NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Alcohol: preventing harmful alcohol use in the community

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for alcohol: preventing harmful alcohol use in the community. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010).
- School-based interventions on alcohol. NICE public health guidance 7 (2007).

2 Overview

2.1 Focus of quality standard

This quality standard will cover the prevention of harmful alcohol use in the community. It will not cover screening and brief interventions because these were covered by NICE quality standard 11.

NICE quality standards describe high-priority areas for quality improvement, which are aspirational but achievable, in a defined care or service area. They focus on aspects of health and social care that are commissioned at a local level. Because they do not set out national policy, some areas of public health guidance 24, such as the introduction of a minimum unit price, legislative changes and the marketing of alcohol, will not be included in the scope of this quality standard.

2.2 Definition

Alcohol-use disorders cover a wide range of health problems. These include hazardous and harmful drinking and alcohol dependence.

Harmful drinking is a pattern of alcohol consumption causing mental or physical damage. Hazardous drinking is a pattern of alcohol consumption that increases someone's risk of harm. This can include mental or physical health consequences (harmful use) as well as social consequences.

Alcohol dependence refers to a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

2.3 Incidence and prevalence

Although the amount most people drink poses a relatively low risk to their health, an estimated 24% of people aged 16 and over are classified as hazardous drinkers. Men are twice as likely as women to be hazardous drinkers (33% of men compared with 16% of women). Younger men and women are more likely to be hazardous drinkers. A similar pattern is seen for harmful drinking. Six per cent of men and 2% of women are classified as harmful drinkers and the proportions are lower in older age groups.[1]

Men in all minority ethnic groups have lower rates of hazardous drinking than white men. According to 2013 figures, 35.8% of white men were hazardous drinkers, compared with 18.6% of black men and 12.0% of South Asian men. Black and South Asian women were also less likely to be hazardous drinkers than white women (4.6% and 3.1%, compared with 16.6%). A similar pattern is observed for harmful drinking.[1]

The likelihood of being a hazardous drinker varies between regions. The proportion of hazardous drinkers ranged from 27.8% of men in the East Midlands to 42.4% of men in the North East, and from 12.2% of women in the East of England to 21.1% of women in Yorkshire and the Humber.[1]

Alcohol dependence patterns are similar to those for hazardous and harmful drinking. Overall, dependence is higher in men aged 16 to 74 than women in (9.3% of men compared with 3.6% of women) and is also higher among younger adults.[1]

In 2011/12, there were 200,900 hospital admissions where the primary diagnosis was attributable to the consumption of alcohol. This was a 1% increase since 2010/11 when there were 198,900 admissions of this type and a 41% increase since 2002/03 when there were around 142,000 such admissions.[1]

In 2011/12, there were an estimated 1,220,300 hospital admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the

[1] Health and Social Care Information Centre (2013) Statistics on alcohol: England.

primary reason for hospital admission or a secondary diagnosis. This was a 51% increase from an estimated 807,700 in 2002/03.[1]

In addition, nearly 10,000 children and young people (under the age of 18) are admitted to hospital each year as a result of their drinking (Department for Children, Schools and Families 2009). [2]

2.4 Management

A combination of management interventions are needed to reduce alcohol-related harm.

Population-level approaches can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm, as well as prevent people from drinking harmful or hazardous amounts. They can help:

- those who are not in regular contact with the relevant services
- those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.

Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. Early interventions can also enable changes in behaviour and prevent extensive damage that may be caused by drinking harmful or hazardous amounts.

The government continues to use both individual and population approaches to address the harm caused by alcohol (for example, in its strategy 'Safe. Sensible. Social.'[3]).

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[2] Department for Children, Families and Schools (2009) Consultation on children, young people and alcohol. London: Department for Children, Families and Schools

[3] Department of Health (2007) Safe. Sensible. Social. The next steps in the national alcohol strategy. London: Department of Health.

Table 1 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life*(NHSOF2) ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life**. 1D Carer-reported quality of life **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1F Proportion of adults in contact with secondary mental health services in paid employment ** (PHOF 1.8, NHSOF 2.5) 1H. Proportion of adults in contact with secondary mental health services living independently, with or without support * (PHOF 1.6) 1I Proportion of people who use services and their carers, who reported they had as much social contact as they would like * (PHOF 1.18)
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care ad their carers are satisfied with their experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services 3E Improving people's experience of integrated care ** (NHSOF 4.9) ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support
Aligning across the health and care system * Indicator shared ** Indicator complementary	

Table 2 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people ***Improvement areas*** **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)
4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services ***Improvement areas*** **Improving experience f healthcare for people with mental illness** 4.7 Patient experience of community mental health services
Alignment across the health and social care system * Indicator is shared ** Indicator is complementary	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improving the wider determinants of health ***Indicators*** *1.2 School readiness*
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make health choices and reduce health inequalities ***Indicators*** 2.18 Alcohol-related admissions to hospital
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.3 Mortality rates from causes considered preventable ** (NHSOF1a) 4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5)
Alignment across the health and social care system * Indicator is shared with the NHS Outcomes Framework (NHSOF) ** Complementary to indicators in the NHS Outcomes Framework (NHSOF)	

3 Summary of suggestions

3.1 Responses

Nine stakeholders responded to the 2-week engagement exercise (27 February to 13 March 2014).

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 1 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Local licensing • Preventing under-age sales • Licensed premises	ASCL, B, TTT
School-based education and advice	SCM
Role of parents or carers	PHE, SCM
Alcohol misuse in the workplace	FOM, TTT
Additional areas • Alcohol during pregnancy • Marketing • Price • Brief interventions • Referral • Screening • Support for family members • Treatment	A, ASCL, B, DH, FOM, LL, PHE, SCM, TCCR, TTT

A, Addaction
ASCL, Association of School and College Leaders
B, Balance, The North Easy Alcohol Office
DH, Department of Health
FOM, Faculty of Occupational Medicine
LL, Lundbeck Ltd.
PHE, Public Health England
SCM, Specialist Committee Members
TCCR, Tavistock Centre for Couple Relationships
TTT, The Training Tree

4 Suggested improvement areas

4.1 Local licensing

4.1.1 Summary of suggestions

Preventing under-age sales

Stakeholders highlighted that despite regulation alcohol is widely used by young people (under 18). Alcohol consumption by younger people is likely to be less controlled then adults and can affect development.

Licensed premises

Stakeholders suggested that local authorities are in a position to encourage socially responsible retailing of alcohol. Stakeholders added that local authorities are currently unclear what actions they should take to enable responsible licensing, with the suggestion of limiting licenses within 'saturated' areas.

4.1.2 Selected recommendations from development source

Table 5 presents recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Preventing under-age sales	**Licensing** NICE PH24 Recommendation 4
Licensed premises	**Licensing** NICE PH24 Recommendation 4

Licensing

NICE public health guidance 24 – Recommendation 4

Who is the target population?

Alcohol licence-holders and designated supervisors of licensed premises.

Who should take action?

- Local authorities.
- Trading standards officers.
- The police.

- Magistrates.
- Revenue and customs

What action should they take?

