Adult Services and Health Select Committee

Review of Alcohol Services

January 2008

Adult Services and Health Select Committee
Stockton-on-Tees Borough Council
Municipal Buildings
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Contents

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ACKNOWLEDGEMENTS

The Committee thank the following contributors to this review.

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Foreword

The Adult Services and Health Select Committee is pleased to present this report on the review of Alcohol Services in the Borough of Stockton-on-Tees.

The review was undertaken following the concerns about the problems caused by excessive drinking of alcohol expressed by the Director of Public Health in his recent Annual Reports. He went so far as to say that alcohol was a greater cause of ill health in this Borough than illegal drugs. The committee wished to find out the scale of the problem, what services are currently available for people who have an alcohol problem and how easy it is to access these services.

During the course of the review it was timely that HM Government published the document "Safe. Sensible. Social. The next steps in the National Alcohol Strategy" and the NHS National Treatment Agency for Substance Misuse published its "Review of the effectiveness of treatment for alcohol problems." The committee drew evidence from these documents and reports from North East Public Health Observatory, the Primary Care Trust and the Strategic Health Authority plans to set up a regional "Office for the Safe Consumption of Alcohol."

Members are most grateful to the many colleagues either employed by Stockton- on-Tees Borough Council or our partner organisations in the Health Trusts and the Voluntary Sector who freely gave up their valuable time from their front line duties to attend and give useful evidence to the Committee. As the review progressed it became clear that more evidence was needed particularly in relation to the financial aspects of the service and the deadline had to be extended. Members were required to attend additional and more frequent meetings to gather up the evidence and draw conclusions and recommendations.

This review has placed a great strain on all those involved and sincere gratitude is expressed to Members of the committee, Ruth Hill as link officer, staff from Democratic Services and to Graham Birtle as Scrutiny Officer who has been able to draw together the masses of evidence and produce this interesting and we hope very useful report.

Several of the recommendations rely on the support and co-operation of our partners to take the appropriate action. The evidence in this report should assist them in this.

We commend this report to all recipients.

Councillor Ann Cains
Chair

Councillor John Gardner
Vice-Chair

Original Brief

Which of our strategic corporate objectives does this topic address? North Tees tPCT Annual Report 2005 (p.7).
What are the main issues? Alcohol is a major cause of chronic liver disease and cirrhosis. The diseases contribute to the greatest level of average years of life lost for both men and women in Stockton Borough. North Tees PCT highlighted alcohol related harm as a main concern in 2005 following the launch of the National Alcohol Strategy which focused on binge and chronic drinking.
The Thematic Select Committee's overall aim/ objectives in doing this work is: Assist the development of local alcohol policies/strategies. To examine and, where appropriate, identify improvements to the cohesive approach being taken by North Tees PCT, the Drugs Action Team, SBC, Cleveland Police, businesses and residents groups. To provide a publicity outlet for drink reduction strategies.
The possible outputs/outcomes are: Improved publicity and awareness of local alcohol services. Reduced incidences of alcohol related disease.
What specific value can scrutiny add to this topic? Assist the development of local alcohol strategies. Determine and improve (where appropriate) the partnership arrangements with health service providers. Highlight investment priorities and strategies.
Who will the panel be trying to influence as part of their work? Health and Well Being Partnership
Duration of enquiry? 5 Months
What category does the review fall into?

Policy Review		**Policy Development**	✓
External Partnership	✓	**Performance Management**	
Holding Executive to Account			

1.0 Executive Summary and Recommendations

1.1 The Committee over a number of years has been made aware of the issue of alcohol related harm by the Director of Public Health, North Tees Primary Care Trust in his annual reports in particular following the launch of a National Alcohol Strategy.

1.2 The culture of 'binge' drinking is particularly strong in this region and that traditional alcohol education programmes have had little impact upon this and that, as a society, we are drinking more, with serious social and health consequences.

1.3 Information that was available showed there to be a number of gaps that existed in service provision to treat alcohol problems. In particular, the North East fared badly for available services which was confirmed when examining Stockton Borough specifically.

1.4 The Committee recommends that the North East Strategic Health Authority working with its public health partners and local authorities, build on the work of local initiatives to develop a campaign to reduce alcohol consumption.

1.5 The Committee recommends that Stockton-on-Tees Borough Council and North Tees Primary Care Trust support the establishment by the SHA of a regional Office for the Safe Consumption of Alcohol (OSCA) in future budget setting processes.

1.6 The Committee utilised expertise throughout the region to examine what could be effectively done on a local, sub-regional and regional basis and worked with information available from the Alcohol Digest 2004 which provided a gap analysis of service provision

1.7 Due to the lack of up to date information available to the Committee **it is recommended that a multi-agency group identified by the Director of Public Health use the process of updating the "Alcohol: A digest for Stockton" published following the publication of the National Alcohol Strategy 2004 to inform the drafting of an alcohol strategy to determine the current extent of problems caused by alcohol consumption and identify commissioning needs.**

1.8 A major issue for the review was the amount of finance that was available to supply alcohol treatment services as monies were not ring-fenced in the way that monies to tackle drug problems were. A specific concern for the Committee was the consideration of including alcohol issues within the remit of the Council's Drug Action Team.

1.9 The Committee recommends that the alcohol strategy group develop a 3-year strategy through multi-agency representation, in keeping with the business planning process, to be costed and taken through the usual PCT/LA (as appropriate) financial approval processes.

1.10 The need for an increased understanding of clinical alcohol services was identified suggesting a 'map' of available services should exist in order to

follow the route likely to be taken by someone affected by alcohol abuse. As no such 'map' exists the Committee questioned the knowledge and awareness of differing health professionals as to the variety of possible services that exist in the borough.

1.11 The Committee recommends that the multi-agency alcohol group undertake a gap analysis that includes needs assessment matched with current service provision. An action plan to address identified gaps would result in the strengthening and development of care pathways.

1.12 Drug Action Team (DAT) monies are ring fenced to deliver services specifically for people affected by drug use and addiction although some local authorities have developed Drug and Alcohol Action Teams (DAAT). The Committee considered that widening the DAT remit has merit although it may endanger the level of work tackling drug issues in the borough. The Committee therefore recommends that **the appropriateness of widening the DAT agenda to include alcohol (DAAT) should be examined as a matter of priority in accordance with the Alcohol Harm Reduction Strategy for England 2004 – Action 20.**

1.13 There is a lack of awareness of the extent of alcohol problems in the borough. Generally, GPs appear not to raise the issue with patients although there is now in place an enhancement scheme that provides financial rewards to GPs who are screening patients. Similarly at University Hospital North Tees, referrals are not always made as a screening programme for people presented at Accident and Emergency has been subject to the availability of additional funding to undertake a pilot project.

