



Kent Alcohol Strategy 2013-2016

Contents

Forward	Page 3
Acknowledgements	Page 4
Introduction	Page 5
Prevention and identification	Page 7
Enforcement and responsibility	Page 9
Treatment	Page 12
Local action	Page 15
Vulnerable groups and inequalities	Page 17
Children and young people	Page 20
Implementation of the strategy	Page 22
References	Page 23
Glossary	Page 25

DRAFT

FOREWORD Since the development of the last Kent alcohol strategy (2010-2013), the County has made good progress on addressing the impact of alcohol on individuals, families and communities. It is particularly pleasing to see that there is a reduction in the number of young people admitted to hospital due to alcohol misuse.

The vast majority of people in Kent enjoy using alcohol sensibly and drink within recommended guidelines. Kent is generally a safe place to go out socialising and many towns have a vibrant night time economy. However, some indicators relating to alcohol harm have increased such as higher numbers of liver deaths and hospital admissions related to alcohol and it is paramount that we take action to reverse the trend in such instances because alcohol-related harm is largely preventable. The social, economic and health impacts of alcohol are often identified with disadvantaged communities, but this can overlook the fact that alcohol harm affects all aspects of our population regardless of age, income, gender or ethnicity.

This is an exciting and changing time to make progress on alcohol related harm because there have been recent structural changes that offer new commissioning opportunities. These changes include a large shift of public health professionals transferring over from the NHS to local authorities and The National Treatment Agency (NTA) becoming a part of Public Health England, a new organisation responsible for the provision of public health services including drug and alcohol prevention and treatment. Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards have recently been established and it is essential that there are close partnerships to ensure there is effective identification of people at risk and closer integration of the treatment process. The Public Health Outcomes Framework has been in operation since April 2013 and focuses on the performance of high-level outcomes to be achieved by local authorities across the public health system. The framework includes a number of outcomes that relate to alcohol misuse, either directly or indirectly: these include reducing the under-75 mortality rate from preventable liver disease, reducing the under 18 conception rate, increasing the successful completion rate of drug treatment and reducing the violent crime rate.

This strategy has been produced in partnership with the many stakeholders from across Kent and organisations directly involved with addressing the effects of alcohol across the County, including Public Health Kent, Kent Police, Trading Standards and the Kent Drug and Alcohol Action Team (KDAAT). We hope that you find this strategy informative and focused on the right priorities to deliver results and we look forward to working with you to reduce the impact caused by alcohol harm in Kent.

Meradin Peachey, Director of Public Health, Kent County Council

Acknowledgements

This Strategy has been prepared by Colin Thompson, Public Health Specialist at Kent County Council. Colin.thompson@kent.gov.uk

The following people are acknowledged for their valuable input;

Katie Latchford, Community Development Team Leader
Jessica Mookherjee, Consultant in Public Health, Kent County Council
Liz Osbourne, Commissioning Officer, Kent Drug and Alcohol Action Team, Kent County Council
Jim Parris, Community Safety Manager, Kent County Council
Gaby Price, Commissioning Officer, Kent Drug and Alcohol Action Team, Kent County Council
Jason Reilly, Principal Trading Standards Officer, Kent County Council
Inspector Ian Sandwell, Strategic lead for drugs and alcohol, Kent Police
Richard Strawson, Trading Standards Manager, Kent County Council
Di Wright, Head of Commissioned Services, Kent County Council

We would also like to acknowledge people attending the alcohol strategy consultation event earlier this year for their input.

This document is a draft and will be distributed for wider consultation. A working strategy group has been established to oversee the development and will be responsible for monitoring progress with the implementation of the strategy.

Introduction

The majority of people in Kent and the UK consume alcohol responsibly. In moderation, alcohol consumption can have a positive impact on adults' wellbeing especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities. The alcohol industry also contributes to the economy (Home Office, 2012).

However, excessive consumption of alcohol is a growing problem in Kent and across the Country. Liver disease is the 5th largest cause of death in England. The average age of death from liver disease is 59 years, compared to 82-84 years for heart & lung disease or stroke, with a 5-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years (Moriarty, 2010).

The Government's Alcohol Strategy written in March 2012, identifies 1 million alcohol related crimes and 1.2 million alcohol related hospital admissions nationally (Home Office, 2012). National and local alcohol strategies seek to reduce this figure. The Government Alcohol Strategy also highlights some stark national figures relating to alcohol harm and the costs associated with that harm: The cost of alcohol misuse to the NHS in England is £3.5 billion per annum (2009 to 2010). The cost of alcohol related crime in England is £11 billion per annum (2010 to 2011). The cost of lost productivity in the UK is £7.3 billion per annum (2009 to 2010). The strategy primarily focuses on the importance on preventing and reducing the impact of alcohol on crime and disorder across the UK. The government acknowledges that cheap alcohol is too readily available and that this has contributed to the increase in alcohol related harm. The Government strategy states that; "Over the past 40 years, alcohol consumption in the UK has doubled, with a significant increase in drinking at home. Sales from supermarkets and off licences now account for nearly half the amount of alcohol sold in the UK." It makes reference to the fact that the government has consulted on introducing a minimum price per unit, with the aim of legislating so that alcohol will not be allowed to be sold below a defined price of 45p per unit of alcohol. However, it is unlikely at the moment that this will be implemented.

