Suffolk Alcohol Strategy
2014 – 2022

Health and Wellbeing
SUFFOLK
Working together to improve people’s health and wellbeing in Suffolk
Healthy, Safe & Prosperous: The Suffolk Alcohol Strategy 2014 – 2022

Foreword

On behalf of the Suffolk Health and Wellbeing Board, I am pleased to introduce Healthy, Safe and Prosperous: The Alcohol Strategy for Suffolk.

We have a vision for people in Suffolk to live happier, healthier lives. The Health & Wellbeing Board brings together organisations from the NHS, local government, police and the voluntary sector to increase the opportunities we have available to us in Suffolk to lead healthy lives. We also want to narrow the differences we see in health between different communities, often linked to deprivation.

Alcohol affects each of the priorities in our Joint Health & Wellbeing Strategy.

**Outcome one:** Every child in Suffolk has the best start in life

**Outcome two:** Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing

**Outcome three:** Older people in Suffolk have a good quality of life

**Outcome four:** People in Suffolk have the opportunity to improve their mental health and wellbeing

But alcohol is a complicated issue. It has potential for great harm, not only associated with serious ill health but also domestic violence, neglect, crime and disorder. But we must not forget that it also plays a significant and important role in our society. The alcohol business sector is particularly important in Suffolk, not only a significant employer but a major player in the county’s tourism industry.

This strategy relies on each partner working collectively with Suffolk communities to understand where the problems lie and how we can best address them. It recognises both sides of alcohol; the positive contribution of alcohol to our society and our economy; and the harm to individuals, families and communities. It looks at both preventing alcohol harm and dealing with it, using evidence based approaches so we direct our limited resources at interventions most likely to work.

Our aim is for a healthy, safe and prosperous Suffolk; one with a balanced and mature relationship with alcohol. I commend this strategy to you and I hope you will join us in putting it into action.

Councillor Joanna Spicer MBE  
Chairman  
Suffolk Health and Wellbeing Board
1 Introduction

As a country we have a complicated relationship with alcohol. We associate it with some of the happiest moments in life, from wetting the head of a new baby to celebrating a birthday. But it is also connected with some of society’s most destructive impulses, including addiction, neglect and violence.

Excessive intake of alcohol poses a significant risk to the health and well-being of individuals, families and communities and is the third greatest overall contributor to ill health after smoking and raised blood pressure.

Many adults drink alcohol, and for many it never causes problems. But for some, alcohol is devastating, leading to imprisonment, injury, disability, death, family breakup and poverty. For others it stops them making the best of life, shortening the years in which they enjoy good health or preventing them from doing well at school or work.

The organisations and partnerships responsible for improving health and well-being and keeping Suffolk safe and prosperous, are struggling to convey clear messages about alcohol. We have strong evidence of the increasing harm to individuals, families and communities but people remain confused about how much they can drink and where to seek help when alcohol use gets out of hand.

A further dilemma is that alcohol use contributes to health inequalities, with less well-off people and communities enduring more of the illness and disruption that alcohol causes. And yet having a job is an important contributor to good health, and alcohol production and tourism are major employers in Suffolk.

This strategy attempts to address all of these points by setting out a vision for Suffolk to have a balanced and sensible relationship with alcohol: healthy, safe and prosperous. It sets a direction of travel around a set of themes and principles, and describes what successful implementation would look like.

The strategy document is supported by appendices outlining the need for alcohol treatment services; the evidence of effectiveness of interventions to prevent and tackle alcohol related harm and the feedback from consultations on the strategy.
2 Why does Suffolk need an Alcohol Strategy?

Safe levels of drinking

The National Institute for Health and Care Excellence (NICE) recommends that:

- men should not regularly drink more than 3 to 4 units of alcohol a day;
- women should not regularly drink more than 2 to 3 units of alcohol a day;
- pregnant women, or women trying for a baby, should avoid alcohol altogether during the first 3 months of pregnancy and thereafter, to protect the baby, no more than 1-2 units, once or twice a week.

Public Health England describes Alcohol Risk Levels:

- **Lower risk** drinking is defined as consumption of fewer than 22 units of alcohol per week for males and fewer than 15 units of alcohol per week for females.
- **Increasing risk** drinking is defined as consumption of between 22 and 50 units of alcohol per week for males and between 15 and 35 units of alcohol per week for females.
- **Higher risk** drinking is defined as consumption of more than 50 units of alcohol per week for males and more than 35 units of alcohol per week for females.
- **Binge drinking** is defined as consumption of at least twice the daily recommended amount of alcohol in a single drinking session.

Example of broad estimates of alcohol units (Edinburgh Drug & Alcohol Partnership 2011)
Alcohol consumption in Suffolk

The majority of adults in Suffolk consume alcohol and many do so without experiencing adverse effects. However, we estimate that 15.1% of the over 18 population in Suffolk drink at increasing or higher risk, similar to our neighbouring counties. 3.8%, or 22,000 people in Suffolk, are dependent on alcohol. A growing number of the population consumes alcohol at a level that currently affects their health or wellbeing or the lives of others, and a further group is drinking at a level that is not currently causing such problems, but is at increased risk of doing so in the future.

The pattern of drinking behaviour is not uniform across the county. All districts have significant populations drinking excessively but particular health issues are evident in Lowestoft and Ipswich1.

The impact of excessive drinking

The effects of alcohol are far reaching at all stages of life from harm to the unborn child through to young people, the working age population and to older people.

Alcohol is a major cause of disabling and potentially fatal illnesses such as liver disease, some cancers, heart disease and conditions associated with obesity, and social problems including social exclusion, unemployment, homelessness, violence, disorder, teenage pregnancy, health inequalities and accidents.

Relative risks of harmful drinking

Table 1: Increased risks of ill health to harmful drinkers

<table>
<thead>
<tr>
<th>Condition</th>
<th>Men (increased risk)</th>
<th>Women (increased risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (high blood pressure)</td>
<td>Four times</td>
<td>Double</td>
</tr>
<tr>
<td>Stroke</td>
<td>Double</td>
<td>Four times</td>
</tr>
<tr>
<td>Coronary heart disease (CHD)</td>
<td>1.7 times</td>
<td>1.3 times</td>
</tr>
<tr>
<td>Pancreatitis (inflammation of the pancreas)</td>
<td>Triple</td>
<td>Double</td>
</tr>
<tr>
<td>Liver disease</td>
<td>13 times</td>
<td>13 times</td>
</tr>
</tbody>
</table>


Alcohol is an addictive drug. Alcohol dependence is a pattern of routinely drinking excessive amounts of alcohol over a long period of time, giving priority over other activities and obligations in life. It can cause or worsen mental or physical health problems and seriously affect relationships with family, and friends. It may affect our ability to work, find employment or result in drinking-related offences.

