



'TOO CHEAP, TOO STRONG, TOO AVAILABLE'

Report of Liverpool LINK Alcohol Task and Finish Group

January 2010

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1.0 EXECUTIVE SUMMARY

- 1.1 This report represents the findings and recommendations of a Task and Finish Group convened by Liverpool LINK in response to a priority identified by LINK members and members of the wider community in Liverpool and in line with the National Indicator 'NI 39 Alcohol-harm related hospital admission rates'. It will be of interest to Liverpool City Council elected members and officers, Liverpool PCT, Liverpool First, Liverpool's voluntary, community and faith (VCF) sector and all other parties involved in addressing health and social issues related to alcohol use.
- 1.2 The Alcohol Task and Finish Group (the Group) was brought together from June to December 2009 to take forward an issue first discussed at the Liverpool LINK launch in January 2009 and then ranked and prioritised by LINK Core Group members against Liverpool LINK's 'Priority Scoring System'. The Group was Chaired by LINK Core Group member Stanley Mayne and supported by the LINK Support Team hosted by Liverpool Charity and Voluntary Services (LCVS). The Membership is shown in Appendix 1. This report expresses the thoughts of the Group and makes a series of recommendations for tackling the issues in Liverpool. In presenting the report, the Group acknowledges and congratulates the efforts which are currently being made to address issues relating to alcohol throughout Liverpool at all levels and thanks all those who gave their time to participate by providing information, evidence, suggestions and details of their own personal experiences.
- 1.3 The Group attempted to 'map and scope' services known to address alcohol in Liverpool and which may have an impact on reducing hospital admissions. It also looked at how Liverpool's strategy considered the issues and how public health messages were delivered.
- 1.4 It next considered how alcohol use may impact on groups which are subject to equalities legislation and gathered comments, suggestions and evidence from the LINK membership and members of the public, including service users.
- 1.5 Finally, based on the available evidence, and any 'gaps' that were identified, the group compiled a series of recommendations which it has presented formally to the Council's Overview and Scrutiny Committee and requested a response within 20 days under the terms of the Local Government and Public Involvement in Health Act 2007.

Recommendations

- 1.6 Recommendations were made under five headings relating to the Liverpool Strategic Alcohol Group's work streams. These can be summarised as follows.

1. Social Marketing

- a) Improving the accuracy of publicly available information and contact details for local alcohol support services.
- b) Introduction of an easily available and regularly updated information card for practitioners and the public.
- c) Improving media coverage of local good practice and success stories.
- d) Influencing media images of alcohol use, including in advertising.

2. Treatment and Interventions

- a) Closer working and improved communication between commissioners and providers to make best use of practitioner expertise and to inform local and national policy and best practice.
- b) Improved inclusion of PCT Neighbourhood work within the strategic agenda and improved involvement of the voluntary, community and faith sector and local residents within the neighbourhood agenda through Liverpool LiNK Neighbourhood Champions.
- c) Greater access to primary care outreach services for street drinkers and other alcohol dependent individuals who find it hard to access services.
- d) Devolution of some alcohol commissioning to neighbourhood level.
- e) Clear, user-friendly, flow-charts outlining referral pathways – for use by service users and providers.
- f) Improved Screening by GPs for alcohol-related factors in presenting conditions.
- g) Greater role for Liverpool LiNK within Liverpool First's Community Engagement and Communications Strategies in respect of public consultation on alcohol strategy (and other relevant health and adult social care issues).
- h) Improved linkage of services providing support to street drinkers and chaotic users.
- i) Long-term (12 month) rehabilitation facilities in Liverpool.
- j) Re-examination of 'weighting' priorities within the tendering process to recognise outcomes as well as cost benefits.
- k) Increased medium to long-term funding for voluntary, community and faith services in support of local strategic priorities.
- l) Greater involvement of GPs in shaping and delivering alcohol strategy.
- m) Standard protocols for hostel staff regarding holding and distributing prescriptions to residents.
- n) Use of peer educators to deliver messages relating to the impact of alcohol (mis)use.
- o) Taking a national lead on strategy relating to perceptions of alcohol use.

3. Crime and Disorder

- a) Use of Probation and community-based support workers to deliver dedicated support packages to prison-leavers with known alcohol problems.

- b) Greater flexibility for Police in dispensing Librium to those in custody.
- c) Looking at the use of restorative justice approaches in respect of alcohol related crime or anti-social behaviour.
- d) Ongoing support for Alcohol Treatment Requirements and Alcohol Treatment Programmes for those within the Criminal Justice system.

4. Commerce and Workplace

- a) More comprehensive health impact assessments in relation to the well-being of communities when considering license applications, including improved community consultation and stricter application of local authority licensing powers.
- b) Greater efforts to monitor the sale of 'bootlegged' alcohol and to intervene where necessary.
- c) Seeking too influence and lead the national debate on pricing alcohol units on the basis of strength.
- d) Seeking to ring-fence alcohol-derived tax revenue for treatment and prevention programmes.
- e) More robust implementation of powers under the Licensing Act 2003.

5. Information and Intelligence

- a) Access to the Liverpool PCT data 'dashboard' by voluntary, community and faith sector partners
- b) Data mapping and co-ordination and the role of Liverpool John Moores University.
- c) The inclusion of dedicated 'research time' within the remit of commissioned services to help enable them not only to demonstrate the impact of their service provision but also to identify any emerging issues of concern.
- d) Membership of the Alcohol Strategy Group.
- e) More support for monitoring of abstinence rates following treatment.
- f) Data on monitoring and evaluation of hostel provision.

BACKGROUND

- 2.1 Liverpool Local Involvement Network (LINK) is one of over 150 LINKs in England which were set up in 2008 under the Local Government and Public Involvement in Health Act (2007) to be independent networks of local individuals and voluntary, community and faith groups with an interest in how their health and adult social care services are commissioned, delivered, monitored and evaluated. Each LINK has certain statutory powers and is required to develop an annual Work Plan focusing on a range of issues prioritised by local residents and service users. Powers include:
- making reports and recommendations to commissioners and getting a reply within 20 days;
 - asking commissioners for information and getting a reply within 20 days;
 - conducting 'Enter and View' visits to some types of health and social care premises to observe the nature and quality of services; and
 - referring issues to the local Overview and Scrutiny Committee and receiving a response.
- 2.2 Liverpool LINK's first Work Plan was based on priorities chosen by LINK members and other members of the public who attended the LINK launch event on 27th January 2009.
- 2.3 Attendees at the event chose three priorities from a list of National Indicators (NIs) which were already being worked towards by Liverpool City Council (LCC), Liverpool Primary Care Trust (PCT) and their local strategic partners in Liverpool First. The priorities chosen were:
- **NI 39 Alcohol-harm related hospital admission rates**
 - NI 56 Obesity among primary school age children in Year 6
 - NI 124 People with a long term condition supported to be independent and in control of their condition
- 2.4 They were also invited to suggest other priorities which were not specifically related to national indicators. These suggestions were then subjected to further public consultation and 'ranked' by LINK Core Group members in line with their adopted 'Priority Scoring System'.
- 2.5 In order to look at the first three topics chosen and consider how the LINK can contribute constructively to local and national discussion, strategy and policy in relation to them, the Core Group set up three smaller working groups of LINK members and other members of the public called Task and Finish Groups.
- 2.6 These Task and Finish Groups have spent the past six months gathering evidence from a range of sources including statutory and voluntary service providers and members of the public, with a view to

understanding local strategy and services and public perceptions of how successful these were at tackling the issues under consideration.

- 2.7 This report provides an interim account of the findings of the **Alcohol Task and Finish Group** and some initial recommendations as to 'next steps'.
- 2.8 As and when Liverpool LINK deems it desirable it may carry out supplementary work to update or improve its reports. At the time of publication this Task and Finish Report is in the process of being screened for any negative impact on equality by the Liverpool LINK Equality and Diversity Working Group. Any findings will be submitted to the Chair of this Task and Finish Group in February 2010. If the need for any further work is identified as a result of the equality screening, this will be implemented via a supplementary report to be published by June 2010.

Liverpool LINK, January 2010

3.0 Alcohol Task and Finish Group – Terms of Reference

3.1 The **Terms of Reference** of the Group were:

- a) To conduct a 'mapping and scoping' exercise to identify the range and extent of alcohol services and alcohol harm-reduction programmes currently operating within the Liverpool PCT area.
- b) To identify any gaps in services
- c) To make recommendations as to:
 - I. how such gaps might be closed *and*
 - II. how services might best work together to reduce alcohol-related hospital admissions in line with National Indicator NI 39 Alcohol-harm related hospital admission rates.

4.0 Liverpool's Alcohol Indicators

- 4.1 Recent data from the North West Public Health Observatory¹ show that Liverpool is ranked 2nd of 324 local authorities in England for hospital admissions for alcohol-related harm. The ten English authorities with the highest rates of alcohol-harm related hospital admissions are shown below.

Table 1) NI 39: Hospital admissions for alcohol-related harm (rate per 100,000 population) 2007/08

| | | |
|----------|---------------------|--------------|
| 1 | Newcastle upon Tyne | 2,615 |
| 2 | Liverpool | 2,612 |
| 3 | Middlesbrough | 2,517 |
| 4 | Knowsley | 2,479 |
| 5 | Preston | 2,470 |
| 6 | Wirral | 2,384 |
| 7 | Halton | 2,325 |
| 8 | Gateshead | 2,322 |
| 9 | Salford | 2,319 |
| 10 | Manchester | 2,297 |

Source: Local Alcohol Profiles for England 2009, North West Public Health Observatory

- 4.2 However, this is not the only alcohol-related indicator which should give Liverpool cause for concern. The table overleaf shows that there are a number of health-specific indicators relating to alcohol use where Liverpool ranks particularly highly. These include issues relating to hospital admissions which can be **attributed** to alcohol use (but where it is not the specific cause of admission), the number of **under 18 year olds** being admitted to hospital for alcohol-specific reasons and the levels of **'harmful' drinking** in Liverpool. The incidence of liver disease seen at the Royal is also increasing amongst women and young people.²
- 4.3 Another statistic of concern is that, based on the ages of Windsor Clinic service users who were involved in Coroners Reports between 2007 and 2009, the median age of death was 45 for males and 47 females³.

