

**Report to:** Overview and Scrutiny Alcohol Sub Group

**Date:** 22<sup>nd</sup> June 2009

**Subject:** Alcohol Treatment and Care

**Report of:** Deputy Chief Executive (Performance)

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**Purpose of report:**

The Overview and Scrutiny Alcohol Sub Group have agreed a work programme which addresses each of the four themed areas in the Manchester Alcohol Strategy in turn, at a series of monthly meetings. The last meeting (May 2009) addressed the theme of education and prevention for low-risk, hazardous and harmful drinkers.

This paper addresses the theme of treatment and care, which aims to ensure the alcohol treatment system is responsive to the needs of harmful and dependent drinkers, their families and carers.

The purpose of this report is to provide background context on issues related to harmful and dependent drinking, through national and local information. Where data is available, comparisons are made to other core cities. The paper also provides information on the Manchester alcohol treatment system, including case studies to illustrate treatment and care pathways; and gives an update on the delivery of the alcohol strategy action plan for treatment and care.

**Recommendations:**

The Alcohol Sub Group is asked to:

- i) Note the content of this report,
- ii) Consider areas for future development, within the context of the key lines of enquiry discussed at the inaugural meeting.

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## 1. Background and context

### 1.1 Definitions of harmful and dependent drinking

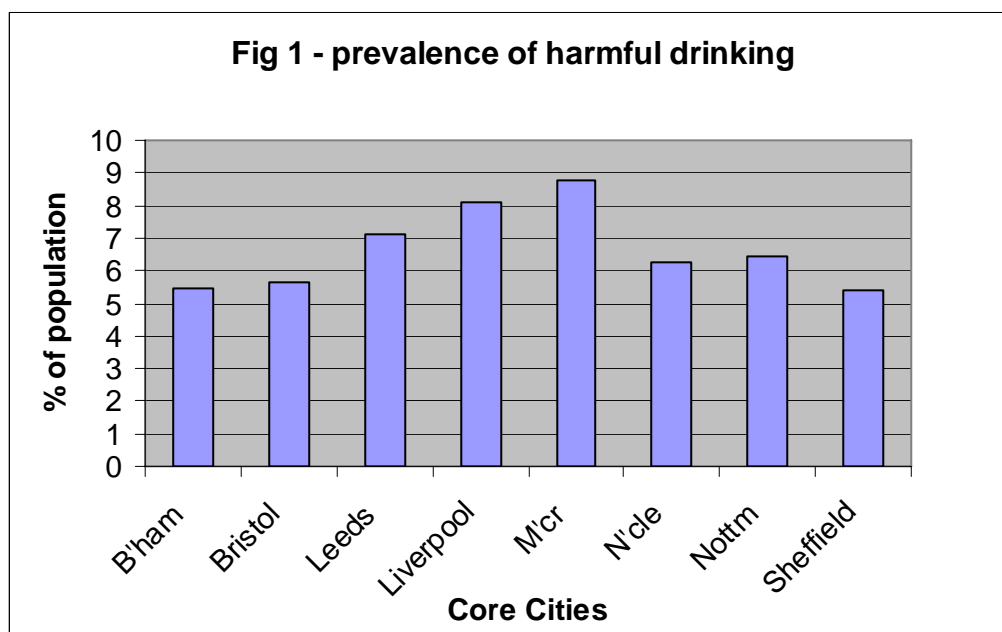
1.1.1 Manchester's Alcohol Strategy provides the following definitions, which are consistent with national guidance:

- *Harmful drinking*: more than the sensible drinking guidelines and already experiencing some alcohol-related harms (but no dependence) <sup>1</sup>.
- *Dependent drinking*: more than the sensible drinking guidelines, experiencing alcohol-related harms and signs of psychological and/or physical dependence.

### 1.2 Prevalence of harmful drinking

1.2.1 The North West Public Health Observatory's (NWPHO) Local Alcohol Profiles for England (LAPE) provide estimates of the prevalence of different types of drinking within Local Authority areas. The most recent estimates, based on 2005 population figures, suggest approximately 30,300 harmful drinkers in Manchester (8.8% of the population aged 16 and over). According to this data, Manchester has the highest prevalence of harmful drinking in England.

Figure 1 compares Manchester to the other core cities.



1.2.2 In 2008, 7,351 Greater Manchester residents took part in the North West Big Drink Debate. One of the objectives was to provide estimates of consumption across the region. Findings from the Big Drink Debate indicate that 9.4% of Manchester residents are drinking at harmful levels. Whilst this is broadly consistent with the LAPE estimates, there are methodological differences in the way the estimates have been arrived at, which mean that comparisons should be made with caution.

<sup>1</sup> Defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

The BDD also suggests that Manchester has the highest prevalence of harmful drinking in the Greater Manchester sub-region.