1.14 The Committee questioned whether people presenting at A & E were screened for alcohol use and directed to appropriate services if this was accepted. It found that pressure on time for screening is particularly relevant and there may also be special difficulties in screening among injured and intoxicated patients. The Committee believe that UHNT A & E need to screen everyone and was informed that funding was required to introduce a pilot project that would screen patients and that the PCT would provide funding for an initial 6 month period.

1.15 The Committee recommends that ongoing alcohol screening be provided at UHNT, subject to the pilot project findings, in order to provide signposting to support services.

1.16 The problem of ascertaining and delivering planned detoxification for patients was highlighted as no hospital beds are specifically provided. A Community Detoxification Service is available through the Addictive Behaviours Service in Neighbourhood Renewal Funded (NRF) areas. This provides a comprehensive service to people who have a history of dependent, chronic or problematic drug or alcohol use. The service works with users to help them withdraw safely from alcohol whilst also helping the families to support the users.

1.17 The Committee recommends that a clinical service specialist be identified to investigate and determine the scale and infrastructure required to provide the appropriate in-patient detoxification services to be commissioned from a range of providers.

1.18 The Committee considered the impact excessive alcohol consumption has on community safety in Stockton Borough. Currently the lack of any referral to alcohol services when someone is detained because of their actions due to alcohol excess does not effectively deal with the cause of the problem. A pilot project in Middlesbrough may provide a suitable solution to this issue.

1.19 The Committee recommends that, subject to positive results of a pilot project in Middlesbrough, the Safer Stockton Partnership consider the suitability of introducing alcohol referrals for arrested individuals.

1.20 The Committee also examined the contribution made by the voluntary and community sector supporting their involvement in commissioned services in the borough.

1.21 The Committee recommends that North Tees PCT strengthens its alcohol services commissioning process by identifying a lead officer with responsibility for determining / coordinating service provision through appropriate multi-agency partnership arrangements.

1.22 The Committee is impressed by the actions being undertaken to reduce future incidences of alcohol misuse and abuse especially reducing binge drinking amongst underage people in the borough. The Committee would subsequently like to see the above initiatives strengthened and added to wherever possible. As a result it recommends **that Stockton-on-Tees Borough Council's PIC (Participation, Involvement and Consultation) Network is consulted to determine how best to deliver services for alcohol reduction / cessation.**

1.23 Whilst it is not possible to control the strength of spirits sold nor the price of cheap alcohol (the example given was of a can of lager able to be purchased for 22 pence, significantly cheaper than buying the equivalent amount of bottled water) the solutions to counteract the effects of alcohol available to Stockton's Adult Services and Health Select Committee appear limited.

1.24 The Committee recommends that the Leader of the Council write to Stockton Borough MPs highlighting the concerns identified during this review and request that appropriate representation supporting sensible and responsible alcohol licensing and retailing is made to Government Ministers and departments.

2.0 Introduction

2.1 Over 90% of adults in Britain, or nearly 40 million people, consume alcohol. It is widely associated with pleasure and relaxation but alcohol misuse can cause a range of social problems, accidents and illnesses and there are strong links between alcohol consumption and violent crime and disorder.

2.2 Nationally, the cost of alcohol misuse to society is currently estimated at over £20 billion per year.

2.3 There are 3 times more alcohol-related deaths than drug-related deaths each year.

2.4 Females aged 18-24 are drinking in greater quantities and more frequently than their male counterparts.

2.5 Alcohol consumption is increasing on a national basis and this trend is more apparent in the North East than in other English regions. The North East experiences the highest levels of alcohol-related harms and action is needed to reduce alcohol consumption and consequently alcohol related violence, disorder and poor health.

2.6 With such a level of alcohol consumption in the North East the need for appropriate treatment would appear to be particularly high but the region has the fewest agencies providing specialist alcohol interventions and the average waiting time for treatment is longer than anywhere else in the country.

2.7 Young people in this region 'binge drink' more regularly than older people and have higher admission rates for accidental alcohol poisoning or exposure to alcohol.

2.8 Alcohol consumption is measured in 'units' with the recommended weekly limit for men set at 21 units and for women set at 14 units. The 'unit' system was devised more than 20 years ago and over time the strength and variety of drinks available has altered considerably.

2.9 One unit of beer or lager is equivalent to a half-pint glass containing a drink with the alcohol content of 3.5 per cent. One unit of wine is a 125 ml glass containing wine at 8 per cent ABV (alcohol by volume).

2.10 The following gives an indication of the alcohol content of drinks regularly available:

- Standard (175ml) glass of wine – 2 units
- Large (250ml) glass of wine – 3 units
- Pint (568ml) of standard lager – 2.3 units
- Pint of premium lager – 2.8 units
- Pint of strong cider – 4.7 units

2.11 Only 10 minutes after having a drink, 50 per cent of the alcohol will be in one's bloodstream. After an hour all the alcohol will have been absorbed. 100ml of alcohol in one's bloodstream by midnight will not be fully flushed out until the following afternoon and it is impossible to speed up the processing of alcohol through one's body any faster.

2.12 The effect of alcohol on the body includes:

- Absorption of information restricted; memory impaired; inhibitions lowered
- Tunnel vision; difficulty in distinguishing light intensity
- Central nervous system impaired; intestinal irritation can lead to ulcers; high levels can lead to coma or death
- Change in fat metabolism, eventually leading to scarring of the liver
- Sexual performance inhibited, possibly leading to impotence
- Co-ordination and motor skills impaired; increased swaying

2.13 The following tables help to identify dangerous levels of alcohol consumption.

Department of Health Definitions for Alcohol Consumption

Consumption	Safe daily consumption on no more than 5 days per week	Safe weekly consumption	Binge Drinking	Hazardous Drinking	Harmful Drinking
Men	3-4 units	< 21 units	8 or more units in one day	22-50 units per week	> 50 units per week
Women	2-3 units	< 14 units	6 or more units in one day	15-35 units per week	> 35 units per week

Common Definitions

Term	**Definitions**
'Binge' Drinking	This can be defined as the consumption of at least 8 units of alcohol for men and at least 6 units for women during a single session (i.e. double the daily recommended alcohol consumption limits).
'Hazardous' Drinking	A pattern of heavy alcohol consumption, which carries with it a high risk of causing future damage to the medical or mental health of the drinker, but which has not yet resulted in significant medical or psychological harm.
'Harmful' Drinking	This can be defined as heavy alcohol consumption, already resulting in significant physical or mental harm to the user. This group, as defined, does not include drinkers that develop alcohol dependence.
'Moderately Dependent' Drinking	Drinkers in this category show moderate levels of alcohol dependence. Moderately dependent drinkers may recognise that they have a problem with drinking, even if this recognition has only come about reluctantly.
'Dependent' Drinking	Dependent drinking is generally categorised by 'psychological dependence', with an increased desire to consume alcohol and difficulty in controlling use, in spite of the potential consequences.
'Severely Dependent' Drinking	People in this category may have serious and long-standing problems and in historic language, have included individuals described as 'chronic alcoholics'.

