

Kent Alcohol Strategy 2014-2016

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Foreword

A safe and sociable Kent

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. 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.

A healthy challenge

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 make sure 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 Kent County Council Public Health, 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 of alcohol harm in Kent.

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Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing, Kent County Council, Chair of KDAAT

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An earlier draft of the strategy was open for formal consultation via the Kent County Council website from early December 2013 until mid- January 2014. A number of updates to the strategy have been made following feedback received.

2014-16 Alcohol Strategy: vision and aims

The overarching vision of this strategy is to reduce alcohol-related harm to individuals, families and communities in Kent. This document outlines how partners and stakeholders will work together towards the following aims:

We will work towards a culture of responsible drinking, where individuals make informed choices about their alcohol use, drink less and less often, by **promoting and supporting change in attitudes and behaviours**.

All sections of the alcohol retail industry will contribute to reducing alcohol-related harm through **commitment and action on responsible retailing**.

We will improve individuals' health and wellbeing through access to effective **early interventions and recovery-focused treatment and care** services for those who need them, including older people and pregnant women.

We will protect children, young people and families from alcohol-related harm and support them to achieve better outcomes through early identification and intervention, access to support and treatment, whole-family approaches, and safeguarding vulnerable children.

We will work with local communities to reduce alcohol-related crime, disorder and antisocial behaviour by tackling alcohol-related offending by individuals, and challenging irresponsible alcohol retailing.

Introduction

Safe, social and responsible

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 ten years (Moriarty, 2010).

New government strategy

The government's alcohol strategy written in March 2012, identifies 1million alcohol-related crimes and 1.2million alcohol-related hospital admissions nationally (Home Office, 2012). National and local alcohol strategies seek to reduce this figure. The 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 £3.5billion per annum (2009 to 2010).

The cost of alcohol-related crime in England is £11billion per annum (2010 to 2011).

The cost of lost productivity in the UK is £7.3billion 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.

Impact of alcohol harm in Kent

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 2010-11, there were 27,760 hospital stays for people in Kent for alcohol-related harm (15.43 per 1,000 population age standardised rate). 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 1.18million.

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.

Our Six Point Pledge and Seven Steps for Reducing Alcohol Harm in Kent

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.

Our pledge and strategy are ongoing - and this plan takes us up to 2016 when we will review our achievements.

Six point pledge for reducing alcohol-related harm in Kent

We Will:

- 1 Improve Prevention and Identification
- 2 Improve the Quality of Treatment
- 3 Co-ordinate Enforcement and Responsibility
- 4 Tailor the plan to the local community
- 5 Target Vulnerable groups and Tackle Health Inequalities
- 6 Protect Children and Young People

Seven evidence-based high impact steps that we will take to help us tackle harm from alcohol in Kent

- 1 Work in partnership: enhance, strengthen and support each other – not duplicate
- 2 Develop activities to control the impact of alcohol misuse in the community
- 3 Influence change through advocacy and leadership
- 4 Improve the effectiveness, quality and capacity of specialist treatment services
- 5 Have specialist workers in key locations – like accident and emergency (A & E) departments
- 6 Provide more help to encourage people to drink less through identification and brief advice
- 7 Amplify national social marketing by local action and publicity

Going Further

The first Kent Alcohol Strategy (2010-2013) focused on six key areas of work:

- Communication
- Adult treatment
- Community safety
- Licensing
- Children and young people
- Hidden harm

The strategy outlined a number of commitments to tackle alcohol misuse. During the lifetime of the strategy considerable progress has been made in some areas of work and less progress in other areas.

The main achievements from 2010 – 2014 have been;

- The establishment of an integrated substance misuse service for adults in both west and east Kent. This has improved aftercare, including wraparound services such as employment and training support.
- The establishment of a new integrated substance misuse service for young people across Kent.
- Effective promotion, awareness and understanding of Alcohol Treatment Requirements (ATR) with treatment providers exceeding ATR targets across the county.
- Increasing the number of Kent Community Alcohol Partnerships (KCAPs) beyond the pilot area to other parts of the county. A KCAP toolkit has been developed and utilised so that any community group with an identified alcohol-related problem can launch their own scheme with support from Trading Standards.
- Implementation of a criminal justice diversion scheme.
- Multi-agency commitment to Multi-Agency Risk Assessment Conference (MARAC) for domestic abuse.

- The delivery of school-based interventions for children and young people who have been identified as vulnerable using a life skills approach.
- Training of Kent neighbourhood police officers to engage with adolescents exposed to alcohol consumption.
- Production of an updated alcohol needs assessment for Kent. This was addressed within the new integrated substance misuse needs assessment for Kent produced in summer 2012.