### 1.3 Prevalence of dependent drinking

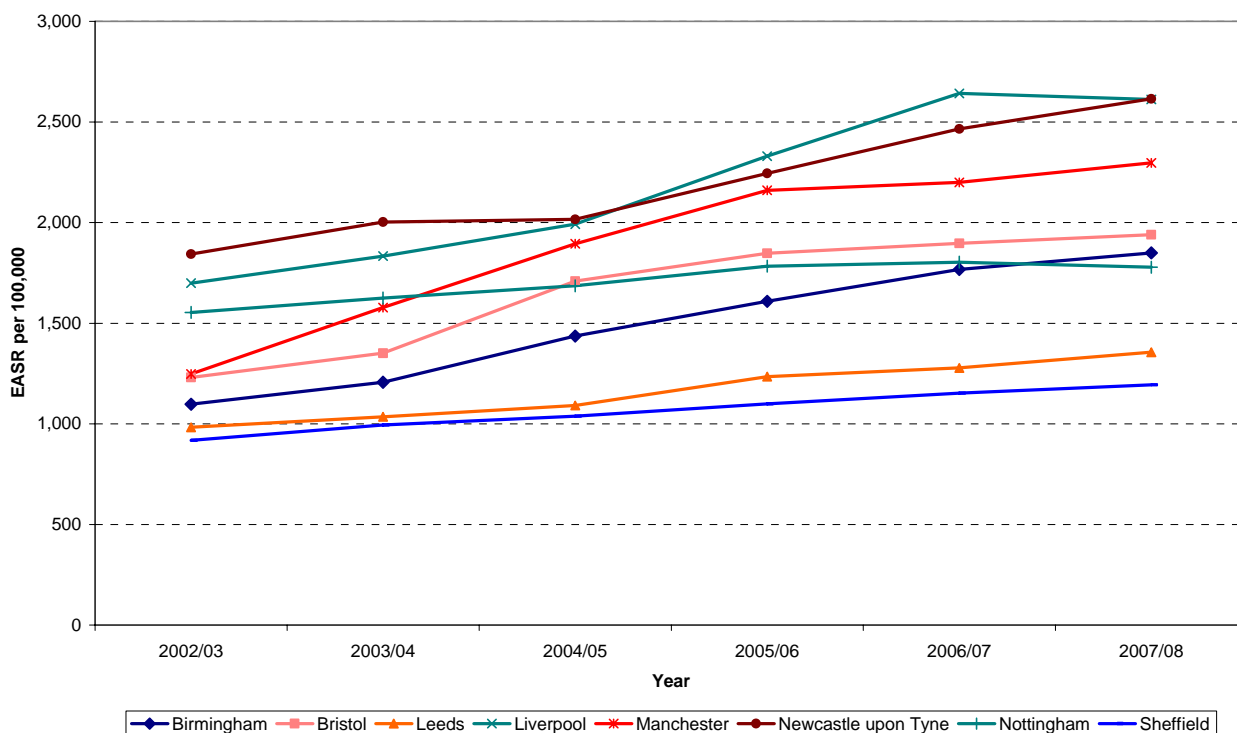
1.3.1 Work carried out as part of the Department of Health's 2004 Alcohol Needs Assessment Research Project (ANARP) estimated that there were 1.1 million adult dependent drinkers adults in England (3.6% of the population).

1.3.2 Using ANARP estimates applied to Office of National Statistics population estimates for Manchester, it is estimated that in 2009 there are 12,850 dependent drinkers in Manchester. This number is projected to increase year on year, as the size of the overall population increases. Appendix 1 shows projections until 2015.

### 1.4 Alcohol-related hospital admissions

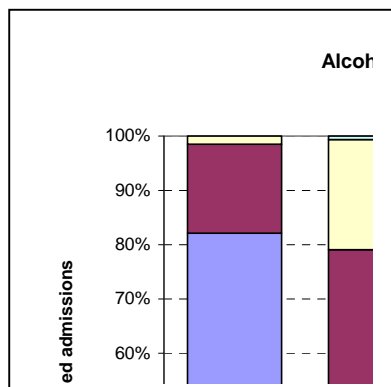
1.4.1 NWPHO data released in February 2009 shows that, although the number and rate of alcohol-related hospital admissions in Manchester is continuing to increase, there is some evidence of a reduction in the rate of growth. In particular, the actual rate of hospital admissions for alcohol-related harm in Manchester in 2007/08 (2,296 per 100,000 population) is 10.4% lower than the projected rate for the same year (2,562 per 100,000). As a result, the projected rate for 2010/11 (3,055 per 100,000) is now below the Local Area Agreement (LAA) target of 3,308 per 100,000. Figure 2 shows a comparison with other core cities.

**Figure 2** Rate of Alcohol-Related Admissions per 100,000 Population (EASR) 2002/03 to 2007/08



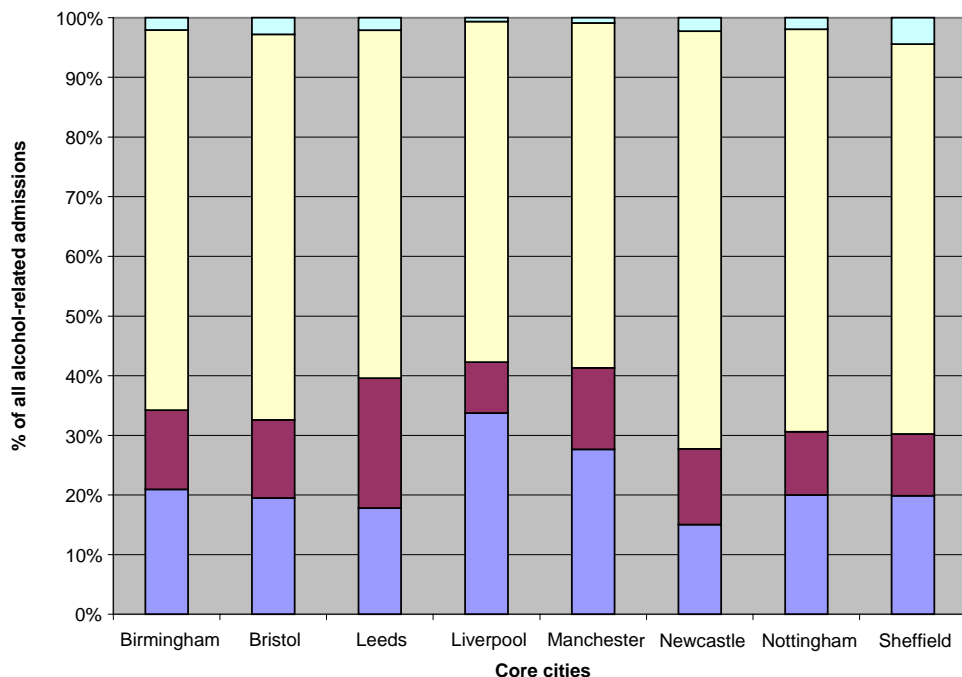
1.4.2 NWPHO have issued figures showing the estimated number (and proportion) of alcohol related admissions in different age groups that are due to specific groups of conditions. These figures show that, overall, 58% of hospital admissions for alcohol-

related harm in Manchester are related to chronic conditions (i.e. chronic degenerative diseases that are associated with long term (often heavy) use of alcohol). Figure 3 illustrates the Manchester breakdown by age group; Figure 4 gives a comparison with other core cities.



