Bristol JSNA Chapter 2016-17

Alcohol Misuse in Adult Population

Chapter information	
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Executive summary

Introduction

Alcohol is a prominent commodity in the UK marketplace. It is widely used in numerous social situations. For many, alcohol is associated with positive aspects of life; however there are currently over 10 million people drinking at levels which increase their risk of health harm. Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups.

In Bristol, the pattern of alcohol misuse is varied and complex, sensitive to cultural and socio-economic characteristics that greatly differ across the City. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

The Public Health England, Local Alcohol Profiles for England (2017) estimates that: *http://fingertips.phe.org.uk/profile/local-alcohol-profiles*

- 15.6% of Bristol population aged 16 years and over abstain from drinking alcohol
- Out of the 84.4% of those who drink, 72.2% stay within the national low risk limits
- 20.3% drink at increasing levels that risk harm in the long term
- 7.5% drink at higher risk levels that harm themselves and others (this includes dependent drinkers)
- 26.3% binge drink and are vulnerable to the acute effects of intoxication such as assault, falls and poisoning.

On one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

The public health burden of alcohol is wide ranging, relating to health, social or economic harms. These can be tangible, direct costs (including costs to the health, criminal justice and welfare systems), or indirect costs (including the costs of lost productivity due to absenteeism, unemployment, decreased output or lost working years due to premature pension or death). Harms can also be intangible, and difficult to cost, including those assigned to pain and suffering, poor quality of life or the emotional distress caused by living with a heavy drinker. Many of these harms impact upon other people, including relationship partners, children, relatives, friends, co-workers and

strangers.

In recent years, many indicators of alcohol-related harm have increased. There are now over 1 million hospital admissions relating to alcohol each year, half of which occur in the lowest three socioeconomic deciles. Alcohol-related mortality has also increased, particularly for liver disease which has seen a 400% increase since 1970, and this trend is in stark contrast to much of Western Europe. In England, the average age at death of those dying from an alcohol-specific cause is 54.3 years. The average age of death from all causes is 77.6 years. More working years of life are lost in England as a result of alcohol-related deaths than from cancer of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate, combined.

Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members and domestic violence and abuse. Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

Key issues and gaps

Alcohol-related deaths

While there has been a slight decrease in alcohol-related mortality in England since 2014, Bristol remains at the same and above the national average level for alcohol-related deaths for both, men and women. Local Alcohol Profiles (March 2017) show Bristol has a significant problem with alcohol-related mortality particularly in men (Bristol rate of 26 deaths per 100,000, England rate 15.9 for 2015). The rate of alcohol-related mortality in women in Bristol was 7.4 in the same period (7.3 in England). Alcohol-related chronic liver disease contributes most to the mortality rates. These deaths were preventable.

Hospital admissions

The rate of hospital admissions for alcohol-specific conditions (narrow measure) in Bristol (2014-15) was 570 per 100,000 population which is significantly higher than the England average (364 admissions per 100,000) and has been consistently higher than England since 2008/09.

There are 48 health conditions that are specifically caused by or contributed to by alcohol misuse. The most common alcohol-related conditions are circulatory diseases, notably high blood pressure and heart disease. The 'broad' measure of alcohol-related admissions measures this. In 2014/15 the Bristol rate was 1,541 per 100,000 compared to the English rate of 1,258; both figures remaining at a similar lever since in 2013.

Since 2014 there were estimated 23,000 deaths related to alcohol use in England. Approximately 6,000 of these were due to alcohol-specific causes. The rate of alcohol-related mortality for men (65.4 per 100,000) is more than double the rate for women (28.8 per 100,000). This **gender health inequality** needs to be address urgently using multi-agency approach.

Physical ill health has been identified as having a significant impact on the recovery potential of people accessing treatment services. **There is an intrinsic link between physical and mental health**; poor physical health can adversely affect a person's mental health and poor mental health can negatively affect physical health.

While great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the current structures of support still tend to deal with the these needs in isolation.

The relationship between ***physical health and substance misuse*** is complex. It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of prescribed medications, chronic pain and self-medication for other symptoms, including mental health, often leads to dependency forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. Chronic liver disease, respiratory illness and blood borne viruses, caused as a result of using substances, are commonly identified within alcohol and drug using populations.

Communication with and feedback from both professionals and service users have indicated that there is a gap for 'medium level' ***mental health support for substance misusers***. It has been suggested that if substance misusers are experiencing either a mental health crisis (high level) or require some low level mental health interventions (e.g. IAPT) then they are able to access these levels of services however a gap still exists for clients requiring more structured mental health interventions in substance misuse services.

However, estimates of prevalence of dual diagnosis are difficult to come by at both a local and national level because various studies have used different diagnostic criteria. Therefore prevalence and incidence rates for substance misuse coexisting with mental health problems in the published literature vary widely.

