BIRMINGHAM ALCOHOL STRATEGY
2012-16

Executive Summary 5

Background 6

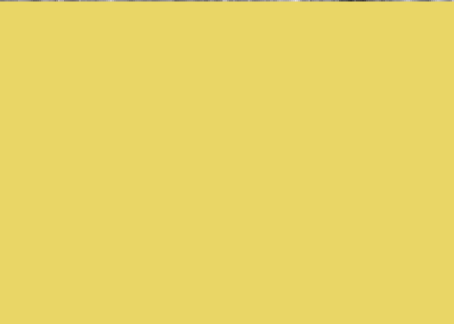
Overview 9

OBJECTIVE 1:
Promote a Safe and Sensible Approach to Alcohol Consumption 10

OBJECTIVE 2:
Protect Families and the Wider Community from the Adverse Impacts of Alcohol 20

OBJECTIVE 3:
Reduce the Impact of Alcohol Related Harms 26

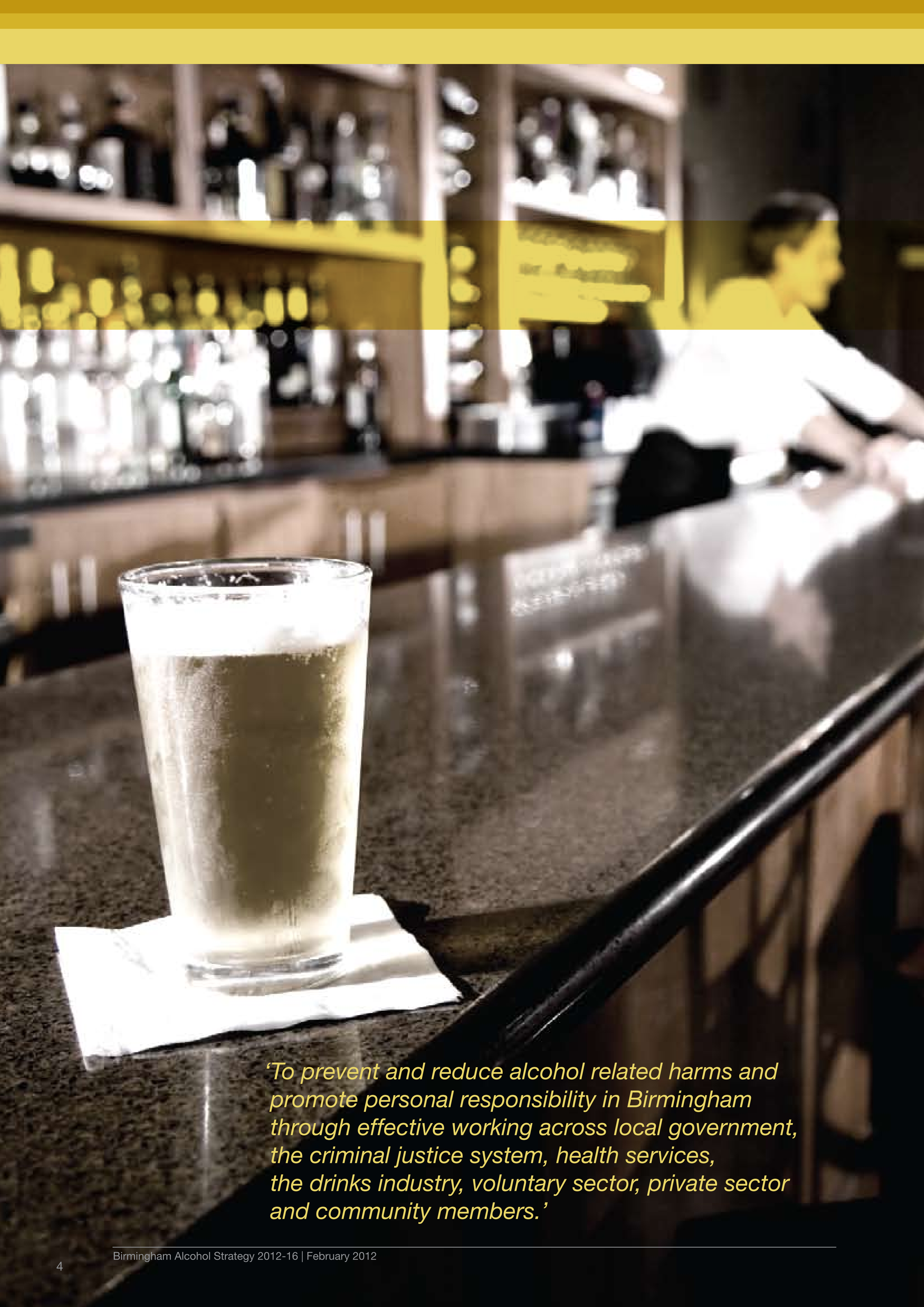
Delivering the Strategy 32



Appendices

Appendix 1 _Glossary 34

Appendix 2 _Delivery Plan 36
- Objective 1 37
- Objective 2 40
- Objective 3 41



‘To prevent and reduce alcohol related harms and promote personal responsibility in Birmingham through effective working across local government, the criminal justice system, health services, the drinks industry, voluntary sector, private sector and community members.’

EXECUTIVE SUMMARY

Vision

An overall vision has been agreed by partner organisations which will focus alcohol work in the city. This vision shapes this strategy and is:

> 'To prevent and reduce alcohol related harms and promote personal responsibility in Birmingham through effective working across local government, the criminal justice system, health services, the drinks industry, voluntary sector, private sector and community members.'

Key Outcomes

In order to achieve this overall vision we have set three key outcomes. These will direct all our work and activity will only be taken forward if it will impact upon them. The outcomes we will be seeking to achieve are:

- Increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities;
- Reduction in alcohol related crime and disorder and perception of crime and disorder;
- Reduction in the adverse impact of alcohol on families and the wider community.

Key Performance Indicators

To measure our overall progress towards achieving these outcomes we have set four key performance indicators. These indicators are linked, as closely as available data allows, to the outcomes:

- Stabilisation of the rate of alcohol-related hospital admissions by reducing the rate of increase by 2% year-on-year;
- Reduction in alcohol related crime and disorder by 10% by end of strategy period;
- Reduction in the loss of months of life lost due to alcohol by 10% by end of strategy period.
- A range of outcomes which demonstrate a reduction in the adverse impact of alcohol on families and the wider community.

BACKGROUND

Following the expiry of the first Birmingham Alcohol Strategy in 2010 the decision was taken to renew it with a focus on the most pertinent issues facing the city. This strategy has been completed firstly as a result of a review of the data, both local and national, producing an understanding of the issues. Secondly a review has been undertaken of local and national policy and practice. Finally an extensive consultation process has been followed with the purpose of obtaining views from a wide variety of stakeholders affected by alcohol, prioritising themes for action and gaining ownership for implementation.

The primary objective of this strategy development process is to ensure that a comprehensive framework for the city is created which complements existing initiatives and priorities and embeds alcohol work into that of other workstreams that will deliver the overall vision. As resources are scarce it is essential that this strategy and its implementation are embedded in mainstream services planning and action.

The strategy indicates our key outcomes to be delivered along with the associated performance measures to assess whether we have been successful. We have included too the measures we will implement to achieve these outcomes. Subsequently more detailed action plans will be developed with specific timescales and milestones. These action plans will detail which agencies will be responsible for ensuring delivery occurs and will be refreshed on an annual basis.

CONTEXT

The key aim of this strategy is to prevent any further increase in drink-related harms in the City and support the development of both a safe and healthy alcohol culture.

1. Key facts

The vast majority of people enjoy alcohol without causing harm to themselves or to others – but for some, alcohol misuse is a very real problem. The National Alcohol Strategy Unit's interim analysis estimated that alcohol misuse is now costing Birmingham around £200 million a year. This is made up of alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence.

These harms include:

- 12,000 violent incidents (around half of all violent crimes);
- 3,600 incidents of domestic violence (around a third) are linked to alcohol misuse;
- Anti-social behaviour and fear of crime – 61% of the population perceive alcohol-related violence as worsening;
- At peak times, up to 70% of all admissions to accident and emergency departments are related to alcohol;
- Up to 170,000 working days are lost through alcohol-related absence;
- In the region of 20,000 children are affected by parental alcohol problems;
- Increased divorce – marriages where there are alcohol problems are twice as likely to end in divorce;
- In 2009, half of all 11-15 year olds had already had an alcoholic drink;
- Nationally in 2009/10, there were 1,057,000 alcohol-related admissions to hospital;
- Parental alcohol misuse has been identified as a factor in over 500 child protection cases.[1]

In addition the National Alcohol Strategy Unit produced a breakdown of the annual financial cost of alcohol misuse to Birmingham which shows the:

- Cost to the health service of alcohol related harm – £54million;
- Cost of drink driving – £10million;
- Cost to criminal justice system – £37million;
- Cost to economy of alcohol related absenteeism – £30million.[2]

The size of the problem in Birmingham is significant.

Figures derived using the Alcohol Learning Centre's ready reckoner in the table below show an estimate of the number of problem drinkers in the City. This ready reckoner was developed by the Alcohol Learning Centre, funded as part of the Department for Health's Alcohol Improvement Programme, to assist the selection of short term interventions to reduce alcohol related hospital admissions.[3]

Category	Number
Hazardous / Increasing Risk Drinkers	117,000
Harmful / High Risk Drinkers	39,000
Dependent Drinkers	22,000

[1] Assessing the Harms Caused by Alcohol to Individuals and Communities in Birmingham, (Birmingham DAAT, February 2010)
[2] ibid
[3] www.alcohollearningcentre.org.uk, these figures are rounded

2. Policy Drivers

A number of policy considerations have been taken in developing the new strategy and delivery structure impacting upon the themes selected and initiatives prioritised. These drivers include:

- The Alcohol Health Needs Assessment undertaken in 2011 provided a range of relevant data identifying issues to focus attention;
- The Alcohol National Support Team visited Birmingham in September 2010 reviewing provision and the structures of services presenting a detailed action plan to shape future services;
- Be Birmingham have published their vision for the medium term as '2026 Vision'. This vision includes the streamlining of partnerships and priorities from 6 to 3. These three partnerships broadly match the focus of the alcohol strategy and its delivery groups;
- The Local Services and Community Safety Overview and Scrutiny committee report 'Reducing the Impact of Drug and Alcohol Misuse in Birmingham',[4] included a range of recommendations; shaping the strategy and its delivery structure;
- Developing NICE guidance for alcohol services will align with the priorities;
- The forthcoming updated national alcohol strategy;
- Government policy on Building Recovery into Communities;
- Government policy in getting people back into work and keeping people in work;
- The development of Public Health England;
- The development of Health and Wellbeing Boards.
- Safeguarding and 'think family'.

More detail on these policy drivers are provided below.

Paying close attention to national policy, there is a clear need to ensure that the emerging strategy is placed within the widest social and economic context embraced locally by the Be Birmingham priorities (for example, the positive impact that alcohol and the alcohol industry can have upon employment and the local economy).

In order for this positive impact to be captured fully, emphasis thus needs to be placed on developing strategies and interventions which highlight the need for responsible attitudes and behaviours.
The enhanced focus on this aspect of alcohol reduction work was made explicit by the title of the last National Alcohol Strategy as Safe, Sensible, Social and emerging national guidance such as the Public Health Responsibility Deal and related Public Health Pledge.[5]

The roles of early interventions and social marketing have increasingly been highlighted nationally in this regard, as has an enhanced and mature relationship with the licensed trade.

In December 2010, the Coalition Government set out its approach to tackling drugs and addressing alcohol dependence, recognising that both of these are key causes of societal harm including crime, family breakdown and poverty. Our developing approach is influenced further by announcements made in April 2011 which laid out the ambition to support alcohol users' access to employment and training opportunities, thus reducing the cost of providing benefits drawn by these individuals.

Over the next 4 years there is a determination nationally to break the cycle of dependence on alcohol and drugs and the wasted opportunities that result. In recognition of the complex causes and drivers associated with dependency, the government advocates that solutions should be holistic and centred around each individual with the expectation that full recovery is possible and desirable.

The updated Drugs Strategy[6], which included reference to alcohol, is structured around three themes of reducing demand, restricting supply and building recovery in communities. The first and last of these are particularly pertinent too for alcohol. Those themes are:

- **Reducing demand –** which concentrates on creating an environment where the vast majority of people who have never taken drugs (or used alcohol harmfully) continue to resist any pressures to do so, and making it easier for those that do to stop. This is key to reducing societal costs, particularly around the lost ambition and potential of young users.
- **Building recovery in communities –** more work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and will offer a route out of dependence by putting the goal of recovery at the heart of the strategy.

This is also the first time that a national drugs strategy has made specific reference to hazardous drinkers.

[4] Reducing the Impact of Drug and Alcohol Misuse in Birmingham - A Report from Overview and Scrutiny (Birmingham City Council January 2010)
[5] Department for Health: Public Health Responsibility Deal (2011)

[6] Home Office: Drugs Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life (2010)

In launching its consultation process for the alcohol strand of Building Recovery in Communities the National Treatment Agency re-iterated this policy thrust in stating:

"It is now recognised that progress needs to be made for people with severe alcohol dependence.
In essence the new strategy seeks to raise the level of ambition for those experiencing both drug and alcohol dependence, focussing on supporting service users to achieve full recovery."[7]

In time new models of care will be published to take this into account; again these will influence the way in which we develop local services.

