Reducing Harm, Improving Care:
Liverpool Alcohol Strategy 2011-14
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Foreword

Alcohol plays an important role in British society and the development of our local economy when used in moderation, but it also causes dependence and contributes to serious health and social problems at considerable cost to our local economy.

In the seven years since our first Alcohol Strategy was launched, Liverpool has been an early adopter of innovative and quality partnership working to reduce alcohol-related harm. The development of the Pssst: be alcohol aware media campaign and the City’s collaboration in establishing the Alcohol and Tobacco Unit to tackle issues like under-age sales highlight our on-going commitment to joint working.

Liverpool has marked the start of 2011 as the beginning of its Decade of Health and Wellbeing, which has heralded a strong recommittment of partnerships across the public, private and voluntary sector to deliver on our vision of Liverpool as a healthy, safe place for residents, the local workforce and visitors alike to experience and enjoy, and an important part of that commitment includes renewed action to tackle the health and social problems caused by alcohol.

Liverpool’s third Alcohol Strategy, Reducing Harm, Improving Care, comes at a challenging time for public services and this places increasing emphasis on the need to maximise the impact of our resources and strengthen partnership working to deliver on a comprehensive set of actions so as to create a more positive culture and attitude toward alcohol and deliver better outcomes for people with alcohol-related problems.

We’d like to thank the efforts of those who have been implementing successive alcohol strategies to date and we hope the new strategy will be positively received as an overview of the comprehensive work being undertaken on your behalf.

Co-chairs of Liverpool Alcohol Strategy Group

Gideon Ben-Tovim

Roz Gladden
1. Executive Summary

**Reducing Harm, Improving Care: the third Liverpool Alcohol Strategy (2011-14)**

Liverpool has had an alcohol strategy since 2004. The first of which was produced in response to the National Alcohol Harm Reduction Strategy (DH 2004).

Its successor, ‘Tackling Alcohol in Liverpool’ (LLSP 2007) sought to meet the challenge, as set out in the second national alcohol strategy, ‘Safe. Sensible. Social.’ (DH 2007), of addressing Liverpool’s alcohol-related health harms, the impact of alcohol on children and families and to consolidate Liverpool Community Safety Partnership’s statutory duty to address alcohol-related crime and disorder.

Since that time there has been increased focus nationally on the need to enhance the knowledge and capacity of local partnerships to tackle alcohol-related harm.

In this challenging new environment for public services, Liverpool’s third alcohol strategy, Reducing Harm, Improving Care will look to:

- Develop a programme of activity for alcohol improvement based on 3 key themes that cut across the alcohol improvement agenda and recognise that the key to improving alcohol outcomes is the strength of our partnership working in Liverpool and maximising the use of resources. These themes are **Prevention**, **Treatment** and **Control**

- Consolidate successful alcohol programmes and interventions that have had a positive impact on alcohol harm minimisation since our local alcohol strategy was first developed

- Build our plans going forward on the strong evidence base and guidance that has arisen from the National Alcohol Improvement Programme, including the High Impact Changes for alcohol harm reduction (see Box 1)

- Put in place an **outcomes-centred** performance management framework that will assist us in evaluating progress against our objectives and identify the current gaps in our alcohol improvement activity

- Ensure that the development of services serves to address health inequalities in the distribution of alcohol-related harm.

**Box 1: The High Impact Changes for Alcohol Harm Reduction**

High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at a local level.

The following activities are calculated to have the greatest impact on health commissioned outcomes and for tackling alcohol-related harm.

These are:

- 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
- IBA – Provide more help to encourage people to drink less
- Amplify national social marketing priorities

Our programme of activity will be based on Key Outcomes that comprehensively reflect the whole alcohol improvement agenda. These are:

- Changing knowledge, skills and attitudes to alcohol
- Creating safer drinking environments
- Supporting individuals needs
- Support for children, young people and parents in need
- Reducing the availability and affordability of alcohol.
Key strategic aims and objectives

The strategic aims of the Liverpool Alcohol Strategy arise from the updated national alcohol strategy, Safe, Sensible, Social (DH 2007) in addition to our local priorities.

The overall aim of the Strategy will be to prevent and reduce alcohol-related problems through partnership working and using the best available evidence of what works so that we can improve the quality of life for people who live in, work in and visit our City.

The Liverpool Alcohol Strategy will promote the following principles:

■ To bring about a shift in attitudes and behaviours toward alcohol and support social, moderate drinking practices

■ To reduce alcohol-related crime and anti-social behaviour including serious violence, assault with injury, sexual violence and domestic violence, and to create safe drinking environments

■ To ensure that the harms caused to young people and their families are minimised through education, early intervention and quality support in addressing alcohol problems

■ To ensure that alcohol harm reduction interventions are targeted to the areas and individuals with the greatest need

■ To recognise that alcohol misuse contributes significantly to a range of health conditions and that the alcohol treatment system needs to be configured to treat an individual’s whole health need

■ To reflect the recommendations of the Marmot review of health inequalities and engage local communities in the decision-making process to ensure the effective local delivery of local alcohol services.

These principles in turn have been developed into a comprehensive set of Objectives which are detailed in Section 4 of the Strategy.

Delivery plans and aspirations

During the life of the third alcohol strategy, Liverpool will seek to:

■ Increase capacity in alcohol treatment services to accommodate at least an additional 2000 patients per year in comparison to the current level

■ Engage 11,000 people every year in alcohol Identification and Brief Advice (IBA) from 2011/12

■ Target over 120,000 increasing and high risk drinkers with alcohol resources and media to engage with them about the health risks associated with their alcohol use

■ Reduce wholly attributable alcohol-related admissions by 5%, based on their projected increase between April 2011 and April 2014.

The strategic framework

The delivery of the alcohol strategy is the responsibility of Liverpool Alcohol Strategy Group, which is jointly chaired by the Chair of Liverpool Primary Care Trust and the City Council’s Cabinet Member for Adult Social Care and Health. The membership is comprised of a number of alcohol stakeholding agencies outlined in Appendix 1.

The Alcohol Strategy Group will oversee the implementation of the Strategy as a whole, the monitoring of associated outcomes and the evaluation of the Strategy’s overall effectiveness. Implementation plans have been developed so as to complement other strategic plans where alcohol is a key issue (see Box 2, overleaf).