A study on mental health centres and substance misuse services in the UK, showed that 85% of alcohol service users had mental health problems, mostly affective disorders and anxiety disorders. Approximately 50% of the alcohol treatment population also had multiple morbidity, i.e. the co-occurrence of several psychiatric disorders or substance misuse disorders.

The Bristol Mental Health Needs Assessment (2012) predicted that people living with mental health conditions are likely to increase in forthcoming years. Given the estimated population increases in both young people and BMEs in Bristol it would suggest that there will be a higher need of dual diagnosis in these cohorts given the higher prevalence of mental health needs identified in these groups. However caution must be applied here because rates of substance misuse vary greatly within these groups (e.g. recent decline in young people using substances, different rates of substance use prevalence between BME groups).

Recommendations

In their Strategy 2016-2021, the Bristol Alcohol Strategy Group develops a plan of actions to achieve the following objectives:

Promote and support changes in attitudes and behaviour.

Ensure alcohol is sold responsibly.

Improve access to early interventions and treatment.

Protect children and families from alcohol-related harm.

Reduce alcohol- related crime and disorder.

Further recommendations were made in the Bristol Substance Misuse Needs Assessment 2016:

More work is needed to address the gaps in the monitoring of information of dual diagnosis clients in substance misuse and mental health services. Being able to effectively monitor this data will inform future needs assessments and identify gaps in service provision.

Address the gap for 'medium level' mental health support for substance misusers.

Address gender health ineqaulitites, in particular focusing on alcohol-related mortality.

Support people to identify issues with drugs and alcohol at an early stage; consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach.

JSNA chapter report

A: What do we know?

1) Who is at risk and why?

In England, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15 to 49 years; for all ages it is the fifth most important. The harm caused by alcohol is determined by levels of alcohol consumption at both the individual- and population-level. These levels are heavily influenced by access to alcohol, which comprises three variable factors: how easy it is to purchase or consume alcohol (availability), how cheap alcohol is (affordability) and the social norms surrounding its consumption (acceptability). These drivers are largely determined by economic and social structures, politico-legal structures and corporate/market structures.

Alcohol consumption can have adverse health and social consequences for the drinker, as well as for other individuals. Its consumption has been identified as a component cause for more than 200 health conditions covered by the International Classification of Disease and injury codes and is associated with social consequences such as loss of earnings or unemployment, family or relationship problems and problems with the law. Many of these harms affect associates of the drinker, such as a partner, child, relative, friend, co-worker or stranger.

Aside from environmental factors, the health and social harm caused by alcohol is determined by three related dimensions of drinking:

- the volume of alcohol consumed
- the frequency of drinking occasions
- the quality of alcohol consumed

For most alcohol-related diseases and injuries, there is a clear dose-response relationship between the volume of alcohol consumed and the risk of a given harm. With increasing dose, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship.

As well as the volume of alcohol consumed, the frequency of drinking occasions affects the risk of harm. For example, repeated heavy drinking is associated with dependence whereas, a single bout of heavy drinking is associated with injuries and risk of cardiovascular disease. The latter relates to the fact that any cardio protective effect of low-risk patterns of alcohol consumption, are completely undone in the presence of heavy episodic drinking.
In addition to the volume and pattern of drinking, a number of individual risk factors moderate alcohol-related harm, such as:

Age: children and young people are more vulnerable to alcohol-related harm

Gender: women are more vulnerable to alcohol-related harm from higher levels of alcohol use or particular patterns of drinking

Familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders is a major vulnerability

Socioeconomic status: people with lower socioeconomic status experience considerably higher levels of alcohol-related harm

Culture and context: the risk of harm varies with the culture and context within which the drinking takes place, for example drinking while driving can result in serious penalties and harm

Alcohol control and regulation: a critical factor in determining levels of alcohol-related harm in a country is the level and effectiveness of alcohol control and regulations.

According to the Health Survey in England: Adult Alcohol Consumtion (2016), in 2015, 83% of adults in England had drunk alcohol in the last 12 months. A higher proportion of men than women drank alcohol in the last year (87% and 80% respectively). For men and women, the proportions of non-drinkers were highest in the youngest and oldest age groups. For men, the prevalence of drinking in the last year was between 87% and 90% among men aged 25 to 74. Similarly, for women between the ages of 25 and 64, the prevalence of drinking in the last year was relatively similar (82% or 83%).

Over half (52%) of adults usually drank alcohol once a week or more often, with men more likely than women to do so (60% and 44% respectively). The proportion who drank once a week or more increased with age among both men and women before gradually decreasing, from the age of 75 for men, and the earlier age of 65 for women. Within every age group a higher proportion of men than women drank alcohol once a week or more.