Kent like many regions in the UK experiences the widespread impact of alcohol misuse. Excessive drinking is a major cause of disease, accounting for 9.2% of disability-adjusted life years (DALYs) worldwide with only tobacco smoking and high blood pressure as higher risk factors.

The Kent Joint Strategic Needs Assessment chapter on alcohol (2012) identified alcohol misuse as a significant area of need, requiring urgent attention. Synthetic estimates are calculated by the North West Public Health Observatory which suggest that 209,260 adults in Kent are drinking at 'increasing risk' levels (22-50 units a week for men and 15-35 units for women). 49,843 drink at 'high risk' levels, showing evidence of harm to their own physical and mental health, and 30,423 people have a level of alcohol addiction (dependency).

In 2009-10, approximately 24,682 people in Kent admitted for alcohol related harm (Equivalent to 1,416 per 100,000 population) These figures reflect not only

admission for alcohol specific conditions (e.g. alcoholic mental or behavioural problems and alcoholic liver disease) but also the significant contribution of alcohol misuse to increased cardiovascular, gastroenterological and cancer admissions: also admissions due to accidents on the road, in the workplace and in the home (including falls).

Estimates from the North West Public Health Observatory show in the 2012 Health profile for Kent that there are 23.1% of the population over 16 years old that are estimated to be either increasing or higher risk of drinking across Kent, this is higher than the England average of 22.3% and equates to 272,258 people, given the population above 16 years old is 1.18 million.

Alcohol-related hospital admissions have risen sharply over the last few years. To help reduce the rate of this, the Department of Health (2009) released seven 'High Impact Changes' designed to highlight practical measures that can be implemented at a local level.

High Impact Changes for Alcohol

- Work in partnership
- Develop activities to control the impact of alcohol misuse in the community
- Influence change through advocacy
- Improve the effectiveness and capacity of specialist treatment
- Appoint an alcohol health worker
- Provide more help to encourage people to drink less through identification and brief advice
- Amplify national social marketing priorities

This document sets the context in which agencies across Kent will work to address the problems associated with alcohol use across the county. The strategy encourages partnership and joint working to create a healthier and safer population by reducing the level of individual and community harm related to alcohol misuse. There are six key areas underpin the strategic framework:

- Prevention and identification
- Enforcement and responsibility
- Treatment
- Local Action
- Vulnerable groups and inequalities
- Children and young people

Prevention and identification

This section details current and planned work on prevention for adults. Prevention for young people is covered in the section on children and young people.

What we know

Opportunistic screening and brief interventions for adults is likely to contribute to the primary outcome of reducing alcohol-related harm and alcohol-related hospital admissions by targeting the delivery of screening and brief interventions to selected populations at an appropriate time and in an appropriate setting reducing alcohol consumption in those drinking at hazardous and harmful levels. This method will also improve rates of identification and referral to specialist treatment for those suffering from significant alcohol dependence and harmful drinkers who have not responded to Brief Interventions.

Identification and Brief Advice (IBA) is a simple method of finding people with an increasing or higher risk of alcohol use (Identification) followed by simple alcohol advice (Brief Advice). The evidence shows that it can be an effective method when delivered to those who drink at "increasing" and "higher" risk levels (Moyer et al. 2002). The objective of IBAs is to motivate and encourage behaviour change related to alcohol use. The 2007 National Alcohol Strategy stated that early intervention, if consistently implemented across the UK, would result in 250,000 men and 67,500 women reducing their drinking from increasing or higher risk to low risk each year. The research evidence shows that the number needed to treat (NNT) in offering screening and brief interventions is eight. This means that for every eight people treated one will change their behaviour (Moyers et al. 2002). This is considerably lower than for smoking cessation, which has a NNT of around 35 or higher (Stead et al. 2008), thus highlighting the potential impact that screening and brief interventions can have. To meet the England average figures for increasing or higher risk drinkers, Kent would need to achieve an alcohol misuse reduction of 9,118. Using the NNT ratio, this would require 72,944 IBAs to be conducted.

Alcohol IBA and referral to treatment services is not routinely undertaken by all health care professionals as part of the diagnosis and referral process. This is especially relevant for cancer, gastro and CVD services (notably hypertension and stroke), where alcohol misuse can predispose to and exacerbate the condition.

NICE guidance (NICE 2010) states that it is important to work with clinical experts and partner agencies to identify potential settings where opportunistic screening, brief advice and extended brief intervention services could be implemented. Targeted settings will typically be frequented by groups who may be at an increased risk of alcohol-related harm. These may be outside of health or social care settings such as criminal justice, housing and education.

What are we doing

- IBAs are currently offered at some GP practices across the county as part of a Directed Enhanced Service (DES). This is only offered to newly registered patients. IBAs are also included as a component of the health check that is given to people at specific ages.

- Kent currently provides approximately 3% of the recommended IBA treatment capacity for increasing risk and higher risk drinkers and demand is likely to increase.