3.0 Background

3.1 In 2004 the Health Improvement Partnership in Stockton Borough published *Alcohol: A Digest for Stockton* which provided a local perspective following the publication of a National Alcohol Strategy.

- About 9 in 10 men (88.9%) and 8 in 10 women (79.5%) are current alcohol drinkers.
- Use of alcohol is strongly related to or influenced by age, sex and socio-economic status. Women, older people, and people living in disadvantaged areas are less likely to drink than men, younger people and people living in affluent areas.
- About 1 in 4 men (25%) 'binge' drink (more than 10 units per man on one occasion) at least once a week or more.
- About 1 in 8 women (12.8%) 'binge' drink (more than 7 units per woman on one occasion).
- At the time of the survey, about 1 in 6 men (15.7%) and 1 in 30 women (3.3%) drink more than the safe weekly consumption rate each week (28 units for men, 21 units for women).

3.2 As well as providing information regarding the extent of problems caused by the amount of alcohol imbibed it also identified gaps in local service provision. These included:

- **Resources and Capacity issues**: Inadequate resources and capacity was considered as implying poor access and long waiting times as well as limitation in the range of provision.

- **Waiting Times**: Long waiting times in all the services were identified. Primary care staff and other agencies had particular problems in referring to secondary services due to the waiting times.

- **Low Profile for Alcohol issues**: Alcohol did not appear as a major issue in comparison to drugs.

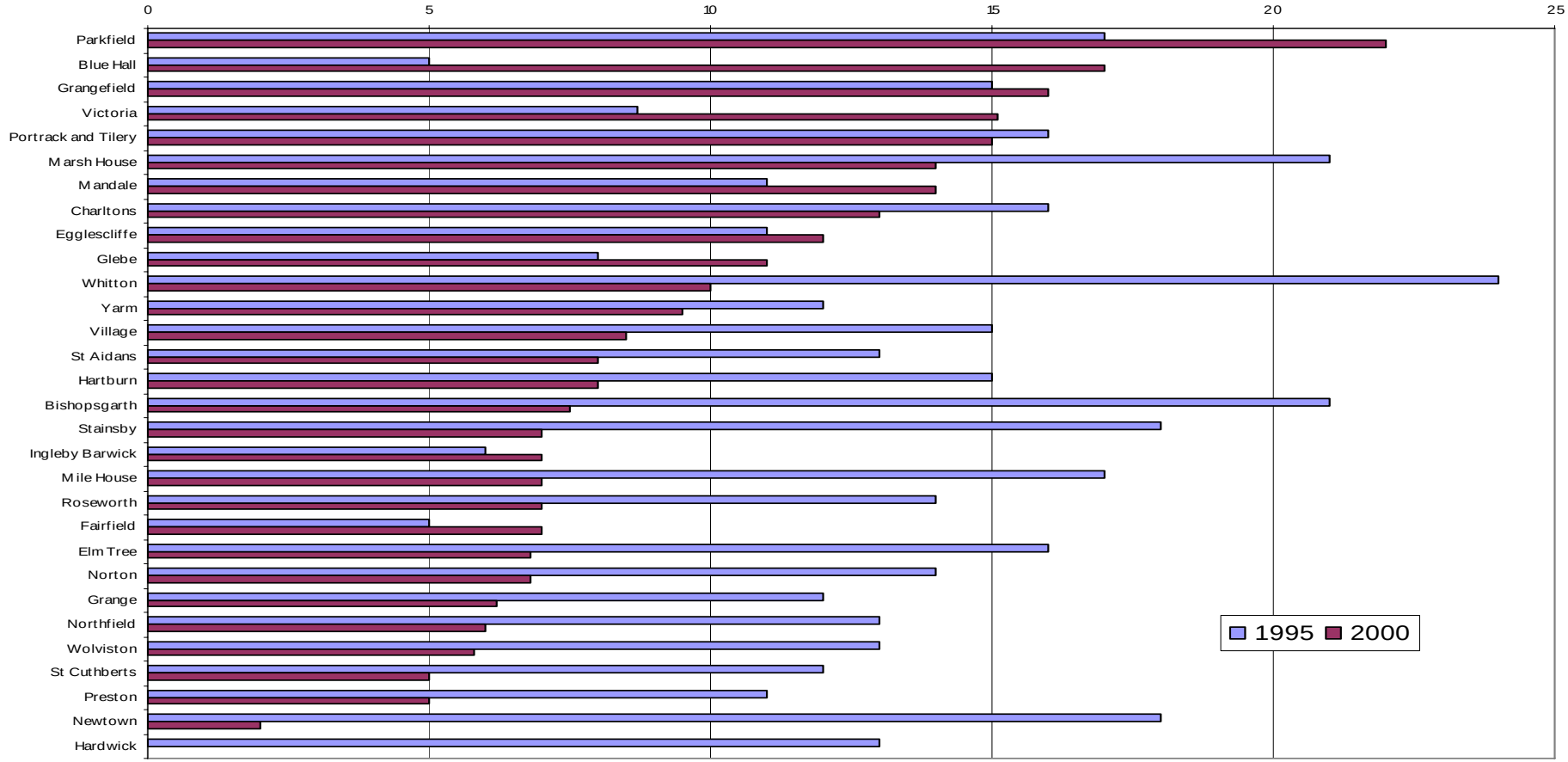
- **No Clear Pathway of Care**: No clear and comprehensive pathway of care for people with alcohol problems.

- **Lack of follow up**: Follow up to home detoxification or residential rehabilitation services were unavailable resulting in a situation where some patients may have reverted to their original situation or even get worse.

- **Screening**: Little or no structured screening service available in primary care to allow early identification and as a result a brief intervention.