¹ Local Alcohol Profiles for England 2009, North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University www.nwph.net/alcohol/lape

² Source: Lifestyles Service

³ Source: The Windsor Clinic

Table 2) Liverpool's Alcohol Indicators for Health and where they rank amongst Local Authorities in England

| | Alcohol Indicator | Rate | Liverpool's ranking (of 324 local authorities) 1st = highest rate |
|----|--|-------------|--|
| 1 | NI 39: Hospital admissions for alcohol-related harm (rate per 100,000 population) 2007/08 | 2,612 | 2nd |
| 2 | Males, all ages, admitted to hospital with alcohol-specific conditions (rate per 100,000 population) 2007/08 | 988 | 2nd |
| 3 | Females, all ages, admitted to hospital with alcohol-specific conditions (rate per 100,000 population) 2007/08 | 468 | 2nd |
| 4 | Males, all ages, admitted to hospital with alcohol attributable conditions (rate per 100,000 population) 2007/08 | 2145 | 1st |
| 5 | Females, all ages, admitted to hospital with alcohol attributable conditions (rate per 100,000 population) 2007/08 | 1187 | 1st |
| 6 | Alcohol-specific hospital admissions, under 18 years (rate per 100,000 population) | 171 | 6th |
| 7 | Months of life lost attributable to alcohol, males 20005/07 | 16 | 4th |
| 8 | Months of life lost attributable to alcohol, females 20005/07 | 8 | 5th |
| 9 | Claimants of Incapacity Benefit due to alcoholism (rate per 100,000 working age population) Nov 2008 | 230 | 33rd |
| 10 | Hazardous drinking, percentage of adults aged 16+ (modelled estimate) 2005 | 23% | 59th |
| 11 | Harmful drinking, percentage of adults aged 16+ (modelled estimate) 2005 | 8% | 2nd |
| 12 | Alcohol specific mortality: males, all ages, (rate per 100,000 population) 2005/07 | 30 | 3rd |
| 13 | Alcohol specific mortality: females, all ages, (rate per 100,000 population) 2005/07 | 14 | 3rd |
| 14 | Mortality from chronic liver disease: males, all ages (rate per 100,000 population) 2005/07 | 30 | 3rd |
| 15 | Mortality from chronic liver disease: females, all ages (rate per 100,000 population) 2005/07 | 16 | 2nd |

Source: Local Alcohol Profiles for England 2009, North West Public Health Observatory

5.0 Mapping and Scoping Liverpool's Alcohol Services and Strategies

- 5.1 The current methods used to reduce alcohol-related harm and, thus, the level of alcohol-related hospital admissions in Liverpool are various and involve many agencies working in the fields of health, community care, crime and community safety, education and youth services. The first task of the Group was therefore to identify key contacts both within the public sector and the voluntary, community and faith (VCF) sector with responsibilities for developing and delivering strategies and services to tackle alcohol misuse, alcohol-related harm and, by inference, alcohol-related hospital admissions.
- 5.2 Meetings took place with public sector partners including Phil Sadler (Alcohol Strategy Lead, Liverpool PCT), Dr Lynn Owens (Nurse Consultant and Clinical Lead for Alcohol, Liverpool PCT), Tom Knight (Director of Integrated Commissioning, Addictions and Offender Health, Liverpool PCT), Sue Neely (DAAT Manager, Integrated Commissioning, Addictions and Offender Health, Liverpool PCT), Sue O'Looney (Liverpool DAAT, Young Persons Commissioner), Taher Qassim and Chichi Bodart (PCT Public Health Neighbourhood Managers, South Central and East areas), Carly Lightowlers (Alcohol Research Team, Centre for Public Health, Liverpool John Moores University), Jeanette Warner (Inclusion Matters), Michelle Lesbriel-Jones (Citysafe Domestic Violence Prevention Co-ordinator), Dave Buckley (Manager, Windsor Clinic) and Mark Choonara (The Basement Advisory Centre, Street Drinkers Outreach Service).
- 5.3 Further 'desk based' research was undertaken to identify alcohol-related services in all sectors and to contact them to check whether publicly available information about them was accurate and up-to-date as well as to enquire about referral methods and waiting times.
- 5.4 Services identified by the Group which appear to be providing some level of support around alcohol use include Addaction, Brownlow Group Practice, CIC Liverpool Addictions Service, Healthwise, Inclusion Matters, Irish Community Care Merseyside, Lifestyles Clinic (Royal Liverpool University Hospital), Liverpool Healthy Schools Team, Manor Lodge, Merseyside Youth Association/Healthline, Mildmay House, OK:UK, Park View Project, North Liverpool Community Justice Centre, Progress to Work (The Social Partnership), Project 8, PSS, Sanctuary Family Support, SHARP, Whitechapel Centre, Windsor Clinic (MerseyCare NHS Trust). Liverpool LINK recognises that these may not be the only available services and would welcome information about any services that have inadvertently been omitted.
- 5.5 As noted above, statistics compiled by the North West Public Health Observatory (NWPHO) at Liverpool John Moores University (LJMU) demonstrate that Liverpool has the 2nd highest rate of alcohol-related hospital admissions in England, however this does not necessarily

indicate that Liverpool has a significantly worse problem with alcohol use than any other area of the country. Indeed, it could be argued that the figures reflect Liverpool's particularly good practice in assessing the degree to which alcohol use is a factor in a range of hospital admissions, a factor which might not be picked up to the same level in other areas.

- 5.6 For instance, the Liverpool Model, in which the role of the Alcohol Specialist Nurse (ASN) has been developed in a hospital setting, was developed by the University of Liverpool and Liverpool PCT in response to data showing that 12% of Accident and Emergency (A&E) attendances and a third of Intensive Therapy Unit (ITU) admissions at the Royal Liverpool Hospital were directly attributable to alcohol use. This model has been commended as an example of good practice by the Department of Health (DH) and Royal College of Physicians (RCP) and is now being replicated in other areas of the country. A very positive finding.
- 5.7 In the course of its' work the Group also learned that alcohol-related hospital admissions are measured by the DH using a trajectory rather than 'actual' numbers and that a proxy measure, the 'alcohol-attributable fraction', is used for this purpose. Admissions are coded and may be anywhere on the scale of 0% to 100% attributable to alcohol including, for instance, poisoning or liver disease.⁴ In Liverpool the A&E Department at the Royal assign a code to every admission because they are very aware of, and are specifically looking for, alcohol-attributable causes of admission. This was demonstrated to the Group when authorised representatives were invited to observe the Lifestyles Services at the Royal and to speak to alcohol-specialist clinicians and A&E staff.
- 5.8 The Group also found that, when compiling regional alcohol-related hospital admission figures, LJMUs use control methodologies but cannot control for the way clerks in individual hospitals input information with reference to the 'alcohol-attributable fraction'. Thus it is possible that alcohol-related admissions figures from the Royal Liverpool Hospital may be particularly high – demonstrating good recording practice – and figures from other local authority areas may be lower, where staff may be less well-trained in screening for alcohol-related factors.
- 5.9 Given this possibility, in addition to Liverpool's ongoing commitment to improving clinical care, clinical practitioners spoken to by Group members felt that it is highly unlikely that alcohol-related hospital admission figures in Liverpool will decrease for 10 years since each improvement in the quality of clinical care sees the numbers of recorded alcohol-related or alcohol-attributable admissions increase. This is an important point to be aware of when measuring any fall or

⁴ A list of the alcohol-attributable factors in hospital admissions is included in Appendix 2

rise in figures and to bear in mind when monitoring and evaluating the success of Public Health campaigns.

- 5.10 Another early task for Group members was to familiarise themselves with Liverpool's current alcohol strategy *Tackling Alcohol in Liverpool – Liverpool Alcohol Harm Reduction Strategy 2007 – 2010* and in particular with the Four-Tier Model of Care, in order to establish what type or 'Tier' of services already exist and what gaps there may be.
- 5.11 The Group was aware of the importance of distinguishing between the needs of a) people who are alcohol dependent and b) people who are at risk of becoming dependent and/or at risk of harming themselves or others through their harmful or hazardous alcohol use⁵. Group members also recognised that individuals in either category may or may not actively seek help or support or acknowledge that they have a 'problem'.
- 5.12 Nevertheless, there is clear evidence that commissioners are attempting both to make best use of the budgets at their disposal, particularly given that the bulk of central government funding for addictions is restricted to Class A drugs with alcohol receiving relatively little designated funding, and to respond to the need for improved, 'joined up' ways of working across provider services. Whilst acknowledging that change can be difficult, commissioners seem willing to make the necessary changes and to break down traditional barriers between services and to lead a cultural shift towards joint working as 'addiction services' looking at prevention, education, treatment, rehabilitation and aftercare services.
- 5.13 Finally, the Group is aware of the different ways that alcohol may be used by diverse sections of the community and that a 'one size fits all' approach to education and the provision of clinical and support services will not reach all local residents or service users and may actively exclude some. The following section considers these issues in particular.

⁵ Harmful drinking is regarded as drinking more than 35 units a week for women and 50 units for men; Hazardous drinking is seen as drinking above the weekly recommended sensible drinking guidelines on a regular basis; Binge drinking is viewed as drinking more than double the daily recommended alcohol units or drinking to get drunk. Source: *'Tackling Alcohol in Liverpool', Liverpool Alcohol Harm Reduction Strategy 2007–2010*, Liverpool PCT / Liverpool City Council.

6.0 Alcohol and Diversity

6.1 Whilst most available research on alcohol use and misuse by equalities groups does not have a specific Liverpool focus it is important that the broad principles of research findings inform Liverpool's alcohol strategy in relation to these groups, particularly as anecdotal evidence obtained by the LINK tends to support such research findings within the local context. Liverpool LINK's Core Group includes Diversity Champions for all groups which are covered by equalities legislation. These Champions have been invited to read and comment on this report with particular reference to how alcohol may be viewed or used by their particular 'communities of interest'. Any findings will be submitted to the Task and Finish Group Chair in February 2010. If the need for any further work is identified as a result of the equality screening, this will be implemented via a supplementary report to be published by June 2010.

Age

6.2 The main public focus around alcohol has been very much around young people and 'binge drinking' but this is not the only age group that is of concern. Indeed the *Drinking in the UK* report (2009)⁶ suggests that there has recently been a decrease in drinking amongst 16 – 24 year olds, particularly young men.

6.3 Although the Liverpool City Region sees over 350 under-18 year olds admitted to hospital annually for alcohol-specific conditions the rate in Liverpool itself is lower than in Wirral and Halton.⁷

6.4 Encouragingly, data recently obtained by the Group from Liverpool John Moores University Centre for Public Health show that the number of alcohol-related hospital admissions at Alder Hey decreased by 56% between 2007/08 and 2008/09 although the number of admissions of females remained close to double that of males. Across the two years the age at which young people were most likely to be admitted for alcohol-related reasons was 14 years old.

6.5 Information from Alder Hey should improve for 2009/10 as a new database will be operational before the start of the next financial year.