What we aim to do and how

- We will identify a greater number of people across the County ensure they are offered appropriate support. This will be done by developing a Local Enhanced Service (LES) for IBAs in the primary care setting and by improving access to them from outside healthcare settings. This could include Hospital Departments, Families and Social Care staff, housing professionals, Health Trainers and Pharmacies.
- We will ensure that training is offered to staff across a number of agencies to carry out IBA. The training will help professionals in identifying individuals whose drinking might be impacting on their health by delivering simple, structured advice.
- We will produce a marketing action plan that will ensure that campaigns will be consistent with pan-Kent branding and use clear, accurate and focussed messages. Campaigns will be evidence-led social marketing campaigns to foster a responsible drinking culture. This could utilise information from the segmentation tool developed by the Department of Health to direct the social marketing work.
- We will maximise on marketing activity that is already trusted by utilising existing branding to include responsible alcohol promotion (Change 4 life campaign and Healthy Passport Scheme).

How will we know we have achieved our aims?

- There will be an increase in the number of people screened for alcohol misuse in targeted settings
- There will be an increase in the number of brief advice and brief intervention sessions delivered both in primary care, hospital and non-health settings
- There will be an increase in the number of referrals for specialist assessment in community-based alcohol treatment services
- There will be an increase in the uptake of treatment in community-based alcohol treatment services following referral
- There will be a reduction in alcohol-related hospital admissions and mortality. This will include a contribution to a reduction in chronic liver mortality.
- There will be a range of effective campaigns will be conducted that will be targeted and specific in raising awareness in specific population groups.

Enforcement and responsibility

What we know

Kent has a vibrant night-time economy that contributes to the County's prosperity as well as its cultural and social life. There are established partnerships that work closely together in ensuring there is responsible practice towards a sensible drinking culture. This is in line with NICE guidance that recommends that it is important to work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others (proxy sales).

Kent Police developed a Night Time Economy (NTE) strategy in the spring of 2013. It has a number of key aims that include;

- Creating town, city and rural environments where residents, workers and visitors are safe and feel safe.
- Actively seek to reduce alcohol related violence in our town and city centres, and rural areas.
- Promoting a responsible attitude towards alcohol through the Kent multi-agency Alcohol Strategies.

Kent County Council Trading Standards have an alcohol strategy with the principal aim of protecting young people from the adverse effects of alcohol. This is done via means of providing effective advice and proactive under age sales enforcement.

Kent Community Alcohol Partnership (KCAP), is a partnership between Kent County Council, Kent Police, the Retail of Alcohol Standards Group (RASG), district councils and health authorities. Trading Standards are the lead agency for this Partnership and a county-wide Operational Group meets regularly to ensure consistency across the various schemes in the county with tactical groups formed to bring together all the local leads for each of the partners. KCAP aims to change attitudes to drinking by:

- Informing and advising young people on sensible drinking
- Supporting retailers to reduce sales of alcohol to underage drinkers
- Promoting responsible socialising
- Empowering local communities to tackle alcohol related issues.

They are unique in partnering with communities and business as well as relevant agencies. Their aim is to maximise opportunities for dealing with local concerns on alcohol related issues that need to be addressed. Partnership pilots ran in three areas of Kent in 2009. The key findings showed a reduction in residents' worries about antisocial behaviour and concerns about personal safety. Furthermore criminal damage in the pilot areas fell during the pilots by 28% overall. The Kent Community Alcohol Partnerships are recognised nationally as being of particularly good practice. A KCAP Toolkit was launched in June 2012 to enable any community group or organisation to establish a KCAP scheme with the support and encouragement of agencies such as Trading Standards. As a result of the toolkit,

additional KCAP have been formed to address issues raised by the community in relation to alcohol. Early indications show that these issues are being addressed.

The government's Public Health Responsibility Deal was launched in March 2011. The aim of this voluntary partnership is for businesses and influential organisations to work collaboratively to improve public health by creating the right environment for people to make informed choices that lead to healthier lives. Alcohol is one of the components of the responsibility deal and consists of a range of collective pledges that we can work in partnership with industry in order to promote a culture of responsible drinking. The pledges include;

- Working with industry to ensure that the majority of products on the shelf will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.
- Providing simple and consistent information to both the off-trade (supermarkets and off-licences) and on-trade (e.g. pubs and clubs), to raise awareness of the unit content of alcoholic drinks, calorie content of alcoholic drinks, NHS drinking guidelines, and the health harms associated with exceeding guidelines.
- Working with industry to ensure effective action is taken to reduce and prevent under-age sales of alcohol.
- Working with communities to develop and support appropriate local schemes designed to address public health issues using a multi-agency framework. The Community Alcohol Partnerships are a good example of relevant work already underway.

What we are doing

Kent Police are involved in a range of activity on the alcohol and community safety agenda in relation to enforcement. This involves work on preventing, reducing and detecting crime and disorder. This includes working with partners to conduct targeted and specified operations to address identified issues in licensed premises, supporting Trading Standards with test purchasing operations and supporting other licensing initiatives.

Kent County Council's Trading Standards Service carry out intelligence led test purchasing operations where there are continuing problems of young people having access to alcohol. These can be concluded by the use of a licence review, penalty notices for disorder (PNDs) or prosecution. The number of test purchases have reduced recently because of a reduction in intelligence received concerning underage sales. However, the Service continues to offer proactive help and advice to businesses to ensure that sales do not take place.