These are the areas where we need to do better from 2014-2016

- Introduce screening and brief interventions for hazardous and harmful drinkers in non-alcohol-specialist settings e.g. primary care, A & E and criminal justice settings.
- Better communication and public awareness
- Identify the additional needs of adults and young people presenting at A & E who are misusing alcohol
- Ensuring the social care and education system are equipped to identify cases where parental misuse is affecting the quality of family life and making sure that there are clearer protocols in place to help them co-ordinate support.

Pledge 1: We will improve prevention and identification of alcohol harm

This section details current and planned work on preventing alcohol-related harm for adults. Prevention for young people is covered in the section on protecting children and young people.

What we know

National research and evaluation has shown that opportunistic screening and brief interventions for adults will contribute to reducing alcohol-related harm and alcohol-related hospital admissions. By targeting the screening and brief interventions to the right people at the right time, and in the best setting, will reduce alcohol consumption for those drinking at hazardous and harmful levels by making people more aware and pointing them in the right direction.

This method will also increase the rates of referral to specialist treatment for those suffering from significant alcohol dependence and harmful drinkers who have not responded to brief interventions. This means that more people who need help will get help.

What is Identification and Brief Advice? (IBA)

Identification and Brief Advice 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 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.

Scale, pace and population

The scale of the problem in a county the size of Kent is considerable. The chart on page 10 shows that there is a large degree of variation within Kent districts in alcohol specific deaths for men. This variation is seen for many alcohol misuse indicators. This is why a 'population' based programme is nationally recognised to be the best way to tackle the problem.

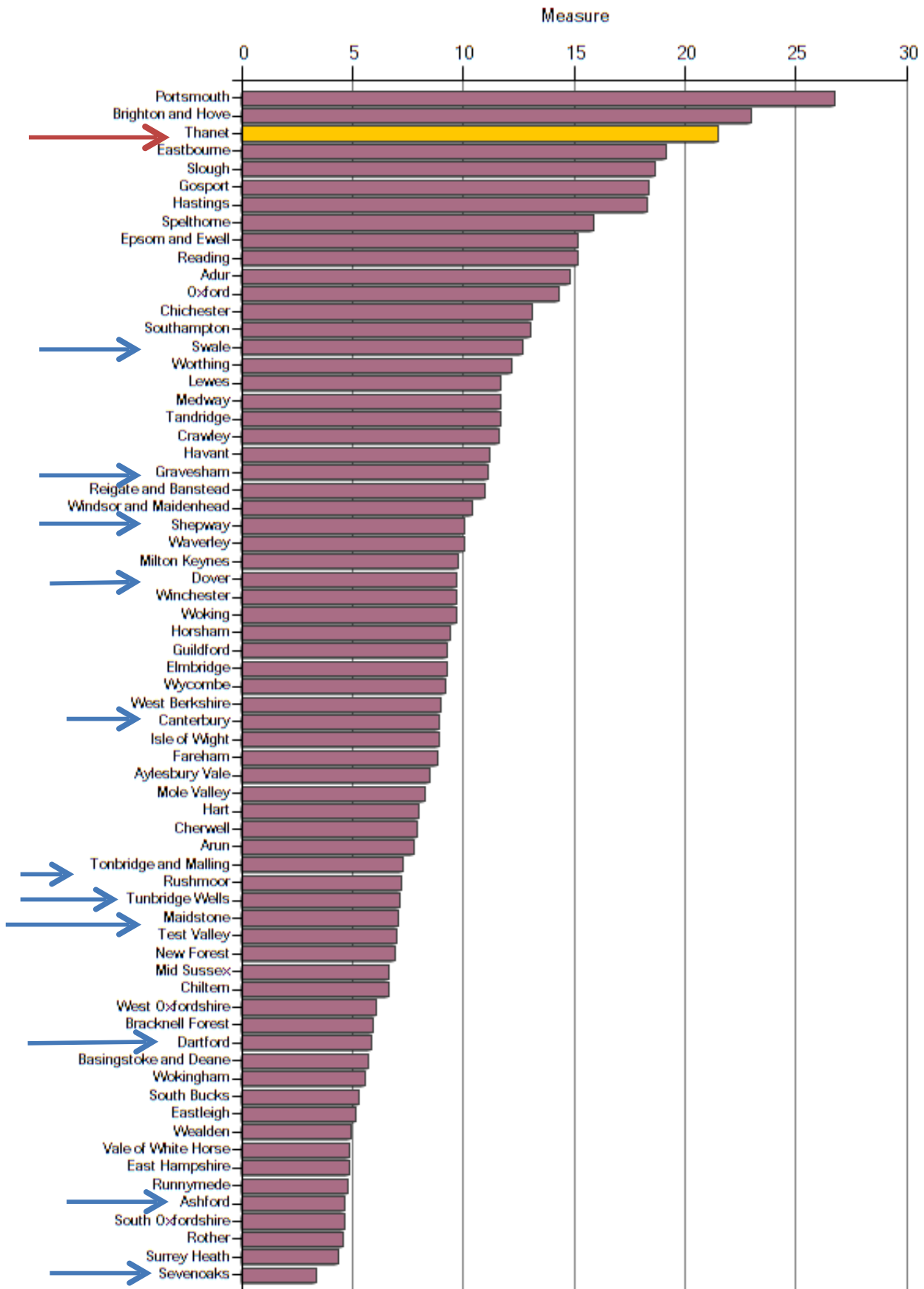
The research evidence shows that the number of people we 'need to treat' (NNT) i.e. offer screening and brief interventions to, is **eight to one**. This means that for every eight people 'treated' or offered screening, one will change their behaviour (Moyers et al. 2002).