**Figure 3**

Figure 4: Alcohol-related hospital admissions by condition, group and age: comparison with other core cities



## 1.5 Headline themes – background information

### 1.5.1 Alcohol misuse and mental health

There is a close relationship between alcohol problems and mental health. People with mental health problems are at raised risk of alcohol problems and vice versa. American research suggests that overall, the prevalence of alcohol dependence is almost twice as high in those with psychiatric disorders as in the general population. A Manchester-based study examined clients with severe mental health problems admitted for inpatient treatment. Of those included in the study, 27% had a dual diagnosis<sup>2</sup>. It is suggested that alcohol can be a factor in as many as 65% of suicide attempts<sup>3</sup>.

Research indicates that a high proportion of people (estimates suggest up to 85%) in alcohol treatment services experience mild to moderate mental health problems (i.e. anxiety and depression)<sup>4</sup>.

Nationally, hospital admissions related to mental and behavioural disorders due to the use of alcohol have doubled since 1997<sup>5</sup>. In Manchester, alcohol-related

<sup>2</sup> Holland, MA. How substance use affects people with mental illness. Nursing Times (1999) 95 46–48

<sup>3</sup> Alcohol Concern 2005

<sup>4</sup> Weaver et al, 1991

hospital admissions for adults related to mental and behavioural conditions range from 26% among 16-24 year olds, to 40% among 35-44 year olds.

### 1.5.2 Alcohol-related brain damage

Alcohol-related brain damage, which can include Wernicke-Korsakoff syndrome, is usually associated with heavy dependent drinking over a long period. Wernicke's encephalopathy, which is usually a precursor to Korsakoff's psychosis, can be treated if diagnosed early enough. It is estimated that currently, 70% of adults who develop Wernicke's encephalopathy will go on to develop Korsakoff's psychosis. Research suggests that 12.5% of dependent drinkers will develop some form of Wernicke-Korsakoff syndrome<sup>6</sup>.

Those affected by Korsakoff's tend to be men between the ages of 45 and 65 with a long history of alcohol misuse and dependency, though it is possible to have Korsakoff's at an older or a younger age. Women can also be affected and they tend to develop Korsakoff's at a slightly younger age than men, as they appear to be more vulnerable to the impact of alcohol.

### 1.5.3 Domestic abuse

Each year it is estimated that 17,000 women in Manchester experience domestic abuse. Using national research that suggests a third of women who experience domestic violence also misuse alcohol, we can estimate that approximately 5,500 women in the city who experience domestic violence also misuse alcohol. Research indicates that there is a correlation between the level of domestic abuse and the level of alcohol consumption. The Manchester Multi-Agency Risk Assessment Conference (MARAC) is a monthly forum where partner agencies discuss how they can support victims of domestic abuse who are at high risk of repeated violent abuse or death. A snapshot taken of the victims known to the MARAC in September and October 2007 showed that 64% misused alcohol.

### 1.5.4 Foetal alcohol syndrome

Alcohol can interfere with the normal development of the unborn baby because the foetus is unprotected from alcohol circulating in the blood system. The most severe effects are the intellectual disabilities associated with the adverse impact of alcohol on foetal brain development and the central nervous system. Damage to the brain is often, though not always, accompanied by distinctive facial deformities, physical and emotional developmental problems, memory and attention deficits, and a variety of cognitive and behavioural problems. These conditions are known as Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD)<sup>7</sup>.

In 2007, the Department of Health updated its advice to women about alcohol and pregnancy. The new guidance, reiterated by the National Institute for Clinical Excellence (NICE) in 2008, stated that pregnant women and those trying to

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<sup>5</sup> Statistics on Alcohol: England, 2007. The Information Centre 2007

<sup>6</sup> Neuropathological alterations in alcoholic brains. Studies arising from the New South Wales Tissue Resource Centre. *Prog Neuropsychopharmacol Biol Psychiatry*. 2003 Sep; 27(6): 951-61. Harper et al, 2003

<sup>7</sup> BMA Board of Science, 2007

conceive should avoid drinking alcohol altogether, with particular emphasis on the first three months of pregnancy due to an increased risk of miscarriage.

There are a range of interventions in place to inform women about the effects of alcohol on the unborn child, including advice on the Alcohol Z cards on the risks of drinking when pregnant or trying to conceive, and referral information for the Manchester Specialist Midwifery Service (MSMS). The MSMS provide specialist interventions for pregnant women who are at risk as a result of substance misuse, including alcohol. There is more information about this service in paragraph 2.1.3 of this report (in the section about Tier 3 services). MSMS offers ongoing support, and referral to treatment services. Manchester Community Health recently ran a campaign advising on the risks of drinking when pregnant, this featured information and signposting posters displayed in the female toilets in bars and clubs around the city.