⁶ Smith, L. and Foxcroft, D. (2009) *Drinking in the UK: An exploration of trends* York: Joseph Rowntree Foundation

⁷ Deacon, L. et al (2008) *Liverpool City Region Alcohol Profile* Liverpool: North West Public Health Observatory; Local Alcohol Profiles for England 2009, North West Public Health Observatory

Table 3) Alder Hey – Alcohol Related Hospital Admissions 2007/08 and 2008/09

| | 2007/08 | 2008/09 |
|--------------|-----------------------------|-----------|
| Sex | Number of admissions | |
| Female | 45 | 21 |
| Male | 26 | 10 |
| Total | 71 | 31 |
| | 2007/08 | 2008/09 |
| Age | Number of admissions | |
| 12 | 5 | 2 |
| 13 | 12 | 3 |
| 14 | 27 | 16 |
| 15 | 27 | 10 |
| Total | 71 | 31 |

Source: Liverpool John Moores Foundation, Centre for Public Health

- 6.6 Nationally, a particular issue of concern, also outlined in the *Drinking in the UK* report, is the documented increase in alcohol consumption amongst 11-13 year olds. Although fewer children overall are drinking those that do drink are, according to the report, drinking greater quantities of alcohol and the main contributory factor appears to be the influence of parents, family and the home environment.
- 6.7 The Group notes that media concentration on binge drinking and young people can detract from addressing other ‘at risk’ groups – particularly those more at risk of hazardous or harmful drinking (e.g. women in their 40s, men in their 30s, university leavers) who may not always access Tier 2 services⁸. The *Drinking in the UK* report indicates that there has been a steady increase in alcohol use amongst middle-aged and older groups in recent years and the Group was pleased to learn that the Liverpool City Region Board has not only identified alcohol as a priority focus during 2010 ‘Year of Health and Wellbeing’ events but will have a particular brief to look at interventions aimed at 35-45 year old males.
- 6.8 The message from members of the public who took part in LINK meetings to discuss alcohol issues is that a range of messages should be aimed at different groups. There was some concern that older people, particularly those who are single or who have experienced the death of a partner may use drink to ‘self-medicate’ in ways which are largely hidden. LINK meeting participants also felt that thought should also be given as to how to encourage younger people to act as educators for older people as well as vice-versa. Attitudes to drinking

⁸ Tier 2 Services are categorised as community-based and primary care-based open access alcohol services offering alcohol-specific brief interventions, outreach and non-care planned approaches. Source: ‘*Tackling Alcohol in Liverpool*’, *Liverpool Alcohol Harm Reduction Strategy 2007–2010*, Liverpool PCT / Liverpool City Council.

and drinking culture have an inter-generational element to them and some participants in LINK neighbourhood meetings suggested, that attitudes towards alcohol need to change. They suggest encouraging a move away from seeing alcohol exclusively as a positive, celebratory, 'fun', social tool without which no event is complete to viewing it more cautiously as a potentially addictive drug, which can have severe health impacts, lead to crime and violence and encourage anti-social behaviour. In this respect young people have as important a role in changing attitudes as any other group.

- 6.9 For instance, the DAAT Young Persons Services Commissioner informed the Group that the past year saw a significant increase in the number of young people accessing counselling services in Liverpool with concerns about the impact their parents' or carers' alcohol use was having on them. Similarly, under 18s with alcohol problems often have complex reasons for their alcohol misuse which cannot be tackled in isolation. Thus, support for such young people involves a multi-agency approach, including mental health services, to minimise the risk of relapse.
- 6.10 The Group was pleased to note the work of the Healthy Schools Team and the 'one stop shop' service now being offered to schools⁹ as well as evidence of a move towards improved consistency of drug and alcohol education in schools (for pupils, parents and teachers) to meet the requirements of Personal, Social and Health Education (PSHE) becoming a statutory subject by 2011. However, it still appears that the focus for Substance Misuse Services for under 18s in Liverpool is still predominantly around illegal drug use despite the evidence that alcohol use is endemic amongst young people and has the potential to cause lasting harm throughout life. Indeed anecdotal evidence from young people who spoke to the Group themselves indicates that alcohol use is in many cases indivisible from drug use.

"Drink a pint, have a line (of cocaine) – that's a night out around here."

- 6.11 The Group was also impressed by work taking place via Merseyside Youth Association (MYA), particularly an alcohol harm reduction programme run by the Healthline project which has been involved in an awareness raising programme in schools (including primary schools) and youth clubs. The current focus is on harm reduction outcomes which involves two 50 minute sessions with each group of young people and measuring of how levels of awareness have changed between the 2 sessions. The project is also involved in targeted work with binge drinking young people and producing evidence of reduction over an 8 week period with additional follow-up work. They have evidence that some young people who were drinking 60 units a week at the start of the programme have reduced to 10 units by the end. Peer educators aged 16 – 19 are supporting the team's work which is

⁹ 'Drugs and Alcohol: Education, Assessment and Intervention' programme

delivered both with groups and one-to-one, as appropriate. A particular concern for the project is preventing or reducing liver sclerosis in young people.

Gender

- 6.12 *Drinking in the UK* highlights the increase in drinking by women and states that, although women are still less likely to drink than men, the gender gap has narrowed over the past 15 – 20 years with possible causes including women’s increased financial independence and the influence of advertising.
- 6.13 In Liverpool, there is certainly no room to be complacent as, when all age groups are taken into account, **Liverpool has the 2nd highest rate of male alcohol-specific hospital admission rates and the highest rates of both male and female alcohol-attributable admission rates in England.**¹⁰ Irish Community Care Merseyside also informed the Group of an increase in alcohol use by female clients within the Irish and Irish Traveller communities.
- 6.14 There are also important implications in respect of gender, alcohol and domestic violence. Liverpool’s Citysafe Domestic Violence Project estimates that alcohol (mis)use is involved in 30% - 40% of all cases of domestic violence and that often both the victim and the perpetrator had been using alcohol at the time of the incident. Furthermore, whilst there has been no noticeable increase in domestic violence perpetrated by women as a result of alcohol use there are increasing levels of sexual violence against women who have been drinking – an issue which the Group was pleased to note was a Social Marketing focus for Liverpool’s Alcohol Strategy Group during November 2009 and which the Group would suggest should remain a priority.
- 6.15 Trans¹¹ people may have particular issues or support needs around alcohol use although research relating to this tends to treat trans people as part of a group including lesbian, gay and bisexual people rather than on the basis of their gender (see **Sexual Orientation** below).

Race

- 6.16 Attitudes to alcohol use vary between racial, cultural and national groups and may or may not be linked to faith-based ‘norms’ or beliefs. Some communities do not tend to use ‘mainstream’ drinking venues or have easy access to public health messages about alcohol. Some may be more susceptible to alcohol dependency than others.¹²

¹⁰ NPHO (2009) *op cit*

¹¹ Trans people are defined by Liverpool LINK as transsexuals, transvestites and transgendered people collectively.

¹² *Prevalence of Substance Use Among Racial & Ethnic Subgroups in the U.S. (May 2008)*, U.S. Department of Health and Human Services

- 6.17 For instance, members of the Chinese community who spoke to the LINK indicated that alcohol use within their community was a major issue of concern and was closely linked to gambling and mental health. However, it was a largely hidden issue as it took place in private or away from pubs, bars and clubs which might display public health information. Furthermore, some – particular older – members of the community did not have the English language skills to adequately understand such messages and did not necessarily feel comfortable discussing the issue with GPs or other health professionals. This may not be an issue that is exclusive to the Chinese community.
- 6.18 Furthermore, Irish Community Care reported that of a caseload of 80 – 90 ‘live cases’ at any one time (including Irish and Irish Traveller individuals experiencing problems with drugs, alcohol and homelessness or currently inmates in local prisons) 90% have alcohol-related issues. Staff also reported an increase in extreme alcohol use within this client group over the past 8 years – particularly sherry and white cider.

Sexual Orientation

- 6.18 Alcohol has traditionally been a factor on the lesbian, gay, bisexual and trans (LGB&T) ‘scene’ with many social activities and opportunities to meet other LGB&T people centring on bars and clubs where alcohol use is prevalent.
- 6.19 Queer Notions, Liverpool’s voluntary mental health support service for LGB&T people reported to Liverpool LINK that alcohol use is a factor in the lives of many clients and that it may be used variously as a coping mechanism when family or relationship pressures become overwhelming and there is a lack of support available; as a way of ‘self medication’ instead of, or in addition to, prescription or non-prescription drugs; as a way of boosting self-confidence and as a way of dealing with past or ongoing negative reactions or abuse from family members or others as a result of institutionalised societal homophobia and transphobia. This very much corroborates academic findings such of those of Eliason and Hughes (2004).¹³
- 6.20 Liverpool’s LGB&T Network has identified Mental Health as one of the ‘Big Five’ issues of concern to local LGB&T people and recognises the way in which alcohol may contribute both to ‘self medication’ and exacerbation of mental health related issues.

www.oas.samhsa.gov/NHSDA/Ethnic/ethn1010.htm#E10E33; Chan, A.W. K. (1986) *Racial differences in alcohol sensitivity*, Alcohol and Alcoholism Vol. 21 No. 1; Caetano, R. et al (1998) *Alcohol Consumption Among Racial/Ethnic Minorities*, Alcohol Health & Research World, Vol. 22, No. 4

¹³ Eliason, M. J. & Hughes, T. (2004) *Treatment counselor’s attitudes about lesbian, gay, bisexual, and transgendered clients: Urban vs. rural settings*. Substance Use and Misuse, Vol. 39, No. 4

- 6.21 Lesbian, Gay, Bisexual and Trans alcohol use is the subject of a new five-year research programme by the Lesbian and Gay Foundation and the University of Central Lancashire (UCLAN)¹⁴ and it will be useful to follow the progress of this research.

Faith

- 6.22 Different faiths view alcohol use in a variety of ways and for some it is completely proscribed. However, faith-based restrictions may present additional problems for those people of faith who develop alcohol problems and do not know where to turn for support.
- 6.23 Furthermore, there is a danger that economic drivers to encourage a dynamic '24-hour' city centre may have a negative impact on city centre use by minority faith groups and others (for example, older people) within the community if these are focused too closely on bars, clubs and venues which are associated with alcohol use

“Strategies to revitalise the urban night-time economy predicated on alcohol implicitly exclude faith communities such as Muslims, which contributes to social segregation.”¹⁵

- 6.24 A final point raised was that the stresses placed on faith leaders by being 'on call' constantly to their congregations and the wider community – often as 'lone workers' – could lead to alcohol-use as a relaxant or as a coping strategy. In this way faith leaders could be compared to people in other high-stress jobs including health services, emergency services and the armed forces.

Disability

- 6.25 People with disabilities who provided information to the Group spoke of alcohol use as a way of coping with their situation by means of self-medication to combat depression or stress. This is of interest in light of recent research in the U.S.A. which shows levels of alcohol dependence amongst disabled people to be particularly high.