- Use local crime and related trauma data to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is 'saturated' with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area.
- Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol licence condition and illegal imports of alcohol.
- Work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others.
- Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales. Test purchases should also be used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others.
- Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases. This includes fixed penalty and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

4.1.3 Current UK practice

Preventing under-age sales

No published studies on current practice were highlighted for this suggested area for quality improvement.

Licensed premises

A case study by alcohol concern found that while Cardiff city centre was able to exercise a saturation policy as part of the 2003 Licensing Act, and as recommended by NICE public health guidance 24, a snapshot survey in 2011 found that 40% of business premises had a license to sell alcohol, with 10% of these being off-licence premises. This type of ‘saturation’ within a localised area has been linked to increased alcohol consumption and alcohol related anti-social behaviour.[4]

[4] Alcohol Concern (2012) - Full to the brim? Outlet density and alcohol-related harm

4.2 School-based education and advice

4.2.1 Summary of suggestions

Stakeholders felt that because children and young people are exposed to alcohol related behaviours from an early age there is a need for education to be tailored to the prevention of harm from alcohol. As well as alcohol not being part of school curriculum they felt that provisions are not in place for teachers to provide this education because they do not have the required skills.

4.2.2 Selected recommendations from development source

Table 6 presents recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
School-based education and advice	**School-based education and advice** NICE PH7 recommendations 1 and 2

School-based education and advice

NICE public health guidance 7- Recommendation 1

Who is the target population?

Children and young people in schools.

Who should take action?

Head teachers, teachers, school governors and others who work in (or with) schools including: school nurses, counsellors, healthy school leads, personal, social and health education (PSHE) coordinators in primary schools and personal, social, health and economic (PSHE) education coordinators in secondary schools.

What action should they take?

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the

age at which young people start drinking and reduce the harm it can cause among those who do drink. Education programmes should:
  - increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially (including the legal consequences)
  - provide the opportunity to explore attitudes to – and perceptions of – alcohol use
  - help develop decision-making, assertiveness, coping and verbal/non-verbal skills
  - help develop self-esteem
  - increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.
- Introduce a 'whole school' approach to alcohol, in line with DCSF guidance. It should involve staff, parents and pupils and cover everything from policy development and the school environment to the professional development of (and support for) staff.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills. (This includes problem-solving and communication skills, and advice on setting boundaries for their children and teaching them how to resist peer pressure.)

NICE public health guidance 7- Recommendation 2

Who is the target population?

Children and young people in schools who are thought to be drinking harmful amounts of alcohol.

Who should take action?

Teachers, school nurses and school counsellors.

What action should they take?

- Where appropriate, offer brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Offer a follow-up consultation or make a referral to external services, where necessary.
- Where appropriate, make a direct referral to external services (without providing one-to-one advice).
- Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services.

4.2.3 Current UK practice

Ofsted's report into personal, social, health and economic (PSHE) education in school, Not yet good enough, found that while most pupils understood the dangers to health of tobacco and illegal drugs, they were less aware of the physical and social damage associated with alcohol misuse.

This report found that teaching required improvement in 42% of primary and 38% of secondary schools, in relation to PSHE. It also found that in 20% of schools, staff had received little or no training in PSHE education.[5]

[5] Ofsted (2013) Not yet good enough: personal, social, health and economic education in schools

4.3 Role of parents or carers

4.3.1 Summary of suggestions

Stakeholders suggested that the influence of parents or carers is key in establishing children's and young people's perception of alcohol. Therefore it is important that parents or carers are educated about alcohol use in children and young people and are included in any initiatives to reduce alcohol use.

4.3.2 Selected recommendations from development source

Table 7 presents recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Parent and/or carer involvement	**School-based education and advice** NICE PH7 Recommendation 1 **Partnerships** NICE PH7 Recommendation 3

Parent or carer involvement

NICE public health guidance 7 - Recommendation 1

Who is the target population?

Children and young people in schools.

Who should take action?

Head teachers, teachers, school governors and others who work in (or with) schools including: school nurses, counsellors, healthy school leads, personal, social and health education (PSHE) coordinators in primary schools and personal, social, health and economic (PSHE) education coordinators in secondary schools.

What action should they take?

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the

age at which young people start drinking and reduce the harm it can cause among those who do drink. Education programmes should:
  - increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially (including the legal consequences)
  - provide the opportunity to explore attitudes to – and perceptions of – alcohol use
  - help develop decision-making, assertiveness, coping and verbal/non-verbal skills
  - help develop self-esteem
  - increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.
- Introduce a 'whole school' approach to alcohol, in line with DCSF guidance. It should involve staff, parents and pupils and cover everything from policy development and the school environment to the professional development of (and support for) staff.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills. (This includes problem-solving and communication skills, and advice on setting boundaries for their children and teaching them how to resist peer pressure.)

NICE public health guidance 7 - Recommendation 3

Who is the target population?

Children and young people in schools.

Who should take action?
- Head teachers, school governors, healthy school leads and school nurses.
- Extended school services, children's services (including the Children's Trust/children and young people's strategic partnership), primary care trusts (PCTs), drug and alcohol action teams, crime disorder reduction partnerships, youth services, drug and alcohol services, the police and organisations in the voluntary and community sectors.

What action should they take?

Maintain and develop partnerships to:
- support alcohol education in schools as part of the national science, PSHE and PSHE education curricula
- ensure school interventions on alcohol use are integrated with community activities introduced as part of the 'Children and young people's plan'
- find ways to consult with families (parents or carers, children and young people) about initiatives to reduce alcohol use and to involve them in those initiatives

- monitor and evaluate partnership working and incorporate good practice into planning.

4.3.3 Current UK practice

Parent and/or carer involvement

A report into children's and young people's decision making around alcohol suggests that parenting strategies enable children and young people to make decisions about alcohol later in life. It highlighted a correlation between parental drinking behaviours and children's and young people's drinking behaviour, with drinking styles in particular (e.g. drinking in moderation) influencing children's drinking behaviour[6].

[6] Joseph Rowntree Foundation (2010) Drinking to belong: Understanding young adults' alcohol use within social settings.

4.4 Alcohol misuse in the workplace

4.4.1 Summary of suggestions

Stakeholders felt that alcohol misuse in the workplace is often a difficult issue that is ignored. It can increase sickness absence and reduce production of staff. They felt that this could be effectively managed through channels such as occupational health, but there are few services within the workplace. An alcohol policy should be available for all employees.

4.4.2 Selected recommendations from development source

This area is not directly covered in NICE PH7 or 24 and no recommendations are presented. The programme development group for PH24 found that a systematic review of brief interventions for alcohol misuse in the workplace presented limited and inconclusive findings for the effectiveness of interventions in this setting.

4.4.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement.

5 Additional areas

5.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be outside the remit of the quality standard referral or addressed by other NICE quality standards.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 25 April 2014.

Alcohol during pregnancy

A stakeholder suggested that there should be clearer information about drinking alcohol during pregnancy and the dangers of foetal alcohol spectrum disorder (FASD), which can lead to lifelong disability. This area of quality improvement is would be better addressed in a quality standard on antenatal care.