In an average week, adults drank a mean of 11.9 units of alcohol; men drank a mean of 14.9 units, and women drank a mean of 8.9 units.

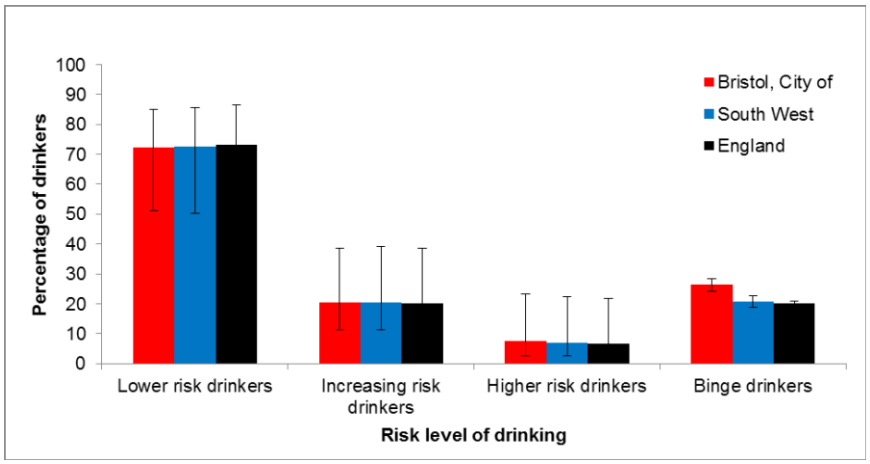
A minority of adults, 13% of men and 20% of women, did not drink in the last 12 months. 55% of men and 64% of women drank at levels which put them at lower risk of alcohol-related harm, that is, 14 units or less in the last week. Twice as many men than women drank at an increasing risk level (27% and 13% respectively); for men this was defined as more than 14 units and under 50 units, and for women more than 14 units and under 35 units. A higher proportion of men than women also drank at higher risk levels; 4% of men drank over 50 units and 3% of women drank over 35 units in the last week.

2) What is the size of the issue in Bristol?

Available data (2011-2014) indicate that approximately 15.6% of Bristol population abstain from drinking alcohol; 84.4 of adults engage in drinking. 18.4% of those binge-drink on heaviest drinking day and 22.3% adult population drink over 14 untis of alcohol a week. It should be noted that people are likely to underestimate the amount they drink in self-reported surveys.

Fig 1 compares the Bristol percentages of drinkers with the South West and England estimates. There is some evidence that the percentage of binge drinkers in Bristol is higher than the regional and national percentage.

Fig 1: Percentage of drinkers within risk level-categories across the South West and England.



Bristol has higher rates than the national average of alcohol related harm as well as higher alcohol- specific and alcohol-related mortality. The prevalence of alcohol use, particularly at the higher levels of risk, within the city indicates that this need is unlikely to reduce in the next few years and is likely to grow with the city's population.

26.3% of alcohol users reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average. In Bristol there are approximately 5,408 admissions to hospital due to alcohol-related conditions a year, where alcohol-related condition is the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Bristol alcohol-related admissions has been consistently higher than the England average, with 1,541 persons per 100,000 population admitted (broad measure) in 2014/15 compared to the England rate of 1,258 admissions per 100,000. The most common reasons for alcohol-related admission episodes in Bristol were cardiovascular disease and mental & behavioural disorders due to use of alcohol.

In 2014 there were 187 alcohol-related deaths in Bristol, which corresponds with the rate of 53.2 per 100,000 population (significantly higher than the England rate of 45.5 per 100,000). It is a bigger problem in males; the rate of alcohol-related mortality was 26.3 deaths per 100,000 men in 2015, compared to females with 7.4 deaths per 100,000 women in the same year.

Bristol has also a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 243.8 admissions per 100,000 male population was significantly higher to the national rate of 152.2 for 2014/15. Bristol rate of 66.3 admissions per 100,000 female population was similar to the national average rate of 67.9 for the same year.

Similarly the deaths from alcoholic liver disease among men under 75 years dominated in Bristol in 2013-15, corresponding with mortality rate in males of 20 per 100,000 which was significantly higher the England rate of 15.4 per 100,000. For female the Bristol rate was 7.8 per 100,000 and only slightly below the national average rate of 8.2.

3) What are the relevant national outcome frameworks indicators and how do we perform?

Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services. It is evident from the Public Health Outcomes Framework that the impact of substance misuse is far reaching and contributes to 92 of the 224 indicators and sub-indicators currently reported through the Public Health Outcomes Framework. The most obvious links are with measures:

2.15i - Successful completion of drug treatment - opiate users

2.15ii - Successful completion of drug treatment - non-opiate users

These indicators are defined as the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment. Two new sub-indicators have been added for 2016:

2.15iii – Successful completion of alcohol treatment

2.15iv – Deaths from drug misuse
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Successful completion of alcohol treatment has been added as an additional sub indicator to reflect the fact that drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision all comes from the same monitoring system.

