Review of Alcohol Misuse Services in Stockport

Report of the Health & Wellbeing Scrutiny Committee

February 2015

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Foreword

One of the reasons the Health & Wellbeing Scrutiny Committee chose to look at Alcohol issues in Stockport was because the official NHS figures showed that there was a problem related to alcohol in Stockport (in that we were worse than regional and national statistics) - but we were all shocked when we came to look in great detail at the actual scale of the problem.

Put simply alcohol related deaths of under 75s in the last full year (2013-14) were almost as many as the combined deaths for cancer and road traffic accidents in the Town - and that doesn't take into account the wider alcohol emergency figures of around 7000 admissions into the health system.

Behind each one of these figures is a person, their family, friends or workmates and the impact the problem has on them and their lives as well.

And as equally important is for everyone to recognise that we're not just talking about the stereotypical 'usual suspects' - this problem is cutting across all age groups and levels of society in our Town.

For many people alcohol is part of a wider health or societal issue (stress, depression, mental health issues, loneliness, isolation) so there isn't a 'one size fits all' solution that can be neatly deployed to solve the problem - the 'health economy' needs to be innovative and supportive in their attempts to provide help.

During our research we met a small group of people who were brave enough to tell us in detail what the impact of alcohol had been on their lives and or their family and friends - it was a very powerful testimony which underpinned the work that the professionals were undertaking in trying to combat the problem.

Finally - we also recognise that for many people meeting friends and 'having a drink' isn't a problem as they act responsibly and they act within limits - but there is a great deal of confusion among people about what are safe levels of alcohol to consume and a consistent message nationally would help inform people.

Thank you to everyone who took part in this piece of work. All your help and advice was much appreciated.

Councillor Tom McGee, Chair of the Health & Wellbeing Scrutiny Committee

Background

In 2014, Public Health England's National Liver Disease Information Service published its *'Local Authority Liver Disease Profiles'.* The key messages for Stockport were stark:-

- *In Stockport, between 2010 and 2012, the average number of years of life lost[1] in people aged under 75 from liver disease is 41 per 10,000 persons. This compares to 36 for breast cancer, 16 for stroke and 5 for road traffic accidents.*

- *In Stockport the rate of premature mortality from liver disease between 2010 and 2012, is significantly higher than the England average for males and similar to the England average for females.*

- *Between 2001-03 and 2010-12, the average number of people per year who died with an underlying cause of liver disease in Stockport, increased from 50 to 79.*

- *The rate of alcohol specific hospital admissions in 2012/13 in Stockport is significantly higher than the England average for males and significantly higher than the England average for females.*

- *There were 1,507 alcohol specific hospital admissions in Stockport in 2012/13 (1,015 male and 492 female). The rate of alcohol specific hospital admissions in Stockport is significantly higher than the England average for males, and significantly higher than the England average for females.*

Across a range of alcohol and liver disease indicators, Stockport was categorised as 'Significantly Worse than England average', whereas for other liver disease indicators, such as Hepatitis B & C and obesity, rates in Stockport were no worse than 'Not significantly different from England average'. By way of comparison with alcohol measures the number of people in Stockport who inject drugs was slightly less than the national average.

In light of these statistics the Scrutiny Committee agreed to undertake a review on Alcohol Services provided in Stockport, with specific reference to these topics:-

- The impact of adult (26+) alcohol misuse on individuals, their families and communities and agencies.
- The way services are currently commissioned and delivered.
- The different types of services and support which are in place, including specialist treatment services, lifestyle services, hospital based interventions and volunteer/service user support.

[1] *'Years of Life Lost ' is an estimate of the average years a person would have lived if they had not died prematurely. It is therefore a measure of premature mortality.*

Local Context

Nationally, levels of alcohol consumption are revealing –the 25% of people who drink over the guideline amount of alcohol will consume near 75% of all the alcohol sold, with the drinking habits of 7% of the population accounting for 33% of all alcohol consumed.

The profile of drinking in Stockport was also stratified, although not necessarily reflective of the popular image of 'problem drinkers' as being young people in town centres. The age cohort with the highest rate of risky drinking over a week were those aged between 40-65. This was reflected in the age profile of those in treatment in 2013/14 where the highest numbers were from the 40-49 year old range. The least deprived/ most affluent were also the most likely to consume risky amounts of alcohol, with the most deprived drinking less on average although they were also more likely to be admitted to hospital for alcohol related admission. This paints a picture of a more affluent cohort drinking larger amounts regularly, but a more deprived cohort either not drinking or drinking dangerously.