Marketing

Stakeholders highlighted that the alcohol industry have a large expenditure on marketing and promotion. They felt that there should be an introduction of tighter regulation, particularly due to the effect advertising can have on children and young people. This area of quality improvement aims to inform national policy and therefore is not within the scope of this quality standard.

Price

Stakeholders highlighted that alcohol has become more affordable in real terms. They felt a minimum unit price would be a key intervention to reduce harmful outcomes from alcohol. This area of quality improvement aims to inform national policy and therefore is not within the scope of this quality standard.

Screening

Stakeholders highlighted that provision of screening required improvement, this included identifying patients who are drinking hazardous or harmful amounts in all health and social care settings including both NHS and non-NHS settings (such as GPs, or dental practices) . This area for improvement was addressed in NICE quality standard 11.

Brief interventions

Stakeholders highlighted that provision of brief interventions required improvement. This area for improvement was addressed in NICE quality standard 11.

Referral

Stakeholders suggested that referral is a key quality improvement area and ensuring that people receive the correct referral. This area for improvement was addressed in NICE quality standard 11.

Support for family members

Stakeholders suggested that there is little support for family member of people consuming alcohol in a harmful manner. They suggested that these family members should be offered an assessment for their own needs as well as ensuring that they are safeguarded from the effects or harmful and hazardous drinking. This area for improvement was addressed in NICE quality standard 11.

Treatment

Stakeholders highlighted that the majority of people considered alcohol dependent are not currently receiving treatment, compared to those who may abuse substances. This area for improvement was addressed in NICE quality standard 11.

Appendix 1: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	Addaction	Key area for quality improvement 1 Whole population and Community Systems approach which includes availability and costing, marketing and licensing, societal and cultural changes	Evidence shows a direct correlation between affordability and availability and alcohol related harm. Between 1980 and 2008 alcohol became 75% more affordable (The NHS Information Centre 2009). Making alcohol less affordable is the most effective way of reducing the harm it causes among a population where hazardous drinking is common – such as in the UK (Chisholm et al. 2004) The philosophy underpinning the community systems approach is that programmes which address complex issues such as alcohol-related harm must intervene at different levels to influence individual knowledge, attitudes and behaviour; social support systems and networks; community capacity to mobilise effective initiatives; coalitions of cooperating organisations; and alliances that affect policy. Programmes must be shaped to meet the needs of individual communities and be based in	In England continued debate and barriers to the implementation of MUP, despite key public health and medical experts supporting it. Various research shows a strong link between affordability and alcohol related harm. In relation to Community Systems Approach, NICE recommends commissioners ensure policies and strategies aim to improve everyone's health and wellbeing and they should work with the local community to develop local strategies Enabling individuals and communities to develop more control (or enhancing their perception of control) over their lives can act as a buffer against the effects of disadvantage, facilitating positive behaviour change, 2007. Community Systems Approach is a vehicle to allowing this Rose Hypothesis suggests that a small reduction in risk among a large number of people may prevent many more cases, rather than treating a small number at higher risk. A whole-population approach explicitly focuses on changing everyone's exposure to risk (Rose 2008) /Prevention Paradox ‘This view acknowledges that risk is distributed throughout the entire	Chisholm D, Rehm J, Van Ommeren M et al. (2004) Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. Journal of Studies on Alcohol 65: 782–93 Rose G (2008) Rose's strategy of preventive medicine. The complete original text. Commentary by Khaw KT , Marmot M. Oxford: Oxford University Press Weitzman and Toben 2004, College Students Binge Drinking and the ‘Prevention Paradox’ – Implications for prevention and harm reduction. J. Drug Education , Vol. 34(3) 247-266, Holder H. D. Alcohol and the Community. A Systems Approach to Prevention. Cambridge, UK: Cambridge University

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			communities, build on community assets and involve active community participation. They involve a shift from a mindset of community services to community empowerment – Sarah Wadd, 2014 Community Systems approach is defined by Holder as (i) addressing a wide range of problem behaviours; (ii) surveying the entire population; and (iii) suggesting interventions that would affect the behavioural environment and promote the decision making process (Holder, 1998)	Population and deviance in the group is directly related to the prevailing normative behaviour in the population. Interventions to reduce problem behaviours thus focus on the community and are directed at producing incremental change throughout a population, rather than wholesale change among subgroups with extreme behaviour patterns' (Weitzman and Toben 2004)	Press; 1998 Behaviour change: the principles for effective interventions. NICE public health guidance 6 (2007).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
002	Addaction	Key area for quality improvement 2 Provision of 'extended brief interventions' and 'brief therapy' in local, accessible and non-addiction/specialist settings	-providing interventions in neutral and anonymous settings e.g. health centres may encourage people identified as at-risk/harmful to engage -providing interventions in the community and locally will reduce barriers to accessibility- travel costs, mobility issues	NICE 2007 recommends that we assess potential barriers to change (for example, lack of access to affordable opportunities for physical activity, domestic responsibilities, or lack of information or resources) and how these might be addressed. This may include financial constraints for travelling to appointments and anxiety about presenting to specialist services. NICE also states importance of supporting structural improvements to help people who find it difficult to change, or who are not motivated. These improvements could include changes to the physical environment or to service delivery, access and provision. (NICE, 2007)	Alcohol Acadamy- Clarifying brief interventions 'Alcohol brief interventions: differences between simple brief advice, extended brief interventions and brief treatment approaches' Behaviour change: the principles for effective interventions. NICE public health guidance 6 (2007).
003	Addaction	Key area for quality improvement 3 Resources and supports made available to family members such as Community Reinforcement Approach Family Therapy (CRAFT)	One of the harmful effects of alcohol use is at Societal level – 'The impact on other family members can be profound, leading to feelings of anxiety, worry ,depression, helplessness, anger and guilt. For example, it can lead to financial worries and concern about the user's state of physical and mental health, as well as their behaviour. It can also affect the family's social life and make it difficult for family members to communicate'.	Repeated clinical trials have shown that the CRAFT approach is 6 times as likely as some other methods to get a loved one into treatment. Using a non-confrontational approach which focuses on reinforcing positive behaviour, CRAFT has proven 60-70% effective in helping family members to access and comply with treatment (Meyers, 2003) Improved outcomes for individuals in accessing and engaging in treatment	Orford J, Natera G, Copello A et al. (2005) Coping with alcohol and drug problems: The experiences of family members in three contrasting cultures. London: Taylor and Francis Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			(Orford et al. 2005 in NICE 2010).		
004	Addaction	Key area for quality improvement 4 Improved referral pathways between Tier 2/3/4/ services	Where it is identified at screening that someone is drinking at harmful levels there should be rapid access to extended brief intervention or brief therapy, even if offered by another provider Interagency referral pathways therefore required in each health and local authority	To reduce delay and potential barriers in accessing treatment 'In each area, commissioners and providers are recommended to develop local systems, which cover the three levels of screening and assessment. The levels of assessment reflect the different levels of complexity and expertise required to carry out the assessment at each stage. In this system, a broad base of personnel – who can carry out less complex screening and screening for alcohol – is required, allowing more opportunities for preventative brief interventions, more points of access to the specialist alcohol treatment system and less delay in treatment entry.' MOCAM 2006	Department of Health (2006) Models of care for alcohol misusers (MOCAM). London: Department of Health.
005	Addaction	Key area for quality improvement 5 Ensure interventions and screenings are targeted and appropriate to level of alcohol use, as well as demographic considerations e.g. older adults	'Women are more vulnerable to the effects of alcohol than men and younger and older people tend to be more vulnerable than those who are middle-aged. In addition, some black and minority ethnic groups are less able to metabolise alcohol than Caucasians' (NICE, 2010) Women aged 65 and Over are 7X	'Attempts to change behaviour have not always led to universal improvements in the population's health. For example, different groups (measured by age, socioeconomic position, ethnicity or gender) react differently to incentives and disincentives, or 'fear' messages. Effective interventions target specific groups and are tailored to meet their needs. This is particularly important where health equity is one of the goals. Service user views may be	Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010). Behaviour change: the principles for effective interventions. NICE public health guidance 6 (2007).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			times more likely to drink everyday than women aged between 16-24 years (ONS,12) Older adults who are Hazardous drinkers respond well to Brief Interventions & Motivational Enhancement . Harmful drinkers respond well to Cognitive-behavioural approaches and to learning new coping skill (O'Connell et al,2003)	helpful when planning interventions' (NICE,2007)	
006	Association of School and College Leaders	Alcohol advertising and media presence	Young people are naturally affected by advertising and positive portrayal of alcohol use in the media.	Alcohol use by the immature is likely to be (even) less well controlled than by adults, can damage growing bodies, and set unhealthy habits. Alcohol misuse by young people is higher in the UK than most comparable countries.	UNICEF report: Child well-being in rich countries, 2014 http://www.unicef.org.uk/Latest/Publications/Report-Card-11-Child-well-being-in-rich-countries/
007	Association of School and College Leaders	Alcohol availability to young people	Despite regulation alcohol is widely used by young people ostensibly too young to obtain it.	Alcohol use by the immature is likely to be (even) less well controlled than by adults, can damage growing bodies, and set unhealthy habits. Alcohol misuse by young people is higher in the UK than most comparable countries.	UNICEF report: Child well-being in rich countries, 2014 http://www.unicef.org.uk/Latest/Publications/Report-Card-11-Child-well-being-in-rich-countries/
008	Association of School and College	Cost of alcohol	Alcohol can be obtained very cheaply, making it easier to over-		