Deaths from drug misuse have also now been included as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others consider the impact of treatment in addiction to recovery outcomes.

Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16 and this indicator directly contributes.

The following list gives an indication of the wide ranging impact substance misuse has on public health outcomes:

- Blood borne virus vaccinations
- Hospital admissions/readmissions
- Employment rates, Sickness absence
- Injuries due to falls, Hip fractures

- Injuries in children, Low birth weight babies, Smoking at the time of delivery, Pupil absence, Child poverty, Entrants to the youth justice system
- Life expectancy, Mortality rates
- Smoking prevalence
- Mental illness
- Social Isolation
- Suicide rates
- Stable and appropriate accommodation, Statutory homelessness
- Domestic abuse
- Violent crime
- Perceptions of community safety
- Re-offending levels.

4) What is the evidence of what works (including cost effectiveness)?

In 2016, following a review of existing evidence on the health effects of alcohol and a public consultation, the UK Chief Medical Officers published new guidelines on low risk drinking. In a move away from daily limits, it is now recommended that men and women should not regularly (defined as most weeks) drink more than 14 units a week. Drinking at this level is considered to be 'low risk', and adults who regularly drink up to this amount are advised to spread their drinking over three or more days. Above this level is considered to be 'increased risk', for men this is now above 14 units and up to 50 units, and for women over 14 units and up to 35 units per week. Men who regularly drink more than 50 units a week and women more than 35 units, are described as 'higher risk drinkers' and are considered to be at particular risk of alcohol-related health problems.

The revised guidance questioned the usefulness of daily limits given that many people don't drink every day and that, to some extent, the daily amounts are misunderstood and seen as a maximum amount of alcohol to drink on a single day or occasion. The revised guidelines instead provide advice for alcohol consumption on single occasions, with the intention of helping individuals to reduce the short-term risks and harm caused by drinking. Adults are advised to limit how much they drink on single occasions, consume alcohol with food and water, and drink alcohol slowly.

The number of alcohol users presenting to treatment has increased dramatically. During 2015/16 ROADS (Recovery Orientated Alcohol & Drugs Service) received a total of 3,300 referrals for 2,433 clients. Of this number 30% of the referrals were for primary alcohol clients (754/2,433). When considering the referral source 43% of the clients referred (385/754) were from GPs and a further 30% (232/754) were self-referrals.
Following an assessment 181 were mild dependent drinkers, 286 moderate dependent and 360 severe dependent. The age and gender profiles are outlined below.