The current adult alcohol treatment system in Stockport is comprised of:

- ***The Healthy Stockport service -*** delivering brief interventions around alcohol as part of a wider healthy lifestyle approach.

- ***Stockport Treatment Access to Recovery Team (START) -*** a single point of access/assessment for adults for both alcohol and drugs. START acts as 'gatekeeper' and referrer to treatment following an assessment of dependency, need and capacity for recovery.

- *P**ennine Care Drug and Alcohol Service*** (NHS provider), ***Addiction Dependency Solutions*** (3rd Sector Provider) and ***Acorn Treatment and Housing*** (3rd Sector Provider - adult specialist alcohol and drug service providers

- ***Hospital based provision*** - Alcohol Liaison Nurse provision to identify alcohol misuse issues in those presenting to the Emergency Department and ensure an appropriate package of care is built around them.

- ***Service user groups and volunteers/peer mentors -*** A variety of people and groups who aim to raise awareness of substance misuse issues and help substance misusers to move towards recovery. In addition, initial support is available in primary care settings, where GPs will ask patients about their drinking and making referrals to the START or Healthy Stockport if appropriate.

In 2013/14, the number of those aged 18 and over in specialist alcohol treatment was 844, an increase of 17% on 2012/13, and the number of new treatment starters was 576, and increase of 10% on the previous year.

In the financial year 2014/15 the following sums were allocated from the Public Health grant:

- Young People's substance misuse (drugs and alcohol): £398,901
- Adult community based substance misuse (drugs and alcohol) treatment: £1,941,279
- Adult residential rehabilitation and inpatient detoxification services (drugs and alcohol): £388,104

What the commissioners said

Fundamentally, Commissioners (Stockport Council) recognised that the statistics quoted above were unacceptable and that in part this was due to deficiencies in the current structure of treatment provided in Stockport. This was not to suggest that the services were, in themselves, poor but that they had been designed around a particular set of circumstances and need that was not wholly appropriate in the current climate. Alcohol Services, commissioned alongside other substance misuses services, heavily favoured medicalised, intensive treatments for those with acute needs. In the case of alcohol this was not always the most appropriate nor the most effective treatment option whereas it may have been more appropriate for those seeking treatment for opiate misuse.

The numbers of people seeking help with opiates and other substances has reduced relative to the numbers seeking help for alcohol misuse: between 2012/13 and 2013/14 the percentage split between those within structured drug and alcohol treatments reversed from 57:42 to 33:67.

Overall the current specialist alcohol treatment provision is considered to be:

- Specialist – interventions are predominantly delivered through structured treatment which is designed to address clients' needs once the client has already reached crisis point. There is a significant lack of early intervention and prevention and post-treatment support.
- Medical - overly focussed on the medical response to substance misuse, which, although an important element of our response to substance misuse, will not meet the needs of future clients if recovery based interventions are also not adopted.
- Deficit based – clients are defined by their problems (substances of use) rather than by their ability to achieve recovery (recovery capital). Payment by Results[2] has improved this to some extent but 'problem management' remains a characteristic of the system.
- Linear – traditional systems can be 'narrow and long'. Clients move into narrow pathways of sequential interventions which can elongate treatment journeys.
- Lack of family support – stable relationships are an important element in recovery; currently there is too little support for families or concerned others. A greater focus also needs to be placed on addressing the issue of hidden harm and supporting children of substance misusing parents.

It was the experience in Stockport that premature use of detoxification treatments for those referred into treatment without proper preparatory work had led to unacceptably high rates of repeat referral and treatment. Greater focus was now given to ensuring that those entering intensive treatments were ready for the challenge and had the appropriate support to sustain abstinence once the intensive treatment had stopped.

[2] This was a national pilot by the Department of Health that sought to link the payments to treatment providers to the sustainability of the recovery of the service users. Payments were linked to how long a service user maintained their abstinence, rather than simply passing through a treatment programme.

Services in the future would have to be commissioned differently: there would need to be greater focus on prevention and early interventions to reduce demand on intensive and costly treatments; and greater emphasis on long term recovery as an outcome.

