APPENDIX A

Bristol Clinical Commissioning Group

BRISTOL
CITY-WIDE
ALCOHOL STRATEGY
2016 – 2020

October 2016
Draft v4.0 (final)

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FOREWORD

Becky Pollard, Director of Public Health, Bristol City Council

The consumption of alcohol is an established part of life in the UK. There are many people who choose not to drink but, for the majority of adults, alcohol is accepted in the routines of daily life.

Yet, alcohol can bring a whole world of harm. For the individual, regular drinking increases the risk of developing illnesses such as cancer, liver cirrhosis and heart disease, and excessive alcohol consumption can lead to dependence. For families, alcohol consumption can lead to relationship breakdown, domestic violence and become a significant factor in poor parenting. For communities alcohol can fuel crime and disorder and can transform parts of the City into no-go areas. For the society, the cost of alcohol consumption includes huge financial burden on public services as health, social care and criminal justice agencies all have to invest a significant amount of resources providing response to the effects of drinking. Alcohol-related work absence due to alcohol consumption and the loss of productivity impact on the local economy and can reduce the ability of our City to thrive and achieve its potential.

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.

Dr Martin Jones, Chair Clinical Commissioning Group, NHS Bristol Clinical Commissioning Group

Alcohol misuse presents a major problem in Bristol that requires a system-wide response. Nationally liver disease is the only major cause of death still increasing year-on year and this statistic is also reflected in our local population with deaths caused by or associated with alcohol higher than the England average. This strategy has been the culmination of a wide range of stakeholders working collaboratively to identify key issues and proposed solutions to ensure that Bristol is a healthy and safe place to live work and visit.

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Rhys Hughes, Superintendent, Avon and Somerset Police

Bristol is a large, diverse and vibrant City with a thriving night time economy. It is also host to a number of large public events and sporting occasions throughout the year, where thousands of people come together to enjoy what Bristol has to offer.

Maintaining a safe environment, particularly when alcohol is involved, is essential for people to be safe and feel safe. To help achieve this, everyone has their part to play.

Unfortunately, alcohol can cause people to act in a negative way, leading to physical and verbal assaults and ultimately, arrest or serious injury. This can have a dramatic impact on those involved and they may live to regret an alcohol fuelled moment for the rest of their lives. It is also important to recognise the impact such behaviour has on society as a whole as it can be felt by the wider community in terms of experiencing anti-social behaviour, detrimental quality of life as well as the health and cost implications.

This workstream brings together a number of partner agencies to identify ways to protect vulnerable people, reduce demand on public services and work with events organisers to make sure their visitors can have an enjoyable and safe time. It has to be a team effort and some of our work has already had tangible success in reducing the number of alcohol related incidents at large events.

I am confident that working with the other leads, to deliver the Bristol Alcohol Strategy, will reduce the harm alcohol can cause and bring real benefits to the city.

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1 EXECUTIVE SUMMARY

1.1 Introduction: Alcohol, public health problem

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. Alcohol has become more affordable over time and the amount of alcohol being sold has been increasing.

Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

Alcohol consumption in Bristol

About 84% of Bristol population aged 16 years and over engage in drinking. Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others. Furthermore, 26.3% 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. It should be noted that people are likely to underestimate the amount they drink in self-reported surveys.

The pattern of alcohol misuse over Bristol 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.

Health harms

Excessive drinking is a major cause of wide range of diseases and injuries. Alcohol and drug use was identified to be the fifth leading risk factor of the burden of disease in England. Alcohol consumption was the third leading behavioural risk factor overall, and the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause.

In Bristol there were 5,408 persons admitted to hospital due to alcohol-related conditions in 2013/14 where alcohol-related condition was 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 1,513 persons per 100,000 population admitted (broad measure) in 2013/14 compared to the England rate of 1,253 admissions per

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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.

Similarly the alcohol-specific hospital admissions where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code, have been consistently higher than the England average over the past few years (e.g. the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14). Furthermore the number of alcohol-specific admissions was more than double in men than women (1,505 versus 650 in 2013/14).

There were 187 alcohol-related deaths in Bristol in 2014, 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 where the rate of alcohol-specific mortality was 28.5 deaths per 100,000 men in 2012-14, compared to females with 7.9 deaths per 100,000 women.

Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. Similarly the deaths from alcoholic liver disease among men under 75 years dominated in Bristol in 2012-14, corresponding with mortality rate in males of 20.9 per 100,000 which was significantly higher the England rate of 11.5 per 100,000.

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services. In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 to 2013/14. Three in four people who attended A&E due to alcohol poisoning arrived by ambulance and one in three were subsequently admitted to hospital overnight. The cost of alcohol misuse to the NHS is estimated to be £3.5 billion every year.

In Bristol there is unprecedented demand for alcohol treatment services since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement. Bristol had a significantly lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%).

Social & economic harms, crime & disorder

Alcohol misuse also places a significant cost burden on society. The estimated cost of alcohol harm to society is £21 billion per year which takes into account the impact alcohol has on health and other public services, the cost of alcohol- related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11billion.

In Bristol there were 3,461 alcohol-related offences recorded in 2012/13. The rate of recorded crime per 1,000 population attributable to alcohol has been consistently higher than the regional and national average (e.g. in 2012/13 the Bristol rate of 8.08 per 1,000 compared to the national rate of 5.74 and regional rate of 4.90). Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13. There is a

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strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related. There is also a well-known link between alcohol misuse and offending.

Harms to children and families

Alcohol misuse can affect families in a range of ways. 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. In 2000 it was estimated that 22% lived with a hazardous drinker and 6% with a dependent drinker. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

Alcohol multi-faceted problem

On the 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.

This strategy 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.

1.2 Where are we now? Current responses to alcohol-related harm in Bristol

Bristol has higher than the national average alcohol related crime as well as higher alcohol related morbidity and mortality.

Current responses to alcohol-related harm in Bristol comprise prevention work, provision of specialist treatment and care, and response to alcohol-related crime and disorder.

Prevention work

The preventative approach to tackling alcohol misuse through education and campaigns is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the

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most likely substance that young people will use. The majority of alcohol prevention with young people in Bristol is delivered in schools. The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work.

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. Furthermore social marketing campaigns have been carried out to raise awareness about alcohol and its risks.

Treatment and care

Alcohol treatment and care for children and young people is delivered through early intervention work with young people as part of the Bristol Youth Links programme. Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services.

The Recovery Orientated Alcohol and Drug Service (ROADS) is an integrated adult substance misuse service available across Bristol 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 Bristol hospitals there are alcohol nurses who provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol. Furthermore alcohol-related problems are a big and increasing part of the primary care workload. Some Bristol GPs offer community detoxification in partnership with the treatment services.

Response to alcohol-related crime and disorder

The Police have developed their operational approach to policing the night-time economy, combining public order policing with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers. The police response to alcohol-related violent crime offences and incidents of anti-social behaviour involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises. The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

As part of their work, Probation Services in Bristol assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be

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referred to a range of interventions around problematic alcohol use. Other structured interventions are available as part of community orders or post-release Licences.

The Bristol City Council Licensing Service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. They conduct proactive inspections at alcohol licensed premises to ensure legislation compliance. The Trading Standards Service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. The Crime Reduction and Substance Misuse Team works with retailers to improve the management of the night-time economy and operates the CCTV presence in the city centre.

1.3 Where do we want to be? Vision for Bristol and our strategy

Our vision for Bristol is to create safe, sensible and harm-free drinking culture, 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.

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit. This can be achieved through partnership working and using the best available evidence of what works.

There are three 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.

1.4 How do we get there? Deliverables and action plan

The aims of the Strategy will be achieved through close collaboration of three Alcohol Workstreams:

1. Alcohol Prevention Workstream
2. Alcohol Intervention Workstream
3. Alcohol Environment Workstream

Each Workstream suggested the desired outcomes and proposed an action plan to be pursued.

Alcohol Prevention Workstream

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Suggested Outcome(s):

- Reduce alcohol consumption causing harm to individuals, families and communities in Bristol.

Suggested Actions:

- Social marketing
  - Deliver a large-scale social marketing campaign across Bristol City
  - Deliver preventative campaigns using social marketing tools and methods
  - Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour
- Education in schools
  - Implement alcohol education in schools
  - Develop work with schools about delivering training for parents
  - Work with young people and adults with caring responsibilities
- Workplaces
  - Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace
- Alcohol Workplace policies
  - Review Bristol City Council alcohol policy and support available for employees with alcohol problems.
- Workforce (Making every contact count)
  - Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers
  - Workforce development in alcohol IBA - (making every contact count
- Community
  - Encourage parents to have conversations with their children through a social marketing campaign
  - Develop training on supporting parents to talk to their children on the harms of alcohol.
  - Develop community engagement strategies.

Alcohol Intervention Workstream

Suggested Outcome(s):

- Reduce alcohol related harm to individuals.
- Earlier identification of health harm caused by alcohol.
- High quality evidence-based treatment to reduce alcohol related harm.
- Children and young people free from alcohol related harm.

Suggested Actions – Planning:

- Needs assessment
  - Provide an overview of current service provision of Bristol Recovery Orientated Alcohol & Drug Service (ROADS) against need and identify how services can meet the identified needs
- Mapping of existing services

- Mapping of patient pathway – specialist services
- Evidence review and economic evaluation
- Primary care review
    - Review of screening and identification used within primary care to include alcohol and liver disease
- Activity data
    - Review of secondary care data (Commissioning for Value datasets) and explore opportunities

Suggested Actions – Delivery:

- System approach to alcohol and liver disease
    - Development of a system approach to alcohol treatment and liver disease (all causes)
- Harm minimisation for high risk groups
- Young People
    - Promoting the young people's substance misuse pathway across all agencies working with children and young people
- Training and education – Healthcare staff
    - GP training
    - Explore the opportunities for online training for ambulance staff and information sharing with primary care
    - Develop Paramedic training at UWE in IBA
    - Mutual aid training for practice based staff (PMs/Community resource co-ordinators)

Alcohol Environment Workstream

Suggested Outcome(s):

- ➢ Reduce individual and community impact from alcohol related crimes and anti-social behaviour.
- ➢ Protect vulnerable people from alcohol related harm.
- ➢ Reduce demand on public and emergency services.
- ➢ Safe events held within the City; reduce alcohol related incidents.

Suggested Actions:

- Wider use of technology
    - Increase the availability of technology to improve the quality of information and evidence
- Diversionary events/activities
    - Provide an alternative to traditional night time economy activities
- Brio night time economy operation
    - Continue to develop this operation into a multi-agency approach to Bristol night time economy
- Intelligence sharing between agencies
    - Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City
- Identification and management of problematic licensed premises

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  - Improving the safety of establishments
- Training and awareness for licensed trade staff
  - Raising awareness of CSE and other vulnerability issues. Early recognition by staff
- Alcohol Recovery Centre
  - Reducing demand for NHS and police. Improved early care for users.
  - Demographic data will assist other work streams
- Re-invigoration of the Pub-Watch Scheme
  - Improve the cooperation of licensed premises to ensure a safer environment
- Management of Cumulative Impact areas
  - To ensure areas are monitored to manage the number of licensed premises
- Structured approach to licensing implications for larger events
- Providing support for people using and working in the City Centre during the night time economy
  - Identification of vulnerable people due to alcohol consumption, providing a safe environment
- Providing support to vulnerable people within the street drinking community

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2 INTRODUCTION

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. The overall trend of alcohol affordability has been increasing over time. In 2014 alcohol was 53.8 per cent more affordable than it was in 1980[1].

Licensing laws have changed allowing the trade to operate late into the early hours. National HM Revenue & Customs data[2] shows that the amount of alcohol being sold is increasing, however this picture may be confounded by the amount of smuggled and counterfeit alcohol. In more recent years tax and duty receipts from alcohol have been noticeably higher due to sustained periods of good weather, or major outdoor/sporting events, which typically increase alcohol receipts.

Over the last decade there has been a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others[3]. Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

In England in 2013, 18% of men and 13% of women drank at an increased risk of harm, and 5% of men and 3% of women at higher risk levels. There were about 1,059,210 alcohol-related hospital admissions in England in 2013/14, where an alcohol-related disease, injury or condition was the primary reason for hospital admission. This was a 5% increase from 2012/13. There were 6,592 alcohol-related deaths in 2013, a 1% increase from 2012. About 194,706 items for the treatment of alcohol dependence were prescribed in 2014 (in a primary care setting or NHS hospital), at the Net Ingredient Cost of £3.43 million.

At the same time alcohol plays an important part in our social lives and in the local 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.

On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the UK economy. 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.

This strategy 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.

[1] Statistics on Alcohol, England, 2015. Health and Social Care Information Centre. June 2015. Available from: http://www.hscic.gov.uk/catalogue/PUB17712/alc-eng-2015-rep.pdf. (Accessed 24/02/2016)
[2] Tax and Duty Bulletins. HM Revenue and Customs. Available from: https://www.uktradeinfo.com/Statistics/Pages/TaxAndDutyBulletins.aspx. (Accessed 24/02/2016)
[3] The Government's Alcohol Strategy. HM Government. March 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf.

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2.1 Safer levels of drinking

The UK Chief Medical Officers' (CMOs) proposed new guidelines to inform the public about the known health risks of different levels and patterns of drinking, and to limit the health risks associated with the consumption of alcohol. These guidelines should help people to make informed choices and judge the risks they are willing to accept from alcohol, whether to drink alcohol, and how much and how often to drink[4].

The guidelines include the following three main recommendations.

1/ A weekly guideline on regular drinking (for both men and women):

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis.
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

2/ Advice on single episodes of drinking, i.e. advice on short term effects of alcohol (for both men and women):

You can reduce the short term health risks from a single drinking occasion to a low level by:

- limiting the total amount of alcohol you drink on any occasion;
- drinking more slowly, drinking with food, and alternating with water;
- avoiding risky places and activities, making sure you have people you know around, and ensuring you can get home safely.

The sorts of things that are more likely to happen if you don't judge the risks from how you drink correctly can include: accidents resulting in injury (causing death in some cases), misjudging risky situations, and losing self-control.

These risks can arise for people drinking within the weekly guidelines for regular drinking, if they drink too much or too quickly on a single occasion; and for people who drink at higher levels, whether regularly or infrequently.

Some groups of people are likely to be affected more by alcohol and should be more careful of their level of drinking on any one occasion: young adults; older people; those with low body weight; those with other health problems; those on medicines or other drugs.

As well as the risk of accident and injury, drinking alcohol regularly is linked to long term risks such as heart disease, cancer, liver disease, and epilepsy.

3/ A guideline on pregnancy and drinking:

- If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

Most women either do not drink alcohol (19%) or stop drinking during pregnancy (40%).

The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy.

Women who find out they are pregnant after already having drunk during early pregnancy, should avoid further drinking, but should be aware that it is unlikely in most cases that their baby has been affected. If you are worried about how much you have been drinking when pregnant, talk to your doctor or midwife.

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[4] UK Chief Medical Officers' Alcohol Guidelines Review. Summary of the proposed new guidelines. January 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf.

In short, the guidelines change the safe alcohol units for men who should not drink more than 14 units of alcohol per week (compared to 21 units in the previous guidelines), the same level as for women. It recommends to spread the 14 units over 3 or more days as 1-2 heavy drinking sessions each week increase the risk of death from long term illnesses, accidents and injuries. It updates the guidelines for pregnant women, clarifying that no level of alcohol is safe to drink in pregnancy.

A unit of alcohol is roughly half a pint of normal strength lager (4.1% ABV). A unit is calculated by reference to the amount (or volume) of the drink and the alcoholic strength (Alcohol by Volume (ABV))[5].

$$\frac{\text{Volume (ml)} \times \text{Strength (ABV \%)}}{1{,}000} = \text{Number of units}$$

A unit is 10ml of pure alcohol (i.e. the amount of alcohol that would be left if other substances were removed). For example 1 litre (i.e. 1000ml) bottle of whisky at 40% ABV has 400ml, or 40 units of alcohol.

The alcohol risk levels as described by Public Health England are defined in the table below. These definitions were amended in line with the new guidelines.

Drinker type	**Men**	**Women**
Lower risk drinkers	Men and women who regularly drink less than 15 units of alcohol per week	
Increasing risk drinkers	Men who regularly drink between 15 and 50 units per week	Women who regularly drink between 15 and 35 units per week
Higher risk drinkers	Men who regularly drink more 50 units per week	Women who regularly drink more than 35 units per week
Binge drinkers	Consumption of at least twice the daily recommended amount of alcohol in a single drinking session	

[5] How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines. January 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489796/CMO_alcohol_guidelines.pdf.