The consequences of alcohol misuse are widespread and include domestic abuse, hidden harm, financial hardship, family breakdown, safeguarding issues, hospital admissions, mental health problems and crime and disorder.
There are inequalities associated with alcohol. People from less well-off communities are more likely to abstain from drinking, but if they do consume alcohol they are more likely to have problematic drinking patterns and behaviour. In the most deprived areas men are five times more likely and women three times more likely to die of an alcohol-related death than those in the least deprived areas\(^2\).

The indicators we have available on the relationship between alcohol and health show a worsening picture. Crime statistics show that alcohol remains a significant community safety concern, but also indicate slight decreases in alcohol related crime.

**Figure 1: Hospital admissions; alcohol related conditions.**
(Source: Suffolk Alcohol Health Needs Assessment, 2013).

**Figure 2: All alcohol related crime.**
(Source: Suffolk County Council Community Safety team, 2013).

Key facts:

- Alcohol is commonly misused: more than 1 in 7 over 18s in Suffolk drink at increasing or higher risk.
- Alcohol consumption varies across the county, but all districts have significant populations drinking excessively. Particular health issues are evident in Lowestoft and Ipswich.
- In many cases alcohol misuse ceases without any form of formal intervention or contact with the criminal justice, health or social care system.
- Approximately 22,000 people in Suffolk are dependent on alcohol – and it is this group of people who have the greatest need for specialist alcohol services.
- Successful treatment requires a sustained abstinence based recovery model. A key feature of this is mutual aid.
- UK alcohol consumption is rising and admissions to hospital as a result of alcohol are increasing.

Children and young people

Children are particularly vulnerable to alcohol, directly through consumption and indirectly through violence and the wider effects of excessive drinking in the home. We know that excessive alcohol use during pregnancy has long term effects on brain and organ development in children. If a child’s main care-giver is unable to provide a secure and consistent relationship with the child it directly affects brain development and later control of the stress response, which is linked to all future learning, behaviour and health.

Alcohol misuse can be linked to behaviours that put a young person at risk of unsafe sex, violence and other criminal behaviours. NICE (2012) reported a survey of 10,000 young drinkers aged 15-16 years where 28% reported that they had experienced violence when drunk, 13% had regretted alcohol-related sex and 45% had experienced memory lapse after drinking.

Alcohol consumed by young people is increasingly likely to be obtained from the home, and school aged children are most likely to be given the alcohol by a family or friend rather than buying it.

People become alcohol dependent for many different reasons including availability of alcohol, peer pressure, anxiety and depression. Dependence can run in families and if a parent is dependent on alcohol, a child is four times more likely to be dependent too.

Emerging trends

There are new alcohol cultures emerging, such as ‘pre-loading’ (or drinking at home) before a night out, where people are four times more likely to drink over 20 units of alcohol during the evening. They are two and a half times more likely to be involved in violence than other drinkers. Accidental alcohol poisoning deaths have increased by more than 200% in the last 10 years and are likely to increase more due to social media drinking games like ‘NekNominate’.
The average intake of alcohol per person has risen steadily over the past 40 years. Drinking at home is widely accepted as the norm, with supermarket pricing and internet purchases of wine by the case enabling easy and cheap access to alcohol. There has also been a dramatic increase in drinking among women, with heavy drinking increasing by a third in the decade prior to 2008\textsuperscript{10}.

**Older people**

Excessive drinking in the older age groups is rising with alcohol related deaths in the UK in 2012 up 18\% for men and 12\% for women aged 75 and over. Alcohol-related hospital admissions, illnesses and mental health disorders are also rising\textsuperscript{11} with a third of older people with drinking problems affected for the first time in later life. Bereavement, physical ill-health, difficulty getting around, becoming a carer, social isolation and loneliness can lead to boredom and depression and alcohol can make these difficulties more bearable. There is less pressure to give up drinking than with younger people, especially when there is no pressure to go to work, fewer family responsibilities, changes in routine or other circumstances\textsuperscript{12}.

There is growing evidence to suggest that safe drinking levels for older people could be less than the current recommended daily limits as they break down alcohol more slowly than younger people. Approximately a third of all prescribed drugs are prescribed to the over 65s. Alcohol can interfere with some medicines and increase the likelihood of confusion and falls\textsuperscript{13}.

---

**The cost of excessive drinking to Suffolk**

Excessive drinking has a social and economic cost to our county.

We estimate 182,000 working days are lost annually in Suffolk through absences caused by drinking and over 3000 people in Suffolk go to work with a hangover every day\textsuperscript{14}.

Alcohol costs per year for the Suffolk economy are estimated as:

- **NHS in Suffolk (excluding Waveney) (2009/10 costs)** - £48,000,000
- **Crime in Suffolk** - £15,000,000 (2009/10 costs)
- **Lost productivity in Suffolk** - £80,000,000 (Institute of Alcohol Studies, 2012)

However, the 699 pubs and 25 breweries in Suffolk employed approximately 9,800 people in 2011/12 making a significant contribution to our local economy\textsuperscript{15}.

---

\textsuperscript{11} Siddique, H. (2014) Alcohol-related deaths among the elderly reach highest ever level. Guardian
\textsuperscript{12} Royal College of Psychiatrists (2014) Improving the lives of people with mental illness RC PSYCH.ac.uk
\textsuperscript{14} NICE (2012) National Institute of Clinical Excellence. Alcohol-use disorders: Preventing the development of hazardous and harmful drinking.
\textsuperscript{15} IWSR (2013) International Wine and Spirit Research
What are we doing already?

There are programmes across Suffolk to raise awareness about drinking and to support dependent drinkers to address their problems. The consensus is that there is much more to do. We need to take coordinated and cohesive action across organisations to address our growing concern about excessive alcohol consumption and to support more people in treatment to progress to full recovery.

Suffolk has a strong reputation around its work on alcohol. We were nationally commended for our partnership working following the Ipswich murders in 2006. Start Afresh is a multiagency initiative designed to tackle the street drinking problem. Our Reducing the Strength programme has attracted a great deal of national attention. This programme has encouraged retailers to voluntarily remove super strength, low price beer, lager and cider favoured by street drinkers from their shelves.

By December 2013, 94 off-licence premises in Ipswich – 64% of the total – had signed up to the Reducing the Strength scheme and been declared “super strength free”.

In the first year police recorded 23.5% fewer incidents related to street drinking reported by the public – a drop from 341 to 261 events\(^\text{16}\).

\(^{16}\) Gornall, J. (2014) New way to call time on high strength, cheap alcohol. BMJ 348:g2572 doi:10.1136/bmj.g2572 (Published 11 April 2014)
What interventions might work?