What the providers said

The Committee received evidence from a number of service providers, representing statutory agencies such as the NHS and Council, as well as third sector providers. Their clients ranged from those with mild to moderate lifestyle concerns to those with severe alcohol dependency. Those organisations that participated in the Review included:-

- START (Stockport Treatment – Access to Recovery Team)
- Healthy Stockport
- ADS (Addiction Dependency Solutions)
- Pennine Care NHS Foundation Trust (Drug and Alcohol Directorate)
- Stockport NHS Foundation Trust (Alcohol Service)

Common themes and concerns emerged from the evidence provided by these organisations and providers.

Challenges of early identification and intervention

Engaging with those who drank excessively or dangerously required them to be minded to address their behaviour, or even to be aware that their consumption was problematic. Discussing problem drinking with a client could be challenge for professionals, particularly those not receptive to the suggestion they had a problem. Confusion over appropriate and safe levels of drinking, how many units were in particular drinks etc, was one obstacle to this task. More common however was the user needing to reach crisis point before seeking help, particularly those at the most severe end of the spectrum. For those with less severe needs, broaching the conversation about drinking could be done through a wider discussion about a healthy lifestyle.

For those presenting at Stepping Hill Hospital with alcohol related conditions, including alcohol intoxication, there were a number of interventions in place to provide support and refer to services. A dedicated alcohol nurse was now embedded within the hospital and referrals were now becoming systematic. Research suggested 1 in 8 people receiving a single brief intervention about their 'risky' (rather than dependent) alcohol use would change their drinking habits.

Ensuring that every opportunity to engage with the public and reiterate lifestyle messages was identified as vital to providing effective preventative services, such as through the 'Making Every Contact Count' approach and through engaging an ever wider group of professionals and services, such as dentists and pharmacists.

Recover, Abstinence and Peer Support

Overcoming dependency and maintaining abstinence needed to be given greater priority in any future service redesign. As part of START's assessment of new referrals greater consideration was being given to a person's suitability for detoxification and additional support provided prior to the treatment in an effort to ensure that this was more effective at leading to sustainable recovery and to prevent the need for repeat treatments.

The importance of an addict's social circumstances in aiding or hindering their recovery was emphasised. In views later echoed by service users, it was stressed that often the social networks around an individual could be decisive in supporting someone in abstinence, or in leading them back into drinking. Socialising with individuals who were themselves dangerous drinkers was more likely to lead to temptation, but being able to sever those ties completely was often not feasible.

Linked to this is the idea of 'recovery capital', which can be defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery"[3]. Put simply, this is the sum of the resources an individual can draw upon to aid them in their recovery, be it physical resources, life skills and experience or other kinds of support. In many cases those with alcohol dependency, be they in treatment or not, will have low levels of this capital which is why they may have become dependent on alcohol or other substances in the first place. In many cases, those in recovery will need practical support to build up this capital to be able to maintain their abstinence.

A key element of this capital is the 'community of interest' of those also in recovery or in abstinence providing peer support. Support groups and mentoring were becoming ever more important tools for sustaining people in recovery as users could provide invaluable experience that current service users could draw on. Importantly, ex-users were often more comfortable at providing challenge and having difficult conversations with current service users than some professional staff.

But this kind of approach need not be limited to those in treatment. Part of maintaining or enhancing a service user's recovery capital also meant ensuring that family members and carers were able to find support and an outlet to be able to cope with the pressure of supporting someone through recovery and, perhaps most crucially, in their abstinence.

The Scrutiny Committee has previously recognised the value of peer support in aiding recovery in the context of mental health and how co-production could be more cost effective than professionals simply providing services to people. Peer support was a cornerstone of efforts to put service users at the heart of, and in control of, their own treatment and recovery.

[3] Quoted in the Advisory Council on the Misuse of Drugs report *'Recovery from drug and alcohol dependence: an overview of the evidence'* December 2012, page 4

Alcohol dependency as a secondary symptom

All those who gave evidence recognised that in many cases of alcohol dependency there was an underlying emotional or mental health problem that was fuelling the desire to drink. While acute cases of alcohol dependency can lead to a physical dependency which can be dangerous to users who abruptly reduce or stop their intake, this is often not the underlying reason for someone continuing to drink dangerously and certainly not the cause. The impact of significant life changes on health, particularly those related to loss, has been well documented in academic literature, and in some cases those suffering the ill-effects of these changes will find comfort in some behaviour that is often dangerous or risky. While providing support or therapy to all these individuals would be impractical and prohibitively expensive, those most in need or at risk of slipping into these behaviours should be able to access support in some form. There was a consensus that expanding the provision of counselling and other talking therapies was likely to have an impact on the number of people who have suffered emotional distress who subsequently slip into alcohol or other substance misuse and dependency. Again, it was stressed that there was key role for public sector staff and professionals in making the most of their contact with the public to signpost or refer to other services.