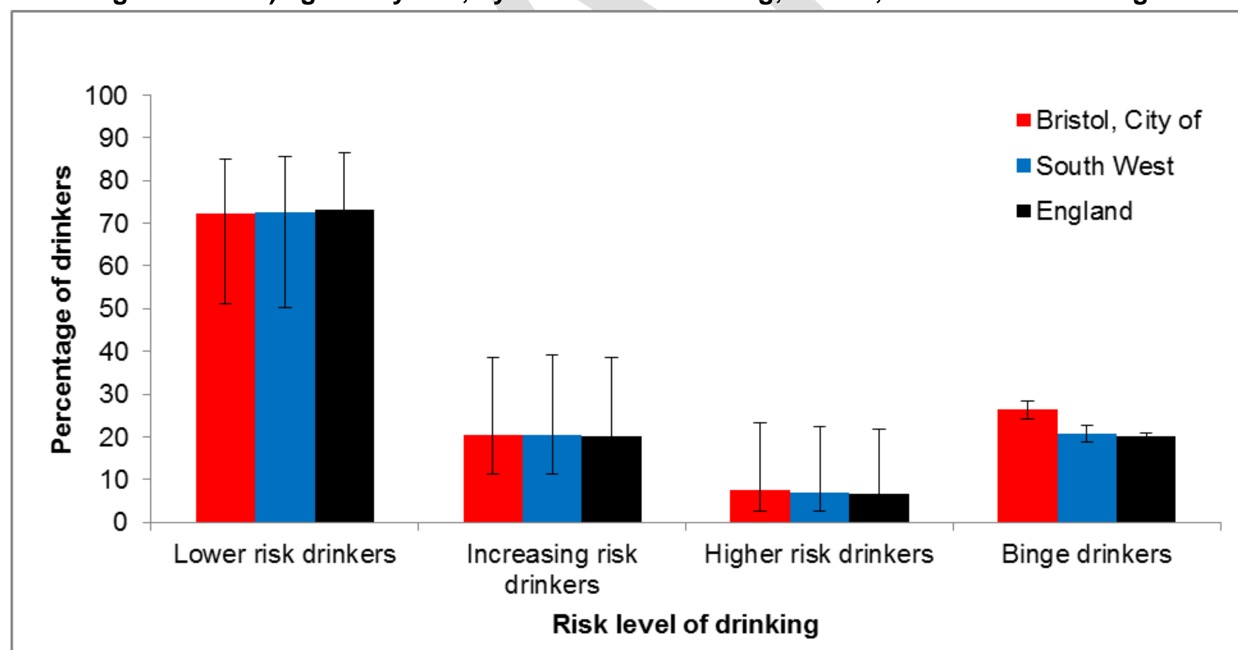
2.2 Alcohol consumption in Bristol

Estimates of local alcohol use are based on national self-reported surveys. The mid 2009 synthetic estimates produced by Public Health England, Local Alcohol Profiles for England (LAPE)[6], reported that;

- 16.0% of Bristol population aged 16 years and over abstain from drinking;
- The remaining 84.0% of Bristol population aged 16 years and over who drink reported to engage in drinking at different levels:
    - 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.

Figure 2.2a 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. There are no significant differences between Bristol, the South West and England in the other percentages.

Figure 2.2a: Mid 2009 synthetic estimate of the percentage within the drinking population (not including abstainers) aged 16 years, by risk level of drinking; Bristol, South West and England



Some research evidence indicates that these estimates could be too low as they do not marry with the Revenue and Customs data that describes the amount sold or brought into Britain[7]. It is likely that people underestimate the amount they drink in self-reported surveys and the true amount may be as high as 60 % more than stated. Given this it is likely that

[6] LAPE (Local Alcohol Profiles for England). Public Health England. Available from: http://www.lape.org.uk/data.html. (Accessed 20/02/2016)

[7] Boniface S, Shelton N. How is alcohol consumption affected if we account for under-reporting? A hypothetical scenario. European Journal of Public Healh 2013. Feb 26 2013.10.1093.

many people who describe themselves as low risk drinkers may in fact be drinking at higher levels and misusing alcohol.

Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across the City of Bristol. Some communities have traditions that dissuade alcohol misuse; these communities include some ethnic and religious groups. For instance many observant Muslims are abstinent. The socio-economic effect of alcohol use includes:

- People from lower socio-economic classes are less likely to misuse alcohol, however if they do drink to excess they tend to develop very severe drinking problems.
- More affluent people with higher income much more likely to drink alcohol daily[8].

Thus the pattern of alcohol misuse over Bristol is varied and complex. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco. This combination of smoking and drinking results in a higher risk of getting cancer. Evidence suggests that non-smokers who drank alcohol were around a third more likely to develop mouth and upper throat cancer than those who didn't drink alcohol. But people who were (ex-) smokers and also drank alcohol, were around 3 times as likely to develop the disease. Furthermore the risk of liver cancer was found almost 10 times greater in people who smoked and drank heavily[9]. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

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[8] Adult Drinking Habits in Great Britain, 2013. Office for National Statistics. Available from: http://www.ons.gov.uk/ons/dcp171778_395191.pdf.

[9] Alcohol facts and evidence. Cancer research UK. Available from: http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/alcohol-and-cancer/alcohol-facts-and-evidence#alcohol_facts6. (Accessed 25/02/2016)

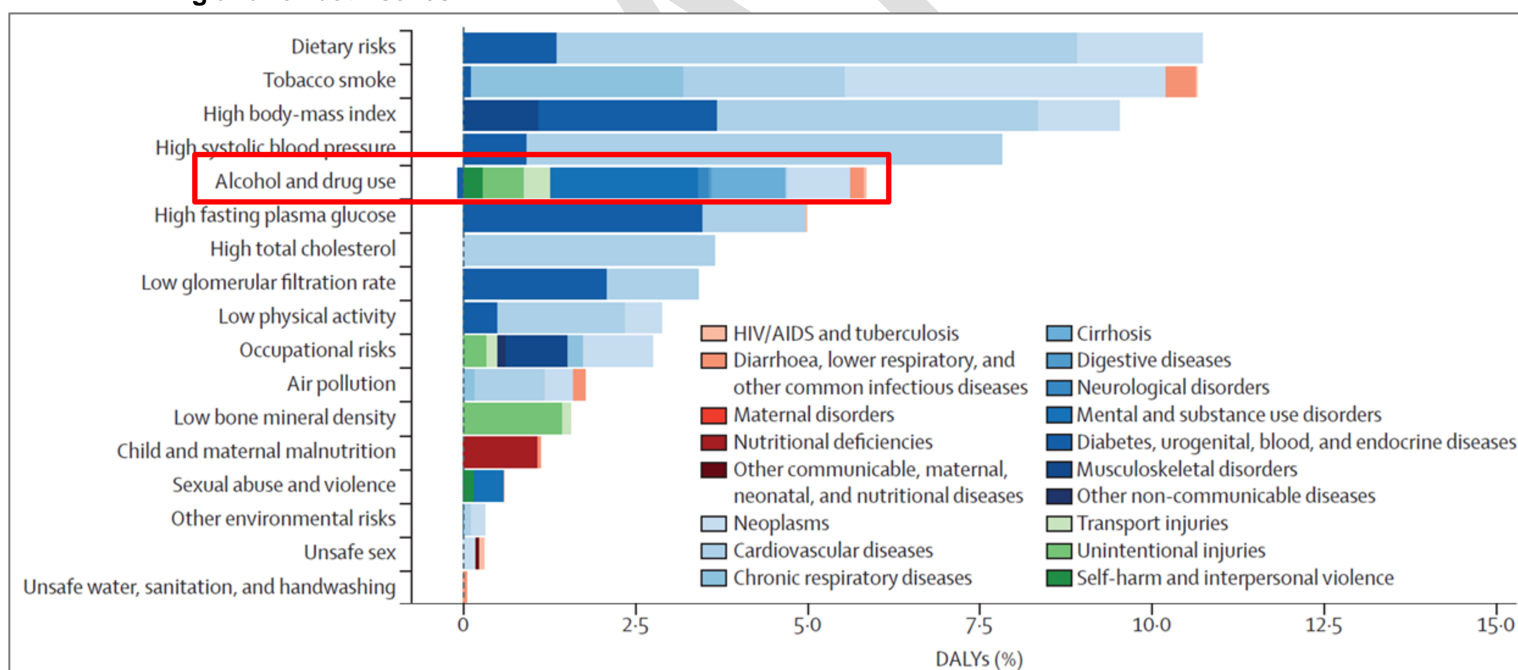
2.3 The impact of alcohol misuse

2.3.1 Health harms

Excessive drinking is a major cause of wide range of diseases and injuries in the UK. In the Global Burden of Disease Study 2013 (GBD 2013), alcohol and drug use was the fifth leading risk factor of the burden of disease in England, and accounted for approximately 6% of disability-adjusted life years (DALYs) (Figure 2.3.1a). Alcohol and drug use caused a greater proportion of total DALYs in men than in women (8% versus 4%). Alcohol, high body-mass index and high fasting plasma glucose were the only leading risks for which attributable burden did not fall between 1990 and 2013.

In GBD 2013, alcohol consumption was the third leading behavioural risk factor overall, but was the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause (cirrhosis due to alcohol accounted for 29% of DALYs due to cirrhosis). However, alcohol also contributed to cirrhosis where it was not the underlying cause. Therefore, the overall proportion of cirrhosis of the liver DALYs attributed to alcohol was 70% in England in 2013[10].

Figure 2.3.1a: Disability-adjusted life-years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes



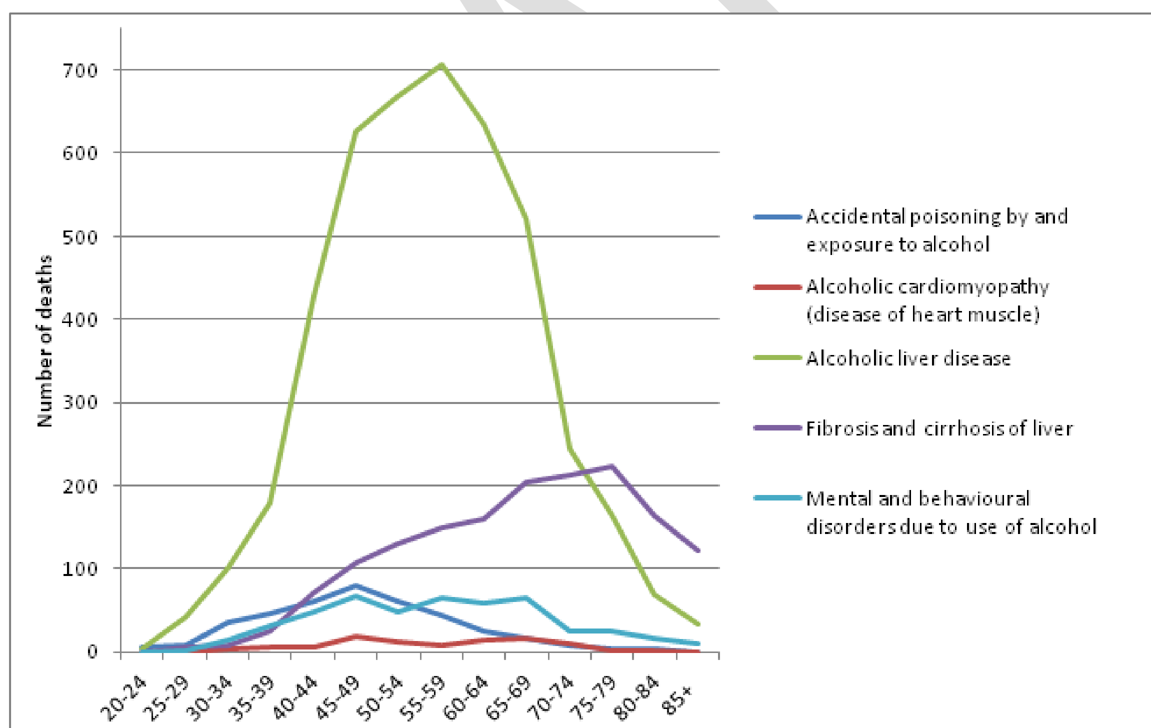
[10] Newton JN, Briggs ADM, Murray CJL, et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2015. Published Online September 15, 2015. http://dx.doi.org/10.1016/S0140-6736(15)00195-6.

Alcohol is linked to, or causes, a range of serious and preventable diseases[11], including the following:

- Causally related to a range of acute and chronic medical conditions, including cancers, cardiovascular disease, and obesity;
- A significant cause of morbidity and premature death;
- Associated (through heavy drinking by pregnant women) with a range of preventable mental and physical birth defects (collectively known as Foetal Alcohol Spectrum Disorders);
- Implicated in many areas of mental ill health, including depression, anxiety and suicide;
- Linked to unintentional injuries and trauma due to violence.

The age-standardised rate of alcohol-related deaths in the UK rose steeply from 1994 to 2008 when it peaked. It has reduced since then, but the 2014 rate of 14.3 deaths per 100,000 population (i.e. 8,697 alcohol-related deaths) was still higher than the rate in 1994 (9.1 deaths per 100,000 population). About 65% of alcohol-related deaths (65%) in the UK in 2014 were among males[12]. Figure 2.3.1b shows the top five alcohol related deaths by causes and age group in 2012[13].

Figure 2.3.1b: The top 5 alcohol related deaths by causes and age group, England and Wales, 2012[13]



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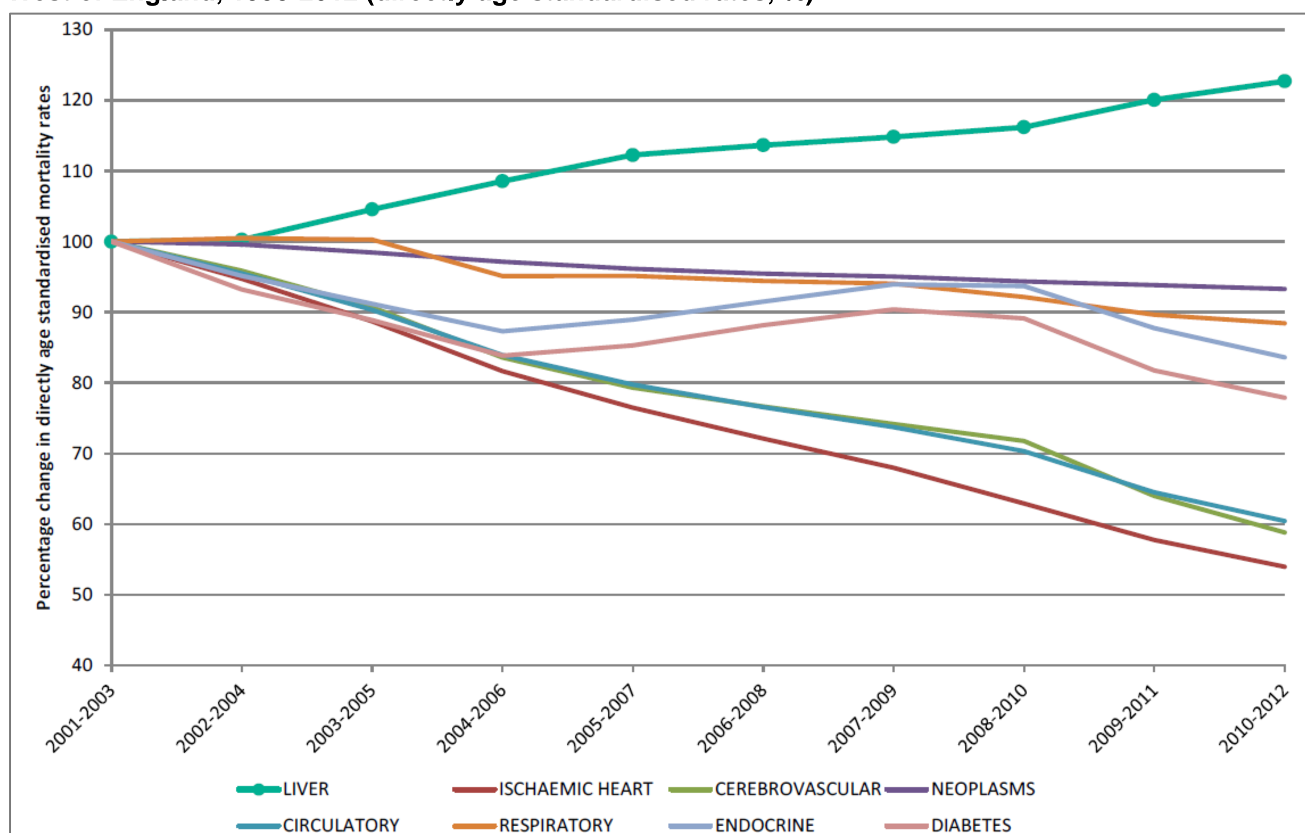
[11] Alcohol misuse: tackling the UK epidemic. BMA Board of Science. February 2008. Available from: http://www.dldocs.stir.ac.uk/documents/Alcoholmisuse.pdf.
[12] Alcohol-related deaths in the UK, registered in 2014. Office for National Statistics. Available from: http://www.ons.gov.uk/ons/dcp171778_431695.pdf.
[13] Liver disease biggest cause of alcohol-related deaths in England and Wales. February 2014. Available from: http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2012/sty-alcohol-releated-deaths.html. (Accessed 25/02/2016)

In 2014 the All-Party Parliamentary Hepatology Group report[14] stated that liver disease is rising at an alarming rate. Between 2001 and 2012, deaths with an underlying cause of liver disease have risen by 40% in the UK and by 23% in the South West[15]. Liver disease is the only major preventable killer disease where annual deaths are on the rise, both nationally and regionally (Figure 2.3.1c). Liver disease is mainly caused by alcohol misuse (but can be also caused by obesity and viral hepatitis).