“In most cases, rates of abuse and dependence were higher for persons with disabling conditions. Almost eight percent (7.9%) of persons with disabilities, for example, were alcohol dependent, compared to only 3.1% of persons who were not disabled... The odds ratio for disabled suggests that persons with disabilities are 130% more likely to be dependent on alcohol than persons without a disability... persons with physical conditions have odds of alcohol dependence that are 29% greater than persons who did not report a physical disability... persons with a serious mental illness are 260% more likely to be

¹⁴ www.partofthepicture.co.uk

¹⁵ Valentine, G. et al (2007) *Drinking places: Where people drink and why*. York: Joseph Rowntree Foundation

*dependent on alcohol than persons who did not report a serious mental illness.*¹⁶

¹⁶ Brucker, D. (2007) *Estimating the Prevalence of Substance Use, Abuse, and Dependence Among Social Security Disability Benefit Recipients*, Journal of Disability Policy Studies, Vol. 18, No. 3

7.0 Obtaining the views of local residents and service users

- 7.1 The LINK Alcohol Task and Finish Group used a range of methods to encourage input from local residents and service users towards this report. These included information requests made in a LINK newsletter which was distributed throughout the city and on the LINK website, information broadcast on Radio City and Radio Merseyside and circulated in the local press. Information was also solicited via the regular LCVS Broadcast and Liverpool Community Network (LCN) and through colleagues within statutory services including the PCT.
- 7.2 A series of public meetings were held across the city (Granby, Tuebrook, Garston, Fairfield and Croxteth) at which members of the public were invited to contribute questions, concerns and information relating to alcohol (including patterns of use, reasons for misuse, education, support services and related factors).
- 7.3 A visit was also made to a service provided by the Voluntary/Community/Faith sector (the Christian Life Centre) to speak to alcohol dependent or chaotic drinkers attending the Centre's free twice-weekly meal service to obtain their views about what was working well for them, what was less helpful and what suggestions they had for improvements to services.
- 7.4 A range of issues, concerns and examples of good practice were raised and identified in these ways. These can largely be grouped under the headings below. All quotes are from more than 50 participants in LINK neighbourhood events at Communiversity, Bridge Chapel Centre, Tuebrook Hope Centre and Crawford House or from service users and volunteers at the Christian Life Centre:

a) Information, services and support

- 7.5 Input from the public indicates that knowledge about alcohol services, how to get help for individuals or family members, how to make referrals to or between services and how services are commissioned appears to be sketchy. Those who spoke to the LINK were, for instance, unclear about:
- a) how the city's alcohol strategy related to them as individuals
 - b) how to differentiate between city-wide strategic approaches / public health messages and specific services to address 'alcohol dependence' and 'hazardous or harmful' drinking
 - c) which services offered self-referral and how to get referred if self-referral was not an option

- d) The management of drinking in public places (e.g. parks) and the impact of 'displacement' of drinking where drinkers are moved from one 'hot spot' to another
 - e) The number of rehab centres in Liverpool.
- 7.6 Questions were also asked about how to find evidence to back-up or counter commonly held beliefs and to distinguish what was true from 'urban myths'. For instance is there any direct link between deprivation, alcohol use and hospital admissions?
- 7.7 Similar questions were raised about the links between mental health (including stress and depression) and alcohol use, for instance was there any evidence-based correlation between these and, if so, was alcohol use a cause or an effect of mental distress? This was a particular concern for some disabled people who raised issues of self-medication to deal with their stresses and frustrations.
- 7.8 Several people also asked how easy it was to obtain data about alcohol-related admissions from hospitals including Alder Hey and the Royal as well as whether police records in respect of alcohol-related crime and disorder provide any indication of the health impacts of alcohol use on the alcohol users with whom police officers come into contact as well as the potential health impact on police officers themselves. A related question concerned whether, or how, our police are trained in terms of how to deal with dependent, harmful or hazardous drinkers with their best health interests in mind.
- 7.9 Clarity over questions such as these would help local people to promote coherent messages about alcohol use to their families and communities and to challenge myths or misconceptions about alcohol use.
- 7.10 There was further uncertainty about whether alcohol-dependent people receive money to maintain their alcohol use and whether any benefits given to individuals might be better spent on providing additional rehabilitation services. This may be a reference to money received for independent living rather than directly in respect of alcohol use.
- 7.11 There was also a lack of clarity around 'points' awarded to those claiming Disability Living Allowance (DLA) on the grounds that they 'need a drink before noon every day' although this was thought to be under review.
- 7.12 Information was also requested as to whether there had been a rise in alcohol-related problems or hospital admissions associated with 24 hour licensing. Indeed, 24 hour licensing provoked much discussion – in terms of both its positive and negative impacts. However, the majority opinion, even amongst those who were alcohol dependent

themselves, was that alcohol was too easily available from a range of outlets, including local shops. As one, self confessed, alcoholic put it;

“What’s to blame? Bargain Booze, Tesco and Asda!”

This view was consistent with that of a volunteer working closely with alcohol users;

“Alcohol is cheap, legal and you can get it 24 hours a day.”

- 7.13 Even those who had used alcohol services were not clear about what they could expect from each service and had been disappointed by this lack of understanding in some cases to the point of actually increasing their alcohol use. For instance one individual said he had been allowed to leave the Windsor Clinic, after he sought help, because he was not exhibiting signs of ‘the DTs’. As soon as he left he went to buy alcohol.

“Am I to blame? Are they to blame? If you’re offered the opportunity to leave – of course you take it! And if you’re a drinker, what’s the first thing you do when you leave? It should be harder to leave places like that.”

- 7.14 One individual went to the Royal under the misapprehension that he would be admitted and stay in for a detoxification programme but he was not admitted and was so upset by this that, again, he went and bought alcohol immediately.

- 7.15 In another case, an individual was disappointed to be offered counselling-type/talking therapy services when he had thought he could obtain treatment.

“Some services, like CIC, just want to talk to you. I don’t need talking support – I can get that from my mates. What I need is Librium. When I couldn’t get that I dealt with my drink addiction by getting addicted to heroin. You think you can sort it out yourself but you swap one addiction for another one.”

- 7.16 A final point raised by alcohol dependent people who spoke to the LINK was that although the police appear to follow guidelines on not removing alcohol from dependent people, which was welcomed, they also appear to have a ‘one size fits all’ rule for the dispensing of Librium to people in cells. It was thought that this specified 6 hours between doses regardless of the level of alcohol use or dependence of the individuals concerned and this was said not always to be adequate. Further clarification is needed on this point.

- 7.17 None of the above points are meant to imply any criticism of the services concerned, which the Group believes are generally working very well in often difficult circumstances, but are included to exemplify the need for clarity of information given to service users at all stages of

their support or treatment paths. What may seem clear or straightforward to a professional alcohol worker is not always as evident to a service user.

- 7.18 There was a strong feeling that voluntary/community/faith led services were more 'understanding' of alcohol users as people and offered a more holistic 'person centred' approach than 'professional' services. Staff and volunteers in such centres may not have professional qualifications but had the advantage of 'trust'. Mainstream services were seen as being target driven rather than patient/service user focused.

"All they're interested in is their figures. It's 'Here's your script – see ya!' – they're not interested in you."

- 7.19 It was generally acknowledged that the many AA groups in Liverpool worked well for people who admitted that they had a problem and wanted to change. However, it was felt that they would never work for people who had no motivation to address their drinking problems.

- 7.20 It was also acknowledged by alcohol dependent individuals that, even when they were registered with GPs, or in touch with support services, they were often more focussed on their addiction than on keeping appointments.

"I got referred to the Lighthouse but I didn't have any money to get there. The thing about addicts is that the addiction comes first – that's where the money goes..."

- 7.21 Prison was seen as having both positive and negative aspects for alcohol dependent people but the lack of support on release was highlighted as a particular problem.

"It's true you can get drugs and alcohol in prison but not true that they're as easy to get as they are outside. But what you get in prison is food, medical care and the chance to cut down slowly. For me, prison was the answer to coming off. The thing is, there's no reason to stay off when you get out and there's no support to help you to. Some people have to move away to get away from their old life. Some people will never want to make the effort but for those that do – they should have support."

- 7.22 This view mirrored the problems also highlighted by those who raised the lack of 'joined up' support for people discharged from hospital following detoxification treatment.

- 7.23 It was noted that homeless people and hostel users often lack self-esteem and that alcohol use can not only be a cause of homelessness or loss of family ties but can also compound such issues. In this regard the Group looks forward to the outcomes of the new Street Drinkers

Outreach Service based at The Basement Advisory Centre and hopes that more resources will be focused on new and existing work with street drinkers in the future.

- 7.24 Finally, the point was made that alcohol can be used by many people – not only those who are dependent – as a form of self-medication and as a confidence-building tool.

b) Changing the messages about alcohol

- 7.25 There was a great deal of concern about the way ‘drunkenness’ has become acceptable or even seen as a badge of honour amongst certain groups. Consistent suggestions were made that messages about the negative, damaging and unattractive aspects of alcohol use should be more hard-hitting and shocking with the aim of making excessive alcohol use and drunken behaviour a ‘shameful’ thing.
- 7.26 These sort of negative messages were thought to be particularly effective when delivered by ‘peer educators’ or people who had experienced alcohol problems and the negative impacts of alcohol on their health.
- 7.27 Part of the problem identified by LINK participants was that alcohol has traditionally been viewed positively in the majority UK culture and its association with celebrations and good times is hard to reconcile with the more problematic aspects of alcohol use, particularly when this might involve individuals having to look at their own behaviour. A recent study shows that whilst most people know that alcohol can be harmful in theory they view the risk as being for other people and are, at best, ambivalent about its impact on themselves.¹⁷
- 7.28 In this context, better education was thought to be needed about the dangers of alcohol use and the short-term as well as long-term impacts. Young people were thought not to respond to longer-term impacts but to be more likely to respond to messages about the effect of alcohol on their mental capacity and, in particular, on their looks. The calorific content of alcohol and its link to weight gain was also thought to be worth promoting more actively, an issue which the Group notes is in fact being addressed within the Social Marketing work stream of Liverpool Strategic Alcohol Group.
- 7.29 It was however acknowledged that self motivation was more important than ‘messages’ and that, in this context, a degree of ‘realism’ was needed and that efforts should be made to focus on ‘safer drinking’ including messages around personal safety (including not leaving alcohol unattended and vulnerable to being ‘spiked’) and safer sex.

¹⁷ ‘Patients’ views on 24 hour licensing: a qualitative study’ in Cobain, K. (2009) *Alcohol Treatment in the National Health Service: Challenging the Paradigm* (PhD thesis, the University of Liverpool)

- 7.30 Media messages were seen to be very influential in shaping attitudes towards alcohol and it was argued that the media needs to work to de-glamorise alcohol rather than promote it – whether actively or passively – as a lifestyle accessory.

“The media has a huge impact in promoting cultural acceptability and the idea that activities can’t be enjoyed without drinking. For example, football journalists promote the idea that drinking is ‘part of the match’ or a standard post-match activity for star footballers, so young people continue to associate drink with something to be aspired to.”

- 7.31 Irresponsible advertising was also criticised. An example cited being a PC World advertisement which encourages students to save money on IT products so they can spend it in the student bar. It was suggested that Liverpool’s Alcohol Strategy Group should complain to the Advertising Standards Authority about such examples.

- 7.32 The cost of alcohol was cited frequently as being a factor in its increased use by all age groups and in making it seem acceptable to use in a range of circumstances.

- 7.33 The fact that alcohol was cheaper to buy in many shops than in pubs or bars was thought to have led to an increase in drinking at home, often in a way that was ‘hidden’ and hard to address. This was a particular concern in relation to women’s use of alcohol including those in their 30s and 40s as well as younger women.