The Trading Standards Service also assist local businesses by running targeted "Challenge 25" operations (testing businesses application of the nationally agreed policy of challenging individuals for suitable identification if they appear under 25). These are supported by advice and training for any business that fails to take the correct action in asking for proof of age to ensure their systems of preventing sales to those under age are robust.

Kent Community Alcohol Partnerships (KCAPs) have been established across the County and a KCAP “Toolkit” has been launched. This is a web based product which provides local communities with the opportunity to establish CAPs in their own neighbourhoods. The Trading Standards Service will continue to support the developments of these partnerships and plans are currently being made for the launch of another KCAP in the Ashford area.

What we aim to do and how

- We will work with Kent Police who will continue to provide a robust Police presence in the NTE in response to demand.
- We will tackle underage alcohol sales by ensuring that a range of partners are contributing to intelligence that can be shared and acted on by trading standards.
- We will ensure that any amendments to the Licensing Act is understood and implemented following government consultation and ensure that the Licensing Act enables the delivery of an effective framework for the enjoyment of alcohol within Kent’s communities. We will be actively engaged in any future consultations.
- We will investigate examples of good practice around the Country, considering the feasibility of introducing them in Kent with the aim of ensuring we are adopting best practice. Good examples already in place include Dover District Council’s adoption of Suffolk’s “Reducing Strength” initiative aimed at preventing the sale of super-strength alcohol from off-licenses. Ideally, Kent will be soon be in a position to share its own best practice with other areas, as was done with the Community Alcohol Partnerships.
- We will consider increasing the number of Community Alcohol Partnership areas to expand their positive impact.
- We will work with local alcohol industry around sign up to the Public Health Responsibility Deal

How will we know we have achieved our aims?

- We will monitor the level of under 18 hospital admissions wholly attributed to alcohol for each district.
- We will improve information sharing between partner agencies to help inform future data monitoring.
- We will monitor organisations across Kent that have signed up to the Public Health Responsibility Deal around alcohol.
- We will highlight and document any sharing of good practice with other areas. This will be included in the Annual Public Health Annual Report.
- We will monitor community Alcohol Partnership successes and new partnerships will be reported at KCAP quarterly steering group.

Treatment

What we know

Data from the National Alcohol Treatment Monitoring System (NATMS) in 2009/10 show that only 1 in 10 harmful or dependent drinkers aged 18 years and over is currently receiving specialist alcohol treatment. This may be due to the delay between developing alcohol dependence and seeking treatment, the limited availability of alcohol treatment services in some parts of England and under-identification by health and social care professionals (NICE 2011)

We know that close liaison with hospitals can be effective at identifying patients who need support and increasing better treatment access. A programme of intensive care management and discharge planning delivered by an Alcohol Liaison Nurse in the Royal Liverpool Hospital was shown to prevent 258 admissions or re-admissions resulting in about 15 admissions per month saved. Economic analysis of such an appointment in a general hospital suggested that it was highly cost effective with the potential of saving ten times more in reducing repeat admission than the cost of the programme (Department of Health 2009).

Brief interventions which can be conducted in general health care settings, can help patients reduce at risk. Brief interventions are generally restricted to four or fewer sessions, each session lasting from a few minutes to 1 hour, and are designed to be conducted by health professionals who do not specialize in addictions treatment. The evidence base suggests (National Treatment Agency 2006) that brief interventions are effective for increasing risk and higher risk drinkers. The NICE guidance states that Brief Interventions can help people to reduce the amount they drink to lower-risk levels and reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence (NICE 2010).

What are we doing

Specialised Treatment services are available across Kent in a wide range of settings. A variety of interventions can be accessed by those in need of help for either their own or someone else's alcohol use. The system across Kent is aimed at recovery and reintegration. There are two providers delivering the recovery services for adults, Crime Reduction Initiative (CRI) in west Kent and Turning Point in east Kent. KCA are the provider across Kent for young people. There is a range of currently provided interventions including; Advice & Information, Structured Psychosocial Interventions, Medication, Harm Reduction, Family Therapy, Group Therapy, Peer Led Activities, Ambulatory & Community Detoxification and assessment & referral to Inpatient Detoxification and Residential Rehabilitation Units. All treatment may be accessed via hub sites or outreach venues.

What we aim to do and how

- We will contribute to reducing the number of deaths related to liver disease.
- We will contribute to the reduction of the number of alcohol specific hospital admissions.