Figure 2.3.1c: Trend percentage change for the main preventable causes of mortality in South West of England, 1995-2012 (directly age standardised rates, %)



2.3.1.1 Hospital admissions

Alcohol-related hospital admission episodes and admissions

The trend in hospital admission episodes for alcohol-related conditions (broad measure) in Bristol was rising from 2008, until it peaked in 2011/12. Since then it has reduced to 2,487 admission episodes per 100,000 population in 2013/14 (Figure 2.3.1.1a). This rate was significantly higher than the 2013/14 England average of 2,111 admission episodes per 100,000 and has been consistently higher than England since 2008/09.

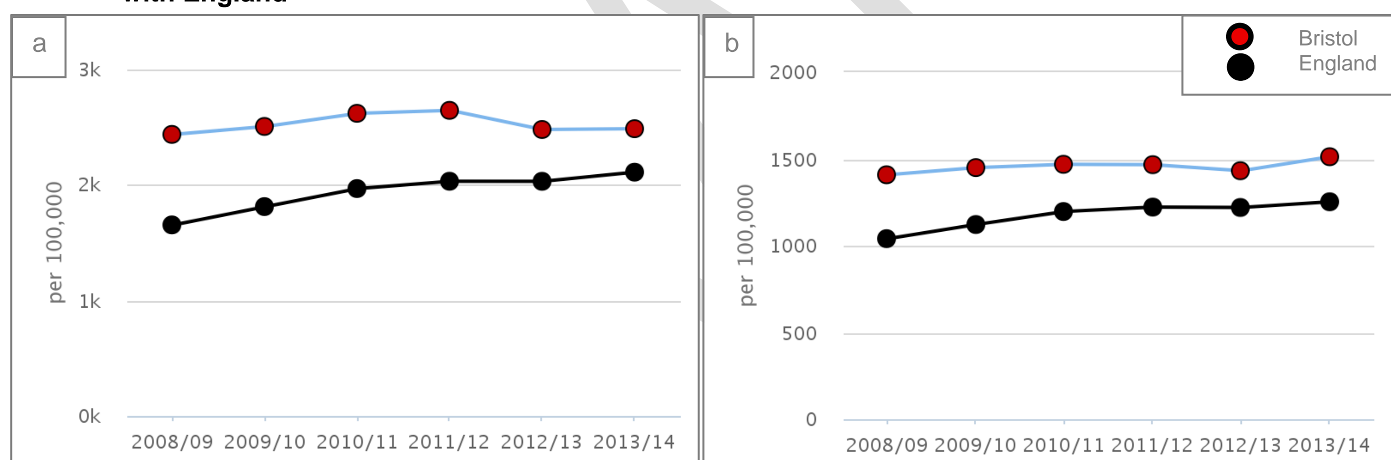
[14] Liver disease: today's complacency, tomorrow's catastrophe. The All-Party Parliamentary Hepatology Group (APPHG) Inquiry into Improving outcomes in Liver Disease. March 2014. Available from: http://www.appghep.org.uk/download/report/APPHG%20Inquiry%20into%20Outcomes%20in%20Liver%20Disease,%20March%202014.pdf.
[15] Public Health England. (2015) Liver Disease in the South West Centre: A health needs assessment. Public Health England: South West. July 2015.

Similarly a rising trend, though with a less significant recent decline, can be observed in alcohol-related admissions (broad measure), with 1,513 persons per 100,000 population admitted to hospital due to alcohol-related conditions in Bristol in 2013/14 (Figure 2.3.1.1b). Again the Bristol rate was significantly higher than the England rate (1,253 admissions per 100,000), as it has been in the past few years.

In crude numbers, there were 8,750 hospital admission episodes for alcohol-related conditions in Bristol in 2013/14. This corresponds to 5,408 persons admitted to hospital due to alcohol-related conditions in the same year.

Alcohol-related conditions comprise all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome[16]. These patients might have conditions linked to alcohol use, for example hypertensive diseases, various cancers and falls. Alcohol-related admission episodes and admissions include the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Attributable fraction values are the proportion of a health condition or external cause that is attributable to alcohol consumption. Therefore these indicators refer to alcohol misuse in the population rather than admissions caused directly/specifically by alcohol.

Figure 2.3.1.1: a/ Admission episodes for alcohol-related conditions (broad measure)[17], and b/ alcohol-related hospital admissions (broad measure)[18], Bristol, 2008/09-2013/14; compared with England



<u>Alcohol-specific hospital admissions</u>

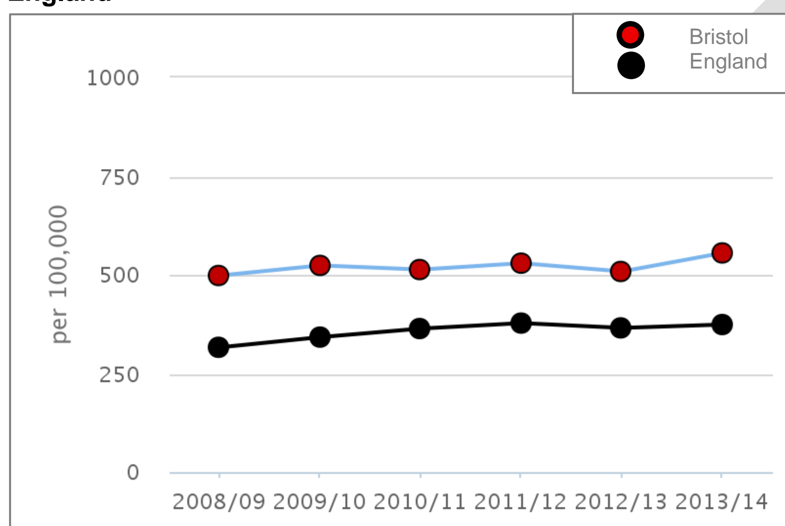
In Bristol the trend in alcohol-specific hospital admissions was fairly stable around 500 admissions per 100,000 population between 2008/09 and 2012/13, but increased to 555 admissions per 100,000 in 2013/14 (Figure 2.3.1.1c). The local rates have been significantly higher than the England rates during the same time period (for example the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14).

[16] Public Health England. (2015) Local Alcohol Profiles for England: 2015 user guide. Public Health England: knowledge and Intelligence Team (North West). Available from: http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
[17] Public Health England (PHE), Local Alcohol Profiles for England (LAPE). Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91409/age/1/sex/4
[18] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91385/age/1/sex/4

In crude numbers, there were 2,160 persons admitted to hospital due to alcohol-specific conditions (where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code) in Bristol in 2013/14.

Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; e.g. alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because 100% of cases are caused by alcohol.

Figure 2.3.1.1c: Alcohol-specific hospital admissions, Bristol, 2008/09-2013/14; compared with England[19]

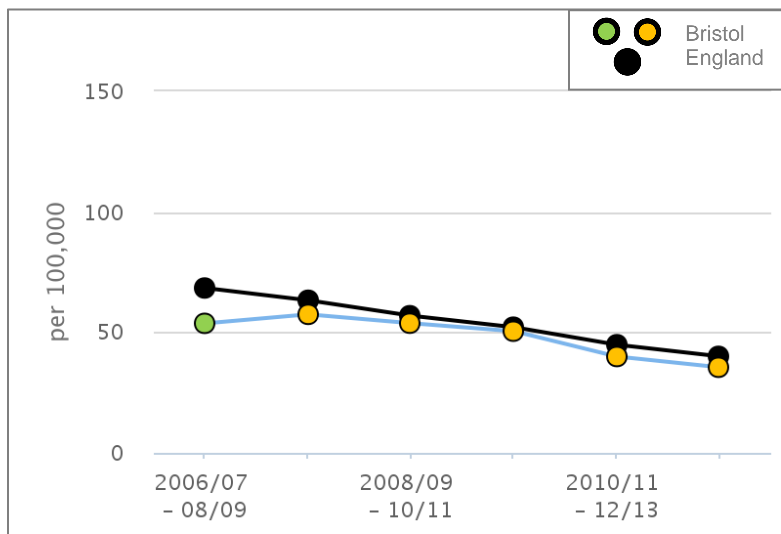


In 2013/14 in Bristol, the number of admissions due to alcohol-specific conditions was more than double in men than women (1,505 versus 650). The trend in alcohol-specific hospital admissions among men looked similar to the overall trend shown in Figure 2.3.1.1c. It was fluctuating around 750 admissions per 100,000 male population between 2008/09 and 2011/12, then slightly dropped to 712 per 100,000 in 2012/13, and increased to 798 admissions per 100,000 in 2013/14. The trend among women was steadily rising, from 261 admissions per 100,000 female population in 2008/09 to 321 admissions per 100,000 female population in 2013/14. The Bristol figures for both males and females were higher than the national average (for example the rate per 100,000 of 798 in males and 321 in females locally versus 515 in males and 241 in female nationally in 2013/14).

Figure 2.3.1.1d shows that in Bristol between 2006/07 and 2013/14, the (three-year average) rates of hospital admissions for alcohol-specific conditions among under 18's were lower than or similar to the national figures. The Bristol rate peaked at 57.5 per 100,000 under 18 population in 2007/08-09/10, and has declined since. In 2011/12-13/14 there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s.

[19] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91384/age/1/sex/4

Figure 2.3.1.1d: Alcohol-specific hospital admissions among under 18s (3-year averages), Bristol, 2006/07-2013/14; compared with England[20]



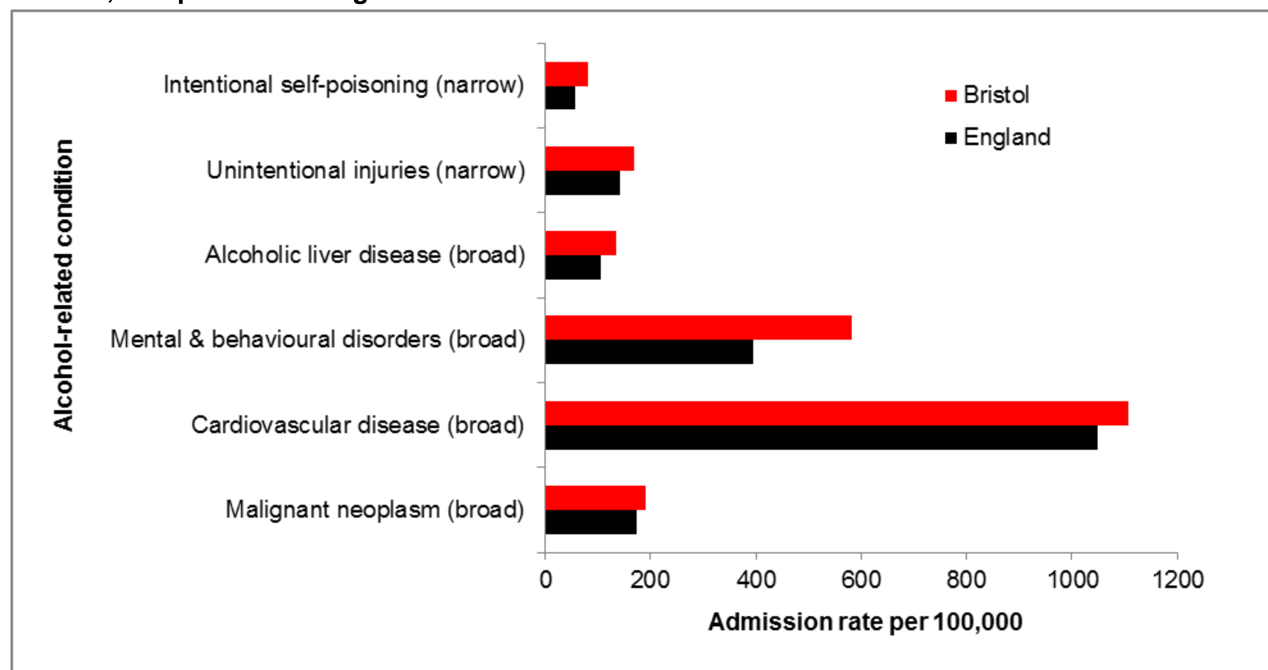
<u>Admission episodes by alcohol-related condition</u>

Figure 2.3.1.1e shows that in Bristol in 2013/14, the most common reasons for alcohol-related admission episodes, i.e. partially attributable to alcohol, were cardiovascular disease (1,108 admission episodes per 100,000 population) and mental & behavioural disorders due to use of alcohol (581 admission episodes per 100,000 population).

The rates of admission episodes for all alcohol-related conditions listed in Figure 2.3.1.1e were significantly higher than the England rates for the same conditions in the same year.

[20] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/90856/age/173/sex/4

Figure2.3.1.1e: Admission episodes for alcohol-related conditions by condition group, Bristol, 2013/14; compared with England[21]



Broad measure refers to admissions to hospital where the primary diagnosis or any of the secondary diagnoses were an alcohol-attributable condition code (e.g. alcohol-attributable malignant neoplasm code);
Narrow measure refers to admissions to hospital where the secondary diagnosis was an alcohol-attributable external cause code (e.g. alcohol-attributable unintentional injuries code).

2.3.1.2 Mortality

In Bristol, the trend in the alcohol-related mortality (i.e. deaths from alcohol-related conditions) was fairly stable between 2008 and 2012, with a rate fluctuating between 52.5 per 100,000 in 2012 to 55.1 per 100,000 in 2008. During this time period the Bristol rates were similar to the national rates. In 2013, the rate of alcohol-related mortality rose to 56.0 per 100,000 (corresponding to 196 alcohol-related deaths) and then dropped again to 53.2 per 100,000 in 2014 (corresponding to 187 deaths). In these last two years the Bristol rates were higher than the rates in England (e.g. in 2014 a rate of 53.2 locally versus 45.5 per 100,000 nationally) (Figure 2.3.1.2a).

The alcohol-specific mortality refers to deaths from alcohol-specific conditions and due to low numbers is reported as three-year pooled estimates. The rate of alcohol-specific mortality has been slightly increasing since 2009-11, from 14.7 per 100,000 in 2009-11 (corresponding to 157 alcohol-specific deaths) to 18.3 per 100,000 in 2012-14 (corresponding to 200 deaths).

As shown in Figure 2.3.1.2b, the Bristol rates have been consistently higher than the England average since 2006-08 (e.g. in 2012-14 a rate 18.3 locally versus 11.6 per 100,000 nationally). This was mainly because of a problem with alcohol-specific mortality in males. In Bristol, the rates among men have been significantly higher than England since 2006-08. For

[21] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132848/pat/6/par/E12000009/ati/102/are/E06000023/iid/91410/age/1/sex/4

example there were 28.5 deaths per 100,000 men in 2012-14, compared to the national rate of 16.1 per 100,000. In females the rate of alcohol-specific mortality was 7.9 per 100,000 in the same period (similar to the national rate of 7.4). In crude numbers, there were 157 alcohol-specific deaths among Bristol men in 2012-14 compared to only 43 deaths among Bristol women.