- 7.34 Non-alcoholic drinks were generally said to be more expensive making them a less attractive alternative to alcohol. There was therefore thought to be a need to address cost issues with supermarkets and pubs perhaps by offering bonuses to pubs for selling non-alcoholic drinks. Again, the Group is aware that the Liverpool Alcohol Strategy Group is currently working on this issue with local licensees.

- 7.35 Drinking specifically to get drunk was seen as a relatively new phenomenon and was something that LINK participants felt should be stigmatised through peer pressure, family ‘norms’ and the media although it was acknowledged that this could be difficult.

“It can be hard to say ‘no’ to a drink – peer pressure and negative images about non-drinkers are difficult for adults to challenge. It must be even harder for young people.”

- 7.36 It was also felt that alcohol should be restricted in public venues such as airports and the Echo Arena

- 7.37 Finally, a suggestion was made that a greater element of ‘restorative justice’ should be brought to bear where people committed offences or engaged in anti-social behaviour as a result of alcohol use.

“People who are sick in ambulances after binge drinking should be made to clean it up when they are sober or pay a fine.”

c) Family and age-specific approaches

- 7.38 The family was seen by LINK participants as being central to positive and negative messages about alcohol use and misuse and it was thought that educational messages and information should be aimed at the whole family and at all age groups. There was a need to break the cycle of misinformation or misuse and particular awareness-raising was required around parents giving their children alcohol, or money that was used to buy alcohol, in unsupervised circumstances.
- 7.39 Parents wanted more information and education to help them talk to their children – particularly around mixed messages about what is and isn't safe or 'good for you'.
- 7.40 Access to alcohol by young people via shops ('corner shops' more than 'off licenses') parents, older siblings, friends, strangers, 'white vans' or delivery services was one of the major issues raised.
- 7.41 Alcohol dependency amongst older people was thought to be high in Liverpool although it was unclear what evidence there was for this and why it should be a particular problem.
- 7.42 Some participants reported that Alder Hey and the Children and Adolescent Mental Health Service (CAMHS) had seen an increase in referrals for children and young people in need of counselling for alcoholism and that this should be a major issue of concern for the city.
- 7.43 The impact of a 'problem drinker' across the whole family was thought to be under-acknowledged and support services for family members – beyond Al-Anon – were said to be in short supply. Family members argued that they should have choice about accessing services either locally or centrally and that whilst local services could be handy, central services may be more anonymous. At present, however, there were thought to be few services either locally or centrally. These views are of interest when compared with the experiences of some service providers. The Windsor Clinic, for instance, has tried to involve families but has tended to meet resistance, for various reasons, from both service users and their relatives, whereas staff at the Royal report that the patients who have the most 'family' support tend to do better – whilst they may continue to drink, their consumption is often reduced, which is an achievement in itself.
- 7.44 There were concerns that increased levels of public drinking (not including licensed venues) set a bad example to young people and that this should be linked to campaigns around the 'public image' of alcohol.

- 7.45 Although there was a strong belief that messages should be aimed at all the family and all age groups there was also an awareness that alcohol use and misuse can vary. For instance people may drink in different ways and for different reasons based on age, class or gender (see also Section 6, above).
- 7.46 It was suggested that children were going to pubs at a younger age since the introduction of pub meals and that pubs should therefore focus less on drinking as their sole reason for existence and more on organising a range of family activities – including sporting teams and coaching activities – where family members can do things together (including drinking) in a safe, supportive environment.
- 7.47 It was felt that most adults as well as most young people are unaware of the size of a standard measure or unit and will massively overestimate the amount of alcohol that it's safe to drink. This has since been corroborated by Merseyside Youth Association (MYA) Healthline Project based on work conducted by their alcohol harm reduction programme.
- 7.48 It was reported that young people appeared to have changed their drinking habits from drinks such as lambrusco and beer to vodka and other spirits.
- 7.49 Alcohol was also reported as being used as a substitute for methadone by some heroin addicts, thus creating further addiction problems.
- 7.50 Finally, it was noted that people who were trying to give up, or cut down on, drinking often found it hard to leave social groups, sometimes including family members, which were linked to drinking.

d) Joint strategic working

- 7.51 There was a recognition from LINK participants that work around alcohol use cuts across a number of services and themes including health, social care, education, youth services, crime and community safety and planning / environment. However, it was felt that services did not always communicate well with each other or engage adequately with local residents. Improved visibility of active community engagement around alcohol would be welcomed particularly from education and police services. There was also uncertainty about how voluntary organisations were involved in preventative work and how the work they were doing was 'joined up' with public sector strategy and services.
- 7.52 Some examples of good practice around joint working were identified however – a good example of which is the work currently taking place within the Liverpool East Neighbourhood Management Area which involves Neighbourhood and strategic PCT officers, local councillors, the police and youth service staff (and which Liverpool LINK has also

been involved in) around young people and alcohol use in the neighbourhood.

7.53 It was felt that more thought should go into a joint strategy for putting out more coherent messages around alcohol use, including 'shock tactics' messages around the negative aspects of alcohol use. It was suggested that educational messages should show a) the physical impact b) the mental impact c) the relationship impact of alcohol use.

7.54 More joint working around offering 'alternative highs' was requested, not only for younger people but by alcohol dependent service users. A community volunteer noted that:

"On occasions this group have spoken to me about boredom and having nothing to do during the day. One or two have said they would like some kind of recreation like table tennis provided, to give them some exercise and as an alternative to watching TV."

7.55 Joint messages about alcohol use and sexual health were also felt to be important.

7.56 A final point was a need to support women's refuges to accommodate alcohol users as the immediate and longer-term consequences of not allowing access were harmful and costly.

e) Influencing the national agenda

7.57 More information was requested on what Liverpool is doing to influence or lead on the national agenda around alcohol. This included efforts to influence advertising and media images of alcohol in similar ways to the work which is currently ongoing in Liverpool around the depiction of smoking in films.

7.58 A particularly strong message from the public was that the relative ease of access to cheap, often strong, alcohol encourages excessive or dangerous drinking amongst all age groups and should be restricted.

f) Good practice

7.59 Individuals who shared their views with the LINK were invited to give examples of good practice which they thought should be highlighted, shared or rolled-out more widely. These included the following.

1. Some good education does happen in Liverpool schools and youth clubs, for example the 'Beer Goggles' exercise in which participants wear a special pair of goggles and attempt to complete various tasks. This exercise emphasises the reduced judgement, problems making choices and physical changes that can be associated with alcohol.

2. Diversionary activities for young people are available in some areas. For example, in South Liverpool the Joint Action Group (SJAG) provides activities and education, takes young people home or offers safe alternative environments. It will also prosecute if necessary.
3. The Windsor Clinic (MerseyCare) was mentioned by several participants as offering a good services and having a good reputation.
4. The PCT 'Inclusion Matters' programme which provides 'joined up' mental health and alcohol support was thought to be a particularly welcome initiative but was only accessible via GP referral and not well known enough amongst GPs or the public.
5. PCT support was available for 'problem' alcohol users (and others) around healthy eating and informed choices which were important – this was a good service and should be more widely promoted.
6. The 'Pub Watch' scheme was thought to be worthwhile and to have useful links to educational messages but landlords only join at their own discretion – it would be even more useful if it was mandatory. However, concerns were also voiced about the perceived conflict of interest of the Portman Group, a group comprising nine alcohol producers which also encourages social responsibility in alcohol retailing and promotion.
7. Trading Standards were thought to do a good job in monitoring Off Licences, which have legal responsibilities not to sell alcohol to under-age drinkers. The problem of the availability of alcohol to young people was generally not thought to lie with Off Licenses themselves but with adults buying or providing alcohol for young people or selling it to them illegitimately.

Summary

- 7.60 The majority of the views expressed by the public can broadly be linked to the strategic aims contained within 'Tackling Alcohol in Liverpool' or are not inconsistent with them.
- 7.61 This suggests that the Liverpool Alcohol Strategy Group has correctly identified the issues of concern to local residents and that strategic partners are already working to address these concerns. This is a very welcome and positive finding.
- 7.62 It would also indicate however that the Strategy has not been entirely successful in meeting its final aim '*To inform and include all stakeholders to ensure that we are making an impact where most needed.*'
- 7.63 For instance, whilst some members of the public are clearly aware of the '*Pssst! Be alcohol aware*' campaign, it is less clear whether they are able to link it to any wider strategy, know which organisations are behind it or are aware of how its success is monitored or how to ask for evidence that this, and other, strategic approaches are working.

Recommendations

- 7.64 Participants also made a number of specific recommendations, including:
1. Introduce an element of 'restorative justice' for alcohol related crime or anti-social behaviour.
 2. Improve publicity of good practice and success stories.
 3. More funding for family support services.
 4. Liverpool should take a national lead on influencing acceptable media images of alcohol use including in advertising.
 5. Liverpool should take a national lead on pressing for an end to the availability of cheap alcohol.
 6. Liverpool should take a national lead on addressing the contradiction between Government messages on safer drinking and healthy lifestyles and Government reliance on tax revenues from the sale of alcohol. More needs to be done to 'ring-fence' such revenue for alcohol treatment and prevention programmes.
- 7.65 We have attempted to incorporate these recommendations from the public within this report's final recommendations – see p.40 below.

8.0 Case Studies

- 8.1 In the course of its work the Group made contact with a number of service users who gave us permission to use their stories as examples of where things have gone well and where there have been gaps in services. We have selected two case studies here which exemplify some of the issues raised. The individuals concerned are anonymous for the purposes of this report but we appreciate their willingness to share their stories.

CASE 1

This woman had been making efforts to address her alcoholism for some time but was struggling. Her drinking was linked, amongst other things, to concerns about her daughter's drug use and the lifestyle her daughter was living in order to support her drug habit and also to debt problems that she was facing herself.

She had been particularly supported by the Together Women Project but this support had now been lost due to the closure of the Lighthouse Project where it was based. Since the loss of this much valued support she had become depressed, lonely and in urgent need of help.

LINK support staff signposted her to services including CIC, the Windsor Clinic and her local Citizens Advice Bureau (CAB) for support with her debt problems.

She had three points which she particularly wanted to make to service commissioners, namely:

1. There are not enough detoxification facilities in the city.
2. There are not enough facilities to help people to get to what services there are. This includes help with transport so that they do not have to expose themselves to stigma while on public transport.
3. Not enough time is given to looking into and solving the problems that are causing people to drink.

From the Group's perspective her case points to concerns expressed elsewhere in this report regarding referral pathways and communication between services. The sudden closure of a trusted and relied-upon service is an unusual situation but nevertheless exposes the gaps in 'wrap around' care for vulnerable individuals whose problems may be exacerbated by changes in circumstances.

CASE 2

This man was a homeless 'street drinker' who had recently been thrown out of a hostel and was in very poor health with limited coping skills and very little family support.

He was admitted to the Royal and put on the High Dependency Unit (HDU) where he received excellent care, became able to breath without an oxygen mask and was discharged to another ward where he had the privacy of a private room.