The Alcohol Strategy’s objectives fall within the remit of three of Liverpool’s strategic partnership groups. These are:

■ Liverpool First for Health (which is due to be succeeded by the Liverpool’s Health and Wellbeing Board)

■ Liverpool Community Safety Partnership (Citysafe) and,

■ Liverpool Children’s Trust Board

The implementation of the Alcohol Strategy is split across these groups, with each board responsible for the delivery of actions appropriate to their own remits.
Box 2: Strategic plans where alcohol is a key issue

- Liverpool PCT’s Operational Plan
- C&YP/Children’s Trust Plan
- Older Person’s Strategy
- Liverpool Drug Treatment Plan
- Community Safety Partnership’s Three Year Strategy (including the Violent Crime, Domestic Violence and Sexual Violence Strategies)
- Local Policing Plan
- Mental Health Strategy
- Homeless Strategy
- Dementia Strategy

Strategic drivers and targets for alcohol improvement

As well as our local strategic plans, a number of Local Area Agreement targets, National Indicators, drivers and duties around alcohol improvement have combined to direct the development of the local alcohol strategy for the areas of health, community safety and for children and young people.

Those Local Area Agreements and National Indicators that informed the alcohol strategy have now been abolished as the mechanism by which Local Strategic Partnership’s report to central Government on performance.

Now, as part of the Healthy Lives, Healthy People NHS reforms a proposed framework for public health outcomes will provide the vehicle for developing indicators and performance indicators for the future. This is likely to still include the rate of hospital admissions per 100,000 for alcohol-related conditions, and the mortality rate from chronic liver diseases in persons under 75 years.
2. Introduction

Alcohol is the most widely used drug in the world and has a significant and valued recreational role. It can and does play an important role in British economy and in society. This is particularly evident in the country’s city centre night time economies.

However, while alcohol is a source of pleasure, it is increasingly becoming a significant cause of personal, social and economic harm. Extended alcohol misuse commonly leads to dependence and alcohol is a major or significant contributor to a range of health problems such as liver and heart disease, cancers, and social problems including unemployment, homelessness, violence, teenage pregnancy and accidents.

Alcohol also has a particularly negative social impact on young people e.g. contributing to a missed education and leading to a failure of young people to reach their full social and economic potential.

Harm from other people’s drinking is common and wide ranging. It ranges from the less severe, such as being kept awake at night by rowdy behaviour or covering for a colleague who fails to turn up for work, through to much more severe consequences, such as domestic violence, road traffic accidents or neglect of children.

Understanding alcohol and its harm

The harms associated with alcohol are complex and wide-ranging, and they either directly or indirectly affect the majority of the population in Liverpool to some degree.

Where we have a clearer understanding of the impact that alcohol is having on individuals or population groups, we can better target our resources and interventions to those experiencing the greatest need.

The impact of alcohol nationally

Current estimates put the cost of alcohol misuse at around £22 billion pounds to the UK economy including £3.7 billion to the NHS alone (AC 2010) and alcohol-related illness or injury accounts for nearly a million hospital admissions per year.

The rate of alcohol-related hospital admissions increases with age and there are an estimated 22,000 premature deaths annually, e.g. in 2005, 4,160 people in England and Wales died from alcoholic liver disease alone – almost double the death rate for that condition than ten years previous. The largest increase in the rate of admission is among men and women aged 50 or more. The peak age for alcohol-related deaths is now around 55-59 for men and women.

There are substantial differences in the health consequences of alcohol use between affluent and deprived communities. Deprived areas suffer higher levels of alcohol-related deaths, hospital admission, crime, truancy, teenage pregnancy and road traffic accidents, which are all linked to greater levels of alcohol consumption.

Locally, an analysis of alcohol use has highlighted the following issues:

- Alcohol is the biggest contributory factor for both violence and serious violence offences recorded by Merseyside police.
- Of those that attended the Royal Liverpool University Hospital as a victim of assault more than half reported that they had consumed alcohol in the previous three hours prior to the attack.
- Alcohol reduces the average life expectancy of women by 7.6 months, the third highest loss for any local authority in England
- It reduces the average life expectancy of men in Liverpool by 14.8 months
- Liverpool has the highest rates of alcohol-related hospital admission in England for both adults and children
- Liverpool residents are twice as likely to die from an alcohol-specific condition, such as liver disease, than the England average
- Hospital admissions due to alcohol in Liverpool residents have increased by 60% in the 5 years to 2009/10
- Alcohol is a feature in more than one third of domestic violence cases in Liverpool.
And from the Liverpool City Centre Perceptions Survey 2010...

- Day time and night time respondents indicated people being drunk in the street made them feel unsafe more than any other of the 13 listed environmental factors.

- The second most important factor to help improve respondents feelings of safety was ‘less drunken behaviour in public places’, which increased from 0% in 2009 up to 32% in 2010;

- Drink-related anti social behaviour (18%) and theft (17%) are the two crimes that the majority of people think most commonly occur in Liverpool City Centre.

**Evidence on alcohol consumption**

The root cause of alcohol-related problems in Liverpool are the increasing levels of alcohol consumption in the population. Nationally, the amount of pure alcohol that individuals consume in their drinks has nearly doubled since the 1960s. The following graph illustrates how alcohol consumption has risen since 1960 as the relative price of alcohol has fallen.

Recent research identifies that this is the equivalent of 26 units per adult drinker per week, which is 10 units per week more than the most reliable estimates from self-reported drinking. This is equivalent to one bottle of wine per adult drinker each week going unreported.

By also taking into account untaxed alcohol, including home brew, alcohol drunk by UK drinkers abroad and illegal imports brings estimated consumption to 30 units of alcohol per adult drinker per week (AC 2009). This is considerably higher than the Department of Health’s guideline recommendations of 14 units per week for women and 21 unit per week for men.

Figure 1: Per capita pure alcohol consumption in relation to its relative price (AMS 2004)
Higher risk drinking levels in Liverpool
The major concern from this research is for the level of drinking defined as causing damage to physical or mental health, known as higher risk drinking. Taking this research into account it is now estimated that as many as 42,000 adult drinkers are drinking at this level in Liverpool.

Increasing risk drinking levels in Liverpool
Based on the same research, an estimated 28% of adult drinkers in Liverpool drink at the increasing risk category, which equates to diseases like cancers, cirrhosis and high blood pressure. This category accounts for approximately 81,500 adult drinkers.

Impact on women
Due to a generally lower body weight, less body fluid, more body fat and smaller livers, alcohol has a more severe effect on women than men. The research highlights that the proportion of men and women drinking over advisory levels in the UK are broadly the same (DH 2004) and this is a considerable cause for concern.

Impact on young people
Data from the national Tell Us 4 survey of 10-15 year olds suggests that approximately one in seven Liverpool children in that age group admitted to having been drunk in the past 4 weeks, while there are uncertainties about the effect that alcohol has on a body that is still developing with organs that haven’t fully matured.