Figure 2.3.1.2a: Alcohol-related mortality[22], Bristol, 2008-2014; compared with England

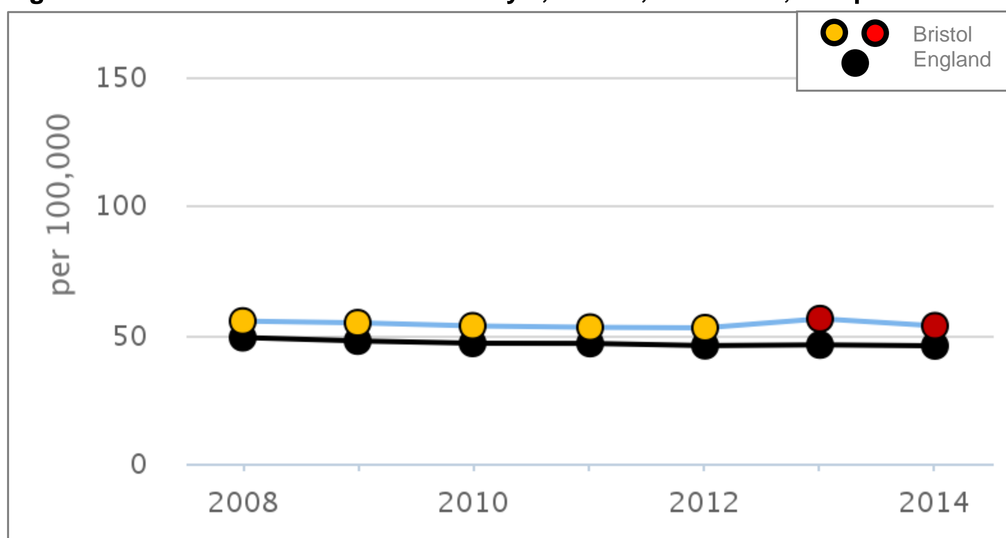
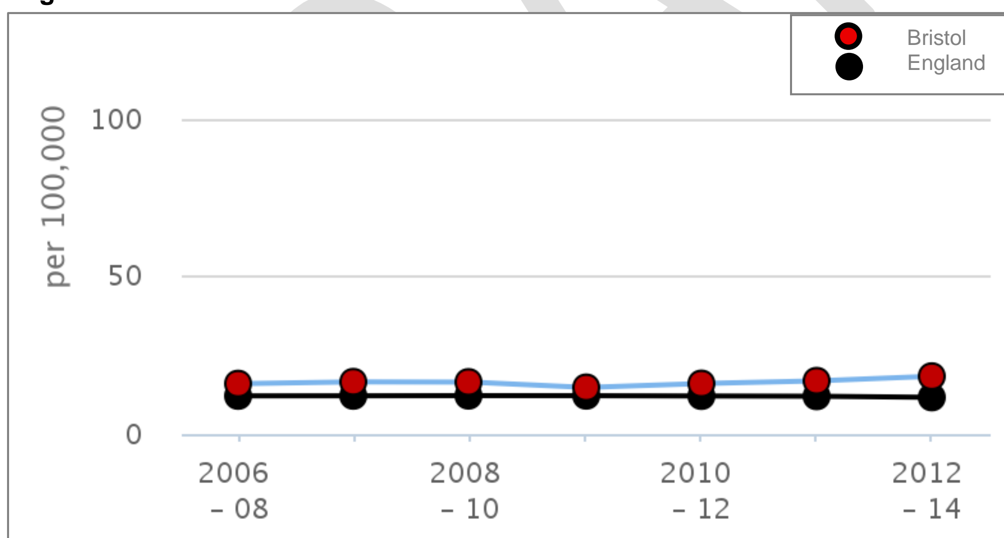


Figure 2.3.1.2b: Alcohol-specific mortality[23], Bristol, 2006-08 to 2012-14; compared with England



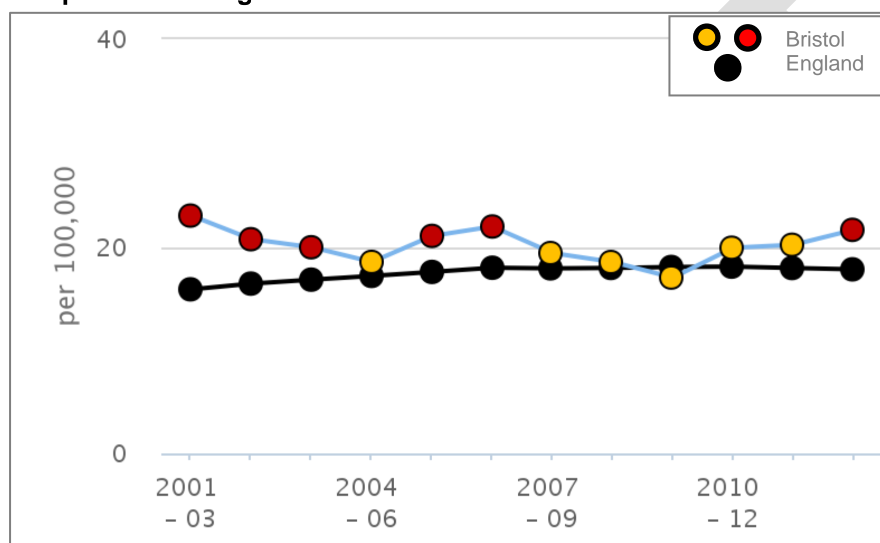
[22] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91382/age/1/sex/4

[23] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91380/age/1/sex/4

2.3.1.3 Alcoholic liver disease

The increasing trend in mortality from preventable liver disease was shown earlier in Figure 2.3.1c. Figure 2.3.1.3a compares the trend in the under 75 mortality from liver disease in Bristol and England during 2001-03 and 2012-14. The red circles on the Bristol trend line indicate rates higher than the England average. To understand the impact of alcohol on the liver disease burden the hospital admission rates for alcoholic liver disease (i.e. number of admissions with a primary diagnosis of alcoholic liver disease) and the under 75 mortality rates from alcoholic liver disease (i.e. number of deaths from alcoholic liver disease in people aged under 75 years) are presented below.

Figure2.3.1.3a: Under 75 mortality rate from liver disease, Bristol, 2001-03 to 2012-14; compared with England[24]



The hospital admission rates for alcoholic liver disease were reported in 2012/13 and 2013/14 only, thus time trend comparisons cannot be made. In Bristol in 2013/14, the admission rates for alcoholic liver disease were 57.1 per 100,000 population which was much higher than the England rate of 31.9. Figure 2.3.1.3b shows that Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. In females the rate of admissions for alcoholic liver disease was 19.4 per 100,000 in the same period (similar to the national rate of 20.3).

The under 75 mortality rates from alcoholic liver disease are due to low numbers reported as three-year pooled estimates. In Bristol in 2012-14, the deaths from alcoholic liver disease among men under 75 dominated, a similar picture to that described above for the admission rates. The mortality rate in males was 20.9 per 100,000, which was significantly higher than England (11.5 per 100,000); whereas the mortality rate in females was only 5.4 per 100,000, similar to the national rate of 5.8 (Figure 2.3.1.3c).

[24] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90929/age/1/sex/4

Figure2.3.1.3b: Hospital admission rate for alcoholic liver disease by gender, Bristol, 2013/14; compared with England[25]

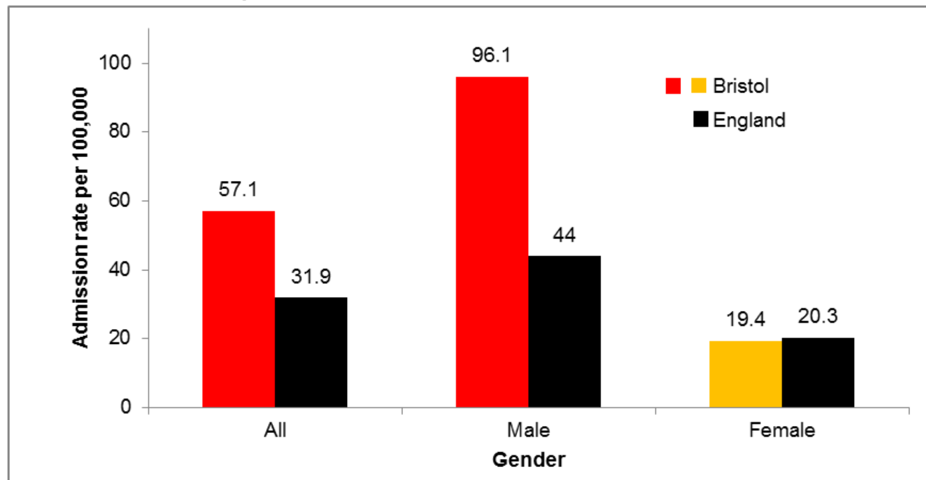
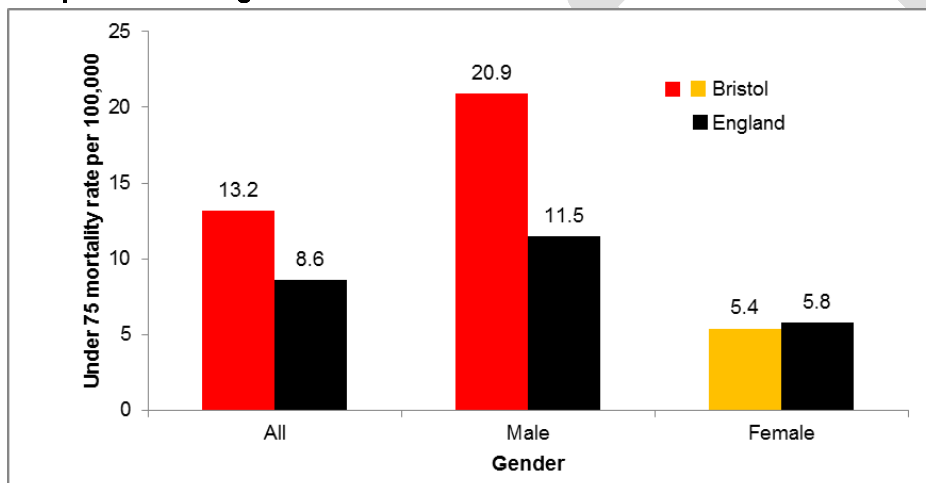


Figure2.3.1.3c: Under 75 mortality rate from alcoholic liver disease by gender, Bristol, 2012-14; compared with England[26]



[25] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90929/age/1/sex/4
[26] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90861/age/163/sex/4

2.3.1.4 Accident and Emergency burden

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services[27].

In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 (rate of 72.7 per 100,000 population) to 2013/14 (rate of 148.8 per 100,000). Three in four people who attended A&E due to alcohol poisoning arrived by ambulance. One in three of those attendees were subsequently admitted to hospital overnight (compared to one in five admissions among people attending A&E for other reasons). In 2013/14, approximately 1 in 20 emergency admissions were for alcohol-specific conditions.

The highest rates of emergency admissions related to alcohol were seen in men in the older age groups (45–64 years of age) which may reflect the chronicity of alcohol-related problems. In 2013/14, 90% of people who attended A&E due to alcohol poisoning and 72% of those who had an alcohol-specific emergency admission, only attended hospital once in that year. This presents a 'teachable moment' and an opportunity to intervene, identify issues of alcohol dependency and provide a specialist advice to prevent progression into alcohol-related chronic disease.

A&E attendance rates due to alcohol poisoning and hospital emergency admissions specific to alcohol has been three to four times higher in the poorest fifth of the population over the past five years.

2.3.1.5 Alcohol treatment

There is unprecedented demand for alcohol treatment services in Bristol since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement[28].

Routes into treatment

Understanding the routes into alcohol treatment gives an indication of the levels of referrals from various settings into specialist treatment. In Bristol in 2014/15, 50% (308/614) of all referrals in alcohol treatment were made by GPs, followed by 22% (135/614) of self-referrals. Nationally these proportions were inverted, with 45% of self-referrals and 19% of GP referrals[29].

Demographic and social characteristics of individuals in treatment

[27] Currie C, Davies A, Blunt I, Ariti C, Bardsley M. Alcohol-specific activity in hospitals in England. Research report. Nuffield Trust. December 2015. Available from: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/alcohol-specific-activity_final-web.pdf.
[28] Bristol Substance Misuse Needs Assessment. Substance Misuse Team. September 2016.
[29] Alcohol data: JSNA support pack. Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17. Bristol. Public Health England.

Demographic characteristics of people in alcohol treatment in Bristol are similar to the national picture. In 2014/15, there were 716 adults in alcohol treatment in Bristol. Of those, 63% were male, similar to the national proportion of 62%. The proportion of adults starting the treatment in 2014/15 was 86% (614/716) which was higher than the national proportion of 69%.

Both locally and nationally, the 40 to 49 year age group is the most represented among adults in alcohol treatment (around 33%), followed by the 50-59 and 30-39 year age groups (around 24% and 23% respectively).

The employment status at the start of alcohol treatment differed locally compared to the national picture. In Bristol in 2014/15, 47% of adults starting treatment reported 'long term sickness or disability', 25% were in 'regular employment' and 24% were 'unemployed or economically inactive'. Nationally these proportions were distributed differently (22%, 27% and 37% respectively).

Length of time in treatment

NICE Clinical Guidance CG115 suggests that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.

Nationally the length of a typical treatment period is around 6 months. However in Bristol the rates of early treatment drop out were high. In 2014/15, 24% of adults in treatment exited in less than a month and further 46% in less than 3 months (compared with much lower national proportions of 12% and 26% respectively).

Treatment outcomes

The data on successful completions of alcohol treatment provides an indication of the effectiveness of the treatment system. A high number of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.

In Bristol, 35% (249/710) of all adults in alcohol treatment successfully completed the therapy in 2014/15[30]. In comparison, nationally the proportion of individuals leaving alcohol treatment successfully was 39%. However Bristol had lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%).

There is a wider issue in Bristol with high numbers of unplanned exits from alcohol treatment. The Bristol proportion of new treatment presentations that had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks was 38% between October 2014 and September 2015. This is much higher than the national average

[30] The Diagnostic and Outcome Monitoring Executive Summary (DOMES). Quarter 3 2015-2016. Bristol.

of 14% and an audit is underway locally to look into the circumstances for people leaving treatment early.

In terms of re-presentations to treatment, Bristol had 27% of individuals in alcohol treatment leaving the treatment successfully (between 1st Jan 2014 and 31st Dec 2014) and not returning within 6 months. This proportion was much lower than the national proportion of 38% during the same time period.

Waiting times for alcohol treatment are an issue in Bristol. The percentage of patients who waited over three weeks to start first intervention was 39% in quarter Oct-Dec 2015, compared to the national average of 4%. Recently some additional funding has been agreed to increase treatment group work capacity in Bristol.

2.3.1.6 Alcohol and mental health

There are close links between alcohol misuse and mental health problems. Some people with mental ill health drink alcohol to alleviate their difficult feelings or cope with their mental illness (called 'self-medication'[31]). Some people with alcohol problems may subsequently develop some mental health problems, such as anxiety and depression, as alcohol may exacerbate these conditions or caused for example alcohol induced dysphoria.

Earlier presented Figure 2.3.1.1e showed that in Bristol, 2013/14, the second highest rate of admission episodes for alcohol-related conditions were for mental and behavioural disorders due to use of alcohol (581 per 100,000 population). A similar picture can be seen nationally when in England in 2013/14, the second highest number of admissions (19%) was for mental and behavioural disorders due to alcohol[1]. Also between 2003 and 2013 about 45% of suicides occurred in patients with a history of alcohol misuse[32].