Fig 2: Gender profile of primary alcohol users presenting to treatment

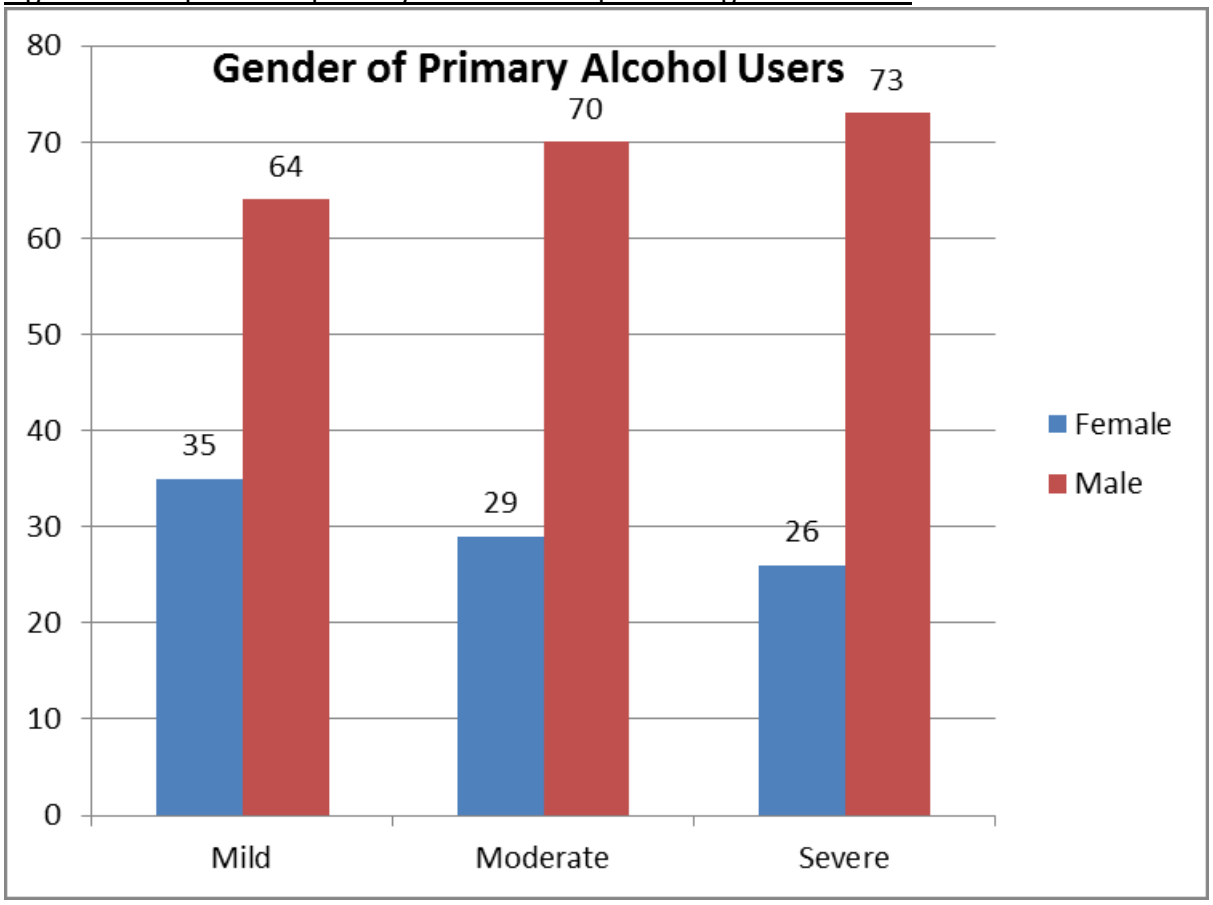
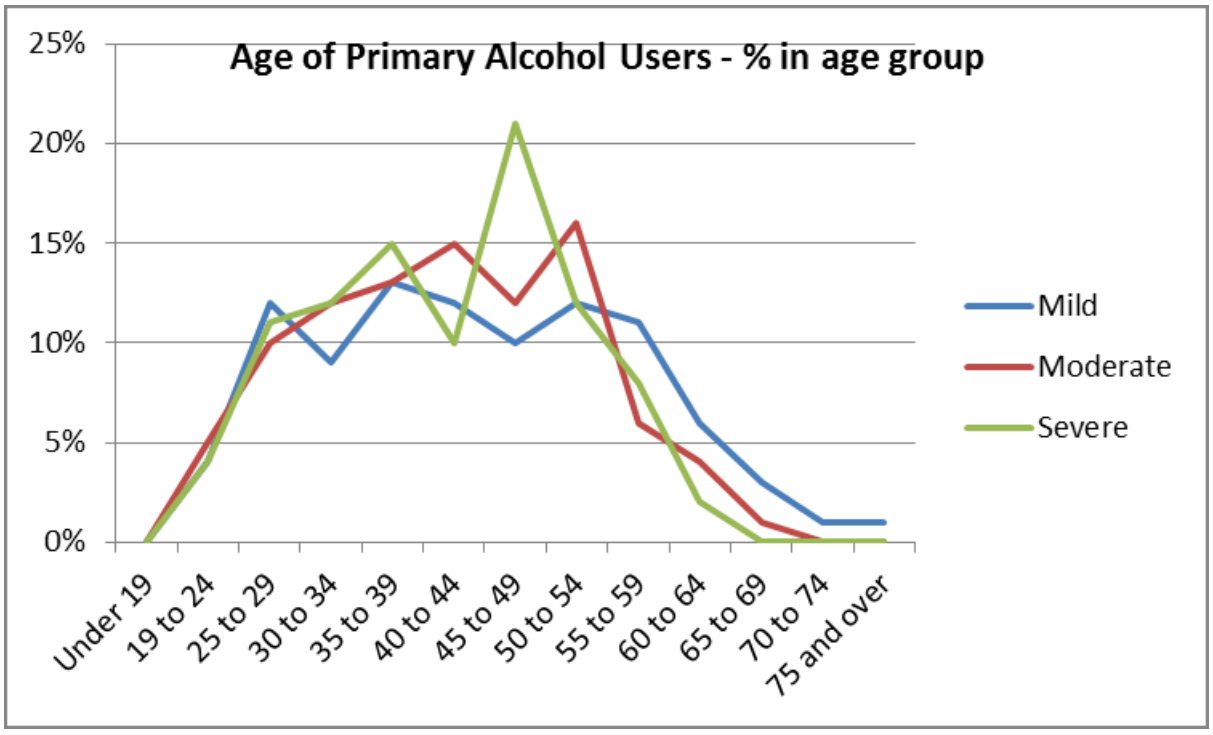


Fig 3: Gender profile of primary alcohol users presenting to treatment



5) What services / assets do we have to prevent and meet this need?