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

In fact, the evidence strongly suggests that the key to avoiding alcohol problems in later life is avoiding drinking until adulthood. Alcohol is drunk at least twice a week by an estimated 630,000 under 18s and nationally nearly 9000 young people needed to access specialist alcohol treatment in 2009 (AC 2010).

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
<th>Common effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lower risk</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| No more than 3–4 units per day | No more than 2–3 units per day | • Increased relaxation  
• Sociability  
• Reduced risk of heart disease  
(for men over 40 and postmenopausal women) |
| **Increasing risk** | | Increasing risk of... |
| More than 3–4 units per day | More than 2–3 units per day | • Low energy  
• Memory loss  
• Relationship problems  
• Depression  
• Insomnia  
• Impotence  
• Accidents  
• Alcohol dependence  
• High blood pressure  
• Liver disease  
• Cancer  
• Brain injury |
| **Higher risk** | | |
| More than 8 units per day or 50 units per week | More than 6 units per day or 35 units per week | |

Figure 2: Alcohol risk levels and associated health harm
Impact in the workplace
Alcohol reduces productivity in the UK. Alcohol is estimated to cause the loss of 17 million working days due to alcohol-related absences and 20 million days due to the reduced number in employment.

Impact on the family
In addition to the personal risks to individuals who consume too much alcohol, the impact on their interpersonal and wider social relationships can also be damaging, leading to problems such as:
- Relationship/family breakdown
- Domestic violence and aggression
- Unsafe or regretted sex
- Poor parenting and child abuse
- Anti-social behaviour and,
- Homelessness and street drinking

It is estimated that as many as 1.3 million children in the UK are affected by a parental alcohol problem and 60% of child protection cases involve alcohol.

Alcohol, deprivation and health inequalities
In Liverpool, as the following graph of alcohol-related admissions by ward ranked by their deprivation scores shows, there is a strong correlation between those areas experiencing the highest economic disadvantage in the City, and those most affected by alcohol-related health harms that cannot be explained by the amounts of alcohol consumed by individuals in these wards alone.

In fact, even the more affluent wards in the south of Liverpool (e.g. Mossley Hill, Church, Woolton) have alcohol-related admission rates equal to or slightly above the national average, while the most deprived wards in the City (e.g. Everton, Kirkdale, Princes Park) have admission rates over 3 times the national average.

In effect, this data highlights the health inequalities that exist between the most and least deprived wards, which in turn emphasises the need for the targeted provision of increased capacity in alcohol services in the most deprived parts of the City.

Figure 3: Correlation of Deprivation and Alcohol Related Admissions Rate per 100,000 Population 2008/09, Liverpool Wards
This phenomenon is also evident in the distribution of alcohol-related death rates across the City, where the highest rates correspond to the most deprived wards (see figure 4). This also reflects the findings of the Marmot review into health inequalities, which found that the lower a person’s social status was, the worse their health would be (Marmot 2010). This Strategy looks to address a number of the policy objectives of the Marmot review, including creating healthier environments and working more preventatively.

Figure 4: Alcohol Related Mortality Rates per 100,000 Population 2004-08 (pooled) all persons, all ages by Liverpool Ward.
The implementation of our previous two alcohol strategies has brought about improvements to the harms caused by alcohol.

The first alcohol strategy (2004-06) was successful in providing the strategic vision and direction to reduce alcohol related harm within an environment that supported economic regeneration and competitiveness.

During that time, we produced and successfully promoted the award winning brand, PSSST! – *Be Alcohol Aware*, which continues to be used to highlight the personal risks associated with alcohol misuse and is closely associated with interventions to promote safe and responsible drinking in the City.

The second alcohol strategy was launched in November 2007 for the period 2007-2010. During that time there have been a number of key developments which underpin the new alcohol strategy which can be related to our alcohol improvement programmes’ three key themes of prevention, treatment and control.

### Developments in prevention and treatment

Since the last local alcohol strategy ‘Tackling Alcohol in Liverpool’ was produced the prioritisation of alcohol treatment and interventions as a public health issue has intensified both nationally and locally. The Department of Health has invested considerable resources in the National Alcohol Improvement Programme (AlP), a regional alcohol team (Drinkwise North West) and has established a National Support Team (NST) for Alcohol Harm Reduction.

The Alcohol Improvement Programme was established in April 2008 to work with PCTs, local authorities and other partners to help reduce alcohol-related hospital admissions across the NHS.

As part of that programme Liverpool PCT signed up to targets to reduce the rate at which alcohol-related admissions increase over a 3-year period until March 2011.

Liverpool PCT has risen to that challenge and has put in place a programme of activity to achieve its key objectives around prevention and treatment:

- To improve access to targeted and opportunistic alcohol identification and brief advice services
- To improve the effectiveness and capacity of specialist treatment and,
- To improve the targeting of high risk and vulnerable alcohol misusers.

The implementation of that programme of activity has put in place the foundation for the effective delivery of objectives of the new Strategy. This has included the following developments:

- As an effective and preventive alcohol treatment system is one that provides services close to where people live and work, the focus on developing a community alcohol service has been a key contributor to Liverpool’s Quality, Innovation, Performance and Prevention (QIPP) programme.

  - The first phase of a programme of alcohol Identification and Brief Advice (IBA) to screen and engage the population across a range of settings has been put in place and will be fully implemented by the Summer of 2011 with ambitious targets for delivery of alcohol Identification and Brief Advice (IBA) during the life of the Alcohol Strategy (see Box 3).

  - Plans to increase the capacity of Tier 2/3 alcohol services are well underway. A new Community Alcohol Service to improve health outcomes for people with alcohol problems will commence in the Summer of 2011 (see Box 4).
A plan for the whole alcohol treatment system in Liverpool, to ensure the effective collaboration of alcohol services for patient outcomes has been written and consulted upon and is now being implemented.

A forum for service providers has been established to support the implementation of the plans for the new alcohol treatment system and will be tasked to the development of improving patient case management and outcomes across that system.

A new brand called ‘What’s Yours?’ has been developed to inform the public about the relationship between alcohol consumption and health (see Box 5).

A City-wide assertive outreach pilot to engage street drinkers in their health and social needs began in November 2009.

A service to provide Alcohol Treatment Requirements (i.e. a community order compelling an offender to undergo treatment, where a dependence on alcohol has been identified) has been established which links in with domestic violence and other violent crime offenders.

A collaboration between local NHS and research establishments called Mersey Best Evidence, Application and Translation of research (MerseyBEAT) has invested in two alcohol research programmes in 2011 that will lead on to better alcohol identification and interventions in the future.

