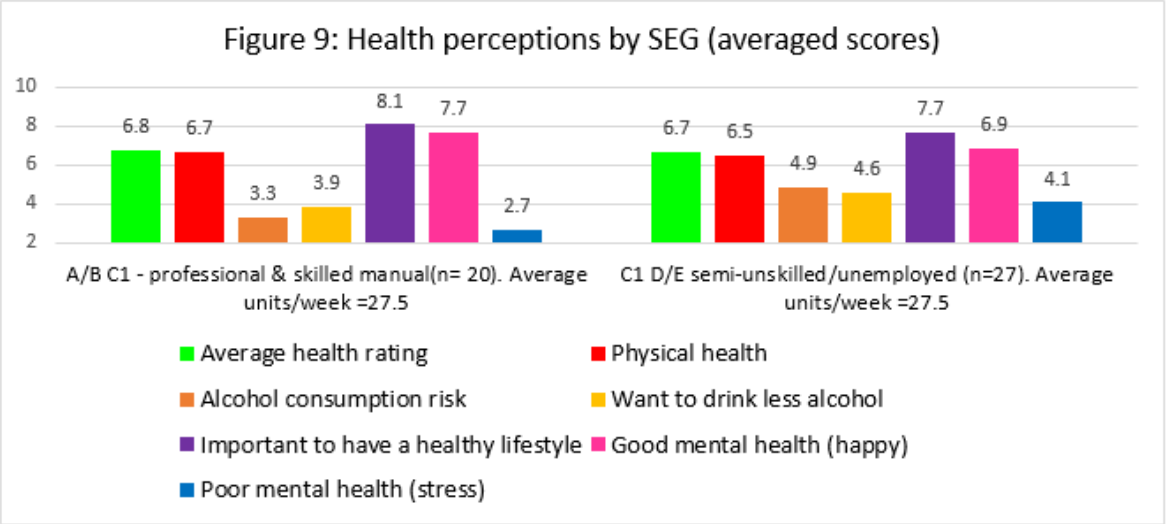
The 14 respondents aged 35-54 and who on average consumed the most alcohol were most likely to want to reduce their consumption. Higher ratings for acknowledging the importance of having a healthy lifestyle increased stepwise with each increase in age banding, whereby those aged 65+ scored its importance as highest.

Amongst this sample, the men tended to drink more units than the females. The females were more aware of how excess alcohol consumption can put their health at risk and more likely to want to drink less alcohol. They also reported being more stressed than the men.

As shown in Figure 51, the 20 respondents in the higher socioeconomic groups (SEG = A/B/C1) rated the importance of having a healthy lifestyle as slightly higher than the 23 in the lower socioeconomic groups (SEG = C2D/E). Similarly those in the higher SEGs were less likely to believe their alcohol consumption put them at risk of ill health and less likely to want to reduce their alcohol consumption

than those in the lower SEGs. There was however no significant difference in the reported alcohol consumption between the two SEG groups sampled.

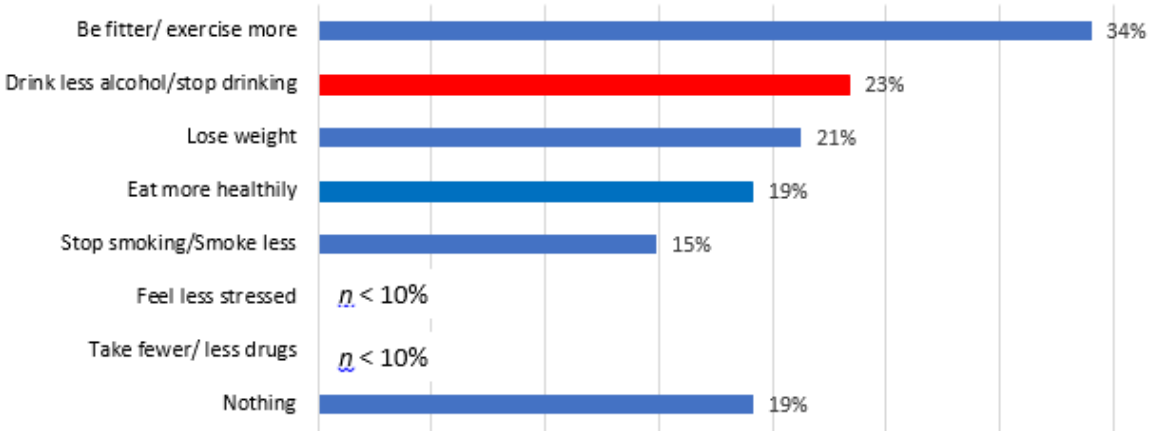
Figure 51: Socioeconomic differences



Source: Foster and Brown, 2019

All 47 respondents were asked which if any healthy lifestyle changes they would like to make. Their answers are shown in Figure 52 below, with getting fitter and/or taking more exercise given as the most popular change, followed by reducing or stopping drinking alcohol. It is possible however that partaking in a survey known to be about alcohol might have biased their answers.

Figure 52: Healthy lifestyle changes



Source: Foster and Brown, 2019

The most popular type of support service to help the respondents to drink less alcohol was felt to be, face-to-face support from the GP surgery. Face-to-face support groups, support to change more than one health lifestyle issue at a time (younger respondents) and face-to-face alcohol (only) specialist were also popular with over half the respondents. These respondents were however successfully recruited face-to-face and therefore this sample might feel more comfortable with such an approach. The least popular options were online support groups, face-to-face at a drugs and alcohol treatment service and face-to-face support from a pharmacist. Given the direct choice, just over half

the respondents would prefer to have one service to support all their healthy lifestyle issues and less than one in three a specialised alcohol service. There was not a great deal of awareness of support services beyond Alcoholics Anonymous (AA), the GP or A&E/hospital-related services.

When asked where information should be placed, the highest proportion mentioned GP surgeries (n=26), followed by Facebook and other social media (n=21), in pubs and or in pub toilet cubicles where people could read posters in private (n=12), supermarkets (n=10), leaflets (n=9), noticeboards (n=9), and online/websites (n=9). 35 used social media and 12 did not.

Actions to consider

1. Trained alcohol specialists to be available in all GP practices.
2. Maximise the opportunities to raise awareness of alcohol harm minimisation and available support with people accessing OYSG.
3. Use social media and settings such as pubs, public toilets and supermarkets for universal and targeted messages.

9.9. DHI service user survey feedback

As part of the commissioned contract, DHI are expected to complete a service user survey with people who use the service every two years. In July 2018, 116 respondents who were engaging with South Gloucestershire Drug and Alcohol services completed a questionnaire about their treatment experiences[2]. Staff and peer mentors encouraged service users to complete the questionnaires at appointments and group sessions. The service users were engaging on account of problematic alcohol and/or drug use.