- We will increase access to treatment and a major contributor to this will be by significantly strengthening the relationship between hospitals and treatment services. This will have a positive impact on reducing alcohol related hospital admissions, increase treatment up take among hard to reach groups and increase new treatment journeys, this will involve;
 - ❖ The establishment of hospital Alcohol and Drug Liaison Community Teams across Kent to undertake in-reach to hospitals departments and wards and will include liaison with psychiatric services.
 - ❖ The establishment of Hospital Alcohol and Drug Liaison Nurse posts within hospitals that will have the remit of reducing the risk and harm of higher risk and possible dependent drinking and will work closely with hospital Alcohol and Drug Liaison Community Team.
 - ❖ Development of after care packages prior to hospital discharge
 - ❖ Provision of substance misuse training to Acute Hospital staff
 - ❖ Improved signposting from hospital staff to substance misuse recovery services.
- We will improve data collection from hospital Accident and Emergency (A&E) Departments in order to uplift data quality which allow for assessment and analyse the scale of the alcohol and drug problem in hospital settings and ultimately reduce the costs associated with A&E attendances.
- We will increase referrals from statutory and non-statutory agencies across Kent into the adult treatment and recovery services for those individuals who are in need of treatment. This will be achieved through the development of referral pathways and raising awareness of treatment/recovery services and what is offered to a variety of organisations including- housing related support, hospital trusts, Primary Care etc.
- We will increase the settings in which interventions can be effectively utilised, for example utilisation of outreach via Roving Recovery Vehicles in East Kent.
- We will utilise learning and good practice in relation to treatment. Such as, areas where pathways have worked effectively and where there has been strong links between treatment services and hospital trusts.
- We will develop strong links between Clinical Commissioning Group's (CCG's) and agencies providing treatment. This will allow for enhanced understanding of treatment needs, screening, referral and advice services and passing relevant information.
- We will reposition the Alcohol Diversion Scheme into the treatment and recovery services across Kent with a view to increasing the treatment uptake of alcohol offenders.

How will we know we have achieved our aims?

- There will be a reduction in liver disease deaths
- There will be a reduction in the rate of hospital admissions wholly attributed to alcohol
- There will be a strong working relationship between hospitals and treatment providers in Kent that will result in better identification of people needing support for their alcohol misuse from a range of hospital departments.
- There will be effective collection of A&E data that will inform the scale of the alcohol problem in hospital settings, reduce costs and potentially be utilised to inform licensing decisions for Public Health.
- There will be enhanced access to treatment services via referrals being made from a wider range of sources including use of outreach.
- There will be improved integration with Clinical Commissioning Group's across the county in relation to the whole system process including alcohol screening, brief advice and referral for treatment.
- There will be enhanced access to offenders to treatment services

Local Action

What we know

There are considerable different needs regarding targeted alcohol priorities across the county. For example, Thanet is considerably worse than the England average for many indicators and is the sixth worst local authority in England for chronic liver mortality and there is a relatively high level of female hospital admissions attributable to alcohol in Canterbury.

Community safety partnerships are defined as “An alliance of organisations which generate strategies and policies, implement actions and interventions concerning crime and disorder within their partnership area”. There are 11 such partnerships across the county with Dartford and Gravesham having a shared partnership.

What are we doing

- Community Safety Partnerships currently represent good practice in multi-agency responses to the alcohol agenda, including joint work with District Councils, Kent Police, County Council, Probation and local community organisations.
- The substance misuse needs assessment highlights a wide range of data for the 12 districts.

What we aim to do and how

- We will ensure that there is clarity as to what is being delivered regarding alcohol initiatives across the county, what the specific local needs are, and that there are effective mechanisms of communication.
- We will ensure there is no replication in any services commissioned by Kent County Council, District Councils, Clinical Commissioning Groups or any other commissioning body. We will map and review provision across the county.
- We will assess if there are any significant gaps in provision at a local level and work with partners to ensure that major gaps are addressed through commissioning.
- We will update the substance misuse needs assessment annually with detail around alcohol misuse at ward level for each district to give a clearer understanding of need.
- We will ensure there are effective links, integration and communication with wider county/district partnerships in relation to the work being undertaken around the alcohol agenda. Such partnerships will include Community Safety Partnerships, Health and Wellbeing Boards, Children’s Services, Troubled Families, Kent Integrated Adolescent Support Service etc.

- We will support local schemes such as Street Pastors in order to make best use of the limited resources available, provide consistent good quality training, help different teams to learn best practice from each other, and continue to make visitors, residents and communities safer whilst reducing the load on emergency and enforcement services.
- We will utilise good practice from within and from outside of the county.

How will we know we have achieved our aims?

- We will ensure that partners across the county will have a clear understanding of all alcohol initiatives that are being delivered relevant for each district.
- We will be aware of any changing local priorities that emerge by having an understanding of local intelligence.
- We will ensure that there will not be any duplication of similar alcohol initiatives being commissioned by different agencies.
- We will ensure that Local Health and Wellbeing boards and Community Safety Partnerships have detailed local actions to tackle problems in their areas.

Vulnerable groups and inequalities

What we know

There are a variety of groups at risk in relation to harm caused by alcohol. This may include those with mental health issues, some BME groups, homeless people, offenders, victim and perpetrators of domestic abuse and many others. Alcohol misuse in these population groups will have a widening effect on health inequalities.

National Alcohol segmentation analysis of Hospital Episode Statistics data (Morleo *et al.* 2009) shows that those at highest risk of being admitted to hospital with a primary or secondary diagnosis that was linked to alcohol, are men aged over 35 who work in an unskilled or manual field or are unemployed.

People from most minority ethnic groups have higher rates of abstention and lower rates of consumption than the majority white ethnic group. However, drinking varies greatly both between and within minority ethnic groups and across gender and socio-economic group, resulting in a very complex national picture of alcohol consumption and alcohol-related harm across ethnicity (Thom *et al.* 2010).