- **Inpatient Detoxification/ Residential Rehabilitation:** There is currently meagre funding identified for this service. This is another big gap on service provision that requires urgent attention.

The percentage of people who reported consuming alcohol above the recommended limit in each ward and Area Board in Stockton in 1995 and 2000.



4.0 Evidence/Findings

4.1 Recognising that this issue is not limited to any specific geographic boundary and that work exists to tackle the issue of alcohol consumption rates the Committee was eager to determine the extent of the problem and what services are available.

4.2 The Committee utilised evidence collated by the North East Regional Alcohol Advisory Group which brings together agencies and individuals from across the region with an interest in the alcohol agenda. This group published a statement of priorities to tackle alcohol misuse.

4.3 The Alcohol Advisory Group has three overarching aims which the Committee supports:

- Developing a preventative approach towards alcohol misuse throughout the North East region;
- Ensuring that services are provided for harmful, hazardous and dependent drinkers and for their families and carers; and
- Promoting public protection through law and policy enforcement.

4.4 Dr Stephen Singleton, Regional Director of Public Health, informed the Committee that the culture of 'binge' drinking is particularly strong in this region and that traditional alcohol education programmes have had little impact upon this and that, as a society, we are drinking more, with serious social and health consequences.

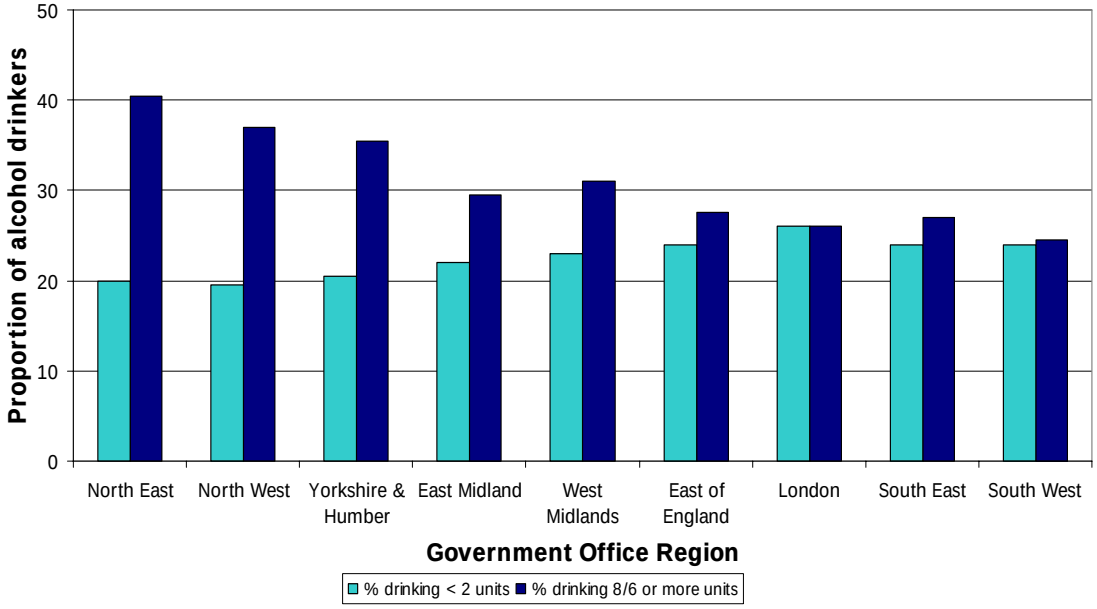
4.5 Although demand for alcohol treatment is particularly high in the North East, the Committee learned that the region has the fewest agencies providing specialist alcohol interventions and the average waiting time for treatment is longer than anywhere else in the country. Young people in this region binge drink more regularly than older people and have higher admission rates for accidental alcohol poisoning or exposure to alcohol. Older people tend to drink more frequently and there is a higher incidence of chronic alcohol related disease amongst these age groups, although cirrhosis of the liver and other alcohol related illnesses are also becoming increasingly common in younger men and women.

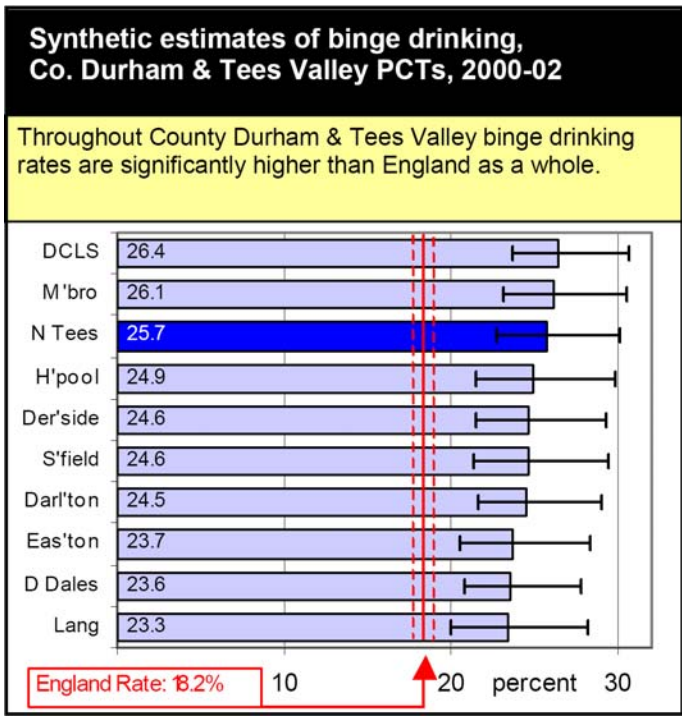
4.6 In order to tackle the deficit in services a regional action plan has been developed with specific priorities identified at a sub-regional level. The Tees Valley priorities are:

- Promote greater co-ordination, consistency and 'join-up' between agencies involved in the alcohol agenda across the Tees Valley.
- Promote mainstreamed information and intelligence-sharing between agencies, to support evidence-based alcohol-related good practice.
- Foster and roll-out family-based educational / prevention programmes, focused on changing behaviour and supplemented by interactive interventions.
- Target 'at risk' groups with educational and preventative messages, aimed at reducing the risk of harm to individuals and those around them.
- Identify and target diverse funding streams to extend treatment provision across the sub-region and reduce the so-called 'postcode lottery'.
- Put measures in place to enable the centralised custody suite in Middlesbrough to offer Tier 1 interventions. (see appendix 1 – page 30)

- Extend training in 'brief interventions' to all areas across the sub-region.
- Foster stronger links between drink-driving convictions and the availability of 'drink awareness' interventions, as part of driving improvement courses.

