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Surrey Substance Misuse Strategy: Alcohol Section

Contents

Foreword

Addressing alcohol harm is a key priority in Surrey as alcohol-related hospital admissions continue to escalate and more than a quarter of adults who consume alcohol doing so above recommended levels. Alcohol misuse has a major impact on our public services, with alcohol harm estimated to cost the NHS in Surrey over £73.5 million a year alone. We know that the social, economic and health impacts associated with alcohol misuse affect the most vulnerable individuals and groups in our society, as well as the population at large.

This strategic approach to addressing the harm caused by alcohol is part of the overall Substance Misuse Strategy. It builds on Surrey's previous Alcohol Strategy (2009-12) and continues to recognise the unique and important contribution organisations such as the NHS, police, county, borough and district councils, prison and probation services, alcohol treatment services, voluntary sector and local industry can make in tackling alcohol misuse in our community. Key to this is the effective delivery of evidence-based interventions to alter drinking culture and behaviours, including early identification of those at risk and appropriate support for those who need it. The evidence is clear; investment in alcohol services and alcohol-specific interventions is highly cost-effective and improves health outcomes.

We hope you find this section informative and look forward to working with you to implement an effective approach to reducing the harm caused by alcohol across the life course.

Executive Summary

Addressing alcohol harm is a public health priority both nationally and locally. In Surrey, alcohol-related hospital admissions have more than doubled in the last decade and it is estimated that over 25% of adults that drink alcohol do so above recommended limits.[1] Around 215,400 people in our county misuse alcohol, 21,000 of whom are moderately or severely alcohol dependent.[1] This has a major impact on many of our public services, with alcohol harm estimated to cost the NHS in Surrey over £73.5 million a year alone.[2] The social, economic and health impacts of alcohol misuse affect both the most vulnerable individuals and groups in our society and the population at large. In order to halt and reverse the trend of increased alcohol-related harm, we need to intervene early to identify those at future risk, and support and empower them to change their behaviour.

Our approach to addressing the harm associated with excess alcohol involves delivering the most effective, evidence-based interventions across the life course. The strategy recognises that alcohol misuse can only be addressed through system-wide change, encompassing both behaviour change interventions at an individual level, as well as policy, environmental, and cultural change at a population level. In particular, our strategy emphasises the need to address alcohol harm and the associated health inequalities collectively in partnership.

Our aim is to prevent and reduce the harm caused by alcohol to individuals, families and communities within Surrey. This will be achieved through co-ordinating activity across the following strategic themes:

Prevention and Early Identification

We aim to ensure that all children and young people receive alcohol education in school, and that parents and carers are supported to address drinking in children and young people. We will work to ensure that the risk of alcohol harm during pregnancy is communicated appropriately to all. We will promote healthy attitudes towards alcohol and encourage individuals to drink less through a range of prevention, education and health improvement methods. This will include highlighting the risks of excess alcohol and the benefits of drinking within the recommended limits, and empowering and enabling people to make an informed choice about their drinking behaviour. We will establish system-wide opportunistic screening and brief advice in order to identify those drinking above recommended levels at an early stage and support them to reduce their drinking. In addition we will ensure those drinking at dependent levels are identified and referred to specialist treatment services.

Treatment and Recovery

We will ensure that recovery-oriented specialist alcohol treatment is available and accessible to all who need it. We will work to increase the capacity of our treatment services and improve uptake and outcomes of those who engage through an integrated, multi-agency response. We will ensure that those affected by alcohol misuse, including carers and family members, have access to health and social care services appropriate to their needs and will work in partnership to develop communities which foster recovery for those with alcohol dependence.

Safer Communities

We will protect the public from the effects of alcohol-related criminal and anti-social behaviour through effective enforcement and regulation. We will create a safe environment in Surrey through responsible retailing and a targeted, proactive approach to community safety and alcohol licensing. We will target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol. We will improve the planning and management of the night-time economy and work together to reduce alcohol-related violence within our town centres, neighbourhoods and homes.

Acknowledgements

We would like to thank the wide range of partners that have contributed to the development of this Alcohol Section. The section has been developed by the Substance Misuse Partnership Group which is made up of the following key partners:

Surrey County Council, including:
Public Health
Adult Social Care
Children, Schools and Families
Customers and Communities

NHS
Clinical Commissioning Groups
NHS England Local Area Team

Public Health England

Police, Probation and Prisons
Office of the Police and Crime Commissioner
Surrey Police
Surrey and Sussex Probation Trust
Surrey Prisons

Borough and District Councils
Community Safety Officers
Policy Officers

Industry representatives

Voluntary sector representatives

Department for Work and Pensions (Job Centre Plus)

Recovery Champions

This expertise of each of these stakeholders has been used to identify the emerging priorities and develop the section in line with local needs.

1. Introduction

When consumed within the recommended guidelines, alcohol can be beneficial to individuals and society, boosting the night time economy and facilitating social interactions and community cohesion. However, there are many people who are drinking too much, too often, resulting in year on year increases in the levels of alcohol-related health problems. In Surrey, a significant proportion of adults drink above recommended levels, contributing to social, economic and physical harm. The misuse of alcohol is therefore a concern to many of our public services including police, community safety, and social and mental health services which support individuals and families affected directly or indirectly by alcohol misuse. Furthermore, excessive alcohol consumption has a detrimental effect on local business due to sickness absence and lost productivity. Alcohol has therefore been highlighted by Surrey's Health and Wellbeing Board as a priority for action.

Our strategic approach to alcohol is set in the context of a society where both the availability and affordability of alcohol has recently reached an all time high. We therefore recognise that building and maintaining effective partnerships is fundamental to achieving a multi-faceted approach to supporting responsible alcohol consumption. This document builds on the successes achieved by a wide range of key stakeholders since 2009. The Substance Misuse strategy is owned and delivered by Surrey Substance Misuse Partnership ensuring all key partners are engaged. The strategy provides a framework for how the Substance Misuse Partnership will work with their partner agencies to implement innovative, evidence-based initiatives in order to respond to the needs of Surrey's residents, families and communities and tackle the inequalities caused by substance and alcohol misuse.

Our aim is to prevent and reduce the harm caused by alcohol to individuals, families and communities within Surrey. We will achieve our aim through activity across three strategic themes:

1. **Prevention and Early Identification**
2. **Treatment and Recovery**
3. **Safer Communities**

As a result of this we expect to see:

- Fewer alcohol related hospital admissions
- More people drinking in line with the recommended limits
- More front line health and social care staff trained to provide brief advice
- More people entering and successfully completing alcohol treatment
- A reduction in alcohol related crime

This document outlines the need for a multi-agency response to alcohol misuse; describes the national and local context and sets out the strategic approach. The launch of this strategy will be followed by an action planning process for each of the themes that will engage key stakeholders.

2. What is Alcohol Misuse?

Alcohol misuse means drinking excessively or more than the recommended limits for alcohol consumption. In the UK, the Department of Health has categorised types of drinking by level of risk, as shown in Table 1. One alcohol unit is equal to 10ml (in volume) or 8g (in weight) of pure alcohol. While it is not possible to say that drinking alcohol is absolutely safe, by keeping within the recommended guidelines, there is only a low risk of harm in most circumstances.

Table 1 Categories of drinking as defined by Department of Health[3]

	MEN	WOMEN
Lower Risk	Less than 14 units a week spread evenly across 3 or more days.	Less than 14 units a week spread evenly across 3 or more days.
Increasing Risk	15-49 units per week.	15-34 units per week.
Higher Risk	More than 50 units per week (or more than 8 units per day on a regular basis	More than 35 units per week (or more than 6 units per day) on a regular basis
Binge Drinking	Consuming more than twice the lower risk levels in one day (> 8 units)	Consuming more than twice the lower risk levels in one day (>6 units)
Alcohol Dependence	Drinking behaviour characterised by an inner drive to consume alcohol, continued drinking despite harm and commonly withdrawal symptoms on stopping drinking	

In January 2016, the Chief Medical Officer issued new alcohol guidelines 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.**

Alcohol Units

One problem with the national guidance on alcohol units is that many people are unaware of what a unit of alcohol is, how it translates into drinks and therefore how many units they consume. For instance, Surrey's Big Drink Debate (2009)[4] revealed that only 16% of respondents (n=645) were aware of the correct drinking guidelines. The images below show some common alcoholic drinks and the amount of units typically contained in each:

3 Units

PINT CIDER
ABV 5.3%

1.6 Units

RED WINE (125ml)
ABV 12.5%

1 Unit

SAMBUCA SHOT
ABV 42%

1.7 Units

BOTTLE OF LAGER
ABV 5.2%

3. Alcohol Misuse in Surrey

3.1 Alcohol Misuse in Adults

Public Health England (PHE) publishes national data on drinking behaviour annually in the Local Alcohol Profiles for England (LAPE). These profiles provide synthetic estimates of levels of drinking throughout the country. The most recent data shows the estimated prevalence of increasing risk drinking in adults (aged 16 and over) in Surrey is 21%, and the estimated prevalence for higher risk drinking is 6%.[1] These rates are similar to national figures, and equate to approximately 164,898 increasing risk drinkers and 50,498 higher risk drinkers in the county.[1] It is also estimated that 18% of adults in the county binge drink. This equates to approximately 164,546 people and is similar to the South East region but lower than nationally.[1]

Increasing risk drinking and higher risk drinking are most common in people aged 25-64.[5] Increasing risk drinking tends to be associated with affluence and it is thought that the biggest driver for changes in levels of increasing risk drinking nationally is the consumption of wine in more affluent subgroups of the population.[6] In contrast, higher risk drinking and binge drinking are associated with deprivation and binge drinking is more common in younger adults (16-24yr olds). In Surrey, it is those aged 35 years and over that present at hospital with alcohol-related health problems, as a result of drinking at increasing and higher risk levels for a sustained period of time.[7]

Local alcohol services are provided within a tiered framework and are delivered in a variety of settings, as shown in Table 2. The level of risk for an individual is assessed and a variety of interventions are delivered depending on the needs of the person. Structured treatment refers to specialised alcohol misuse treatment and care that is co-ordinated and planned. In Surrey, this level of intervention is delivered at tiers 3 and 4. There is currently no routine alcohol Identification and Brief Advice (IBA) commissioned at tiers 1 and 2 within primary healthcare and there is limited delivery of alcohol IBA at tiers 1 and 2 in non-health settings.

Table 2 Alcohol Interventions and Settings (Tiers 1-4)

Tier	Interventions	Setting
1	▪ Identification of increasing risk, higher risk / dependent drinkers ▪ Information on sensible drinking ▪ Simple brief interventions to reduce alcohol-related harm ▪ Referral of those with alcohol dependence or harmful drinking	Mainstream services i.e. Primary Care (GP Surgeries, Pharmacies) Secondary Care (Hospitals)
2	▪ Open access facilities and outreach ▪ Alcohol-specific advice, information and support ▪ Extended brief interventions to help alcohol misusers reduce alcohol-related harm ▪ Assessment and referral of those with more serious alcohol-related problems	Mainstream services or specialist alcohol services, Telephone Helpline, Arrest Referral
3	▪ Community based specialised alcohol misuse assessment, treatment and care that is co-ordinated and planned	Community based specialist alcohol treatment services
4	▪ Residential, specialised alcohol treatments with co-ordinated care planning to ensure continuity of care and aftercare	Residential specialist alcohol treatment and rehabilitation services

The treatment system in Surrey offers a range of interventions to individuals drinking at higher risk levels and those with alcohol dependence. Around 2% of the adult population in Surrey or an estimated 21,671 are moderately to severely dependent on alcohol and there were approximately 1400 clients[i] recorded in structured treatment for alcohol in 2013-14.[8,9]

There is limited data on drinking patterns among Surrey adults however national data on alcohol consumption suggests that there has been a significant increase in drinking within the home in recent years:

- Purchases of alcoholic drinks bought for consumption within the home in the UK increased by 38% between 1992 and 2002[10]
- The overall volume of alcoholic drinks purchased for consumption outside the home decreased by 46% between 2001 and 2011[10]
- Drinking within the home has increased and women are more likely to be home drinkers than men[11]

[i] Alcohol cited as primary drug of choice

- Adults who drink mainly at home report that they are aware that they run a risk of higher overall alcohol consumption but tend to play down the possibility that increased consumption may lead to longer-term harm.[12]

3.2 Alcohol Misuse in Children & Young People

There is clear evidence that children who start drinking at an early age are more likely to develop alcohol problems in adolescence and adulthood, and that those who begin drinking before age 13 are at the greatest risk of alcohol misuse later in life.[13] In addition, evidence shows that drinking before the age of 14 is associated with increased health risks, engagement in risk taking behaviours such as underage sex, having more sexual partners, use of drugs/substances, and involvement in violence and risky driving behaviours. Consequently, alcohol use at this age can result in teenage pregnancy, crime and disorder, and employment problems. Heavy drinking during adolescence may also affect normal brain functioning during adulthood. Parents and carers need to be aware of the relationship between their own drinking behaviour and alcohol use in their children.[14]

While there is limited data on drinking behaviour among children and young people in Surrey, a recent survey suggests there has been an increase in the number of secondary school children in Surrey reporting to have had an alcoholic drink. In 2012-13 a survey was carried out on the smoking and drinking behaviour of young people attending three of Surrey's secondary schools based in Runnymede, Reigate & Banstead and Mole Valley.[15] Over 50% (n=845) of children reported to have drunk alcohol and 13% (n=107) reported they had been drunk on three or more occasions in the past month. The most popular ways of obtaining alcohol was from parents (49%), friends (38%) and from home (25%). In order to improve intelligence available on health of young people, a new Health Related Behaviour Questionnaire is planned to be commissioned in all Surrey secondary schools from 2015-16. This will include questions on drinking behaviour, improving our understanding of the level of need within this population.

With regard to alcohol treatment, Surrey data from Quarter 4 2013-14 indicates that 56% (n=206) of clients aged under 18 within Substance Misuse Services were in

treatment for alcohol[ii]. This compares with 55% (n=19,298) nationally.[16] Of those clients aged under 18 in treatment for alcohol in Surrey, only 14% (n=28) had been referred into treatment from Accident and Emergency (A&E) departments.[17] This represents an opportunity to increase referrals of young people with alcohol misuse from acute hospitals into local treatment services.

3.3 Alcohol and Families

Parents and carers are the biggest single influence on outcomes for children and young people.[18] A positive parenting experience enables children to develop good emotional wellbeing and positive resilience through - a supportive and caring family; a safe and secure home; engaged parenting; promotion of tolerance and good behaviour; and promotion of optimism and positivity.[19]

Conversely, poor parenting contributes to poorer health, cognitive, emotional, educational and social outcomes among children and is also linked to child substance misuse related issues.

The quality of parenting may be compromised for particular groups of children, such as Looked After Children, Children in Need and Young People Leaving Care and those identified through the Family Support Programme. These groups of children may be at higher risk of childhood abuse, neglect, and exposure to other traumatic stressors known as Adverse Childhood Experiences (ACEs) and, as a result, more likely to develop alcohol and substance misuse issues.[20]

Parental alcohol or substance misuse can cause significant harm to foetal and child development, either directly through exposure to the toxins in utero (Fetal Alcohol Spectrum Disorders - FASD), or indirectly through its potential impact on parental capacity. The incidence of FASD in the UK is currently unknown, but it is associated with a multitude of long-term physical, cognitive and behavioural problems, including brain damage, facial deformities, intellectual disabilities, physical and emotional

[ii] Alcohol cited as 1st, 2nd or 3rd drug of choice in any episode in the year

developmental problems, memory and attention disorders. [21] Mental illness and drug and alcohol dependency may also develop as additional complications.

Alcohol misuse also increases the risk of parents becoming less loving, nurturing, caring, consistent or predictable which can negatively impact on a child's development. Children and young people may suffer a range of short and long-term problems as a result of living with a parent that has an alcohol problem including anti-social behaviour, emotional problems, poor school performance, poor relational development and alcohol and substance misuse.[22]

In 2013-14, 53% all adults (n=536) in treatment for substance misuse (including alcohol) were parents.[23] In addition, issues of parental alcohol misuse were recorded in 16% (n=197) of children on a Child Protection Plan at any one time between July and December in 2013.[24] Since over 25% of adults in Surrey that drink, do so above recommended levels, many children and young people are at risk of being affected by parental alcohol misuse in our county.

3.4 Alcohol and Health

Excessive consumption of alcohol significantly increases risk to long-term health. Alcohol is associated with more than forty serious medical conditions, including liver disease and mouth, bowel and breast cancer and is one of the major preventable causes of death in England.[25] In particular, liver disease, to which alcohol is a major contributor, is the only major cause of death still increasing year on year.[26]

Alcohol-Related Hospital Admissions in Surrey

Alcohol-related hospital admissions in Surrey have more than doubled since 2002.[1] This upward trend is evident across the region and the country as a whole, although the rate of increase has slowed since 2010. The rate of alcohol-related hospital admissions in Surrey has been comparable to the regional rate over the last decade, but lower than the national rate.[1] For instance in 2011-12, the rate of alcohol-related hospital admissions in England was 1974 per 100,000 population while the rate in the South East and Surrey were 1548 and 1532 per 100,000 population

respectively.[1] In addition, admissions to hospital due to alcohol in those aged under 18 in Surrey are significantly lower than in England.