For women living in the most deprived areas, alcohol-related death rates are three times higher than for those living in the least deprived areas. For men living in the most deprived areas, this is even worse: alcohol-related death rates are over five times higher than for those living in the least deprived areas (Department of Health 2009).

Offenders in the criminal justice system are more likely than the general population to be drinking at increasing and higher risk levels. For example, around 63% of men in the prison population report drinking at hazardous levels, compared with 38% of men in the general population (Social Exclusion Unit 2002).

People with mental health problems are at increased risk of alcohol misuse. Depression, anxiety, schizophrenia and suicide are all associated with alcohol dependence. (Ellinas *et al.* 2008).

Dual diagnosis involves supporting someone with a mental health illness and substance misuse problems. The combination can be a significant challenge for services with one of the main difficulties being large number of agencies involved in a person's care – mental health services and specialist rehabilitation services, organisations in the statutory and voluntary sector all contribute but not always with sufficient communication. As a result, care can be fragmented and people can be missed. It is vital to explore a way forward via outreach to identify potential service users at the earliest opportunity. Crawford *et al.* (2003) found that increased rates of substance misuse are found in around a third to a half of people with severe mental health problems. Where drug misuse occurs it often co-exists with alcohol misuse. Homelessness is frequently associated with substance misuse problems; Community Mental Health Teams typically report that 8-15% of their clients have dual diagnosis problems and Prisons have a high prevalence of drug dependency and dual diagnosis.

According to the Kent Drug and Alcohol Action Team (KDAAT), Alcohol is the most commonly used substance among dual diagnosis clients in Kent. Half of substance misuse service users are estimated to have mental health needs (National Mental Health Development Unit and The NHS Confederation, 2009); this would equate to 982 people in alcohol structured treatment (dependent drinkers alone). Increasing and higher risk drinkers are likely to be best served by Primary Care mental health services.

A UK study showed that 51% of respondents from domestic violence agencies claimed that either themselves or their partners had used drugs, alcohol and/or prescribed medication in problematic ways in the last five years (Humphreys et al. 2005). A number of studies have found that the perpetrators use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober (Brecklin 2002).

What we are doing

- Work is currently being undertaken to support the implementation of the dual diagnosis joint working protocol. Dual diagnosis workshops are currently being hosted aimed at improving joint working between substance misuse services and mental health services in Kent.
- A criminal justice forum for substance misuse has been set up bringing together a range of agencies across the county.

What we aim to do and how

- We will establish mutual referral pathways with Kent Fire and Rescue Service to highlight and protect vulnerable people who may be at increased fire risk due to mental health and substance misuse issues.
- We will ensure there is access between alcohol and sexual health services with alcohol treatment staff being able to spot the signs of sexual violence by making available basic training on sexual exploitation. We will ensure there is a care pathway between alcohol services and Sexual Health services that will include sexual assault referrals and other sexual exploitation services.
- We will ensure there is access between alcohol and domestic abuse services with alcohol treatment staff being able to spot the signs of different levels of domestic abuse and referring to the appropriate service. We will ensure there is a care pathway in place between alcohol services and domestic abuse services.
- We will review action for addressing the housing needs of problematic alcohol users (to include: data requirements; awareness training for housing officers and private landlords; criteria for priority housing; assessing need for floating support and assertive outreach). We will also review housing policies to ensure there is equitable access for housing needs.

- We will support the implementation of the protocol to better meet the needs of dual diagnosis clients and up skill the substance misuse and mental health workforce in Kent. This will improve quality of care provided to dual diagnosis, increase successful treatment completions for dual diagnosis clients and increase the number of joint care plans between substance misuse and mental health provider.
- We will ensure that all treatment involves committed services that appropriately and sensitively meet the needs of vulnerable groups and Kent's diverse communities.
- We will create better linkages between Criminal Justice System alcohol interventions, the alcohol treatment system, and anti-social behaviour interventions, in order to reduce alcohol related harm and offences.

How will we know we have achieved our aims?

- There will be care pathways will be in operation between alcohol services and other services that deal with vulnerable groups such as people who are accessing sexual health and domestic abuse services
- There will be a mutual referral pathway will be in operation in partnership with Kent Fire and Rescue Service.
- There will be an enrichment of the housing needs for problematic alcohol users and we will also be clear as to the level of equitable access for different parts of the county.
- There will be an implementation of the dual diagnosis protocol to ensure needs of dual diagnosis clients will be better met than what they are currently.
- There will be more effective partnership working with the criminal justice forum with the overall aim resulting in a reduction in alcohol related crime.

Children and young people

What we know

Young people may learn from older generations that excessive alcohol consumption is culturally acceptable which can increase the risk of substance misuse problems becoming entrenched at a young age. Young people are negatively affected by alcohol misuse through their own misuse as well by the misuse by their parents and carers. Parental alcohol misuse strongly correlated with family conflict, domestic violence and abuse. The consequences for children relate to their immediate harm as well as longer term impact. These impacts vary according to young people's age and stage of development but include emotional health and wellbeing as well as social functioning and educational engagement.

Guidance from the Chief Medical Officer (Chief Medical Officer guidance 2009) advises parents and children that an alcohol-free childhood is the healthiest and best option. If children drink alcohol, it should not be until they are at least 15 years old.