A further priority for the current government is the desire to help people move into and progress in work whilst supporting the most vulnerable. A central aspect of this policy drive is the move to reform the benefit system to tackle poverty, worklessness and welfare dependency. The Welfare Reform Bill contains a range of measures which aim to support this priority.

Allied to this the government also undertook a review chaired by David Frost, former Director General of the British Chambers of Commerce and Dame Carol Black, National Director for Health and Work which was published in November 2011 of the sickness absence system. This review provided analysis of the sickness absence system along with offering challenging and new insights into this complex problem as well as a number of recommendations. The government will respond to this review in due course.

The coalition government outlined the way in which public health work will be developed in England in the White Paper 'Healthy Lives, Healthy People: Our strategy for public health in England'. Key within this White Paper will be both the transfer of responsibility for public health work locally to local authorities and the formation nationally of Public Health England. More information on the responsibilities of each body was set out in a Command Paper in July 2011[8]. Whilst the precise details will be developed further; amongst other issues covered in that command paper was the confirmation that the National Treatment Agency would be transferred into Public Health England and that local authorities would be expected to develop holistic responses to ensuring the health and well-being of their local communities are promoted.

In addition to these arrangements the government has announced that Health and Wellbeing Boards will be established located in local authorities. They will act as a forum to bring together elected councillors, local authority officers, patient representatives and clinical commissioning groups to develop shared understanding of local need, develop joint local priorities, and encourage commissioners to work in a more integrated and joined up manner. Birmingham has already established a Shadow Health and Wellbeing Board.

The Supporting People Programme aims to help vulnerable people improve their quality of life by providing a stable environment, which enables them to live more independently. Under this programme there are many different groups of people who qualify for help. In Birmingham people with substance misuse problems are one of these groups. However a number of other groups will also have needs relevant to this strategy, for example people with mental health needs. In developing services as a result of this strategy we will ensure that we link with the Supporting People Programme.

As part of service development, we are committed to achieving a shift in professional awareness relating to safeguarding in the context of substance misuse and will develop a 'think family' approach in line with current National Treatment Agency guidance and growing political recognition. This recognises that providing coordinated support across adult, children and substance misuse services for children and their families will result in better outcomes for vulnerable persons. Birmingham is also a pilot site for the implementation of the Social Care Institute for Excellence's 'Think Child, Think Parent, Think Family' guide.[9] Alcohol treatment workers need to play a role in identifying vulnerability and work with partners to ensure those at risk are safe from harm and have accessible support.[10] Birmingham DAAT has reinforced their commissioning intentions in this regard by incorporating safeguarding into the common assessment procedures of all service providers.

The Birmingham Safeguarding Adult and Safeguarding Children Boards work towards improving protection practices for vulnerable adults and children respectively. The latter has a statutory duty to coordinate how agencies work together to safeguard and promote the well-being of children and young people in Birmingham and to ensure the effectiveness of safeguarding arrangements.

The children of parents or carers who are substance dependent are more likely to develop behaviour problems and are vulnerable to developing substance misuse problems themselves. Further, their well-being may be impaired to the extent that they are suffering or likely to suffer significant harm. Birmingham's Safeguarding Children Board has set out guidance in this respect;[11] the procedures within it shape the way in which we will respond to this issue.

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[7] Letter sent from National Treatment Agency to Alcohol Stakeholders, 1st March 2011
[8] HM Government, Healthy Lives, Healthy People Update and Way Forward, July 2011

[9] See also: Social Care Institute for Excellence: Think Child, Think Parent, Think Family (July 2009, updated December 2011) Whilst this applies specifically to mental health, the principles around taking a whole-family approach to improve outcomes is equally applicable to the substance misuse context, especially given the prevalence of dual diagnosis.
[10] http://www.nta.nhs.uk/uploads/yp_drug_alcohol_treatment_protocol_1109.pdf
[11] Birmingham Safeguarding Children Board: Child Protection Procedures Section 25

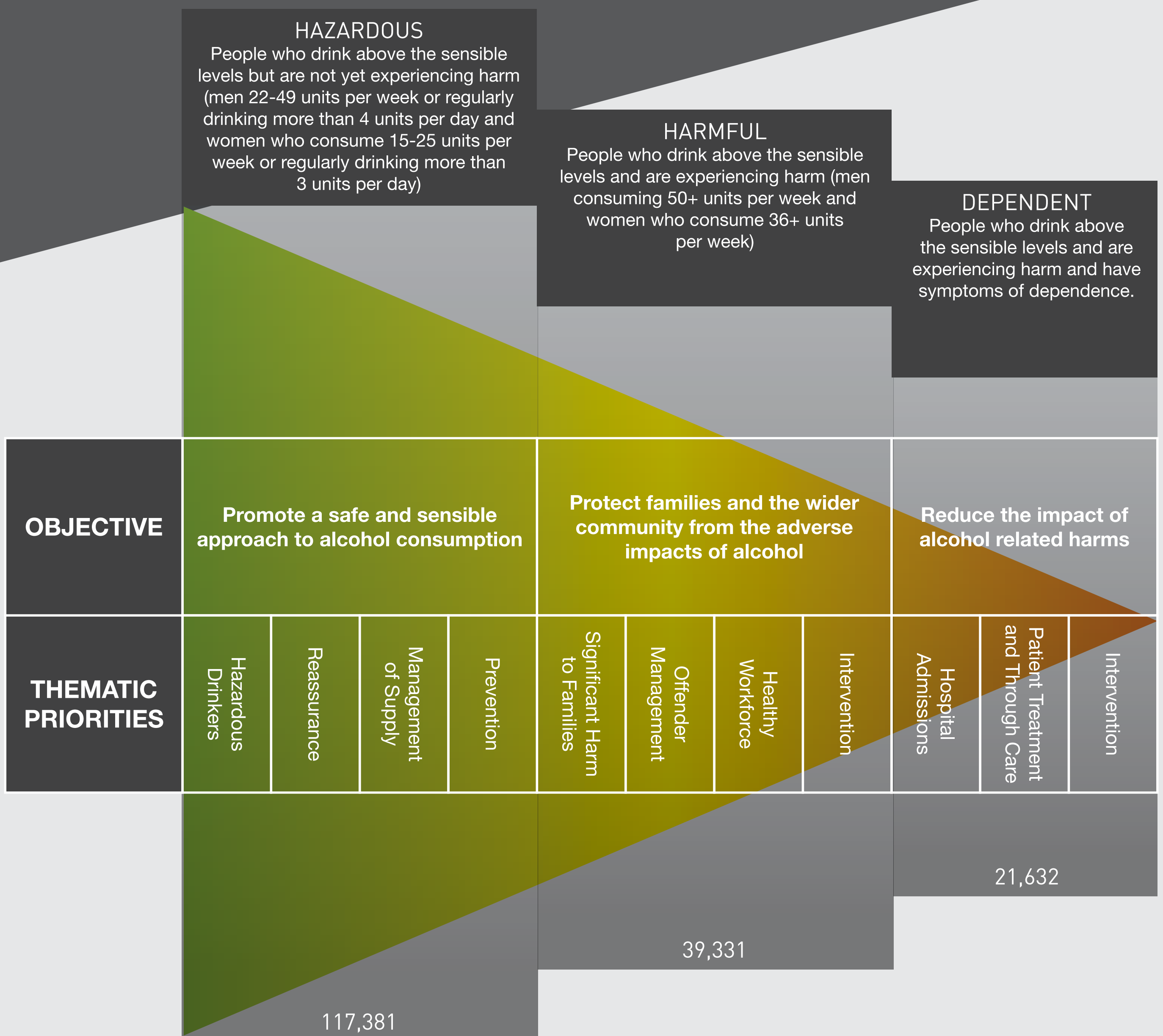
OVERVIEW

In order to achieve the key outcomes and corresponding key performance indicators for this strategy we have contextualised our approach and focused our delivery. These have been designed to be cross-cutting to cement effective partnership working:

- Promote a safe and sensible approach to alcohol consumption;
- Protect families and the wider community from the adverse impacts of alcohol; and
- Reduce impact of alcohol related harms.

Our overall philosophy is to address all types of drinking behaviour with the most appropriate methods and interventions. The diagram below demonstrates this philosophy recognising the increasing scale of seriousness of drinking behaviour along with the approaches we will utilise to tackle these behaviours.

The diagram also includes the estimates of the numbers of Birmingham residents likely to be demonstrating each type of drinking behaviour outlined earlier; these figures are derived using the Alcohol Learning Centre's ready reckoner. This ready reckoner was developed by the Alcohol Learning Centre, funded as part of the Department for Health's Alcohol Improvement Programme, to assist Primary Care Trusts to select short term interventions to reduce alcohol related hospital admissions.[12]



[12] www.alcohollearningcentre.org.uk

OBJECTIVE 1:

Promote a safe and sensible approach to alcohol consumption

Related Outcomes and Targets

In addition to the key performance indicators for the strategy as a whole we will monitor the achievement of this objective by setting specific outcome targets. These have been selected to match as closely as possible to the thematic priorities and are based on available datasets. For this objective the outcome targets are as follows:

- 15% of hazardous drinkers will be engaged in brief interventions;[13]
- Improve the perceptions of safety by 2% by the end of strategy period;
- Ensure compliance with licensing legislation evidenced by a reduction in the number of formal objections across the lifespan of the strategy;
- Reduce underage drinking and promote parental responsibility via annual dedicated social marketing campaigns.

Summary of Actions

- Incorporate the 'every contact counts' principle ensuring that the process of alcohol screening, the delivery of brief interventions and referral onto specialist treatment when appropriate is a part of all public sector health and social care contracts;
- Ensure individuals who drink at hazardous levels receive a brief intervention;
- Support the introduction of the QOF (Quality Outcomes Framework) points system for local GPs which will incentivise them to screen, deliver brief interventions and refer into treatment when necessary;
- Develop the screening of as many patients as possible for alcohol who present at hospital services;
- Maintain a range of services which support the promotion of a safe and sensible approach to alcohol consumption in a range of settings including:
    - Hospital
    - Primary care
    - Pharmacy
    - Community
    - Criminal justice;
- Invest in the training of the general public sector workforce to deliver the safer drinking message;
- Conduct evidence-led social marketing campaigns to foster a responsible drinking culture. We will use the information from the segmentation tool developed by the Department of Health to direct our social marketing work. The overall aim of this marketing activity will be to achieve a cultural change in attitudes towards alcohol consumption;
- Develop Community Alcohol Partnerships where appropriate;

[13] Department of Health recommends that if 15% of dependent drinkers are in treatment that this will be a level of treatment delivery which will have a strategic impact. The principle has been acknowledged to apply to hazardous and harmful drinkers also.

- Establish mutual referral pathways with West Midlands Fire Service so that the vulnerable can be safeguarded from fire;
- Target policing and other enforcement agency activity on preventing alcohol-related violent crime and anti-social behaviour in the night time economy and act vigorously against those who commit offences;
- Target agency activity on preventing anti-social behaviour in emerging neighbourhood hotspots across the city. We will also act vigorously against those who commit offences;
- Continue to implement individual actions aimed at preserving our successes in reducing alcohol related crime and will replicate those that work elsewhere in the city;
- Raise licensed premises standards by increasing venue participation in Best Bar None;
- Promote Licensing Act review powers allowing greater involvement in decision-making and the requirement for early 'mediation' to local communities, organisations and prospective licence holders;
- Maintain a focus on underage drinking in licensed premises and underage/proxy sales in off-licenses/ supermarkets in order to ensure young people do not obtain alcohol illegally;
- Continue to lobby for the implementation of a minimum unit price for alcohol;
- Aim to reduce sexual violence linked to the night time economy including a joint media campaign relating to rape and safer drinking;
- Ensure that there is a formal care pathway from alcohol services to the Sexual Assault Referral Centre and other sexual violence services;
- Ensure alcohol staff know how to spot the signs of sexual violence by making available basic training on sexual violence;
- Support national social marketing messages but ensure that our own evidence-led social marketing focuses specifically on promoting familial responsibility as well as the individual responsibilities of young people and expectant mothers.

Thematic Priorities – 1. Hazardous Drinkers

According to the 2010 Local Alcohol Profile produced by the North West Public Health Observatory,[14] Birmingham is below its regional counterparts with regard to estimates of the prevalence of hazardous (increasing risk) and binge drinking. Birmingham also has the lowest rate across the eight core cities which provide an appropriate large urban comparator group (figure 1).[15]

Nevertheless this should not be seen as a reason for inaction or complacency.

Indeed it was a predominant view amongst operational and strategic consultees in the strategy development process that the level of hazardous drinking remains a cause for concern, particularly in relation to specific population groups. This includes regular excessive alcohol consumption amongst students (manifesting in anti-social behaviour) and a lack of awareness amongst expectant mothers of the damage that even moderate drinking can cause to the foetus (foetal alcohol spectrum disorders).