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	Leaders		use it.		
009	Balance, The North East Alcohol Office	The introduction of a minimum unit price (MUP) of 50p per unit of alcohol. A MUP links alcohol price to the strength of each product. MUP should be reviewed regularly to ensure alcohol does not become more affordable over time.	A range of studies have found that increasing the price of alcohol can reduce road accidents and fatalities; workplace injuries; deaths from cirrhosis of the liver; various kinds of violent crime, including assaults, rapes, robberies and homicide and spouse and child abuse(1)	There is extensive and consistent evidence that increasing the price of alcohol reduces consumption and alcohol-related harm (2) Making alcohol less affordable will reduce consumption and the harm it does to individuals, families and communities.	(1) Babor T., et al. (2003) - Alcohol: No Ordinary Commodity: Research and Public Policy (2) Stockwell et al (2012) Does minimum pricing reduce alcohol consumption? The experience of a Canadian province.
010	Balance, The North East Alcohol Office	The reduction of the availability of off licensed premises selling alcohol	Over the past 30 years there has been more than a 25% increase in the number of off-licensed premises, such as convenience stores and supermarkets that sell alcohol for consumption elsewhere	A range of studies clearly indicate that limiting outlet density within a community may be an effective means of reducing alcohol-related problems(1)	Alcohol Concern (2012) - Full to the brim? Outlet density and alcohol-related harm
011	Balance, The North East Alcohol Office	The Introduction of tighter regulations to reduce alcohol promotions and advertising – similar to that in place in France's "Loi Evin"	In the UK, expenditure by the alcohol industry on marketing and promotion is substantial and significantly more than expenditure on health promotion marketing and advertising. In 2003, it was estimated that the UK alcohol industry's £800m spend on marketing(1)	Young people are thought to be particularly susceptible to advertising. A review of 7 international research studies (2) concluded that there is evidence for an association between prior alcohol advertising and marketing exposure and subsequent alcohol drinking behaviour in young people. When it comes to alcohol advertising, the UK is amongst the most relaxed in Europe in terms of regulation. This is particularly	British Medical Association (2009) – Under the Influence Smith, L., and Foxcroft, D (2007) - The effect of alcohol advertising and marketing on drinking behaviour in young people: systematic review of published longitudinal

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				evident when compared to France and its Loi Evin, which prohibits direct or indirect advertising of alcoholic drinks on television and cinema, in stadiums, public and private sports grounds, swimming pools, competition areas and all areas used by youth associations for education.	studies
012	Balance, The North East Alcohol Office	Investment in the system for the treatment and prevention of alcohol misuse	There are an estimated 1.6 million people now dependent on alcohol in England(1),	Only around 6% of dependent drinkers in England receive treatment compared to more than half of people who are addicted to drugs	(1) Alcohol Concern (2013) – 15:15 The case for better access to treatment for alcohol dependence in England
013	Balance, The North East Alcohol Office	Clearer information to inform about the dangers of Foetal alcohol spectrum disorder (FASD) caused by drinking alcohol whilst pregnant	The exact prevalence of FASD in the UK is not known, however, international prevalence studies in countries such as the United States, Canada, Australia, Finland, Japan and Italy state that at least 1 in 100 children are affected. Using this data this would equate to at least 6,000–7,000 babies born with FASD each year in the UK(1)	There are several classifications under the broad umbrella term Foetal alcohol spectrum disorder (FASD) but in its simplest term it is a spectrum of behavioural, emotional, physical and neurological issues that are caused by the consumption of alcohol on a developing foetus during pregnancy. This may result in a lifelong disability that has no cure. This is however preventable.	(1) National Organisation on Foetal Alcohol Syndrome (2011) - Foetal alcohol spectrum disorder, Information for parents, carers and professionals
014	Department of Health	Screening and Brief Interventions	It is important that the Quality Standard references the existing NICE quality standard on screening and brief interventions.	This is to ensure that the topic will be covered in its entirety.	Please see NICE quality standard 11 which covers screening and brief interventions. http://guidance.nice.org.uk