Excess alcohol consumption can increase the risk of a person having unprotected sex (Rehm et al 2012).

What we are doing

Treatment services for children and young people aged between 10 to 17 years old are delivered by KCA. They offer a range of provision that includes supporting professionals and parents and engaging young people, early intervention (group work), specialist treatment (1-1 interventions) and criminal justice work.

RisKit is delivered by KCA. It is a specialist programme targets young people who are identified as vulnerable or are involved in risk taking behaviour, such as drug and alcohol use, or unprotected sex. It is delivered in schools and young people are screened with those who are identified as most likely to be involved in risk taking behaviour offered intense support around. RisKit aims to help young people to build their skills and resilience, explore the reasons why they might take risks in order to help them make safer choices for them. It has been evaluated it was shown that it is effective at reducing risk taking behaviour including alcohol misuse. Currently the programme does not have the capacity to cover all of the schools in the county.

DUST (Drug Use Screening Tool) training is delivered across Kent by KCA to staff working with vulnerable young people. It includes alcohol as well as drug awareness and involves identifying risks, engaging young people, screening and referral.

KCAPs are designed to tackle under-age drinking and associated problems in partnership with local stakeholders. Further details of KCAP are included in the enforcement and responsibility section.

What we aim to do and how

- We will lead the collaboration undertaking a campaign that will focus on increasing the number young people under the age of 15 that abstain from alcohol in line with the advice of the Chief Medical Officer by developing a

strategy for the delivery of alcohol education in Kent at primary and secondary education

- We will also progress and support social marketing campaigns that provide guidance to parents about their children's use of alcohol and ones aimed at reducing the negative impact of parental alcohol misuse on children and young people.
- We will review and implement the delivery of the Hidden Harm Strategy in particular ensuring that there are practical working relationships between adult treatment services and children's social services in Kent.
- We will reduce the negative impact of parental alcohol misuse on children and young people by training practitioners in social care about the impact of alcohol misuse on parenting and by identifying practical ways for children and families services and specialist alcohol treatment services to work together in the care of parents who misuse alcohol.
- We will increase the numbers of young people accessing specialist community treatment through improved pathways and early intervention referrals (A&E attendance from alcohol poisoning, for example).
- We will ensure that young people are systematically screened and offered brief interventions for alcohol misuse in various settings. For example, Accident and Emergency departments, sexual health clinics and via Kent Integrated Adolescent Support Services (KIASS) workers. Assessment should lead to brief intervention and specialist treatment as required.
- We will work to ensure that there integrated services for young people receiving support for alcohol misuse. For example, we will work to progress KIASS working at early intervention, specialist support, sexual health etc.
- We will increase the capacity of the RiskIt programme to extend it to a greater number of schools across Kent.

How will we know we have achieved our aims?

- There will be a reduction in the overall alcohol specific hospital admissions for under-18 year olds.
- There will be a reduction in the number of schools exclusions related to alcohol.
- There will be an increase in the estimated number of young people abstaining from consuming alcohol.
- There will be a reduction in the teenage pregnancy rate

- There will be campaigns undertaken will be successful in increasing awareness among young people regarding the risks that can due to alcohol misuse. Such campaigns will be evaluated as to their effectiveness.

Implementation of the strategy

A strategy implementation group will monitor progress on the strategy. This group will meet on a quarterly basis to monitor progress and will review the strategy on an annual basis. The strategy implementation group will include a range of partners from;

- Kent County Council Public Health Department
- Kent County Council – Kent Drug and Alcohol Action Team (KDAAT)
- Kent Police
- Kent County Council Trading Standards
- A representative from one of the district councils
- A representative from primary care

The strategy implementation group will develop an action plan with a timeline and agreed responsibilities to ensure that actions developed will be focussed on achieving the outcomes within the strategy. They will have the role of ensuring delivery plans and individual actions are robust and enacted (refreshing them on a periodic basis), and that partners undertake their assigned responsibilities. They will provide the reports to the KDAAT Board, and other relevant committees, and make the case for commissioning of services as appropriate.

The KDAAT Board will be the accountable body for the strategy and therefore take overall responsible for the targets and performance measures. They will scrutinise reports, periodically provide progress updates, highlight successes and good practice as well as request remedial action when necessary.