This is considerably better than for smoking cessation, which has an NNT of around 35 or higher (Stead et al. 2008), and means that the potential impact that screening and brief interventions can have is huge.

To meet the England average figures for increasing or higher risk drinkers, Kent needs to achieve an alcohol misuse reduction of **9,118**. Using the NNT ratio, this means we need to offer at least **72,944** IBAs across Kent.

Alcohol IBA and referral to treatment services is currently not routinely undertaken by all health care professionals as part of the diagnosis and referral process. This is especially important for the treatment of conditions such as cancer, gastro and cardiovascular disease services (notably hypertension and stroke), because alcohol misuse can contribute to the cause the conditions and make them worse.

This Chart Shows the Alcohol Specific Mortality Rate for Men across all district councils in the South East per 100,000 people 2008-10. The Regional average is 10.1 and this Chart shows that Kent districts have a wide range. Thanet has the worst (highest) death rates and Sevenoaks has the lowest.



Source: LAPE Profiles 2013

Working with the experts

The National Institute for Health and Care Excellence 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 offered.

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.

Make the health of older people a priority

Drugscope (2014) produced a report which demonstrated that alcohol-related hospital admissions for men and women over 65 rose by 136% and 132% respectively in the eight years to 2010. So although most admissions for alcohol harm are for people under 65 – we must make sure that we also tackle the health of older people.

What we are doing now

- Intervention and Brief Advice (IBA) services 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 but as yet, we are not systematically monitoring this.
- Kent currently only provides approximately 3% of the recommended IBA coverage for increasing risk and higher risk drinkers and we are sure demand is likely to increase.

What we aim to improve and how

- Firstly – we will work with the experts and contract them properly to provide the IBA, then we can monitor how many are being done. We will then identify a greater number of people across the county and ensure they are offered appropriate support. We will do this by developing a **Local Enhanced Service** (LES) for IBAs in primary care. We will also make sure

there is access to them from outside healthcare settings too, because we know many people do not regularly see their GP. These settings will include hospital departments, health 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 have a focus on specific population groups (i.e. older people, students, the military and pregnant women.)
- We will maximise on marketing activity that is already trusted by using existing branding to include responsible alcohol promotion (Change 4 Life campaign and Healthy Passport Scheme).

How will we know we have achieved our aims?

- Once we know how many people we are screening we will then set increasing targets to increase in the number of people screened for alcohol misuse in various settings- aiming for 9% coverage (from our estimated current position of 3%).
- 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 year on year.
- We will see an increase in the number of referrals to specialist assessment in community-based alcohol treatment services.
- We aim to have more people taking up treatment in community-based alcohol treatment services following referral and also making a recovery.

- There will be a reduction in alcohol-related hospital admissions and mortality. This will include a contribution to a reduction in chronic liver mortality. We are realistic however- this aim will take time – but we hope to make inroads so we can continue to make gains and improvements from 2016 onwards.
- There will be a range of effective campaigns that will be targeted and specific in raising awareness in specific population groups. We will evaluate how effective these campaigns are.

Pledge 2: Improve the quality of 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 these types of posts 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 one hour, and are designed to be conducted by health professionals who do not specialise in addiction treatment. The evidence base suggests (National Treatment Agency 2006) that brief interventions are effective for increasing risk and higher risk drinkers. 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 now?

We have commissioned specialised treatment services that are available across Kent in a wide range of settings. A variety of interventions can be accessed by those in need of help for their own, or for someone else's alcohol use.