What service users and carers said

The Scrutiny Committee were keen to engage the views of service users, and their families and carers, to gain an understanding of the challenges they faced in seeking help and in sustaining their recovery. The Committee were also aware of the need to approach this engagement carefully and sensitively, so members met with a small group of users at Cirtek House, the Pennine Care NHS Foundation Trust substance misuse centre in Stockport. This group included three service users, the wife of a service user, a carer whose sister was a service user, and a volunteer who had a relative who had died from an alcohol related illness.

Members heard some powerful testimony from this group, describing their own personal stories and how they came to be in treatment at Cirtek House. In common with the evidence provided by service providers, these service users talked about 'hitting rock bottom' and realising only then that they needed help. In the case of the carers, they talked about the frustration of not being able to convince their loved ones of the need to get help, and in one of the cases of not having reached the point at which the drinker *wants* to get help and to change.

Perhaps more pertinent for the Committee were the descriptions of the troubles users encountered once they had been referred into services, some of which were barriers to the effectiveness of treatment and the sustainability of their recovery. There was a degree of overlap with the concerns and issues raised by service providers.

Diagnosis and referral

There was a concern raised about the missed opportunities for healthcare professionals to identify problem drinking, or to take appropriate steps when they were made aware of the dangerous levels being consumed. It was recognised that often someone suffering from an addiction could be manipulative and deceitful in order to hide their addiction and get access to substances they needed, but the testimony from the service users pointed to a number of missed opportunities by healthcare professionals in a number of settings. In particular, regular visits to family GPs did not elicit referrals to appropriate services, such as START. This was echoed in the evidence from commissioners and providers themselves about the variability in referral rates, with some practices never having made a referral. Was this because some GPs were finding other ways to support their patients with alcohol misuse issues, or were they simply not having these conversations with patients? Most worryingly, one of the service users had a number of cardiac episodes that required extended periods of hospitalisation but despite contact with a number of hospital staff no conversation was had about unsafe drinking levels let alone a referral.

It had been commented during the session that some GPs seemed to prefer to prescribe rather than have a conversation with the patient to address the underlying issue. In one case, it was a locum GP who was the first to raise the levels of drinking, but someone working within the Department for Work and Pensions who actually made the formal referral to services.

What more could be done by the Clinical Commissioning Group to monitor referrals being made by GPs and to monitor whether lifestyle questions were even being asked?

What are partners doing to ensure front line staff were sufficiently trained to identify those with alcohol dependency and appropriately signpost to services?

Similarly, concerns were raised about access to specialist mental health services such as Cognitive Behaviour Therapy (CBT) and Improving Access to Physiological Therapies (IAPT) and the long waiting lists for these services, particularly in the case of 'dual diagnoses' of other mental health needs such as depression and anxiety. The consequence of these delays meant that users were more likely to relapse into addition or withdraw from services entirely.

In response to the these concerns, the Clinical Commissioning Group provided the Committee with information about waiting times for CBT and IAPT services, which indicated that the position at end December 2014 was:-

- Step 2 – Psychological well-being Services (PWS) – 100% of people can access treatment within 8 weeks
- Step 2 – Psychological well-being practitioners (Pennine Care) 78% access treatment within 8 weeks and 95% access treatment within 18 weeks (in January this had reduced to no waiting time)
- Step 3 – Cognitive behavioural therapy (CBT) – 62% of people access treatment within 8 weeks and 82% access treatment within 18 weeks
- Step 3 - Counselling – 23% of people access treatment within 8 weeks and 66% of people access treatment within 18 weeks.

It was also commented that in cases where alcohol dependency was masking an underlying mental health problem assessments of the service user should be able to identify their key needs over time and services should be able to provide the necessary therapeutic interventions to support them.

In relation to accessing Step 3 IAPT services, for CBT and counselling there continued to be some concerns, largely based on the length of time people were in treatment, however good progress around waiting times was being made.

Access to secondary care psychological services requires people to be care co-ordinated and this therapy takes place as part of a care package.

Can commissioners and service providers do more to ensure those in treatment have more timely access to other mental health services, such as IAPT and counselling?