## **2. The alcohol treatment system in Manchester**

### 2.1 Overview of the treatment system

- 2.1.1 The alcohol treatment system in Manchester is based upon the national service framework '*Models of care for alcohol misusers*' (NTA 2006) and the guiding principles of the '*Review of the effectiveness of treatment for alcohol problems*' (NTA 2006). Both of these documents are recognised as best evidence-based practice for the design and delivery of alcohol treatment systems.
- 2.1.2 *Models of care for alcohol misusers* (MoCAM) advocates a four tier approach to treatment provision. Appendix 2 outlines the treatments that should be offered at each tier. Broadly speaking, Tiers 1 and 2 cover early interventions for hazardous and some harmful drinkers, delivered in mainstream services, such as Identification and Brief Advice (IBA). Information on these interventions was presented to the Overview and Scrutiny Alcohol Sub Group at its meeting focussing on education and prevention (May 2009). Tier 2 interventions also include assessment for higher risk drinkers (i.e. harmful and dependent drinkers), in order to access specialist services. Tiers 3 and 4 cover specialist treatment provision for people drinking at harmful and moderately or severely dependent levels, and also for drinkers with complex needs.
- 2.1.3 There are a wide range of services available to Manchester residents, across all tiers in the MoCAM model. The key services are summarised below:

**Tier 1:** Tier 1 services cater for the needs of people who might be classed as low risk drinkers, hazardous drinkers and harmful drinkers. Tier 1 services available in Manchester include primary prevention public health programmes, and the Identification and Brief Advice interventions outlined at the May 2009 meeting of the Alcohol Sub Group. Tier 1 services can also include residential provision for people who drink, where this does not include specialist treatment i.e. detox or rehabilitation, and support for carers:

- Homelessness services offer citywide provision including direct access hostel accommodation for single men and women, and families

- Mary and Joseph House provides residential care for people who have past or present mental health problems or alcohol dependency. Alcohol Care Managers provide appropriate care and support to residents.
- Morning Star Hostel offers temporary accommodation for homeless men who continue to drink. Referrals are made by homelessness and housing agencies and the Cornerstones day centre
- Manchester Carers Centre provides information, advice and support for carers who look after someone with an alcohol problem.
- Manchester Carers Forum provides a forum for all carers and former carers

**Tier 2:** providers and settings include specialist services providing open access support to reduce alcohol-related harm, or other services that have the relevant competencies. Tier 2 interventions cater for people who might be classed as harmful and moderately dependent drinkers who are seeking treatment. Services include:

- The Alcohol Assessment and Care Management Team is a citywide service which offers assessment to adults 18-64 who have alcohol problems and commissions social care services to meet assessed need. The team is part of the Community Alcohol Team service, it provides the social care elements of the service and also carry out carers' assessments.
- The Booth Centre provides a drop-in service and activity centre for homeless people - services include food, education, advice, support to access mainstream services and referral. The aim is also to link street drinkers into alcohol services.
- Cornerstones offer drop-in and support for homeless people including street drinkers and heavy drinkers, and have space for heavy drinkers to drink.
- Counted In offers a service for rough sleepers aged 18+. An outreach team helps with accommodation, access to services such as GP, drug, alcohol, mental health. A resettlement team follows on from outreach to offer long-term support, and to facilitate move on from temporary accommodation.
- An Alcohol Arrest Referral scheme, which provides brief interventions in a range of locations around the city, where the police have identified that alcohol is a feature within an individual's offending behaviour.
- Alcoholics Anonymous offers AA meetings across the city.
- Frank Cohen support group, based in North Manchester, provide support and help and advice to people with dependency problems. This includes daily support groups, weekly AA meetings, a women's group, a counselling service, information and advice, and a support drop-in.
- Zion Alcohol Group provides information and advice, guidance and support.

**Tier 3:** providers include specialist community based care-planned treatment and can involve comprehensive substance misuse assessment, care planning, care co-ordination, a range of psychosocial therapies, a range of evidence-based interventions for assisted alcohol withdrawal, and pharmacotherapies to address alcohol misuse. Tier 3 services are designed to meet the needs of people who might be classed as moderate to severely dependent drinkers and who are seeking treatment. Services include:

- CAT (Community Alcohol Team) provides an alcohol link worker service offering weekly/fortnightly clinics in GP surgeries/health centres, and providing specialist treatment health interventions. CAT manages the alcohol arrest

referral scheme and provides community detoxification in a person's own home. The team provides the treatment component of Alcohol Treatment Requirements.

- Specialist Midwifery Service includes a team of midwives working city wide to offer support to pregnant women, women and their families around drugs, alcohol and HIV. The service provision is rooted in the sphere of public health and embraces all aspects of vulnerable, socially excluded life-style. The team comprises 4 specialist midwives, 2 for drug and alcohol issues, one for HIV/sexual health, and one for domestic abuse/perinatal mental health. The team has a city-wide remit and broad ranging responsibilities including providing training in brief interventions in alcohol and antenatal HIV testing.
- Alcohol and Drug Abstinence Service (ADAS) offer reduction and motivation counselling (RAMP) working with people still using alcohol but clear desire to stop. This includes a structured day programme, and a 6 week family therapy programme. A supported housing project at Acorn House is available for homeless people starting the treatment programme, which includes 8 week abstinence day care treatment and a 12 week aftercare support service.
- Brian Hore Unit (BHU) provides an alcohol day treatment service. It is an NHS service open to Manchester residents, based in the Withington area. Services include a nurse clinic, daily support groups, a structured programme, one-on-one counselling, drop-in centre, community and out-patient detoxification, specialist prescribing and supervision of Antabuse.
- A nurse consultant post for dual diagnosis offers advice and interventions to help clients cut down or stop using drugs or alcohol.

**Tier 4:** providers include specialist residential/in-patient care-planned treatment. Tier 4 services are able to meet the needs of people who might be classed as severely dependent drinkers and those with complex needs and who are seeking treatment.

- Inpatient detoxification: a range of placements are available for individuals who are referred to the Community Alcohol Team/ Alcohol Care Managers and assessed as needing inpatient detoxification. In consultation with the service user, the assessment process identifies the most appropriate option depending on the presenting circumstances, and facilitates access to the relevant service. Recent improvements to co-ordination of assessment and referral processes also ensure that there is better monitoring of repeat detoxifications, which is important in terms of improving outcomes for service users<sup>8</sup>. Officers in the Drug and Alcohol Strategy Team are currently working with other key stakeholders including NHS Manchester to assess levels of need and to review current detoxification provision. Proposals for future provision will be developed following consultation with service users, carers and other key stakeholders. It is important to determine the balance between community and residential options and the balance of future provision within and outside of the city boundaries.