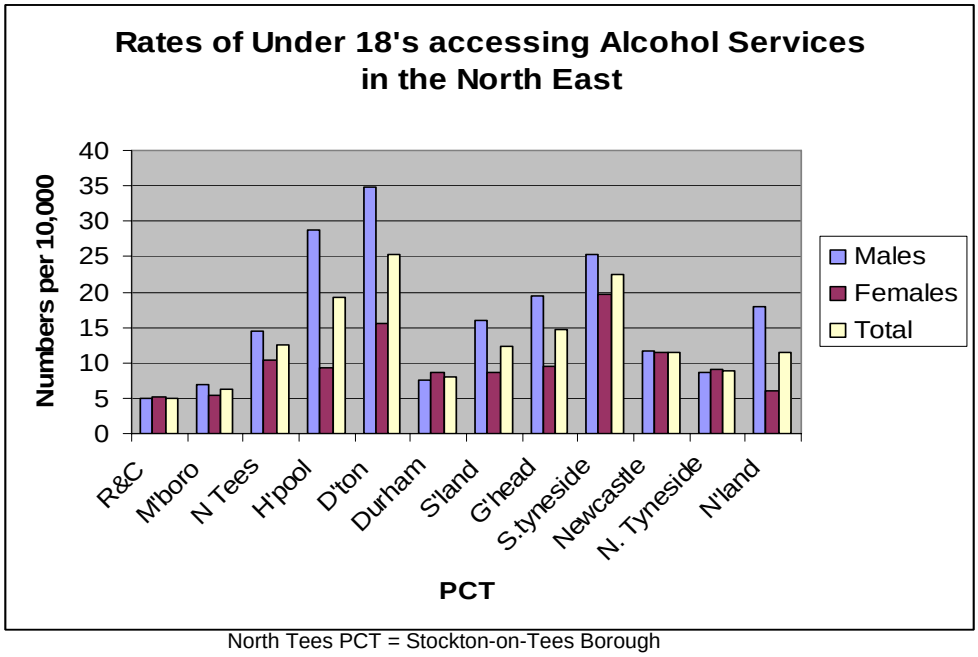
4.7 The evidence of binge drinking and lack of awareness of service provision was supported by evidence provided by the North East Public Health Observatory (NEPHO).





4.8 Particular interest was shown by NEPHO for the work being undertaken by the Committee to improve alcohol service provision as an investigation by NEPHO determined that information was poor, there was a lack of regional treatment

services, no routine data was available at primary care level and the criminal justice sector had very limited data regarding health provision.



North Tees PCT = Stockton-on-Tees Borough

4.9 Dr Singleton highlighted the importance of alcohol consumption as being the major contributor to mortality rates surpassing tobacco as smoking had been effectively targeted through the FRESH campaign. He therefore felt that a similar approach should be undertaken to combat the problems caused by alcohol.

4.10 As a means of delivering the message of reducing alcohol consumption reduction in the region in October 2007 Dr Singleton published consultation on a strategy for 21st Century Health and Well-Being in North East England. It contained the proposal to explore the establishment of a regional Office for the Safe Consumption of Alcohol (OSCA) that would coordinate social marketing, lobbying and collective action in relation to alcohol consumption in the North East.

4.11 The Committee recommends that the North East Strategic Health Authority working with its public health partners and local authorities, build on the work of local initiatives to develop a campaign to reduce alcohol consumption.

4.12 The Committee recommends that Stockton-on-Tees Borough Council and North Tees Primary Care Trust support the establishment by the SHA of a regional Office for the Safe Consumption of Alcohol (OSCA) in future budget setting processes.

4.13 As well as examining the proactive approach being considered to reduce alcohol consumption the Committee was eager to analyse the reactive treatment services available locally and subsequently held discussions with health practitioners from primary, secondary and voluntary and community services.

4.14 The Committee worked from information available in the Alcohol Digest 2004 which provided a gap analysis of service provision (see paragraph 3.2).

4.15 Due to the lack of up to date information available to the Committee **it is recommended that a multi-agency group identified by the Director of Public Health use the process of updating the "Alcohol: A digest for Stockton" published following the publication of the National Alcohol Strategy 2004 to inform the drafting of an alcohol strategy to determine the current extent of problems caused by alcohol consumption and identify commissioning needs.**

4.16 Throughout this review the issue of finance that is available to address the problems caused by excessive alcohol consumption was raised. It was therefore necessary to take evidence from Neil Nicholson, Director of Finance, North Tees PCT.

4.17 The Committee was informed that the PCT Finance and Commissioning Plan for 2007/8-2009/10 was based on an overarching Needs Assessment, and that £2.6M had been earmarked for expenditure on Public Health and Health Inequalities issues, which would include alcohol services. Any underspends would be carried forward into next year.

4.18 Whilst the treatment of drug related problems receives targeted funding, such as DAT funding, no similar targeted was available for alcohol services despite it being recognised by the Director of Public Health that alcohol abuse is one of the biggest health problems facing the region. The Director of Finance however welcomed fully costed proposals aimed at addressing alcohol problems as it was stated that resources were available for this service. In addition, private sector and Third Sector finance solutions were also available to supplement these resources.

4.19 Neil Nicholson gave specific financial information which highlighted the PCT having an increased focus on commissioning. The PCT has provided monies for Choosing Health agenda - £1m 06/07; £0.5m 07/08; £0.4m 08/09.

4.20 General Practitioners have been offered a financial inducement for providing extended services which could include alcohol referral or treatment and the effectiveness of this needs to be evaluated when appropriate.

4.21 Within Stockton Borough 11 GP practices are providing locally enhanced services at level 1 which means that patients must be screened and identified as having a level of need in relation to alcohol misuse and be included within the practice register in order to be offered brief interventions and/or support to modify behaviour.

4.22 9 practices are operating at level 2 which enables a patient to be engaged in treatment such as a detoxification regime. The treatment will be provided by the practice and may be offered with support from, or in partnership with, specialist addictive behaviour services.

4.23 The Committee learned that the Tees, Esk and Wear Valleys Mental Health Trust (TEWV) have a £30m budget but its use for alcohol services could not be detailed when questioned.

4.24 The Committee recommends that the alcohol strategy group develop a 3-year strategy through multi-agency representation, in keeping with the

business planning process, to be costed and taken through the usual PCT/LA (as appropriate) financial approval processes.