Support for Carers and Families

It would be easy to forget that for every person addicted to alcohol there was likely to be a family who are also suffering from the ill-effects of substance misuse but without the opportunities to seek treatment. But for those in treatment and recovery, the support of their family was often vital to sustain them through treatment and sobriety. This was the clear message from both the service users, their carers and from service providers.

The carers who took part in the session with the Committee stressed the value of the family support group available through Cirtek House, though they highlighted that awareness of the availability of this support was not as widely known as it could be. They were also concerns that because this support was not offered directly to those in treatment, that these services would be vulnerable to future spending reductions.

Were partners doing enough support provided to families and carers to those in treatment and recovery to ensure that these key allies were able to support their family member through recovery?

Practical Support

For many of those involved in treatment or in recovery, this understandably becomes their primary focus. Because of this, the service users and their carers stressed the value of the practical support available to them through Cirtek House, but they also shared a frustration that more of this type of support wasn't available.

Particularly unexpected was the testimony of one carer whose relative was a long-term service user with Cirtek House but who had not fully engaged with treatment and was consequently prone to relapses. One of the contributing factors leading to these relapses was the fact that this person was living unsupported within the community. It was suggested that some form of sheltered or supported accommodation would provide an environment more conducive to sobriety and recovery. The difficulty was that sheltered housing was not available to those aged under 60.

Other problems encountered were related to access to benefits and other forms of financial support. One of the service users who had previously been employed in a series of skilled jobs talked about how his family was struggling to cope on one income during his treatment because despite the fact he had been referred to treatment by the DWP, they do not inform the Job Centre Plus of this and so he was not eligible for any support during his treatment and recovery, thereby putting additional pressure on him needing to find employment (see case study below).

***CASE** STUDY*

Mike was employed in a skilled job. When Mike became too ill to work he approached the Department for Work and Pensions and made a claim for Employment and Support Allowance (ESA). He was placed on contribution based ESA work related activity group benefit. Mike did not disclose his alcohol issue at that stage. This entitled him to 52 weeks of benefit payments.

At his first ESA personal advisor interview Mike's advisor suggested he might be on the wrong benefit, suggesting that he should be on support group benefit. This would entitle him to payments beyond 12 months. Mike was advised to leave the situation until he had received a planned operation.

Following the operation, and at a further ESA interview, a different advisor picked up on the fact that he might have an alcohol problem and contacted the START team for him during the interview. She organised an appointment and he subsequently entered treatment.

Job Centre Plus advisors informed Mike that they were not able to change his benefits from "activity group", to "support group", even though his alcohol problem was now acknowledged. They told him that this decision needed to be made elsewhere within the DWP. At the end of the 52 weeks he received a means test, and the decision was made that his wife's earnings were sufficient to provide for them both, so his benefits ceased. With support from treatment services and Welfare Rights, Mike has appealed against the above and is awaiting an outcome decision.

In light of this:-

Can partners utilise their resources more effectively to provide practical support for people in recovery, such as housing and benefits, and to work with other agencies to better identify those in treatment or recovery whose entitlements might be affected by this?

Commissioning Differently

In common with all public sector bodies, Stockport Council has had to re-evaluate its expenditure to ensure it can make the most of its limited resources. In line with this need, the Council has embarked on its 'Investing in Stockport' Programme to redesign services to meet current and future challenges. Part of the emphasis has been on preventing avoidable demand on expensive services with uncertain outcomes through commissioning preventative services or focussing on early intervention.

Running concurrently with this Review, the Council's Executive had begun consultation on the 2015/16 and 2016/17 Investing in Stockport Proposals, which included a project called the 'Preventative Commissioning Strategy' (PCS). The aim of this piece of work was to re-evaluate all the Council's commissioned preventative services to determine whether they were achieving value for money and contributing to the Council's desired outcomes. Many of the contracts for these services had been transferred to the Council with the transfer of Public Health functions to the Council from the NHS in April 2013, and it was felt timely to look at the range of services in the round.

One element of the PCS was to re-commission Drug and Alcohol Services. The business case for this proposal was submitted to the Scrutiny Committee and key passages are quoted below[4].