A review of the evidence base for tackling alcohol harm is detailed in appendix 4. This helps us identify the clinical and cost effectiveness of interventions to change attitudes, knowledge and behaviours in relation to alcohol consumption generally and for those who are drinking at harmful or hazardous levels.

Behaviour change is most likely to occur when we take a strategic approach to tackling alcohol. We need to combine interventions at individual, community and population-level, recognising that there are multiple target groups, including our staff and contractors who support change in others. Key interventions include:

- Presenting moderate drinking as a sensible alternative to binge drinking.
- Assessment and advice in GP, A&E and workplace settings.
- Implementing structured brief advice programmes for children, young people and adults, including extended brief interventions in over 16s and the workplace.
- Delivering brief advice in targeted areas of health inequalities, providing information and facilitated goal setting.
- Targeted interventions aimed at pregnant women.
- Interventions that target significant events or transition points in people’s lives.
- Social marketing campaigns aimed at universities, colleges and other educational establishments.
- Using alcohol risk education and campaigns that support local initiatives.
- School based interventions.
- Accessible alcohol treatment and recovery services.

The evidence of effectiveness for many potential interventions is still lacking. As we implement our strategy we need to robustly evaluate the impact of our actions.

What will success look like?

Progressive improvement in:
- Alcohol-related admissions to hospital
- Mortality from liver disease
- Take up of the health check programme for those eligible adults aged 40-74 – this includes screening for alcohol from April 2013
- Alcohol related crime
- Serious crime in a public place
- Alcohol related anti-social behaviour
- Alcohol related domestic abuse
- Availability of data on lifestyles and drinking habits for young people.

Governance

The implementation of the Suffolk Alcohol Strategy will be overseen by a multiagency group under the auspices of the Health & Wellbeing Board. Membership of the group will reflect the wide range of partners including the NHS, local government, education and business partners and the voluntary and community sector. The terms of reference will include coordination and monitoring of the delivery of an action plan. The group will have strong links with the governance group for commissioning of drugs and alcohol treatment services.
How this strategy was developed

The Suffolk Alcohol Strategy has been developed as a key priority for the Suffolk Health and Wellbeing Board as part of the delivery of its Joint Health & Wellbeing Strategy.

Before the development of the Health and Wellbeing Board, Great Yarmouth & Waveney had already published its own local alcohol strategy. Healthy, Safe and Prosperous: The Suffolk Alcohol Strategy is a county wide strategy which is aligned with and builds on the Great Yarmouth and Waveney strategy.

The Suffolk Alcohol Strategy was developed over 2013 to 2014, and is the result of a great deal of engagement and collaboration. Between July and September 2013, a series of structured conversations were held with key stakeholders. A questionnaire was sent to all schools in Suffolk and a business survey was conducted via the Suffolk Chamber of Commerce. In October, a lively stakeholder workshop was held with attendees from the alcohol industry, alcohol treatment services, the voluntary sector, service user and carer groups, local government and the NHS.

The results of the interviews, the stakeholder event, a review of the evidence of effectiveness of interventions and a health needs assessment on alcohol treatment services were used to inform the aims, principles, objectives and delivery themes in the strategy.

The Suffolk Health & Wellbeing Board endorsed the draft Suffolk Alcohol Strategy in December 2013 for distribution for further comment. Many comments have been received and some in-depth discussions held, particularly with the voluntary and community sector and with district and borough councils.

Emergent themes from stakeholder engagement:
3 Aim of the Strategy

People living and working in Suffolk will have a balanced and healthy relationship with alcohol, with individuals, families and communities experiencing substantially reduced harm from alcohol.

Themes

- Establishing safe and sensible drinking as the norm.
- Preventing further increases in levels of ill health caused by alcohol.
- Improving the health of problem drinkers of all ages and their families.
- Reducing the incidence of alcohol related crime and anti-social behaviour.
- Developing a Suffolk Public Health responsibility to work with local producers and suppliers of alcohol.

Principles

- We will adopt an evidence based planning framework for short, medium and long-term behaviour change interventions.\(^{17}\)
- We will take a population life course approach, decreasing harm to the population as a whole and providing services to people most in need.
- We will work collaboratively across the public sector, voluntary and community services and the business community.
- We will convey clear and consistent messages about alcohol.
- We will work throughout the lifespan and take into account the physical, emotional and mental health impact of alcohol on individuals, families and communities.
- We will base our actions on the evidence of what is effective, on population need and potential gain.
- We will place an emphasis on personal responsibility.
- We will minimise alcohol related harm.
- We will make every contact (with services) count.
- We will commission work to establish Suffolk population base lines which will enable us to develop measurable outcomes.

Delivering the strategy

The strategy will be underpinned by an action plan. Key activities will be:

**Theme 1: Encourage safe and sensible drinking as the norm.**

- Work with schools and colleges to establish materials to deliver the personal, health and social education (PHSE) curriculum.
- Develop and share communications resources for health promotion, from preconception to old age.
- Increase the local impact of national campaigns.
- Work with employers to decrease alcohol-related lost productivity.
Theme 2: Prevent further increases in levels of ill health caused by alcohol.
- Embed a programme of brief interventions in primary and secondary health and care services.
- Increase opportunistic testing for problem drinking and referral to specialist services where they are needed.
- Training for front line workers to improve identification and management of hidden harm from alcohol.

Theme 3: Improve the health of problem drinkers of all ages and their families.
- Improve access to evidence based, recovery focussed, high quality treatment services for problem drinking based on the 2013 Alcohol Healthcare Needs Assessment (see appendix 1).
- Establish a Suffolk Healthcare Alcohol Partnership to oversee progress.
- Improve access to mutual aid and support for families and people in recovery.

Theme 4: Reduce the impact of alcohol related crime and anti-social behaviour.
- Evaluate the Reducing the Strength campaign.
- Consider further development of harm reduction interventions at times and places when alcohol related unrest is most likely e.g. New Year’s Eve.
- Consider expansion of night time economy schemes such as purple flag and Best Bar None across the county.
- Consider use of local policies such as cumulative impact, early morning restrictions, late night levies and drinking in public place orders.

Theme 5: Develop a responsibility deal with producers and suppliers of alcohol in Suffolk.
- Reduce illegal alcohol sales.
- Reduce irresponsible alcohol promotion.
- Develop collaborative health improvement programmes.
- Work with Suffolk employers to reduce sickness absence and low productivity due to alcohol.
- Consider rolling out Reducing the Strength across Suffolk.
Appendices

Appendix 1: Alcohol Healthcare Needs Assessment: Executive Summary

Appendix 2: Local Area Alcohol Profiles England

Appendix 3: List of Organisations attending the Stakeholder Day and individual interviews and synopsis of feedback

Appendix 4: Interventions to reduce alcohol consumption and the harm caused by alcohol – a review of the evidence

Review Date

June 2016
Appendix 1
Alcohol Healthcare Needs Assessment

Executive summary

This document reports on the healthcare needs for the identification and management of individuals in Suffolk with alcohol use disorders.