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<sup>8</sup> There is evidence to suggest that repeatedly undergoing alcohol detox can have detrimental effects, both psychologically and physically. This has been termed the "kindling effect". Repeat instances of withdrawal/detox can cause a build of a glutamate, an excitatory brain chemical. Increased glutamate levels in the brain are thought to contribute to the intensity of cravings and the severity of withdrawal symptoms. Cravings can become significantly increased in intensity, and severity of withdrawal symptoms can worsen and the person starts to experience seizures or fits.

- ECHG Newbury House provides an abstinence-based Supported Housing scheme funded under the Supporting People programme, so people have to be homeless when they move in, and it must be their main residence. It offers a group-based therapeutic recovery programme which is split into 2 halves, the usual length of the total programme is 12-14 months. Newbury House also manages some move-on accommodation in the form of self-contained flats.
- Bennett House is a registered care home, providing an abstinence-based therapeutic environment for alcohol dependent men in six self-contained flats, with a high level of support to prepare for return to community.
- The Heavy Drinkers Project offers supported accommodation for men and women unable to maintain independent accommodation due to alcohol-related difficulties. Residents can drink on premises but sharing is discouraged. The project operates on a harm reduction model. Individual drinking plans are agreed with residents to stabilize alcohol consumption and reduce harms. Move-on accommodation is available for residents, and Adult Social Care can provide additional personal care support to residents where required.
- Wentworth House is based within the borough of Bury, and provides a detox service for alcohol dependent people with complex needs. This includes mental health assessment, a care programme approach, one-to-one counselling, men and women's groups and family/carer groups.
- Applications for funding for drugs and alcohol residential rehabilitation programmes are assessed on a regular basis by a multi-agency panel including representatives of the Community Alcohol Team and Adult Social Care.

2.1.4 In order to illustrate the Manchester alcohol treatment system as it works on a practical, day-to-day basis; a selection of case studies have been prepared. These are attached as Appendix 3.

## 2.2 Need and capacity in the treatment system

2.2.1 As outlined in Sections 1.2 and 1.3 of this paper, Manchester has high numbers of both harmful and dependent drinkers. Some of these individuals will not consider their alcohol use to be problematic and consequently will not access treatment services. Others may reduce their drinking independently of commissioned services, often with help from family, friends, and mutual support groups such as Alcoholics Anonymous.

2.2.2 In 2007, NHS Manchester and the Drug and Alcohol Strategy Team commissioned a *Needs and Capacity Analysis for Alcohol Treatment* in the city. The study identified that approximately 19% of dependent drinkers in the city were accessing treatment at Tiers 3 and 4 (specialist services). This compares favourably to provision in other areas for dependent drinkers, and to the current national guidance from the National Treatment Agency (NTA), which suggests that commissioners should provide treatment services for at least 10% of their dependent drinking population. It should be noted that this figure is currently under revision. The most recently viewed Department of Health draft guidance on commissioning alcohol treatment interventions suggests that commissioners need to ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT.

- 2.2.3 The *Needs and Capacity Analysis for Alcohol Treatment* also identified that there was insufficient provision for early intervention with hazardous and harmful drinkers, which can prevent people from developing more severe alcohol misuse problems requiring input from specialist treatment services and other mainstream health and social care services. This has subsequently been addressed by NHS Manchester commissioning a range of Identification and Brief Advice (IBA) services, through the Improving Health in Manchester Programme. This includes expansion of the current IBA provision at Manchester Royal Infirmary, and extension of this provision to all Accident and Emergency Departments in the city; increasing IBA provision in primary care and other mainstream services; and continuation of the Alcohol Arrest Referral pilot.
- 2.2.4 Commissioners are aware that whilst Manchester's alcohol treatment system is generally regarded as being advanced in comparison with other areas, regionally and nationally, there remains a need to explore opportunities for further increasing capacity in the system. This includes identifying whether there are opportunities to make more effective use of mainstream resources to address issues relating to alcohol misuse. Commissioners are currently identifying opportunities for using the support offered by the Health Inequalities National Support Team (NST) to address these issues. Recent investment in IBA and other services (i.e. care facilitator posts within each hospital, to ensure that harmful and dependent drinkers have access to the additional care that they need when they leave hospital, and to reduce the number of repeat alcohol-related hospital admissions), is also expected to make an impact in the medium to longer term on the number of people developing more severe alcohol misuse problems requiring higher levels of care and treatment.
- 2.2.5 As identified in previous reports to the OSC Alcohol Sub Group, the level of ring fenced investment in alcohol services at national and local levels is relatively low, given the prevalence, scale and complexity of need and the impacts of alcohol-misuse upon society. However expenditure upon tackling alcohol related ill health, crime, wider impacts upon society and the cost to the U.K. economy is very significant. It will be important to maintain a partnership approach to developing local strategies that will, over time, enable resources to be re-distributed to support those services and interventions which are known to increase the effectiveness of treatment for people with alcohol problems, such as effective care co-ordination and the provision of support for carers and family members.

### 2.3 Other issues that affect engagement with treatment, and recovery

- 2.3.1 As outlined in section 2.2 above, Manchester has a comprehensive alcohol treatment and care system, which includes both specialist and mainstream providers and services. However, there are a range of factors which influence engagement with and the success of alcohol treatment, and subsequent recovery. Following its recent visit to Manchester, the National Support Team (NST) for Health Inequalities highlighted that Manchester's Alcohol Strategy recognises these factors, and ensures that there are a range of locally accessible wraparound services including housing, education, training, homelessness and assertive outreach. The NST recommended that this approach should be enhanced to ensure that housing and employment/training services should be mapped through the patient journey, and have offered support to develop this. The following

paragraphs provide more information about some of the approaches currently in place, which can facilitate access to treatment, and the likelihood of sustaining the gains made in treatment.