The aims of the re-design of this service was to achieve:

- *improved outcomes for Stockport residents*
- *a more integrated preventative model of intervention*
- *reduced demand for specialist and acute services*
- *Efficiency savings.*

Part of the rational for the change is because:

> *…the treatment system set up to deal with the 'heroin waves' of the 1980's and 90's is no longer a suitable response to current substance misuse patterns. In recent years there have been substantial and significant changes in the sector, for example:*
>
> - *a more recovery-orientated treatment system*
> - *an ageing 'traditional' drug population*
> - *changing patterns of drug use; fewer people using heroin; fewer people injecting drugs; and increasing use of psychoactive substance, legal highs, image and performance-enhancing drugs*
> - *Alcohol becoming an emerging and increasingly priority issue.*
>
> *…Alcohol is a particular key local concern, with Stockport performing significantly worse than the England average in a wide range of alcohol indicators…in order to concentrate more on early intervention and long term recovery, we need to reduce demand for specialist high cost services.*
>
> *It will be based on the following principles:*

[4] The sections included in this chapter have been chosen in the main because they are reflective of the discussions to have arisen from during the course of this Review, some of which is highlighted elsewhere in this report.

- *Targeted Prevention and early intervention – potential problematic substance users will be identified earlier and interventions put in place to help prevent escalation to crisis level. This will lead to improved outcomes for people and reduce the need for later costly crisis intervention and prevent long term health and social problems, thus leading to longer term savings.*

- *Specialist Treatment – this service element will be primarily focussed on the delivery of treatments such as psychosocial interventions, group work, pre and post-detoxification work, and improvement of personal health and wellbeing. Substitute prescribing will be provided where required as an important but secondary function.*

- *Recovery – all services are expected to work towards recovery as an ambition for all clients, and this will be supplemented by a specific service for those moving on and post treatment. Substance misusers can suffer a high likelihood of relapse, however properly structured post-treatment assistance can mitigate this risk. The new service will provide support post-treatment and focus on helping clients to re-integrate into the local community, link into peer support/mutual aid, help clients to access education, training and employment, and help clients who have suffered a 'brief' relapse.*

- *Breadth of available support – The treatment system will be 'broad but thin'. Clients need to be able to access directly into a broad base of interventions which meet their current needs. Clients can move 'along' the system to other interventions or access interventions concurrently but the client should never be far from an exit point.*

- *Evidence based interventions - All commissioned interventions will be evidence based and compliant with NICE guidelines and quality standards.*

- *Primary care – There should be more effective use of primary care services, potentially through substance misuse workers being linked in to hub based arrangements.*

A key feature of the new service will be:-

> *Person-centred substance misuse targeted preventative and treatment services so that individuals' needs are identified and they are supported to sustained long term recovery. Outcomes will be focussed on health and wellbeing, abstinence, successful completion and long term recovery…*

And as a consequence

> *…the services awarded the contracts will be expected to work in an integrated way across the whole treatment system and also with wider services such as housing, Education Training & Employment providers, mental health services, domestic abuse services and criminal justice agencies… a person experiencing substance misuse issues could expect to receive a rounded and consistent assessment of their holistic needs, which could result in the individual receiving support from more than one service (whilst still having one overall care co-ordinator).*
>
> *…Our approach to clients will be based on their requirements and on their recovery capital (ability to achieve recovery) rather than driven by their substances of use.*
>
> - *Greater focus on family and concerned others*
> - *Greater focus on long term recovery and building resilience*
> - *Greater focus on mental health and wellbeing*

As part of this process, the Council undertook a range of consultations with stakeholders, including focus groups with service users. The qualitative feedback from these sessions was shared with the Scrutiny Committee, and much of it echoed the feedback the Committee had received from the service users it had engaged with as part of its Review.

The core principals underpinning the PCS business case were in accord those the Scrutiny Committee had come to see as central to the commissioning of alcohol services, and reflected previous recommendations made by the Committee as part of other reviews: a focus on prevention and early intervention as opposed to intensive treatment once conditions had become acute and when outcomes were less certain; and focussing on sustainable recovery and support in the community rather than creating dependence on treatment within 'service land'. In considering these proposals, and the feedback from service users, the Committee recognised that while the potential scaling back of treatment services that were clearly much valued by those who had successfully completed them, that model was not delivering sufficiently strong outcomes and that the benefits of reducing this provision would allow for greater focus on recovery and early interventions that would ultimately outweigh the concerns about loss of service.

Can the Council ensure that the any future services commissioned will addresses this Committee's concerns in relation to access to mental health support, practical support and support for families and carers?

Given the profile of those whose drinking was most risky and dangerous was known to commissioners, are will the new model of service delivery ensure that limited resources are targeted effectively at those cohorts most at risk, while maintaining a service for all those who need and seek help?