The majority of respondents were from the age category 25-44, followed by 45-64 and then 19-24. This is representative of the whole treatment service in general. 94% of respondents identified as White or White Other, with 5% identifying as part of a minority ethnic group. This follows the ethnic profile of the population of South Gloucestershire. Of the respondents, 61% identified as males and 39% as female. 56 people self-identified as having disabilities and of these 42 considered themselves to have a mental health condition. 83% identified as heterosexual, 10% preferred not to say and the remaining 7% identified as bisexual, a gay woman/lesbian or 'other'.

The questions asked, analysis of the answers received and some commentary from the collated report is stated below[2]:

(1) Where did you receive your treatment?

38% of service users who responded to this survey were seen in their GP surgeries, with 25% being seen at the DHI treatment centres and a further 25% being seen at both locations.

(2) What are you seeking treatment for?

44% reported as being in treatment for only drug use, followed by 37% for alcohol only and 16% for concurrent drug and alcohol issues.

(3) How long have you been in treatment for?

Approximately 50% had been in treatment for over two years, so would have been able to give views that spanned their experience of treatment both pre- and post-commissioning of the new treatment system. Some had been in treatment for up to 20 years, but 35% did not answer this question.

(a) Have you noticed any changes in your treatment over the last year?

The most positive comments were about interactions with staff and a better service being received, with one service user saying *"My new worker has been more helpful and is very easy to talk to".* The main negative comments were around the withdrawal of the drop-in option at the treatment centre with one client commenting *"drop in now gone which results in a negative vibe as it is not possible to just come and hang out*".

(b) Were the changes positive or negative?

Of the 40% who answered, 30% had experienced the changes as a positive, 6% as negative and 4% hadn't noticed a change.

(4) Can you get to your appointments easily?

85% of service users stated they could get to appointments easily. Of those who couldn't, 8 cited transport issues, 9 cited issues which were either to do with their health, financial circumstances or work commitments.

(5) Are you happy with the venue for your appointment?

96% were happy with the venue of their appointment with the remainder unhappy or not answering the question. Re-commissioning brought services into GP surgeries more and another treatment site was opened in Patchway, which was reported as being liked by service users.

(6) How often do you see your key worker?

A third of clients stated that they were being seen on a weekly basis, with 50% being seen fortnightly, which ties in with substitute prescribing practices for drugs other than alcohol.

(a) What groups have you attended?

Service Users reported that they had engaged with a variety of groups including preparation for change, into action, relapse prevention, SMART recovery, fellowships and wellbeing groups. 20% of service users stated not attending any group sessions.

(b) Are you happy with the support available to you?

Of the service users completing the survey, 97% stated that they are happy with the support available to them. When asked, what would improve their treatment experiences, the main responses were more groups, more time with key workers and more practical help. Some comments were: *"If you could let us keep one worker they change all the time!"*; *"Acupuncture at Patchway, more Smart meetings at Patchway"*; and *"Being made more aware of what's available to you - like signposting. It would be good to know what is going on."*

(c) What would improve your treatment experience?

The most popular answer for this question (albeit in less than 10% of respondents) was for a greater availability of groups, the next most popular answers were for increased appointment times/frequency (less than 5%) and more practical help (less than 5%).

(7) If you are in Shared Care, do your primary care worker and GP work well together?

Just over half of those completing the survey were not in shared care, with 44% in shared care. Of those in shared care, three quarters felt their GP and primary care worker worked well together.

(a) Give an example of how your primary care worker and GP work together:

Service users highlighted positive experiences with their prescriptions being ready and encouragement by staff to come off of meds or support with other areas. Negative comments came around poor pain management and mental health support.

(8) Have you met any peer mentors during your treatment?

Nearly 50 service users said they had come into contact with peer mentors. Of these 50, eighteen were solely being seen at the GP surgery and just seven had come into contact with peer mentors at the treatment centre.

(9) How would you rate your treatment with South Gloucestershire Drug and Alcohol Service

Of the 116 responses received, 14 service users didn't rate the service. Of the 102 service users who did rate the service, 77% rated the service at 8 or above out of 10.

(10) Do you feel well connected to activities going on in your community?

Half of the respondents felt well connected to activities going on in their community, with 28 % not feeling connected.

(a) Has your key worker supported you to become more involved in your community?

Two thirds of respondents felt they had been supported by their key worker to become more involved in their communities, with 12% feeling that their key worker had not supported them with this.

(b) How could we help you to get more involved in your local community?

A quarter of respondents were happy with the support they were currently receiving around community support but another quarter felt that more information was needed to enable them to engage with the community. Respondents also said they needed more encouragement to engage with communities, help getting to community activities and that times community events were held were not compatible with their schedules.

A more detailed description has not been included so as to preserve service user confidentiality where small numbers were involved.

Specific feedback from service users (not already reviewed elsewhere) which will be taken into account when producing the new Alcohol Action Plan include:

Actions to consider

1. Discuss retention of key workers with DHI, and consider this issue when recommissioning.
2. Greater support for, signposting to, and information about community involvement

9.10. Residents' views on problematic drinking behaviour

In 2017 the Viewpoint panel numbered 1,127 South Gloucestershire residents who volunteer to be consulted on a range of topics[3]. The Viewpoint November 2017 Public Health Survey report included

information about their views on four local problematic drinking behaviours and how satisfied they were with the council's responses[3]: The behaviours surveyed were:

1. Excessive alcohol consumption
2. Drinking in public
3. Underage alcohol sales
4. Young people drinking

59% of the panel (n=6650) responded[3]. Although weighting was applied in an attempt to make the responses representative of the local population in terms of numbers living in priority neighbourhoods, gender and ethnicity, it could not be done for age[3]. The survey answers are therefore significantly biased towards over 45 age groups and cannot be seen as representative of those aged 16-44[3].

The majority of respondents to this survey (89%) did not perceive there to be a big problem with excessive consumption of alcohol in their neighbourhood and only 12% were dissatisfied or very dissatisfied with how the council were tackling the problem[3]. Most (39%) expressed not knowing what the council were doing about it, or were neither satisfied nor dissatisfied (28%) about the Council's actions[3].

Most respondents (95%) did not think there was a big problem in their local area with drinking in public spaces, perceiving it to be either not a problem (39%) or only a small problem (48%)[3]. The majority were either satisfied (22%), or neither satisfied nor dissatisfied (27%) with how the Council were dealing with it[3]. Most (35%) expressed not knowing whether they were satisfied or dissatisfied with how the Council were dealing with drinking in public. A further 6% were very satisfied and 2% very dissatisfied[3].

51% of respondents did not know whether there was a problem in their local area with underage alcohol sales of alcohol. 28% considered it to be a small problem, 15% as not a problem and 7% a big problem[3]. The majority (48%) did not know whether they were satisfied or dissatisfied with the way the Council were dealing with underage sales. 23% were neither satisfied nor dissatisfied. 14% were satisfied, and 11% were dissatisfied. 3% were very satisfied and 1% very dissatisfied[3].