Box 3: Alcohol Identification and Brief Advice (IBA)

There is extensive literature to evidence the effectiveness of alcohol IBA. For every 8 people who receive IBA at least one will change their drinking to low risk levels. Identification and Brief Advice is a two part process. ‘Identification’ refers to the application of a validated alcohol screening tool. The Alcohol Use Disorder Identification Test (AUDIT) is definitive as it allows the ‘screener’ to determine without the need for further screening what ‘pathway’ the patient/client should be directed to, dependent upon their AUDIT score. For reference the AUDIT screening tool is outlined in Appendix 5.

Liverpool Primary Care Trust has developed ambitious targets for the delivery of alcohol IBA through a range of engagement routes. The following targets have been determined for three of those routes:

<table>
<thead>
<tr>
<th>Planned IBAs</th>
<th>2011/2012</th>
<th>2012/2013</th>
<th>2013/2014</th>
<th>Totals</th>
</tr>
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<tbody>
<tr>
<td>GPs</td>
<td>6000</td>
<td>7500</td>
<td>7500</td>
<td>21000</td>
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<tr>
<td>Pharmacies</td>
<td>4080</td>
<td>4080</td>
<td>4080</td>
<td>12240</td>
</tr>
<tr>
<td>Community Alcohol Outreach Team</td>
<td>1500</td>
<td></td>
<td></td>
<td>1500</td>
</tr>
<tr>
<td>Totals</td>
<td>11580</td>
<td>11580</td>
<td>11580</td>
<td>34740</td>
</tr>
</tbody>
</table>

In addition to these alcohol IBA services Liverpool PCT is also training over 500 frontline staff across a range of health and non-health settings to engage the public in their alcohol use using the alcohol IBA screening tool. We estimate that this approach might lead to another 10,000 people a year being engaged in their alcohol use.
Box 4: Increasing the capacity of alcohol services in Liverpool

A new community alcohol service launches in Liverpool in the Summer of 2011. The new service has been designed to increase the capacity of alcohol services to work with people whose alcohol use is harmful to their health.

The service will be designed to:

- Be a setting where patients can receive alcohol assessment, support, treatment and referral in community neighbourhood settings across the City
- Deliver effective pathways from acute settings (e.g. hospitals) in to primary care, which will reduce alcohol-related admissions.
- Reduce the number of patients requiring a referral to Tier 4 in-patient and residential alcohol treatment services when an alternative pathway would be more effective and appropriate
- Work with other alcohol-related service providers to improve the accessibility and quality of alcohol-treatment pathways across primary care, hospital and community settings.

When it reaches capacity, the service will increase the numbers of harmful drinkers that can be treated and prevented from becoming more serious cases by over 2000 patients per year.

Box 5: What’s Yours? Highlighting the link between alcohol and ill health

A range of resources has been developed to highlight the physical health risks associated with drinking above the daily recommended limits for alcohol consumption and signpost people to sources of self-help and support.

Under the banner of What’s Yours: Find out if your drinking is affecting your health, the resources include an easy-to-use alcohol unit wheel and drinks diary, to help people work out if their drinking puts their health at risk.

The What’s Yours brand is targeted primarily at 35-55 year old men and women who are most at risk of developing one of 44 health conditions, including liver cirrhosis, hypertension and gastro-intestinal and breast cancers as a result of excessive drinking.

In 2010/11, through a series of campaigns over 60,000 people were directly targeted with the What’s Yours brand through maildrops, radio adverts and other media. Over the life of this Alcohol Strategy we intend to target an additional 120,000 through further media work, a new website and the engagement of at-risk individuals.
Next steps in prevention and treatment

The key to tackling the health harms associated with alcohol is to change attitudes and behaviours and bring about a reduction in the amount of alcohol consumed in the population. The price and availability of alcohol are key obstacles to this goal as they create the impression, particularly in young people, that alcohol is an everyday consumer item, rather than a legal but potentially harmful, habit-forming drug.

In response to this concern there have been concerted calls nationally from health and other professional bodies to increase the purchasing price of alcoholic drinks based on the amount of alcohol in them, either through taxation or by introducing a minimum unit price on these products.

Both Liverpool City Council and Liverpool Primary Care Trust have signed up to support the process of lobbying the Government for this policy change nationally, and are working in partnership both at a regional level and through the Core Cities to effect this change (see Box 6)

The development of a new community alcohol service will serve as a platform around which improvements to the whole alcohol treatment system, with a strong focus on health outcomes, can be built. We will consult widely with alcohol stakeholders on the delivery of the new plan.

In addition to the work that is underway we will be looking to improve the reach of specialist alcohol treatment services into a diverse range of services that support people with alcohol misuse problems and their families.

A key part of the process of reducing health inequalities will involve improving the appropriateness of local alcohol services. An alcohol health needs assessment will be undertaken to identify the gaps in the proposed new treatment system, e.g. on the following issues:

- The needs of patients with alcohol-related brain injury and other people whose needs lead to recurrent and prolonged hospital admissions
- The needs of those with dual diagnosis of mental health problems and alcohol misuse
- A review of the needs of the City’s established BME communities and other equality groups.

Going forward, particular attention will need to be given to addressing the needs of children and young people, and closer integration with the plans of the Children’s Trust Board.

Box 6: Lobbying for a minimum unit price on alcohol products

Research from the University of Sheffield says that establishing a minimum price of 50 pence per unit of alcohol, as well as restricting promotions, would be the most effective way to reduce the harm caused by alcohol.

Their calculations show a 50p limit would mean 2,900 fewer premature deaths a year as well as 41,000 fewer cases of chronic illness as well as reducing the incidence of crime by 46,000 incidents and lost work days by 300,000 per annum nationally.

The effect of minimum pricing would have the most positive impact on children and on high risk drinkers

Additionally, a minimum pricing policy would not punish drinkers who drink within the recommended amounts – a 50p minimum unit price would cost these drinkers about an extra £1 per month.
Developments in control
Citysafe, Liverpool’s Community Safety Partnership, working with partners in areas such as Licensing, Trading Standards and the Primary Care Trust have developed a matrix of inter-related initiatives to reduce the potential impact of alcohol-related crime and anti-social behaviour.

The key objectives for this agenda support the prevention and control themes of the new Alcohol Strategy:

■ To reduce alcohol-related crime and disorder in Liverpool and,
■ To promote a safe and sensible drinking culture across the City.

Liverpool city centre’s safety and crime record has greatly improved over the last ten years as the City’s renaissance as a cultural and social venue for the region has increased.