References

- Brecklin, L, (2002). The role of perpetrator alcohol use in the injury outcomes of intimate assaults, *Journal of Family Violence*, 17 (3), 185-196
- Chief Medical Officer Guidance (2009) Guidance on the Consumption of Alcohol by Children and Young People from the Chief Medical Officers of England, Wales and Northern Ireland
- Crawford V, Clancy C and Crome, I. B. (2003) Co-existing problems of mental health and substance misuse (Dual Diagnosis): a literature review. *Drugs: Education, Prevention and Policy*, 10 (Suppl.), pp.S1–S74.
- Department of Health (2009) Signs for Improvement: Commissioning interventions to reduce alcohol-related harm. London: Department of Health.
- Department of Health (2010) 'Healthy Lives, Healthy People our strategy for public health in England' Department of Health
- Ellinas T, Garland L, Gohil D, Kirkman J, Rankin J, Ritson A. (2008). *Alcohol misuse: tackling the UK epidemic*. London: BMA Board of Science
- Home Office (2012) The Government's Alcohol Strategy Home Office, Home Office Drug and Alcohol Unit
- Humphreys, C, Thiara, R.K. & Regan (2005) Domestic Violence and Substance Misuse, Overlapping Issues in Separate Services, Greater London Authority and the Home Office
- Kent Joint Strategic Needs Assessment 2011-2012
- Moriarty. K.J et al. (2010) *Alcohol-related Disease – Meeting the challenge of improved quality of care and better use of resources*. London: British Society of Gastroenterology, Alcohol Health Alliance UK and British Association for Study of the Liver
- Morleo M, Dedman D, O'Farrell I, Cook P A, Burrows M, Tocque K, Perkins C, Bellis M A. *Alcohol-attributable hospital admissions: segmentation series report 3* Liverpool: Centre for Public Health & North West Public Health Observatory
- Moyer A, Finney J, Swearingen C, Vergun P (2002) Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction* 97:279-292.
- National Institute of Health and Clinical Excellence (2010). NICE Public Health guidance 24, Alcohol Use disorders – preventing harmful drinking
- National Institute of Health and Clinical Excellence (2011). NICE Commissioning guide: Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults

National Mental Health Development Unit and The NHS Confederation (2009)
London: National Mental Health Development Unit and The NHS Confederation

National Treatment Agency. The Review of the effectiveness of treatment for alcohol problems , National Treatment Agency for substance misuse 2006

Rehm J, Shield KD, Joharchi N, Shuper PA. (2012) Alcohol consumption and the intention to engage in unprotected sex: systematic review and meta-analysis of experimental studies. *Addiction* 107, 51-9

Social Exclusion Unit (2002). *Reducing re-offending by ex-prisoners*. London: Social Exclusion Unit

Stead, L., Perera, R., Bullen, C., et al (2008) Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews*, issue 1, CD000146. Wiley InterScience.

Thom, Lloyd C, Hurcombe R, Bayley M, Stone K, Thickett A and Watts B in collaboration with Tiffany C. (2010) Report to the Department of Health: Black and Minority Ethnic Groups and Alcohol – a scoping and consultation study. Middlesex: Department of Health

DRAFT

Glossary

Brief Interventions	Short, evidence-based, structured conversation about alcohol consumption with a patient/client, that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their alcohol consumption and/or reduce their risk of harm.
Care pathway	<p>A care pathway is “anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team.</p> <p>It has locally agreed standards based on evidence where available to help a patient with a specific condition or diagnosis move progressively through the clinical experience.</p>
Clinical Commissioning Groups	Local groups that include GPs and other health professionals and are responsible for purchasing appropriate health care that meet the needs of their population.
Community Alcohol Partnerships	Bring together local retailers, trading standards, police, health, education and other local stakeholders to tackle the problem of underage drinking and associated anti-social behaviour.
Daly	The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.
Dependent drinking	<p>Alcohol is both physically and psychologically addictive. It is possible to become dependent on it.</p> <p>Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life.</p>
Direct Enhanced Service (DES)	Schemes that the NHS are required to establish or to offer contractors the opportunity to provide, linked to national

	priorities and agreements.
DUST	Drug and alcohol use screening tool
Harmful drinking	Harmful drinking is defined as when a person drinks over the recommended weekly amount of alcohol and experiences health problems that are directly related to alcohol.
Hazardous drinker	Hazardous drinking is defined as when a person drinks over the recommended weekly limit of alcohol (21 units for men and 14 units for women).
Health and wellbeing board	Health and wellbeing boards exist in top tier and unitary authority as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
Higher risk drinker	Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week
IBA (Identification and Brief Advice)	Identification: using a validated screening tool to identify 'risky' drinking, such as the AUDIT The delivery of short, structured advice aimed at encouraging behaviour change in relation to reducing alcohol consumption.
Increasing risk drinker	Men who regularly drink more than 3 to 4 units a day (but drink less than the higher risk levels) Women who regularly drink more than 2 to 3 units a day (but drink less than the higher risk levels)
Joint Strategic Needs Assessment	Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin the health and well-being strategies, a proposed new statutory requirement and commissioning plans.

	<p>The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. The NHS and upper-tier local authorities have had a statutory duty to produce an annual JSNA since 2007.</p>
KDAAT	<p>Kent Drug and Alcohol Action Team. The team within Kent County Council that commission drug and alcohol treatment services.</p>
Local Enhanced Service (LES)	<p>Schemes agreed by commissioners in response to local needs and priorities, sometimes adopting national service specifications.</p>
NICE	<p>The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.</p>
NNT (Numbers Needed to Treat)	<p>Number Needed to Treat refers to the ratio of patients treated to those who will avoid a negative outcome as a result. (E.g. A substance dependence with an NNT of 5 means 5 people were treated for every 1 that quit or did not suffer a bad outcome.)</p>
Public Health Responsibility Deal	<p>The Public Health Responsibility Deal aims to tap into the potential for businesses and other influential organisations to make a significant contribution to improving public health. Organisations signing up to the Responsibility Deal commit to taking action voluntarily to improve public health through their responsibilities as employers, as well as through their commercial actions and their community activities.</p>