2.3.1.7 Combination of alcohol and other drugs

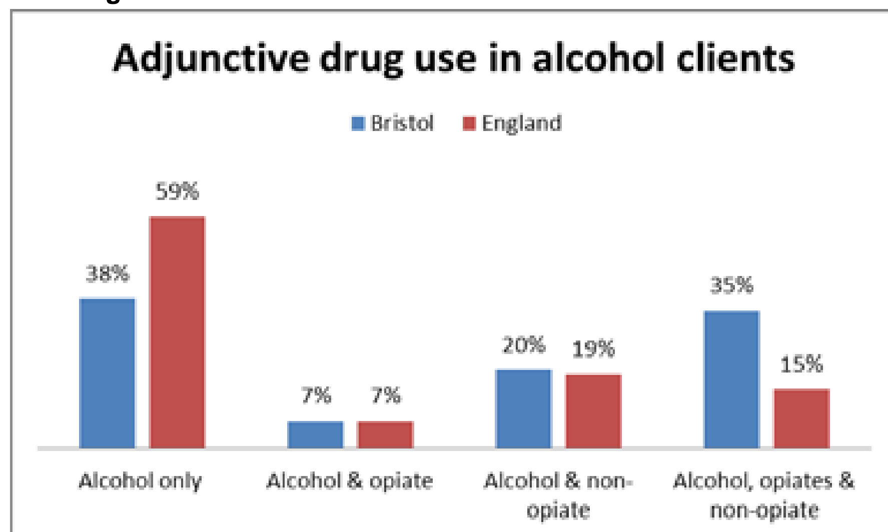
People in treatment for alcohol misuse in Bristol are more likely to use alcohol alongside other drugs, which can make treatment challenging. Figure 2.3.1.7a compares the English averages with Bristol for adjunctive drug use[33].

[31] Mental Health Foundation. Alcohol and mental Health. Available from: https://www.mentalhealth.org.uk/a-to-z/a/alcohol-and-mental-health. (Accessed 05/04/2016)

[32] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report – July 2015. Healthcare Quality Improvement Partnership. Available from: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf.

[33] Joint Strategic Needs Assessment (JSNA) report 2015. Data profile of Health and Wellbeing in Bristol. Available from: https://www.bristol.gov.uk/documents/20182/305531/JSNA+2015+v4/fc4df8f4-5c65-4b2e-8ee3-e6ad56f1004f.

Figure 2.3.1.7a: Additional drug use in alcohol clients of ROADS, Bristol, 2014/15; compared with England



Most young people up to age of 18 years, who attend young people's substance misuse services, report that they use a combination of substances, mainly alcohol and cannabis. Patterns of substance misuse in Bristol are also changing among adults. There is an aging population of opiate and crack users, and fewer young adults joining the cohort. It is thought to be due to an increasing use of a range of substances in combination, including alcohol and 'novel psycho-active substances'.

The population of Bristol is relatively young with a median (average) age of 33 years compared to 39 years for England and Wales[33]. It is therefore important for the drug and alcohol treatment system to ensure appropriate targeting of services towards the younger population.

DRAFT

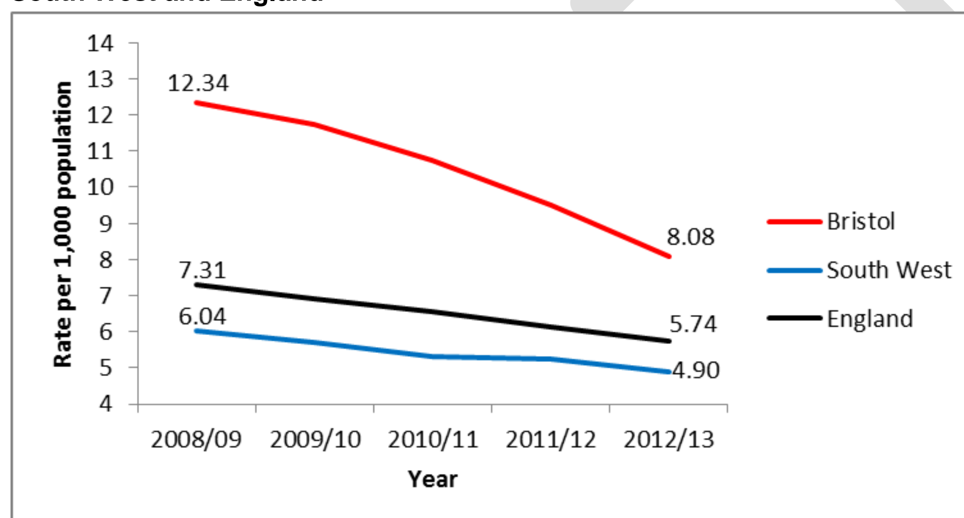
2.3.2 Crime and disorder

2.3.2.1 Alcohol-related crime

Figure 2.3.2.1a shows that alcohol-related recorded crimes (based on the Home Office's former 'key offence' categories) have decreased in Bristol in the recent years. The rate of recorded crime per 1,000 population attributable to alcohol dropped from 12.34 per 1,000 in 2008/09 to 8.08 per 1,000 in 2012/13. However the Bristol rate of 8.08 per 1,000 was still significantly higher than the regional and national average in the same year (4.90 and 5.74 per 1,000 respectively).

In crude numbers, there were 5,081 alcohol-related offences recorded in Bristol in 2008/09 and 3,461 offences in 2012/13. There is a strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

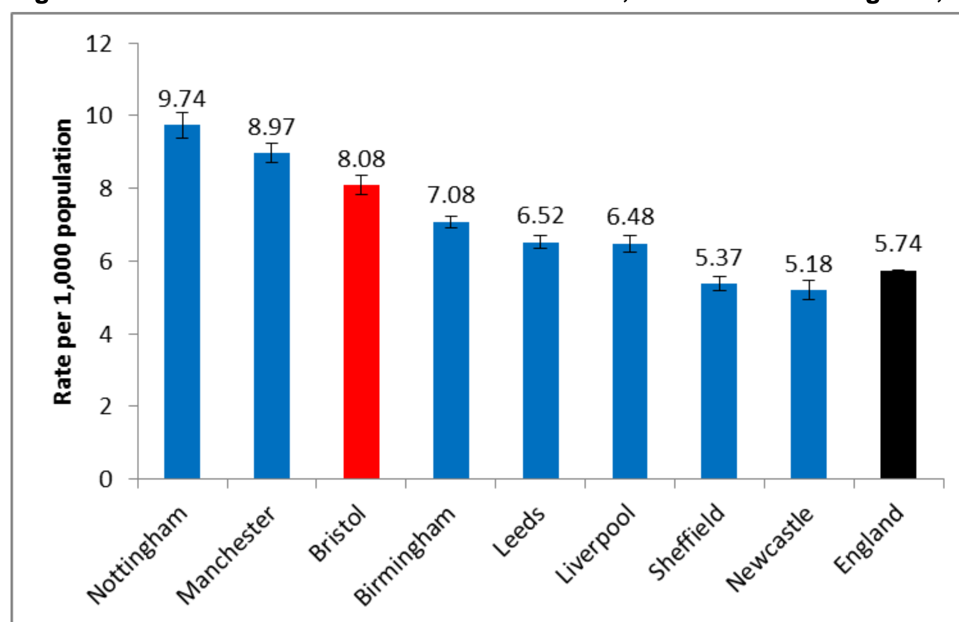
Figure 2.3.2.1a: Alcohol-related recorded crimes, Bristol, 2008/09-2012/13; compared with South West and England[34]



Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13 (Figure 2.3.2.1b). To some extent, this could be due to different arrest policies in the different police forces which lead to different reporting outcomes, and to different recording practices by different forces. For example, reporting of domestic violence has increased in Bristol due to the excellent work by operation Bluestone, which has resulted in more victims feeling confident to come forward and report incidences to the police.

[34] PHE. LAPE. Available from: http://www.lape.org.uk/data.html

Figure 2.3.2.1b: Alcohol-related recorded crimes, core cities and England, 2012/13[34]



Also the Bristol rate of alcohol-related violent crime reduced from 7.39 per 1,000 in 2008/09 (corresponding to 3,043 offences) to 5.57 per 1,000 in 2012/13 (corresponding to 2,385 offences). Despite the decline, Bristol rates remained significantly higher than those of the South West (3.66 in 2012/13) and England (3.39 in 2012/13) (Figure 2.3.2.1c).

Furthermore, Bristol had one of the highest alcohol-related violent crime rates out of all the core cities in 2012/13 (Figure 2.3.2.1d).

Figure 2.3.2.1c: Alcohol-related violent crimes, Bristol, 2008/09-2012/13; compared with South West and England

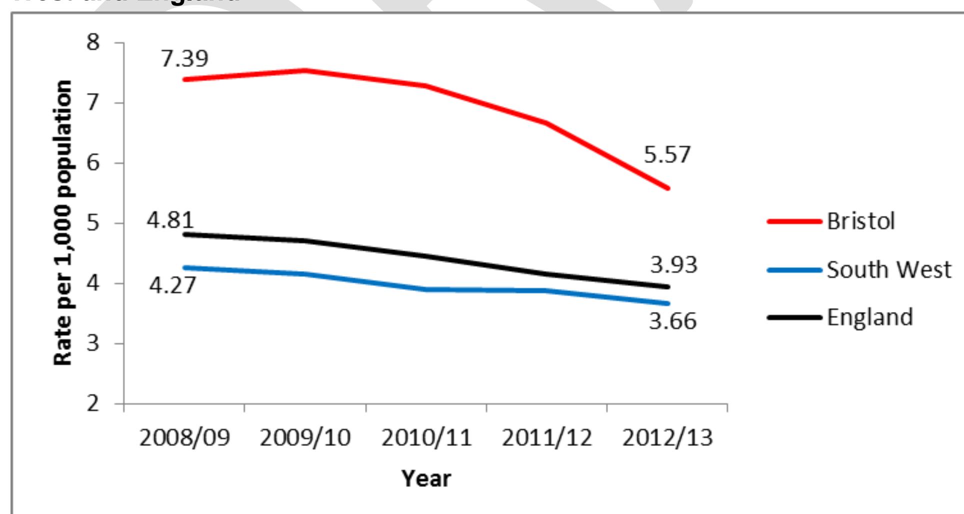
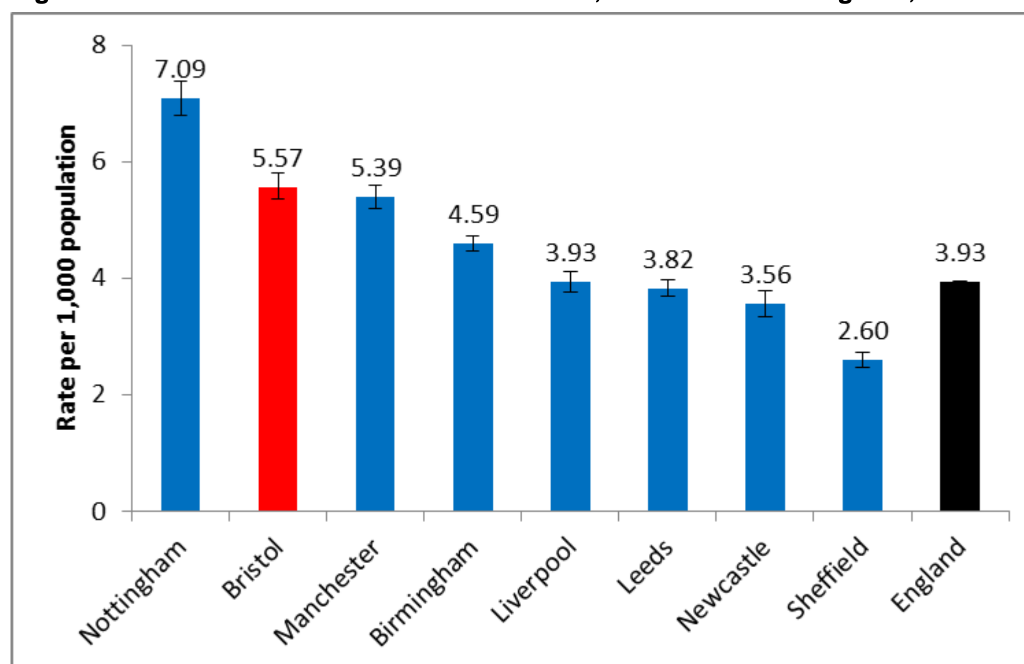
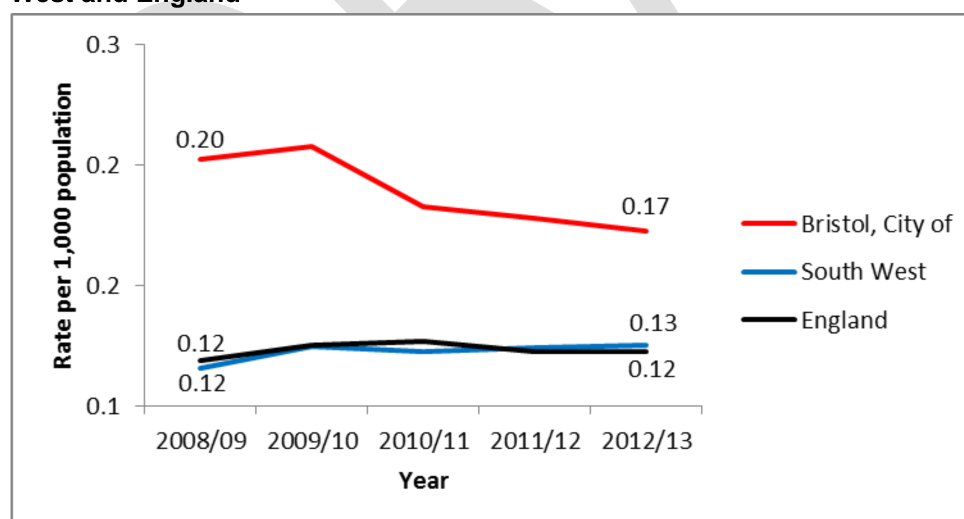


Figure 2.3.2.1b: Alcohol-related violent crimes, core cities and England, 2012/13[34]



In terms of alcohol-related sexual crimes, the number of offences and rates are much lower, locally and nationally. For example, in 2012/13 there were 74 sexual crimes related to alcohol reported in Bristol, corresponding to a rate of 0.17 per 1,000 population which was higher than the national and regional rate in the same year, but the difference was not statistically significant (Figure 2.3.2.1e).

Figure 2.3.2.1e: Alcohol-related sexual crimes, Bristol, 2008/09-2012/13; compared with South West and England



2.3.2.2 Anti-social behaviour

Data about community perceptions of anti-social behaviour is gathered in the annual Quality of Life in Bristol survey.

In 2013, 29% of Bristol residents perceived anti-social behaviour was a problem in their local neighbourhood. This indicator measures concern with anti-social behaviour in the neighbourhood that is likely to include vandalism, graffiti, rowdiness, drunkenness, harassment, drug dealing, prostitution etc. People with lower educational qualifications, Black and minority ethnic people and people living in social housing were more likely to report anti-social behaviour was a problem in the local area[35].

Survey respondents experienced a greater problem specifically from drunk and rowdy behaviour. 50% of residents felt drunk and rowdy behaviour in public places was a problem in the city. This indicator measured a perceived problem in the city rather than in the local neighbourhood. The 2013 percentage represented an improvement since 2009, when the indicator measured 54%, however it still indicated that in the perception of the community alcohol is considered to play a greater role than the data indicates. The highest proportion of concerned residents were from the inner city and deprived areas[35].

2.3.2.3 Alcohol misuse in offenders

A link between alcohol misuse and offending is well known. Overall, the rate of alcohol use among prisoners was slightly lower than that of general population, when comparing those who said they drank on at least one occasion in the previous 12 months (78% of prisoners versus 83% of the general population)[36]. However, amongst those prisoners who drank alcohol in the four weeks before custody, the amount of hazardous drinking was higher than in the general population. They drank alcohol on a median 12 days in the month before custody, and reported consuming similar amounts of alcohol on days on which they drank, a median of 12 units. 63% of prisoners who drank alcohol in the four weeks before custody would be classified as binge drinkers and a third of them said they drank on a daily basis[36].

19% of prisoners (who drank alcohol in the year before custody) reported needing help for an alcohol problem. Alcohol use among prisoners was also associated with reconviction on release (although to a lesser extent than drug use)[36].

In 2009/10, an analysis of 19,225 prison based Offender Assessment System assessments found that 19% of prisoners who received an assessment were reported to have needs in relation to alcohol misuse. Furthermore, 36% of prisoners who received an assessment were reported to have exhibited violent behaviour related to their alcohol use[36].

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[35] Quality of Life in Bristol. Quality of Life in your neighbourhood survey results 2013. Bristol City Council. April 2014. Available from: https://www.bristol.gov.uk/documents/20182/33896/qol2014final.pdf/f9b9cb4a-7dc4-4f6c-9dca-5b11d893217d.
[36] Light M, Grant E, Hopkins K. Gender differences in substance misuse and mental health amongst prisoners. Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. Ministry of Justice Analytical Series. 2013.Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf.

The Bristol Youth Offending Team carried out 1,350 assessments of young people in 2012/13. Of these, 199 (15%) assessments identified that alcohol use was a re-offending risk factor for 114 individuals (some were assessed more than once).