In that time, Citysafe and its partners have continued to make excellent progress against its plans, through developments that will strengthen alcohol prevention and control within the new Strategy:

■ Co-ordinating a 3 year local community safety strategy through the Partnership’s sub-groups (including the City Centre Joint Agency Group and the Violent Crime Group).
■ Implementing recommendations from the Designing Out Crime research report into City Centre’s violent crime hotspots (See Box 7 for details).
■ Developing the Goldzone policing initiative to tackle alcohol-related crime and disorder in the City Centre
■ Commissioning high visibility policing enforcement operations.
■ Supporting the Taxi Rank Marshalling Scheme.
■ Implementing enforcement actions to reduce the sale of alcohol to under 18’s and target the supply of illicit alcohol and tobacco through the City’s Alcohol and Tobacco Unit (ATU)
■ Improving training available to bar staff in licensed premises.

■ Working with schools to provide better information and advice on alcohol and drugs through the ‘Healthy Schools’ programme.
■ Developing a cocaine/alcohol enforcement pilot in the city centre including alcohol interventions as an option for conditional cautions

Box 7: Designing Out Crime in the Night Time Economy
Citysafe commissioned research to examine the environmental factors that contribute to crime and disorder in the City Centre’s night time economy to develop recommendations for action to be implemented through Citysafe’s City Centre Joint Agency Group. The recommendations are set out in short, medium and long term timescales. Progress so far includes:

• The setting up of an interest group for Concert Square to deal initially with the acute problems associated with the Square and then to create a new identity for the area.
• The staging of Liverpool Light Night, a family orientated event involving extending the City Centre’s cultural offer.
• A Cavern Quarter Stakeholder Group established to determine future vision for the area based on its musical heritage.
• Traffic flow studies are currently being undertaken in key city centre night time economy locations, most notably Seel Street.

The full Designing Out Crime report includes medium and long term recommendations for preventing violent crime and alcohol related disorder in the night time economy. Where appropriate lessons learned could be applied in other areas of the city.
Next steps in crime reduction and community safety

Despite the encouraging reductions in recorded crime, the City Centre remains the focal point for violent crime both in terms of serious violence and assault with injury.

Citysafe acknowledges that levels of recorded crime, particularly relating to the night time economy have began to ‘plateau’ and that further intervention is required if crime levels are to further reduce.

Priorities for 2011-2014 have been developed based on findings from the ‘Designing Out Crime’ report, the City Centre Perceptions Survey and other sources.

Other developments

The second alcohol strategy, ‘Tackling Alcohol in Liverpool’ also identified a range of supporting activities required to deliver change on the scale required in the City, including:

■ The importance of communication plans and social marketing in communicating effectively with the public and changing behaviour toward alcohol.

■ The need for accurate information and intelligence to inform the development of alcohol improvement plans, particularly around the work of Citysafe and the improvement of the alcohol treatment system in the City.

■ The need to engage with employers to develop alcohol improvement work with the local workforce.

■ The importance of having a good working relationship with local licensees to encourage the responsible retailing of alcohol to young people and to bring about a reduction in binge drinking.

A number of initiatives have been developed in these areas which will contribute to the overall implementation of the new Alcohol Strategy:

■ Liverpool Primary Care Trust (PCT) has funded the Alcohol and Tobacco Unit (ATU) as a joint PCT/City Council venture to tackle alcohol and tobacco health issues through enforcement, education and business engagement.

■ Health@Work were commissioned to provide alcohol-related workplace information and brief interventions to a range of businesses in Liverpool.

■ The Workplace Wellbeing Charter has been developed and promoted within workplaces in Liverpool, to promote staff health with specific provision for alcohol.

■ The analysis of the nature and extent of alcohol-related crime in Liverpool using partnership data has helped us to develop a detailed picture of need, e.g. the data from A&E departments is helping Citysafe to target hotspot locations and bars. In turn, such activity is beginning to produce a reduction in the number of referrals to A&E departments. January 2007 – December 2009 saw a 28% reduction in assault related admissions to A&E.

■ The analysis of Hospital Episode data for alcohol-related conditions has allowed us to carefully target new alcohol brief interventions activity, treatment services, and communication to people with the greatest need.
The third Liverpool Alcohol Strategy aims to consolidate the successes of the first two strategies as outlined in the previous chapter and in doing so develop a new approach to the implementation of the alcohol strategy that builds upon the language of alcohol harm reduction.

In October 2010, the framework and targets under which Local Strategic Partnerships (LSPs) reported nationally on performance were scrapped. We are now able to look in detail at the key strategic aims and objectives in this Strategy and develop an approach that is focused on improving outcomes.

An outcome-focused approach has a number of advantages:

■ By monitoring outcomes as well as establishing delivery targets we are proving the benefits of activities we deliver on and can be more focused on results.

■ It allows us to develop and map our main objectives and their key outcomes, and to plan, develop and work toward longer-term goals.

■ It allows us to better understand the relationship between different objectives and how they contribute to the long term aims.

■ For that same reason it allows us to better prioritise the work that we do and determine what we will and won’t do when opportunities arise.

■ It allows us to develop outcomes that cut across all of our priorities which in turn will strengthen partnership working.

■ It allows us to develop a range of related outcomes for specific target groups e.g. street drinkers, young people, etc.

Using this approach we have identified those key outcomes and objectives that comprehensively describe Liverpool’s alcohol improvement agenda that we can work in partnership to deliver.

Identifying long term goals

These are the goals which the new Alcohol Strategy are ultimately working towards. They correspond to the high level aims of the Local Strategic Partnerships:

■ Safer families and communities
■ Healthier individuals and populations
■ Reduced health, social care and justice costs
■ Increased workplace productivity
■ Increased educational attainment.

These goals are delivered through five Key Outcomes which correspond to the aims of the new Alcohol Strategy.

Key outcomes

■ Changing knowledge, skills and attitudes to alcohol
■ Creating safer drinking environments
■ Supporting individuals needs
■ Support for children, young people and parents in need
■ Reducing the availability and affordability of alcohol.

By adopting these Key Outcomes we can map a pathway of activity for each one, through a set of Objectives and their corresponding Outcomes as highlighted in Figure 5. Delivering on these objectives will help us to achieve our aims.

Figure 5: The development of Key Outcome Pathways

Using this approach we have identified those key outcomes and objectives that comprehensively describe Liverpool’s alcohol improvement agenda that we can work in partnership to deliver.
A Pathway for each Key Outcome has been developed from their related objectives and corresponding outcomes, as listed in Box 8. These pathways are outlined in full in Appendix 3.