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					/qs11
015	Faculty of Occupational Medicine	Access to advice for employees on alcohol misuse at work	Alcohol misuse in the workplace is a very difficult issue for both affected employees, their colleagues and for managers. Because of this it is often ignored and the problems that it causes in the workplace continue. It is responsible for increased sickness absence and reduced production	The costs to British industry have been estimated at £6.4billion per year. There are also substantial individual financial, career and health losses for individuals. Drinking alcohol before or during work that is safety sensitive will increase the risk of an accident. In 2009, alcohol misuse in doctors was the most common allegation resulting in suspension from the Medical Register, and driving under the influence was the most common allegation resulting in a warning from the GMC	Cabinet Office, Prime Minister's Strategy Unit. Alcohol Project: interim analytic report. London: Cabinet office, 2004 Don't mix it. A guide for employers on alcohol at work. INDG240. London: HSE, 1996. http://goo.gl/9QVP7 General Medical Council FTP Fact Sheet 2009: Allegations. http://goo.gl/jy1nh
016	Faculty of Occupational Medicine	Access to advice for employers on alcohol misuse at work	Alcohol misuse in the workplace can be very effectively managed through occupational health practitioners who are trained and experienced in managing alcohol misuse.	Much of the harm that workers experience is preventable and simple interventions in the workplace could benefit workers who misuse alcohol, their colleagues and their managers. The MoCAM system suggests 4 tiers of intervention, of which tiers 3 and 4 should be delivered by specialist alcohol treatment services. However, both tier 1 and 2 can be delivered in settings where alcohol treatment is not the main focus, including occupational health.	NHS National Treatment Agency for Substance Misuse. Models of care for alcohol misusers (MoCAM). London: Department of Health 2006. http://goo.gl/Qqe7p

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				Few occupational health services provide appropriate levels of support for alcohol misuse at work as advised by the Faculty of Occupational Medicine. Much more should be done to publicise good models of care throughout the UK	http://www.fom.ac.uk/event/management-of-alcohol-misuse-in-the-workplace
017	Faculty of Occupational Medicine	Access to support for alcohol misuse at work through occupational health practitioners trained and experienced in managing alcohol misuse			
018	Faculty of Occupational Medicine	Alcohol policies for employers	All employers should have an alcohol policy. It is very difficult to deal with alcohol problems at work without one.	Employers need a system for removing an employee who is under the influence of alcohol at work. They need methods for investigating alcohol misuse or working under the influence of alcohol. They also need to recognise that alcohol misuse is a health problem to support employees as long as they cooperate fully with treatment.	Guidance on alcohol and drug misuse in the workplace. London: Faculty of Occupational Medicine, 2006
019	Faculty of Occupational Medicine	Access to occupational health services for all of the UK workforce		Apart from the limited advice that can be obtained from HSE, there is no access to specialised occupational health care for some 70% of the national workforce, nor for almost all of the unemployed.	http://www.fom.ac.uk/wp-content/uploads/pp_natstrat.pdf
020	Lundbeck Limited	Key area for quality improvement 1: Access	Lundbeck is an ethical research-based pharmaceutical company	The World Health Organisation has indicated that there is ‘good evidence that	1 - HM Government, The Government’s Alcohol

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		to alcohol services appropriate for the level of harmful drinking	specialising in brain disorders, such as depression and anxiety, bipolar disorder, schizophrenia, Alzheimer's disease, Parkinson's disease and alcohol dependence. Lundbeck welcomes this topic engagement exercise on preventing harmful alcohol use in the community. Considering the wide-reaching burden attributable to alcohol-related harm - costing society an estimated £21 billion1 and the NHS in England £3.5 billion2 every year - there is a clear and well-evidenced need for addressing alcohol-related harms to be made a health priority by commissioners and health professionals. Lundbeck recommends that this Quality Standard prioritises the delivery of access to alcohol services appropriate for the level of harmful drinking as a key area for quality improvement. At the higher levels of harmful drinking people may become alcohol dependent. One in twenty adults is believed to be dependent	treatment can reduce the health burden attributable to substance use and possibly the amount of alcohol and drugs consumed in a country'.6 In the European Study of the Epidemiology of Mental Disorders (ESEMeD), which included general population surveys in six European countries, only 8.3% (95% CI: 3.8% - 12.8%) of people diagnosed with an alcohol use disorder in the past 12 months received any formal treatment for their condition during that period.7 Currently only around 6% of people who are alcohol dependent in England actually receive treatment.8,9,10 Even though there was a slight increase in the number of people entering specialist treatment for alcohol problems in England In 2011-12,8 the current 6% treatment rate is well below the 15% rate regarded as a 'medium' level of access to treatment according to the North American Rush model.11 Alcohol services, in particular treatment services, are historically underfunded compared to drug services. This has a negative impact upon alcohol treatment service provision and waiting times. With this in mind it is important that commissioners support the delivery of appropriate services for alcohol	Strategy, March 2012 2 - National Treatment Agency for Substance Misuse, Alcohol Treatment in England 2011-12, January 2013 3 - The Centre for Social Justice, No quick fix, September 2013 4 - NICE, CG115, Alcohol dependence and harmful alcohol use. Available online at: http://www.nice.org.uk/CG115 (Last accessed 12 March 2014) 5 - NHS Choices, The risks of drinking too much. Available online at: http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx (Last accessed 12 March 2014)

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			on alcohol in England.3 NICE commissioning guidance recommends increasing the proportion of people in the local population with alcohol dependence who enter and complete treatment in a setting appropriate to their need.4 This is especially true for people with mild alcohol dependence (defined in NICE Clinical Guideline115 as those scoring 15 or less on the SADQ, which correlates broadly to those classified as 'higher risk' by the Department of Health5). People with mild alcohol dependence may not want to be assessed and treated in a specialist service alongside more severely dependent patients who require assisted withdrawal.4 A more appropriate setting is primary care with management by GPs or other healthcare professionals.	dependence, taking into particular account people with mild levels of dependence, who do not require assisted withdrawal. Community-based, non-specialist services which incorporate a range of psychological, psychosocial and pharmacological interventions will be better suited to the needs of these patients. .	6 - Babor et al., 2010a; Smart & Mann, 2000; Reuter & Pollack 2006, cited in 'ATLAS on substance use (2010)'. Accessible online at: http://www.who.int/substance_abuse/ activities/msbatlaschtwo.pdf (last accessed 12 March 2014) 7 - Rehm J, Shield KD. Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: potential gains from effective interventions for alcohol dependence. Canada: Centre for Addiction and Mental Health (CAMH); 2012. Available at http://www.camh.ca/en/research/news_and_publications/reports_and_books/Documents/CAMH%20Alco

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					hol%20Report%20Europe%202012.pdf. (Last accessed 12 March 2014) 8 - National Treatment Agency for Substance Misuse, Alcohol Treatment in England 2011-12, January 2013 9 - NICE, Alcohol-use Disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence, clinical guidance 115, February 2011 10 - NICE, New guidance to tackle alcohol problems. Accessible online at: http://www.nice.org.uk/newsroom/news/NewGuidanceToTackleAlcoholProblems.jsp