Between April 2012 and March 2013, Avon & Somerset Probation Trust assessed some of their clients to see if they have an alcohol need linked to their offending behaviour. They found that of the Bristol offenders who were supervised in the community and assessed, 54% had alcohol needs.

Prisoners are screened for substance misuse issues at the reception screen. In 2014/15 in HMP Bristol, 36% of new receptions began a drug treatment episode. Of those, 13% were alcohol only users and further 16% alcohol and non-opiate users. There are occasions where prisoners are not honest at reception about their alcohol use, and initially do not receive any intervention. They usually re-present a few days later when they start feeling unwell without any clinical support. In 2014/15, the outcome of the secondary screen showed that monthly additional 38% of prisoners were referred onto Integrated Drug Treatment Service. Of those referrals, 29% were alcohol only users and further 27% alcohol and drug users[37].

2.3.2.4 Alcohol and victims of crime

Evidence suggests that drinking may increase vulnerability to crime, especially among young adults. Over the last decade, in around half of all violent incidents the victim believed the offender(s) to be under the influence of alcohol at the time of the offence. This proportion increases in incidents that occurred in the evening and night, at weekends, and in public places[38].

Alcohol can increase the risk of being a victim of crime such as assault or mugging. Certain population groups are identified as being particularly at risk from these types of crimes, such as students. The Bristol Royal Infirmary A&E department produces monthly reports on the number of people attending A&E after an assault. This is shared with the council crime reduction team and the Police. The data contributes to the intelligence available for police to use to target poorly managed licensed premises.

Alcohol can also be used by victims of domestic abuse as a coping mechanism. In some cases, alcohol can be used by perpetrators to further control and stigmatise victims.

2.3.2.5 Alcohol and accidents

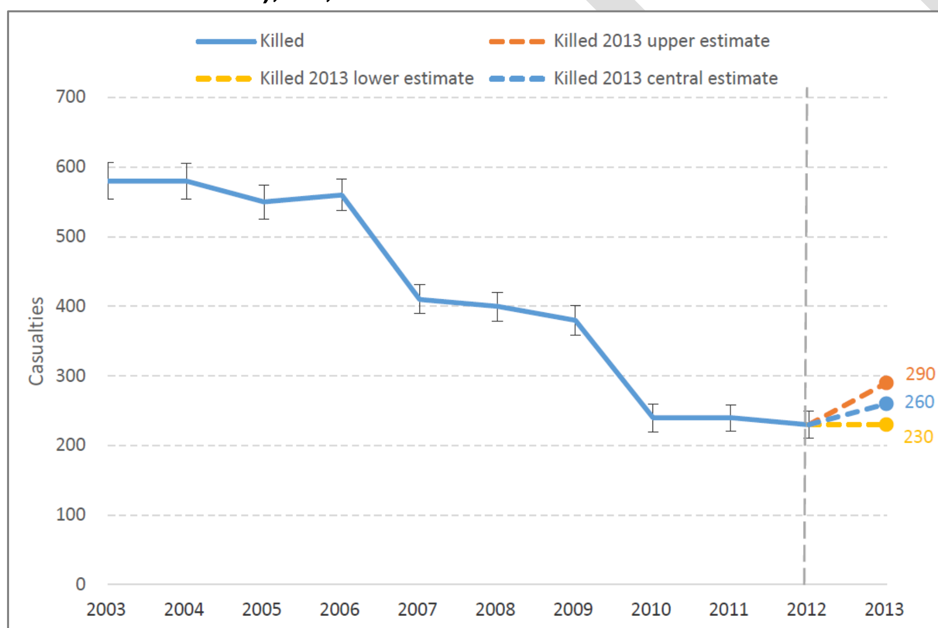
Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related.

[37] Prison Health and Social Care Needs Assessment. HMP Bristol. S Squared Analytics. 2015.
[38] Modern Crime Prevention Strategy. Home Office. March 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf.

The effect of alcohol or drugs on casualty rates in accidental dwelling fires is well known. In England in 2011/12, there were 8% (2,483) of accidental dwelling fires where impairment due to suspected drug or alcohol use was recorded as a contributory factor. Impairment due to alcohol or drug use resulted in 41 deaths and 1,208 injuries from these fires. The fatality rate is three times higher and the rate of serious injuries is four times higher where drug or alcohol impairment was a contributory factor than where alcohol or drug impairment was not a factor[39].

Alcohol is a recognised contributory factor in road accidents. In the UK in 2013, about 15% of all deaths in reported road traffic accidents involved at least one driver over the drink drive limit. Over the last 10 years, the number of drink drive deaths has been decreasing (Figure 2.3.2.5a). However, there were still about 260 drink drive deaths reported in 2013 which might have been prevented if drivers did not consume alcohol. Furthermore, 8,290 casualties of all types in drink drive accidents were reported in the UK in 2013, of which 1,100 were seriously injured casualties[40].

Figure 2.3.2.5a: Killed casualties in reported drink drive accidents (error bars show 95% confidence intervals), UK, 2003-2013



[39] The effect of alcohol or drugs on casualty rates in accidental dwelling fires, England, 2011-12. Department for Communities and Local Government. December 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35829/effect_of_alcohol_on_casualty_rates_in_fires_in_the_home_FINAL__2_.pdf.

[40] Estimates for reported road traffic accidents involving illegal alcohol levels: 2013 (second provisional). Self-reported drink and drug driving for 2013/14. Statistical release. Department for Transport. February 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402698/rrcgb-drink-drive-2013-prov.pdf

2.3.3 Harms to children and families

Alcohol misuse can affect families in a range of ways. 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, such as anxiety, depression and social exclusion. Adults who are considered to be 'vulnerable' can be adversely affected either through their own alcohol misuse or because they are at increased risk of abuse and neglect from family members or carers who are misusing alcohol.

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, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent. In 2000 it was estimated that 22% (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker[41]. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

In a serious case reviews done by the National Society for the Prevention of Cruelty to Children (NSPCC) it was found that babies are at risk of sudden infant death syndrome if their parents/carers co-slept with their child when under the influence of alcohol or drugs, this was due to overlaying. Children were also at higher risk of accidents (fire, drowning) due to a lack of adequate supervision from an intoxicated parent/carer[42].

The normalisation of alcohol misuse in some families means that children may be more likely to develop alcohol problems themselves in later life, thus continuing the cycle. Intervening can build greater family resilience, which in turn can lead to better outcomes for children.

2.3.3.1 Domestic violence and abuse

The relationship between alcohol and domestic abuse is complex. While it is not possible to state a direct causal relationship that alcohol misuse automatically results in domestic abuse, there is evidence that where domestic abuse exists, alcohol is often present, either for the perpetrator or the victim[43]. Alcohol misuse can increase the severity of violence[44] and is often used as an excuse for violence.

In Bristol in 2012/13, there were 595 Multi Agency Risk Assessment Conferences (MARAC) cases, of those 185 recorded perpetrator alcohol misuse (31%). MARACs are organised for the most serious and high risk cases of domestic violence and abuse.

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[41] Manning V, Best DW, Faulkner N, Titherington E. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. BMC Public Health. 2009; 9(1):377-389.

[42] Learning from case reviews involving parental substance misuse. NSPCC Briefing. November 2013.Available from: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances.

[43] Galvani S. Grasping the nettle: alcohol and domestic violence. Alcohol Concern's information and statistical digest. June 2010. Available from: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Grasping-the-nettle-factsheet-revised-June-2010.pdf.

[44] Gilchrist E, Johnson R, Takriti R, Weston S, Beech A, Kebbell M. Domestic violence offenders: characteristics and offending related needs. Findings 217. Research, Development and Statistics Directorate. Home Office London. 2003. Available from: http://webarchive.nationalarchives.gov.uk/20110218135832/http:/rds.homeoffice.gov.uk/rds/pdfs2/r217.pdf.

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2.3.3.2 Parental substance misuse

Children whose parents/carers misuse alcohol can suffer a range of poor outcomes, including behavioural and/or psychological problems, poor educational attainment, low self-esteem, offending behaviour, and risk of sexual exploitation.

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Evidence suggests that alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings[45].

An analysis of serious case reviews of children found that parental substance misuse was featured in 25% (47/189) of cases reviewed[46]. This may be an underestimate as there is currently no routine screening by children and families services for parental alcohol misuse. Local experience is that parental mental health issues and domestic abuse also commonly featured in serious case reviews, in many cases concurrently with substance misuse.

Maternal alcohol misuse in pregnancy can also be linked to Foetal Alcohol Spectrum Disorders (FASD). These are a series of preventable mental and physical birth defects resulting from maternal alcohol consumption during pregnancy. FASD are lifelong conditions that can significantly impact on the life of the individual and those around them.

2.3.3.3 Young people's alcohol misuse

Young people's misuse of alcohol is addressed as part of a wider range of responses to substance misuse. Alcohol and cannabis are the substances most commonly used by young people. Alcohol use among children and young people can result in a range of adverse outcomes, including organ damage, increased risk of unsafe or regretted sex, teenage pregnancy, unintentional injuries, and being a victim or perpetrator of crime or antisocial behaviour. Early use of alcohol is also a predictive factor in problematic use of alcohol in adulthood.

As shown earlier in Figure 2.3.1.1d, there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol in 2011/12-13/14, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s.This was similar to the national figure in the same time period.

There were 196 young people under the age of 18 years in treatment for substance misuse in Bristol in 2011/12. Of those, 101 used alcohol (16 used alcohol only, 85 used alcohol and cannabis).

[45] Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services. NHS National Treatment Agency for Substance Misuse. 2011. Available from: http://www.nta.nhs.uk/uploads/supportinginformation.pdf.
[46] Brandon M, Bailey S, Belderson P, et al. Understanding Serious Case Reviews and their Impact. A Biannual Analysis of Serious Case Reviews 2005-07. Department for children, school and families. June 2009. Available from: http://www.haringeylscb.org/sites/haringeylscb/files/biennial_review_scrs_200507_brandon-3.pdf.

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Bristol Drug Project provides the Bristol Youth Links Substance Misuse Service, which supports young people who have lower levels of need than those in the treatment services. The service aims to target young people in the earlier stages of substance use in order to prevent escalation into more problematic patterns. In the first three quarters of 2013/14, they saw 215 young people about substance misuse issues, of those 72 (33%) recorded alcohol as the substance that they use most frequently.

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2.3.4 Social and economic harms

2.3.4.1 Worklessness

While the alcohol industry brings benefits to Bristol, alcohol misuse also has a damaging effect on the performance and productivity of our local economy. It can be a barrier to rejoining the labour market for those out of work, and can impact on the workplace through absences and reduced productivity.

It is estimated nationally that up to 17 million working days are lost each year through sickness absence attributed to alcohol[32]. Alcohol misuse may also affect productivity of workers in their workplace and may result in shorter working lives and early retirement.

Alcohol can be responsible for inability to work and unemployment. The prevalence of dependent drinkers among benefit claimants is twice the prevalence in the general population[47]. Being out of work can put people at increased risk of ill health and premature mortality, and can be linked to increased substance misuse and mental ill health, as well as reduced psychological wellbeing.

In Bristol, 47% of patients who started alcohol treatment in 2014/15 self-reported long-term sickness or disability, and 24% of patients were unemployed or inactive. Improving job outcomes for this group is essential to sustaining recovery and requires improved multi-agency responses.

2.3.4.1 Homelessness

Links between alcohol misuse and homelessness are well established, both as a cause and a consequence. Alcohol misuse can impact on an individual's ability to maintain a tenancy; conversely, lack of stable accommodation is considered by many homeless alcohol misusers to be a significant barrier to their recovery.

Physical and mental health problems are prevalent among the homeless population, and evidence suggests that one third of all deaths among the homeless population are a result of drugs or alcohol[48]. In Bristol, housing problem was self-reported by 7% of adults who started alcohol treatment in 2014/15, and urgent housing problem by additional 3% of new treatment starters. Also the Bristol Compass Health, which provides the primary care for homeless people, estimates that 18% of their clients have problematic alcohol use or are dependent drinkers.

[47] Hay G, Bauld L. Population estimates of alcohol misusers who access DWP benefits. Department for Work and Pensions. 2010. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214391/WP94.pdf.
[48] Homelessness: a silent killer. A research briefing on mortality amongst homeless people. Crisis. December 2011. Available from: http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf.

2.4 Cost of alcohol misuse

Alcohol misuse places a significant cost burden on society and a strain on our NHS services.

The estimated cost of alcohol harm to society is £21 billion per year’. This figure takes into account the impact alcohol has on health and other public services, the cost of alcohol-related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11billion[38].

Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. This estimate of £3.5 billion is an updated figure to the one given in 2008 when it was estimated that the cost of alcohol harm to the NHS in England was £2.7 billion (in 2006/07 prices). This updated estimate takes into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm.

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3 CURRENT RESPONSES TO ALCOHOL-RELATED HARM IN BRISTOL

3.1 Education, prevention and campaigns

3.1.1 Prevention work for children and young people

Prevention

The main focus of the approach to tackling alcohol misuse in young people is prevention. This is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the most likely substance that young people will use. In England in 2013, 39% of young people aged 11-15 years said they had drunk alcohol at least once, compared to 16% who said they had ever taken drugs[49].

The majority of alcohol prevention with young people in Bristol is delivered in schools. Alcohol education is statutory within the school science curriculum, it is often taught within personal social and health education (PSHE), which is non-statutory. PSHE is part of a programme focusing on substance misuse more broadly, under the guidance of the Bristol City Council's Healthy Schools team manager. The guidance focuses on high quality, evidence based drug and alcohol education and knowledge of best practice. It is advised that alcohol education should be part of a whole school approach and should be delivered in both primary schools at Key stages 1 and 2 and secondary schools at Key stages 3 and 4.

Outside of schools, other colleagues within the wider children and young people's workforce are also encouraged to deliver good quality education focusing on the prevention of alcohol misuse among young people. Bristol City Council's Public Health team deliver training on basic drug and alcohol awareness (level 1) and delivering drug and alcohol education (level 2) as part of the 4YP programme and all workers are encouraged to attend these sessions.

Working with Parents

The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work. Examples include advice to pregnant women about alcohol use, advice and information to parents of teenagers based on the guidance from the Chief Medical Officer[50]. Training is delivered through the 4YP training programme for those working with parents, carers and families on how to support their clients to talk to effectively to children and young people about alcohol and drugs.

[49] Fuller, E and Hawkins, V. Smoking, drinking and drug use among young people in England in 2013. Health and Social Care Information Centre. 2014. Available from: http://www.hscic.gov.uk/catalogue/PUB14579/smok-drin-drug-youn-peop-eng-2013-rep.pdf
[50] Donaldson, L. Guidance on the Consumption of Alcohol by Children and Young People. Department of Health. 2009. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf

The Safeguarding Children's Substance Misuse Group, which reports to Bristol Safeguarding Children's Board, has produced a protocol for agencies working with drug using parents to ensure that the safeguarding of children is prioritised and that recommendations from previous serious case reviews become part of service delivery. The council's Safer Bristol team commission Hidden Harm work from the Drugs and Young People Project to reduce risk and build resilience with young people who have child protection concerns. This work has recently been evaluated and there is significant evidence to show that it effective in reducing risk and building resilience among these young people, reducing the likelihood that these young people will grow up with substance misuse problems.

Hidden Harm work is also offered within Bristol Youth Links service for those aged 9-19 years who fall outside the threshold for social care involvement.

Training for the children and young people's workforce on working with children affected by Hidden Harm issues is available through the 4YP programme.

3.1.2 Adult prevention work

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.

An IBA service is being developed for pharmacies, aimed at people who buy hangover cures for gastric problems.

In addition Public Health trains front-line workers to deliver IBAs. Workers already trained include: Support to Stop Smoking workers, sexual health services staff, health visitors, community workers for older people, and children's centre staff.

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 campaign aimed at young people using the

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council's Ministry of Cheer web site, a safeguarding vulnerable people campaign aimed at carers who drink, and pharmacy campaigns targeting people with high blood pressure.

Alcohol awareness sessions have been developed for front-line workers.

3.2 Treatment and care

3.2.1 Treatment and care for children and young people

Early Intervention

Funding is in place to deliver early intervention work with young people as part of the Bristol Youth Links programme. This is provided by Bristol Drug Project and is mainly delivered in secondary schools. The Youth Links Service is the first point of referral for young people aged 19 and under living in Bristol who need extra support because of their alcohol or drug use. They may be offered up to six 1:1 sessions or they may attend group work. The worker helps them to think about how they can make positive changes to their alcohol use, including cutting down and stopping, in order to reduce risks. Referral into this service can be made by anyone and the referral pathway is dealt with in detail in the 4YP level 1 training.