By far the most common reason for alcohol-related hospital admissions in both men and women in Surrey is hypertensive diseases.[27] The second most common reason of alcohol-related hospital admissions is mental and behavioural disorders.

Surrey's Joint Strategic Needs Assessment (JSNA) on alcohol provides a full analysis of data on alcohol-related and alcohol-specific hospital admissions, alcohol-specific mortality, and mortality from chronic liver disease. The data shows that there is no evidence of significant variation between boroughs and districts in Surrey for any of these indicators, with the exception of alcohol-related hospital admissions.

Alcohol and Mental Health

Alcohol has a role in a number of conditions including anxiety, depression, psychiatric disorders and suicide.[28] Many people drink alcohol to help them cope with emotions or situations that they would otherwise find difficult to manage, and evidence shows that those who consume high amounts of alcohol are vulnerable to higher levels of mental ill health.[29] Alcohol misuse and mental ill health often co-exist (known as dual diagnosis) and some people use alcohol as a form of self-medicating to cope with symptoms of mental illness.

Good mental health and lower levels of mental illness, however, are associated with reduced health risk behaviours, including reduced smoking, alcohol and substance misuse.[30] There is clear evidence that wellbeing and resilience – that is the capacity of individuals and communities to deal with stress and adversity – are linked to the prevention of mental ill health and consequently lower levels of alcohol and substance misuse.[30] The development of good mental health, wellbeing and lifelong resilience to adversity is primarily dependent on positive parent–child or carer–child relationships which are fundamental to healthy emotional, social and cognitive development.[30]

In Surrey, there is limited data on the prevalence of alcohol misuse among those with mental ill health, however 20% (n=203) of clients in treatment for alcohol misuse in 2013-14 were recorded as dual diagnosis.[23] Moreover, qualitative feedback from

the consultation on the strategy indicated there is a need to improve the identification and treatment of clients with alcohol and substance misuse within mental health services, and that there is a need to improve referral pathways between substance misuse and mental health service providers.

3.5 Alcohol and Crime

Alcohol consumption contributes to crime and disorder such as violent crime, domestic abuse and drink driving , and thus has an impact on public safety. Alcohol-related crime and social disorder is estimated to cost UK taxpayers £11bn per year.[31] In 2010-11, there were almost one million alcohol-related violent crimes and the British Crime Survey 2009-10 revealed that victims believed the offender(s) to be under the influence of alcohol in half of all violent incidents.[32,33, 34]

Pre-loading, which involves drinkers consuming alcohol in private settings prior to attending nightlife venues, has been found to significantly increase total alcohol consumption during a night out and also doubles the chance of being involved in violence.[35] Whereas, the rate of crime attributable to alcohol in Surrey is significantly lower than the rate regionally and nationally, it still impacts significantly on community safety and the public purse.

Public perception of crime and disorder

Public concern about alcohol-related crime often relates to offences involving a combination of criminal damage offences, drunk and disorderly and other public order offences, often involving young males between 18 and 30 years of age, but increasingly involving young females.

Local data from Surrey County Council's Residents Survey over the last three years suggests that there has been a decrease in the percentage of people that perceive there to be a problem with drunk or rowdy behaviour in public places.[36] This may be a result of the economic downturn because people have had less disposable income to spend on alcohol, and drinking in late night establishments. It may also be due to the community safety work undertaken during the implementation of Surrey Alcohol Strategy (2009-12).

Alcohol and Domestic Abuse

Increasing risk and higher risk drinking is a major contributor to the occurrence of intimate partner violence, with both victims and perpetrators at greater risk of substance and alcohol misuse.[37] Female victims of domestic violence are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.[38] Furthermore, domestic abuse, alcohol/substance misuse and mental ill health often co-exist as factors in the complex issues facing individuals, families, children and young people. The actual prevalence of domestic abuse is likely to be much higher than the reported incidents.[39]

Drinking and Driving

While there was a 17% rise nationally in fatal drink-drive accidents between 2011 and 2012, the number of accidents in Surrey where at least one driver had a positive breath test has steadily declined since 2008.[40]

Alcohol Misuse among Prisoners

Rates of alcohol misuse among prisoners are considerably higher than in the general population:[41]

With five prisons within its boundaries, there is a significant need in Surrey relating to alcohol misuse among those entering prison. A full set of recommendations on the commissioning of alcohol services within prisons can be found within the JSNA on Health of Prisoners.[42]

Homelessness and those with no fixed abode

The links between substance misuse and homelessness are well established and drug and alcohol misuse can be both a cause and consequence of homelessness.[43] Often those that become homeless have experienced traumatic and chaotic lives and consequently have a series of complex needs around mental health problems, drug and alcohol dependency and offending.[43]

Alcohol-related mortality is also known to be high among homeless people with drug and alcohol abuse accounting for just over a third of all deaths in this group.[44] In Surrey, it is consistently recognised that it is a challenge to secure accommodation

for single people and couples with complex problems including alcohol/drug use, mental health problems and a history of offending.[45,46,47]

3.6 Alcohol and Inequalities

Alcohol consumption is strongly linked to health, social and economic inequalities:

- People who are employed are more likely to drink alcohol than their unemployed counterparts. They are also more likely to drink to increasing risk and higher risk levels. [48]
- Those on the highest income bracket are more likely to drink alcohol than those on lower incomes. They are also more likely to drink more frequently and above recommended limits.[49]
- Despite this, the negative impact of alcohol on health disproportionately affects the unemployed, manual workers, and those on lower incomes - people from deprived groups experience far greater health harm from alcohol than those from higher socioeconomic groups.[49]

In order to tackle these inequalities, this element of the strategy will need to address both the harm caused to individuals in the lower socioeconomic groups, as well as the harm to those in the highest socioeconomic groups. This will require targeting of alcohol-specific interventions and treatment at different sections of the populations, using the most effective approach appropriate to each group, while taking a universal approach towards the general population.

3.7 Financial Impact of Alcohol

Alcohol-related harm is now estimated to cost society in England £21 billion annually.[50] These costs can be broken down as follows:

- NHS costs, at about £3.5 billion per year (at 2009–10 costs)
- Alcohol-related crime, at £11 billion per year (at 2010–11 costs)
- Lost productivity due to alcohol, at about £7.3 billion per year (at 2009–10 costs, UK estimate)

According to modelling by the National Health Intelligence Service, alcohol is estimated to cost the NHS in Surrey over £73.5 million a year.[2] Table 3 provides a breakdown of the costs associated with different types of drinking. It shows that the highest level of cost is related to increasing risk drinking, reinforcing the need to prioritise interventions aimed at reducing alcohol intake within this population.

Table 3 Estimated cost of lower, increasing and higher risk drinking to NHS in Surrey (2012-13)[2]

Type of Drinking	Cost (£000s)
Higher risk drinking	14,006
Increasing risk drinking	45,720
Lower risk drinking	14,010
	73,736

4. National Context

Nationally, alcohol misuse places a huge burden on the NHS and other public services. In 2009-10, the number of hospital admissions due to alcohol misuse in England reached 1.1 million; a 100% increase since 2002-03.[1] If this rise continues, by 2015 1.5 million people will be admitted to hospital every year as a result of health problems associated with excess alcohol.[51] Moreover, alcohol dependence in the UK is significantly under-diagnosed and under-treated with only 6% of alcohol dependent patients aged 16–65 years receiving treatment each year.[52]

4.1 National Policy

The Government Alcohol Strategy, published March 2012, acknowledged the harms associated with current levels of alcohol consumption in England and set out six outcomes for addressing alcohol harm and reducing the number of people drinking to excess:[53]

- A change in behaviour so that people think it is not acceptable to drink in ways that cause harm to themselves or others

- A reduction in the amount of alcohol fuelled violent crime
- A reduction in the numbers of adults drinking above NHS guidelines
- A reduction in the number of people 'binge drinking'
- A reduction in the number of alcohol related deaths
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed

It originally proposed that these outcomes would be achieved through a range of methods including the introduction of a minimum unit price (MUP), banning the sale of multi-buy discount deals; zero tolerance of drunken behaviour in A&E departments; a late night levy to get pubs and clubs helping to pay for policing; and improved powers to stop serving alcohol to drunks. However, following consultation, the Government announced it would not be introducing an MUP or a ban on multi-buy promotions at this point. As a result, some local areas are taking steps to adopt their own approach to pricing and regulation using local levers.