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					11 - Rush, B (1990) A systems approach to estimating the required capacity of alcohol treatment services, British Journal of Addiction, 85: 49-59
021	Lundbeck Limited	Key area for quality improvement 2: Delivery of effective referral pathways	Lundbeck recommends that this Quality Standard prioritises the delivery of appropriate referral pathways for harmful drinking and people identified with alcohol dependence. While measures for the delivery of screening and brief intervention are outside the scope of this review, in order to maximise the benefits of identifying people potentially at risk of alcohol misuse, it is essential to ensure that patients are referred to the appropriate service. Patients who are suitable for treatment in the community setting for instance, such as those identified with mild dependence, should be assessed and treated in that setting where possible and	Current care, treatment and referral pathways for alcohol misuse are diverse across England to reflect local needs and services. Ensuring a Quality Standard with evidence-based measures to support commissioners to deliver effective referral pathways will help improve patient experience and coordination between services. As well as highlighting how best to refer patients with alcohol dependence, we would also recommend that this quality standard incorporates measures for educating healthcare professionals about the benefits of identification and appropriate referral. This is particularly pertinent as a survey of GPs in England found low levels of motivation for addressing problem or dependent drinkers' alcohol issues, with busyness, lack of training or contractual incentives cited as key barriers.13	12 - NICE, Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults. Commissioning guide. Implementing NICE guidance, August 2011 13 - Wilson G B et al., Intervention against excessive Alcohol Consumption in Primary Health Care: A Survey of GPs' attitudes and practices in England 10 years on, Alcohol & Alcholism (September-October 2011) 46 (5):570-

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			referred onward appropriately. Ensuring that healthcare professionals are comfortable in the delivery of appropriate referral pathways can therefore contribute to service users accessing treatment in the most beneficial environment. Improving referral practice can also help to address alcohol dependence at an earlier stage, before people become more severely dependent and require more specialist treatment. In order to deliver effective referral pathways it is also important that alcohol services are commissioned through an integrated approach between local authorities and Clinical Commissioning Groups, with clear lines of responsibility outlined for service provision. NICE reports that commissioning high quality alcohol services using an integrated, whole-system approach can increase access to evidence based interventions, which could improve outcomes for people, such as better health,		577

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			wellbeing and relationships.12		
	Public Health England	Psycho-social interventions	As stated in NICE guidance CG115 'Alcohol-use disorders – diagnosis, assessment and management of harmful drinking and alcohol dependence,' harmful drinkers and people with mild alcohol dependence should be offered a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Psycho-social interventions are a key element in the delivery of alcohol treatment.	There has been some confusion caused by NICE guidance PH49 (Behaviour Change: individual approaches) about appropriate theoretical approaches, interventions and also appropriate qualification, competency, training, supervision and clinical governance required to deliver those interventions. Local commissioners and providers appear to be making local decisions about what is appropriate based upon scarce resources, resulting in little consistency in the quality of delivery. This concern is exacerbated by the de-commission of many Mental Health Trusts as providers of alcohol services and therefore there appears to be reduced access to psychological services and formal psycho-social interventions. Clarity and guidance is needed on what constitutes extended brief interventions, how this differs from brief treatment and how, where and when this is delivered within an alcohol treatment system. Clarity and guidance is needed on the difference between family therapy, family interventions and family work. What approaches are the most appropriate within the alcohol treatment system and as above clarifying qualification, training, supervision and governance.	The National Drug Treatment Monitoring System monitors the delivery of specialist alcohol treatment and from 1 April 2011 to 31 March 2012, it indicates that 51% of people, who were in specialist treatment at that time, received a structured psychosocial intervention and 40% were not receiving a form of structured psychosocial intervention.

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022	Public Health England	Safeguarding	The appropriate identification and management of risk is a fundamental part of clinical practice. Alcohol misuse depending upon the circumstances may constitute a significant risk for children and adults. Clear guidance would improve pathways and ultimately more appropriately safeguard children and adults in the care of alcohol services.	Considerable work has helped to clarify protocols for parental alcohol misuse e.g. "Supporting information for the development of local joint protocols between drug and alcohol partnerships and children and family services" PHE 2013 There needs to be further clear statements on the relationship between substance misuse and safeguarding (child and adult). Clarification of when alcohol misuse constitutes a safeguarding risk for children and adults, for example: a child's own use of alcohol and adult misuse other than in terms of their ability to parent. For example, when does intoxication become a safeguarding issue and what would be an appropriate response, does the Local Authority have the responsibility to protect? Each Local Authority appears to have a completely different threshold and interpretation based upon management of scarce resources.	
023	Public Health England	Mental Health pathways	As stated in NICE guidance CG115 'Alcohol-use disorders – diagnosis, assessment and management of harmful drinking and alcohol dependence,' it is important to help people who have mental health problems.	Despite previous guidance, there still appears to be confusion between alcohol and mental health services regarding role and function and who is responsible for the range of mental health problems. This has been made worse by changes in the commissioning landscape, the management	Of those individuals in specialist alcohol treatment, the National Drug Treatment Monitoring System's recording of mental health concerns is minimal.

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			Mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment.	of scare resources and the de-commission of some Mental Health Trusts as providers of alcohol services. Pathways for severe and enduring mental health problems and alcohol misuse appear to work well, however pathways do not work so well for other common mental health problems and personality disorders. This would seem to result in alcohol services trying to manage mental health problems. Do alcohol services have the appropriate skills to manage mental health problems and vice versa? Do we require joint commissioning guidance?	
024	Public Health England	Ensure training for dental teams follows the evidence-based standard developed for prevention (Delivering Better Oral Health, 2009, version 3 in press 2014).	The incidence of oral cancer has steadily increased since the 1970's and now oral cancer amongst men is more common than cervical cancer in women (Conway et al., 2006). The most important risk factors for oral cancers are the combined effect of tobacco use and consumption of alcohol, which together account for about three quarters of oral cancer cases (La Vecchia et al., 1997). A substantial body of high quality evidence has highlighted the effectiveness of delivering	The 'alcohol-use disorders: preventing harmful drinking' guidance, recommendation 10: states those who trained within dental surgeries should identify adults drinking alcohol at a hazardous or harmful level via screening. The area for quality improvement should link training of dental teams to Delivering Better Oral Health: An evidence-based toolkit for prevention.	Conway D et al., (2006). Incidence of oral and oropharyngeal cancer in the United Kingdom (1990-1999) – recent trends and regional variation. Oral Oncol;42: 586-592. Kaner E et al. (2007). Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews. CD004148. La Vecchia C et al.,

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			brief advice to drinkers. The most recent Cochrane review included 29 RCTs of brief interventions delivered in primary care settings, reported significant reductions in weekly drinking at one year follow up with an average reduction of 4-5 drinks per week (Kaner et al., 2007). Drinking above recommended levels is also associated with non-carious tooth surface loss due to the acidity of drinks such as alcopops, cider and wine (Robb and Smith, 1990). Finally, there is some evidence that alcohol is also associated with increased risk of periodontal disease (Amaral et al., 2008). Advanced periodontal disease gradually destroys the periodontal membrane and the surrounding bone causing 'pocketing' and creates gaps between the gum and root of the tooth. This can destroy the supporting bone leading to tooth mobility and loss which impacts on quality of life (Locker 2004) and the ability to support the consumption of a varied diet (Ervin 2008).		(1997). Epidemiology and prevention of oral cancer. Oral Oncology; 33: 302-312. Department of Health and British Association for the Study of Community Dentistry. Delivering Better Oral Health: An evidence-based toolkit for prevention (Second Edition). 2009, The Stationery Office: London (third edition in press). Amaral CS et al (2008). The relationship of alcohol dependence and alcohol consumption with periodontitis: a systematic review. Journal of Dentistry; 37: 643-651. Robb ND and Smith BG. (1990). Prevalence of pathological tooth wear in patients with chronic alcoholism. British Dental Journal; 169: 367-369. Bansal, M., S. Rastogi, et al. (2013). "Influence of periodontal disease on