40% thought there was a small problem with young people's drinking in their local area, with 30% not knowing, 14% considering it a big problem and 13% not a problem[3]. The majority (46%) did not know whether or not they were satisfied with the way the Council is tackling young people's drinking. 24% were neither satisfied nor dissatisfied. 14% were dissatisfied and 12% satisfied. 2% were very dissatisfied and 2% very satisfied[3].

9.11. Views on NHS spending for alcohol interventions?

The Healthier Together Citizens Panel was set up by BNSSG Clinical Commissioning Group to understand the needs and wants of the Bristol North Somerset, and South Gloucestershire population so as to inform local decisions relating to health outcomes[4]. Comments noted when the panel were asked their opinions about differences in spending/support according to a geographic area's level of deprivation included *"…alcohol and drugs classes should be made more available in*

deprived areas"[4]. In reply to a question about whether or not they would favour the introduction of a 12 week course to improve health before elective surgery, one member who was against this replied *"…I'm dying as an alcoholic. But it's down to me to stop"[4].*

9.12. References

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[2]Hamman-Wills, E (2019) Survey User Questionnaire feedback - South Gloucestershire

[3]South Gloucestershire Council (2017) Viewpoint, Research Report, Public health survey, November 2017, Available at http://www.southglos.gov.uk//documents/Public-Health-Viewpoint-Report-November-2017.pdf

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10. Economic evaluation

10.1. Background

In England, 25% of the population (33% of men and 16% of women) consume alcohol at levels that increase their risk of alcohol-related ill health[1]. Alcohol misuse is a major risk to health, causing a range of cancers, heart disease, liver disease and mental health conditions among others. Around 24,000 people die from alcohol related causes each year, with an average age of death of 54. Whilst it is now accepted that there is no 'safe' level of consumption, the more alcohol that is consumed, the more the risk of harm increases. Alcohol misuse does not only affect the drinker. Alcohol is a factor in many crimes. Approximately 18% of children in need are affected by alcohol misuse and parental alcohol misuse is involved in over a third of serious case reviews[2]. The annual cost of alcohol related harm to society in England is estimated to be at least £21.5bn.

Table 11[3] Annual cost of alcohol related harm to society in England

	England (£ billion)
Criminal Justice	£11.4
Workplace and wider economy	£6.4
Healthcare	£3.5
Drink driving	£0.16
Total	£21.5bn

There are, however, many evidence based, effective interventions available to both prevent alcohol dependence developing and to support those who have developed a dependence through treatment and into recovery. Nevertheless, councils have been subject to unprecedented financial pressure in recent years and so it becomes ever more important that available money is spent in ways that produce the most effective and most equitable population health and wellbeing outcomes.

Commissioners must decide how to divide their alcohol funding between treatment and prevention. Historically, a far greater proportion of public health alcohol budgets have gone into treatment, partly because the evidence base for treatment was (historically) stronger but partly because the population who require treatment present with more immediate and visible problems than the population that require prevention.

Indeed, the success we have seen in reducing rates of tobacco use are likely to have come from the use of wraparound interventions, covering primary, secondary and tertiary prevention and including, pricing, advertising, treatment and legislation. Creating a culture change in the way society views smoking. Whilst some of these activities would be more effectively addressed at a national level for alcohol, we still have powers to influence some of these factors locally.

The purpose of this report is to examine the available options for treatment and prevention of alcohol misuse. It will look at their effectiveness and cost effectiveness, in order to inform commissioning and planning decisions in South Gloucestershire.

10.2. Reducing Alcohol Harm - The local context

In South Gloucestershire it is estimated that approximately 49,000 individuals, or almost a quarter of adults drink at levels that are likely to harm their health and almost 10,000 people (1 in 20 adults) require treatment for alcohol misuse[4]. Approximately 1% of adults (2,100 people) in South Gloucestershire are estimated to be dependent on alcohol[iii]. This is lower than the England average (1.39%), but not significantly so[5].

South Gloucestershire has been identified as having one of the highest levels dependant drinkers not accessing treatment in England, with estimates that at least 90% of dependant drinkers[iv] are not in treatment[6].

South Gloucestershire had a total drug and alcohol budget of £2.104 million for 2019/20. This has decreased from £2.476 million in 2016/17. The budget includes all staffing, commissioned treatment services, prevention and early intervention work for both drugs and alcohol. Drug and Alcohol treatment services are commissioned in a block contract from the provider DHI and so it has not been possible to accurately estimate which proportion of the budget is spent on drugs and which on alcohol.

[iii] (AUDIT score 16-19 and SADQ score of 16+ or AUDIT score over 20 and SADQ score of 4+.)

[iv] This may have been impacted by methods used to record alcohol users in treatment – many of whom came in on a non-structured basis. This has now been changed and so it is likely there will be an increase in the numbers in structured treatment for alcohol as a result

10.3. Effective Prevention and Treatment[7]

There are 4 broad levels of alcohol prevention and treatment (see Figure 53 below). A combination of interventions are needed to reduce alcohol-related harm and to identify the root causes of alcohol misuse in society which Public Health England consider to be: the addictive nature of alcohol, limited understanding of health risks of alcohol, failure of health professionals to address alcohol as a causal factor in ill health, socio-economic deprivation and lack of local system join up.

Population level primary prevention: These are interventions that work at a population level including people who may not drink at all. Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:

- those who are not in regular contact with services
- those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.
- Population-level approaches can also help prevent people from drinking harmful or hazardous amounts in the first place.

Interventions that are classified as primary prevention include minimum unit pricing, licensing interventions such as reduced hours, education based interventions or advertising restrictions.