Figure 1 – Local Alcohol Profile 2010: Synthetic Estimate of Increasing Risk and Binge Drinking[16]

Core City Comparison

City	Increasing Risk Drinking	Binge Drinking
Leeds	25.3	22.2
Liverpool	22.6	25.2
Manchester	22.5	25.1
Bristol	20.0	30.1
Newcastle upon Tyne	19.5	30.9
Nottingham	18.7	25.0
Sheffield	17.9	30.1
Birmingham	16.3	16.3
(West Midlands)	(18.3)	(18.8)

[14] www.nwph.net/alcohol/lape/

[15] Hazardous drinking: Synthetic estimate of the proportion of the population aged 16 and over who report engaging in increasing risk drinking; Binge drinking: Synthetic estimate of the proportion of adults who consume twice the daily recommended levels of alcohol in a single session.

[16] Increasing risk (hazardous) drinking - synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in increasing risk drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. Binge drinking – synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women).

The Alcohol Learning Centre has developed a segmentation system examining the propensity to be at risk of excessive levels of drinking. The data is based on the ACORN socio-economic classification system, but specific to alcohol.

This map illustrates segments where the residential population has a higher propensity to have drinking problems (figure 2).

The Department of Health has recommended primary and secondary priority audiences for social marketing based on this segmentation (see map key). Particular areas of concern are shown to be situated in Northfield, Yardley and Erdington.

A 'cultural' change with regard to both the use and attitudes towards the consumption of alcohol in the City is required. This can be achieved by the delivery of a range of social media initiatives that target those of the population who are at greatest risk of harm with the most appropriate public health information, delivered in the most effective way.

Initiatives should be focused especially on the family, those at greatest risk of health harms and at times when alcohol related harms are most likely to occur including major sporting events and national celebrations.

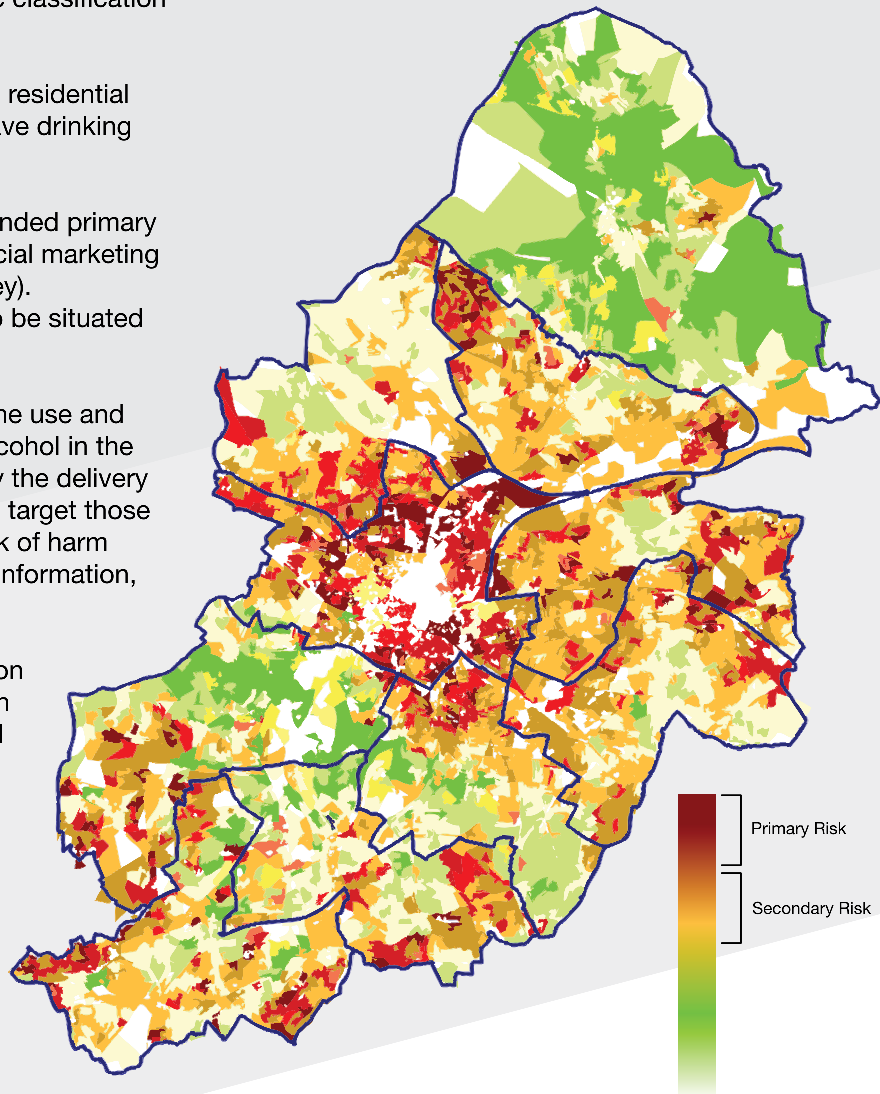
It is also essential, however, that we recognise that there will be significant geographical variation in relation to risk and vulnerability.

Local areas will need to develop their own preventative and intervention priorities based on an assessment of need at a sub-population level.[18]

This could include the adoption of a Community Alcohol Partnership in specific areas in the city.

A coherent and structured approach to hazardous drinking also needs to be centred on early identification of abnormal drinking behaviour and early intervention. According to a Department of Health report, opportunities to identify and advise are not fully exploited. The pattern in alcohol screening by General Practitioners and health workers is erratic and even rarer in other areas of the health service (e.g. Accident and Emergency).[19] A recent representative survey of General Practitioners undertaken for the Alcohol and Education Research Council revealed that most do not routinely ask patients about their drinking behaviour, unless in response to obvious physical indicators.[20]

Figure 2 – Propensity to have drinking problems by residence (Alcohol Learning Centre)



At a local level alcohol service providers have been commissioned to work within a cluster of GP surgeries, offering brief support sessions. However, systematic screening of patients in primary care is not currently taking place. It should be noted however that, as part of the over 50's national health check programme, Birmingham includes screening for alcohol conditions.

National evidence also suggests that identification and brief advice in secondary care is cost-effective by reducing the need for intensive treatment at a later date. The Paddington Alcohol Test (PAT) developed at Imperial College Healthcare Trust, St. Mary's Hospital, utilises a screening questionnaire followed by advice on the consequences of drinking and an invitation to see an alcohol nurse specialist at a later date. Data has shown that for every two patients accepting an appointment, there was one less re-attendance over the next year.[21]

[18] See the governance section for a fuller discussion of the local delivery model.

[19] Department of Health: Reducing Alcohol Harm: health services in England for alcohol misuse (2008)

[20] Lock, C et al: "A survey of general practitioners' knowledge, attitudes and practices regarding the prevention and management of alcohol-related problems: an update of a World Health Organisation survey ten years on" (February 2010). The report concluded that "Levels of identification could be increased through the adoption of screening for alcohol problems into the GP contract." (p.36)

[21] Touquet, R and Brown, A: "Revisions to the Paddington Alcohol Test for Early Identification of Alcohol Misuse and Brief Advice to Reduce Emergency Department Re-attendance" – published in Alcohol and Alcoholism Advance Access (2009)

Birmingham has this aspect of the 'alcohol liaison role' covered at all four A&Es providing assessment, brief intervention advice and post-discharge care plans. Further progress is required to ensure that all patients attending hospital because of alcohol misuse are identified and offered interventions or treatments appropriate to their needs.

West Midlands Fire Service (WMFS) has long recognised the link between alcohol and vulnerability to fire. Not only does alcohol limit people's ability to respond to a fire it can increase their likelihood of having a fire in the first place as it changes people's perceptions of risk (i.e. falling asleep whilst holding a cigarette or cooking whilst drunk). Where alcohol is co-morbid with other vulnerability factors (such as poor mental health, drug dependency or poor health) that risk exponentially increases.

The statistics for Birmingham show that for 10% of all accidental dwelling fires alcohol or drugs were involved. However, the figures below demonstrate the proportions of injuries and fatalities that result from these fires. Whilst overall fires involving alcohol form a small percentage of incidents they form a disproportionate number of injuries and fatalities.

Figure 3 – Injuries and Fatalities in Accidental Dwelling Fires[22]

Alcohol/Drug involved Accidental Fires 2009-2011 (as % of total)

Accidents	2009	2010	2011
Injuries	9 (18.4%)	16 (29.1%)	8 (16.3%)
Fatalities	3 (21.4%)	2 (28.6%)	3 (60.0%)

WMFS works with partner agencies to facilitate mutual pathways, enabling vulnerable persons to be referred to drug and alcohol services for substance misuse support and into WMFS for Home Safety Checks. There is a need to further improve links with partner agencies and explore more options for mutual training, referrals and holistic interventions.

What we will do:

We will incorporate the 'every contact counts' principle ensuring that the process of alcohol screening, the delivery of brief interventions and referral onto specialist treatment when appropriate is a part of all acute and community contracts.

We will ensure individuals who drink at hazardous levels receive a brief intervention

We will support the introduction of the QOF points system for local GPs which incentivise them to screen, deliver brief interventions and refer into treatment when necessary.

We will develop further the screening of as many patients as possible for alcohol who present at hospital services, the percentage target of those presenting to be screened will be a contractual requirement.

We will maintain a range of services which support the promotion of a safe and sensible approach to alcohol consumption in a range of settings including:
- Hospital
- Primary care
- Pharmacy
- Community
- Criminal justice

We will invest in the training of the general public sector workforce to deliver the safer drinking message.

We will conduct evidence-led social marketing to foster a responsible drinking culture. We will use the information from the segmentation tool developed by the Department of Health to direct our social marketing work. This will entail targeting specific geographic areas and/or specific types of increasing risk drinkers (e.g. expectant mothers and students). The overall aim of this marketing activity will be to achieve a cultural change in attitudes towards alcohol consumption, and thus prevent individuals moving up the scale of drinking behaviour shown in the overview diagram of this strategy.

We will develop Community Alcohol Partnerships where appropriate.

We will establish mutual referral pathways with WMFS so that the vulnerable can be safeguarded from fire.

[21] 2011 stats are currently incomplete until the end of the financial year.

Thematic Priorities – 2. Reassurance

Alcohol-involved crime has fallen consistently in the city over the last four years. Community Safety Partnership performance summary statistics show a 24.5% decrease against the 2007/08 baseline as at March 2011. Nevertheless, according to the Local Alcohol Profile 2010 Birmingham has the second highest rate of alcohol-attributable recorded crime in the West Midlands, and the fourth highest rate for alcohol-attributable violent crime. In relation to the other core cities, rates in Birmingham are noticeably lower than Manchester, Nottingham and Bristol (see figure 4).

Figure 4 – Local Alcohol Profile 2010: Alcohol-attributable recorded and violent crimes[23]

Core City Comparison

City	Alcohol-attributable recorded crimes	Alcohol-attributable violent crimes
Manchester	14.5	8.9
Nottingham	14.2	9.7
Bristol	14.1	10.0
Birmingham	11.1	7.9
Liverpool	10.5	7.1
Leeds	9.2	5.3
Newcastle upon Tyne	8.5	6.3
Sheffield	7.7	4.9
(West Midlands)	(8.1)	(5.9)

During the policing year 2010/11 there were 3597 offences with an alcohol marker. Inconsistencies around alcohol flagging are well documented, and this figure should not be considered as representing a cumulative total of alcohol-related offending across the city.[24] Nevertheless it is a valuable dataset for analysing the nature of offending behaviour. As could be expected 60% of offences took place between 21:00 and 03:59, the core periods being Friday evening/Saturday morning and Saturday evening/Sunday morning. This clearly associates alcohol-related offending with the night time economy. Almost two thirds of offences (66%) were classified as violence against the person.

At a constituency level more than a third of offences took place in Ladywood (covering the City centre). The next highest volume areas were Erdington and Sutton Coldfield which also contain local urban centres with substantial night time economies (figure 5).

Figure 5 – Alcohol-related crime statistics 2010/11

Alcohol-related offending (2010/11)

District	Offences with alcohol-related markers	Alcohol-related violence against the person
Ladywood	1261 (35.1%)	854 (35.8%)
Erdington	553 (15.4%)	346 (14.5%)
Sutton Coldfield	429 (14.9%)	241 (10.1%)
Northfield	266 (7.4%)	180 (7.5%)
Perry Barr	249 (6.9%)	170 (7.1%)
Edgbaston	231 (6.6%)	176 (7.4%)
Selly Oak	219 (6.1%)	146 (6.1%)
Yardley	133 (3.7%)	93 (3.9%)
Hodge Hill	127 (3.5%)	103 (4.3%)
Hall Green	112 (3.1%)	76 (3.2%)

[23] Crude rates per 1000 population based on Home Office recorded crime data 2009/10. Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit.

[24] For example there were 5481 violent offences committed in Birmingham between 22:00 – 03:59 from October 2009 – September 2010. It can be assumed that an extremely high proportion of these would be alcohol-related and linked to the night time economy.

Statistical information reveals that the level of anti-social behaviour in the city has declined steadily in recent years, falling from an average of 8000 incidents a month to 5000 since November 2009. 57% of cases are classified as rowdy or inconsiderate behaviour, a category closely linked to alcohol consumption. The predominant hotspot for anti-social behaviour incidents is the city centre. There are secondary hotspots around Sutton Town Centre and Erdington Town Centre, which correlates with the alcohol-related crime dataset.

However, despite the declining rate of alcohol-involved crime and anti-social behaviour, challenging perception is a key component of the reassurance agenda. The following table (figure 6) shows information from the Birmingham Tracker Survey examining resident perception of safety. This reveals that 58.1% of residents feel safe outside in their local area at night. There is significant variation at a local level, ranging from 72.5% in Sutton Coldfield to just 46.8% in Yardley. Perceptions of safety during the day are unsurprisingly higher (87.8%), though Yardley residents again express highest levels of concern.