Specifically, this assessment: (1) reviews routinely collected local data and other forms of health intelligence in relation to alcohol treatment services in Suffolk; (2) collects additional information through formal stakeholder consultation with specialist providers and a series of focus groups with service users; (3) performs a gap analysis of current services against recommended best practice guidelines; (4) uses resource modelling to determine the likely cost impact of any proposed changes.

The majority of adults in Suffolk consume alcohol and many do so without experiencing adverse effects. However, a growing number of the population consumes alcohol at a level that currently affects their health or wellbeing or the lives of others, and a further group is drinking at a level that is not currently causing such problems, but is at increased risk of doing so in the future.

There are no direct, robust and consistent measures available for the number of people within Suffolk who abstain, or who drink at lower risk, increasing risk or higher risk levels. Comparable and consistent measures of alcohol consumption are available from national lifestyle surveys that measure individual drinking levels and this type of survey can be used to derive synthetic estimates. This report uses the General Lifestyles Survey – a national survey – as its data source. Based on this, it is estimated that 15.1% of the over 18 population in Suffolk drink at increasing or higher risk. This is not significantly different from 15.4% prevalence in the East of England.

In many cases alcohol misuse occurs without any form of formal intervention or contact with the health or social care system, however it is generally accepted that the more severe the harmful alcohol use is, the greater the need for formal health care intervention. The most severe kind of harmful drinking behaviour is known as alcohol dependence – this is characterised by the presence of symptoms such as tolerance to alcohol, craving, relief of withdrawal, and neglect of alternative pleasures. It is estimated that approximately 3.8%, or 22,000 people in Suffolk fall into this category – and it is this group of people with the greatest need for specialist alcohol services.

This report assesses the health effects of alcohol through both mortality and morbidity indicators. Alcohol-specific and alcohol-attributable mortality in Suffolk as a whole do not differ significantly from the East of England, although there are particular areas in Suffolk with significantly higher mortality – these are Ipswich, Forest Heath and Waveney. The rate of alcohol-related hospital admissions has risen over the last 10 years (although not significantly different from the rest of the country). Using the old PCT populations, Great Yarmouth and Waveney PCT has a higher rate of alcohol-related hospital admission than Suffolk PCT.

In addition to the health impact of alcohol-related harm, this report also assesses the relationship of alcohol in Suffolk with crime and anti-social behaviour, loss of productivity in the workplace, road traffic accidents, and family and social problems.
In Suffolk, the identification and screening of harmful alcohol use occurs in general NHS commissioned healthcare services. GPs in Suffolk have the opportunity to engage with a direct enhanced service (DES) held by NHS England. The DES is to reward practices for case finding in newly registered patients aged 16 and over. It also aims to deliver a simple brief intervention to help reduce alcohol-related risk in adults drinking at hazardous and harmful levels.

Practices are required to screen newly registered patients aged 16 and over using either one of two shortened versions of the WHO AUDIT questionnaire: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete (hereafter referred to as ‘initial screen’). If a patient is identified as positive, the remaining questions of the ten question AUDIT questionnaire are used to determine hazardous, harmful or likely dependent drinking (‘full screen’ hereafter). This report indicates significant inter-practice variability with regards to engagement with screening of newly registered patients in Suffolk GPs. Approximately 25% of GP practices did not screen even one new patient, and of those that did do an initial screen, far fewer full screens and brief interventions are conducted than would be expected based on current epidemiological evidence.

The difficulties observed in opportunistic screening for alcohol use disorders observed in primary care is mirrored in hospitals. Both West Suffolk Hospital and Ipswich Hospital have specialist alcohol health care staff (though with different models), to coordinate the screening of alcohol use disorders particularly in A&E and to deliver brief interventions and sign posting and referrals to relevant agencies. In addition, in 2012/13 there was a contractual arrangement between the PCT and the hospital trusts (through a CQUIN) for hospitals to conduct a minimum number of alcohol screens, and referrals to specialist agencies. This CQUIN was not met by the relevant trusts.
In fact, according to data from the National Alcohol Treatment and Monitoring Service, less than 5% of all referrals into alcohol specialist services in 2012/13 were from hospitals. This figure is low, considering that in that same time period approximately 12,000 episodes for hospital admissions in Suffolk were related to alcohol.

Specialist alcohol treatment in Suffolk is commissioned by Suffolk County Council and delivered by four agencies – Suffolk Alcohol Treatment Services (SATS), and CRI Lowestoft deliver open access clinics and structured psychosocial and other structured treatment; while Phoenix Futures and Open Road deliver structured day programmes (Open Road also deliver structured psychosocial treatment). In total, across the four agencies nearly 800 individuals received a structured treatment in 2012/13 – 239 of these were on a day programme. Using waiting times as a proxy for system capacity, this report observed that waiting times were highest in psychosocial treatment (average of 40 – 50 days wait), compared to day programmes (average of less than 5 days wait).

Successful community-based medically assisted alcohol withdrawal is dependent on prior assessment and preparation of the patient and regular monitoring to pre-empt complications and ensure appropriate drug dosages. This report demonstrates that the majority of community-based medically assisted alcohol withdrawal is initiated by the GP without input from specialist services. Based on GP prescribing data, of the estimated 2,000 episodes of community based medically assisted alcohol withdrawal in the last year, only 55 (3%) of these episodes benefited from specialist provider input in the last year, this means that there is variation in standards of care for such patients across the county. In addition to patient safety concerns that this finding raises, the lack of specialist input for such individuals and the administration of community detoxification regimes without appropriate aftercare could impact upon the clinical effectiveness and success of the treatment. While pharmacotherapy is most frequently used in Suffolk to
facilitate withdrawal from alcohol in dependent drinkers, fewer individuals receive medication such as acamprosate, disulfiram or naltrexone for relapse prevention. Triangulation of available data suggests that only 5% of eligible patients receive this treatment in Suffolk. One possible reason for the low rates of specialist input in prescribing is the lack of a medical lead for SATS (the largest alcohol specialist provider in Suffolk by volume of patients seen). This report explores the potential for the addition of 0.4 wte consultant psychiatrist to the SATS team and finds an initial investment of £44,000 would be required for 100 consultant sessions per year.