Secondary prevention: Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

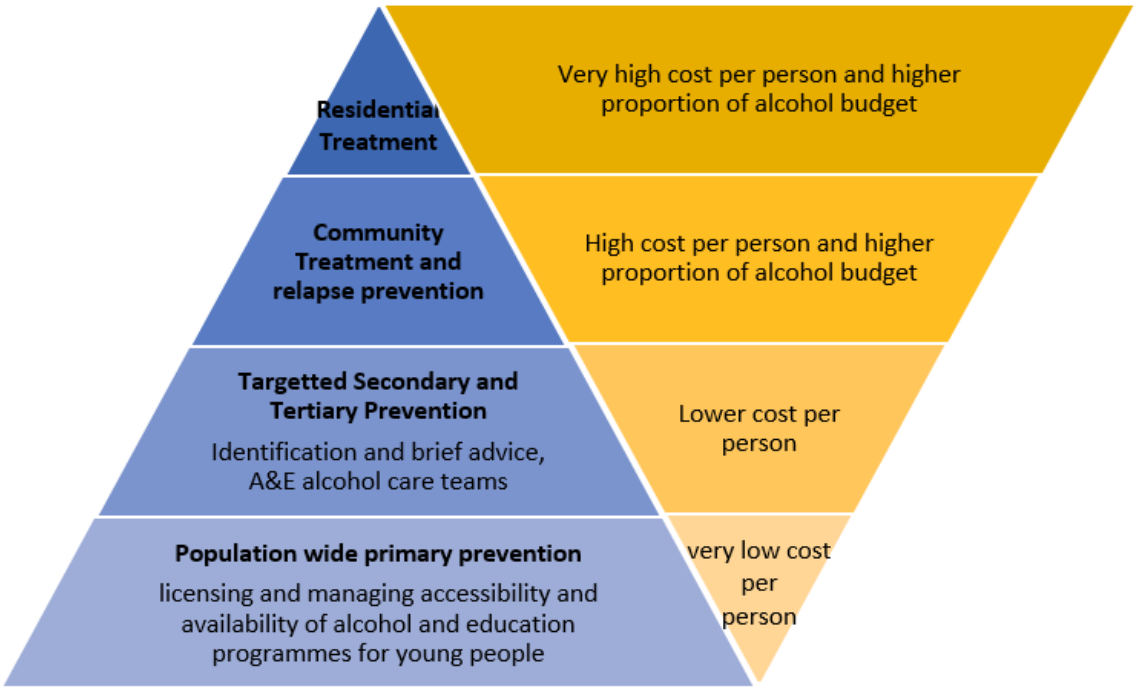
These interventions identify and target individuals who may have some early levels of hazardous drinking in order to prevent further harm. This may include interventions such as alcohol care teams in secondary care or identification and brief advice delivered in primary care.

Treatment: this may be community or in patient treatment and may involve pharmacological interventions, psychosocial interventions or a combination of both

Relapse prevention: generally provided in community settings, aimed to support people who have already successfully completed treatment to maintain abstinence or harm reduction.

In addition to services commissioned directly for alcohol prevention and treatment, people using these services will often have other needs and be using wider health services, mental health services and social care services simultaneously.

Figure 53: Graphic representation of increasing population numbers benefiting from levels of prevention and treatment and associated costs.



10.4. Economic Evaluation Tools

There are many different types of economic evaluation, providing various perspectives and levels of detail and depth.

Spend and Outcomes Analysis (SPOT) is good starting point to look at comparative analysis of spend on alcohol prevention and treatment compared to alcohol related outcomes can be examined, to see if either outcomes or spend are higher or lower than other areas. The tool is only as good as the data that goes into it. If spend data in particular has been misclassified then differences between areas may be an artefact of the data rather than a true difference. The aim of this tool is to stimulate questions and discussion at a local level, not to provide answers about how money could or should be spent in the future.

Cost-benefit analysis (CBA) is a systematic approach to examining the costs and benefits of an intervention. Outcomes are expressed in monetary terms and so different interventions can directly be compared, however, it does not capture outcomes such as increased quality of life. When conducting a CBA, it is important to state from what point of view the benefits will be captured. For example whether it will include savings to healthcare only or whether wider societal savings will also be considered.

Return on investment uses information from the cost benefit when it has been determined that an intervention will be cost saving, to determine how much money the intervention will save per £1 spent over a predetermined period. So a ROI of £3 over 5 years means that for every £1 spent, £3 will be saved in avoided costs over a 5 year period.

When using cost-benefit evaluations to make funding decisions, it is important to be aware that the part of the system which pays for the intervention will not necessarily receive the benefits or savings.

Cost effectiveness analysis (CEA) is another systematic approach to looking at costs and benefits of an intervention but here outcomes are measured in 'health units' for example, the cost per 1 death prevented.

Cost-utility analysis is a type of CEA, but here outcomes are measured in 'health units' that capture not just the quantitative gain, i.e. extra years of life, but also the qualitative aspects of this i.e. the quality of life. The measures used to reflect this are called QALY's (Quality Adjusted Life Years) or DALY's (Disability adjusted life years). NICE will generally recommend that interventions costing less than £30,000 per QALY are funded.

10.5. Spend and Outcomes[8]

The spend and outcomes tool is one way of measuring the effectiveness of how alcohol funds are spent. It is a comparative tool that looks at spend and outcomes in one local authority compared to other, similar, areas. It enables local authorities to consider whether they have better or worse outcomes and higher or lower levels of spend. With the aim of having better outcomes and the same or lower levels of spend than other areas. It is intended as a tool to stimulate questions about spend and outcomes, rather than provide answers. However, in South Gloucestershire we have established that historically our spend has been incorrectly categorised in this tool, this means that any comparisons we may have been able to make with other areas will not be valid as the SPOT tool is not showing a true reflection of alcohol spend in South Gloucestershire and thus cannot be used to draw any comparative conclusions about spend and outcomes at this time

10.6. Cost effectiveness of interventions

10.6.1. Local population-wide Primary prevention

Public Health England recommends that:

Responsible authorities should exercise Licensing and Trading Standards powers fully to help manage and regulate the supply of alcohol in on and off licensed premises, to address local objectives to prevent crime and disorder, ensure public safety, prevent public nuisance and protect children from harm.

Partner agencies should share data and intelligence (within data sharing agreements) to inform plans and execute effective multi-agency responses to identified issues. Holistic responses, including drug and alcohol specific resources, help to build resilience and support healthy choices in young people[9].

Advertising[10]. NICE found that interventions targeted at whole populations around alcohol advertising (either banning advertising to children or increasing positive messaging aimed at adults, both reduced the proportion of people in the population drinking.

Pricing[11]. 50p per minimum unit price of alcohol has been shown to result in a 0.4% reduction in people using alcohol (in South Gloucestershire this is approximately 800 people) and is low or no direct cost to implement. In particular, minimum unit pricing strategies have been shown to have the greatest impact on people most likely to experience harm from alcohol.

A ban on price promotions offering a >20% discount was shown to result in a 0.5% decrease in people using alcohol and is also associated with low or no direct costs. Whilst both of these pricing interventions are extremely cost effective when rolled out across a large area, there effectiveness is likely to be significantly reduced if only implemented in a small area such as South Gloucestershire due to the ease of visiting neighbouring local authorities to purchase alcohol that is not subject these price controls.

School based education programmes[12]. NICE found that classroom based alcohol skills activities and alcohol education in the school curriculum for children aged 10-15, reduced the number of people who use alcohol by between 0.23 and 0.34% at a unit cost of between £35 and £170. These focus on: encouraging children not to drink, delaying the age at which young people start drinking and reducing the harm it can cause among those who do drink.