4.25 As highlighted above, Drug Action Team (DAT) monies are ring fenced to deliver services specifically for people affected by drug use and addiction. The Committee was aware of certain local authorities that had developed Drug and Alcohol Action Teams (DAAT) and was keen to explore the possible introduction of a DAAT in Stockton Borough. Contained in the Alcohol Harm Reduction Strategy (2004) is an action for Drug Action Teams to be encouraged to become Drug and Alcohol Action Teams (or other local partnership arrangements) to assume greater responsibility in commissioning and delivering alcohol treatment services although their capacity to do so needs to be carefully considered.

4.26 The only anomaly that exists regarding alcohol funding within the DAT is that an amount of funding is made available through Stockton Together Against Substance Harm (STASH) to provide an under 18 specialist able to deal with both alcohol and drugs use. STASH is funded through the Young Persons Substance Misuse Grant and provides equal spend for drugs and alcohol as the only mainstreamed funding available.

4.27 Evidence provided by Sue Maddison, Joint Strategic Commissioner Drugs, Prison Healthcare and Social Inclusion, questioned the value of including the alcohol agenda with the drugs agenda. Whilst believing such consideration has merit it was believed that it endangered the level of work tackling drug issues in the borough. Other issues of concern raised included; resourcing; the requirement of a needs analysis; need for increased understanding of clinical services.

4.28 The need for an increased understanding of clinical alcohol services was identified very early in this review by Committee Members who had requested a 'map' of available services so that they could follow the route likely to be taken by someone affected by alcohol abuse. No such 'map' existed which meant the Committee questioned the knowledge and awareness of differing health professionals as to the variety of possible services that exist in the borough.

4.29 The Committee recommends that the multi-agency alcohol group undertake a gap analysis that includes needs assessment matched with current service provision. An action plan to address identified gaps would result in the strengthening and development of care pathways.

4.30 The Committee recommends that the appropriateness of widening the DAT agenda to include alcohol (DAAT) should be examined as a matter of priority in accordance with the Alcohol Harm Reduction Strategy for England 2004 – Action 20.

4.31 Evidence was sought from secondary care services which provided an opportunity for the Committee to determine what services were available from the University Hospital North Tees (UHNT) and TEWV.

4.32 It was reported that alcohol related incidents (e.g. violent acts or accidents) were a major contributor to high numbers of A & E referrals at UHNT at weekends and certain late evenings. Although there was no evidential increase in the number of incidents following the introduction of new Liquor Licensing hours, A & E staff were treating people later in an evening as it was suggested

that many people took advantage of purchasing cheap alcohol which was consumed prior to them visiting pubs and clubs. The availability of cheap alcohol, whether from pubs or local shops, had seen a trend amongst people of binge drinking. This problem was felt to be exacerbated by promotions such as 'Happy Hours' in pubs.

4.33 The Committee questioned whether people presenting at A & E were screened for alcohol use and directed to appropriate services if this was accepted. It was reported that it was often very difficult to statistically evidence the age and identity of people with alcohol problems due to their condition at the time of admission.

4.34 The National Treatment Agency for Substance Misuse in its 'Review of the effectiveness of treatment for alcohol problems' examined the context for screening in A & E departments. It found that pressure on time for screening is particularly relevant and there may also be special difficulties in screening among injured and intoxicated patients.

4.35 Questionnaires used are based on self-reports of alcohol consumption which can be influenced by deliberate under- or overestimation of consumption and by failures of memory and other cognitive factors. Even so, the Committee believe that UHNT A & E need to screen everyone which is not currently the policy due to issues with funding. The Committee was informed that funding was required to introduce a pilot project that would screen patients and that the PCT would provide funding for an initial 6 month period.

4.36 The Committee recommends that ongoing alcohol screening be provided at UHNT, subject to the pilot project findings, in order to provide signposting to support services.

4.37 The Committee was made aware of the Primary Alcohol and Drugs Service (PADS). The service offers support to Stockton Borough patients at UHNT who have identified alcohol or drug-related injury or illnesses and feel they need help. Referral can be via A & E, hospital ward staff or self-referral. The service provides an assessment and short-term interventions and gives advice and information on; harm minimisation, relapse prevention and services available within Stockton. PADS liaise with relevant services, advocate on behalf of the patient and maintain contact until help from the most appropriate service can be accessed.

4.38 Ms Luczakiewicz (PADS) advised that problems could be experienced when considering the referral of patients due to a shortfall in available services/insufficient capacity. Accommodation was also often an issue for some patients; particularly if they found themselves in temporary accommodation surrounded by people who were also experiencing difficulties in drink or drug dependency.

4.39 All children related incidents are automatically referred to PADS and follow up visits arranged. The Committee was particularly concerned to hear of a young person aged 10 recently being treated and referred because of alcohol misuse.

4.40 Some doubt was introduced as to the future viability of PADS. It costs approximately £70k to operate this service which is currently made up of: £22k from the PCT, £13k from DAT, and £35k from the Northern Rock. The Northern Rock element is due to be withdrawn in March 2008 and the Committee was

made aware that with the loss of 50 per cent of the service operating costs the service would become untenable.

4.41 Part of the care pathway provided by PADS is to ascertain and deliver planned detoxification for patients. The problem highlighted to the Committee by Dr Metcalf was an inability to admit patients electing to take on detoxification as no hospital beds are specifically provided.

4.42 A Community Detoxification Service is available through the Addictive Behaviours Service in Neighbourhood Renewal Funded (NRF) areas. This provides a comprehensive service to people who have a history of dependent, chronic or problematic drug or alcohol use. The service works with users to help them withdraw safely from alcohol whilst also helping the families to support the users.

4.43 The Committee recommends that a clinical service specialist be identified to investigate and determine the scale and infrastructure required to provide the appropriate in-patient detoxification services to be commissioned from a range of providers.

4.44 As mentioned at 4.42 an Addictive Behaviours Service (ABS) exists in NRF areas to provide access to assessment, planning and interventions within adult alcohol services in Stockton. When information was supplied to the Committee about this service there was no waiting list for clients with drug problems but there was a 3-4 week wait to access alcohol support and this waiting time was likely to lengthen although not for NRF area clients.

4.45 ABS had approximately 140 clients when evidence was provided. Half of the clients were from NRF areas and in June 2007 there had been 42 referrals and caseloads were full.

4.46 It was thought by the ABS that they required 2 full time alcohol nurses to cope with the current capacity as well as having a system to refer less dependent clients to another service for brief interventions or similar, such as the Albert Centre.