Figure 6 - Birmingham Tracker Survey (Quarter 3 2011)[25]

Perception of Safety outside in the Local Area (2010/11, 12 month rolling average)

District	Night Q1 2011	Night Q2 2011	Night Q3 2011	Day Q1 2011	Day Q2 2011	Day Q3 2011
Edgbaston	60.1%	60.5%	61.2%	95.6%	95.1%	93.3%
Erdington	55.3%	53.9%	53.5%	91.2%	91.0%	90.4%
Hall Green	63.2%	63.3%	65.3%	90.8%	91.0%	92.6%
Hodge Hill	59.5%	56.9%	54.8%	84.3%	82.3%	81.8%
Ladywood	57.5%	50.7%	50.1%	90.0%	84.7%	85.6%
Northfield	57.0%	55.3%	57.2%	93.8%	94.2%	93.8%
Perry Barr	58.0%	57.7%	54.8%	89.3%	92.0%	91.1%
Selly Oak	65.2%	65.8%	65.1%	90.6%	90.5%	92.5%
Sutton Coldfield	71.5%	73.1%	72.5%	98.0%	97.6%	97.9%
Yardley	58.6%	53.4%	46.8%	88.1%	82.2%	78.5%
Birmingham	60.6%	59.0%	58.1%	91.2%	90.0%	89.8%

What we will do:

We will target policing and other enforcement agency activity on preventing alcohol-related violent crime and anti-social behaviour in the night time economy and vigorously act against those who commit offences.

We will target agency activity on preventing anti-social behaviour in emerging neighbourhood hotspots across the city. We will also act vigorously against those who commit offences.

[25] 12 month rolling averages are based on the preceding 12 months (e.g. Q3 2011 is January 2011 – December 2011).

Thematic Priorities – 3. Management of Supply

Alcohol is a key element of the economic viability of the city centre and other district centres. Birmingham's two main entertainment areas alone (Broad Street and Hurst Street/Arcadian) attract in excess of 70,000 visitors on a Friday and Saturday evening. The vibrancy of the night time 'offer' is also shown by licensing statistics which reveal a stable number of on-licenses against a national backdrop of pub closures and declining trade beer sales.

It should also be noted that there has been a steady increase in the number of off-licenses which does raise concerns around the availability of cheap alcohol. The number of off-licences in particular can have an impact in neighbourhoods across the city and effective management of them has been raised as a concern.

An increase in the number of reviews (predominantly on crime and disorder/public safety grounds) in the last 12 months which can be sought by Responsible Authorities or affected businesses/members of the public does however demonstrate active scrutiny taking place of licensing decisions (figure 7).

Figure 7 - Number of Licenses and Reviews 2008 - 2010

Number of Licenses and Reviews

	2008	2009	2010
On-license (including premises for both on and off sales)	1296	1245	1283
Off-license	875	885	936
24hr	81	147	176
Reviews	9	3	22

Of paramount importance in preserving the vibrancy of the Night Time Economy in both the city centre and its neighbourhoods is ensuring that measures to promote responsible retailing and public reassurance are in place, these matters also forming part of the Public Health pledge. There have been considerable successes in this regard, including the Birmingham Best Bar None and Taxi Marshalling initiatives. The reduction in violent crime in the area covered by the Broad Street Business Improvement District is a demonstrable outcome of this activity.

The achievement of the Purple Flag award recognises Birmingham City Centre's status as a safe place to visit. The Assessors and Panel for this award were impressed by particular strengths, including:

- The impressive crime reduction, the uniformed presence on the streets and the police 'Operation Be Safe';
- Early evening shopping and the pedestrian environment;
- The long term commitment to the city centre which started over 20 years ago and continues to improve today.

The city has made use of available legislation to introduce alcohol restriction areas to address street drinking and public disorder, and cumulative impact policies which introduce an assumption that no new licenses will be granted in areas of high proliferation. Zones in Broad Street, Hurst Street and Central Moseley have been established and further proactive measures introduced to tackle alcohol-related disorder (e.g. surveillance).

Vigilance has also been maintained around underage sales. During 2010/11 Trading Standards carried out 67 test purchase operations. Only 6 cases resulted in a sale. The number of complaints received concerning underage sales has also reduced on a year on year basis.

Much emphasis has been placed regionally and nationally on implementing a minimum price per unit of alcohol. The Directors of Public Health in the West Midlands wrote to the then Prime Minister in early 2010 requesting a minimum price to be implemented and early in 2011 the Coalition Government announced plans to ban sales of alcohol below unit cost plus duty, which is expected to be implemented in 2012. Additionally the Core Cities Health Improvement Collaborative lobbied in 2010 for legislation to be passed prohibiting the sale of alcohol for less than 50p per unit of alcohol as a means of reducing the consumption of alcohol and its associated problems.

In 2010 there were 1,210 reported sexual offences in Birmingham, 959 of which were classified as serious. These figures represent approximately 44% of the offences for the West Midlands police force area as a whole.

Of particular relevance to the night time economy is the fact that there appears to be a direct relationship between those that attend bars and nightclub regularly and those at a higher risk of sexual assault. This trend is consistent across both sexes, but more prominent among women. The 2010 British Crime Survey showed that women who attend bars or nightclubs more than once a week were 2.3, and 4.5 times respectively, more likely to be victims of sexual assault than women who do not attend.

The literature also suggests that a high proportion of reported crimes involve high levels of alcohol consumption - either by the victim, perpetrator or both. A literature review conducted by Fawcett (2007) cited conservative estimates by Munroe and Finch, (2006) suggesting that alcohol was involved in 30% of cases of reported rape. Similarly, a study conducted by Her Majesty's Inspectorate of Constabulary (HMIC) in 2007 found that around half of reported rape cases involved alcohol. This same study found that there was a lower conviction rate in cases where the victim was intoxicated.[26]

What we will do:

We will continue to implement individual actions aimed at preserving our successes in reducing alcohol related crime and will replicate those that work elsewhere in the city.

We will raise licensed premises standards by increasing venue participation in Best Bar None.

We will promote these Licensing Act review powers allowing greater involvement in decision-making and the requirement for early 'mediation' to local communities, organisations and prospective licence holders.

We will maintain a focus on underage drinking in licensed premises and underage/proxy sales in off-licenses/supermarkets in order to ensure young people do not obtain alcohol illegally.

We will continue to lobby for the implementation of a minimum unit price for alcohol.

We will aim to reduce sexual violence linked to the night time economy including a joint media campaign relating to rape and safer drinking.

We will ensure that there is a formal care pathway from alcohol services to the Sexual Assault Referral Centre and other sexual violence services.

We will ensure alcohol staff know how to spot the signs of sexual violence by making available basic training on sexual violence.

[26] As contained in Sexual Violence Needs Assessment for the West Midlands Police Force Area, November 2011, NHS Birmingham East and North.

Thematic Priorities – 4. Prevention (Children and Young People)

As part of our commitment to adopting a 'think family' approach, we will ensure that this ethos is embedded within our prevention activity. According to local agency representatives, many young people across the city are learning from older generations that excessive alcohol consumption is culturally acceptable, enhancing the risk of substance misuse problems becoming entrenched at a young age. Incidents of parents actively providing alcohol to young people remains a key issue, both in the home and in licensed premises.

Data from the Brighter Futures (Birmingham Children's Well-Being) Survey 2009/10 indicates that 7% of young people aged 12-16 drink at least once per week,[27] equivalent to 4,600 pupils of secondary school age across the city. The national Smoking, Drinking and Drug Use Survey 2009 paints a bleaker picture. A crude estimate would place the figure at 7,210 for a slightly younger age group (11-15) in Birmingham. Further details are provided in the table below (figure 8).

Figure 8 – Estimate of alcohol use derived from Smoking, Drinking and Drug Use Survey 2009

Crude Estimates of Alcohol Use in 11-15 Population

Alcohol Use	National Findings	Birmingham Estimate (n=60,060)
Almost every day	1%	600
About twice a week	5%	3,000
About once a week	7%	4,200
At least once a week	12%	7,210
About once a fortnight	8%	4,810
About once a month	8%	4,810
Only a few times a year	20%	12,010
Doesn't drink now	52%	31,230

The Smoking, Drinking and Drug Use Survey also revealed a changing national trend in relation to previous surveys. The proportion of 11-15 year olds indicating that they had drunk in pubs and bars had fallen (7%), but there were increases in the percentages drinking in the home (64%) or outside (27%). This demonstrates the clear need for promoting greater parental responsibility.

The role of alcohol in teenage pregnancy is complex with research typically focusing on risky sexual behaviour. Drinking alcohol lowers people's inhibitions, and makes them more likely to do things they would otherwise not do. Young people are particularly at risk because, at their stage of life, they are still testing the boundaries of what is acceptable behaviour.

Research suggests:[28]

- One in five girls (and one in ten boys) aged 14 to 15 goes further than they wanted to in a sexual experience after drinking alcohol. In the most serious cases, alcohol could lead to them becoming the victim of a sexual assault or exploitation;
- If young people drink alcohol, they are more likely to be reckless and not use contraception if they have sex. Almost one in ten boys and around one in eight girls aged 15 to 16 have unsafe sex after drinking alcohol. This puts them at risk of sexual infections and unwanted pregnancy;
- A girl who drinks alcohol is more than twice as likely to have an unwanted pregnancy as a girl who does not drink.

A further group of specific concern is that of pregnant mothers. There is growing recognition of the risk of foetal alcohol spectrum disorders (FASD) consequent on mothers drinking during pregnancy. However FASD, which can manifest in learning disabilities, neurodevelopment abnormalities and facial anomalies, remains both under diagnosed and under publicised.

[27] Survey is for 12-18 year olds, but 97% of responses to the survey are from 12-16 year olds.
[28] Research findings have been taken from Directgov on 19th March 2011.
http://www.direct.gov.uk/en/Parents/Yourchildshealthandsafety/Youngpeopleandalcohol/DG_183848

The National Organisation on Foetal Alcohol Syndrome suggests that 1 in 100 children are born with alcohol-related disorders, equating to 7000 children in Britain and 172 per annum in Birmingham.[29] It should be noted that there are risks to the foetus well below consumption at hazardous or harmful levels, rendering it potentially more difficult for a mother to recognise that she has a problem and accept support.[30]

National social marketing messages are currently targeted at preventing binge drinking, social drinking and dependent drinking and healthy living. These messages, which vary between young men and young women, need to be supported by local activity.

What we will do:

We will support national social marketing messages but ensure that our own evidence-led social marketing focuses specifically on promoting familial responsibility as well as the individual responsibilities of young people and expectant mothers.

[29] According to the Birmingham City Council Demographic Briefing 2011/05: "2010 Births and Deaths" there were 17,240 live births in Birmingham in 2010.
[30] The British Medical Journal suggests brief interventions may be used to reduce alcohol consumption in pregnant women. See www.bestpractice.bmj.com/best-practice/monograph/1141/prevention.html

OBJECTIVE 2:
Protect families and the wider community from the adverse impacts of alcohol

Related Outcomes and Targets

In addition to the performance indicators for the strategy as a whole we will monitor the achievement of this objective by setting specific outcome targets. These have been selected to match as closely as possible to the thematic priorities and are based on available datasets. For this objective the outcome targets are as follows:

- 30% of alcohol services seeing family members/ significant others where the drinker is classed to be a dependent drinker;
- 80% of those individuals arrested for an alcohol related offence are offered an appropriate treatment intervention;
- We will establish a baseline for alcohol-related absence amongst Birmingham's key employers and set reduction targets as appropriate
- 900 children and young people accessing and completing brief interventions.

Summary of Actions

- Ensure alcohol services comply with 'think family' and deliver family focused interventions;
- Enhance the identification of carers and seek to develop and promote available support pathways;
- Seek to replicate emerging good practice concerning families with complex needs;
- Continue the workforce development programme to train alcohol services in addressing domestic violence/ hidden harm (and vice versa). This will include an understanding of overlapping issues and awareness of appropriate referral pathways;
- Continue to increase the effectiveness and availability of the alcohol treatment system for offenders. We will prioritise making these services more focused on achieving key outcomes, for example of reducing re-offending and alcohol use;
- Seek to increase the uptake for prolific and priority offenders into alcohol treatment as a way of addressing the underlying causes of their offending and reducing the economic impact of this behaviour;
- Establish a healthy workforce pilot programme for the city's main employers in order to reduce alcohol-related absenteeism;
- Commission innovative provision to ensure early intervention with the vulnerable cohorts. This may include (i) peer-led support programmes; (ii) targeted outreach approach aimed at specific times (e.g. night working); (iii) community drop-ins hosted in accessible settings;

- Enhance identification through health, education and criminal justice settings of children and young people in families affected by alcohol consumption. We will ensure appropriate early intervention pathways and support are available;
- Undertake targeted work with those most at risk of sexual exploitation.

Thematic Priorities – 1. Hazardous Drinkers

Excessive alcohol consumption has wide ranging consequences not just for the individual concerned, but also for the surrounding familial nexus.
The physical, social and financial demands on carers or 'concerned others' of drug and alcohol users, and the sociological damage that these can render, have only relatively recently been acknowledged in national research.[31] A very conservative estimate, whereby only half of people with harmful or dependent drinking had just one 'concerned other', would still mean that there are in excess of 30,000 Birmingham residents directly affected by another's alcohol misuse. Only a tiny fraction of this population access the available carer support services across the city. We are attempting to increase our potential to offer support to this cohort by including carer identification in the mandatory assessment tool used by all commissioned alcohol service providers.