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			The impact of periodontal disease as an inflammatory mediators on systemic diseases are well documented within the literature, for example links to cardiovascular disease, respiratory disease, metabolic syndrome, adverse pregnancy outcomes and dementia (Bansal, Rastogi et al. 2013).		systemic disease: inversion of a paradigm: a review." Journal of Medicine & Life 6(2): 126-130. Ervin, R. (2008). "Healthy Eating Index scores among adults, 60 years of age and over, by sociodemographic and health characteristics: United States, 1999-2002." Advance Data(395): 1-16. Locker, D. (2004). "Oral health and quality of life." Oral health & preventive dentistry 2 Suppl 1: 247-253.
025	Public Health England	Identify systems to support partnership working through accident and emergency services for dentistry.	Excessive alcohol intake is also associated with dental trauma and facial injury either through accidental falls, road traffic accidents or violence, both domestic and street related (Hutchison et al., 1998).	The 'alcohol-use disorders: preventing harmful drinking' guidance, recommendation 12: states referrals to be made to specialist services if one or more of the following has occurred. They: show signs of moderate or severe alcohol dependence have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem show signs of severe alcohol-related impairment or have a related co-morbid	Hutchison IL et al. (1998). The BAOMS UK survey of facial injuries part 1: aetiology and the association with alcohol consumption. British Journal of Oral Maxillofacial Surgery; 36: 3-13. Smith A J, Hodgson R, Shepherd J P (2003). A randomised controlled trial

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				condition (for example, liver disease or alcohol-related mental health problems). The area for quality improvement should ensure that models of good practice as demonstrated in the Cardiff Model are considered by commissioners of services. This will ensure that the safer communities agenda is realised and healthcare professionals working within secondary care can support the identification of individuals at risk.	of a brief intervention after alcohol-related facial injury. Addiction 98:43-52.
026	SCM1	Appropriate and relevant alcohol education provision within the school curriculum (5-18 years) within a broader Personal, Social, Health Education (PSHE) context.	Children are exposed to alcohol and/or alcohol related behaviours from an early age. Children know much more about an alcohol using world than adults imagine. There is a need – in terms of education to prevent harm from alcohol – to start from where children are and what they know or perceive, to devise a developmental programme of alcohol related education to enable children to grow up safely in an alcohol using world. Revisiting knowledge, understanding, attitudes and skills as appropriate to the developmental age and experience of the learners. Alcohol education in schools has	'Most children understood the dangers to health of tobacco and illegal drugs but are less aware of the physical and social damage associated with alcohol misuse, including personal safety' Ofsted 2013 Provision needs to be more than information giving: Ofsted recommends that schools should ensure timely and appropriate learning about the physical and social aspects of alcohol misuse. 'Deficit knowledge is not the problem… but a failure to connect with knowledge as relevant to their experience' (Joseph Rowntree Foundation 2010) Alcohol education focusing on the observance of unit intake per session and	Not yet good enough: personal, social, health and economic education in schools Ofsted 2013 Drinking to belong: Understanding young adults' alcohol use within social settings. Joseph Rowntree Foundation 2010 Effectiveness of delivering alcohol education lessons in years 8 & 9 – found to significantly delay the onset of drinking alcohol Talk about Alcohol evaluation NFER http://www.alcoholeducationtrust.org/pdfs/NFERfinal.

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			to be more than just giving information about alcohol Whilst accurate knowledge is essential this alone will not help us to handle what can be difficult social situations where perhaps our peers are encouraging us to experiment with alcohol. Managing difficult situations requires skills, strategies, language and lot of self-confidence.	promotion of 'sensible drinking' does not start at the place of many young people's experience. It runs counter to the way that alcohol is used within peer groups and therefore seems unlikely to affect behaviour change in the short term. Teaching and learning (and teacher development) needs to attend to new behavioural trends that may impact on children and young people e.g. Neknominate	pdf
026	SCM1	Continuing professional development (CPD) and specific training for teachers delivering PSHE /alcohol education.	Delivering high quality PSHE/Alcohol education requires competent (skills, knowledge and understanding) confident teachers. Not good enough to be an 'add-on' to a teacher's work load without training & development time.	Deficiencies in pupil learning result in part from inadequacies in subject-specific training and support for PSHE education teachers –Ofsted 2013 Recommendation to department of education by Ofsted that staff teaching PSHE in schools (including alcohol education) have training	Not yet good enough: personal, social, health and economic education in schools Ofsted 2013
027	SCM1	Parent education on alcohol use; modelling behaviours, talking to children and young people about alcohol.	Influence of parents is key in establishing ideas of contextual appropriateness for different styles of drinking alcohol. The importance of parental influences on children's alcohol use should be communicated to parents, cares and professionals. Families make different decisions	Parents and carers require advice on how to respond to alcohol use and misuse by children. Many parents and carers are ignorant of the degree of influence of their own modelling behaviours on children's perception of and attitudes to alcohol (On the Brink investigation tool - children's perceptions of alcohol Collins, Smart, Wetton 2002)	Guidance on the consumption of alcohol by children and young people Sir Liam Donaldson CMO Dec 2009 Drinking to belong: Understanding young adults' alcohol use within

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			about how they introduce or choose not to introduce their children to alcohol. 68% of 11 – 12 year olds who drink alcohol do so with their parents. By age 15 74% of young people who drink alcohol do so with their friends so it is important is that we talk about alcohol with our children and to start this discussion early.	mumsnet parent questions and discussions e.g. giving children alcohol talkaboutalcohol.com Alcohol Education Trust identify the need to support parents in talking about alcohol with their children	social settings. Joseph Rowntree Foundation 2010
028	SCM1	Quality standards for visiting speakers/external contributors to PSHE/Alcohol education	Many secondary schools rely on external organisations and contributors to support and/or deliver aspects of alcohol education.	Many organisations supply/deliver information giving/knowledge focussed resources but do not attend to attitudes and values, providing the opportunity for pupils to think about what they and others feel about alcohol; what they might say and do if alcohol is available and what might be the consequences of their choices. Some schools use ex-addicts with no proper assessment or evaluation. Schools need to be encouraged/helped to consider the particular value of an external contribution and how this supports intended learning outcomes for pupils.	Example of Guidance for schools using external contributors for PSHE www.pshe-association.org.uk
029	SCM1	School policy for alcohol, comprising the 4 areas above but also addressing alcohol on school premises; management of alcohol	Earlier government guidance (Drugs guidance for schools DfES 2004) has been superseded by DfE and ACPO Advice for schools which does not address Alcohol, not curriculum and staff training	There is no current comprehensive guidance to support schools	Drugs guidance for schools DfES 2004