The emphasis of the national strategy across all its domains from behaviour change, to enforcement, to investment, is on *localism*. The Government Alcohol Strategy asks local areas to take responsibility for decision making and work in partnership to give communities the information they need to hold local services to account. In addition, localities have been granted greater powers to reduce alcohol harm through the changes to Public Health, the introduction of Police and Crime Commissioners, and by rebalancing the Licensing Act (2003). Our challenge is to combine the steer from national policy with our own intelligence on local needs, into an effective strategy which successfully tackles alcohol-related crime and reduces health inequalities in Surrey.

In March 2011, the Government also launched the Public Health Responsibility Deal, the aim of which is for a network of partners from industry, local authorities and the public health community, to work together to improve public health. The Responsibility Deal is based around five core commitments and a series of collective pledges which partners voluntarily sign up to aimed at creating an environment that

empowers and enables people to make informed choices about leading healthier lives.

4.2 National Indicators and Key Guidance

There are a number of relevant national indicators, guidance documents and key drivers for alcohol that have influenced the development of the Alcohol Section summarised in Annex 1. These include indicators within the NHS and Public Health Outcomes Framework (2013-16), the Clinical Commissioning Group (CCG) Outcomes Indicators and targets within the Government Alcohol Strategy (2012). In addition, Annex 3 outlines the National Institute of Clinical Excellence (NICE) guidance which relates to alcohol and which has been used to inform the strategy.

5. Local Context

Alcohol-related harm affects many aspects of society and cuts across a number of agendas both within and outside Surrey County Council. The local context is therefore complex and action on alcohol needs to have a presence in a range of strategies and influence a number of partnership boards. Horizon scanning for both the drug and alcohol sections of this Substance Misuse Strategy is being published in an accompanying report. The document provides an overview of the key guidance drivers which align with the strategy and have influenced its development.

6. The Evidence Base

The National Institute of Health and Care Excellence (NICE) recognise that the most effective strategies are those which are delivered in partnership and take a multi-faceted approach towards influencing positive cultural, social, environmental and behaviour change.[54] In addition, the Department of Health has identified seven High Impact Changes which, if undertaken by NHS and local government, have the greatest impact on health commissioned outcomes for reducing alcohol-related harm.[55]

The emphasis should be on collective responsibility towards promoting, preventing and protecting the population from harm and on addressing the underlying socio-economic and wider determinants of health and inequalities. For this reason, our strategic approach to alcohol is aligned with three key domains which encompass prevention, early identification, treatment, recovery, enforcement and regulation. Since the primary reason for the increase in alcohol-related harm within society is due to the increased availability and affordability of alcohol, long-term success at a local level will only be achieved if population measures to reduce the availability and affordability of alcohol are introduced on a national scale. Evidence indicating that this is the most effective approach to reducing alcohol harm is unequivocal.[56,57,58]

There is also clear evidence that investment in alcohol services and alcohol-specific interventions for adults is highly cost-effective and improves health outcomes. For every £1 spent on rigorous, evidence-based alcohol interventions, £3 is saved.[51] In addition, for every £1 invested in specialist alcohol treatment, £5 is saved on health, welfare and crime costs.[52]

A summary of the best available evidence for each strategic theme is provided in the following section.

6.1 Prevention and Early Identification

Adults

Knowledge and Awareness

Delivery of clear, consistent messages regarding alcohol is essential for prevention and education among adults. Alcohol campaigns are an integral part of increasing awareness of the risks of excess alcohol and promoting healthier attitudes towards drinking. NICE recommend that for alcohol campaigns to be effective they must be part of a multi-faceted strategy or policy delivered in partnership and should be informed by social marketing techniques reflecting local need.[59]

Communication of targeted messages at specific groups, in line with NICE guidance, is also necessary for prevention of alcohol harm. For instance, FASD are completely

preventable through the elimination of drinking during pregnancy.[21] Pregnant women and women planning to become pregnant should therefore be advised to avoid drinking alcohol in the first three months of pregnancy, because there may be an increased risk of miscarriage and FASD. Women should also be advised that if they choose to drink alcohol after the first trimester, they should drink no more than 1-2 UK units once or twice a week and should not get drunk or binge drink while they are pregnant because of the harm this can cause their unborn baby.[60]

Since the number of people drinking at home over recent years has increased and there is evidence that people downplay the risks associated with this, it is of concern that alcohol education and strategies typically focus on drinking outside of the home, in younger age groups and on binge and problem drinking.[11] There is a need to ensure that prevention and education is aimed at those drinking in the home and on habitual drinking where middle-aged and older-aged adults may regularly be exceeding daily and weekly recommended limits.

NICE quality standards (QS) are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They are developed independently by NICE, in collaboration with health and social care professionals, their partners and service users.

NICE QS for alcohol dependence and harmful alcohol use identifies the need for appropriate alcohol awareness training in health and social care:[61]
Statement One: Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

Early identification and brief advice

Delivery of identification and brief advice (IBA) / brief interventions has been shown to be one of the most effective approaches to helping people drinking at increasing and higher risk levels to reduce their drinking to lower risk.[62] Health and social care professionals have a key role in delivering such interventions and making appropriate referrals to specialist services. Historically, alcohol IBA has been

delivered within primary care, but there is increasing evidence of its effectiveness in other settings including A&E departments, pharmacies, schools, social care and the criminal justice system. As such, NICE has recommended widespread implementation of early IBA in a range of health and social care settings, in particular within General Practice and through Alcohol Liaison Nurses based within hosptials.[59] Early identification of alcohol misuse among vulnerable groups such as pregnant women, prisoners/offenders, those with mental health issues/dual diagnosis, victims and perpetrators of domestic abuse, homeless people, and Lesbian, Gay and Bisexual (LGB) individuals is necessary to reduce the associated inequalities.

NICE QS for alcohol dependence and harmful alcohol use identifies the need to delivery alcohol IBA within health and social care:[61]
Statement Two: Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice.

Integrated care pathways

Integrated care pathways (ICPs) are structured multidisciplinary care plans which outline essential steps in the care of patients with a specific clinical problem. They are used to translate national guidance into local protocols and clinical practice, in order to promote more efficient patient-centred care. Furthermore, they are used to reach or exceed existing standards, improve communication and care planning, and decrease inconsistencies in practice.[63] In Surrey, there is an opportunity to develop a system-wide ICP and to ensure that services provided are truly seamless.

Children and Young People

Knowledge and Awareness

The Chief Medical Officer advised children, parents and carers, that an alcohol-free childhood is the healthiest and best option. If children do drink, it should not be before the age of 15. NICE recommend that a 'whole school approach' is taken to alcohol so that alcohol education is integrated within the Personal, Social and Health Education (PSHE) curriculum in line with Department for Education (DfE) guidance. NICE also recommends that teachers, school nurses and school counsellors should

offer one-to-one brief advice on alcohol and provide referral to external services where appropriate.[59] Due to the relationship of alcohol with other risk-taking behaviours (smoking, drugs, and sexual health), provision of targeted and universal prevention and education measures on alcohol within schools should form part of a holistic approach to improving health and wellbeing among young people. This should include education on the risks of drinking during pregnancy and the links with FASD. There is also a need to educate parents on the risks of underage drinking and offer them alcohol-specific support to improve their capacity to tackle their own child's consumption, for instance through opportunities to access local parenting programmes.