Bristol has the ***"Recovery Orientated Alcohol and Drug Service" (ROADS),*** an integrated adult substance misuse service available across the City for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

In the hospitals there are ***Alcohol Nurse Specialists***, based in the Bristol Royal Infirmary and at Southmead. These nurses provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol, some also provide symptom triggered prescribing for patients. There are sound safeguarding processes in place for children and vulnerable adults, and good working relations with the mental health team. The alcohol nurses cover A&E, the hepatology ward and the medical assessment unit.

Substance Misuse Specialist Midwives operate from the city's maternity units to co-ordinate the midwifery care for women who misuse substances in pregnancy or pregnant women who are in substance misuse treatment. The midwives liaise closely with the consultant obstetricians, neonatologists and Complex Needs service when planning care for these women and their families.

Inpatient (Detox and Stabilisation) and Residential Rehab (Detox, Primary and Secondary) Inpatient provides ***a clinically safe inpatient detoxification*** or stabilisation regime to the most complex individuals whose needs cannot be met in the community or through a residential rehab detox. This provision requires a planned regime of 24-hour medically directed evaluation, care and treatment of substance related disorders in an acute care inpatient unit, staffed by designated addiction accredited physicians, as well as clinicians and recovery workers.

This service provides ***medically supervised prescribing***, assessment, care and treatment to individuals requiring detoxification from either drugs or alcohol.

Residential rehabilitation is a specialised service offering accommodation, support and rehabilitation to people with complex drug and/or alcohol and other health needs. This is provided according to a recovery plan and includes intensive and structured programmes delivered in a residential environment.

In order to reflect the increasing levels of complexity for substance misusers at both a local and national perspective, an established complex needs provision identifies and case- hold the most ***vulnerable and chaotic clients*** across the city who are affected by substance misuse (we predict this cohort to be in the region of 20% of the overall treatment population). Key to this success is to proactively link with local physical and mental health services to collaborate and optimise the treatment offer for complex clients.

A planned substance misuse liaison service (SML) will operate out of GP practices participating in the Alcohol Detox and/or OST primary care local enhanced contracts. The

SML will care coordinate primary alcohol and opiate clients attending their GP practice for pharmacological interventions, deliver appropriate psychosocial interventions commensurate to need and facilitate pathways with the Recovery Centres.

The SML will be expected to enable capacity for 1,488 primary alcohol clients to undertake community alcohol detoxes per year. It is expected that the SML will prepare clients for detox, support them through the withdrawal process and offer brief post-detox support to facilitate access to a Recovery Centre for ongoing psychosocial interventions, relapse prevention and aftercare. It is envisaged that the SML will work with clients for a maximum of 4-6 weeks.

A GP Public Health Service (Shared Care) is being negotiated to increase the availability of prescribing for alcohol withdrawal within Primary Care. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services to support the success of the detox.

The Early Engagement and Intervention Service operates across Bristol in order to engage with drug and alcohol users, including those who are not in contact with ROADS services. Interventions to improve health and reduce the harms associated with drug and alcohol use are delivered as well as supporting those furthest away from services to access treatment in a timely manner.

Contact with non-treatment seeking drug and alcohol users will be established to ensure early interventions can be delivered to reduce health complexities and support people to access services to improve the wellbeing of individuals not currently accessing ROADS services. This will need to include in-reach to hostels and non-commissioned dry-houses as well as effective partnership working with allied services (e.g. homelessness, mental health, etc.) and facilitate access to help meet individuals' needs.

Some ***GPs offer community detoxification*** in partnership with the treatment services. ROADS Complex Shared Care nurses work in primary care in areas where there are high numbers of problem drinkers. They support GPs to work with clients with complex needs to enable their care to remain within their local practice and GPs have further support from the ROADS lead consultant to support the delivery of primary care based interventions.

The Clinical Commissioning Group commissions hospital services and there are a number of planned care pathways that relate to alcohol, for instance ***inpatient and outpatient hepatology services for cirrhosis of the liver.***

Identification and Brief Advice (IBA) is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services.

IBA services have been developed and are operational in:

- Bristol Royal Infirmary Accident and Emergency Department, the Medical Assessment Unit, and some wards
- Some wards in North Bristol NHS Trust
- GP practices who operate the National Direct Enhanced Service (for new registrations), or the Public Health Alcohol Service (for patients with hypertension, newly diagnosed depression, or who have been to hospital with an alcohol misuse related injury)
- Custody suites.

Licensing Service. This service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. The Licensing Service conducts proactive inspections at alcohol licensed premises to ensure compliance with premises licence conditions and other related legislation. The Service undertakes to work with licence holders in effecting compliance, recommending and ensuring improvements where necessary, but takes punitive action where necessary.