Availability[13]. Restricting alcohol availability, for example through reduced access to retail outlets for specified periods of the week has been shown to be very cost effective if fully enforced (at least 80% coverage) with a cost of $624 (approx. £570) per DALY saved in European countries. With a cut off of £30,000 per DALY/QALY used to estimate cost effectiveness by NICE, this can be considered exceptionally cost effective. It has been estimated that interventions that reduce alcohol availability reduce the amount of people who drink by 0.2%. In South Gloucestershire, this would result in a reduction of approximately 400 people, however, there was no evidence given regarding whether these were people at higher or lower risk. Again, these types of measures would be more effective at a larger geographic footprint as it would prevent people simply crossing the border into neighbouring authorities to purchase alcohol.

10.6.2. Secondary, Targeted Prevention

Public Health England Recommends:

Evidence based interventions such as Screening and Brief Advice (IBA) can help individuals reduce their alcohol consumption, which reduces risks of ill health and deaths. IBA in primary and secondary care has been shown to reduce weekly drinking by 12%, which reduces the risk of alcohol related illness by 14% and absolute risk of alcohol-related death by 20%
Hospital based Alcohol Care Teams: identify inpatients and A&E attenders with alcohol problems and provide specialist care. These services save money by reducing length of stay, re-admissions (by 3%), A&E attendances (by 43%) and ambulance call-outs[14].

Screening and brief interventions seek to tackle the poor understanding of alcohol-related health risks amongst patients. Screening and brief intervention in primary care has been shown to save the NHS £27 per patient, per year or equivalent of £136 over 5 years[15]. IBA in secondary care has been shown to produce a £28 return on investment per patient receiving brief alcohol advice each year over four years[16].

For example:

Costs and return on investment figures vary depending on how and where the screening is done and who undertakes the screening and brief intervention, for example, costs are lower if it is delivered by a practice nurse rather than a GP. A review of 23 studies reported strong evidence that IBA in primary healthcare is a cost-effective option for reducing alcohol misuse. In addition, there has also been some evidence that screening and brief interventions can be effective in other settings such as sexual health clinics, with family support via schools or A&E departments, but further research is needed to confirm the elements that lead to success in these various circumstances.

The National Institute for Health and Care Excellence (NICE) recommends delivering IBA in all adult health, social care and criminal justice settings[17]. PHE guidance for local leaders working across sustainability and transformation partnership footprints also recommends that IBA is provided in all primary and secondary healthcare settings.

Hospital alcohol care teams

Hospital alcohol care teams reduce the demand for hospital services. The return on investment can be £3.83 for every £1 invested[18].

For example, a consultant-led, multi-disciplinary ACT in Bolton saved 2,000 alcohol related bed days and reduced readmissions by 3%. An external evaluation showed a 43% reduction (3,814 to 2,155) in alcohol-related A&E attendances alone, in the year following the introduction of a small alcohol care team in the Alexandra Hospital, Worcestershire[19].

There are many different versions of alcohol liaison or care teams operating in secondary care but successful team should seek to reduce harm to individuals, particularly those whose alcohol use impacts most heavily on services. This should be done through improving staff awareness of alcohol-related ill health in hospitals and providing specialist care to alcohol misusing patients, through:

1. Training for healthcare staff on screening, and brief advice (as per risky behaviours CQUIN)
2. Comprehensive alcohol use assessments
3. Care planning
4. Delivering medically assisted alcohol withdrawal management and psychotherapeutic interventions
5. Planning safe, accelerated discharge and continued alcohol treatment in community services (note: alcohol assertive outreach teams should be considered as a complementary intervention.

Assertive outreach teams are a relatively new concept in tackling alcohol harm. They work with ‘high impact users’ of emergency services and early analysis has shown they have achieved up to 62% cost savings[20]. PHE recommend that Alcohol Assertive Outreach Teams (AAOT) are established to reduce repeat users of
hospital and other services such as police and social services. CCGs and local authorities work together to commission outreach teams in hospitals or the community that complement alcohol care teams by identifying and proactively engaging patients with repeated admissions. AAOT will also work face-to-face with patients to implement tailored care plans that address their alcohol dependence, mental/physical health and welfare needs.

Example of an assertive outreach team:

Sandwell established an assertive outreach team to work with change resistant drinkers. A group of 16 individuals were identified who were estimated to have cost police, ambulance, hospital and A&E services £244,000 in the past 12 months. Post-intervention data showed that a reduction in costs from £244,000 to £97,700 at the end of year one. After adjusting this figure to account for a death, there was an estimated saving of £142,800. The project costs were £25,000. On this basis the return on investment in 12 months was £4.71 for each £1 spent.

In addition to financial returns, adopting this way of working also led to improved joint working between agencies, opportunities to challenge poor practice and support to commissioners to identify unmet need and gaps and blockages in care pathways.

10.6.3. Specialist treatment and recovery

Public Health England recommends:

Evidence based treatment and recovery services are essential to motivate and support people with drug and alcohol problems. They should provide a range of interventions, according to the level and type of dependency and an individual's assessed need.

Components of the treatment system include: community, inpatient and residential services; integrated pharmacological and psychosocial interventions (where appropriate); holistic, recovery focussed support; addressing family/parenting issues; and building support networks.

Treatment services that are evidence-based and deliver a broad range of effective interventions to meet the needs of the local alcohol-dependent population, making sure that:

- all alcohol dependent adults have quick access to alcohol specific-pathways within the treatment system, with services delivered from non-stigmatising settings
- the treatment system has established care pathways with a range of health, social care, criminal justice and community agencies
- there are individually-tailored packages of psychosocial, pharmacotherapy and recovery interventions that can be accessed by the target populations and which deliver good outcomes for dependent drinkers
- safeguarding practice is continuously monitored, regularly reviewed and reported on to ensure the safety of alcohol and drug users, their families and wider social groups
- the number of people successfully completing treatment is increasing and their recovery from dependence is sustained

Broadly alcohol treatment delivers a return on investment of £3 for every £1 spent, rising to £26 over a 10 year period[21].

Alcohol treatment has been shown to be cost effective in terms of reduction in costs of NHS and Social care costs, crime benefits, and Quality Adjusted Life Years (QALY) benefits to the individual (which can be allocated a cost per QALY in order to give them a comparative financial value). The model below does not include QALY benefits to the individual's wider networks such as children and family. The benefits in terms of Quality Adjusted Life Years gained as a result of not being a victim of crime and to the individual who is in treatment and recovery themselves can be assigned a financial

value, with the largest return on investment being in terms of QALY benefits to the individual receiving the treatment which are valued at over £2.5 million over 10 years.

The total cumulative social and economic return of alcohol treatment services in South Gloucestershire council are therefore £4.1million locally over 10 years.

Figure 54: Return on investment of alcohol treatment for South Gloucestershire Council.