The term of the approach the services in Kent are taking is 'Recovery'. 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. They provide a range of interventions including; advice and 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. These services are for both drugs and alcohol and this is a recent development. Over the course of time we are seeing more people with alcohol addiction in treatment services.

What we aim to do and how

- We will continue to contribute to reducing the number of deaths related to liver disease. We will do this by working with hospital gastroenterologists as well as with treatment providers to improve access to these treatments.
- We will contribute to the reduction of the number of alcohol-specific hospital admissions. We will do this by making preventative treatments more accessible so that fewer people bypass these services and end up in hospital.
- We will:
 - Establish hospital Alcohol and Drug Liaison Community Teams across Kent to undertake in-reach to hospital departments and wards and will include liaison with psychiatric services

- o Create 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 teams
- o Develop aftercare packages prior to hospital discharge
- o Provide substance misuse training to acute hospital staff
- o Improve 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 get better data quality which will allow us to more accurately assess 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' (i.e. agreed ways for clinical working) 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 effective, 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 have been strong links between treatment services and hospital trusts. We will learn lessons from other parts of the country as well as sharing our successes.
- We will create more seamless services across Clinical Commissioning Groups (CCGs) and agencies providing treatment. This will allow for better understanding of people's treatment needs, screening, referral and advice services and passing relevant information.
- We will reposition the Alcohol Diversion Scheme into treatment and recovery services across Kent with a view to increasing the treatment uptake of offenders who misuse alcohol.
- We will promote good partnership working with Alcoholics Anonymous and other agencies to ensure that pathways are designed to enable the most chronic alcohol users are able to receive the most appropriate support for their individual needs.

How will we know we have achieved our aims?

- There will be a reduction in liver disease deaths from 2014 onwards – although we recognise that this will take time.
- There will be a reduction in the rate of hospital admissions wholly attributed to alcohol and we will monitor the scale of the reduction year on year.
- 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 Groups across the county in relation to the whole system process including alcohol screening, brief advice and referral for treatment.
- There will be increased access of offenders to treatment services

Pledge 3: Co-ordinate 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 underage, 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.

What are Kent Community Alcohol Partnerships (KCAPS)?

Community Alcohol Partnerships form a key strategy of both the police and trading standards which aim 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.

Kent Community Alcohol Partnerships (KCAPS)

KCAPS 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 now

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 has 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 underage 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 community alcohol partnerships 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 soon be in a position to share its own best practice with other areas, as was done with 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.

Pledge 4: Tailor plans to the local community needs

What we know

Kent is a large county with considerable local variation. This means that there are different needs and different priorities for reducing alcohol harm across the county.

Some examples :

- Thanet is considerably worse than the England average for many indicators and is the sixth worst local authority in England for chronic liver mortality.
- Canterbury has a relatively high level of female hospital admissions attributable to alcohol.
- Tunbridge Wells has higher admissions related to alcohol for older people.
- Swale has high numbers of offenders in need of treatment services.
- Maidstone has high levels of 'binge drinking' due to its night time economy.

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.
- We provide substance misuse needs assessments that highlight 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 services, 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.

Pledge 5: Target vulnerable groups and tackle health inequalities

Mind the Gap: Kent's Health Inequalities Strategy and alcohol's link to mental distress.

Alcohol misuse is a big contributor to health inequalities in Kent and are often the result of people's social, economic and mental distress. This section deals with those groups who suffer disproportionately and are most vulnerable to the impact of alcohol misuse and is a key element in Kent's contribution to tackling population level health inequalities and tackling mental distress.

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 vulnerable populations has a widening effect on health inequalities. People who die from liver disease often die aged 45-55 which is very early compared with CVD deaths (average age 75).

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.

Minority groups

People from most minority ethnic groups have higher rates of abstinence from alcohol and lower rates of alcohol 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).

Deprivation

Women who live in the most deprived areas have alcohol-related death rates that 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

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).

Mental health

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).

Self harm

People who have or are recovering from drug and alcohol problems are at greater risk of self-harm than the general population. Approximately 25% of people who self-harm will have a diagnosis of alcohol misuse (National Collaborating Centre for Mental Health, 2012). In people who repeatedly self-harm the use of alcohol and drugs can increase their risk of self-harm. This may either occur due to the effects of intoxication or due to the absence of previous forms of self-medication during the withdrawal phase of recovery. Approximately 50% of people presenting to A&E following self-harm

will have consumed alcohol immediately preceding or as part of their self-harming behaviour and this is more common in men (National Collaborating Centre for Mental Health, 2012). Local data reflects this finding; the audit of A&E attendances for self-harm in Kent found that alcohol was associated with 41% of attendances for self-harm (NHS Kent and Medway 2012). Overall self-harming behaviour linked to alcohol is more common in women and levels of self-harm related to drug misuse is also rising in women. (Royal College of Psychiatrists 2010)

Dual diagnosis

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.