**Box 8: Alcohol Improvement Objectives and Outcomes**

**Key Outcome 1: Changing knowledge, skills and attitudes toward alcohol**

**Objectives**

1a Public awareness campaigns  
1b Increased availability of alcohol Identification and Brief Advice (IBA)  
1c Frontline staff training around alcohol harms  
1d Alcohol workplace policies  
1e Improved substance misuse education in schools

**Outcomes**

1.1 Increased knowledge of unit content and individuals’ own consumption  
1.2 Increased knowledge around recommended limits and the health risk of not drinking in moderation  
1.3 Increasing awareness of the tools, support and services available for help-seeking individuals  
1.4 Increasing the skills of young people to limit their alcohol consumption  
1.5 Increasing knowledge and changing attitudes to alcohol and drinking  
1.6 Reducing the acceptability of hazardous drinking and drunkenness

**Key Outcome 2: Creating safer drinking environments**

**Objectives**

2a Action against drunkenness and alcohol-related anti-social behaviour  
2b Managing the NTE/Designing Out Crime  
2c Review provision of alcohol outlets  
2d Enforcement of responsible retail practise

**Outcomes**

2.1 Fewer intoxicated drinkers on the streets/in cells  
2.2 Early identification and management of hotspots  
2.3 Review alcohol provision in identified areas  
2.4 Fewer intoxicated drinkers generally  
2.5 Reduced number of anti-social/crime incidents

**Key Outcome 3: Supporting individuals needs**

**Objectives**

3a Target for delivery of alcohol Identification and Brief Advice (IBA)  
3b Targeting of IBA to primary care and other settings  
3c Workforce development in alcohol IBA  
3d Increased investment in treatment services  
3e Workforce development in specialist services  
3f An integrated care pathway for offenders

**Outcomes**

3.1 Increased incentive to deliver quality alcohol IBA in NHS and other settings  
3.2 Increased quality of IBA in the workforce  
3.3 Increased capacity and quality of specialist services to meet demand  
3.4 Increasing access for offenders requiring support  
3.5 Increased number of quality brief interventions delivered across NHS and other settings  
3.6 Increased detection and referral of harmful and dependant drinkers
Key Outcome 4: Support for children, young people and parents in need

Objectives
4a Improved identification, assessment and referral of children and young people affected by parental, and their own, substance misuse
4b Strengthening networking amongst agencies
4c Building the preventive capacity of young people through the provision of information, advice and support
4d Provide effective services for children affected by substance misuse

Outcomes
4.1 Improved screening of drinking in pregnancy, parental and children’s alcohol misuse
4.2 Increased sharing of appropriate information between agencies
4.3 Improved quality of services for children affected by substance misuse
4.4 Improved identification, assessment and interventions with children affected by parental and their own alcohol misuse
4.5 Improved effectiveness of engagement with children affected by alcohol misuse

Key Outcome 5: Reducing the availability and affordability of alcohol

Objectives
5a Assessment of the over-provision of licenses
5b Training around selling to drunks and underage sales
5c Enforcement against serving drunks, underage sales and responsible retailing
5d Lobbying for a minimum price for alcohol based on strength

Outcomes
5.1 Over-provision assessment leading to targeted licensing control
5.2 Increased knowledge of legal and social responsibilities
5.3 Increased detection and prosecutions for law breaking
5.4 Increased support for a minimum unit price for alcohol
5.5 No increase in density in over-provided areas
5.6 Increased refusal to serve someone who is drunk
5.7 Increased deterrent to not serve someone who is drunk
5.8 Increased actual and relative price of on- and off-sale alcohol
Co-ordinating the Alcohol Strategy Implementation Plan

The Alcohol Strategy’s Implementation Plan is divided into the partnership themes of Prevention, Control and Treatment. Each theme contains a set of actions that have been cross-referenced to each outcome within the Key Outcome Pathways in Appendix 3.

Given the challenging and changing environment under which we work the current Implementation Plan is presented as a snapshot of the activity being delivered at the time the Strategy was written and it will change over time, while our objectives and outcomes will remain constant. The current Implementation Plan can be found in Appendix 4.

The Alcohol Strategy Group (ASG) will ensure the effective delivery of the Alcohol Strategy by performance managing and evaluating these actions and developing new activity for the implementation where gaps have been identified.

Progress against, and updates to, the Implementation Plan will be presented to the Alcohol Strategy Group on a regular basis and the Plan itself will be made available to view on the ‘What’s Yours’ website: www.whatsyours-liverpool.nhs.uk

The following actions will help us to deliver on the implementation of the Alcohol Strategy

Developing a dashboard of alcohol outcomes

In order to performance manage the delivery of the Alcohol Strategy, a dashboard of measurable activity has been developed, with one dashboard for each Key Outcome.

The activity and outcomes will change as the delivery requirements of the alcohol improvement programme develop over the life of the current Alcohol Strategy.

Embedding alcohol objectives into the local strategic framework

It’s essential for the successful implementation of the alcohol strategy to ensure that those objectives that are not currently written in to the business plans of the relevant Liverpool Strategic Partnership thematic groups are incorporated into those plans going forward.

Identifying gaps and inequalities in the alcohol improvement programme

An advantage of working to the Key Outcomes pathways is that it will clearly indicate what activity will need to be developed to close the gaps in delivery against those alcohol improvement outcomes and in working toward our wider objectives.

Furthermore, data collected on alcohol-related admissions and the take up of alcohol services will enable us to monitor whether those people and areas most in need of alcohol services are benefiting from them, and closing the gap in alcohol-related health inequalities.

Liverpool Alcohol Strategy Group will be able to focus on the identification of those gaps and inequalities and propose new developments and partnership commissioning activity to close them.

Maintaining good alcohol stakeholder communication

A 100+ strong stakeholder group has been established in preparation for the development of this Strategy. Additionally, a service provider stakeholder group has been established to support development work across the whole alcohol treatment system.