Early Identification and Brief Advice

Children and young people aged 10 to 15 years who are thought to be at risk from their use of alcohol should be given support by any professional with a safeguarding responsibility for children and young people and who regularly comes into contact with this age group.[59] Identification and brief advice should be delivered by health and social care, criminal justice and community and voluntary professionals in both NHS and non-NHS settings to young people aged 16 and 17.[59]

6.2 Treatment and Recovery

Adults

Alcohol treatment is highly cost effective and should involve a range of behavioural, psychological or pharmacological interventions delivered by specialist alcohol services, and complemented by mutual aid, such as Alcoholics Anonymous and SMART recovery groups. Interventions may or may not involve complete abstinence, but should depend on the patient's own goals, developed with the support of a specialist. [64] Evidence shows the quality of treatment has an impact on recovery outcomes and should ideally be person-centred, optimistic, designed to help in a number of outcome domains, well-managed, and delivered by a skilled workforce.[65]

Nationally, there is a lack of diagnosis of alcohol misuse and treatment provision for alcohol dependent patients. This reflects the absence of early identification in primary care and other settings and therefore referrals into treatment services. In addition, there is often a long delay between people developing alcohol dependence and seeking help.[64] In 2010, Alcohol Concern reported that in order to provide 15% of dependent drinkers with alcohol treatment – or 'medium level access' recommended by NICE - current national expenditure on alcohol treatment would need to be doubled.[52] This investment would yield an estimated cost saving of £1.7 billion for the public sector.[66]

NICE QS for alcohol dependence and harmful alcohol use identifies the need for access to specialist alcohol treatment:[61]
Statement Three: People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

Our challenge will be to work towards increasing capacity within our treatment services in line with NICE guidance, which is to ensure at least one in seven dependent drinkers can access treatment locally.[59] Our initial objective is to ensure that at least 9% of dependent drinkers in Surrey can access appropriate alcohol interventions via our treatment services, which will indicate the successful delivery of an effective Integrated Care Pathway. The development of an Integrated Care Pathway should ensure that carers, young carers and family members of those who misuse alcohol, are identified and signposted to appropriate support as part of this pathway.

NICE Quality Standard regarding support for families and carers of people who misuse alcohol is identified in Statement Seven:[61]
Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

Children and Young People

Children and young people aged 10 to 15 years who are thought to be at risk from their use of alcohol should be given support by any professional with a safeguarding responsibility for children and young people and who regularly comes into contact with this age group.[59] As with adults, extended brief interventions should be delivered in both NHS and non-NHS settings to young people aged 16 and 17.[59] Specialist drug and alcohol treatment for young people (under 18s) is associated with reduced drug and alcohol consumption, reduced crime, reduced numbers not in education, employment or training (NEET), improved educational outcomes, and improved wellbeing.[67] The immediate and long-term benefits of specialist substance misuse treatment for young people therefore significantly outweighs the cost of providing the treatment. It is estimated that for every £1 for spent on young people's drug and alcohol treatment, between £4.66 and £8.38 is saved.[67] Our task will be to ensure sufficient investment is sustained in current alcohol treatment services for children and young people and that these continue to meet the needs of the local population.

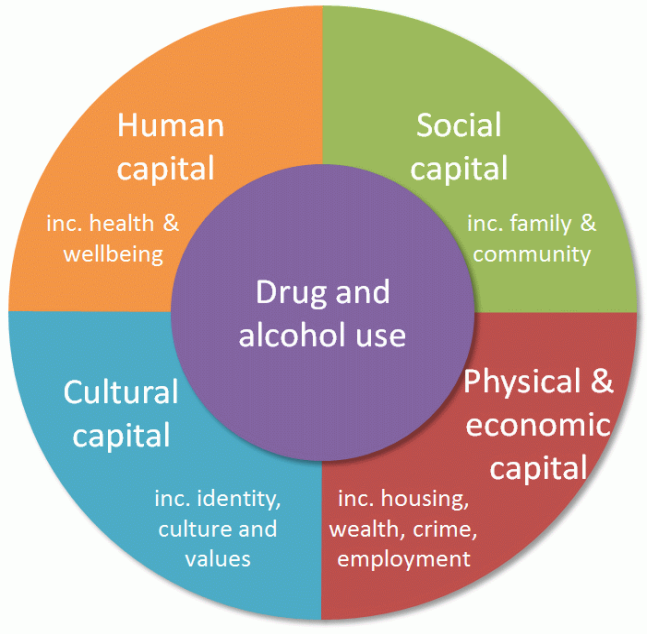
Recovery

Recovery has typically been described as a process which encompasses the overcoming of alcohol dependence, plus maximising of health, wellbeing, social integration and contribution to society.[65] The recovery process requires an individual to achieve or maintain outcomes in a number of interrelated domains – not solely abstinence from or control of alcohol and/or drug use. Recovery therefore involves working towards, and hopefully achieving, positive outcomes in a range of other recovery capital domains including having positive relationships, a sense of wellbeing, a meaningful occupation and adequate housing.[65]

Figure 1 shows that the four key recovery domains identified by Granfield and Cloud (2001) are: social capital outcomes (support and obligations related to family and group relationships); human capital outcomes (health and wellbeing, aspirations, educational achievements etc.); physical capital outcomes (tangible assets such as

property and money); and cultural capital outcomes (values, beliefs and attitudes linked to social conformity and the ability to fit into dominant social behaviours).[65]

Figure 1 Recovery Outcome Domains



As such, changes in the recovery capital in one domain may have either a positive or negative impact of recovery capital in other domains. Therefore, overcoming alcohol dependence and achieving sustained abstinence/control requires development and maintenance of capital across all the recovery domains. The implication of this is that alcohol treatment services must be 'recovery-oriented' by seeking to build capital across the range of domains; and communities must be recovery-oriented by offering a supportive environment in which to 'recover', for instance through the provision of a range of mutual aid groups and social networks.

International evidence indicates that:[65]

- Families or partners may hinder recovery (if they are dysfunctional or have dependence issues themselves) or aid recovery (if they are supportive)
- Supportive local communities can enable recovery.
- Involvement with mutual aid can significantly improve recovery outcomes, with most evidence based on the study of 12-step fellowships in the USA.

- Some factors, including more active or frequent involvement and becoming a 12-step sponsor, are associated with greater improvement in outcomes.
- Active encouragement to engage with mutual aid enables better outcomes, though coerced involvement is not beneficial.
- There is an 'identity shift' for many people in recovery from being a 'drinker', to being someone who is abstinent or has 'normal patterns' of use, to achieve sustained recovery.
- Building of non-substance-using family and social support networks is crucial to recovery and there is higher cultural fertility for recovery and abstinence in some countries than in others.
- Stigma in local communities can adversely impact on recovery outcomes and, in particular, can discourage those with dependence from seeking help, and can inhibit their chances of employment and social re-integration.

NICE recommends that all people seeking help for alcohol misuse should be given information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and encouraged to participate in community support networks and self-help groups by attending meetings and arranging support so that they can do so.[64]

6.3 Safer Communities

The Role of Alcohol Licensing

Effective licensing is a key aspect of addressing alcohol harm. It has been suggested that the increased availability of alcohol in the UK has largely been driven by licensing practice which has focused on pubs and bars. As a result, shops and supermarkets now dominate alcohol sales and pre-loading is now commonplace along with binge drinking and the associated crime and disorder.

In order to address this, Public Health need to contribute to the licensing process which should seek to control the overall availability of alcohol, as well as the effects of drunkenness. In April 2012, health authorities were given a statutory role in licensing, under the Police Reform and Social Responsibility Act (PRSA) 2011. Directors of Public Health (DPHs) now have a statutory duty as a 'responsible authority' within the Licensing Act 2003.

Our task will be to actively encourage the use of this new power, drawing on A&E assault data, hospital admission data, ward level and other health data, where appropriate, in order to influence alcohol licensing within the county. In addition, we need to ensure local partnerships consider public health in their licensing decisions, reduce the availability of alcohol and enforce legislation preventing the sale of alcohol to people who are already drunk.

NICE recommend that resources are made available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is the illegal purchase of alcohol for someone who is under-age or intoxicated), and non-compliance with any other alcohol licence condition/ illegal imports of alcohol.[59] Test purchases (using 'mystery' shoppers) should be used to:

- help ensure compliance with the law on under-age sales
- to identify and take action against premises where sales are made to people who are intoxicated
- in the event of a refusal, assist in understanding the cause of any complaints e.g. those illegally purchasing alcohol for others.

Finally, sanctions should be fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases.

In Surrey, advisory visits to businesses, based on Trading Standards' guidance (www.surreycc.gov.uk/agerestrictedsales) are used to implement the above measures and assist traders in understanding their obligations to protect children from harm, which helps ensure compliance throughout the system. Test purchases are made on an intelligence led basis, and where advice has been given.[iii] In addition, responses to the consultation on the strategy suggest there is a need to work with local alcohol retailers including supermarkets to reduce the visibility of alcohol off-trade, and explore ways to ensure responsible retailing of alcohol and restricted promotions.

Minimum Unit Pricing

[iii] Surrey Tading Standards welcomes information at tsintelligence@surreycc.gov.uk. Members of the public can also call 08454 040506 to report sales of alcohol (or any other age restricted product e.g. Tobacco) to children.