Domestic violence

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).

Accidents

Alcohol is one of the leading causes of accidents, from domestic to traffic related. On a positive note, the number of fatal drink driving road accidents reduced almost six-fold between 1979 and 2012, although drink drive accidents still account for 16% of all road deaths in Britain (Drinkaware 2013). Alcohol is the single biggest cause of accidents at home. Of the 4,000 fatal accidents that happen in homes in the UK every year, 400 are alcohol-related. Alcohol is a factor in up to one in four workplace accidents. In 2008, the London Fire Brigade estimated that almost a third of accidental fire deaths in the capital were alcohol-related (Drinkaware 2013)

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. In order to achieve this, we will need to work with the Joint Policy Planning Board (JPPB) for housing.
- 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 need a greater understanding of the needs of some groups (i.e. **older people, migrant communities and vulnerable adults**) to minimise the barriers in accessing treatment services or support.
- 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.
- We will ensure that there is better linkage with those recovering from alcohol problems with mental health treatment services to reduce **self-harm**.
- Services with a role in reducing alcohol misuse (including schools, youth services, district authority licensing etc) should target, or continue to target young people, especially females, in order to reduce unintentional injuries from poisoning.
- Ensure that campaigns and marketing undertaken takes account of the relationship between alcohol and accidents.

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.
- Alcohol awareness will be more prominent in the training and delivery of front line care staff for better treatment of vulnerable adults
- We will work with military covenants and the armed forces networks to raise awareness of alcohol pathways for ex-military and armed forces.

Pledge 6: Protecting children and young people from alcohol harm

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 as 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. RiskKit 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.

Young offenders

Evidence suggests that vulnerable young people are more likely to drink, and alcohol use amongst young offenders is known to be high (Audit Commission 1996).

Alcohol use and violent crime are commonly perceived to be closely associated. The most direct element of the relationship is when crime is actually carried out under the influence of alcohol. Half of all victims of violent crime believe their attacker was under the influence of alcohol at the time (Home Office 2010). Based on data from the 2004 Offending, Crime and Justice Survey, young people's drinking behaviour between the ages of 10 and 17 years is associated with 80,640 violent offences per year, of which 34,560 are cases of assault resulting in injury, and 27,200 property offences, including 15,360 cases of criminal damage

(Bellis et al. 2007). In the UK, more than one in five young males aged 15 to 16 years expect to get into trouble with the police after drinking.

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, children's social services, KIASS and youth justice 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.
- We will work closer with youth justice agencies and KIASS to increase partnership working and understanding of alcohol-related violence in young people with the aim of reducing it.
- We will work with KIASS, the young people's treatment provider and other appropriate agencies to support an increase in numbers of young people accessing specialist community treatment services.

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 from 2014- 2016, even a 3% reduction is a good short term outcome although we want to increase this to 15% over a longer period of time.
- 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. However will we have to consult the population on what this outcome will look like over time.
- There will be a reduction in the teenage pregnancy rate in line with national trends.
- There will be a reduction in the barriers in young people accessing treatment services which we will assess by talk to young service users and increased uptake.
- 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: We will produce a detailed plan during 2014.

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
- 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 responsibility 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.

Resources Needed: Cooperation and Investment

In order to deliver this strategy it will be important to ensure the detailed plan of action is properly resourced. It is safe to say that there is a considerable amount of public money invested in substance misuse services and if this money is used flexibly to tackle alcohol as well as drugs then gains can be made for population health. Much of this does not need a huge investment as some of the actions identified in this strategy need co-operation rather than hard cash. However – to deliver campaigns and IBA's at scale and pace will require that this issue be given equal priority to other public health and social care objectives. Details of the resources will be published separately.

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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 mbehaviour 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	<p>Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week</p> <p>Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week</p>
IBA (Identification and brief advice)	<p>Identification: using a validated screening tool to identify ‘risky’ drinking, such as the AUDIT</p> <p>The delivery of short, structured advice aimed at encouraging behaviour change in relation to reducing alcohol consumption</p>

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. 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.
KDAAT	Kent Drug and Alcohol Action Team. The team within Kent County Council that commission drug and alcohol treatment services.
Local enhanced service (LES)	Schemes agreed by commissioners in response to local needs and priorities, sometimes adopting national service specifications.
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.
NNT (Numbers Needed to Treat)	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.)
Public Health Responsibility Deal	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.

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