In keeping with the High Impact Change around partnership working and influencing change through advocacy we will continue to maintain regular updates to these groups, and the development of a dedicated email address for on-going alcohol consultation (whatsyours@liverpoolpct.nhs.uk) which will ensure that we have a medium for the continued engagement and involvement of alcohol stakeholders in the future.
References


AC 2010: Alcohol Concern. Right time, right place – alcohol harm reduction strategies with children and young people. London. Alcohol Concern. 2010


Appendix 1:
Liverpool alcohol stakeholders agency representation

- Liverpool Primary Care Trust
- Liverpool City Council
- Liverpool First (Local Strategic Partnership)
- Government Office North West
- Drinkwise North West
- Citysafe: Liverpool Community Safety Partnership
- Royal Liverpool Children’s NHS Trust
- Royal Liverpool and Broadgreen University Hospital NHS Trust
- Aintree University Hospitals NHS Foundation Trust
- Merseycare NHS Trust and The Windsor Clinic
- Community Integrated Care Addiction Services
- Action on Addiction
- Addaction and Young Addaction
- Liverpool Charity and Voluntary Services
- Liverpool John Moores University
- The University of Liverpool
- Liverpool Community Health NHS Trust
- Brownlow Health
- Merseyside Police
- Merseyside Fire and Rescue Service
- Liverpool Local Involvement Network (LINk)
- Merseyside Probation Service
- Inclusion Matters
- The Park View Project
- The Breckfield Centre
- Liverpool Lighthouse
- The Social Partnership
- Frontline Trust
- ICE Group UK
- The British Beer and Pub Association
Appendix 2: National drivers for alcohol improvement

Drivers in blue font are now abolished and will be subject to revision through the Liverpool Strategic Partnership

Drivers for health

- The Joint Strategic Needs Assessment for Alcohol
  This requires PCTs and local authorities to assess the current and future health and wellbeing needs of their population. The findings of the JSNA will lead to shared priorities to improve outcomes and reduce health inequalities, and will be used to inform targets within the Local Area Agreement.

- The NHS Operating Framework
  The Framework sets out the specific requirements for the NHS in taking forward the delivery of national priorities.

- Performance management
  PCTs are performance managed by the Strategic Health Authority and the Healthcare Commission against local and Vital Sign indicators, the most significant of which is Vital Sign target (VSC26): reduction in the projected rate of increase of alcohol-related hospital admissions.

Drivers for crime and community safety

- The Strategic Intelligence Assessment
  A statutory requirement to assess local crime and disorder issues and the findings inform the Local Strategic Partnership’s annual plans

- The indicator in Public Service Agreement (PSA) 23: To reduce violent crime and disorder, especially assault with injury

- The indicator in PSA 25: To reduce the percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area

- Performance management of enforcement agencies

- Performance management of the National Offender Management Service (NOMS)

- Performance management of Local Strategic Partnerships (LSPs) by Government Office against indicators within Local Area Agreements (LAAs)

- Performance management of Merseyside Police Authority by the Home Office against indicators embedded within their plans

- The Community Safety Partnership’s Three Year Strategy (statutory requirement)
  With refreshed annual plans – to reduce crime, disorder, anti-social behaviour, drugs, substance misuse and environmental crime related local issues.

  To tackle crime and disorder and put in place plans and strategies to tackle crime, disorder and substance misuse depending on local priorities

- Other relevant partnership plans
  Including the Violent Crime Strategy, Policing Plan, Domestic Violence Strategy

- The Licensing Act 2003

Drivers for children, families and society

- The indicator in Public Service Agreement 14 to reduce the proportion of young people frequently misusing substances

- Performance management of LSPs by Government Office against indicators within Local Area Agreements

- Performance management of young people’s substance misuse treatment by the National Treatment Agency (NTA)

- Healthy Schools status

- Ofsted inspections of schools
  Reports for which are publicly available

Cross-cutting drivers

- Choosing Health – the Public Health White Paper


- Safe, Sensible, Social: The next steps in the National Alcohol Strategy (DH 2007)
Appendix 3: Key Outcome Pathways 1-5

Key Outcome 1: Changing Knowledge, Skills and Attitudes toward Alcohol

Objective 1a
Public awareness campaigns

Outcome 1.1
Increased knowledge of unit content and individuals’ own consumption

Objective 1b
Increase availability of alcohol Identification and Brief Advice (IBA)

Outcome 1.2
Increased knowledge around recommended limits and the health risk of not drinking in moderation

Objective 1c
Frontline staff training around alcohol harms

Outcome 1.3
Increasing awareness of the tools, support and services available for help-seeking individuals

Objective 1d
Alcohol workplace policies

Outcome 1.4
Increasing the skills of young people to limit their alcohol consumption

Objective 1e
Improved substance misuse education in schools

Outcome 1.5
Increasing knowledge and changing attitudes to alcohol and drinking

Outcome 1.6
Reducing the acceptability of hazardous drinking and drunkenness

Key Outcome 1
Changing Knowledge, Skills and Attitudes towards Alcohol
Key Outcome 2: Creating Safer Drinking Environments

Objective 2a: Action against drunkenness and alcohol-related anti-social behaviour

Outcome 2.1: Fewer intoxicated drinkers on the streets/in cells

Objective 2b: Managing the NTE/Designing Out Crime

Outcome 2.2: Early identification and management of hotspots

Outcome 2.5: Reduced number of anti-social/crime incidents

Objective 2c: Review provision of alcohol outlets

Outcome 2.3: Review alcohol provision in identified areas

Objective 2d: Enforcement of responsible retailing practice

Outcome 2.4: Fewer intoxicated drinkers generally

Key Outcome 2: Safer drinking environments
Key Outcome 3: Supporting Individuals Needs

**Objective 3a**
Target for delivery of alcohol Identification and Brief Advice (IBA)

**Objective 3b**
Targeting of IBA to primary care and other settings

**Objective 3c**
Workforce development in alcohol IBA

**Objective 3d**
Increased investment in treatment services

**Objective 3e**
Workforce development in specialist services

**Objective 3f**
An integrated care pathway for offenders

**Outcome 3.1**
Increased incentive to deliver quality alcohol IBA in NHS and other settings

**Outcome 3.2**
Increased quality of IBA in the workforce

**Outcome 3.3**
Increased capacity and quality of specialist services to meet demand

**Outcome 3.4**
Increasing access for offenders requiring support

**Outcome 3.5**
Increased number of quality brief interventions delivered across NHS and other settings

**Outcome 3.6**
Increased detection and referral of harmful and dependent drinkers

**Key Outcome 3**
Supporting Individuals Needs (in a timely, sensitive and appropriate manner)
Key Outcome 4: Support for Children, Young People and Parents in Need

**Objective 4a:**
Improved identification, assessment and referral of children and young people affected by parental, and their own, substance misuse

**Outcome 4.1**
Improved screening of drinking in pregnancy, parental and children’s alcohol misuse

**Objective 4b:**
Strengthening networking amongst agencies

**Outcome 4.2**
Increased sharing of appropriate information between agencies

**Objective 4c:**
Building the preventive capacity of young people through the provision of information, advice and support

**Outcome 4.3**
Improved quality of services for children affected by substance misuse

**Objective 4d:**
Provide effective services for children affected by substance misuse

**Outcome 4.4**
Improved identification, assessment and interventions with children affected by parental and their own alcohol misuse

**Outcome 4.5**
Improved effectiveness of engagement with children affected by alcohol misuse
Key Outcome 5: Reducing the availability and affordability of alcohol