Unfortunately however, some residents from a local hostel got into his room with bottles of vodka, and he was asked to leave the hospital despite having been close to death just days previously.

He contacted a local faith organisation where he was given food and helped to find another hostel place where three meals a day are supplied. His only surviving brother lived locally and was able to provide support. He had been treated at Fazakerley Hospital and had another appointment at the Royal for plastic surgery on his left leg where he had wounds that were not healing.

At the time of contact with this individual he had not had contact with the Lifestyles Support Team at the Royal and did not appear to have been referred to the team for specialist support by either HDU or other medical staff.

Again, whilst there are some positive elements in this case – notably the skills of the HDU staff and the support received from a Third Sector organisation – the main failing is in an appropriate referral route and lines of communication between professionals, in this case professionals based within the same hospital.

Existing referral protocols make it difficult for a voluntary, community or faith organisation to make a direct referral to a specialist service (the Lifestyles team) but the referral was nor made within the hospital and the chances are high that, should this individual find himself back on the streets either because he loses his hostel place or because he is discharged from hospital without support, that his chances of survival are not good and that he may end up as another statistic.

9.0 Identifying Good Practice and Gaps in Services

9.1 In the course of its work the Group has found much that is to be applauded in terms of work around alcohol-related issues in Liverpool. There is clearly good work being undertaken by motivated, committed and well-informed individuals and organisations including voluntary, community and faith groups, PCT providers, Liverpool City Council, the police, schools and youth services. PCT commissioners are also clearly committed to improving services and addressing issues of concern.

9.2 In particular, the model for utilisation of Alcohol Specialist Nurses; designed in Liverpool and supported and developed by the RLBUHT, Liverpool PCT and The University of Liverpool, has been highlighted in several DH documents, the National Audit office, and the RCP as best practice, and is now being implemented in many hospitals nationally.

*'The Lifestyles Team was set up when staff at the Royal Liverpool Hospital realised the size of the burden that alcohol-related attendances placed on the hospital. One-third of admissions to intensive treatment units and 12% of attendances in the accident and emergency (A&E) department were directly attributable to alcohol. They found that employing an alcohol specialist nurse in the A&E department to assess patients prevented unnecessary admissions to the hospital and encouraged better patient education and links with other services. An 18 month evaluation and effectiveness study of the model showed that it resulted in the discharge of 258 patients who might otherwise have been admitted, resulting in substantial cost savings to the hospital. The discharge of these patients accounts for a cost saving on bed days of at least £175,000. Preventing the admission of as few as 23 patients could cover one year's salary for the alcohol specialist nurse. The scheme was also shown to improve clinical practice and patients' satisfaction and to increase the confidence and skills of nurses caring for these patients. Significant reductions in alcohol consumption by hazardous and at-risk drinkers and reductions in the use of healthcare by heavy and dependent drinkers were also recorded.'*¹⁸

9.3 Additionally, Liverpool has a National Institute of Health Research bid to conduct a Randomised Control Trial (RCT), the first of its kind in the world, to investigate the impact of Alcohol Specialist Nurses on individuals drinking following admission to hospital.

9.4 The Group was particularly impressed by the joint working taking place within Liverpool's monthly Multi-Agency Risk Assessment Conferences (MARAC) where staff from Citysafe, probation, victim support,

¹⁸ Pirmohamed M., Brown C, Owens L. et al. (2000) 'The burden of alcohol misuse on an inner-city general hospital', Quarterly Journal of Medicine, 93: 291–5

voluntary organisations, social housing providers and NHS staff from the Royal, Women's and Aintree hospitals share information on domestic violence cases and arrange suitable support and referrals – including to alcohol services.

- 9.5 The services provided by the Windsor Clinic are also worthy of commendation, particularly given that referrals have doubled in the past five years from 46 per week to 92 per week on average whilst there are still only 16 beds available (12 for rehabilitation and 4 for detoxification). Furthermore, the facilities within which the clinic operates are less than fit for purpose, having been built as a TB ward in the 1930s. Nevertheless, 8 out of 10 service users who complete the outpatient rehabilitation programme and who then access follow up support groups for a year are successful, based on research carried out at the Clinic. Service users who drop out at any stage are, understandably, considerably less successful.
- 9.6 Other work of note includes that taking place at Mildmay House, a supported housing project for single men aged 18 - 49 years, which has a dedicated alcohol worker and links to St Brides Church Allotment Project where residents grow their own organic vegetables and which is currently making a bid to be designated a Centre of Excellence.
- 9.7 The Group was also interested to learn about a new open-access health centre in Everton which will aim to meet Darzi Report Recommendations on community support and could provide a hub for neighbourhood alcohol services.
- 9.8 However, it is the Group's opinion that there are a number of key gaps in services – most of which could be addressed by improved communication between service providers and improved referral mechanisms and support packages.
- 9.9 These findings very much support those of a report produced by IMPACT (The International Health Impact Assessment Consortium) in 2005 which stated

*'Generally it was found that there is a lot going on in Liverpool much of which is very good quality. However this work is often piecemeal and generally it was felt that opportunities are being lost for partnership working.'*¹⁹

- 9.10 The Group believes strongly that its work to date demonstrates that Liverpool LINK itself can be a catalyst for improved information exchange, cross-sectoral and intra-sectoral partnership working. In this way it has a key role to play in closing some of the communication

¹⁹ Fox, D. et al 2005, *Making an Impact: building capacity for health impact assessment in Liverpool, Rapid Health Impact Assessment of the Draft Liverpool Alcohol Strategy*, IMPACT (The International Health Impact Assessment Consortium), Department of Public Health, University of Liverpool

gaps and helping to strengthen service provision and, most importantly, in improving the day-to-day experiences of individuals as they access alcohol information, support and treatment services. Clearer lines of communication will ultimately lead to a clearer route for service users, patients and those that support them.

Commissioner / Provider linkages

a) Service Tiers

- 9.11 Whilst Commissioners tend to feel that the main gaps lie in community-based, 'easy-access' services (Tier 2), practitioners perceive the main gaps to be in more specialist services (Tier 3 and 4).²⁰
- 9.12 Perhaps the truth lies somewhere between these two approaches. Tier 2 services can provide a vital support to individuals who are at risk of needing Tier 3 or 4 services and have the potential to decrease the instances in which such individuals are admitted to hospital. They are also a vital source of support following hospital discharge and thereafter on an ongoing basis.
- 9.13 Evidence from the public and from health practitioners would indicate that there is indeed a lack of Tier 2 services in Liverpool – that is, in the words of the 'Liverpool 4 Tier Model of Care', 'community based and Primary Care based open access alcohol services' which are 'non-care planned'.
- 9.14 Whilst Alcoholics Anonymous can be extremely productive for those who wish to remain abstinent and who benefit from the approach offered by the programme it is not always suitable for all needs and circumstances and a range of Third Sector responses are required.
- 9.15 Location of services is a difficult consideration. Whilst ease of access is important, local venues may be off-putting for those who are concerned about anonymity. Therefore, centrally located venues which are close to public transport links are a useful option. Accessibility outside of 9 – 5 office hours is also important.
- 9.16 Again, it is important to recognise that Tier 3 and 4 services tend to deal with a small minority of individuals with alcohol-related problems or conditions and that whilst these are vital and in need of continued support from Commissioners – the role of Public Health education and

²⁰ Tier 2 is explained on p13 above. Tier 3 services include those which are nurse-led alcohol-specific, community based, offer care planned assessment and treatment and community detoxification as well as those which offer structured treatment for people with a dual diagnosis and hospital-based structured treatment. Tier 4 services are those which provide specialist residential alcohol treatment which is care planned and includes aftercare. Source: 'Tackling Alcohol in Liverpool', *Liverpool Alcohol Harm Reduction Strategy 2007–2010*, Liverpool PCT / Liverpool City Council.

innovative ways of dealing with alcohol use before it becomes problematic and leads to hospital admissions is also crucial.

b) Public Health and neighbourhood-based priorities

- 9.17 At present it would appear that whilst Public Health Neighbourhood Managers in all five Neighbourhood Management Areas in the city have 'alcohol' as a priority within their Neighbourhood Area Agreements they have no dedicated resources to undertake community based education and awareness raising on the issue and are not necessarily well-supported by central resources, despite ongoing funding being available for campaigns such as the **Pssst! Be Alcohol Aware** social marketing 'brand' which was established under the auspices of Citysafe (Liverpool's Crime and Disorder Reduction Partnership) with the laudable remit of bringing together the main agencies in the city which campaign around alcohol use and misuse – and deal with its consequences – including Liverpool PCT, LCC, Merseyside Police and Merseyside Fire and Rescue Service, to work under a single, recognisable, 'banner'.
- 9.18 Whilst the Group believes this is a sensible approach which has been successful in creating a recognisable 'brand' and promoting a unified message around alcohol facts, figures and myths it is not clear whether, or how, the campaign has been linked to any monitoring of the number of alcohol-related hospital admissions in Liverpool or how it is linked to general health indicators that might demonstrate whether Liverpool residents are reducing their alcohol intake or using alcohol more safely.
- 9.19 Nevertheless there is evidence that alcohol-related issues are being tackled at neighbourhood level in creative ways and involving good partnership approaches, for instance work in Liverpool East with the police, youth service, local councillors and others involved with the PCT to address drinking in parks and on the Loop Line.

c) The role of GPs

- 9.20 This leads to another potential gap in service provision, or perhaps more accurately in service 'linkage', namely referral from GPs to specialist alcohol services. Members of the public are much more likely to visit a GP than a specialist alcohol service (90% of population visit a GP within a 5 year period – women more often than men)²¹ and a range of presenting factors could alert GPs to possible problematic alcohol use (e.g. sleeplessness / tension / gastritis etc) yet, at present there is no encouragement for GPs to play a more active role in screening not only by asking structured questions which could lead to timely referrals but by offering income generation through the Quality Outcomes and Framework (QUAF).