### 2.3.2 Access to education, training and employment (ETE)

The Community Alcohol Team and Alcohol Care Management Team (ACMT) routinely address access to ETE with clients as part of their detox assessment and care planning arrangements. Links have been developed with Progress to Work, who will only accept referrals for clients who have stopped drinking. The ACMT are also actively encouraging detox providers to address access to Progress to Work with clients whilst they are in detox. The Brian Hore Unit also provide an Employment Advisor service on a weekly basis, for their clients.

ACMT also routinely refer clients to the Manchester Education Resource Centre, which offers a range of services for people who have difficulty accessing mainstream education provision, including numeracy and literacy courses. ACMT report that their detox and aftercare assessments often also identify that clients have a range of informal networks through which they are able to access employment opportunities, once they have detoxed and are alcohol-free. The DAST is developing relationships with Job Centre Plus to improve pathways to training and employment for people who misuse drugs and alcohol.

### 2.3.3 Supporting People

The Supporting People programme offers vulnerable people the opportunity to improve their quality of life by providing a stable environment which enables greater independence. A range of services are commissioned in Manchester by Supporting People, including accommodation-based and floating support services for drug and alcohol clients. This includes the services at Newbury House, Acorn House, and the Heavy Drinkers Project, identified in paragraph 2.1.3 (above); and also other short-term accommodation including hostels, shared housing, and bed and breakfast accommodation for male and female alcohol users.

### 2.3.4 Dual diagnosis<sup>9</sup>

The Dual Diagnosis Team has a remit to advise, support and supervise practitioners undertake research projects; and to develop and maintain a clinical network across all sectors and manage a weekly Out Patients Clinic primarily for assessment of clients coexisting (mental health and substance misuse) needs so that advice on future management can be provided to the relevant services.

The primary purpose of the specialist Dual Diagnosis Service is to raise awareness of 'dual diagnosis' issues and enhance practitioner skills - through training, consultancy and clinical network activity - to enable them to provide more effective services to people who misuse drugs and/or alcohol and have mental health related needs.

### 2.3.5 Service user and carer involvement and support

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<sup>9</sup> The term "dual diagnosis" refers to a combination of mental health and substance misuse problems

There have been a number of recent developments in this area of work, which are outlined in Section 3 of the Treatment and Care Action Plan update, which is attached as Appendix 4.

### 2.3.6 Other services

Partners involved in the delivery of the Manchester Alcohol Strategy are also currently exploring ways of developing responses to changing need and local policy, for example the implementation of whole family approaches to the provision of drug and alcohol treatment services, and encouraging services to work across organisational boundaries i.e. dual diagnosis, and substance misuse services which can address both alcohol and drug use.

## 3. Delivery of the Manchester Alcohol Strategy treatment and care theme

### 3.1 Treatment and care action plan

3.1.1 The Manchester Alcohol Strategy 2008 – 2011 includes a strategic aim to ensure that the alcohol treatment system is responsive to the needs of harmful and dependent drinkers, and their families and carers. A detailed action plan outlines the work to be carried out by a range of partner agencies to deliver this aim.

3.1.2 The objectives in the alcohol strategy and the treatment and care action plan contribute towards the national and local performance indicators to reduce the increase in the rate of alcohol-related hospital admissions (NI 39), which is included in the Local Area Agreement and the PCT Vital Signs framework.

3.1.3 In addition to the impact on health, alcohol misuse impacts on a number of other areas, including crime, families, communities and the economy. The alcohol strategy will contribute to improvement in other areas, including:

- Reducing the rate of/ gap in all age, all cause mortality (NI 120)
- Serious violent crime rate (NI 15)
- Perceptions of drunk and rowdy behaviour as a problem (NI 41)
- Healthy life expectancy at 65 (NI 137)
- Substance misuse by young people (NI 115)

Work to address alcohol misuse in adults will also impact positively on the delivery of work to further develop safeguarding, parenting and family interventions in the city.

Ensuring that the alcohol strategy is aligned with others will enable maximum benefits from delivery of the objectives outlined in the alcohol strategy action plans.

3.1.4 Progress against each of the objectives in the treatment and care action plan is outlined in Appendix 4, with particular reference to activity scheduled to take place before by August 2009. The order of objectives has been slightly altered from the action plan which appears in the Alcohol Strategy 2008-11 document in order to group together activities of a similar nature.

3.1.5 The Alcohol Sub Group should note that the objectives in the action plan have been assigned a specific completion date, which partners responsible for delivery work towards. In many cases, where the original objective has been achieved, partners will continue to deliver work throughout the course of the three year strategy. This will be reflected in annual updates of the action plans.

#### **4. Conclusion**

4.1 The committee is asked to note this report, the information provided about the context of alcohol use and misuse, and the examples of work that is underway through the Alcohol Strategy 2008 – 2011 treatment and care action plan, including the responses by partner agencies. The treatment and care action plan will continue to be developed and updated, to ensure that the delivery of alcohol treatment and care contributes to the delivery of other strategies, national and local policy and to make sure services are responsive to local alcohol related need.