Objective 5a
Assessment of the over-provision of licenses

Outcome 5.1
Over-provision assessment leading to targeted licensing control

Outcome 5.5
No increase in density in over-provided areas

Objective 5b
Training around selling to drunks and under age sales

Outcome 5.2
Increased knowledge of legal and social responsibilities

Outcome 5.6
Increased refusal to serve someone who is drunk

Objective 5c
Enforcement against serving drunks, under age sales and of responsible retailing

Outcome 5.3
Increased detection and prosecutions for law

Outcome 5.7
Increased deterrent to not serve someone who is drink

Objective 5d
Lobbying for a minimum price for alcohol based on strength

Outcome 5.4
Increased support for a minimum unit price for alcohol

Outcome 5.8
Increased actual and relative price of on- and off-sale alcohol

Key Outcome 5
Reducing the availability and affordability of alcohol
<table>
<thead>
<tr>
<th>Action by Cross-Cutting Theme</th>
<th>Working toward outcome...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>• To continue with the development of the What’s Yours brand, working to promote unit alcohol awareness, drinking in moderation, the health risks associated with excessive alcohol consumption and the multiple routes available to access alcohol support and services.</td>
<td>1.1 – 1.3, 1.5, 3.6</td>
</tr>
<tr>
<td>• To support the extension of the new alcohol Identification and Brief Advice (IBA) programme across health and non-health services, e.g. in hospitals and a specific target for the delivery of alcohol IBA in the population.</td>
<td>3.1, 3.2, 3.5, 3.6</td>
</tr>
<tr>
<td>• To develop an alcohol IBA training programme to services working with young people and parents.</td>
<td>4.1, 4.4, 4.5</td>
</tr>
<tr>
<td>• To promote the supply of polycarbonate glasses and low and non-alcoholic beverages, free water and a responsible retailing code of practice and provide conflict awareness training for bar and club staff.</td>
<td>1.6</td>
</tr>
<tr>
<td>• To provide a forum for services working with young people and parents to increase information sharing, promote preventative working and identify gaps in provision.</td>
<td>1.4, 4.2 – 4.5</td>
</tr>
<tr>
<td>• To re-design and update the Pssst website to reflect young peoples’ and young adults issues around alcohol misuse.</td>
<td>1.4, 1.6</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
</tr>
<tr>
<td>• Establish activity that will tackle drunkenness and unacceptable behaviour in the night-time economy and neighbourhoods.</td>
<td>2.1, 2.2, 2.4, 2.5, 5.2, 5.3, 5.6, 5.7</td>
</tr>
<tr>
<td>• Closer working of enforcement agencies (licensing, planning, environmental enforcement, noise abatement, public protection, parking and highways) to target problem premises.</td>
<td>2.3</td>
</tr>
<tr>
<td>• Development of Licensees Watch groups and closer working between the licensing trade and police, trading standards and Licensing.</td>
<td>2.1, 2.2, 2.4, 2.5</td>
</tr>
<tr>
<td>• Continued targeting of underage drinking and of alcohol-related sexual exploitation and violence.</td>
<td>2.1, 2.2, 2.4, 2.5</td>
</tr>
<tr>
<td>• Consult on introduction of a cumulative impact licensing policy in the city centre and use planning controls to limit the growth of pubs and clubs.</td>
<td>2.1, 2.2, 2.4, 2.5, 5.1, 5.5</td>
</tr>
<tr>
<td>• For local and regional agencies to continue to work in partnership to lobby for stronger controls on the price and availability of alcohol.</td>
<td>5.4, 5.8</td>
</tr>
<tr>
<td>• Tackle irresponsible drinking promotions through joint enforcement operations.</td>
<td>2.1, 2.4, 2.5</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>• To implement the whole alcohol treatment system plan and develop appropriate performance indicators to manage the quality of the plan.</td>
<td>3.3</td>
</tr>
<tr>
<td>• Ensure that accessible and effective services for street drinkers are maintained and developed to further reduce the need for the group to access secondary care.</td>
<td>3.6</td>
</tr>
<tr>
<td>• Ensure that access points for offenders requiring alcohol treatment services are increased across the criminal justice system.</td>
<td>3.4</td>
</tr>
<tr>
<td>• To refresh the children and young people’s substance misuse referral pathway for information, advice, support and treatment.</td>
<td>4.3 – 4.5</td>
</tr>
</tbody>
</table>
### Appendix 5:
The Alcohol Use Disorders Identification Test (AUDIT)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2-4 times per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2-3 times per week</td>
<td></td>
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<tr>
<td></td>
<td>4+ times per week</td>
<td></td>
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<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1-2</td>
<td></td>
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<td></td>
<td>3-4</td>
<td></td>
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<td></td>
<td>5-6</td>
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<tr>
<td></td>
<td>7-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10+</td>
<td></td>
</tr>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</td>
<td>Never</td>
<td></td>
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<tr>
<td></td>
<td>Less than monthly</td>
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<tr>
<td></td>
<td>Monthly</td>
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<td>Weekly</td>
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<td></td>
<td>Daily or almost daily</td>
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<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td></td>
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<tr>
<td></td>
<td>Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td></td>
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<td></td>
<td>Weekly</td>
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<tr>
<td></td>
<td>Daily or almost daily</td>
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</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
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<td>Weekly</td>
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<tr>
<td></td>
<td>Daily or almost daily</td>
<td></td>
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<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td></td>
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<td></td>
<td>Less than monthly</td>
<td></td>
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<td>Monthly</td>
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<td>Weekly</td>
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<tr>
<td></td>
<td>Daily or almost daily</td>
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<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
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<td></td>
<td>Less than monthly</td>
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<td>Monthly</td>
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<td>Weekly</td>
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<td></td>
<td>Daily or almost daily</td>
<td></td>
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<tr>
<td>How often during the last year have you been unable to remember what happened the night before because you had been drinking?</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less than monthly</td>
<td></td>
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<td>Monthly</td>
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<td>Weekly</td>
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<tr>
<td></td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, but not in the last year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, during the last year</td>
<td></td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, but not in the last year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, during the last year</td>
<td></td>
</tr>
</tbody>
</table>

- Patients scoring less than 8 would not require IBA. The outcome in this instance would be to give the patient alcohol advice literature if appropriate.
- Patients scoring between 8 and 15 would be given simple brief advice (although patients scoring over 16 can also benefit).
- Patients scoring over 16 and not dependent on alcohol would benefit from brief advice and as part of the brief advice should be advised to contact their GP or self-refer into the community alcohol service (when it launches around July 2011).