Tackling the cultural factors

The Committee early in the Review recognised that the largest obstacle to reducing unsafe levels of alcohol consumption were the underlying cultural norms around drinking. Stockport was not alone in this struggle and it was beyond the scope of this Review and of the Council itself to seek to overturn decades of ingrained attitudes towards alcohol and drinking.

The Committee considered the recent Greater Manchester Alcohol Strategy, developed by the GMCA to complement the GM Stronger Together Strategy for Growth and Reform, and the designation of Greater Manchester of the one of 20 Public Health England Alcohol Action Areas. The former identified the damage done to communities and the economy of Greater Manchester by alcohol, particularly in terms of crime and the loss to the economic activity because of the alcohol related ill-health: *"the combination of crime, health, worklessness and social care costs to Greater Manchester arising from alcohol are estimated at £1.2billion per year – around £436 per resident."*[5]

The Strategy also recognised that alcohol consumption and the activity associated with that were 'unbalancing' local economies, and one of its three key outcomes is 'establishing diverse, vibrant and safe night-time economies'[6]. The underlying presumption however was that licensed premises must form part of this future mix and that this is connected to the long-term economic future of the city-region.

While noting the obvious synergies between the GM Strategy and the issues to emerge from this Review, by its very nature the Strategy had little to say about the kind of interventions needed at the level of an individual service user, and much of the detail about the kind of actions partners to the Strategy were expected to take was reserved for the as yet unpublished Action Plan.

Most pertinent to the aims of this Review were Priorities 6-11 of the Strategy[7]:-

- Priority 6: Supporting the prioritisation of domestic abuse victims, promoting data sharing and new approaches as a part of Greater Manchester's programme to address complex dependency.

- Priority 7: Developing and evaluating interventions to address alcohol and wider substance misuse by offenders at the point of arrest, sentence and release.

- Priority 8: Prioritising activity that supports attitude and behaviour change among young people and their families, and challenges social norms.

- Priority 9: Ensuring consistency of best practice in the delivery/uptake of alcohol identification and brief advice.

[5] Gm Strategy, Page 8
[6] Ibid, page 14
[7] Ibid, page 13

- Priority 10: Supporting the development of local recovery organisations and networks, creating the conditions to maximise their role as community assets for reducing alcohol harm.

- Priority 11: Ensuring a collaborative and evidence-based approach to commissioning interventions that address alcohol dependence effectively.

Can Public Health England provide further detail on the activity that will underpin these priorities with particular reference to Stockport?

One of the recommendations contained in the Strategy is that the GMCA continue to lobby the Government for Minimum Unit Pricing (MUP) for alcohol. This was something that the Committee, in line with a previous Council Meeting resolution to support MUP, continues to believe it would be an effective tool to mitigate some of the excesses of alcohol consumption and that it is something the Council should continue to lobby for.

Will the Council, working in conjunction with partners in so far as possible, revisit MUP and continue to lobby government in this area? Can this be considered as part of the planning for the enhanced Combined Authority and the elected Mayor?

One area the Council and its local partners have an important role is in delivering lifestyle messages, and in particular about safe and unsafe levels of drinking. A key element of the preventative agenda was early intervention and providing lifestyle advice and signposting. The Council's Healthy Stockport Service being the most visible element of approach. It was recognised by a number of those taking part in the Review that the usual public health messages in relation to alcohol were confused and unhelpful – knowing the unit value of particular drinks, knowing what a safe unit intake was, the difference between public perception of 'binge' drinking and the professional definition.

The Committee recognised the shortcomings in the clarity of this message, but also the importance of being able to provide a coherent, easily understand and remembered message to the public through publicity material or through 'health chats' and other forms of contact.

Do the public understand how many units are safe? Should the Council and CCG consider reformulating their public health messages about alcohol, perhaps without reference to units?

Whilst the national evaluation of the Payment by Results pilot has not yet been completed, the Committee were pleased to hear that locally there have positive outcomes from the Stockport pilot. This pilot rewards service providers for focussing on and securing long term recovery and abstinence. The decision to proceed with a Payment by Results commissioning model is likely to be made by individual local areas rather than as part of a national push towards it. The key role of PHE in providing data support for the Pilot was acknowledged and if Stockport is to continue to commission on this basis, ongoing data support would be required.

Would the Council consider making representations to Public Health England to secure future data support for a Payment by Results model of commissioning?