Service provision for carers or 'concerned others' needs to recognise the fact that (i) the supportive needs or requirements of a carer will be radically different from the service user themselves; and (ii) that there is no uniform 'carer' persona and each will have their own demands based on their ability and propensity to cope with the caring role. Effective service provision must therefore be personalised, appropriate to local circumstances and suitable to embrace the diverse plethora of needs that will arise. Birmingham is currently working as part of a national pilot developing new approaches to working with families with complex needs. The pilot is focussed on the Shard End ward. The pilot takes a 'whole system approach', including evidence-based preventative and early intervention work as well as targeted support for specific families, and involves a wide range of agencies that are also part of this strategy. As good practice emerges from this pilot we will seek to replicate this elsewhere in the city.

Exposure to familial alcohol misuse can also be linked to the cycle repeating in subsequent generations. Research completed by Birmingham DAAT, focusing on data relating to young people within the criminal justice system, found that recent exposure to alcohol misuse in the family significantly increased the likelihood of the young offender themselves having a substance misuse issue.[32]

This is a clear demonstration of the need for a family focused approach and to safeguard dependent children within the alcohol treatment system.[33]

In order to help achieve this we are in the process of developing a joint protocol to integrate substance misuse, adult and children services, thus providing a holistic family approach to treatment and joined-up support at every point of entry.

Establishing a whole-family approach at each stage of the care pathway will necessitate changing organisational structures and processes, and challenging the practice of managers and practitioners.

Alcohol is inextricably linked to domestic abuse. 46% of domestic violence cases were found to have been committed under the influence of alcohol.[34] Research has shown that family members of substance misusers are more likely to experience a high degree of violence and experience (or witness) abuse than the general population.[35] Alcohol can also be turned to as a coping strategy for victims. Research into using alcohol treatment populations revealed that as many as 60-80% of women receiving support for alcohol misuse had experienced domestic violence in the previous year.[36]

In 2010/11 23% of the alcohol-related offences dataset described above were classified as domestic violence, the vast majority taking place within a residential setting (83%). The table below (figure 9) shows that more than 40% of these offences occurred within just two constituencies, Erdington and Ladywood.

At a ward level primary hotspots are revealed as being Kingstanding (7.7%), Nechells (6.6%), Stockland Green (5.8%) and Ladywood (5.3%). A significant proportion of domestic violence episodes result in hospital treatment. A voluntary data collection programme exists across the Birmingham A&E departments which collects locational and temporal information from assault victims to help inform tactical policing and other preventative initiatives. This dataset reveals that 12.5% of assault attendances logged were committed by partners or relatives, with 15% of incidents occurring within the home environment.

[31] Adfam: We Count Too: a good practice guide and quality standards for work with family members affected by someone else's drug use (2005)
[32] Study of end of order assessments – April 2009 to February 2011. Odds ratio = 2.547

[33] A substance misuse assessment tool is now being used to identify relevant families and the young people within who will require this support.
[34] Walker et al: "Crime in England and Wales 2005/2006" (Home Office Statistical Bulletin 09/06)
[35] R. Velleman and L. Templeton: "Understanding and modifying the impact of parents' substance misuse on children": Advances in Psychiatric Treatment (2007), vol. 13, 79-89
[36] K. Chase et al: "Factors associated with partner violence among female alcoholic patients and their male partners (2003) Journal of Studies on Alcohol, no. 64 (1) 137

Figure 9 – Alcohol-related domestic violence offences 2010/11

Alcohol-related offending (2012/11)

Alcohol Use	Domestic Violence with alcohol-related markers (% proportion of total occurring in each Constituency)
Erdington	173 (20.8%)
Ladywood	166 (20.0%)
Edgbaston	98 (11.8%)
Northfield	91 (11.0%)
Sutton Coldfield	64 (7.7%)
Selly Oak	63 (7.6%)
Perr Barr	62 (7.5%)
Hodge Hill	46 (5.5%)
Yardley	44 (5.3%)
Hall Green	24 (2.9%)

An information mapping exercise conducted in 2008 by Birmingham and Solihull Mental Health Trust/ Women's Aid revealed a complete lack of connectivity between domestic violence and mental health services (including substance misuse). This pointed to a clear training need for substance misuse workers concerning how to approach domestic violence (and vice versa), understanding concepts of power and control and abuser/abused dynamics.

An initial training programme for alcohol and domestic violence workers was subsequently carried out, covering the following key dynamics: (i) how to enquire about issues around domestic violence (rather than remaining suppressed); (ii) joint-working; and (iii) signposting knowledge and procedure.

What we will do:

We will ensure that all alcohol services comply with 'think family'. Through the delivery of whole-family focused interventions, we will ensure that an increasing percentage of all drinkers presenting at services will have a family member / significant other involved in their treatment.

We will enhance the identification of carers and seek to develop and promote available support pathways.

We will seek to replicate emerging good practice concerning families with complex needs.

We will continue the workforce development programme to train alcohol services in addressing domestic violence/ hidden harm (and vice versa). This will include an understanding of overlapping issues and awareness of appropriate referral pathways.

Thematic Priorities – 2. Offender Management

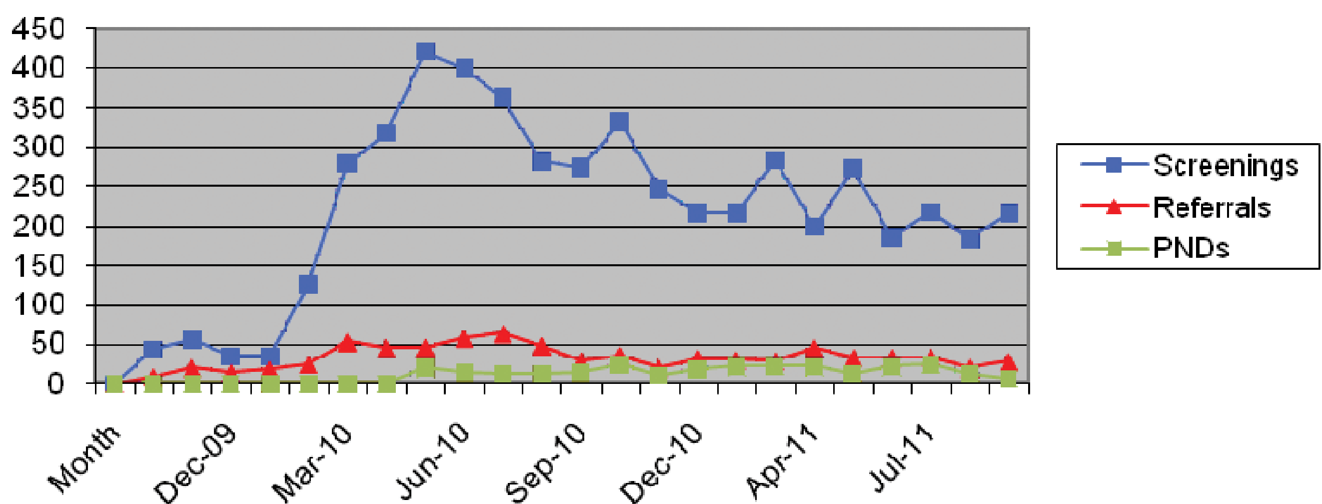
The scale of alcohol-related offending has been examined above. Historically there has been a lack of treatment options available for offenders, recognised in national policy and explicitly within Birmingham's last alcohol strategy. Considerable efforts have been made in the city to rectify this position.

In 2010 the alcohol arrest referral scheme in Birmingham was reconfigured to provide a comprehensive service across the city's four Local Policing Units. West Midlands Police delivers the custody based component as an extension of the existing Drug Intervention Programme.[37] Workers based in the custody suite screen and conduct a preliminary triage assessment of offenders arrested for alcohol-related offences. Brief interventions are delivered and onward referrals made where appropriate. These take the form of community-based extended brief interventions or priority access to specialist treatment.

A Penalty Notices for Disorder (PND) waiver scheme has also been launched citywide since October 2010, allowing penalties for alcohol-related offences to be waived on condition that two one hour brief intervention sessions are completed with the arrest referral treatment providers. This currently has completion rates in excess of 75% compared with around 36% for arrest referral generally (which is in line with national pilot studies).

The chart below (figure 10) demonstrates the number of screenings, referrals for interventions and PND waivers issued since scheme inception. In line with a decline in the level of arrests the number of screening and referrals has dropped in recent months. The fact that the scheme is voluntary also has implications for the rate of take-up.

Figure 10 – Alcohol Arrest Referral Scheme screenings, referrals and Penalty Notices for Disorder 2009-2011[38]



Research into the arrest referral cohort has revealed the presence of a group of dependent drinkers who are more serious offenders and have not previously been engaged in treatment. The DAAT has worked with partners to implement Alcohol Treatment Requirements for this group, which began in November 2010.

The Prolific and other Priority Offender (PPO) Strategy is a national Home Office initiative aimed at reducing crime by targeting those individuals who offend most or otherwise cause most harm to their communities. It is based on the premise that 0.5% of active offenders commit at least 10% of all serious crime. Birmingham has 318 designated PPOs; 28 are juveniles and 50% are currently on remand or in custody.

Whilst an analysis of OASys data has indicated that PPO levels of alcohol misuse are "typical of the wider offending population"[39], this does not detract from the fact that a tangible proportion of PPOs have complex alcohol issues which hinders their rehabilitation and resettlement efforts and impacts on the city when they re-offend. A pathway has been developed for prolific and priority offenders who have alcohol issues or alcohol related offending. However to date the uptake of these services has not been as great as expected. This is partly because, unlike for offenders using Class A drugs, the use of alcohol is not illegal and thus the criminal justice system cannot be used in the same way.

[37] Treatment can also be offered to courts as a conditional bail mechanism.
[38] Note that there is no data available for March 2011 due to contract management changes

[39] P. Dawson: 'The national PPO evaluation – research to inform and guide practice' (Home Office Online Report 09/07)

The prison population is a further specific group of concern. OASys data shows that approximately one third of offenders in Birmingham have an alcohol need related to their offending, emphasising the need for prison-based interventions to improve future health outcomes and reduce the risk of future reoffending. Release is a particularly poignant time individuals are at their most vulnerable after months of abstinence, necessitating accessible community-based provision and support for family members where appropriate.

The potential for using a range of offences as a point of capture for individuals to progress to treatment has been highlighted as an issue. Taking these opportunities could prove to be a valid method of capturing individuals who may not otherwise present themselves for treatment. The potential for using vehicle offences, such as drink driving, for this purpose in particular was raised in the strategy development process as being of value.

What we will do:

We will continue to increase the effectiveness and availability of the alcohol treatment system for offenders. We will prioritise making these services more focused on achieving key outcomes, for example of reducing re-offending and alcohol use.

We will seek to increase the uptake for prolific and priority offenders into alcohol treatment as a way of addressing the underlying causes of their offending and reducing the economic impact of this behaviour.

Thematic Priorities – 3. Healthy Workforce

Recent national focus has centred on the number of individuals claiming incapacity benefit as a result of health problems related to obesity or drug and alcohol issues leading to calls for 'tough action' by Central Government. Figures released by the Department for Work and Pensions (DWP) have shown that there are more than 40,000 people nationally claiming benefit as a result of alcohol addiction. The Local Alcohol profile contains crude estimates per 100,000 population and reveals that Birmingham compares favourably to most of the core cities with the exception of Sheffield (figure 11). However, the rate is still far in excess of the regional average.

Figure 11 – Local Alcohol Profile 2010: Incapacity benefit claimants[40]

Core City Comparison

City	Claimants of incapacity benefits – working age
Manchester	405.7
Nottingham	246.4
Bristol	237.0
Newcastle upon Tyne	221.7
Liverpool	214.0
Leeds	155.5
Birmingham	148.1
Sheffield	107.9
(West Midlands)	(103.2)

Further DWP analysis has highlighted the fact that only 25% of AUDIT 20+ dependent drinkers are in receipt of any welfare benefits, compared with 80% of problematic drug users. The implication is that a high proportion of harmful and dependent drinkers (60,000 based on the ready reckoner estimate) are actually able to sustain employment. However, absence from the workplace may still be a factor. Alcohol-related absenteeism is estimated to cost the UK economy £1.5 billion per annum. Extrapolating these figures to the Birmingham context places the cost to the local economy at a staggering £29.7 million.

What we will do:

We will establish a healthy workforce pilot programme for the city's main employers in order to reduce alcohol-related absenteeism.

Thematic Priorities – 4. Intervention (Children and Young People)

Reaffirming the message from the National Drugs Strategy, Birmingham DAAT has identified nine vulnerable cohorts of specific interest requiring a more targeted approach to prevention and intervention, namely: (i) young offenders and those at risk of offending; (ii) truants and persistent absentees; (iii) excluded pupils; (iv) those in care and care leavers; (v) those who have been homeless; (vi) those exposed to substance misuse within the family; (vii) teenage parents; (viii) those young people who have been sexually exploited or are sex workers; and (ix) those with mental health concerns.