It is important to note that these medications are expensive. In order to bring current practice up to 30% of eligible patients (i.e. 93 patients per year on relapse prevention medication), the total cost of the drug, plus the additional monitoring, equates to additional upfront investment of over £33,000.

Additional savings could be generated from the reduction in relapse rates, however the model presented in this report notes that only 6 fewer patients would relapse than would otherwise have under the current scenario (equating to an investment of more than £5,500 for each person who did not relapse).

In order to improve effective commissioning and delivery of services to the population, this report makes 16 recommendations grouped across four themes. These are:

**Theme: Joint working in the new commissioning landscape**

**Recommendation 1:** This report proposes the formation of a Suffolk alcohol healthcare partnership comprising the local authority, CCGs, healthcare provider partners, the police and crime commissioner, Suffolk Constabulary and lay representatives.

The group will be responsible for sharing information between partner organisations, exploration of ways of joint commissioning and further integration of the various services currently provided in Suffolk.

It is envisaged that there will be a sub-group of healthcare commissioners to lead on commissioning.

**Recommendation 2:** The Suffolk alcohol healthcare partnership would also be responsible for monitoring the quality of services offered in Suffolk.

**Theme: Screening and brief interventions**

**Recommendation 3:** CCGs to increase awareness among GPs and practice nurses on the benefits and practice of screening and brief intervention using the AUDIT tool through information distribution in the GP newsletter and discussion at the Local Medical Committee.

Public Health to work with services commissioned and provided by the local authority to promote “Making Every Contact Count” and to ensure alcohol screening is available where appropriate.

**Recommendation 4:** GPs to ensure practice staff are aware of the need for screening of new patients, and highlight the importance of appropriate follow up for patients who are screened and found to be positive.
Recommendation 5: CCGs to consider outcome-based commissioning for alcohol screening from hospital trusts.

Recommendation 6: CCGs to explore contractual arrangements between hospital trusts and mental health trusts to identify if alcohol screening and reporting would be an appropriate addition to a future contact.

Recommendation 7: Community based alcohol specialist providers to monitor service activity and capacity and report on this regularly to the local authority commissioners.

**Theme: Equity in specialist service provision**

Recommendation 8: Specialist providers to explore their capacity for delivery of outreach clinic.

Recommendation 9: Assessment of future tenders for community based alcohol specialist services should take into account access for individuals in geographically isolated locations. This could be in the form of an equality impact assessment.

**Theme: Improving access to psychosocial interventions**

Recommendation 10: Specialist providers to estimate the likely requirements needed to improve access to structured psychosocial interventions.

Recommendation 11: Commissioners to consider likely increase in cost required to meet the NICE guidance and balance against potential savings. As potential savings likely to be seen most demonstrably in the NHS, joint commissioning could be considered as an option for this scenario.

**Theme: Ensuring appropriate pharmacological interventions are used**

Recommendation 12: CCGs to raise awareness of alcohol specialist service provision for community based detoxification programmes through the GP newsletter and discussion at the local medical committee.

Recommendation 13: Providers to write to GPs to publicise their services in community detoxification.

Recommendation 14: CCGs to consider adoption of standardised clinical protocol for community based detoxification including clear criteria for individuals that are likely to be appropriate and those that may require inpatient detoxification.

Recommendation 15: Commissioners to consider the 0.4 wte consultant psychiatrist model presented in this report and determine whether it is able to fulfil considerable cost implications of this.

Recommendation 16: Commissioners to consider whether the benefits outweigh the costs of increased prescriptions of anti-relapse medication.
Appendix 2:
Local Area Alcohol Profiles England – Suffolk

<table>
<thead>
<tr>
<th>Measure</th>
<th>England Average</th>
<th>Regional Average</th>
<th>England Best</th>
<th>England Worst</th>
<th>25th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months of life lost - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months of life lost - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific mortality - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific mortality - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality from chronic liver disease - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality from chronic liver disease - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-attributable mortality - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-attributable mortality - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific hospital admission - under 18s</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific hospital admission - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific hospital admission - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-attributable hospital admission - males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-attributable hospital admission - females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol-attributable conditions (previously NI39)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-related recorded crimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-related violent crimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-related sexual offences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claimants of incapacity benefits - working age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality from land transport accidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge drinking (synthetic estimate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees in bars - % of all employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol treatment - prevalence per 1,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
District Summaries Local Alcohol Profiles [2013] - Summary Points

Full profiles for Districts and Boroughs are available from Local Alcohol Profiles for England (LAPE) 2013: www.lape.org.uk/

Babergh
- It is estimated that the total drinking population in Babergh is 61,910 (aged 16 and over).
- More than one in ten people (13.2%) aged over 16 in Babergh abstain from drinking alcohol, representing around 9,420 people.
- Just over one in seven drinkers (72.7%) in Babergh are classified as ‘lower risk’ drinkers.
- A fifth of drinkers (20.6%) in Babergh are drinking at ‘increasing risk’ levels.
- Along with Suffolk Coastal and Waveney, Babergh has the lowest estimated proportion of drinkers that are ‘higher risk drinkers’ (6.7%).

Forest Heath
- It is estimated that the total drinking population in Forest Heath is 39,600 (aged 16 and over).
- More than one in ten people (15.4%) aged over 16 in Forest Heath abstain from drinking alcohol, representing around 7,210 people.
- Just over one in seven drinkers (73.2%) in Forest Heath are classified as ‘lower risk’ drinkers.
- A fifth of drinkers (20.0%) in Forest Heath are drinking at ‘increasing risk’ levels.
- Just under 7% of drinkers (6.9%) in Forest Heath have levels of drinking that are regarded as ‘higher risk drinking’.

Ipswich
- It is estimated that the total drinking population in Ipswich is 86,250 (aged 16 and over).
- Almost two in ten people (13.2%) aged over 16 in Ipswich abstain from drinking alcohol, representing around 17,920 people.
- Just over one in seven drinkers (73.8%) in Ipswich are classified as ‘lower risk’ drinkers.
- Almost a fifth of drinkers (19.0%) in Ipswich are drinking at ‘increasing risk’ levels.
- Over 7% of drinkers (7.2%) in Ipswich have levels of drinking that are regarded as ‘higher risk drinking’.
- Ipswich has a significantly higher rate of alcohol-attributable hospital admissions for females than the regional average (919.0 per 100,000 population of all ages, compared to 730.7).
- Ipswich has a significantly higher rate of alcohol-attributable conditions than the regional average (2009.4 per 100,000 population of all ages, compared to 1631.1).
- Ipswich also has significantly higher rates of:
  - alcohol-related recorded crimes (7.9 per 1,000 population compared to 5.0 for the East of England region),
  - alcohol-related violent crimes (6.0 per 1,000 population compared to 3.6 for the East of England region), and
  - alcohol-related sexual offences (0.2 per 1,000 population compared to 0.1 for the East of England region).
Mid Suffolk

- It is estimated that the total drinking population in Mid Suffolk is 67,400 (aged 16 and over).
- More than one in ten people (13.2%) aged over 16 in Mid Suffolk abstain from drinking alcohol, representing around 10,250 people.
- Just over one in seven drinkers (71.6%) in Mid Suffolk are classified as ‘lower risk’ drinkers.
- A fifth of drinkers (21.0%) in Mid Suffolk are drinking at ‘increasing risk’ levels.
- Over 7% of drinkers (7.4%) in Mid Suffolk have levels of drinking that are regarded as ‘higher risk drinking’.