4.47 The Committee subsequently met Kevin Wilson, Chief Executive, The Albert Centre which provides a Community Alcohol Counselling Service. The service provides early intervention, counselling and support to anyone in Teesside who is referred to it due to misuse of alcohol. The service engages with alcohol dependent clients to get them into some form of treatment and help them to reduce the likelihood of further alcohol related harm. Drop-in sessions are held for anyone affected by alcohol and education, advice and information is available.

4.48 Kevin Wilson also brought to the Committee's attention a pilot project that was operating in Middlesbrough whereby individuals who were arrested when under the influence of alcohol were referred to alcohol/counselling services so that a needs assessment could be made of their drinking habits.

4.49 The police usually issue a fine, or arrest an individual who, if convicted can be given a community sentence as well as receive a fine. The pilot project, it is hoped, will help to reduce the high number of people arrested for incidences whilst under the influence of alcohol.

4.50 The Committee recommends that, subject to positive results of a pilot project in Middlesbrough, the Safer Stockton Partnership consider the suitability of introducing alcohol referrals for arrested individuals.

4.51 ABS in association with the Alliance Psychological Service (APS) operate a mental health and alcohol dual diagnosis service in NRF areas. This provides support for individuals with mental health and alcohol problems as well as providing assessment of the problems and the development of care delivery plans. The Alliance Psychological Service specifically provides counselling and psychological interventions.

4.52 The community counselling offered by APS was presented as a pioneering system. The flexibility that the APS could operate suggested that it could deal with the underlying issues causing alcohol abuse and provided a relapse prevention group in order to achieve long-term results.

4.53 The Committee was informed that APS do not limit the number of sessions and will alter the approach taken to suit the client so as to ensure the individual attends the counselling sessions offered. The example was given that transport to and from the APS location in High Newham Road, Hardwick would be provided to make sure a client attended the sessions.

4.54 The impression given was that the limitations for the APS was the low staffing levels (3 FT + 1 Children's Counsellor (new post)) and a lack of long-term funding as the contracted delivery was only known for the current financial year.

4.55 The Committee recommends that North Tees PCT strengthens its alcohol services commissioning process by identifying a lead officer with responsibility for determining / coordinating service provision through appropriate multi-agency partnership arrangements.

4.56 As well as the known health issues caused by high alcohol consumption, the ease of availability and the community safety issues were of interest to the Committee so a brief examination of each was undertaken to determine what, if anything, can be done to counteract the level of binge drinking and subsequent behavioural problems that are caused.

4.57 There are 5 Alcohol Designation Zones across the borough, covering the town centres of Stockton, Billingham, Thornaby, Yarm and Norton that provide the Neighbourhood Enforcement Service the power to seize alcohol from anyone of any age if the bottle or can is open.

4.58 The Confiscation of Alcohol (Young Persons) Act 1997 provides police officers in uniform and Neighbourhood Enforcement Officers the power to remove alcohol from persons under the age of 18 in a public place where alcohol is being consumed or the officer reasonably suspects consumption is about to take place.

4.59 During 2006/07 there were 480 incidences of alcohol seizure and it was approximated that of those incidences 90 per cent were seized from people under the legal age to drink. From September 2007 information is now kept as to the type of alcohol that is being seized. Very cheap vodka is available throughout the borough and this is included in the type of alcohol that is removed from people under 18 years old caught drinking.

4.60 The Committee was informed that the names of underage young people caught drinking alcohol are passed to an Anti-Social Behaviour Case Worker who corresponds with a persons' parents or guardian.

4.61 Young people do assist the Council's Trading Standards department. A number of 12-13 year olds are recruited to attempt to purchase alcohol. During 2006/07 there were 59 attempted test purchases with 16 sales achieved by the young people resulting in a number of fixed penalty notices being issued.

4.62 At the time of taking evidence for this review 27 tests had been carried out resulting in 4 sales having been achieved. This has brought about extra conditions placed on the offending outlets which, if caught re-offending, will result in referral to the Council's Licensing Committee.

4.63 Proxy sales, whereby an adult purchases alcohol for someone underage, is a problem in the borough although this is a responsibility for the police. However, CCTV footage is now being extended so as to provide the police with evidence to deal with this problem.

4.64 A number of initiatives do already exist that attempt to reduce the occurrence and availability of alcohol for young people under 18 years old. These include identity cards and accredited schemes as well as a targeted scheme in schools and youth clubs. The latter scheme has no direct funding which may have implications regarding its success.

4.65 The Committee is impressed by the actions being undertaken to reduce future incidences of alcohol misuse and abuse especially reducing binge drinking amongst underage people in the borough. The Committee would subsequently like to see the above initiatives strengthened and added to wherever possible. As a result it recommends **that Stockton-on-Tees Borough Council's PIC (Participation, Involvement and Consultation) Network is consulted to determine how best to deliver services for alcohol reduction / cessation.**

4.66 Licensing remains an issue with an increased ease by which someone can purchase alcohol at most times of the day or night. Within Stockton Borough alcohol is available in two 24 hour licensed premises (Tesco, Asda). Middlesbrough has a couple of 24-hour alcohol delivery services which also provide a home delivery service to the Stockton area. No such trading licences have been granted in the borough as Stockton's Trading Standards are unable to be provided with proof that underage sales will not occur.

4.67 Whilst it is not possible to control the strength of spirits sold nor the price of cheap alcohol (the example given was of a can of lager able to be purchased for 22 pence, significantly cheaper than buying the equivalent amount of bottled water) the solutions to counteract the effects of alcohol available to Stockton's Adult Services and Health Select Committee appear limited.

4.68 The Committee recommends that the Leader of the Council write to Stockton Borough MPs highlighting the concerns identified during this review and request that appropriate representation supporting sensible and responsible alcohol licensing and retailing is made to Government Ministers and departments.

5.0 Conclusion

5.1 As with most reviews undertaken by Stockton's select committee with responsibility for scrutinising health services the problems caused by societal attitudes toward issues are fraught with difficulties to identify possible solutions to something enjoyed by most participants

5.2 Alcohol consumption is no different in that in moderation it can be enjoyed but overindulgence and continued excessive use does have an impact on the individual and his or her friends and family, if not the wider community, depending on the actions of the person in question.

5.3 The Committee therefore recognising the increased intake of alcohol especially amongst young people was eager to investigate the support services available to ascertain that it met the needs.

5.4 Using information 3-4 years old the Committee had hoped to see the gaps in services identified at that time to be resolved. It understands that financial focus has been aimed toward reducing illegal drug use as has been directed from central government but believes that alcohol excess is a greater problem due to the social acceptability of alcohol consumption.