Alcohol only clients in treatment in 2016-17	**In treatment benefit**	**In treatment and recovery benefits**		
		By Yr 3	By Yr 5	By Yr 10
NHS and LA gross benefits	£23,909	£304,766	£474,838	£848,208
Crime economic gross benefits	£146,996	£240,195	£295,865	£424,450
Crime social (QALY) gross benefits	£82,965	£137,637	£171,936	£253,150
QALY gross benefits to the individual	£240,920	£943,487	£1,402,313	£2,573,676

2016-17 gross benefit per person	£3,436
Long-term gross benefit per person	£28,469

Cumulative social and economic return	**£494,790**	**£1,626,087**	**£2,344,951**	**£4,099,484**

Source: PHE 2016/17 Alcohol and Drugs SROI Tool v1.1[22]

Community Treatment

Pharmacological support

Drug treatment combined with social support has been shown to be a cost effective way of treating alcohol misuse in the community. For example, Nalmefene with psychosocial support was shown to be more effective than social support with placebo. At a cost of £5,100 per QALY gained this was considered cost effective for people with alcohol dependence who have a high drinking risk level but who do not require immediate detoxification[23].

Community prescribing can also be used to support relapse prevention in people who have already completed a course of treatment to stop using alcohol. The drugs work through reducing cravings for alcohol in people who have consumed large amounts over a long period of time.

Acomprosate was found to cost an additional £5,043 per additional QALY compared to standard care, which is considered cost effective by NICE.

Structured Psychosocial treatment

There are a number of different types of structured psychosocial treatment that have been shown to be effective and cost effective in reducing frequency or quantity of drinking behaviour.

Motivational Enhancement Therapy is counselling to evoke rapid and internally motivated change and it was found to be cost-effective in reducing average number of drinks per day at one month follow up in 8 randomised controlled trials. The cost of the intervention was £129 per person and the benefits were £722 per person, with savings in health care, alcohol treatment services, criminal justice and social services[24]. In one study reported a return on investment of £5.60 for every £1 invested.

Social behaviour network therapy (SBNT)[25] is a psychosocial intervention which builds upon the premise that social network support for change is central to the resolution of addictive behaviour. It was found to be cost saving with a return of £4.62 at 12 months for every £1 spent. Participants reported highly significant reductions in drinking and associated problems and costs. The cost of the intervention was £221 per person and benefits were £1,020 per person with savings in health care (27%), criminal justice (38%), social care (2%) and other alcohol treatment (32%)[26]. Using these figures, If 5% of dependant drinkers (105 people) in SG completed the programme it would cost £23,000 but would result in savings of approximately £107,100 within a year, with estimated savings to healthcare of £29,000, criminal justice of £40,700 and £34,200 in alcohol treatment after just one year.

10.6.4. Specialist interventions for young people

Public Health England recommends:

Specialist interventions with young people using psychosocial or harm reduction approaches contribute to improvements in health and wellbeing, educational attainment, absence from school or training and risky behaviours through addressing alcohol dependence have a potential return on investment of £5 to £8 for every £1 invested. The majority of these benefits are related to reductions in crime[27].

10.7. Conclusions

All economic analysis relies on multiple complex assumptions and so outputs, whether in the form of ROI's QALY's or ICERS should be viewed a guide or an approximation of what may occur rather than a definite snapshot of the future. Unless the circumstances of an intervention are identical and it is applied in an identical manner, to an identical population and system in identical context as it was under test conditions, then outcomes will naturally vary, sometimes considerably. Therefore, just because a trial showed a promising return on investment, it does not necessarily mean that the same magnitude of returns will be felt in a different situation at a different time. This caveat should not invalidate the results discussed in this paper but encourages the reader to interpret with caution.

There is however, a wealth of evidence on the cost effectiveness of alcohol treatment and prevention, the majority of which shows considerable return on investment in the short, medium and long term. Many of the direct financial savings occur to health services, emergency services and the criminal justice system, with of course huge benefits also experienced by the individuals concerned in terms of increased quality of life and increased length of life (QALY's). However, there has been little evidence found in writing this report of reduced need for alcohol treatment services as a result of these treatment or prevention initiatives. This may simply reflect that this has been excluded in research proposals, but it is more likely that there is such a large invisible part of the iceberg of unmet need for treatment services in the population, that it would take much greater investment in prevention over longer timescales in order to actually reduce the demand for

treatment. In addition, as each study uses different methodology and uses different perspectives when calculating the costs and benefits of interventions, we cannot directly compare the outputs.

Not all effective preventative interventions actually require a substantial direct financial outlay. For example, minimum unit pricing, restricting availability and school based education programmes are all low cost with outcomes in the form of reduced drinking and associated cost savings reliably demonstrated. Interventions such as these do however require something money can't buy, a political will within organisations and society to make a cultural change in the way we think about and use alcohol. They are also things, minimum unit pricing and restricting availability in particular, that work better at larger geographical levels than a single local authority and so require cross geography and cross sector working to achieve.

One of the initial questions that we set out to answer as part of this economic evaluation was – are there better returns on investment for prevention or treatment, and as such should some of the budget currently invested in treatment be invested in prevention? Looking at the available evidence shows that there is little doubt that alcohol treatment and prevention are both effective and cost effective. An effective alcohol system should therefore include all levels of prevention and treatment from primary prevention in the form of full use of Licensing and Trading Standards powers to help manage and regulate the supply of alcohol in on and off licensed premises, targeted secondary prevention in the form of screening and brief interventions in primary and secondary care, alcohol care teams in secondary care and multiagency assertive outreach teams to work with 'high impact' users and effective community and inpatient treatment services for dependant drinkers. However, we have limited funds available (in public health alcohol budgets at least) to deliver this array of interventions and ever growing demand for treatment services. In South Gloucestershire especially, we have one of the highest levels of unmet need for dependant drinkers in the country and so it would be unethical to remove access to effective treatment from people with an existing drinking problem in order to put it into funding prevention. Equally, it feels unethical and illogical not to try to reduce the ever growing tide of people with lower levels of hazardous drinking, many of whom will become future dependant drinkers requiring expensive treatment services, and all of whom are damaging their health and wellbeing and putting pressure on services in the present.

In seeking solutions in terms of what to commission, we should ensure we also examine how things are commissioned, taking a single issue focus for a person who is complex, with a chaotic life and multiple needs may be part of the problem rather than the solution[28].

Someone in need of drug and alcohol treatment is likely to have other issues, mental health problems, crime and disorder offences, domestic and sexual violence, uncontrolled debt, chronic health conditions and adverse childhood experiences which all interact to with each other and will not be responsive to a single issue approach to treatment for any one of them.