Treatment

Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services. Bristol City Council's Safer Bristol team commissions two treatment services, with funding from Bristol Public Health and the Police and Crime Commissioner.

The first is the Young People's Substance Misuse Treatment Service, which supports young people with mental health problems and other health needs and is based in Children and Adolescents Mental Health Service (CAMHS). The second is the Drugs and Young People's Project, which supports young people who have social work involvement and is based in the council's Children and Families Service. There is also a treatment worker in the council's Youth Offender Team (YOT). Current practice is for these agencies to work together as one treatment service. Treatment is care planned with the young person and may include psychosocial elements, harm reduction, prescribing and family support, depending on the young person's needs.

3.2.2 Treatment and care for adults

The "Recovery Orientated Alcohol and Drug Service" (ROADS) is an integrated adult substance misuse service available across Bristol 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.

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ROADS is comprised of 5 Clusters designed to operate as a single integrated treatment system (Appendix 1). The 3 treatment clusters (Engagement, Change and Completion) deliver appropriate interventions dependent on a client's stage of change. Engagement focuses on engaging individuals into treatment and delivers low threshold brief interventions. Change provides higher tier structured treatment interventions including specialist services for people with complex needs and inpatient detoxification & access to residential rehab. Completion offers post-treatment support around training, education, volunteering and employment to enable people to reintegrate with their community.

Advocacy and support for families and carers is delivered by the Support cluster whilst Housing Support provides accommodation and support for people to sustain their tenancies.

There are multiple referral routes into ROADS, including self-referral, GPs, hospital, Job Centre and the criminal justice system to ensure services are accessible for all the people in need of them. The services on offer respond to the varying needs of Bristol's problematic drinkers and work to motivate and support people to achieve sustained recovery from addiction. This reduces the negative impact alcohol has in Bristol.

In the hospitals there are alcohol nurses 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.

Alcohol-related problems are a big and increasing part of the primary care workload. Most practices screen new registrations for alcohol misuse, and some operate a local alcohol service targeting people with specific ailments.

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.

3.3 Alcohol-related crime & disorder; night-time economy

3.3.1 Police

The Police have developed their operational approach to policing the night-time economy. Called 'Brio' this approach combines public order policing, which uses identification and

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targeting of problem areas, with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers.

On a typical Saturday or Sunday night (22.00-04.00), in the Bristol city-centre night-time economy area, the police deal with an average of six violent crime offences. Of these three are recorded as involving Actual Bodily Harm with the bulk of the remainder being for more minor violent crime or disorder offences. In addition to this there are usually more than ten reported incidents of Anti-Social Behaviour which the police respond to, they also deal with spontaneous demand from bad behaviour observed by patrolling officers. For the overwhelming majority of these crimes and incidents alcohol is deemed to be a significant factor. The police response to this demand involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises.

The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

3.3.2 Probation

Since June 2014 Probation Services in Bristol have been delivered by two organisations – the National Probation Service (responsible for advice to the courts and the supervision of offenders assessed as high risk of harm) and a Community Rehabilitation Company (covering Bristol, Somerset, Bath, Gloucester and Wiltshire, and responsible for the supervision of offenders assessed as low and medium risk of harm). Their responsibility is to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to change their lives.

As part of this work they assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be referred to a range of interventions around problematic alcohol use, including the Drink Impaired Drivers Programme, the Low Intensity Alcohol Programme or the Building Skills for Recovery Programme.

Other structured interventions are available as part of community orders or post-release Licences and if the person is drinking at dependent levels they can be referred to specialist services sometimes by using the Alcohol Treatment Requirement associated with a community order.

The National Probation Service also supervises offenders included in the IMPACT (serious acquisitive offenders often with multiple substance misuse) and IRiS cohorts (dangerous offenders).

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3.3.3 The Bristol Council's services

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.

3.3.4 Joint working

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.

Bristol's management of its lively and attractive night-time economy has resulted in the award of Purple Flag Status for the last three years.

3.4 Targeting and protecting vulnerable groups

3.4.1 People with complex needs and chaotic lifestyles

Police and council workers address street drinking issues by supporting the work of the Streetwise Team (a joint police/council team) who use the integrated offender management method to assist street drinkers to change their offending behaviour and address their alcohol misuse.

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Bristol runs two ‘wet sessions’ a week where street drinkers can access, health services, housing advice and mental health workers. The Wet Clinic is the only GP lead health clinic for street drinkers in England.

The Big Lottery ‘Fulfilling Lives – Multiple Needs’ project started in 2014, it will enable people with chaotic lives and complex health and social issues to access help, and be case managed by specialist workers.

The re-commissioning of Bristol Mental Health services in 2014 will result in a new Assertive Engagement Service for people with chaotic lifestyles and complex needs, many of the most vulnerable dependent drinkers will be able to access this service. Formerly the mental health services were unable to assess or treat dependent drinkers.

3.4.2 Children, young people and families

Young people’s treatment services are delivered by three agencies, forming an integrated treatment team. These are:

- The Young People’s Substance Misuse Treatment Service (YPSMTS), which is part of Children and Adolescent Mental Health Service (CAMHS) and works with young people up to the age of 18 years with substance misuse problems and complex needs.

- The Drugs and Young People Project (DYPP), which is part of Children and Young People’s Services (CYPS) and works with young people who misuse substances and have social workers.

- The Youth Offending Team which supports young offenders who also misuse drugs and alcohol.

DYPP also supports young people with social workers whose parents and carers misuse drugs and alcohol. The child protection concerns for most of these families are closely related to their parents’ substance misuse.

Early intervention work is delivered by Bristol Drugs Project, as part of ‘Bristol Youth Links’ targeted work. They work with young people who are using drugs and alcohol and with those whose parents use drugs and alcohol where there is no social care involvement.

Support for families of alcohol misusers is provided by Developing Health and Independence (DHI) in the new ROADS service.

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4 VISION FOR BRISTOL

Our vision for Bristol:

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.

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5 OUR STRATEGY

5.1 Aim of the strategy

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit.

This can be achieved through partnership working and using the best available evidence of what works.

There are three broad aims:

1	**Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.** (PREVENTION/CAMPAIGNS)	*Alcohol Prevention Workstream*
2	**Provide early help, interventions and support for people affected by harmful drinking.** (ACCESS TO SERVICES AND PATHWAY FOR LIVER DISEASE)	*Alcohol Intervention Workstream*
3	**Create and maintain a safe environment.** (REDUCTION OF AVAILABILITY AND ACCESSIBILITY, SAFE NIGHT TIME ECONOMY)	*Alcohol Environment Workstream*

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6 STRATEGY WORKSTREAMS

		ALCOHOL PREVENTION (Workstream 1)	ALCOHOL INTERVENTION (Workstream 2)	ALCOHOL ENVIRONMENT (Workstream 3)
Aim		**Increase knowledge and change attitudes towards alcohol**	**Provide early help, interventions and support for people affected by harmful drinking**	**Create and maintain a safe environment**
Team	**Lead**	Becky Pollard	Dr Martin Jones	Supt Rhys Hughes
	Coordinator	Leonie Roberts	Dr Kate Rush, Kath Williams	Insp Martin Rowland, Nick Carter
	Members	Sarah Westlake, Cllr Claire Hiscott, Petra Manley, Blanka Robertson, Jackie Beavington, Geraldine Smyth, Liz McDougall, Rob Bennington	Lynn Stanley, Dr Anne McCune, Dr Tim Williams, Sally Arnold-Jones, Jude Carey, Blanka Robertson	Michelle Phillips, Sally Arnold-Jones
Suggested outcomes		• **Reduce alcohol consumption causing harm to individuals, families and communities in Bristol**	• **Reduce alcohol related harm to individuals** • **Earlier identification of health harm caused by alcohol** • **High quality evidence-based treatment to reduce alcohol related harm** • **Children and young people free from alcohol related harm**	• **Reduce individual and community impact from alcohol related crimes and anti-social behaviour** • **Protect vulnerable people from alcohol related harm** • **Reduce demand on public and emergency services** • **Safe events held within the City; reduce alcohol related incidents**
Suggested outputs		• Improve community discussion about alcohol leading to change of attitude and behaviour to alcohol consumption • Increase knowledge about recommended limits and about the health risk of not drinking in moderation • Increase staff information and training on alcohol awareness and harm • Reduce stigma and shame associated with alcohol dependence • Increase skills of people to drink within the recommended guidelines • Advocacy role to reduce the availability of alcohol and increase the price	• Improve screening and detection of alcohol-related health harm in primary care • Reduce alcohol related hospital admissions • Improve individual and family access to treatment and support • Increase successful completion of treatment	• Develop multi-agency information sharing at tasking meetings • Enforcement of alcohol related violence • Increase knowledge of legal and social responsibilities within the licensed trade • Effective monitoring of cumulative impact areas • Reduce community impact of the street drinking community

7 DELIVERABLES AND ACTIONS

Alcohol Prevention (Workstream 1)					
Suggested Actions	**Evidence and/or Baseline**	**Activity/Targets**	**Timescale**	**Lead Agency**	**Contributing Agencies**
Social marketing Deliver a large-scale social marketing campaign across Bristol City	The Government's Alcohol Strategy, HMGovernment, 2012 UK Chief Medical Officers' Alcohol Guidelines Review, DoH, 2016 EU Social marketing guidance Evidence\social-marketing-guide-public-health.pdf	Scoping document produced– steering group formed. Target audience identified.	2016	Public Health and Addictions Health Integration Team	Public Health England
		Development of a social marketing plan.	Start 2017		
		Implementation e.g. social media, media stories.	2018		
		Evaluation report produced, e.g. number of campaigns, number of people reached, feedback from stakeholders.			
Social Marketing Deliver preventative campaigns using social marketing tools and methods Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour		Implement Public Health England OneYou campaign across Bristol	2016/2017	Public Health delivery teams/Public Health England	Public Health England
		Dry January Campaign		Public Health Strategic and Delivery Teams	
		Promote use of Drinkaware Application			
		Introduce Alcohol Free Zones at public events		Bristol City Council Events Team	
		Host the Alcohol Big Debate		Public Health Strategic and Delivery Teams	

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Education in schools – Implement alcohol education in schools Develop work with schools about delivering training for parents Work with young people and adults with caring responsibilities		Increase the number of schools delivering alcohol education within PSHE, according to best practice recommendations.	2016/17	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
Workplaces Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace	Health and Safety Executive https://www.bhf.org.uk/publications/health-at-work/health-at-work-guide-to-alcohol http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Alcohol-and-the-Workplace.pdf http://www.cipd.co.uk/NR/rdonlyres/EFE87A7D-B088-43C0-A0B5-B6F71DA1E678/0/mandrgalcmisuseg.PDF	Provide alcohol awareness training for local employers (first priority – organisations signed up to the Workplace Wellbeing Charter. Currently 30 organisations who employ 30,000 staff). Support Charter organisations to achieve the Alcohol standard (this includes policy, practice and support to staff - target 20 organisations). Provide brief intervention training for Charter organisations. Provide materials and resources to assist organisations to promote awareness amongst their own staff (using One You materials). Include guidance and campaigns which promote alcohol awareness in monthly Health at Work Newsletter.	January 2017	Public Health	
Alcohol Workplace policies Review Bristol City Council alcohol policy and support available for employees with alcohol problems.	Alcohol and Substance Misuse Policy NICE Guidance PH24 https://www.nice.org.uk/guidance/ph24	Policy reviewed Brief intervention and e-learning module developed.	2016/17	Public Health	

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Workforce (Making every contact count) Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers Workforce development in alcohol IBA - (making every contact count	NICE Guidance PH24 https://www.nice.org.uk/guidance/ph24 http://www.alcohollearningcentre.org.uk/eLearning/IBA/	Commission Pilot Pharmacy Alcohol Identification and Brief Advice Service (IBA) Plan the roll out of IBA to professionals in health care and non-health care settings. Develop and implement mechanism for training follow-up	2016/17	Public Health	
Community Encourage parents to have conversations with their children through a social marketing campaign Develop training on supporting parents to talk to their children on the harms of alcohol.		4YP parents' campaign launched April 2016. Evaluate after 6 months. Re promote every six months through schools, GP surgeries, parent support groups, Think Family, Early Help etc.	Launch April 2016. Evaluate Oct 2016. Re-promote Nov 2016. Evaluate March 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
		Alcohol will be included in redesigned 4YP training programme, especially in the course focusing on supporting parents to talk to children and young people about difficult issues.	New courses launched 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
Community Develop community engagement strategies.		Enable Neighbourhood Partnerships to develop local action plans to address the harms related to alcohol. Promote community events that don't involve alcohol. Encourage local licensed businesses to promote alcohol-free hours during opening times.	2016/17	Public Health Strategic and Delivery Teams	Bristol City Council

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Alcohol Intervention (Workstream 2)					
Planning					
Suggested Actions	**Evidence and/or Baseline**	**Activity/Targets**	**Timescale**	**Lead Agency**	**Contributing Agencies**
Needs assessment Provide an overview of current service provision of Bristol Recovery Orientated Alcohol & Drug Service (ROADS) against need and identify how services can meet the identified needs	Needs assessment	Health needs assessment Review current service provision (multidisciplinary) Identify unmet needs Identify how services can address unmet needs	Complete 2016	Substance misuse team	Public Health
Mapping of existing services	None	A comprehensive mapping exercise to capture all existing services (primary care, secondary care, specialist)	End 2016/ 2017	Substance misuse team	CCG
Mapping of patient pathway – specialist services	None	Consider service provision from patient perspective Identify potential changes/improvements to inform re-commissioning process		Substance misuse team	Healthwatch
Evidence review and economic evaluation		Understand the current evidence base including cost effectiveness in relation to specific services/interventions (e.g. alcohol nurses) Collaborative working with South Gloucestershire. Short life working group to be established to define parameters of work	To commence Autumn 2016	Bristol CCG/Public Health	In conjunction with South Gloucestershire CCG
Primary care review Review of screening and identification used within primary care to include alcohol and liver disease	NICE CG115 Audit will provide baseline	Audit of current practice	Apr - Jul 2016	CCG	
		Repeat audit	Apr 2017		
Activity data Review of secondary care data (Commissioning for Value datasets) and explore opportunities	Right Care – Commissioning for value datasets	Initial review of opportunities and deep dive to test initial findings	End 2016	CCG	

Alcohol Intervention (Workstream 2)

Delivery

Suggested Actions	Evidence and/or Baseline	Activity/Targets	Timescale	Lead Agency	Contributing Agencies
System approach to alcohol and liver disease Development of a system approach to alcohol treatment and liver disease (all causes)	NICE CG115 Lancet 'Addressing Liver disease in the UK'	Develop a standardised approach for screening and identification within primary care using outcomes from audit	Jul - Oct 2016	CCG	Secondary Care (UHB and NBT)
		Develop clear pathways between primary care, community care and secondary care services	Jul 2016 – Jul 2017		
		Explore new models of working including non-invasive measurement of fibrosis and outreach management of cirrhosis complications e.g. elastography		Public Health – pilot, CCG – longer term	Secondary Care, Local Authority Commissioning, GP practices, Service providers
Harm minimisation for high risk groups	Needs assessment	Identify treatment resistant cohort Address through harm reduction strategies incorporated into re-commissioning process	Jul-Oct 2017	Substance misuse team	
Young People Promoting the young people's substance misuse pathway across all agencies working with children and young people	Baseline to be determined following review of training delivery	Training programme delivered by Public Health Number of people in the children and young people's workforce who are trained to screen young people, identify those who are using alcohol and refer them into the Bristol Youth Links early intervention service	Apr 2016 – Mar 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	

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Training and education – Healthcare staff					
GP training	NICE CG115	Update for GPs on current pathways and best practice in relation to alcohol/liver disease incl. mutual aid	October 2016	CCG	Secondary care (UHB and NBT)
Explore the opportunities for online training for ambulance staff and information sharing with primary care	None	Review online Identification and Brief Advice (IBA) training		Public Health	
		Develop electronic information sharing with primary care		South West Ambulance Service	
Develop Paramedic training at UWE in IBA	None	Scoping		South West Ambulance Service	
Mutual aid training for practice based staff (PMs/Community resource co-ordinators)	Measure through representations – Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months	Run a specific Facilitated Access to Mutual Aid training session for all practice managers		Substance misuse team Bristol City Council	