5.5 The relaxation of the opening hours for public houses appears to send mixed messages. Whilst it may be hoped that Britain will adopt a European approach to how people socialise (longer opening hours thereby reducing the need to drink large amounts of alcohol relatively quickly) the reality of high levels of binge drinking challenge the assumption that a changed approach will soon be achieved.

5.6 The Committee commends the work undertaken by all sectors attempting to tackle the problems associated with alcohol misuse and abuse and hopes that this report will be seen as another supporting document to which the multi-agencies can utilise in their work to combat the worst aspects of alcohol excess.

Appendix 1

The four tiers of intervention

Tier		
1	**Definition**	Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.
	Interventions	Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 alcohol interventions: • alcohol advice and information • targeted screening and assessment for those drinking in excess of DH guidelines on sensible drinking and for those who may need alcohol treatment • provision of simple brief interventions for hazardous and harmful drinkers • referral of those requiring more than simple brief interventions for specialised alcohol treatment • partnership or 'shared care' with specialised alcohol treatment services, e.g. to provide specific alcohol treatment interventions within the context of their generic services.
	Settings	Tier 1 interventions can be delivered by a very wide range of agencies and in a range of settings, the main focus of which is not alcohol treatment. For example: primary healthcare services; acute hospitals, e.g. A&E departments; psychiatric services; social services departments; homelessness services; antenatal clinics; general hospital wards; police settings, e.g. custody cells; probation services; the prison service; education and vocational services; and occupational health services. Such interventions can also be provided in highly specialist non-alcohol specific residential or inpatient services, which have service users with high levels of alcohol-related morbidity who may require care plans and support to facilitate their access to alcohol-specific provision. Examples include: specialist liver disease units, specialist psychiatric wards, forensic units, residential provision for the homeless, and domestic abuse services.
2	**Definition**	Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.
	Interventions	Tier 2 interventions include open access facilities and outreach targeting alcohol misusers, which provide: • alcohol-specific information, advice and support • extended brief interventions and brief treatment to reduce alcohol-related harm • alcohol-specific assessment and referral of those requiring more structured alcohol treatment • partnership or 'shared care' with staff from Tier 3 and Tier 4 provision, or joint care of individuals attending other services providing Tier 1 interventions • mutual aid groups, e.g. Alcoholics Anonymous • triage assessment, which may be provided as part of locally agreed arrangements.

Tier		
	Settings	Tier 2 provision may be delivered by the following agencies, if they have the necessary competence, and in the following settings: specialist alcohol services; primary healthcare services; acute hospitals, e.g. A&E and liver units; psychiatric services; social services; domestic abuse agencies; homelessness services; antenatal clinics; probation services; the prison service; and occupational health services.
3	**Definition**	Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.
	Interventions	Tier 3 interventions include: • comprehensive substance misuse assessment • care planning and review for all those in structured treatment, often with regular keyworking sessions as standard practice • community care assessment and case management of alcohol misusers • a range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse • a range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate • structured day programmes and care-planned day care (e.g. interventions targeting specific groups) • liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).
	Settings	Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community (or sometimes on hospital sites). Other delivery may be by outreach (peripatetic work in generic services or other agencies, or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions. Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but alcohol specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care. The work in community settings can be delivered by statutory, voluntary or independent services providing care-planned, structured alcohol treatment.
4	**Definition**	Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.
	Interventions	Tier 4 interventions include: • comprehensive substance misuse assessment, including complex cases when appropriate • care planning and review for all inpatient and residential structured treatment • a range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse • a range of structured evidence-based psychosocial therapies and support to address alcohol misuse

Tier		
		• provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.
	Settings	Specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal (detoxification), stabilisation and assessment of complex cases. Residential rehabilitation units for alcohol misuse. Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit. Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their other needs (e.g. pregnancy, liver problems) and this may be best provided for in the context of those hospital services (with specialised alcohol liaison support).

Project Plan

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KEY TASK	DETAILS/ACTIVITIES	DATE	RESPONSIBILITY
Scoping of Review			Scrutiny Officer Link Officer
Tri-Partite Meeting		15 June 2007	Select Committee Chair and Vice Chair, Cabinet Member(s), Corporate Director(s), Scrutiny Officer, Link Officer
Agree Project Plan		23 July 2007	Select Committee
Publicity of Review		w/c 30 July 2007	Scrutiny Officer
Obtaining Evidence	Introduction / Overview (P. Kelly – Public Health Rep; T. Sangowawa – Public Health Rep; J. Fraser – Public Health Rep) Regional Perspective (Dr Stephen Singleton; Margaret Kynoch-MacDonald – GONE; Dr David Chappel – NEPHO)	23 July 2007 6 August 2007	Select Committee / Scrutiny Officer

	Preventative Services / Primary Care (J. Fraser – Public Health Rep; R. Thornham - Medical Director for Tees; C. Parker - PEC GP Lead; J. Berry – GP Rep; S. Maddison – Joint Strategic Commissioner Drugs, Prison Healthcare and Social Inclusion; K. Azam – Joint Strategic Commissioner) Secondary/Tertiary Care (S. Groves – A&E Manager; Mr Emmerton – A&E Clinical Director; F. Hammersley – A&E Sister; K. Luczakiewicz – PADS Team Leader; C Sheldon – PADS Manager; T. Carnworth – Director of Addictions Services TEWV NHS Trust; J. Maddison – Specialist Regional Lead TEWV NHS Trust; N. Lonergan – Local Regional Lead TEWV NHS Trust.) Voluntary/Community Sector (K. Reay – Addictive Behaviours; K. Wilson – Albert Centre; J. Jacobs – A Way Out; L. Kane-Fidgeon – Alliance Psychological Services; STASH.) Finance Neil Nicholson, Director of Finance NTPCT	3 September 2007 17 September 2007 1 October 2007 7 November 2007	
Members decide recommendations and findings		19 November 2007	Select Committee

Tri-Partite Meetings		1 October 2007 w/c 19 November 2007	Select Committee Chair and Vice Chair, Cabinet Member(s), Corporate Director(s), Scrutiny Officer, Link Officer
Circulate Draft Report to Stakeholders		w/c 26 November 2007	Scrutiny Officer
Final Agreement of Report		7 January 2008	Select Committee
Consideration of Report by Executive Scrutiny Committee		15 January 2008	Executive Scrutiny Committee
Report to Cabinet/Approving Body		17 January 2008	Cabinet/ Approving Body