St Edmundsbury

- It is estimated that the total drinking population in St Edmundsbury is 76,550 (aged 16 and over).
- More than one in ten people (13.5%) aged over 16 in St Edmundsbury abstain from drinking alcohol, representing around 11,950 people.
- Just over one in seven drinkers (72.4%) in St Edmundsbury are classified as ‘lower risk’ drinkers.
- A fifth of drinkers (20.8%) in St Edmundsbury are drinking at ‘increasing risk’ levels.
- Just under 7% of drinkers (6.8%) in St Edmundsbury have levels of drinking that are regarded as ‘higher risk drinking’.

Suffolk Coastal

- It is estimated that the total drinking population in Suffolk Coastal is 87,780 (aged 16 and over).
- More than one in ten people (13.9%) aged over 16 in Suffolk Coastal abstain from drinking alcohol, representing around 14,170 people.
- Just over one in seven drinkers (72.8%) in Suffolk Coastal are classified as ‘lower risk’ drinkers.
- A fifth of drinkers (20.5%) in Suffolk Coastal are drinking at ‘increasing risk’ levels.
- Along with Babergh and Waveney, Suffolk Coastal has the lowest estimated proportion of drinkers that are ‘higher risk drinkers’ (6.7%).

Waveney

- It is estimated that the total drinking population in Waveney is 81,340 (aged 16 and over).
- More than one in ten people (15.1%) aged over 16 in Waveney abstain from drinking alcohol, representing around 14,470 people.
- Almost three quarters (74.0%) in Waveney are classified as ‘lower risk’ drinkers.
- Almost a fifth of drinkers (19.3%) in Waveney are drinking at ‘increasing risk’ levels.
- Along with Babergh and Suffolk Coastal, Waveney has the lowest estimated proportion of drinkers that are ‘higher risk drinkers’ (6.7%).
- Waveney also has significantly higher rates of:
  - alcohol-related recorded crimes (5.5 per 1,000 population compared to 5.0 for the East of England region) and
  - alcohol-related violent crimes (5.5 per 1,000 population compared to 3.6 for the East of England region).

Definitions

Drinking population: non-abstainers; figures calculated by removing number of abstainers from the total mid-2009 population estimate (2011 Census based) of all people aged 16 and over.

Number of abstainers: synthetic percentage estimate from Local Alcohol Profiles for England 2013 applied to the mid-2009 population estimate (2011 Census based) of all people aged 16 and over.

Sources

Local Alcohol Profiles for England (LAPE) 2013: www.lape.org.uk/
Appendix 3:
List of organisations attending the stakeholder day and individual interviews.

Anglia Care Trust
Community Action Suffolk
Suffolk Congress
Families Anonymous
Genesis Housing Association
Healthwatch
Ipswich Hospital
Ipswich and East Suffolk Clinical Commissioning Group
Livewell Suffolk
Norfolk and Suffolk NHS Foundation Trust
Open Road treatment services
Phoenix-Norcas treatment services
Police and Crime Commissioner’s Office
Suffolk Chamber of Commerce
Suffolk Coastal District Councillor
Suffolk Coastal District Council officer
Suffolk Constabulary
Suffolk County Councillors
Suffolk County Council Children and Young People’s Directorate
Suffolk County Council Adult and Community Services Directorate
Suffolk County Council Public Health Directorate
Suffolk County Council Trading Standards
Suffolk Family Carers
Suffolk schools and colleges
St Edmundsbury Borough Council
The Matthew Project
West Suffolk Clinical Commissioning Group
Appendix 4:

Interventions to reduce alcohol consumption and the harm caused by alcohol:

A review of the evidence of effectiveness.

Introduction

The Suffolk JSNA Alcohol Needs Assessment recognises that whilst the majority of adults in Suffolk consume alcohol without experiencing adverse effects, a growing number consume alcohol at a level that currently affects their health or wellbeing or the lives of others. A further group is drinking at a level that is not currently causing such problems, but is at increased risk of doing so in the future. It is estimated that 15.1% of the over 18 population in Suffolk drink at increasing or higher risk.
Alcohol is cross-cutting across all the Suffolk Joint Health and Wellbeing Strategy outcomes and is an area of increasing concern with many inter-dependencies. It requires the commitment of all stakeholders in order to make a sustained reduction in the harm caused by alcohol. Changing behaviours in alcohol consumption is a key objective of this strategy.

A review of published literature and guidance was undertaken to determine the evidence base for interventions to promote behaviour change generally and specifically to reducing alcohol consumption and the harm caused from excess alcohol consumption. The current review considered those preventative interventions that take place at individual, community and population levels and in healthcare and non-healthcare settings, particularly workplaces and schools and which have potential to alter current patterns of disease.

This review is not concerned with the specialist management and treatment of patients with identified high level needs such as medically assisted alcohol withdrawal or psychological services. It is commonly held that less severe alcohol problems are appropriate for behavioural interventions, whereas more severe problems need specialty addiction treatment (Jepson et al, 2006).

There is a vast amount of literature on the topic of behaviour change for health improvement. The topic covers a number of theoretical perspectives and views on the best approaches are contested. In undertaking this review we looked at high level evidence in the form of national guidance and reviews of systematic reviews. The key advantage of this method is the ability to draw together evidence from a large number of studies creating a broad overview of the topic in a short period of time. However, a key limitation is that they are distant from the original research or programme evaluation and it is therefore difficult to identify individual examples of good practice. The review does however enable the identification of key themes. These are set out below under the headings of general principles for behaviour change interventions and specific interventions for the reduction of alcohol consumption and the harms caused by alcohol.
Evidence to inform general principles of behaviour change interventions.

There is a lack of practical advice on which techniques should be used to tackle specific behaviours and with people from specific populations or with particular risk factors (NICE 2014).