Alcohol Environment (Workstream 3)

Suggested Actions	Evidence and/or Baseline	Activity/Targets	Timescale	Lead Agency	Contributing Agencies
Wider use of technology Increase the availability of technology to improve the quality of information and evidence		Real time Sec 35 dispersal information sharing with partners (app to circulate photos of those issued orders to increase likelihood they will actually disperse)	6-12 months	Police	Bristol City Council
	Number of incidents reported by taxi marshals 15/16	Issuing of body-worn cameras to taxi marshals		Bristol City Council	
Diversionary events/activities Provide an alternative to traditional night time economy activities		Diversionary events/activities in areas of high alcohol use and/or proliferation of licensed premises – use links to events managers	6-12 months	Bristol City Council	Police
Brio night time economy operation Continue to develop this operation into a multi-agency approach to Bristol night time economy		Enhancement to Police Night Time Economy Operation through implementation of mini multi-agency operations and thematic leads within police teams for issues such as taxis, drugs, underage sales etc.	6 months	Police	
Intelligence sharing between agencies Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City		Monthly review meetings Weekly Brio debrief/review meetings	Immediate	All agencies	All agencies
Identification and management of problematic licensed premises Improving the safety of establishments	Number of 'red' premises in 15/16 and average time at red	Police and Bristol City Council Joint Enforcement Team tasking group delivering targeted multi-agency work towards problem premises	Immediate	Bristol City Council	Police
		Monitor length of time premises stay as 'red or high risk'			
Training and awareness for licensed trade staff Raising awareness of CSE and other vulnerability issues. Early recognition by staff		Training for Licensing Sub-Committee members on aims of strategic plan Adoption of Child Sexual Exploitation awareness training by Security Industry Association	6-12 months	Bristol City Council	
Alcohol Recovery Centre Reducing demand for NHS and police. Improved early care for users. Demographic data will assist other work streams	Number of Alcohol Recovery Centre (ARC) users for 15/16	Monitor demographic data of users. Number of users Night Time Economy	3-6 months	South Western Ambulance Service NHS Foundation Trust	
	Number of days ARC deployed	Consider signposting to other care paths where appropriate			

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Re-invigoration of the Pub-Watch Scheme Improve the cooperation of licensed premises to ensure a safer environment		Review of current process involving all stakeholders to suggest new approach	6-12 months	All agencies	All agencies plus Trade
Management of Cumulative Impact areas To ensure areas are monitored to manage the number of licensed premises		Review of current zones for effectiveness and scoping for potential new areas (Stapleton Road/Church Rd/Arena)	6 months	Bristol City Council	Police
Structured approach to licensing implications for larger events		Joint Enforcement Team to review events calendar and suggest suitable events for approach and protocol for managing licensing applications	6-12 months	Bristol City Council	Police
Providing support for people using and working in the City Centre during the night time economy Identification of vulnerable people due to alcohol consumption, providing a safe environment	Number of incidents reported to Bristol Stand against Racism and Inequality (SARI) by staff working in the Night Time Economy Number of hate crimes reported	Develop strategies and interventions to help people working in the Night Time Economy e.g. taxi/bus drivers Education re CSE and vulnerability	12 months	Bristol City Council	Police, Bristol Stand against Racism and Inequality, Transport providers
Providing support to vulnerable people within the street drinking community	Number of homeless people recorded (Charity and BCC data)	Deliver on the joint strategy for the homelessness situation	12 months	Bristol City Council	
		Provide interventions and support for street drinkers			
	ASB and other crime related calls	Enforcement activity to reduce ASB/criminality			

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APPENDICES

Appendix I

Bristol Recovery Orientated Alcohol & Drugs Service (ROADS)

The new Bristol ROADS was launched in November 2013 following a competitive tendering process. It is a single service consisting of 5 clusters delivered by different providers working together to deliver the Public Health Outcome 2.15: Increase the number of problematic substance misusers who successfully complete drug treatment, and Public Health Outcome 2.18: Decrease the numbers of alcohol related admissions to hospital.

All providers are supported by SARI & The Diversity Trust to ensure delivery of culturally competent services responsive to the needs of Bristol's population.

ROADS links with different forms of Mutual Aid including SMART, AA, NA, CA and FA in order to support clients' recovery journey.

Breaking Free Online an on-line treatment and recovery programme offers support and tools to sustain individual treatment benefits is also offered to all clients.

Engage Cluster

Delivered by St Mungo's subcontracting with Bristol Drugs Project (BDP) and AWPT Bristol Specialist Drug & Alcohol Services (BSDAS).

Engagement offers people their route into ROADS treatment and support services and is designed to work with people experiencing problems with a broad range of substances:

- primary alcohol users
- opiate users (OUs)
- non -opiate users (NOUs) including users of New Psychoactive Substances (NPS)
- prescribed and over the counter medicines.

A key role for Engagement is to 'set the tone' for an individual's treatment and recovery journey, whether this is their first contact or the most recent over, perhaps, a long period. Service users will be encouraged to 'try change' through asset-based assessment and high visibility of recovery – through images, conversations, Peers involvement in service delivery and through 2 Trainee posts which will offer progression into work opportunities for Peers and other volunteers who have a history of problematic drug or alcohol use.

The key elements of Engagement are:

1. Triage, comprehensive assessment and Recovery planning

Service users are assessed using an asset-based assessment system – which assesses individual need at the point of initial referral and then refers to appropriate ROADS interventions.

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It's important to stress that this single system isn't a single physical point of contact – which would make it more difficult for people across Bristol to access – but a service delivered at multiple locations including over 50 GP Surgeries. BDP's main premises at 11 Brunswick Square, BS2 8PE will offer direct access for self-referrals Monday –Friday 9am – 8pm and Saturday 10am – 5pm.

Referrals from other agencies will be made using a simple faxed referral form and many will continue to be self-referrals.

2. Assertive Outreach
Targeting individuals and groups who aren't in treatment but who can benefit from advice and information to reduce risk - and, where appropriate, can be supported into treatment.

Reaching out to particularly vulnerable or under-represented populations' e.g. street homeless, female sex workers as well as early adopters of 'new' substances e.g. LGBT community and student population through regular involvement in night time economy events.

3. Low threshold and brief interventions
There are separate routes for primary alcohol and primary drug users – to offer maximum choice for people.

Primary alcohol pathway:
AUDIT will be used to identify severity of alcohol use and the most appropriate interventions:

- AUDIT score 8-15 Alcohol Brief Intervention (ABI) at assessment or single 30 min session if needed;
- AUDIT score 16-19 ABI at assessment plus onward referral to Controlled Drinking Group or up to 3 x 1-1 sessions;
- AUDIT score 20+ ABI at assessment then onward referral to CHANGE.

Group work for Controlled Drinking, Preparation for Alcohol Detox and Alcohol Detox Support groups are held weekly at venues in North (Gloucester House, Southmead Hospital); Central (Colston Fort) and South Bristol (Knowle West Media Centre).

Primary drug pathway offers:

- Brief interventions for users of non-opiates or new psychoactive substances– with integrated ITEP mapping.
- And Preparation for Recovery groups (2 groups a week). These build motivation for change and offer a clear pathway for criminal justice referrals.

4. Needle and Syringe Programme

5. Harm reduction and healthcare interventions
Interventions designed to reduce harm and death including:

- Dry Blood Spot Testing for HBV/HCV testing will be offered 'there and then' to people who express interest in having a test;

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- ‘Super Accelerated’ HBV vaccination (course complete in 21 days), targeting at-risk populations;
- Safer Injecting, Overdose Prevention and Naloxone training and supply: Naloxone reverses the effect of opiates/opioids and can save lives if rapidly administrated.

Other groups for targeted harm reduction work are people using controlled substances like Ketamine – which can causes significant urinary tract damage and those using New Psychoactive Substances – where little may be known about their chemistry or effects.

6. Transitions from Young People’s Drug Treatment Services

BSDAS will have a dedicated role to ensure the safe transition of young substance users from Bristol’s Young People’s Drug Treatment Service to adult services – where appropriate. This will involve joint working during a 4-6 month period before a young person needs to move into ROADS but the main aim of this work will be to secure a successful exit from treatment wherever possible.

Change Cluster

Delivered by BSDAS with sub-contractor BDP.

The Change Cluster provides the core treatment elements of ROADS working with both drugs and alcohol and focus on detoxification and abstinence. It will be client-focused and offer a range of psychosocial group work and individual care packages to support the effectiveness of the clinical interventions offered.

Services will be delivered from Colston Fort (which will retain an alcohol and abstinence focus), Stokes Croft (which will take on a ‘Complex’ focus and continue the dispensing function), and a number of BDP sites. There will also be satellite group work provision in the North, South and Centre of the city to increase access.

Following assessment in the Engagement Cluster, service users will have an individual care plan which will contain a number of the following treatment options. Care will be co-ordinated and reviewed throughout the Change Cluster and on exit.

1. Shared Care:

The Change Cluster will increase support for primary care, enabling people to be cared for by their GP, rather than needing referrals to specialist provision.

This service offers a layered approach including an Enhanced Shared Care service for people pursuing abstinence. There will also be a Complex Shared Care element which will provide nurses with six surgeries to work with clients with alcohol and dual diagnosis issues.

2. Specialist Prescribing:

This includes detoxification, substitute prescribing and prescribing to prevent relapse. Daily dispensing will run every weekday morning from Stokes Croft. Pharmacy links will be further developed to strengthen delivery and practice.

3. Group work:

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Group work will contain a number of options within the Change Cluster (in addition to those offered within Engagement and Completion Clusters):

- 12-step programme – Three times a week co-facilitated by group workers and peers;
- Structured Recovery Programme – This operates daily and contains both topic-based and psychosocial interventions;
- Alcohol Detox Support Group - Run from satellite sites and open to people pursuing alcohol detox through specialist services and shared care.

4. Psychosocial Interventions:
This follows a mind-mapping format Motivational interviewing techniques will be used alongside ITEP/BTEI approaches.

5. Specialist Psychological Interventions:
A limited number of intensive, specialist interventions such as DBT will be available for those service users who would most benefit from this approach.

6. Maternity and Family Support Services:
This covers both drug and alcohol problems and is delivered by a multi-disciplinary team, comprising of Midwives, Social Workers, Family Liaison workers and Specialist Drugs workers with named leads for professional liaison and client work. The focus of this service is to minimise the harm to mother and baby from problematic misuse, focusing on any Safeguarding concerns.

7. Inpatient Services:
There are seven beds on Acer Unit, Blackberry Hill Hospital, for stabilisation and detoxification. Whilst the majority of detoxification will happen in community settings, ROADS aspires to increase demand for detox and with this will come a proportion of complex cases, requiring inpatient treatment.

<u>Completion Cluster</u>

Delivered by BDP subcontracting with Business in the Community, VOSCUR & Volunteer Bristol, Windmill Hill City Farm, Demand Energy Equality, The Community Farm.

There are three key elements in Completion:

1. Recovery Sustainment Programmes
These offer real choice for individuals – with separate programmes for primary alcohol and primary drug users as well as one combining drug and alcohol users.

1.1. Combined Drug & Alcohol pathway
Individuals can access:

- 12-Step aftercare programme
  With two groups a week delivered at Colston Fort, supporting 12 Step Fellowship meetings;
- Community Reinforcement Approach (CRA) programme

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An individual programme for 8 weeks running alongside a weekly group which promotes individual engagement with their family and community. This builds on BDP's successful Boost CRA programme.

1.2. Primary Drug Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol - including evening and Saturday sessions.

1.3. Primary Alcohol Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol – including evening and Saturday sessions.

2. Targeted programmes to support individuals

2.1. Parenting Workshops

These offer support for people with a drug or alcohol problem who are also a parent. Their primary aim will be to help individuals identify with their role as a parent more strongly than with their role as a user of drugs or alcohol. These will be available across ROADS and with partners external to ROADS e.g. Children's Centres.

2.2. Peer Recovery check-ups

These are structured follow-ups of individuals who have successfully completed treatment in the Change cluster. Undertaken by Peers this involves a proactive structured intervention by telephone, using ITEP guided maps to support service users successfully exiting ROADS by reinforcing success and offering opportunities to re-engage early if needed.

2.3. Peer HCV support

Peers will offer individual support to service users who are starting HCV treatment – walking alongside them to maximise the opportunity for individuals to stay engaged with treatment through 'rough patches' and to successfully complete HCV treatment. Increasing the number of people completing HCV treatment is the only effective way of reducing HCV prevalence (number of people who have Hepatitis C) and the consequent future health care costs – so has important Public Health impact as well as improving individuals' quality of life.

2.4. Naltrexone Prescribing

Bristol City Council Substance Misuse commissioning team will be working with the Change Cluster to initiate and expand prescribing of Naltrexone (opiate-blocking drug) as part of an individual's recovery support plan. This is currently under-used in Bristol – but can offer tangible support to individuals during the early months of their recovery to reduce the risk of relapse.

3. Training Education Volunteering & Employment (TEVE) Opportunities

These offer meaningful occupation at a time of great vulnerability for individuals who approaching the end of their treatment, or who have just successfully left it.

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3.1. TEVE-Lite: short-term focused sessions (1-3) to explore options, sign-posting and referrals e.g. completing TPR3's to engage JCPlus in conversation about an individual's recovery plan and opportunities to increase their readiness for work.

3.2. TEVE–Contingency Management (CM) – "rewards for recovery"
This service will in reach into Change to establish TEVE CM prior to successful exit from treatment. This will be targeted at individuals in the Enhanced Shared Care stream who are completing their detox over a 6 month period as well as those completing alcohol detox.

A TEVE CM contract will be developed over 3-5 sessions which identifies behaviours and activities which are meaningful to an individual and can earn them 'rewards for recovery' e.g. successful completion of programmes in Completion, completing a volunteering placements, negative drug screens.

Individuals can accumulate 'rewards for recovery' as credits on a 'Capital Card' for which can be used against a range of training programmes run by City of Bristol college or other relevant source.

Support Cluster

Developing Health and Independence (DHI) will be delivering a new and innovative service in Bristol, called the 'Support Service', which will work closely with the other Recovery Orientated Integrated Substance Misuse Treatment (ROIS) providers.

The Support Service will have four main elements:

1. **Tackling discrimination and Stigma**
During the journey of recovery and social reintegration, service users may face discrimination and stigma. DHI will be engaging with local communities to dispel misunderstandings around drugs and alcohol. This will include promoting closer working with the treatment service, those being supported in recovery and the communities in which they live.

2. **Carer Support**
Holistic recovery means supporting the families and carers of those with drug and alcohol issues. DHI will be providing advice, information, one to one and group support for families in need, and will also be providing training for family members to become 'family champions' who can help run peer led family groups to support one another.

3. **Peer Support**
Recovering service users can often be the best support for those a little further behind in their own recovery. DHI will be providing a comprehensive recruitment, training, and support package to those in recovery so that they can provide the best encouragement to others in their recovery and develop skills for their own future.

4. **Advocacy**

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Service Users can sometimes lack confidence to raise their own voice when things go wrong or services do not meet their expectations. DHI has teamed up with The Care Forum who will provide advocacy support for individuals to resolve issues in relation to their treatment and thereby maximise their chances for a prolonged successful recovery.

Housing Support Cluster

Delivered by Addiction Recovery Agency (ARA) with sub-contractors, The Junction Project and the Salvation Army, the housing support cluster provides accommodation based and floating support.

Appropriate and safe housing is an integral part of a person's recovery and the Housing Support Cluster provides:

- Preparation Accommodation
  For those people where the treatment provider has a clear pathway for recovery in place but advocates that the service user is unable to maintain non problematic substance misuse use without stable housing.

- In Treatment accommodation
  For those people stabilised and engaged and working on their recovery plan with the Change provider, on stable medications and working towards non problematic use

- Abstinent Accommodation
  For those people who are totally abstinent after detox programme and needing an abstinent environment supporting their abstinent programme.

Floating support work with service users at all stages of engagement with ROADS where there person is a risk of homelessness or treatment breakdown which would jeopardise the tenancy.

- This service will be cross tenure and include owner occupiers, licensees and tenants. Floating support services will work with a range of private and social landlords including registered social landlords and Bristol City Council.

For further information, please go to: http://www.bristol.gov.uk/page/community-and-safety/drug-and-alcohol-misuse-treatment

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