The extent of hidden harm in the city is by its very nature difficult to quantify. In 2004 the Government estimated that there were up to 1.3 million children affected by a parent's alcohol use in the UK,[42] equating to approximately 20,000 children in Birmingham.

Numerous studies have attempted to ascertain the exact nature of the effects of familial alcohol misuse on dependent children. It has been strongly linked to increased risk of exposure to domestic violence[43] and the development of mental health problems. Research by Brisby et al found that this group are four times more likely to be at risk of a psychiatric disturbance.[44] Behavioural problems such as anti-social behaviour, aggression and truancy have also been reported.[45] These characteristics are closely aligned to the cohorts discussed above. Such vulnerabilities render the child at an increased risk of developing substance misuse issues themselves and becoming the harmful and dependent drinking population of the future.

Birmingham commissions an adolescent alcohol service for those aged 16 to 21 specifically aimed at engaging with these vulnerable cohorts. It provides brief and extended interventions alongside group work. Drawing on established partnership arrangements, activity is targeted at 16 plus care leavers, teenage parents, young offenders and those not in education, employment or training. Under 16s are referred to specialist provision. During 2010/11 there were 445 recipients of brief interventions, with a further 215 benefitting from extended interventions.

Demonstrating Birmingham's changing approach to the delivery of family-orientated services and commitment to effective safeguarding procedures, four Integrated Access Teams have recently been introduced. These establish a single of point of contact for members of the public and professionals seeking to raise concerns about a young person and provide advice or referrals to the Social Care First Response Team, Integrated Family Support Team or universal settings as appropriate to the level of risk.[46]

What we will do:

We will commission innovative provision to ensure early intervention with the vulnerable cohorts. This may include (i) peer-led support programmes; (ii) targeted outreach approach aimed at specific times (e.g. night working); (iii) community drop-ins hosted in accessible settings.

We will enhance identification through health, education and criminal justice settings of children and young people in families affected by alcohol consumption. We will ensure appropriate early intervention pathways and support are available.

We will undertake targeted work with those most at risk of sexual exploitation.

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[42] Alcohol Harm Reduction Strategy for England (2004)
[43] R. Velleman and L. Templeton: "Understanding and modifying the impact of parents' substance misuse on children": Advances in Psychiatric Treatment (2007), vol. 13, 79-89
[44] T. Brisby et al: Under the influence, coping with parents who drink too much (1997) Alcohol Concern. See also J. Orford and R. Velleman: Risk and Resilience: Adults who were the children of Problem Drinkers (1999)
[45] C. Mahoney: In a different world: Parental drug and alcohol use and a consultation into its effects on children and families (2001) Liverpool Drug Dependency Unit
[46] See also the Specialist Services section for a description of the Integrated Family Support Team development which will deliver prevention and early intervention services.

OBJECTIVE 3:
Reduce the impact of alcohol-related harms

Related Outcomes and Targets

In addition to the performance indicators for the strategy as a whole we will monitor the achievement of this objective by setting specific outcome targets. These have been selected to match as closely as possible to the thematic priorities and are based on available datasets. For this objective the outcome targets are as follows:

- 15% of drinkers classed as harmful and dependent engaged in an appropriate treatment option;[47]
- Reduction in the proportion re-entering treatment within 12 months by 30% by the end of the strategy period;
- We will increase beyond 1200 the number of young people accessing and completing structured treatment. This will be stepped with 1000 in 2011/12, 1200 in 2012/13 and a further 200 in each subsequent year.

Summary of Actions

- Support the screening of at risk groups in GP, community and hospital settings and ensure they receive the appropriate alcohol intervention;
- Support the services which deliver interventions in hospital settings including the Rapid Assessment Intervention and Discharge service (RAID);
- Ensure that an individual admitted to hospital for alcohol specific and related conditions are managed into community based services effectively, especially the hospital ‘frequent attendees’;
- Continue to increase the number of alcohol referrals from GP’s by systematically sending out lists of patients admitted to hospital for alcohol specific conditions to their GP asking them to review and refer the individual into treatment if necessary. We will track the subsequent rate of future hospital admissions once the individual is in alcohol treatment so to monitor the effectiveness of treatment;
- Ensure that services are responsive to patients admitted to hospital for alcohol specific conditions by monitoring treatment outcomes including reductions in units of alcohol consumed, rates of hospital admission, mental and physical health, social well-being, employment status, housing status and criminal activity;
- Continue to improve treatment outcomes for problem drinkers through their treatment journey to ensure their mental health, physical health, social care concerns and offending behaviour are addressed in the context of the ‘recovery agenda’. This will include improving services for patients with dual diagnoses. Robust treatment system outcome monitoring systems will demonstrate this;

[47] Harmful appropriate treatment option classed as extended brief interventions and dependent includes both detox and psycho-social support.

- Ensure that treatment services are culturally sensitive to the needs of the range of BME groups in Birmingham;
- Continue to support and expand the reach of programmes providing access to employment in line with the recovery model, recognising the different needs of alcohol users;
- Develop multiagency responses to addressing alcohol related harms in high risk groups including the hostel, homeless and student population;
- Ensure that family focused integrated service provision occurs across the City's agencies in order to address the mental, physical health, emotional well-being and social care concerns of vulnerable cohorts;
- Develop specialist treatment provision for parents and carers.

Thematic Priorities – 1. Prevention of Hospital Admissions

Reducing alcohol related hospital episodes (including admissions) requires a particular focus on preventing harmful and dependent drinkers becoming frequent attendees to A&E departments. A significant proportion of frequent attendances are associated with alcohol misuse (drug misuse, chronic disease and mental health problems also feature prominently). Previous research has found that the admissions rate amongst this cohort is almost twice as high as for the regular hospital population,[48] representing a huge drain on NHS resources. Hospital admissions data also indicates that a significant proportion of frequent attendees require acute sector support/palliative care and that community-based provision will be inadequate. It is those at risk of becoming frequent attendees who have a greater potential for change and recovery.

Department of Health data reveals that alcohol specific and related hospital admissions cost Birmingham at least £25.5 million a year. The rate of admission is increasing at approximately 6-8% per annum, and this rate of increase has been consistent for the last five years. The Quality Innovation Productivity and Performance agenda (QIPP) has a focus on improving patient experience as well as reducing unnecessary costs on the health care system.

Preventing these frequent attendances and admissions in this group can be achieved via enhanced identification, a case-management approach and improved access/engagement with primary care and community-based alcohol services: moving the focus of care from the hospital to the community (including prescription and detoxification).

Significant steps are being taken in the city to develop a robust approach to managing this cohort. Systems are being developed to improve the identification and tracking of dependent drinkers in both primary and secondary care, and to enhance communication such that GPs are aware of the presence of dependent drinkers within their patient group. Pathways are in place between GPs and alcohol treatment providers to encourage their uptake into treatment.

The commissioned tier 2 service across the city's District and General Hospitals works to ensure that suitable patients identified in secondary care are transferred seamlessly to community-based provision for structured intervention and case coordination. A Hospital Drug and Alcohol Liaison Team has also been commissioned: this is responsible for the assessment, management and referral of patients admitted to hospital wards with substance misuse problems. There is a similar emphasis on ensuring that patients not currently involved in treatment are engaged with community-based alcohol services on discharge.

What we will do:

We will support the screening of at risk groups in GP, community and hospital settings and ensure they receive the appropriate alcohol intervention.

We will support the services which deliver interventions in hospital settings including the Rapid Assessment Intervention and Discharge service (RAID).

We will ensure that an individual admitted to hospital for alcohol specific and related conditions are managed into community based services effectively, especially the hospital 'frequent attendees'.

We will continue to increase the number of alcohol referrals from GP's by systematically sending out lists of patients admitted to hospital for alcohol specific conditions to their GP asking them to review and refer the individual into treatment if necessary. We will track the subsequent rate of future hospital admissions once the individual is in alcohol treatment so to monitor the effectiveness of treatment.

We will ensure that services are responsive to patients admitted to hospital for alcohol specific conditions by monitoring treatment outcomes including reductions in units of alcohol consumed, rates of hospital admission, mental and physical health, social well-being, employment status, housing status and criminal activity.

[48] A Dent et al: 'The impact of frequent attendees on a UK emergency department' (Dec 2010) Eur J Emerg Med 332

Thematic Priorities – 2. Patient Treatment and Continuing Care

Data concerning mortality emphasises the incidence and impact of chronic alcohol misuse in the city. The table below (figure 12) shows that Birmingham has a mid-position compared to the other core cities (4th or 5th). Mortality for males is also far higher than the regional average, but actually lower or on a par for females.

There is significant variance across the city, reflected in the relative PCT profiles. Male mortality in the Heart of Birmingham area is revealed as being consistently higher. Conversely this PCT has the lowest rates for female mortality. Alcohol-specific mortality for females in Birmingham East and North and Birmingham South exceeds the regional average. Alcohol-attributable mortality and chronic liver disease for females in Birmingham South is also in excess of the West Midlands benchmark (figure 13).

Figure 12 – Local Alcohol Profile 2010: Alcohol mortality rates[49]

Local Alcohol Profile 2010

Alcohol Profile	Birmingham	Core City range (rank)	West Midlands
Alcohol-specific mortality (males)	21.9	13.6 – 33.3 (4)	16.8
Alcohol-specific mortality (females)	7.9	5.4 – 14.0 (4)	7.9
Mortality from chronic liver disease (males)	20.7	13.1 – 31.2 (5)	16.7
Mortality from chronic liver disease (females)	8.3	6.5 – 15.0 (5)	8.6
Alcohol-attributable mortality (males)	50.1	34.8 – 69.2 (4)	44.2
Alcohol-attributable mortality (females)	17.2	13.5 – 28.8 (4)	18.1

Figure 13 – Local Alcohol Profile 2010: Alcohol mortality rates by PCT

Local Alcohol Profile 2010 by PCT

Alcohol Profile	BEN	HOB	SOUTH
Alcohol-specific mortality (males)	20.0	28.3	20.3
Alcohol-specific mortality (females)	9.1	5.3	8.1
Mortality from chronic liver disease (males)	19.4	26.9	18.5
Mortality from chronic liver disease (females)	8.5	5.7	9.7
Alcohol-attributable mortality (males)	47.7	60.3	47.8
Alcohol-attributable mortality (females)	16.1	14.7	19.9

[49] Deaths from alcohol-specific conditions, chronic liver disease and alcohol-attributable conditions. Standardised rates per 100,000 population.

In the strategy development process it was highlighted that there is a need for more integrated service provision in order to reduce the prevalence of alcohol-related disease and enhance quality of care for high need/vulnerable clients showing symptoms of (or at risk of) alcohol dependency. This recognises the fact that physical, mental health and social care concerns need to be assessed and addressed via accessible pathways to maximise the potential for a successful treatment outcome in line with the recovery model. The hospital-based liaison services described earlier play an important role in referring and engaging patients into community-based treatment and support.

Birmingham DAAT currently commissions a service which focuses upon providing practical work skills and training for previous users of drugs or alcohol to enable them to enter work or education. This project shows promise to date although it has focused more upon former drug users than alcohol.[50]

There is a clear association between mental health problems and alcohol dependence, a fact highlighted by the 2010 Drugs Strategy. Historically there have been treatment issues for dual diagnosis patients, with mental health services unwilling to engage with clients until they were free from drink. The DAAT has been working to establish a clear pathway for this group in line with the Department of Health's Dual Diagnosis guidance (2002).

The need for appropriate accommodation to be provided for as part of this recovery and treatment pathway was raised throughout the strategy development process. The linkages between appropriate housing provision and other social care services were highlighted as forming an important part of supporting users of alcohol towards recovery and re-integration into society, as highlighted in the Supporting People Programme.

What we will do:

We will continue to improve treatment outcomes for problem drinkers through their treatment journey to ensure their mental health, physical health, social care concerns and offending behaviour are addressed in the context of the 'recovery agenda'. This will include improving services for patients with dual diagnoses. Robust treatment system outcome monitoring systems will demonstrate this.

We will ensure that treatment services are culturally sensitive to the needs and the range of BME groups in Birmingham.

We will continue to support and expand the reach of programmes providing access to employment in line with the recovery model, recognising the different needs of alcohol users.

We will develop multiagency responses to addressing alcohol related harms in high-risk groups including the hostel, homeless and student population.

[50] Turning Point: Improving Employment Outcomes For Drug & Alcohol Users: Treatment To Recovery, The Way Forward Based On Lessons Learnt (2011).

Thematic Priorities – 3. Specialist Services (Children and Young People)

The National Drugs Strategy 2010 has emphasised the importance of coordinated specialist services for young people:

> *"Substance misuse services, youth offending services, mental health services and children's services will work together to ensure the relevant support is in place for those who are most vulnerable... For those very few young people who develop dependency, the aim is to become drug or alcohol free. This requires structured treatment with the objective of achieving abstinence."*[51]

Significant elements of this 'package of care' are already in place in Birmingham through a commissioned specialist tier 3 substance misuse service for young people. It receives referrals from across the spectrum of children's and youth offending services working with vulnerable cohorts, including the Youth Offending Team, Arrest Referral, Services for Child Looked After, Leaving Care Services and the Teenage Pregnancy Unit.

The service received 327 referrals within the first 11 months of 2010/11 following commission. 167 cases involved alcohol misuse as a primary (48), secondary (115) or tertiary (4) drug. Highest referrals to date by ward of residence have been from Erdington (11.4%) and Handsworth (6.0%).