Evidence considered in this review has been drawn from NICE Public Health Guidance PH6 (2007) and PH49 (2014) together with an effectiveness review of interventions, approaches and models at individual, community and population level (Jepson et al, 2006), and a cost effectiveness review (NWPHO, 2011). The latter two reviews also commented specifically on the effectiveness of interventions aimed at reducing alcohol consumption and the harm from alcohol. There are a number of key themes that emerge from this evidence and which support the recommendations presented below.

1. **Adopt a strategic approach**

A local behaviour change policy and strategy should be developed to inform all behaviour change objectives. Such a strategy should ensure all organisational policies support behaviour change and should operate across organisations.

Strategies need to identify whose behaviour they seek to change, recognising there are multiple target groups, including those professions who can support behaviour change in others. Developing an understanding of how each sees the problem is a key aspect.

Sustained behaviour change is most likely to occur when a combination of interventions at the individual, community and population-level are used. Strategies with interventions that target many levels simultaneously tend to be the most effective. However, these interventions should be focused, involving a small number of techniques.

Multiple level interventions aimed at individual behaviour change should cover the range of very brief, brief, extended brief and high intensity.

Interventions require a long term commitment, particularly when changing social norms. Short-termism leads to reversion of behaviours and reduced campaign credibility.

A strategic approach also needs to be mindful of the competition, for example from the drinks industry, and the constraints on organisational resources.

2. **Plan carefully**

Behaviour change interventions should be planned carefully taking full account of local and national context. Particular attention needs to be given to the socio-economic context and the wider determinants which may work against positive outcomes. Prevention and behaviour change needs to take account of the context of the lives they seek to improve and should employ multifaceted approaches to address complex issues that impact in different ways on different people.

A planning framework should be adopted for all behaviour change interventions. NICE (2014) advocate a 6 stage intervention mapping process.

3. **Be aware of and utilise theories of behaviour change**

The importance of having a theoretical basis for the design and evaluation is well established. The theoretical basis of any intervention should be stated at the planning stage and be evident throughout.
4. **Assess community needs and assets**
Interventions should be based on a sound knowledge of community needs and should build upon existing skills and resources within the community. Evidence for such should be drawn from local health needs assessment and asset mapping.

5. **Address health inequalities and deliver ethical interventions.**
Consideration should be given to the potential for interventions to have a negative impact on health inequalities. The principle of proportionate universalism should be adopted to help ensure health inequalities and inequalities in access to services are addressed.

6. **Work in partnership**
Those responsible for the development and delivery of behaviour change interventions should work across a broad partnership of local and national stakeholders, including the recipients of the interventions. To be fully effective, local and collective action requires partnership and capacity-building across different sectors and sustained leadership at different levels of society.

7. **Ensure training is available and is undertaken**
Practitioners at all levels should be equipped with the necessary competencies and skills to support behaviour change, including training in appropriate communication skills. Training and development should form part of an overarching behaviour change strategy.

Courses on the use of evidence based approaches should be based on theoretically informed evidence based practice.

8. **Undertake an evaluation**
Evaluation should be undertaken locally or as part of a larger evaluation. Opportunities to undertake and publish formal evaluation to add to the evidence base should be sought.

Wherever possible evaluation should include an economic effectiveness analysis.

**Effective interventions supporting a reduction in alcohol consumption and the harm caused by alcohol.**

In addition to the reviews by Jepson et al and the NWPHO, national public health guidance from NICE (PH24, 2010), the WHO European action plan (2011) and a report on 7 case studies (Stead et al, 2009) provide evidence of interventions supporting a reduction in alcohol consumption and the harm caused by alcohol. This section is also informed by the Leicestershire and Leicester Total Place Pilot.

**All action** to reduce the negative impact of alcohol should include interventions to modify drinking patterns including reducing binge drinking. Presenting sensible moderate drinking as an attractive option has been shown to be effective in case studies.

At the **individual level** there is evidence of a small positive effect of brief behavioural counselling interventions in reducing alcohol intake in problem drinkers.

Physician advice or counselling is known to be more effective than advice from lay people for reducing alcohol consumption. Screening and brief intervention within primary care and A&E has also been shown to be cost-effective and in some scenarios, cost saving. Economic analysis found that several examples of screening and brief advice in GP and A&E settings produce estimated cost savings.
The evidence supports the widespread implementation of structured brief advice programmes using recognised evidence based resources for children, young people and adults who have been identified through appropriate screening using validated tools, as hazardous or harmful drinkers. Where there is ongoing contact with clients aged 16 and over, extended brief intervention should be offered.

The strongest evidence of efficacy is found in brief interventions within the realm of psychosocial treatments.

Brief advice has been shown to be effective in disadvantaged groups and may support work to address health inequalities. Providing information and facilitating goal setting have been found to be the most helpful techniques when dealing with low income groups.

Targeting interventions at women during pregnancy is also recommended.

Interventions that target significant events or transition points in people’s lives have been shown to be successful.

At a community level there is insufficient evidence to determine the effectiveness of peer organisation and social norming campaigns. However a single normative social marketing campaign aimed at selected universities and other educational establishments was reported as being successful.

Education campaigns and information about health risks given on alcoholic beverage labels can be used to support local action and alcohol policy measures.
Settings approaches such as school based and workplace interventions have been shown to be effective for some behaviours, though their impact on alcohol is not known. Brief interventions in the workplace are likely to be cost effective and should be trialed.

**Population level** approaches can reduce aggregate level of alcohol consumed. There is evidence of variable quality that found an effect of mass media campaigns aimed at reducing alcohol impaired driving. However there is no evidence of mass media campaigns improving knowledge or attitudes relating to alcohol.

Policy change, including minimum pricing and restricting availability and marketing is likely to be a more effective, and more cost effective, way of reducing alcohol-related harm among the population than actions undertaken by local health professionals. Concerted action across all sectors is required to reduce the availability of alcohol.

---

**Case study**

A limited number of case studies are presented in the reviewed literature though a number have been identified through snowballing through reference lists and web enquiries. These are presented in appendix A to this report.

**Current interventions in Suffolk**

Suffolk has undertaken and gained national recognition for innovative work to reduce the consumption of and the harm done through alcohol consumption. The Suffolk Alcohol Strategy includes reference to such novel interventions as well as more mainstream programmes. These include the identification and screening of harmful alcohol use through general NHS commissioned healthcare services, including a direct enhanced service for GPs.

Both West Suffolk Hospital and Ipswich Hospital have specialist alcohol health care staff to coordinate the screening of alcohol use disorders, particularly in A&E, and to deliver brief interventions and sign posting and referrals to relevant agencies. In addition, in 2012/13 there was a contractual arrangement with the hospital trusts (through a CQUIN) for hospitals to conduct a minimum number of alcohol screens, and referrals to specialist agencies.