Some areas have begun to rethink the systems they use to address these complex lives; Plymouth, for example has set up a creative solution panels in order to co-ordinate responses around an individual[29]. They have pooled budgets between mental health, public health and the CCG and use these to consider a package of support that meets the needs of the whole person and results in a joint care package. This was initially used for the most complex cases but is becoming the system norm over time. This kind of flexibility is in itself complex and requires buy in from motivated individuals and joint discussions between commissioner, provider and senior management about where risk and governance sits. It is a long way from the traditional way of commissioning to very specific outcomes and performance managing individual organisations against these but benefit of

this way of working with people is it can be both more effective and cost saving, particularly in the medium and longer term.

The causes of individual alcohol misuse are multifactorial and complex and thus the solutions must reflect this complexity. If we truly want to tackle alcohol misuse at a local level then we must address as many as possible of the causal factors and recognise that alcohol misuse is not a problem that occurs in isolation in someone's life.

The Organisation for Economic Co-operation and Development suggests that alcohol polices should be combined to create a critical mass effect, changing social norms around drinking to increase the impact on alcohol-related harm in a similar way that occurred with smoking[30]. Effective, population level support starts with primary prevention measures such as minimum unit pricing; uses secondary prevention to support people who are starting to experience or are at risk of developing health harms from alcohol; and provides effective treatment services to help people into recovery, acknowledging the complex individual they are and the multiple issues that affect their lives. Underlying all this should be a movement to rethink the way we interact with alcohol in society.

Effective local systems must be coherently planned by local government, NHS and criminal justice partners to provide effective interventions to address the full range of drinking behaviours and harms to individual drinkers, families and communities. PHE has developed the alcohol CLeaR system improvement tool[31] to support local government and its partners to review local structures and delivery arrangements, and evaluate what works well to reduce alcohol-related harm.

This report highlights that whilst there are many evidence based treatment and prevention options that can and should be commissioned in order to reduce harm from alcohol misuse, this must be driven by strategic partnership working supported by clear vision and governance from the senior leaders across the system. Having this in place does not have a specific cost attached, and the benefits cannot be specifically calculated but is essential to ensure a whole system approach to alcohol harm reduction in an area.

10.8. Actions to consider

1. Ensure Spend allocations between and within drugs and alcohol are as robust and valid as possible so that spending decisions between prevention and treatment initiatives can be understood, tracked and evaluated.
2. Explore implementing a pooled budget for alcohol prevention across healthcare, justice and social care as the return on investment from prevention will be experienced across the system.
3. Establish a multidisciplinary Assertive Outreach team to work with high impact users who have struggled to engage with services. Ensure outcomes are evaluated, including the costs.
4. Ensure that treatment and recovery options are based on the latest available evidence of effectiveness and cost effectiveness and are regularly evaluated.
5. Local leadership to consider supporting changes in alcohol advertising, licensing and pricing at a local level, interventions that are low cost to implement but have good return on investment in preventing problem drinking.
6. Consider extending (and evaluating) screening and brief alcohol interventions to settings other than healthcare, for example via social care, children's services, further and higher education, prisons and youth justice etc. Ensure outcomes are recorded and robust evaluation is conducted as part of this.

7. Seek assurance that the risky behaviours CQUIN is fully embedded in Secondary Care provider trusts and that an alcohol liaison team is working with patients who attend with conditions that may be alcohol related. Ensure its impacts are evaluated.
8. Ensure evidence based alcohol prevention activities are included in the healthy school award[v] locally.
9. Develop a modelled options appraisal including costs and benefits to apply screening and brief interventions within primary care, explore the outcomes if different proportions of the population are reached.

[v] The South Gloucestershire Health in Schools programme (HiSP) brings together the best evidence based health promotion practice and sets achievable challenges to improve the health and wellbeing for everyone within the school community. HiSP is an award scheme open to all primary, secondary and special schools.

10.9. References

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11. Appendices

Appendix 1: NHS Health Check Practitioners Survey

Survey to investigate alcohol AUDIT procedure and referral pathways

1. If clients score 5 or over (low risk) for the first three alcohol questions (AUDIT-C) do you ask the remaining seven questions on the template to complete a full AUDIT?

   Yes □ No □ If no, what is the reason?.....

2. What do you do if clients score 8 or over (increasing risk/hazardous drinking) on the full AUDIT? *Tick all that apply.*

□ Give brief advice to reduce drinking (following guidance in the patient results booklet)

□ Refer client to DHI (Developing Health & Independence)/South Gloucestershire Alcohol Service

□ Other action (*please describe*)……..

□ Nothing (if nothing, what is the reason?)……

3. What do you do if clients score 16 or over (higher risk/harmful drinking) on the full AUDIT? *Tick all that apply.*

□ Give brief advice to reduce drinking (following guidance in the patient results booklet)

□ Refer client to DHI (Developing Health & Independence)/South Gloucestershire Alcohol Service

□ Other action (*please describe*)……

□ Nothing (if nothing, what is the reason?)……

4. What do you do if clients score 20 and over (indicating possible alcohol dependency) on the full AUDIT? *Tick all that apply.*

□ Give brief advice to reduce drinking (following guidance in the patient results booklet)

□ Refer client to DHI (Developing Health & Independence) /South Gloucestershire Alcohol Service

□ Other action (*please describe*)……

□ Nothing (if nothing, what is the reason?)……

5. (a) Do you know who DHI are? Yes □ No □
   (b) And what they provide? Yes □ No □

Appendix 2: Stakeholder engagement questions

Mental health and substance misuse survey

1. Have you had any referrals rejected for dual diagnosis reasons?
    - If so, what was the reason given?
    - Are there other barriers to accessing services which exist? i.e. waiting list times, capacity of the service, other needs of the patient/client, expectations of the patient/client and their family of which service is right for them at that time.
    - If you have any other comments please share them here:

The five strategic questions

1. What are your organisation's priorities with respect to alcohol, and what outcomes do you want to see from the new strategy?

2. To keep your risk of alcohol-related harm low, the NHS recommends not regularly drinking more than 14 units of alcohol a week.
    - How effectively do you think this is being done in South Gloucestershire currently?
    - Do you see any gaps?
    - What are the opportunities for the HWB (and SSCSP) and its member organisations to promote this message?

Alcohol-related harm describes the detriments of drinking alcohol to an individual, a community or society. These can manifest as crime, nuisance or disease. Alcohol-related disease could be either physical such as the development of heart disease, or mental such as the development of depression. Such harms could be exclusively or partially caused by alcohol.

3. How effectively do you think we are working together to prevent or reduce alcohol-related harm to the individual e.g. accidents, liver disease, educational attainment?
    - What are the opportunities for the HWB (and SSCSP) and its member organisations to reduce alcohol-related harm to the individual?
    - Do you see any gaps?

4. How effectively do you think we are working together to prevent or reduce alcohol-related harm to families and the community e.g. crime, domestic violence and abuse, antisocial behaviour?
    - What are the opportunities for the HWB (and SSCSP) and its member organisations to reduce alcohol-related harm to families and the community?
    - Do you see any gaps?