The linkage between alcohol misuse and mental health is also a particularly pertinent dimension in this context. The Child and Adolescent Mental Health Service (CAMHS) have estimated that between 60-76% of young substance misusers have co-existing mental health problems.[52] As an example of good practice, there is provision in place to enable substance misuse and mental health to be treated simultaneously via specialist CAMHS substance misuse workers who receive referrals from both CAMHS and the tier 3 service.

64% of referrals to the specialist tier 3 provision to date have come from criminal justice agencies demonstrating the presence of an effective pathway. Clients identified via the Arrest Referral Scheme can also be referred to the tier 2 service for extended brief interventions where appropriate.

We recognise however the need to ensure that specialist provision does not focus on the young person in isolation, but also includes the wider family in terms of developing a full understanding of the nature of the substance misuse issue and in care planning. This will improve health outcomes by promoting resilience and the wellbeing of all family members. There is also a need to manage risk by providing ready access to safeguarding services where appropriate, and to make available specialist treatment provision for parents and carers.

Birmingham has enhanced specialist provision further by implementing fully an integrated family support model, with 16 family support teams across the city. These will deliver support to children and families assessed by social care as not meeting the threshold for social work intervention, but still requiring additional support. Individuals and their families with benefit from a single point of contact who will coordinate delivery and ensure outcomes are achieved. The aims of the teams are to protect children from significant harm, improve their engagement in learning and achievement in education and to reduce health inequalities. Responding to alcohol-related harms will be intrinsic to the delivery carried out by these teams.

What we will do:

We will ensure that family focused integrated service provision occurs across the City's agencies in order to address the mental, physical health, emotional well-being and social care concerns of vulnerable cohorts.

We will develop specialist treatment provision for parents and carers.

[51] Home Office: Drugs Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life (2010) pp.11-12.
[52] Estimate referenced in Children and Young People Substance Misuse Needs Assessment 2011.

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DELIVERING THE STRATEGY

In order to ensure that the targets set in this strategy can be achieved we have outlined a number of underlying principles. The following principles will be used to direct activity and to measure progress:

- We will ensure that actions developed will be focussed on achieving the outcomes within the strategy. As part of this process we will place a greater focus on achieving outcomes for jointly commissioned services including reflecting national policy on payment by results;
- There will be an increased emphasis placed on using a wide-range of information to target actions towards areas and groups of greatest need;
- When developing services and activities as a result of this strategy a particular focus will also be placed upon reducing health inequalities. This will also link to the previous principle of targeting areas of greatest need;
- We will develop robust mechanisms to identify and demonstrate economic gains that are made by investments on services. These models will seek to identify future costs of non-action that have been saved. Examples of this would include health costs and those costs involved in responding to crime and anti-social behaviour.

The Quality Improvement Plan (QIPP) will provide another tool to deliver this strategy's health outcomes not least as it outlines that seeking cost savings should be an overall ethic.

The governance arrangements have been designed to ensure that the strategy is linked into the Be Birmingham structures providing each partnership and group with distinct roles. A diagrammatic representation is provided overleaf.

The Health and Well-Being Board will be the accountable body for the strategy and therefore take overall responsible for the targets and performance measures. They will thus receive reports, periodically, on the progress against these targets and request remedial action is taken, as necessary, and highlight successes.

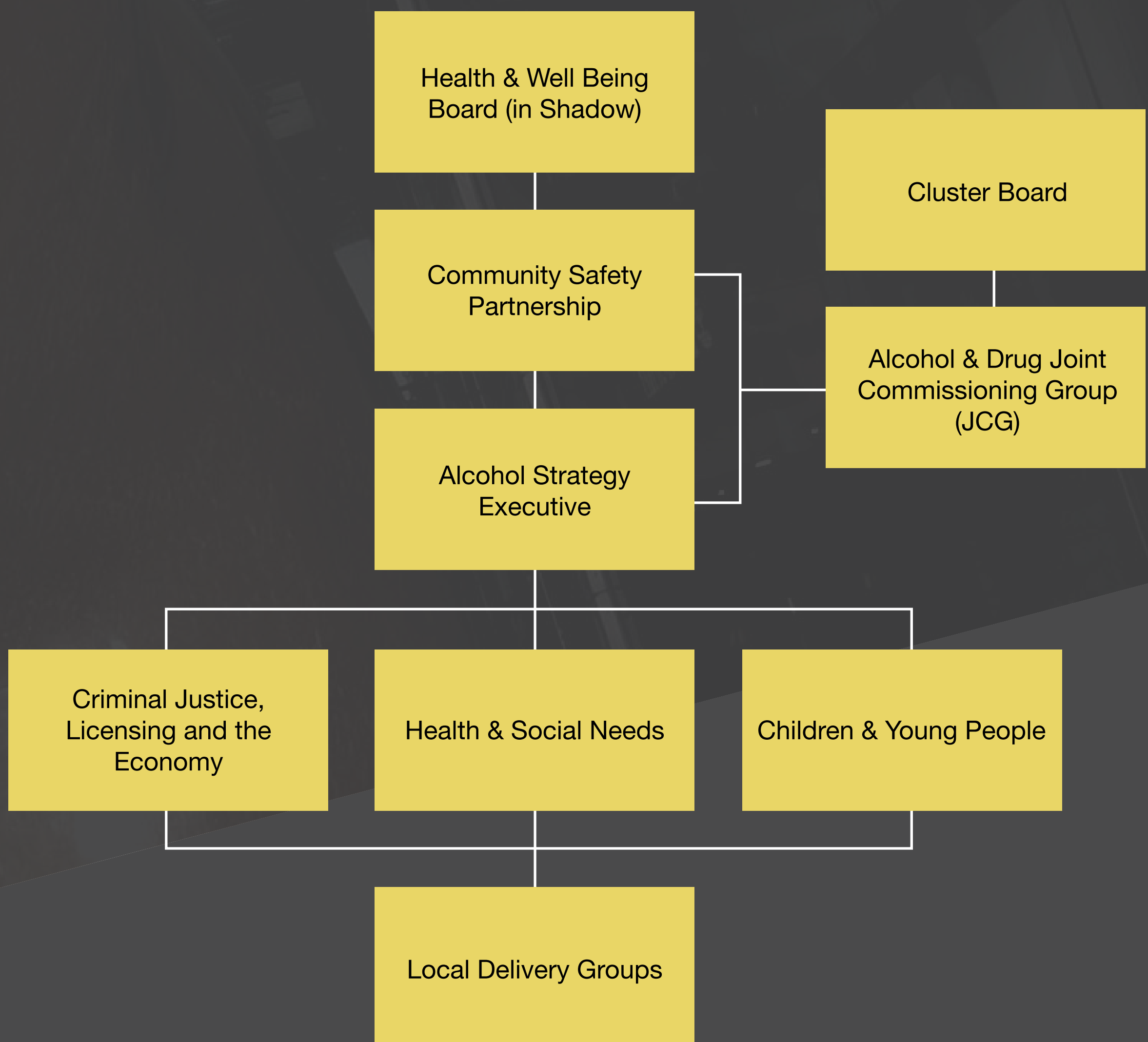
Responsibility for the implementation of the strategy will lie with the Alcohol Strategy Executive Group. They will have the role of ensuring delivery plans and individual actions are robust and enacted (refreshing them on a periodic basis), and that partners undertake their assigned responsibilities. They will provide the reports to the Health and Wellbeing Board, and other relevant committees, and make the case for commissioning of services as appropriate.

In practice the operational delivery of the strategy will be jointly carried out by the Alcohol Coordination and Commissioning Manager from the DAAT and the Strategy and Performance Officer from the Community Safety Partnership.

Commissioning decisions for treatment services which are identified from the priorities of the strategy will be undertaken by the current DAAT Joint Commissioning Group alongside the Cluster Board.

Oversight for the operational delivery of the identified actions and identification of emerging needs and issues for action will be carried out in two ways. Citywide oversight will be provided by three multi-agency theme groups. However, local ownership is crucial to the success of the strategy. Geographical-based delivery and tasking will be provided by an appropriate partnership group within the four delivery zones recently formed in the city. In addition these groups will seek to ensure that interventions developed locally act in furtherance of the overall strategy objectives and will make sure that commissioned services are influenced by a local assessment of need (including the identification of vulnerable groups) and priorities.

Figure 14 – Representation of Governance Structure



APPENDICES

Appendix 1_Glossary

ACORN	A geo-demographic information system categorising United Kingdom postcodes into various similar types based upon census data and other information such as lifestyle surveys. Stands for A Classification of Residential Neighbourhoods.
Alcohol-related Crime	Has no legal definition but comprises both offences such as drunkenness or drink-driving where alcohol is defined along with offences in which the consumption of alcohol is thought to have played a role of some kind in the committing of the offence, usually in the sense that the offender was under the influence of alcohol at the time.
Best Bar None	National award scheme supported by the Home Office aimed at promoting responsible management and operation of alcohol licensed premises.
Birmingham DAAT	Birmingham Drug and Alcohol Action Team
Birmingham and Solihull Cluster	The Birmingham and Solihull NHS Cluster comprises Heart of Birmingham Teaching Primary Care Trust, NHS South Birmingham, NHS Birmingham East and North, and Solihull Primary Care Trust. While PCTs will retain their Boards and statutory responsibilities, the cluster has appointed a single Chief Executive.
Brief Interventions	Short, evidence-based, structured conversation about alcohol consumption with a patient/client, that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their alcohol consumption and/or reduce their risk of harm.
Community Alcohol Partnerships	Bring together local retailers, trading standards, police, health, education and other local stakeholders to tackle the problem of underage drinking and associated anti-social behaviour.
Core Cities	The councils of England’s eight largest city economies outside London.
DIP	Drug Intervention Programme.
Extended Brief Interventions	Structured therapies taking perhaps 20–30 minutes and often involving one or more repeat sessions.
FASD	Foetal Alcohol Spectrum Disorders is an umbrella term for several diagnoses that are all related to prenatal exposure to alcohol (i.e. while a baby is still in the womb).
Healthy life expectancy	Is an estimate of how many years are lived in good health over the lifespan.
Local Policing Units	In the West Midlands these match local authority boundaries. Due to Birmingham’s size there are 4 such units in the area covered by the local authority.
Months of life lost	An estimate of the increase in life expectancy at birth that would be expected if all deaths among persons aged under 75 years were prevented.
OASys	OASys is the abbreviated term for the Offender Assessment System, used in the England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.
PND	Penalty Notice for Disorder.
PPO	Prolific and other Priority Offender.

Primary Care Trusts	Primary Care Trusts commission primary, community and secondary care from providers. Due to be replaced by Commissioning Consortiums from 2013.
Public Health Pledge	Organisations signing up as partners to the Public Health Responsibility Deal commit to play their part in improving public health. In signing up, they agree to take action voluntarily to support the Responsibility Deal's ambitions.
Public Health Responsibility Deal	The Public Health Responsibility Deal aims to tap into the potential for businesses and other influential organisations to make a significant contribution to improving public health. Organisations signing up to the Responsibility Deal commit to taking action voluntarily to improve public health through their responsibilities as employers, as well as through their commercial actions and their community activities.
QIPP	Quality, Innovation, Productivity and Prevention is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector which aims to improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care.
QOF	Quality Outcomes Framework is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.
RAID	Rapid Assessment Intervention and Discharge service's aim is that patients are assessed rapidly ensuring that they receive appropriate interventions for their mental or physical health whether as inpatients or once they return to the community.
SARC	Sexual Assault Referral Centre provides a comprehensive and co-ordinated service to individuals who have experienced rape or sexual assault.
Supporting People Programme	Supporting People Programme offers vulnerable people the opportunity to improve their quality of life by providing a stable environment which enables greater independence. Supporting People is a working partnership of local government, service users and support agencies.
Think Family	Think Family aims to secure better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family services.
Tier 1	Generic services that are available to any member of the general public. They aren't specialist alcohol services but staff will usually have some experience of working with alcohol users. For example GPs, pharmacies and social workers.
Tier 2	Open access services are specifically for people with alcohol problems offering advice, information and low level support.
Tier 3	Community based structured programmes for a nominated period of time.
Tier 4	Provide an intensive structured programme controlled within a residential environment.
Violent incidents	Violent crimes are those where the victim is intentionally stabbed, punched, kicked, pushed, jostled, etc. or threatened with violence whether or not there is any injury. In published crime statistics, violent crime – both as measured by the British Crime Survey and by police recorded crime – is grouped into two broad, high-level categories of violence with injury and violence without injury. In the British Crime Survey robbery is included as a violent incident whereas the police record robbery separately.