²¹ General Household Survey (2006)

- 9.21 Whilst the latter issue is something that requires a national commitment to address, there is no reason why Liverpool should not take a lead on pushing for national change (as it did so successfully with the smoking ban in public places / places of work) and there may also be ways of exploring the provision of additional support for GPs through Local Enhanced Services (LES) – that is the programme of locally developed services which are not already provided through essential or additional services or alternatively helping essential and additional services to deliver to a higher specified standard.

d) Loss of expertise

- 9.22 In summary it would appear to the Group that the system as it currently operates in Liverpool still tends too much towards a ‘silo’ approach to tackling alcohol issues, despite having recognised the need to ‘join up’ services (e.g. through the Pssst! initiative) and present a unified message.
- 9.23 The Group is concerned that there remains a lack of communication between different teams within the PCT (e.g. Public Health, Unplanned Care, Neighbourhood teams, Lifestyles Team), between frontline practitioners and service commissioners and between services operating across the public and VCF sectors.
- 9.24 The Commissioner / Provider split has perhaps not encouraged communication and may have had a negative impact on service innovation in Liverpool in that provider knowledge and expertise may not be utilised sufficiently in the commissioning process.
- 9.25 It was not apparent to all who contributed to the Task and Finish process where the ultimate decisions for commissioning lie (i.e. with the Senior Commissioner or the Strategic Lead?) or what statistical data or other information informs the commissioning process – although it is made clear in Liverpool’s Alcohol Strategy that ‘alcohol treatment services have been commissioned and developed in line with the MoCAM’ (Models of Care for Alcohol Misuse).
- 9.26 There is a danger that some relevant knowledge around the needs of alcohol users may not to be utilised in the commissioning process – particularly in relation to VCF services. Liverpool LINK was recently invited to attend a joint commissioning meeting with PCT and LCC officers which provided a very positive demonstration of the way in which a range of officers from those two organisations worked together to tackle alcohol-related issues. It would be very welcome if VCF representation could become a standard element of such meetings – within guidelines which would ensure no conflict of interest could occur for service providers which might benefit or be open to accusations of benefiting from such involvement. At present, VCF knowledge and expertise is not listed in Liverpool’s alcohol strategy and it would be

useful to address this when the next strategy is produced (to cover 2011 onwards) – in line with the LINK’s recommendations that it should be written into Liverpool First’s Community and Communications Strategies as a key VCF partner. Increased involvement of the VCF sector in developing strategy and influencing commissioning might help to improve transparency in this regard and the LINK would be an ideal body to take this forward.

10.0 Recommendations

- 10.1 The Liverpool LINK Alcohol Task and Finish Group has taken the view that it would be helpful to group its recommendations under the 5 strands of the Liverpool Alcohol Strategy Group's work stream in order to join up working with partners in the public sector and also to feed into the development of Liverpool's new alcohol strategy which is due to be written in 2010 and which Liverpool LINK would like to contribute to as an independent voice for local residents, service users and voluntary, community and faith sector organisations.

The 5 strategic headings are:

1. Social marketing
2. Treatment and interventions
3. Crime and disorder
4. Commerce and workplace
5. Information and intelligence

- 10.2 Given Liverpool LINK's very specific health and social care remit it is inevitable that the majority of recommendations fall within strands 2, 4 and 5. However, owing to the cross-cutting nature of the subject some recommendations have also been made under other the other headings.

1. Social marketing

- 10.3 Whilst conducting the mapping and scoping exercise for this report it became clear that publicly available details about a number of services were incorrect – including website information, contact numbers and types of services available. The Group would therefore like to recommend that every effort is made to ensure that service contact details are kept up to date for the benefit of service users, referral agencies and others. Such a requirement could for instance be included as part of a contractual obligation. This is an important point since it may take a lot of courage for someone to try to contact a service and the consequences of then not being able to make initial contact could potentially be extremely negative.
- 10.4 On a related note, information about what users can, and cannot, expect from services should be as clear as possible. According to service users, misunderstandings can lead to disappointment, frustration and, often, to increased alcohol consumption. A recommendation would therefore be that a regularly updated 'concertina-style', credit-card sized, information card with details about alcohol services should be developed, similar to those that already exist in relation to homeless support services or NHS Choices.
- 10.5 Further recommendations include

- a) Improving publicity of good practice and success stories both amongst partner agencies and in the local and national media.
- b) Actively working to influence acceptable media images of alcohol use including in advertising.

2. Treatment and interventions

- 10.6 It is clear from the Group's work over the past few months that there is a great deal of good practice happening in Liverpool around a whole range of issues relating to alcohol awareness, use and misuse. This includes public health messages and awareness-raising; work in neighbourhoods; work led by both the public and voluntary, community and faith sectors; clinical and community-based treatment, academic research and data analysis; education and support services.
- 10.7 A large number of organisations are potentially involved in work around alcohol-related harm and very often this can be confusing to service providers and users and others providing advice, information and support. More work is needed to clarify the processes and to provide a framework within which all the relevant professionals will be able to work.
- 10.8 It has become apparent to the Alcohol Task and Finish Group that communication between all those with an interest in alcohol services could be improved. A particular area of concern is the potential loss of cohesion between the 'purchaser' and 'provider' strands of the PCT and the loss of practitioner knowledge within the commissioning process. The commissioning and service providing arms of the PCT may benefit from closer working and from providers having greater opportunities to contribute their practice-based expertise to inform World Class, evidence-based commissioning. For instance, where Liverpool has practitioner expertise which is helping to develop policy at a national level (for instance through Dr Lynn Owens' involvement in developing National Institute for Health and Clinical Excellence (NICE) guidelines) that these skills knowledge and expertise could also help, support and inform local policy.
- 10.9 A range of agencies both within and external to the PCT have a strategic interest in alcohol or a remit to work on alcohol and related issues and could benefit from a more 'joined up' approach to information sharing. Amongst these are:
 - Public Health
 - Lifestyles Team and A&E at the Royal
 - A&E at Alder Hey
 - DAAT
 - Voluntary/Community/Faith services
 - GP practices
 - Windsor Clinic

- Mental health services
 - Sexual health services
 - Inclusion Matters
 - Citysafe
 - Police
 - Schools and youth services
- 10.10 The Neighbourhood Public Health agenda in particular appears somewhat separate from others but Liverpool LINK could play a role in joining services up and encouraging better communication between PCT services and the voluntary sector particularly through the LINK Neighbourhood Champions who are well positioned to work closely with Public Health Neighbourhood Managers.
- 10.11 More work is needed to determine how best to focus the balance of resources at neighbourhood and central levels. Public Health Neighbourhood Managers appear currently to have no designated budgets to focus on neighbourhood priorities, including alcohol, yet there is some evidence from LINK participants that community-based services are popular with local residents whether targeted at young people, parents, families or alcohol-dependent individuals and, importantly, such services are thought by service users to reduce the risk of hospital admissions. It would therefore make sense for Public Health Neighbourhood Managers to have some input into commissioning at a local level.
- 10.12 Although all patients who attend the Royal and see the Lifestyles team, are registered with a GP as a matter of priority the Group has found evidence that street drinkers who are not in touch with public sector services are often without any primary care support. On the basis of the good work done by Taher Qassim (PCT Public Health Manager for the South Central Neighbourhood) in helping homeless people to access GPs – as reported to the Group by voluntary sector service providers and users – it is recommended that more service providers should provide outreach work to alcohol dependent individuals in the places where they feel comfortable rather than expecting them to keep formal appointments. For example, the Practice Nurse from the Brownlow Group Practice could visit the Christian Life Centre on a Saturday morning and have access to a substantial number of homeless or hostel-based alcohol users. Such regular, informal, contact with PCT staff could help to break the misconception held by many street drinkers that there is no help available to them.
- 10.13 It is further recommended that the PCT should develop a ‘user-friendly’ chart showing clear referral routes / pathways for GPs and others working with patients or clients where alcohol is a problem. Such an exercise would help to clarify referral routes for all concerned as there is currently some confusion as to how and where clients can be referred. For instance can Inclusion Matters refer directly to the Lifestyles Team, can clients self-refer to Inclusion Matters and where

can clients be referred for aftercare and support following discharge from hospital, detoxification units, rehabilitation or Alcohol Treatment Orders or Programmes? This is particularly pertinent given the recent loss of the Lighthouse service and the re-structuring / re-commissioning of many voluntary sector addiction support services under the auspices of Addaction.

- 10.14 Clearer referral pathways might also be a way to encourage GPs to screen for alcohol related factors in a range of presenting conditions and could be argued for as a relatively cheap way of saving money on treatment down the line on the basis that prevention is better than cure. It is understandable that where GPs are inundated with patients they will need to make decisions about how best to invest in patient care and that alcohol misusers may not be prioritised highly – but they should be encouraged to use any opportunities to screen patients for alcohol-use and related medical issues and refer as appropriate.
- 10.15 The Group found some confusion amongst the public and professionals alike as to where the final decisions on service commissioning lay and how commissioning decisions were informed by the city's alcohol strategy or by public consultation. Given the increasing 'duty to involve' the public in service commissioning and delivery and recent recommendations²² it was felt that there should be a greater role for the public to play in this and that the LINK offered one useful route for public involvement. To some extent this will be addressed by the inclusion of an authorised LINK representative on the Alcohol Strategy Group but it would also be helpful for the LINK to be written into Liverpool First's Community Engagement and Communications Strategies and included in all consultations relating to health and adult social care – including those specifically about alcohol services.
- 10.16 There would appear to be value in increasing the availability of dedicated outreach and support services for street drinkers and chaotic alcohol users, including encouraging more 'professional' services to link into community venues for regular visits – provided this was done on community terms and agreed in advance. Whilst the current commissioning of a 6 month Street Drinkers project is welcome the Group is concerned that it this may be too short a period to achieve lasting results and recommends that project staff should liaise closely with voluntary organisations already working with street drinkers so as not to duplicate efforts and in order to share information and expertise.

²² See, for example a) *Local Government and Public Involvement In Health Act 2007* b) *Section 242(1B), NHS Act 2006 – Public Involvement and Consultation* c) Colin-Thome, D. (2009) *Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation*. London: Department of Health

- 10.17 In respect of rehabilitation services there is a need for long term rehab places in Liverpool as the Windsor Clinic only provides short term rehab and to access 12 month programmes means going to Chester or Blackburn. There is currently no plan to extend the three week residential programme at the Windsor, however the Group understands that the whole service is currently undergoing a root and branch review and looks forward to the outcomes of a report in February.
- 10.18 A further issue of concern is that the tendering process for alcohol services seems to be weighted in favour of cost at the expense of outcomes or expertise leaving existing services unable to look at outcome measures because commissioners appear more concerned with methods than successful outcomes. An opportunity to re-examine this balance would be welcome.
- 10.19 The Group further recommends that:
- a) Given that NHS cuts of 20% across the board over the next 5 years will undoubtedly have an impact on alcohol service provision it is vital that service efficiency and care pathways are improved and maximised and that PCT / LCC service commissioning is targeted more effectively towards voluntary, community and faith sector organisations in order to support the existing alcohol strategy for the city. This might include more commissioning of community-based, community-led support services which alcohol users trust and will attend regularly. Voluntary services struggle for funding for core running costs and project work is often short-term funded but such services, can do much to encourage safer alcohol use and access to health and social care services and can provide generalist support in ways that are not always prioritised by public sector services. They can, subject to funding, also lead on the provision of 'constructive alternatives' to alcohol use (for example, practical skills training) and on 'halfway houses' providing holistic support and preparing people for independent or semi-independent living – both of which service users indicated would be of value to them and, again, contribute both to fewer hospital admissions and to improved after-care on discharge from hospital (or release from prison). The Department of Health recommendation that more alcohol specialist nurses are employed within hospitals also suggests that some additional provision should be available via that route.
 - b) GPs are encouraged to become more involved in shaping and delivering the city's alcohol strategy and in improving their screening and referral for alcohol related conditions. It is unclear to the Group whether this is something that is already happening, or could happen, through Locally Enhanced Service (LES) programmes – further information would be welcomed.