Don't forget the liver

Returning to where we began with the Public Health England's National Liver Disease Information Service *'Local Authority Liver Disease Profiles'* 2014 quoted at the beginning of this report, the document concludes by posing a series of questions that local authorities or other public bodies with an interest in liver health should ask themselves in order to ensure that it is taking sufficient steps to address the significant rise in liver disease. The Scrutiny Committee believes that the answers to these questions are fundamental to ensuring that future service provision and policy is reflective of the need to address this health epidemic.

For the Health & Wellbeing Board: 'Has alcohol and its links with liver disease been included in your Joint Strategic Needs Assessment (JSNA)?'

For the Council: 'Are the links between availability of alcohol and alcohol related harm explicitly considered in local licensing policy, and when reviewing new licensing applications?'

For the Council and Clinical Commissioning Group: 'Are local health and social care staff trained to routinely provide early identification of problem drinking and provide brief alcohol advice?'

Perhaps most centrally for the purposes of the Review, in specific reference to the Council's planned re-commissioning of drug and alcohol services:

'Do local alcohol services have sufficient capacity to meet current and future alcohol treatment needs?'

Acknowledgements

The gratitude of the Scrutiny Committee is recorded to all those involved in the Review, listed below:

Members of the Health Scrutiny (including substitute members)

Cllr Tom McGee (Chair)
Cllr Susan Ingham (Vice-Chair)
Cllr Walter Brett
Cllr Kevin Dowling
Cllr Chris Gordon
Cllr Adrian Nottingham
Cllr Maureen Rowles
Cllr June Somekh
Cllr John Wright

Professional Advisers and Contributors

Simon Armour – Senior Public Health Specialist (Alcohol), Stockport Council
Alison Leigh - Community Safety and Neighbourhoods Manager, Public Health Substances Lead, Stockport Council
Phil Leigh - Community Safety Operations Manager (Drugs), Stockport Council
Tori Dante – START Manager, Stockport Council
Bill Hooley – Addiction Dependency Solutions (ADS)
Grant Jackson – Alcohol Nurse, Stockport NHS Foundation Trust
John Leach – Healthwatch Stockport
Brett Pagdin – Healthy Stockport Service
Matthew Phoenix - Service Manager, Stockport Drug and Alcohol Service, Pennine Care NHS Foundation Trust
Dr Donna Sager – Deputy Director of Public Health
Tony Stokes – Chair, Healthwatch Stockport
Dr Steve Watkins – Director of Public Health

The Committee also wish to extend their thanks to the service users, carers, relatives and volunteers from Cirtek House who participated in the review anonymously.

Appendix 1 - Summary of Questions

What more could be done by the Clinical Commissioning Group to monitor referrals being made by GPs and to monitor whether lifestyle questions were even being asked?

What are partners doing to ensure front line staff were sufficiently trained to identify those with alcohol dependency and appropriately signpost to services?

Can commissioners and service providers do more to ensure those in treatment have more timely access to other mental health services, such as IAPT and counselling?

Were partners doing enough support provided to families and carers to those in treatment and recovery to ensure that these key allies were able to support their family member through recovery?

Can partners utilise their resources more effectively to provide practical support for people in recovery, such as housing and benefits, and to work with other agencies to better identify those in treatment or recovery whose entitlements might be affected by this?

Can the Council ensure that the any future services commissioned will addresses this Committee's concerns in relation to access to mental health support, practical support and support for families and carers?

Given the profile of those whose drinking was most risky and dangerous was known to commissioners, are will the new model of service delivery ensure that limited resources are targeted effectively at those cohorts most at risk, while maintaining a service for all those who need and seek help?

Can Public Health England provide further detail on the activity that will underpin these priorities with particular reference to Stockport?

Will the Council, working in conjunction with partners in so far as possible, revisit MUP and continue to lobby government in this area? Can this be considered as part of the planning for the enhanced Combined Authority and the elected Mayor?

Do the public understand how many units are safe? Should the Council and CCG consider reformulating their public health messages about alcohol, perhaps without reference to units?

Would the Council consider making representations to Public Health England to secure future data support for a Payment by Results model of commissioning?

For the Health & Wellbeing Board: ‘Has alcohol and its links with liver disease been included in your Joint Strategic Needs Assessment (JSNA)?’

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For the Council and Clinical Commissioning Group: ‘Are local health and social care staff trained to routinely provide early identification of problem drinking and provide brief alcohol advice?’

‘Do local alcohol services have sufficient capacity to meet current and future alcohol treatment needs?’