Introduction of a Minimum Unit Price (MUP) is recognised as one of the most effective interventions for reducing alcohol harm. Research undertaken by the University of Sheffield indicates the following:[68]

- Effects on health are estimated to be substantial with deaths are estimated to reduce by 48 per annum within the first year and a full effect after 10 years of 374.
- Illness also decreases with an estimated reduction of 1,000 acute and 400 chronic cases within year 1.
- Hospital admissions are estimated to reduce by 1,900 in year 1, and a full effect after 10 years of 10,600 avoided admissions per annum.
- Healthcare service costs are estimated to reduce by £8m in year 1, with a Quality Adjusted Life Years (QALY) gain valued at £21m.

In addition, NICE indicate that an MUP (unlike a tax increase) would prevent retailers from passing on any increase to producers, or absorbing it themselves. It would also encourage producers to reduce the strength of products. As an example of the effect of minimum pricing, over a 10-year period it is estimated that a 50p minimum price per unit would reduce the cost of alcohol-related problems by £9.7bn.[59]

In the absence of a nationally mandated MUP, some local councils are introducing local MUP policies and banning sales of high strength alcohol. For instance, in 2013, Newcastle City Council requested that all new licensing applications and variations include a voluntary condition to not sell alcohol at below 50 pence per unit. Premises that do not agree to the condition, and are associated with alcohol-related problems such as anti-social behaviour, have a license review instigated by the council. Several other councils are considering employing such legislation in an attempt to reform the environment within which alcohol can be bought (namely off-licences), and its affordability. While there is a lack of evidence base around this particular approach, it is reasonable to assume that any significant price changes should have some effect at local level, however demonstrating this in smaller populations would be very difficult.

Alcohol Interventions in the Criminal Justice System

Drug treatment systems are an essential component of healthcare in most prisons and commissioners are urged to ensure their effective implementation. All local prisons should provide detoxification for drugs and alcohol following evidence-based protocols. The expected outcomes of Her Majesty's Chief Inspectorate of Prisons (HMCIP) are that prisoners with substance related needs (including alcohol) are identified at reception and receive effective treatment and support throughout their stay in custody. All prisoners should be safe from exposure to and the effects of substance use while in prison.[69] Our challenge will be to work in partnership with NHS England Area Team to ensure that all prisoners in Surrey receive drug and alcohol interventions and treatment in line with the evidence-base and guidance on best practice.

NICE guidance specifically on domestic abuse provides comprehensive information and recommendations on how health services, social care and the organisations they work with can respond effectively.[70] This guidance includes the need to provide all substance misuse staff with appropriate domestic abuse training, the need for routine screening for domestic abuse within substance misuse services, and the need for clear pathways between specialist substance misuse and domestic abuse outreach services.

7. Strategy into Action

Addressing alcohol harm as a shared priority is the most effective way to bring about change and can have a significant impact on achieving efficiencies for all partners. By taking an innovative, integrated approach and using the expertise and resources of different agencies it is possible to jointly design and commission services which may better meet the needs of the local population and are able to have a real impact on reducing unnecessary spend. As discussed, a whole range of organisations are involved either directly or indirectly in addressing the impact of alcohol. Working effectively in partnership will allow us to address the wider determinants of alcohol harm. Annex 2 outlines the main stakeholders and provides an overview of their responsibilities in delivering alcohol agenda. Annex 3 shows that, along with Public

Health, the impact of alcohol affects every single department within the County Council.

Governance and Accountability

As per the Health & Social Care Act (2012), Surrey County Council holds overall responsibility for the success of the Substance Misuse Strategy through the Director of Public Health. Overall delivery of the Alcohol Section will be governed by the Surrey Community Safety Board (CSB). The CSB will provide strategic leadership, accountability and scrutiny, and will oversee the work programme of the Substance Misuse Partnership Group. The Substance Misuse Partnership Group will be accountable to the CSB and responsible for coordinating implementation to ensure that successful delivery is achieved across all three of the strategic themes. The Alcohol Section is also aligned to the Prevention Priority within Surrey's Health and Wellbeing Strategy and the Director of Public Health will be responsible for informing the Health and Wellbeing Board on delivery and progress.

The Alcohol Section of Surrey's Substance Misuse Strategy is owned by the Surrey Substance Misuse Partnership Group. The role of the partnership is to develop and deliver the Surrey Substance Misuse (drugs and alcohol) Strategies. The terms of reference for this group include:

- Report directly to the Community Safety Board on a quarterly basis.
- Ensure the delivery of the relevant sections of Surrey's Joint Strategic Needs Assessment (JSNA) and make certain this steers the development and delivery of local strategies.
- Develop and deliver Surrey's Substance Misuse Strategy (2014-17) through inter-agency coordination and alignment of priorities.
- Produce an annual substance misuse treatment and recovery plan for adults and young people.
- Coordinate and align recovery orientated interventions across communities including criminal justice settings.

Opportunities in Surrey

Surrey's Joint Strategic Needs Assessment (JSNA) on alcohol provides comprehensive information on the needs of the local population with regard to alcohol. The data suggests that, despite clear national guidance, there are currently large gaps in service provision and standards of care relating to alcohol locally, particularly regarding limited provision of early identification and brief advice.[71]

As such, the JSNA has been used to inform the strategy's development, taking into account the prevalence and type of alcohol misuse locally, individuals and groups most vulnerable to alcohol misuse and in greatest need, current level and range of service provision, and gaps in delivery. The document also describes in detail a number of opportunities that have been identified to build on our existing work and improve provision of alcohol interventions.

7.1 Strategic Aim

The overall aim of the alcohol section is to prevent and reduce the harm caused by alcohol to individuals, families and communities within Surrey.

Indicators and Outcomes

The following key indicators and outcomes will be used to measure the success of the strategy:

- 100,000 adults aged 18+ per year screened to determine their alcohol consumption
- 15% of increasing and higher risk drinking aged 40-74 identified offered brief advice
- A reduction in alcohol-related hospital admissions
- A reduction in alcohol-related crime
- A reduction in the number of children and young people under the age of 18 reporting to drink alcohol
- A minimum of 9% of alcohol dependent individuals accessing treatment in Surrey

- An increase in the number of alcohol dependent patient who successfully complete treatment and do not represent for treatment within 6 months [iv]
- An increase in referrals from Accident and Emergency Departments to 10% of all referrals into young people treatment

7.2 Strategic Themes and Objectives

Based on the local epidemiological information and intelligence on needs, along with the national priorities and guidance on the most effective ways to reduce alcohol harm, the objectives have been aligned to the following three strategic themes:

Prevention and Early Identification

We aim to ensure that all children and young people receive alcohol education in school, and that parents and carers are supported to address drinking in children and young people. We will work to ensure that the risk of alcohol harm during pregnancy is communicated appropriately to all. We will promote healthy attitudes towards alcohol and encourage individuals to drink less through a range of prevention, education and health improvement methods. This will include highlighting the risks of excess alcohol and the benefits of drinking within the recommended limits, and empowering and enabling people to make an informed choice about their drinking behaviour. We will establish system-wide opportunistic screening and brief advice in order to identify those drinking above recommended levels at an early stage and support them to reduce their drinking. In addition we will ensure those drinking at dependent levels are identified and referred to specialist treatment services.

Objectives

- To deliver an annual alcohol campaign targeted at our priority groups and most vulnerable individuals and communities, and which supports national campaign messages where appropriate
- To ensure high quality information is available on drugs and alcohol
- To increase the number of people who receive alcohol identification and brief advice

[iv] figure to be agreed when more robust data becomes available in November 2014

- To increase and improve intelligence on alcohol use in children and young people
- To deliver universal alcohol education within Surrey schools and targeted support for schools in areas of greatest need
- To reduce the number of children who report drinking alcohol and being drunk

Treatment and Recovery

We will ensure that recovery-oriented specialist alcohol treatment is available and accessible to all who need it. We will work to increase the capacity of our treatment services and improve uptake and outcomes of those who engage by developing an Integrated Care Pathway for alcohol. We will ensure that those affected by alcohol misuse, including carers and family members, have access to health and social care services appropriate to their needs and will work in partnership to develop communities which foster recovery for those with alcohol dependence.

Objectives

- To increase availability of and access to specialist alcohol treatment services
- To increase the number of clients who successfully complete treatment[v]
- To increase referrals made from hospitals and Accident and Emergency departments into treatment services for adults and young people
- To develop and deliver an Integrated Care Pathway for alcohol to ensure that those in need of help, including carers, young carers and family members, are identified and signposted to appropriate support as part of this pathway
- To improve pathways between drug and alcohol, mental health and domestic abuse services
- To increase the number of prisoners who receive alcohol identification and brief advice and treatment

[v] (figure to be agreed when more robust data becomes available in November 2014)

Safer Communities

We will protect the public from the effects of alcohol-related criminal and anti-social behaviour through effective enforcement and regulation. We will create a safe environment in Surrey through responsible retailing and a targeted, proactive approach to community safety and alcohol licensing. We will target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol. We will improve the planning and management of the night-time economy and work together to reduce alcohol-related violence within our town centres, neighbourhoods and homes.