The JSNA, however, identifies opportunities for further service development and improvement in primary and secondary care services.
References


Leicestershire together (2010) Leicester and Leicestershire Total Place Final report online at www.leicestershiretogether.org/total_place_final_report.pdf


Appendix A Case studies

Manchester Comprehensive Care Pathway Development

NHS Manchester has been working with three NHS Acute Hospital Trusts across the city to implement the Alcohol Identification and Brief Advice (IBA) programmes in each of the Accident and Emergency departments. One of the aims of the project was to reduce the impact of alcohol on the health of patients identified as at risk while attending the Manchester Royal Infirmary (MRI) Emergency Department, improve the management of inpatients and help to target resources aimed at reducing alcohol-related crime. This pilot started in December 2006.

Patients seen are asked an initial question: ‘Have you had a drink in the last 12 hours?’ If the answer is positive they are then asked a short series of questions using an evidence based screening tool – currently the Alcohol Use Disorders Identification Test Consumption (AUDIT-C). If they are positive for this then they are given an alcohol brief intervention.

Source: NWPHO (2011) A review of the cost-effectiveness of individual level behaviour change interventions

An integrated service for young people in Leeds

To improve the approach to alcohol and drug misuse for young people in Leeds, the city council set up a single service. ‘Platform’, a partnership with two local charities, plays a key role in working with schools on education and acting as a training/consultancy service for the wider young people’s workforce as well as providing treatment and support for drug misuse.

Anyone referred to the service is assessed by a key worker who looks at what they are currently using and the impact of that on their life – from housing to school attendance and crime.

By having a single service, the council believes it has helped create greater clarity about where young people need to go to for help. The early signs show that the approach is working with figures showing drug use is falling, while the service has been recognised by Ofsted as an exemplar of good practice.

Source: Local Government Association

Encouraging male pub-goers to drink less – Cheshire and Merseyside

Cheshire and Merseyside’s public health network has worked with the pub industry to run a social marketing campaign to get pub-goers to drink less. It has been targeted mainly at men in the 35 to 55 age group. The campaign – called ‘Drink a Little Less, See a Better You’ – involved drinkers being offered health checks and advice about their drinking habits. They were also encouraged to take part in what was dubbed the wind-down between 10pm and 11pm when they were offered free entry in a prize draw in return for buying a soft drink instead of alcohol.

The campaign was promoted through the use of branded postcards, beer mats and stickers that were displayed in pubs. Evaluation has shown that nearly half of drinkers reported consuming less afterwards.

Source: Local Government Association
Glossary of terms

**Accidental alcohol poisoning**
Poisoning happens when you take into your body a substance that damages your cells and organs and injures your health. Accidental alcohol poisoning results from drinking a toxic amount of alcohol, usually over a short amount of time (i.e. binge drinking), that unintentionally results in alcohol poisoning.

**Brief Intervention**
A Brief Intervention is a short structured technique aimed at helping people change their lifestyles for the better.

**Domestic abuse**
The cross-government definition of domestic violence and abuse is:
Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and/or emotional.

**Harmful drinking**
Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol related accidents or physical illness such as acute pancreatitis. Clearly this category includes a wide range of problems and exists on a wide spectrum of severity, from alcohol-related injuries through to life threatening chronic alcoholic liver disease, or absenteeism after an isolated drinking binge through to job loss. This group of drinkers can also be defined as scoring 15 or more on the AUDIT.

**Hazardous drinking**
This is defined as drinking above a level that may cause harm in the future, but is not currently causing clear evidence of harm. Some would limit this definition to the physical or mental consequences (as in harmful use). Others would include the social consequences. This group of drinkers can also be defined as scoring eight or more on the Alcohol Use Disorders Identification Test (AUDIT).

**Health and Wellbeing Board**
Set up in every upper-tier local authority to improve health and care services and the health and wellbeing of local people. The Board brings together key commissioners to assess the needs of the local population through the Joint Strategic Needs Assessment, to produce a Health and Wellbeing Strategy to inform the commissioning of health, social care and public health services and to promote greater integration across health and social care.

**Health Inequalities**
The differences in health, life chances and life expectancy between different geographical areas and different groups of people.

**Hidden harm**
Children and young people experiencing some degree of harm due to presence within family of: substance misuse, domestic conflict/abuse/violence, poor mental health. Providing early intervention to prevent harm to children and young people experiencing these factors has been prioritised for action by the Children’s Trust and the Suffolk Safeguarding Children’s Board.
Illegal alcohol sales
This can refer to the sale of alcohol outside of legally licensed premises. It can also refer to the illegal sale of alcohol to anyone under 18, or the illegal sale of liqueur chocolates to anyone under the age of 16. Additionally, staff under the age of 18 must not sell alcohol without knowledge of the sale by the owner, designated premises supervisor or other employee over 18, it is also illegal for anyone to attempt to purchase alcohol under the age of 18. It is illegal for a person over 18 to buy alcohol for a person under the age of 18 (proxy purchase).

Joint Health and Wellbeing Strategy
A high level, overarching framework to address the needs identified in the Joint Strategic Needs Assessment and set agreed priorities for action.

Licensing applications
Anyone operating premises or organising events that include the sale or supply of alcohol must have a licence. The Licensing Act 2003 amalgamated six licensing regimes, which covered the sale and supply of alcohol, the provision of regulated entertainment and the provision of late night refreshment, and replaced them with a single system of premises licences. Application for a license can usually be made through the local authority website or the application can be downloaded from the www.gov.uk website.

Liver disease
This term is used to describe many disorders that impede the normal functioning of the liver. Alcohol-related liver disease (ARLD) refers to liver damage caused by alcohol misuse. It covers a range of conditions and associated symptoms. Example stages of ARLD include: Alcoholic fatty liver disease, Alcoholic hepatitis and cirrhosis.

Mutual aid
Mutual aid can be explained in the simplest terms as people with similar experiences helping each other to manage or overcome issues.

Pre-loading
This is where alcohol is consumed prior to going out for the night – usually at home.

Recovery Grant Scheme
Public Health Suffolk invest money in ideas or projects that will: help sustain recovery in the community, improve housing status, enhance employment opportunities, provide diversionary activities, offer opportunities to those who often miss out.

Recovery networks and forums
Alongside a comprehensive treatment programme, people recovering from substance misuse problems are motivated to improve their quality of life, regain their confidence and self-respect and put something back into the community in which they live. Voluntary and Community groups within Suffolk can play a vital part in assisting with an individual’s recovery journey. Networks and forums help people come together to exchange views, experiences and provide support and help to each other.

Social exclusion
Lack of or denial from the principal social system and its rights and privileges, this is typically as a result of poverty or the fact of belonging to a minority social group. There are impacts in relation to health, wellbeing, quality of life and equity.