## Appendix 1

### 1. Current and projected prevalence of different types of drinking

Adults aged 16-65	2006			2007			2008		
	All	Men	Women	All	Men	Women	All	Men	Women
Any alcohol disorder	83848	57553	26295	85229	58501	26728	86264	59211	27053
Hazardous/harmful	73117	48466	24652	74321	49264	25058	75224	49862	25362
Binge drinkers	46597	31806	14791	47364	32329	15035	47939	32722	15217
<b>Alcohol dependence</b>	<b>12374</b>	<b>9087</b>	<b>3287</b>	<b>12578</b>	<b>9237</b>	<b>3341</b>	<b>12731</b>	<b>9349</b>	<b>3382</b>
Adults aged 16-65	2009			2010			2011		
	All	Men	Women	All	Men	Women	All	Men	Women
Any alcohol disorder	87114	59795	27319	87990	60396	27594	88760	60924	27836
Hazardous/harmful	75965	50353	25612	76729	50860	25869	77401	51305	26096
Binge drinkers	48411	33044	15367	48898	33377	15522	49326	33669	15658
<b>Alcohol dependence</b>	<b>12856</b>	<b>9441</b>	<b>3415</b>	<b>12985</b>	<b>9536</b>	<b>3449</b>	<b>13099</b>	<b>9620</b>	<b>3479</b>
Adults aged 16-65	2012			2013			2014		
	All	Men	Women	All	Men	Women	All	Men	Women
Any alcohol disorder	89397	61362	28035	89875	61690	28185	90273	61963	28310
Hazardous/harmful	77956	51673	26283	78373	51949	26424	78720	52180	26541
Binge drinkers	49680	33911	15770	49946	34092	15854	50167	34243	15924
<b>Alcohol dependence</b>	<b>13193</b>	<b>9689</b>	<b>3504</b>	<b>13264</b>	<b>9741</b>	<b>3523</b>	<b>13322</b>	<b>9784</b>	<b>3539</b>
Adults aged 16-65	2015								
	All	Men	Women						
Any alcohol disorder	90672	62237	28435						
Hazardous/harmful	79068	52410	26658						
Binge drinkers	50389	34394	15995						
<b>Alcohol dependence</b>	<b>13381</b>	<b>9827</b>	<b>3554</b>						

## Appendix 2

### Models of Care for Alcohol Misusers (MoCAM) – Tiered model for alcohol interventions

#### Tier 1 interventions

- Identification of hazardous, harmful and dependant drinkers
- Provision of information on sensible drinking
- Simple 'brief advice' (formerly know as a brief intervention) to reduce alcohol related harm
- Signposting and referral of those who require more significant interventions
- These generic services will encounter all levels of drinkers but as a minimum should offer 'interventions' to hazardous drinkers via identification and brief advice in line with department of health guidelines
- Examples of such non alcohol specific services include GP surgeries, health centres, community based services, Accident and Emergency departments, general hospital wards, police custody suites, housing and homelessness services and social departments.

#### Tier 2 interventions

- Open access alcohol-specific facilities
- Provision of alcohol specific advice, information and support
- Extended or enhance brief interventions and brief (non structured) treatment to reduce alcohol related harm
- Shared care with staff from Tier 3 services
- Assessment (triage) and referral for those with more serious alcohol related problems
- Mutual aid support groups (such as AA) and aftercare groups
- Settings for the delivery of such interventions include hospital liver units, domestic abuse agencies, primary health care, community based alcohol services, Accident and Emergency departments, acute hospitals, housing and homelessness services
- Family focused interventions to safeguard and provide support to children of dependant alcohol users.

#### Tier 3 interventions

- Community based specialised alcohol misuse assessment and treatment that is structured, coordinated and care planned
- Provision of comprehensive assessment, structured treatment and keyworking
- Provision of a range of evidence-based prescribing and psychosocial therapies to address alcohol misuse
- Community based alcohol detoxification
- Community care assessment (for residential rehabilitation)
- Settings for the delivery of such interventions include GP practices involved in a shared care scheme and designated community based alcohol services and specialist mental health alcohol services.

#### Tier 4 interventions

- In-patient co-ordinated (residential) specialist alcohol detoxification and stabilisation interventions.

## **Appendix 3 – case studies of clients using the alcohol treatment system**

### Case Study 1

#### *Background*

Male 50 years old. Reported he was drinking 2 litres cider daily at 5 units per litre. Living in Bed and Breakfast accommodation, staff there reported he was drinking considerably more than this.

Physiologically health deteriorating, considerable muscle wastage and used a frame for mobility. Not able to leave room and dependant on other residents for support.

Had been living in temporary accommodation for many years, and had not seen a GP for over two years as GP would not visit the accommodation which he felt was unsafe.

#### *Interventions provided*

On assessment the client expressed a wish to become alcohol free, he recognised the impact drinking was having on his life, and presented as motivated to address his alcohol use.

Assessment identified that client had concerns about being able to remain alcohol free while living in bed and breakfast accommodation.

Alcohol Care Manager (ACM) identified support necessary to successfully complete detoxification, including working alongside health colleagues to complete joint assessment to ensure a plan for safe detox, and support to client to begin to safely reduce drinking whilst waiting for detox.

ACM referred the client to single person's homelessness services and worked with them to identify appropriate accommodation. The client was supported to view and sign for the property. Admission to detox was arranged so that the discharge date would coincide with the date identified for the client to move into his own property.

The care manager worked with an out of area detox unit to identify the client's support needs and ensure that appropriate physiotherapy and personal care support was also provided in order to enable the client to complete his detox. The detox itself went well with the unit reporting no concerns and the client engaging with all aspects of the unit including group work

#### *Aftercare arrangements*

On discharge the client moved into his own property with support from the Reablement Team (the Adult Social Care physical disability service which works to re-establish independence) from day of discharge. Casework support from care manager remained in place, including support to access charitable organisations to furnish his new home, and re-registration with a GP, including arranging a home visit for a health assessment.

An alcohol support worker has been allocated to support the client in accessing his local community including shops and post office. Housing support services are assisting with benefit uptake and Community Care Grant application.

Support continues with abstinence, the client has been referred to a Community Alcohol Team (CAT) Linkworker who will carry out home visits to support relapse prevention work; the client also plans to use the Brian Hore Unit for longer term support with abstinence (services provided include groupwork and daycare).

Ongoing physiotherapy and Occupational Therapy continues in the community to assist the gentleman to independently access alcohol support services, and Intermediate Care have now begun working alongside Reablement colleagues.

To date the client has remained abstinent.

## Case study 2

### *Background*

36 year old male, drinking 182 units of alcohol weekly. Client had a previous history of heroin use, although not for the past 6 years.