- c) A standard protocol is introduced for hostel staff around the holding and distribution of Chlordiazapoxide prescriptions for residents. According to hostel residents, some GPs will allow hostel staff to hold Chlordiazapoxide tablets and give them out to patients as prescribed, which works well and is appreciated - but not all GPs or hostels will do this. A standard system would help all parties to know where they stand on this issue.
- d) More 'hard hitting' awareness raising groups might provide short-term answers where people are not yet 'lost' to alcohol, particularly if run by 'peer educators' / people who have (mis)used alcohol and can relate to / have empathy with alcohol users.

10.20 Finally, given the amount of existing good practice in Liverpool and the potential for further improvements based on increased partnership working and improved communication, there is a real opportunity for Liverpool to take a national lead on alcohol strategy and changing the acceptability of certain types of behaviour associated with alcohol use, as it did with the national debate on smoking in public places. There may also be worthwhile lessons to learn from current work in Leicester under the Total Place pilot scheme to deliver improvements in service outcomes and efficiency savings in relation to alcohol and drug abuse.²³

3. Crime and disorder

10.21 Although the LINK does not involve itself directly with issues relating to crime and community safety a number of comments received from LINK members and the public have touched on this area, which can be closely linked to both physical and mental good health in many ways. The Group therefore recommends:

- a) Dedicated support packages for prison-leavers delivered jointly between probation and community-based alcohol support workers should be encouraged to help such individuals navigate this critical time in their lives and encourage them not to 'relapse'.
- b) Encouraging greater flexibility by the police when dealing with the treatment of alcohol dependent people and the dispensing of Librium whilst in custody to allow for individual need, following suitable assessment.
- c) Actively working to introduce an element of 'restorative justice' in respect of alcohol related crime or anti-social behaviour.
- d) Supporting the ongoing implementation of the recently introduced Alcohol Treatment Requirement (ATR) – a court order for instance

²³ www.localleadership.gov.uk/totalplace/pilot/leicester-and-leicestershire

for a brief intervention, detoxification or rehabilitation – in court cases involving domestic violence and where alcohol is identified as an issue; and Alcohol Treatment Programme voluntary alcohol interventions, where appropriate, for other offenders who may be offered assessment and support whilst in custody suites.

4. Commerce and workplace

10.22 Concerns around licensing focused on the need for more comprehensive health impact assessments to be conducted when considering applications for alcohol licences with LINK participants suggesting that notices around lamp posts are not enough to judge the potential impact of licensed premises on communities.

10.23 Since the IMPACT report in 2005²⁴, community pubs have closed and venues with 24 hour licenses have opened up all over the city centre, alcohol outlets are increasing every day and the LINK has evidence, based on attending meetings, that some tenants' and residents' groups are concerned about the amount of licenses granted to shops and supermarkets in their neighbourhoods.

10.24 The Group therefore recommends:

- a) More robust community consultation around granting licences to sell alcohol. Health impact assessment should consider not just people who are alcohol dependent or harmful / hazardous drinkers (or those at risk of becoming so) but also the mental health impact / stress on those family and community members who have to live with the consequences of easily available alcohol.
- b) Consideration to be given to a reintroduction of the requirement of a quarter mile radius around (off)licensed premises. The Group believes that this may be possible under the relevant legislation.

“more recognition is needed of how national alcohol strategies might be interpreted differently or have a different impact on specific locales. This is particularly pertinent in the light of the Licensing Act 2003, which has given local authorities more power to potentially dictate local licensing strategies. Geographical disparities may thus emerge in approaches to regulating and policing alcohol consumption.”²⁵

- c) Seeking to address the issue of services delivering alcohol to people's homes or selling illicit alcohol by monitoring such practices and intervening where necessary.

²⁴ Fox, D. et al, op cit

²⁵ Valentine, G. et al (2007) *Drinking places: Where people drink and why*. York: Joseph Rowntree Foundation

“Young people buying bootlegged alcohol is a serious concern, says a Merseyside police officer, Paul McHugh. ‘It is a far greater problem than class A drugs, in part because of the ease of access. Kids turn up at someone’s door with a fiver in their sticky hand and come away with alcohol. The bootleggers don’t care who they sell to. For five quid these kids can get 24 ‘dumpsies’ - bottles of smuggled beer.”²⁶

- d) Actively seeking ways to influence the national debate on the availability of cheap alcohol and the pricing of units on the basis of strength.
- e) Actively seeking to ‘ring-fence’ alcohol-derived tax revenue for alcohol-related treatment and prevention programmes.
- f) More robust implementation of existing powers to refuse alcohol at the point of sale, knowingly obtaining or attempting to obtain alcohol for a person who is drunk and generally in relation to fining licensees under the Licensing Act 2003 for allowing disorderly conduct or selling alcohol to a person who is drunk.

5. Information and intelligence

10.25 At present it appears that whilst huge amounts of relevant data are being collected (for example by primary and secondary health and care providers, third sector organisations and the police) it is not always easily accessible or shared. Furthermore, frontline service providers, by the very nature of their work, routinely have limited time in which to interpret the data they compile. The Group welcomes the forthcoming data ‘dashboard’ due to be introduced by Liverpool PCT by April 2010 and recommends:

- a) That voluntary sector partners have access to and, where appropriate, contribute to information and intelligence held by Liverpool PCT.
- b) Since the North West Public Health Observatory (Liverpool John Moores University) already collates some of the available alcohol data in some form it would make sense to involve them in co-ordinating a ‘central’ data-mapping and co-ordination service on behalf of all partners in the Alcohol Strategy Group.

10.26 The Group is concerned that the Windsor Clinic’s ability to conduct its own research has been reduced due to the division of staff time between the Alcohol and Drug teams which the psychology service has to provide. This is a recent move and has limited their capacity due to their new clinical commitments. The Group would therefore

²⁶ Lashmar, P. (2000) *Bootleggers are selling alcohol to eight-year-olds*, The Independent, 1st March 2000

recommend that, wherever possible, an element of 'research time' is included within the remit of commissioned services to help enable them not only to demonstrate the impact of their service provision but also to identify any emerging issues of concern.

- 10.27 Despite evidence of much positive work in Liverpool (as outlined in a recent report by the London Assembly amongst others)²⁷ the Group is concerned that there is still evidence of 'silo' working and that better use could be made of shared experience, information and practice. This would help to make best use of resources, reduce duplication, ensure 'smarter' commissioning and targeting of gaps and – most importantly – lead to improved experiences for patients / service users and their family members and a smoother 'journey' through the range of services on offer with improved referrals and handovers and better patient / service user awareness of what support can be expected from which services. The Group therefore recommends reviewing and strengthening the membership of the Alcohol Strategy Group, the frequency of its meetings and the ways in which information is fed into and out of the group to practitioners in the field – in all sectors. It is hoped that the recent invitation to the LINK to join the Alcohol Strategy Group can be the beginning of this process and that the work the LINK has already done in bringing a range of partners together will be a catalyst for improved future coordination of work. It may be of value to look at how other PCT areas handle multi-agency working around alcohol and not only to learn from their good practice but also to share the best of what Liverpool is doing.
- 10.28 Data from the Lifestyles team at the Royal shows that following detoxification programmes there is a 70% abstinence rate over the following 12 months; an impressive figure and one which it would be worth monitoring in the longer-term. The Group recommends an extension of this monitoring to provide a clearer sense of long-term abstinence rates and any potential drop-off over time.
- 10.29 A final recommendation is to conduct an exercise to establish staffing and training levels at hostel accommodation for alcoholics, together with information on how these establishments are monitored and evaluated.

Closing Summary

- 10.30 The time has never been more opportune for PCTs and their strategic partners to work with LINKs to provide patient and public involvement²⁸ and we therefore hope that Liverpool's Alcohol Strategy Steering Group will welcome these recommendations in a spirit of partnership and co-operation and will continue to work closely with Liverpool LINK in the future in an effort to ensure the widest possible public

²⁷ *Too Much Too Young?*, London Assembly (2009)

²⁸ See for example the recommendations contained in David Colin-Thome's recent report on Mid-Staffordshire NHS Foundation Trust

involvement and consultation on the commissioning, delivery, monitoring and evaluation of alcohol services in the city and the ongoing development of the strategic framework within which such services sit.

APPENDIX 1

ALCOHOL TASK AND FINISH GROUP MEMBERSHIP

| | |
|-----------------------|--|
| Stanley Mayne: | Liverpool LINK Core Group member (Chair) |
| Jean Dobson: | Liverpool LINK member |
| Anne Gorton: | Liverpool LINK member |
| Jacquie Jones: | Liverpool LINK member |
| Stella Cairns: | Liverpool LINK member |
| Mavis Morgan: | Liverpool LINK member |

Support provided by Claire Stevens (LINK Network Development Officer)

The Group would like to thank all those members of the public who contributed their observations, experiences, questions and suggestions. We could not have completed this report without you. We would also like to thank all the PCT and NHS officers, City Council officers and academics at Liverpool John Moores University and the University of Liverpool who were so generous with their time and in providing documents and data to us. We value your willingness to share your knowledge and expertise.

APPENDIX 2

‘Alcohol Attributable fractions’

These are the ‘alcohol-specific’ factors in hospital admissions
Condition ICD-10 codes Male AF Female AF

- Methanol poisoning
- Mental and behavioural disorders due to use of alcohol
- Ethanol poisoning
- Degeneration of nervous system due to alcohol
- Alcohol-induced pseudo-Cushing's syndrome
- Alcoholic polyneuropathy
- Alcoholic myopathy
- Alcoholic liver disease
- Alcoholic gastritis
- Alcoholic cardiomyopathy
- Accidental poisoning by and exposure to alcohol

These are the ‘alcohol-attributable’ factors in hospital admissions

- Accidental exposure to excessive cold
- Acute pancreatitis
- Air/space transport accidents
- Alcohol-induced chronic pancreatitis, other chronic pancreatitis
- Assault
- Chronic liver disease
- Diabetes mellitus
- Drowning
- Epilepsy and status epilepticus
- Fall injuries
- Fire injuries
- Firearm injuries
- Gastric ulcer
- Gastro-oesophageal laceration-haemorrhage syndrome
- Heart failure
- Hypertensive diseases
- Inhalation and ingestion of food causing obstruction of respiratory tract
- Intentional self-harm/Event of undetermined intent
- Ischaemic heart disease
- Malignant neoplasm of breast
- Malignant neoplasm of larynx
- Malignant neoplasm of lip
- Malignant neoplasm of liver and intrahepatic bile ducts
- Malignant neoplasm of oesophagus
- Malignant neoplasm of oral cavity and pharynx
- Malignant neoplasm of other digestive organs
- Malignant neoplasm of stomach
- Oesophageal varices
- Pneumonia and influenza
- Psoriasis L40 excluding
- Road accidents
- Spontaneous abortion
- Stroke
- Supra ventricular cardiac arrhythmias, atrial fibrillation and flutter
- Tuberculosis
- Water transport accidents
- Work/machine injuries

Source: Deacon, L et al (2008) op cit

Further information and additional copies:

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