Trading Standards Service. This service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. They use an intelligence led approach to achieve compliance and respond to complaints alleging the illegal sale of alcohol products. The Service can undertake checks for compliance for underage sales and works in partnership with other enforcement agencies to tackle the problem of underage sales, and of counterfeit and smuggled alcohol products.

Crime Reduction and Substance Misuse Team This team works with retailers to improve the management of the night-time economy through initiatives like Pubwatch. They operate the CCTV presence in the city centre which contributes to reducing alcohol fuelled disorder.

Social Marketing campaigns have been carried out to raise awareness about alcohol and its risks. The DrinkSmart campaign has been operational since 2010, and includes self-help materials for people who are concerned about their alcohol use and want to make changes. Targeted campaigns include: a series of campaigns aimed at young people, a safeguarding vulnerable people campaigns aimed at carers who drink, and pharmacy campaigns targeting people with high blood pressure.

6) What is on the horizon?

In the Bristol Joint Health and Wellbeing Strategy (2016 Re-fresh), 'Tackling alcohol misuse' emerged as one of the three priorities for the Health and Wellbeing Board. The 'Bristol City-wide Alcohol Strategy' and its Action Plan attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

One of the broad aims of the new Strategy is to increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption. It includes the

commitment to use social marketing tools and other techniques to gather intelligence about attitudes to alcohol use and drinking behaviour to inform strategic actions.

7) Local views

Bristol's Big Drink Debate

From October 2016 to the end of January 2017, Bristol Public Health led the ***Bristol's Big Drink Debate***, an initiative to get people thinking and talking about alcohol, using a variety of techniques such as online survey, focus groups, workshops, stands and social media. It aimed to inform actions that would create an environment within which the consensus about acceptable drinking behaviour and culture is moved towards a less harmful relationship with alcohol.

The Debate and survey engaged with people who are at early stages of the behavioural change cycle. Over 1600 people took part in the survey and more than 300 participated further in focus groups and community engagement, debating about alcohol consumption in the City. We have seen a good representation from all Wards, however, the higher percentage of responses received were from central Bristol Wards, Lawrence Hill, Central and Ashley. People as young as 16 and up to 60+ took part. BME communicates were somewhat under-represented.

The results from the debate showed that the majority drink within the government guidelines, mainly to socialise, relax and unwind. Nearly as many people drink at home as in public houses and bars. However nearly 53% of residents think drinking is a problem in Bristol. Frequent comments were concerning issues such as social acceptability, binge drinking, impact on public services, anti-social behaviour, role of parents and schools in education, negative personal and family history and the role of government in licencing legislation and alcohol pricing.

Data gathered from the survey were analysed and presented to the Bristol Alcohol Strategy Group where a number of recommendation for action were made. A report was produced and is due to be published in May 17.

What do staff/users/carers think?

The physical health snapshot from March 2016 of Shared Care and Housing clients asked the practitioners to comment on the difficulties they have encountered in providing their services with regard to the support clients require, with two main themes emerging from the responses received.

The first theme indicated by practitioners across both services was that the structures for healthcare and treatment are not flexible enough to encourage meaningful engagement with the clients. This included:

- Not having the same GP each time - no one gets to know the client
- Appointments not being long enough, nor frequent enough, to meet the clients' needs
- Long waits at surgery put off clients from attending

• Clients being too chaotic to make appointments made
• Struggling to attend specialist appointments, e.g.: hospital appointments, due to transport reasons. One client had an appointment where she had to take 3 buses' to attend.
• Cancellations from clients who are particularly unwell (renal failure, daily epileptic fits and osteoporosis)
• After assessment people don't ask about physical health needs
• Looking for reasons to kick people off waiting lists
• Shared care workers are too busy and are flat out. Clients are presenting with a lot of chaos. Caseloads are too big and time with clients is too short.
• No structured pain management or a clear referral pathway

B: What does this tell us?

8) Key issues and gaps

Communication with and feedback from both professionals and service users have indicated that there is a gap for 'medium level' mental health support for substance misusers. It has been suggested that if substance misusers are experiencing either a mental health crisis (high level) or require some low level mental health interventions (e.g. IAPT) then they are able to access these levels of services however a gap still exists for clients requiring more structured mental health interventions in substance misuse services.

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The Bristol Mental Health Needs Assessment predicted that people living with mental health conditions are likely to increase in forthcoming years. More work is needed to address the gaps in the monitoring of information of dual diagnosis clients in substance misuse and mental health services. Being able to effectively monitor this data will inform future needs assessments and identify gaps in service provision.

In 2014 there were an estimated 23,000 deaths related to alcohol use in England. Approx 6,000 of these were due to alcohol-specific causes. The rate of alcohol-related mortality for men (65.4 per 100,000) is more than double the rate for women (28.8 per 100,000). This gender health inequality needs to be address urgently using multi-agency approach.