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		related incidents (pupils and staff)	issues.		
030	SCM2	Key area for quality improvement 1	Family members affected by someone in alcohol treatment should be involved in care planning	Evidence suggests that involving the family in the user's treatment can support recovery Over the past three decades there has been increased recognition by researchers in the field of the important role that families of drug users can play, both in terms of influencing the course of the substance related problem and in contributing to the achievement of positive outcomes when drug users are attempting to change their problematic behaviour, either within or outside the treatment system. Recently, the needs of family members that arise from the stress that they experience as well as the role and potential contribution that adult family members can make to treatment intervention for drug problems have been recognised in the research, clinical and policy arenas.	This has been noted, for example, in the UK National Drug Strategy (HM Government, 2008), the National Treatment Agency for Substance Misuse guidelines for commissioning families and carer services (NTA, 2008) and the National Institute for Health and Clinical Excellence (NICE) guidance on psychosocial interventions for drug misuse (NICE, 2007).
031	SCM2	Key area for quality improvement 2	Family members of someone with an alcohol problem should be offered an assessment of their own needs	Research tells us: 'Substance users cause problems for their families – it has been estimated that every problem drug or alcohol user influences two family members to the point of them requiring primary health care services'. "Every substance misuser will negatively affect at least two close family members' to a sufficient extent that they will require	Service provision for the children and families of alcohol misusers: a qualitative study, Sarah Zohhadi, Lorna Templeton and Richard Velleman Supporting families and carers of drug users: A

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				primary health care services." Velleman (2002) – Family Interventions in Substance Misuse	review, Velleman, 2002 Supporting the supporters: Families of Drug misusers, UK Drug Policy Commission, 2009 Psychological interventions with families of alcohol misusers: a systematic review – C Russell, Lorna Templeton and Richard Velleman
032	SCM2	Key area for quality improvement 3	Family members of someone with an alcohol problem should be referred to local support services, if available	Adfam is in touch with approximately 150 groups and services across the country which offer support to families, ranging from helplines and buddying to therapeutic family therapy	Out of focus: How families are affected by problem drinking, and how they look for help: Adfam, 2012
033	Tavistock Centre for Couple Relationships	Key area for quality improvement 1: Relationship support services to couples where one partner is at risk of harmful drinking	There is good evidence to show that a harmful drinking often results from poor couple relationship quality (see right). Providing support to couples in the form of relationship support where one partner is at risk of harmful drinking (i.e. their drinking is hazardous) has the potential to reduce the likelihood of that person's drinking becoming harmful.	Care and treatment of people who are at risk of harmful drinking does not currently include supporting and improving the couple relationship of that person (where appropriate); this runs counter to evidence (see right) regarding the impact of relationship difficulties on alcohol consumption which suggests that supporting couples, and thereby improving couple relationships, has substantial potential for reducing alcohol misuse. Furthermore, couple therapy for men with alcohol problems has been shown to produce better outcomes for their children than individual	Research on relationship quality and alcohol misuse: One study of 69 heterosexual couples found that women tend to drink more than men in response to relationship difficulties and low levels of intimacy from their partner (Levitt, 2010). This finding corroborates those from earlier studies which

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				treatment (Kelley, Fals-Stewart, 2002). Research clearly demonstrates that children' attitudes to alcohol use are highly influenced by parental ones (DCSF, 2010). Including a focus on the couple relationship as a way of reducing the likelihood of harmful alcohol use therefore would bring benefits not only to adults but to future generations also.	indicate that women whose relationships lacked intimacy reported increased drinking problems over time compared to women with more intimate relationships (Wilsnack, 1984). A longitudinal study however – which followed couples over a period of nine years – found that husbands, not wives, tend to drink in response to marital problems (Romelsjo, Lazarus, Kaplan, & Cohen, 1991). The thrust of these findings is supported by two studies conducted in 2006. The first of these demonstrated a greater likelihood of people abusing alcohol one year after scoring highly on a rating of marital dissatisfaction, leading the authors of the study to observe that "if marital dissatisfaction is related to the course of alcohol use

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					disorders, then reducing marital dissatisfaction should reduce the likelihood of onset or recurrence of alcohol use disorders" (Whisman, 2006). While the second study, of nearly 5,000 adults aged 18 to 64, showed that the marital discord underlying a divorce (rather than the divorce itself) to be associated with the onset of alcohol abuse, social phobia and chronic low mood (Overbeek, 2006).
034	The Training Tree	Key area for quality improvement 2 Raise awareness of risk categories in the professional population	Professionals need to be clear about alcohol messages in order to raise awareness with public/patients/clients Commissioners need a good understanding of risks and what they can do to ameliorate them using a whole system approach Workforce well-being: Alcohol impacts significantly on the workforce in terms of health, resilience, performance, sickness	Professionals are often unclear about risk categories, units, thresholds of risk etc and this means they cannot open the subject with general public with confidence Commissioners need a better understanding in order to commission effective services which will address the needs of the local population A whole-system map for commissioning and an up to date JSNA including alcohol are crucial. The workforce is a neglected area of concern regarding alcohol, yet the impacts	NICE Guidance PH49 http://guidance.nice.org.uk/PH49 Recommendation 9 could help to achieve a greater understanding in public through increasing professional awareness and ability to raise issue Whole system Guide: http://publications.nice.org.uk/services-for-the-identification-and-

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			absence All recommendations from NICE Guidance	are huge	treatment-of-hazardous-drinking-harmful-drinking-and-alcohol-cmg38/34-whole-system-commissioning-of-high-quality-alcohol-services http://publications.nice.org.uk/alcohol-lgb6/what-can-local-authorities-achieve-by-tackling-alcohol-misuse
035	The Training Tree	Key area for quality improvement 3 LA to provide strong leadership for improvements in the way alcohol impacts on local communities	LA are in a position to provide leadership and to work collaboratively to encourage socially responsible retailing and consumption of alcohol Recommended by NICE Guidance	LA are unclear of what actions they can take to put public health at the heart of all council decisions eg responsible licensing decisions, local alcohol free zones etc Without this in place, all other actions to ameliorate the impact of alcohol in local communities will be diluted	http://publications.nice.org.uk/services-for-the-identification-and-treatment-of-hazardous-drinking-harmful-drinking-and-alcohol-cmg38/34-whole-system-commissioning-of-high-quality-alcohol-services http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24/recommendations
036	The Training Tree	Key area for quality improvement 4 Regulate the price and	MUP is a key intervention to reduce harmful outcomes from alcohol (Sheffield University)	MUP, marketing, licensing and availability are key population initiatives. Alcohol is a recognised serious public health issue.	http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-

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		availability of alcohol		Local initiatives would be strengthened through national approaches and policy measures	drinking-ph24/recommendations http://www.shef.ac.uk/polopoly_fs/1.156503!/file/scotlandjan.pdf
037	The Training Tree	Key area for quality improvement 5 Community engagement	Enabling local communities to be involved in the decisions that affect them is recommended by NICE Guidance	Helps to build health literacy in local communities; to build resilience and assets in local communities too Without this the sustainability of approaches will be weakened	http://publications.nice.org.uk/community-engagement-ph9/recommendations