5. A local authority must "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…" The purpose of the DAP is to provide a life-course, whole population level strategic approach to preventing and tackling the harms caused by drugs and alcohol in SG, rooted in a robust evidence base. This needs to be done in partnership and the NHS Long Term Plan highlights the need for more NHS action on alcohol.
    - How effective do you think the current alcohol services we commission or provide across the life course in South Gloucestershire are?
    - Do you see any gaps?
    - What are the opportunities for the HWB (and SSCSP) and its member organisations to improve services

The four questions (a)

1. What are the three most important things to you in relation to alcohol?
2. What we doing well at in relation to reducing alcohol harm in South Gloucestershire?
3. Where are the gaps / issues/ problems in relation to reducing alcohol harm in South Gloucestershire?
4. What should we be prioritising in our strategy?

Following feedback from participants at the first large stakeholder event in Patchway, small changes were made to the questions for subsequent events

The four questions (b)

1. What are the most important things to you in relation to alcohol?
2. What are we doing well at to reduce alcohol harm in South Gloucestershire?
3. What are the issues that are stopping us from reducing alcohol harm in South Gloucestershire?
4. What do you think we should be prioritising in our Alcohol Strategy?
5. Any other comments

Adult service user engagement questions

1. What are the most important things to you in relation to alcohol?
2. What are we doing well at to reduce alcohol harm in South Gloucestershire?
3. What are the issues that are stopping us from reducing alcohol harm in South Gloucestershire?
4. What do you think we should be prioritising in our Alcohol Strategy?

Young people group engagement questions

1. Do you think alcohol use is a problem for your age group/in your local area? If so, what are the issues?
2. Is it easy for teenagers to choose not to drink alcohol? What are the pressures?
3. In what ways can drug and alcohol services reach lots of young people to give them information and help to keep them safe?
4. How do you think drug and alcohol services could help people to make changes? What would you want if you were the client?
5. Why do young people drink in South Gloucestershire?
6. What is the most difficult aspect of managing situations where others are using drugs and alcohol?

Young service user questions

1. Can you tell me about your treatment journey? broken down into following sections:
    - Referral to service
    - Meeting a drugs worker
    - Working towards goals
2. What could have been better?
3. Thinking about the future, what would be of help to you?

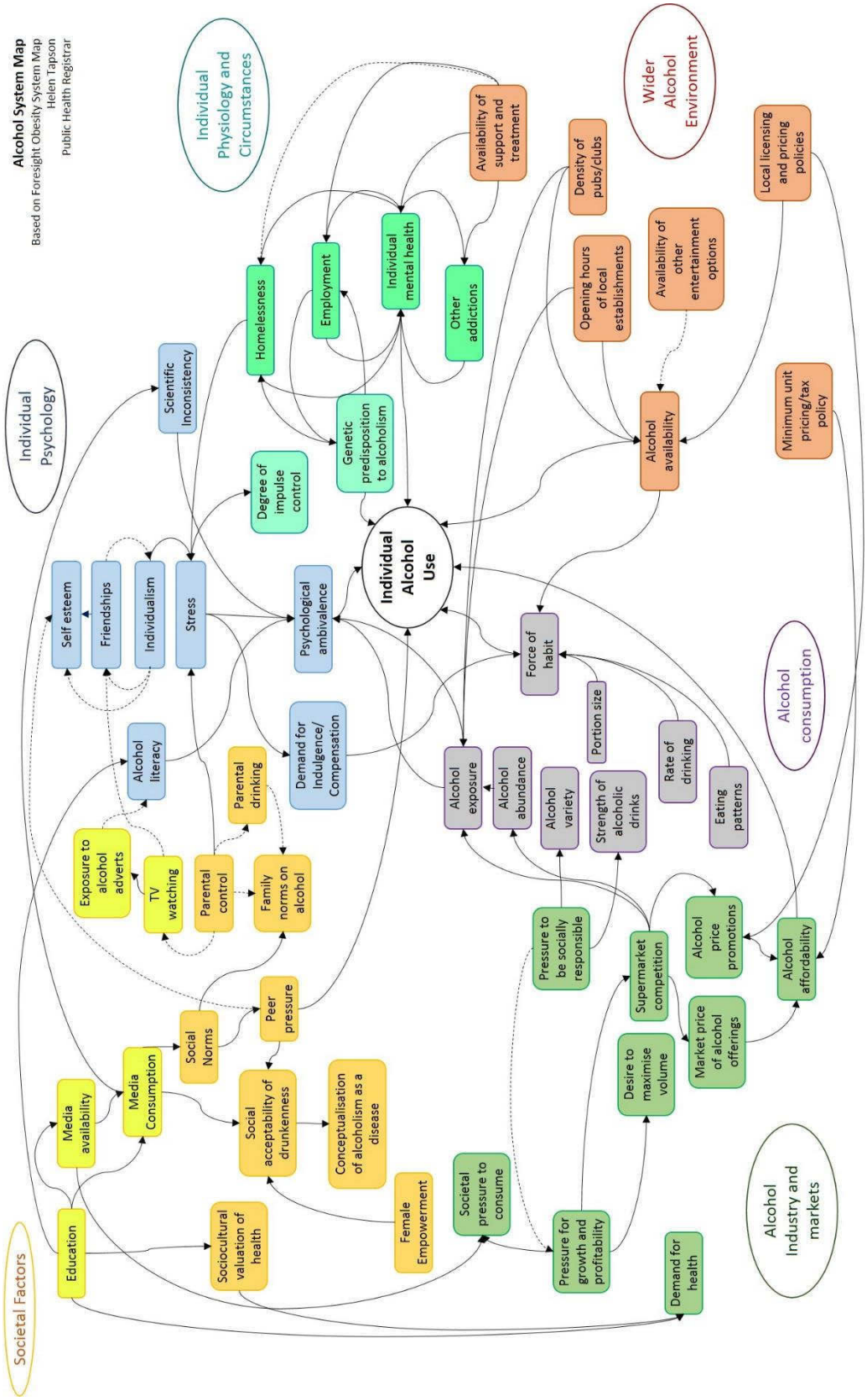
Criminal justice participant questions

1. What are the most important things to you in relation to alcohol?
2. What are we doing well at to reduce alcohol harm in South Gloucestershire?
3. What are the issues that are stopping us from reducing alcohol harm in South Gloucestershire?
4. What do you think we should be prioritising in our Alcohol Strategy?

We know that people who are in contact with the criminal justice system have worse outcomes from treatment than those who are not. The following questions relate specifically to CJ service users.

5. What drug and alcohol services should we be providing for people in contact with the criminal justice system?
6. What do you think services are doing wrong when working with people who are also in contact with the criminal justice system?
7. What might stop you from accessing and successfully completing treatment?

Appendix 3: Alcohol system map



Source: Tapson, H, Economic Evaluation