Objectives

- To reduce the level of crime, violence and anti-social behaviour where alcohol is a factor
- To improve the quantity and quality of assault data collected and shared by Accident and Emergency departments and initiate data collection by ambulances where possible
- To reduce the percentage of people who perceive there being a problem with drunk or rowdy behaviour in public places within their neighbourhood
- To undertake 100 intelligence-led underage sales interventions[vi]
- To develop a process to incorporate the impacts on public health into licensing practice
- To ensure that all clients referred to alcohol and substance misuse services are screened for domestic abuse and referred to specialist domestic abuse outreach services/ Multi-Agency-Risk-Assessment-Conference (MARAC) as appropriate
- To ensure that all alcohol and substance misuse services have safeguarding policies and procedures in place for both adults and children

[vi] (includes test purchasing and advisory visits)

7.3 Strategic Principles

The following strategic principles will underpin the delivery of our strategy and are required for its success:

Working in partnership

We are committed to delivering the strategy in partnership through multi-agency joint working in order to maximise the impact on reducing alcohol harm in Surrey.

Localism

We will ensure that the strategy reflects the Surrey-wide local needs, and will support boroughs, districts and CCGs to adapt and deliver the strategy to reflect the needs in their local area.

Proportionately targeting the most vulnerable

We are committed to targeting activity towards our most vulnerable individuals and groups in line with Marmot's notion of proportionate universalism, in particular where higher levels of alcohol-related harm exist in areas of greatest deprivation.[72] This principle involves targeting the strategy at the following broad sub-groups:

1. Those who are more likely to drink above recommended levels
2. Those who are most likely to suffer from alcohol-related harm
3. Those who are most likely to cause harm to or have a negative impact on others as a result of their drinking behaviour

Based on the evidence of local needs, the following six specific groups have been identified as priorities for action:

1. **Individuals drinking at increasing risk levels**
2. **Individuals and families with complex needs (ie those with mental health and alcohol issues combined, victims/perpetrators of domestic abuse)**
3. **Children (under 18s)**
4. **Those in the criminal justice system**
5. **Homeless people and those with no fixed abode**
6. **Pregnant Women**

Needs-led

We will ensure our action is informed by a comprehensive understanding of the needs of individuals, families and communities by undertaking an annual Joint Strategic Needs Assessment

Evidence-based

We are committed to delivering evidenced-based, equitable alcohol interventions aimed at reducing inequalities.

Inclusive and Integrated

We will seek to include all stakeholders (individuals, groups, organisations) in the development and delivery of the strategy and will ensure that an integrated, collaborative approach is taken at all levels

Customer-focused

We will listen to our service users and the local community to develop locally appropriate interventions

Sustainable

We will focus our efforts and invest our resources in interventions which are sustainable and that will have a long-term impact on reducing alcohol harm

Accountability

We will foster relationships with a shared vision and mutual understanding, ensuring that all partners signed-up to the strategy are committed to its delivery

8. Delivering our Priorities

In order to achieve our objectives, detailed action plans will be developed in partnership, which seek to build on new and existing areas of work. These action plans will be informed by the evidence base, national strategies and guidance, and the locally-identified need outlined in the JSNA. Implementation of a range of population measures aligned to each objective will be necessary to achieve a sustained reduction in alcohol harm. Annex 4 outlines some of the measures this

may include. In addition, we will update the JSNA on alcohol annually which reflects need across the whole spectrum of alcohol-related harm and ensures that our strategic priorities accurately reflect the emerging needs of the local population. We will ensure investment is sufficient for a range of alcohol harm reduction services across primary prevention, early intervention and specialist treatment that is commensurate with the level of identified need.

Next Steps

Following the launch of the strategy, co-design workshops and planning sessions will be held, inviting stakeholders to engage in developing robust delivery plans. In addition, implementation groups will be established formed of representatives from Surrey Substance Misuse Partnership and from other key agencies where appropriate.

Table 4 broadly outlines the activities which will be prioritised during the course of the three year strategy.

Table 4 Delivery Priorities for Alcohol Section

Year	Delivery Priorities
2014/15	Establishing Tiers 1 and 2 alcohol IBA Re-commissioning of specialist drug and alcohol treatment services Increasing capacity within the treatment system
2015/16	Establishing Tiers 1 and 2 alcohol IBA Developing an Integrated Care Pathway for alcohol Developing a licensing process to incorporate the impacts on public health
2016/17	Improving alcohol education in schools Delivering an Integrated Care Pathway for alcohol Increasing alcohol treatment and support within prisons

9. Annexes

ANNEX 1 National Indicators for Alcohol

	Indicator
NHS Outcomes Framework: 2014-15	• 1.3 Under 75 mortality rate from liver disease. • 2 Health related quality of life for people with long-term conditions. • 4.9 Improving people's experience of integrated care
Public Health Outcomes Framework: 2013-16	• 2.10: Self-harm. • 2.15: Successful completion of drug treatment. • 2.16: People entering prison with substance dependence issues who are previously not known to community treatment. • **2.18: Alcohol-related admissions to hospital.** • 4.6i: Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population. • 4.6ii: Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population.
Government Alcohol Strategy: Ambitions	• Reduction in the amount of alcohol-fuelled violent crime. • Reduction in number of adults drinking above the NHS guidelines. • Reduction in number of alcohol-related deaths.
CCG Outcomes Indicator Set: 2014-15	• C1.3 Reducing premature mortality from the major causes of death: cardiovascular disease ○ Cardiac Rehabilitation Completion • C1.7 Reducing premature mortality from the major causes of death: liver disease ○ Under 75 mortality rate from liver disease • C1.8 Reducing premature mortality from the major causes of death: liver disease ○ Emergency admissions for alcohol-related liver disease • C3.14 Improving recovery from mental health conditions ○ Alcohol: admissions • C3.15 Improving recovery from mental health conditions ○ Alcohol: readmissions

NHS Health Checks	• From April 2013, an alcohol check will be included for all people attending a NHS Health Check. In patients who's AUDIT score is high and indicates that they may possibly be dependent on alcohol, the NHS Health Check practitioner or the GP should consider and discuss with the patient a referral to local specialist services for appropriate assessment and treatment.
Alignment with QIPP	• Quality: Reduction in number of adults drinking above the NHS guidelines. • Reduction in number of alcohol-related deaths. • Prevention: Alcohol related harm. • Productivity: Reduction in alcohol related hospital admissions. • Alcohol contributes to absenteeism, accidents in the workplace and decline in work performance (NICE CG115).

National Institute of Clinical Excellence (NICE) guidance on alcohol:

- Alcohol disorders – preventing the development of hazardous and harmful drinking. NICE public health guideline 24 (2012)
- Alcohol dependence and harmful alcohol use. NICE clinical guideline 115 (2011)
- Alcohol dependence and harmful alcohol use quality standard. Quality standard 11 (2011)
- Alcohol use disorders: physical complications. NICE clinical guideline 100 (2010)
- School based interventions on alcohol. NICE public health guideline 7 (2007)
- Antenatal Care. NICE clinical guideline 62 (2010)

ANNEX 2

Key Stakeholder Involvement and Responsibilities in Alcohol Harm Reduction

Stakeholder	Involvement
Health Services Surrey County Council Public Health, Clinical Commissioning Groups, NHS Local Area Team, Acute Trusts, GPs, Community pharmacies, Ambulance Services, Mental Health Services, Maternity Services, Alcohol Treatment Services	Commission and provide health services to prevent, reduce and treat health problems which are directly or indirectly related to alcohol. Seek to promote and improve the health and wellbeing of the local population and ensure services are accessible and available to all.
Police, Probation, Prison Office of the Police and Crime Commissioner	Prevent, manage and reduce crime, anti-social behaviour, domestic violence, and drink-driving where alcohol is a factor. Responsibilities include alcohol enforcement licensing and provision of support to offenders to help them engage with alcohol treatment and recovery.
Borough and District Councils Community Safety, Licensing, Housing, Policy	Responsibilities of boroughs and districts include community safety, licensing, housing and policy. In particular, involvement of boroughs and districts in Community Safety Partnerships is key to tackling local issues relating to alcohol.
Education Providers Schools, Colleges, Universities	Primary and secondary schools are responsible for delivering alcohol education and should take a 'whole school' approach to alcohol. Colleges and universities are key settings for disseminating campaign messages and general alcohol information.
Housing Providers	Housing can play a key role in helping people to tackle their substance misuse. A lack of housing and support can at best render treatment ineffective and at worst unusable or inaccessible.