Physical ill health has been identified as having a significant impact on the recovery potential of people accessing treatment services. There is an intrinsic link between physical and mental health; poor physical health can adversely affect a person's mental health and poor mental health can negatively affect physical health.

Whilst great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the current structures of support still tend to deal with the these needs in isolation.

It is equally important to recognise the fact that the relationship between physical health and substance misuse is complex. It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of prescribed medications, chronic pain and self-medication for other symptoms, including mental health, often leads to dependency forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. Chronic liver disease, respiratory illness and blood borne viruses, caused as a result of using substances, are commonly identified within alcohol and drug using populations.

9) Knowledge gaps

The following are recommendations made in the substance misuse strategic needs assessment, carried out by the BCC Substance Misuse Team: https://www.bristol.gov.uk/documents/20182/33003/Final+Report+Substance+Misuse+Needs+Assessment.pdf

Bristol needs a structured treatment system that provides a range of evidence based interventions to maximise recovery opportunities. Commissioners need to ensure the system can manage a broad range of conditions and client complexities. Treatment options should include access to a range of psychosocial and pharmacological interventions, including relapse prevention.

Within structured treatment there needs to be an enhanced focus on the delivery of health protection and harm reduction interventions.

Retain a hospital based service to provide support to drug and alcohol users who are admitted to wards.

Continue to support a maternity service for pregnant substance misusing women and their partners. Investigate effectiveness and efficiency of various delivery options to maximise outcomes for both drug and alcohol users.

Continue to work with PH colleagues to improve access to HCV treatment for clients.

Continue to support hospital based alcohol liaison work.

Improve data monitoring is required to understand the needs of dual diagnosis in Bristol. Further work is required as to how we can demonstrate good outcomes for this cohort in order to build these in to future service specifications.

Explore how feasible it is for social prescribing services to work with substance misuse clients with low level mental health needs and link with commissioners.

Review what happens when children who have been exposed to parental substance misuse are taken into care.

Continue to link with the commissioners of young people's substance misuse services and the Drugs and Young People project to meet the needs of children affected by parental

substance misuse.

Maintain close working with young people's treatment services to ensure a smooth transition for young people moving from young peoples into adult treatment.

Review the substance misuse knowledge/skills of those practitioners who are the main contact with families to meet the parents and children's needs. This needs to consider drug and alcohol awareness.

The combined impact of domestic violence, substance misuse and mental health is recognized. The services offered to these vulnerable individuals need to be sufficiently resourced. Learning from the Golden Key initiative will be critical in informing the approach.

Peer support offers considerable benefits to both the peers and those receiving their support. This should be considered as a fundamental part of a treatment system.

C: What should we do next?

10) Recommendations for consideration

The Bristol Alcohol Strategy aims to make our City safer, healthier and happier place to live, to work, and to visit by working with individuals and communities to reduce alcohol consumption and alcohol-related harm. While we have already made a considerable progress in developing effective ways we deal with alcohol misuse in the City, we recognise the great potential for us to work with partner organisations to promote a positive behavioural change leading to improved health and wellbeing for everyone.

Our vision for Bristol is to create safe, sensible and harm-free drinking culture in Bristol, through partnership working and using the best available evidence in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

There are 3 broader aims of the Strategy:

1. Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.
2. Provide early help, interventions and support for people affected by harmful drinking.
3. Create and maintain a safe environment.

Partners in Bristol have a co-ordinated approach to dealing with licensed premises that sell alcohol illegally or irresponsibly. The regulatory authorities - Council licensing, Police licensing, planning, pollution control, environmental health work together to identify problem premises and take action through a Joint Tasking process. Problem premises are 'Red' tagged and worked with to improve their performance against the National Licensing

Objectives. There are joint enforcement visits involving the Police, council licensing and trading standards staff.

Supporting people to identify issues with drugs and alcohol at an early stage is a key part of early intervention. Consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach which aims to support people in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Substance misuse is hugely stigmatised and it is crucial that when someone seeks support they receive it in a timely manner. One in five referrals received by the ROADS Engagement service in 2015 were self-referrals with all the others being made by professionals. GPs accounted for nearly half of all referrals. Early referral and intervention are crucial to maximising successful outcomes with age of initiation and length of using career having a real effect on people's recovery potential. 97% of opiate clients and 92% of non-opiate clients.

Bristol has a thriving mutual aid recovery network including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and SMART Recovery. Between these groups there are over 130 meetings a week held in Bristol, including specific groups for women and the Lesbian, Bisexual, Gay & Transgender (LBGT) community. ACT (Acceptance & Commitment Therapy) Peer Recovery another Public Health England recognised mutual aid support group are hoping to become established locally over the coming months.

11) Key contacts

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Bristol JSNA process – website: www.bristol.gov.uk/jsna / email: jsna@bristol.gov.uk

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