APPENDICES

Appendix 2_Delivery Plan

Key Performance Indicators

To measure our overall progress towards achieving these outcomes we have set four key performance indicators. These indicators are linked, as closely as available data allows, to the outcomes:

<table>
<tr><th>Outcome</th><th>Target</th><th>Measure</th></tr>
<tr><td>Stabilisation of the rate of alcohol-related hospital admissions</td><td>Reducing the rate of increase by 2% year-on-year</td><td>
<table>
<tr><th>Rate of Increase</th><th>06/07</th><th>07/08</th><th>08/09</th><th>09/10</th></tr>
<tr><td>Overall Rate</td><td>9.0%</td><td>4.1%</td><td>4.9%</td><td>9.1%</td></tr>
</table>
<table>
<tr><th colspan="2">Rate of Increase</th><th>06/07</th><th>07/08</th><th>08/09</th><th>09/10</th></tr>
<tr><td rowspan="2">Alcohol Specific</td><td>Male</td><td>3.3%</td><td>2.0%</td><td>6.4%</td><td>4.5%</td></tr>
<tr><td>Female</td><td>9.5%</td><td>7.7%</td><td>0.0%</td><td>0.4%</td></tr>
<tr><td rowspan="2">Alcohol Specific</td><td>Male</td><td>3.9%</td><td>3.0%</td><td>6.4%</td><td>4.3%</td></tr>
<tr><td>Female</td><td>5.0%</td><td>5.9%</td><td>3.7%</td><td>3.6%</td></tr>
</table>
</td></tr>
<tr><td>Reduction in alcohol related crime and disorder</td><td>10% reduction by end of strategy period</td><td>- Alcohol Special Interest Marker Feb 2010/11 rate of 3.25 per 1,000 population
- There were 3,582 crimes across Birmingham with Alcohol Special Interest Marker in the calendar year of 2011)
- Alcohol related violent crimes 2010/11 rate of 6.61 per 1,000 (Birmingham currently ranking 4th out of the 8 core cities.)</td></tr>
<tr><td>Reduction in the loss of months of life lost due to alcohol</td><td>10% reduction by end of strategy period</td><td>2010/11- 11.11 months lost for males and 4.68 for females.</td></tr>
<tr><td>Reduction in the adverse impact of alcohol on families and the wider community</td><td>Evidence a reduction in related harms</td><td>To be base-lined:

- reduction in alcohol related DV;
- reduction in the number of alcohol related child protection cases;
- alcohol related evictions;
- perceptions of alcohol related crime; and
- perceptions of drunk and rowdy behaviour.</td></tr>
</table>

Objective 1: Promote a safe and sensible approach to alcohol consumption

Related Outcomes and Targets

Outcome	Target	Measure
Hazardous drinkers will be engaged in brief interventions	15% of hazardous drinkers will be engaged in brief interventions	- 15% of the population who are drinking hazardously will receive a brief intervention. - According to Department of Health figures 130,000 adults are drinking hazardously, hence the need for 19,500 brief interventions
Improve the perceptions of safety	Increase of 2% by end of strategy period	- 2010/11 16.77% of Birmingham residents stated that people being drunk and rowdy in public spaces was a very big problem /a fairly big problem in their local area.
Ensure compliance with licensing legislation	Reduction in the number of formal objections across the lifespan of the strategy	Regulatory services to base line
Reduce underage drinking and promote parental responsibility via annual dedicated social marketing campaigns	Maintain or reduce current rate	- Alcohol-specific hospital admission – under 18s rate of 48.3 per 100,000 population. (Birmingham ranks 6th out of the 8 core Cities)

Summary of Actions

Action	Initiative	Lead	Timescale
Incorporate the 'every contact counts' principle ensuring that the process of alcohol screening, the delivery of brief interventions and referral onto specialist treatment when appropriate is a part of all public sector health and social care contracts	In acute, mental health, community, contracts for 2012/13 QIPP	Relevant commissioners	In place for 2012/13
Ensure individuals who drink at hazardous levels receive a brief intervention	15% of hazardous drinkers receive the appropriate intervention	Alcohol DAAT lead	In place for 2012/13
Support the introduction of the QOF (Quality Outcomes Framework) points system for local GPs which will incentivise them to screen, deliver brief interventions and refer into treatment when necessary	Alcohol strategy manager to pursue as part of the with CCG / cluster commissioning plan	Alcohol DAAT lead/ CCG's	In place for 2013/14

Action	Initiative	Lead	Timescale
Maintain a range of services which support the promotion of a safe and sensible approach to alcohol consumption in a range of settings including: Hospital services Primary care Pharmacy Community Criminal justice	 RAID and Aquarius services All GP's surgeries have access to alcohol services in actual GP surgeries deliver 6000 interventions through pharmacy based services per annum as aligned with LDGs maximise use of AR, PND and ATR disposal routes for offenders	Alcohol DAAT lead to report on	2012/13
Invest in the training of the general public sector workforce to deliver the safer drinking message	Train 1000 individuals a year to have the ability to screen, deliver brief interventions and to refer to treatment where necessary.	Alcohol DAAT lead to report on	2012/13
Conduct evidence-led social marketing campaigns to foster a responsible drinking culture. We will use the information from the segmentation tool developed by the Department of Health to direct our social marketing work. The overall aim of this marketing activity will be to achieve a cultural change in attitudes towards alcohol consumption	For 2012/13 deliver a social marketing campaign which seeks to reduce teenage drinking by influencing their parents and families approach to alcohol and parenting skills	DAAT alcohol lead	2012/13
Ensure that there is a locally focused multi agency response to alcohol harms	Develop local alcohol plans for each of the four Local Delivery Group areas and develop Community Alcohol Partnerships where appropriate	Local Delivery Group Leads / alcohol DAAT lead	2012/13
Establish mutual referral pathways with West Midlands Fire Service	So that the vulnerable can be safeguarded from fire; create systems which ensure that drinkers who are identified as of risk of causing alcohol related domestic fires are given the appropriate preventative guidance and intervention.	Alcohol DAAT lead / Fire Service	2012/13

Action	Initiative	Lead	Timescale
Target policing and other enforcement agency activity on preventing alcohol-related violent crime and anti-social behaviour in the night time economy and act vigorously against those who commit offences	Contribute to the BCSP delivery plan – 'The Night Time in the Economy'	CSP	2012/13
Target multi agency activity on preventing anti-social behaviour in emerging neighbourhood hotspots across the city	Multi agency Contribute to the four LDG plans across the City	LDG leads	2012/13
Raise licensed premises standards by increasing venue participation in Best Bar None	Best Bar None is being actively promoted in 2012/13 with a target of 100+ licensed premises to be included in 2012/13.	Regulatory services	2012/13
Maximise the use of the 2003 Licensing Act	Promote Licensing Act review powers allowing greater involvement in decision-making and the requirement for early 'mediation' to local communities, organisations and prospective licence holders	Regulatory services	2012/13
Minimise under age alcohol sales	Maintain a focus on underage drinking in licensed premises and underage/proxy sales in off-licenses/supermarkets in order to ensure young people do not obtain alcohol illegally	Trading standards	2012/13
Contribute to the Governments wish to introduce a minimum unit price	Continue to lobby for the implementation of a minimum unit price for alcohol, in line with the Government Alcohol Strategy 2012	Alcohol lead / Public health	2012/13
Aim to reduce sexual violence linked to the night time economy	Introduce a joint media campaign relating to rape and safer drinking	CSP	2012/13
Address Sexual Assault	Ensure that there is a formal care pathway from alcohol services to the Sexual Assault Referral Centre and other sexual violence services and also ensure alcohol services know how to spot the signs of sexual violence by making available basic training on sexual violence	Sexual Violence Lead / DAAT alcohol lead / CSP	2012/13

Objective 2: Protect families and the wider community from the adverse impacts of alcohol

Related Outcomes and Targets

Outcome	Target	Measure
Alcohol services seeing family members/significant others where the drinker is classed to be a dependent drinker	30% by end of strategy period	Monitor through alcohol treatment provider contracts
Individuals arrested for an alcohol related offence are offered an appropriate treatment intervention	80% of offenders receive an intervention by end of strategy period	Monitor through Arrest Referral and alcohol marker statistics
Establish a baseline for alcohol-related absence amongst Birmingham's key employers	Set reduction targets as appropriate	To be developed with Public Health
Children and young people at risk completing the appropriate intervention	900 at risk young people to receive and intervention by the end of strategy period (teenage preg/young offender/care leaver)	Monitor contract for CYP services

Summary of Actions

Action	Initiative	Lead	Timescale
Ensure alcohol services comply with 'think family' and deliver family focused interventions	DAAT through contracts 30%	Alcohol DAAT lead	2012/13
Enhance the identification of carers and seek to develop and promote available support pathways	Through DAAT treatment providers	Alcohol DAAT lead	2012/13
Seek to further develop emerging good practice concerning families with complex needs	Treatment providers and Birmingham University to develop best models and practises	Alcohol DAAT lead	2012/13
Ensure DV and alcohol issues are identified and addressed through the respective services	Continue the workforce development programme to train alcohol and DV services in addressing domestic violence/ hidden harms.	CSP DV lead/DAAT alcohol lead	2012/13
Ensure that access for offenders into the alcohol treatment system is maximised where appropriate.	Continue the ATR ,expand the PND, review AR, engage with the night time economy plan, develop prison in reach and other disposal routes	Alcohol DAAT lead/ West Midlands Police	2012/13
Ensure that the impact caused by prolific and priority offenders in the context of alcohol related harms is minimised	Seek to increase the uptake for prolific and priority offenders into alcohol treatment as a way of addressing the underlying causes of their offending and reducing the economic impact of this behaviour	Prolific and Priority Offender Lead	2012/13

Action	Initiative	Lead	Timescale
Address and reduce alcohol-related absenteeism in the city	Establish a healthy workforce pilot programme for the city's main employers in order to reduce alcohol-related absenteeism	Public Health Healthy Work force Lead	2012/13
Support vulnerable groups affected by the harms caused by alcohol	Utilisation of third sector alcohol service contracts	Alcohol DAAT lead	2012/13
Enhance identification of children and young people in families affected by alcohol consumption	Enhance identification through health, education and criminal justice settings of children and young people in families affected by alcohol consumption. We will ensure appropriate early intervention pathways and support are available.	Adult and CYP DAAT	2012/13
Address the problem of illegal production and sales of alcohol	Implementation of the Public Protection Committee's – report findings 'Tackling the Trade in Illegal Alcohol'	The Public Protection Committee	2012/13

Objective 3: Reduce the impact of alcohol related harms

Related Outcomes and Targets

Outcome	Target	Measure
Drinkers classed as harmful and dependent engaged in an appropriate treatment option	15% by end of strategy period	In treatment compared against Department of Health figures for Birmingham
Reduction in the proportion re-entering treatment within 12 months	30% by end of strategy period	71.32% of clients entering structured alcohol treatment have not been in treatment in the area before as at Q3 of 2011/12
We will increase beyond 1200 the number of young people accessing and completing structured treatment	Stepped with 1000 in 2011/12 1200 in 2012/13 Further 200 in each subsequent year	As measured through BDAAT contract monitoring

Summary of Actions

Action	Initiative	Lead	Timescale
Support the screening of at risk groups in GP, community and hospital settings and ensure they receive the appropriate alcohol intervention	As part of the 'Every Contact Counts' initiative. This means that every opportunity is taken when the public are in contact with services that the appropriate alcohol intervention is delivered, whether brief or more structured.	BDAAT alcohol lead / Public Health / service commissioners / CCG's / hospital provision	In contracts for 2012/13
Develop services which deliver interventions in hospital settings	Develop services which deliver interventions in hospital settings including the Rapid Assessment Intervention and Discharge service (RAID) and related third sector pathways into community provision	BDAAT / RAID strategic group / hospital alcohol operational pathway meetings	2012/13

Action	Initiative	Lead	Timescale
Manage heavy drinkers who present at hospital based provision more effectively - so to reduce readmission rates	Ensure that an individual admitted to hospital for alcohol specific and related conditions are managed into community based services effectively, especially hospital 'frequent attendees'	BDAAT alcohol lead	2012/13
Effectively engage primary care (GP's) in the alcohol agenda, especially with respect to reducing inappropriate hospital admissions.	Continue to increase the number of alcohol referrals from GP's by systematically sending out lists of patients admitted to hospital for alcohol specific conditions to their GP asking them to review and refer the individual into treatment if necessary. We will track the subsequent rate of future hospital admissions once the individual is in alcohol treatment so to monitor the effectiveness of treatment	BDAAT alcohol lead	2012/13
Ensure alcohol treatment services are responsive to the most vulnerable / greatest need drinkers	Ensure that alcohol treatment services are responsive to the most vulnerable / greatest need drinkers by monitoring 'recovery' treatment outcomes including reductions in units of alcohol consumed, rates of hospital admission, mental and physical health, social well-being, employment status, housing status and criminal activity	BDAAT alcohol lead	2012/13
Ensure that treatment services are culturally sensitive to the needs of the range of BME groups in Birmingham	Utilise the DAAT community development plan, with the development of baseline so to track progress	BDAAT alcohol lead	2012/13
Continue to support and expand the reach of programmes providing access to employment in line with the recovery model, recognising the different needs of alcohol users	Track numbers gaining employment as part of the DAAT treatment provider monitoring process	BDAAT alcohol lead	2012/13
Develop multiagency responses to addressing alcohol related harms in high risk groups including the hostel, homeless and student population	As part of LDG's / DAAT multiagency working groups	BDAAT alcohol lead	2012/13
Ensure that family focused integrated service provision occurs across the City's agencies in order to address the mental, physical health, emotional well-being and social care concerns of vulnerable cohorts	30% of individuals who present at alcohol treatment services receive a family focussed intervention	BDAAT alcohol lead	2012/13
Develop specialist treatment provision for parents and carers	DAAT / BCC commissioned services	BDAAT parent and carers lead	2012/13

BIRMINGHAM COMMUNITY
SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Birmingham Drug & Alcohol Action Team
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