Charities and Voluntary Organisations	Local charities and voluntary organisations play a vital role in supporting individuals with substance misuse and alcohol issues, for instance through treatment, telephone help or mutual aid groups.
Alcohol Industry	Alcohol industry partners have a role in promoting and encouraging responsible drinking and ensuring and working in partnership with the police to establish a safe night-time economy.
Pharmaceutical Industry	The pharmaceutical industry has a general role in working in partnership to address alcohol harm. It may offer medications licenced for alcohol dependence, or drugs which assist with long term conditions or illnesses caused by alcohol harm. Under Association of the British Pharmaceutical Industry and Department of Health Joint Working Guidance, this industry may offer a useful partner to assist in projects that help support service improvements, service redesign, health and wellbeing education campaigns, healthcare professional training and other health and wellbeing programmes. Please see http://www.abpi.org.uk/our-work/library/guidelines/Pages/joint-working-handbook.aspx
Service Users	Service user involvement is one of the most important measures and determinants of quality in public health planning and delivery. This involves a partnership between commissioners and service users which is key to improving quality and outcomes of substance misuse and alcohol services.

Academic Health Science Network (AHSNs) and Strategic Clinical Network	Improve patient outcomes around alcohol by influencing and supporting clinical excellence and disseminating best practice. AHSNs align education, clinical research, informatics, innovation, training and education and healthcare delivery. Their goal is to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems. Strategic Clinical Networks focus on priority service areas to bring about improvement in the quality and equity of care and outcomes of their population, both now and in the future.

ANNEX 3

Impact of Alcohol on Surrey County Council Departments and Directorates

Directorate	Department	Impact
Chief Executive	Public Health	Lead commissioner of specialist alcohol treatment services for Surrey population – both adults and children. Strategic lead on Surrey Substance Misuse Strategy (2014-17)
Adults and Communities	Social services, home care, protecting adults, carers support, rehabilitation, care homes, supported housing, community meals, libraries, fire services	Responding to and supporting adults who are affected by alcohol misuse; looking after and supporting children living with parents suffering as a result of alcohol misuse
Housing, Community Safety and Regeneration	Youth justice, neighbourhood policing, antisocial behaviour, trading standards, and licensing	Alcohol is a major factor in community safety, and is perpetually related to adult and youth offending
Children and Young People's Services	Children and family services such as Education (including special needs), child protection, youth activities, teenage pregnancy, adoption, and fostering	Prenatal alcohol is associated with Fetal Alcohol Syndrome Disorders (FASD). Parental alcohol misuse is associated with poorer health, cognitive, emotional, educational and social outcomes among children. This may have an impact on social care system. Alcohol use in young people can lead to teenage/unwanted pregnancies and Sexually Transmitted Diseases

Corporate Resources	Democratic services, councillors, council meetings, human resources, procurement, finance, freedom of information, corporate complaints, public relations	Alcohol misuse costs businesses. Alcohol misuse contributes to absenteeism and reduced productivity. Alcohol misuse can also affect the reputation of local organisations
Environment and Transport	Construction and maintenance of roads, parking, road safety, recycling campaigns, recycling/ waste sites, public transport and environment	Alcohol causes drink driving accidents and deaths. There are significant costs associated with cleaning up town centres and recycling/rubbish generated by alcohol-fuelled nights.

ANNEX 4 Interventions to Reduce Alcohol Harm across the Strategic Themes

Strategic Theme	Interventions / Actions
Prevention and Early Intervention	Developing alcohol Prevention Plans aligned with Surrey's Health and Wellbeing Strategy for CCGs and boroughs and districts Initiating data collection to improve intelligence on drinking patterns, behaviours, and attitudes towards alcohol among adults and children Delivering an annual alcohol campaign which supports national campaign messages and reflects local need. Ensure local area campaigns are aligned and co-ordinated across agencies Developing an Alcohol Communications Plan to ensure alcohol messages are consistent and aligned with the alcohol section Initiating a Health Related Behaviour Questionnaire within Surrey schools Ensuring high quality, age-appropriate information and resources are available on drugs and alcohol Raising awareness of drink spiking, in particular among children and young people Working with schools to ensure evidence-based alcohol education is an integral part of the school curriculum via the PSHE curriculum and that a 'whole school' approach is taken to alcohol involving parents, staff and pupils. This should include education on the risk of alcohol harm during pregnancy. Identifying best practice examples on provision of alcohol education to children and young people Commissioning alcohol IBA within a range of health and non-health settings in line with Making Every

Prevention and Early Intervention	Contact Count. Ensuring targeted IBA is available for vulnerable groups. Commissioning Alcohol Liaison Nurses / Alcohol Liaison Services within all acute hospitals and that a range of services is available to support and reduce the number of alcohol-related frequent hospital attendees. Ensuring Surrey's Supporting Families Programme includes evidence-based alcohol IBA Ensuring NHS Health Checks Programme includes evidence-based alcohol IBA in line with regulations and guidance Developing and maintaining community based partnerships to tackle alcohol Exploring preventative approaches to FASD and recommend a needs assessment/evidence review is undertaken in Surrey Ensuring that children diagnosed with FSAD are appropriately followed up in primary care. Working with NHS England Local Area Team to ensure prisoners receive adequate education / communication around alcohol Working with local public and private organisations to ensure alcohol policies are in place Ensuring local arrangements are brokered with industry partners to promote responsible marketing, promotion and selling of alcohol Ensuring The Public Health Responsibility Deal is appropriately promoted and facilitated, with a range of local organisations committing their support

Treatment And Recovery	Working in partnership to develop and deliver an Integrated Care Pathway for alcohol Ensuring the general public, service users and staff in other mainstream services have ready access to information that enables them to understand the alcohol services available, the pathways between them and points of entry. Ensure alcohol services are promoted widely. Ensuring care pathways and services are geographically and socio-culturally appropriate to those for whom they are designed Commissioning Alcohol Liaison Nurses/Alcohol Liaison Services within all acute hospitals and ensure that a range of services is available to support and reduce the number of alcohol-related frequent hospital attendees. Ensure linkages to and in-reach from community alcohol services are offered to support patients requiring further treatment and recovery support e.g. housing. Ensuring Tier 2, 3 and 4 alcohol services are embedded into the existing substance misuse commissioning framework Ensuring Alcohol Treatment Services in all settings offer evidence-based, effective recovery-orientated interventions in line with NICE guidance and Quality Standards Ensuring services are appropriate for and accessible to the most vulnerable groups including children and young people, women, prisoners/offenders, those with mental health issues/dual diagnosis, victims and perpetrators of domestic abuse, homeless people, Black and Minority Ethnic (BME) groups, and Lesbian, Gay, Bisexual (LGB), those in civil partnerships

Treatment And Recovery	Ensuring a range of recovery support interventions and services are accessible to facilitate the recovery journey (e.g. peer support, mutual aid, family/parenting support, employment, training and housing) and working to develop recovery-oriented communities Working with NHS England Local Area Team to ensure prisoners have access to specialist alcohol treatment and that integrated pathways are in place between the prison and community alcohol treatment and recovery support services to ensure managed through-care that is monitored and improved on a regular basis. Identify opportunities to develop, support and strengthen recovery networks in Surrey Explore ways to identify and address stigma associated with alcohol misuse and recovery from alcohol dependence locally
Safer Communities	Ensuring local crime, health and social care data is incorporated into licensing Ensuring hospital assault data is shared routinely to inform improvements in community safety activity, employing use of Alcohol Enforcement Team where necessary. Where possible, initiating data sharing by local ambulance services. Optimising the use of existing legislation to target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol

Safer Communities	Ensuring a 'cumulative impact' policy is adopted if an area is saturated with licensed premises. This will be used to inform the implementation of a range of measures and conditions that are available to the local licensing board. Working in partnership to deliver Best Bar None, Challenge 21, Pubwatch, Designated Public Place Orders (DPPOs) across the county Re-establish Alcohol Enforcement Team for covert operations relating to alcohol enforcement Work with local alcohol retailers (including supermarkets) to reduce the visibility of alcohol off-trade. Explore ways in which to ensure responsible retailing of alcohol and restricted promotions

10. List of Tables

11. List of Annexes

12. References

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