The client had stable accommodation, living with his partner, though the relationship was strained due to levels of alcohol use.

He was in full time employment though currently on sick leave from work, and with a high risk of losing employment, although his employers were sympathetic and willing to continue with his employment if he became alcohol free.

The client's partner was invited to and attended the initial assessment and given information about services and support for families and carers.

### *Interventions provided*

A CAT Linkworker had been working with the client developing motivation and identifying appropriate aftercare. He was then referred to the Alcohol Care Management Team for an assessment, to include social care assessment and detox assessment.

The social care assessment identified a return to employment and maintenance of stable accommodation as important to his recovery and this was added to the client's existing support plan, which identified detox followed immediately with completion of 5 week programme at the Brian Hore Unit.

Detox was arranged with an out of area provider. The detox was successful and the client engaged with the support offered. He was discharged from detox, and engaged with the support offered by the Brian Hore Unit, successfully completing the 5 week programme he had been referred to.

### *Aftercare arrangements*

The client remains on the caseload of the Alcohol Care Management team, in order to provide ongoing support. At his last review, 3 months post treatment, he had maintained sobriety. He has returned to employment and continued in his existing relationship and stable accommodation

## Case Study 3

### *Background*

44 year old male drinking up to 45 units alcohol daily, with significant withdrawal symptoms if unable to purchase alcohol

Physiologically he appears to have degree of cognitive damage linked to history of bare knuckle boxing. In addition there are concerns around mental health issues, including paranoid ideation and significant depression.

The client had a history of criminal offences including assault and racially aggravated public order. He was also a client of the Probation Service, who worked alongside the Alcohol Care Management Team to co-ordinate the case through the imposition of an Alcohol Treatment Requirement.

#### *Interventions provided*

The assessment identified that the client presented a significant level of risk to both himself and others. It became apparent that the client had ongoing involvement in bare knuckle fighting, and it is suspected that he is paid for this with alcohol.

There were difficulties with the assessment process due to combination of the client's cognitive damage and intoxication/ withdrawal symptoms, but it was agreed to refer the client for detoxification. The assessment also included exploration of potential aftercare support, but the client was not able to identify what services and support he required, due to the issues outlined above. Plans were made for the client to access the Brian Hore Unit on discharge from detox, and for Floating Support Services to assist with maintenance of the client's existing tenancy. The floating support was subsequently withdrawn due to concerns about the level of risk posed by the client.

Given the client's history and risk levels it was initially difficult to identify an appropriate detox facility. The Alcohol Care Management Team worked with an out of area treatment provider who agreed to assess the gentleman, following this assessment they agreed that they would be able to provide support and a date for admission was made.

The detox itself was successful and the detox provider reported that the gentleman presented no difficulties whilst with them, he engaged with the support and there were no concerns around his behaviour.

Unfortunately, the client began to drink again on the day that he was discharged from detox.

#### *Aftercare arrangements*

Services remain in place including Probation and BHU, the case has transferred to community alcohol social worker who is attempting to arrange a period of residential rehabilitation to provide support necessary for this gentleman to develop skills to maintain sobriety in the community. This will follow another attempt at detoxification, which is currently being arranged prior to the cessation of the client's Alcohol Treatment Requirement. On going multi-disciplinary meetings are held between CAT Linkworkers, Alcohol Care Management, Probation, and the Brian Hore Unit (Consultant Psychiatrist) to review and plan the client's treatment and care and manage the associated risks, including arrangements outlined above.

There are ongoing difficulties in terms of care planning, due to the client's cognitive impairment and ongoing heavy alcohol use.

<b>1. IMPROVING ALCOHOL TREATMENT AND CARE</b>			
Aim: to ensure the alcohol treatment system is responsive to the needs of harmful and dependent drinkers, their families and carers			
WHAT	WHEN	WHO	PROGRESS UPDATE (June 09)
<b>1. Alcohol and mental health</b>			
1.1	Undertake research to baseline and project local incidence of Wernicke-Korsakoff syndrome and identify appropriate local responses	April 2009	Public Health Associate Team Manager (Alcohol) ASC Head M/Health Joint Commissioning Alcohol Strategy Manager
			<ul style="list-style-type: none"> <li>An F2 doctor (Junior Doctor) on placement with public health completed an initial piece of research into the prevalence of and services available to people with alcohol related dementia In April 2009. Report currently being finalised for circulation. Will cover: review of existing research, evidence and data (national and local), identifying good practice from other areas, survey of local service providers (including primary, secondary and emergency care, voluntary and community sector, nursing and social care)</li> <li>Initial indication, based on a literature review and qualitative research, is that there needs to be an improvement in assessment services as the disease is hard to identify, with a high percentage of dementia in younger people caused by Alzheimer's (30%), trauma or other cause.</li> <li>The working group will re-convene to discuss the findings and to identify the most effective interventions, which may involve re-assessment of current continuing care provision.</li> <li>Early indications re: prevalence from an initial questionnaire to service providers (75% response rate) identified 68 known cases and up to 47 additional probable cases, however it is likely that there are substantially more undiagnosed cases.</li> </ul>
1.2	Develop a Dual Diagnosis strategy for the city, based on the recommendations of the Mental Health and Substance Misuse Needs Assessment, which will form part of the mental health service 10 year commissioning strategy, and the DAST's treatment planning	September 2008	Head of Joint Commissioning Head of M/Health Commissioning
			<ul style="list-style-type: none"> <li>Draft Mental Health Commissioning Strategy presented to Adult Health and Wellbeing Overview and Scrutiny Group, and currently undergoing further consultation</li> <li>Draft strategy identifies issues relating to mental health and substance misuse (including alcohol) and identifies action to develop a dual diagnosis action plan</li> <li>Mental Health Joint Commissioning Team developing complex needs strategy which will address main recommendations and actions made in Substance Misuse and Mental Health review, DAST involved.</li> <li>DAST and Community Alcohol Team attend Dual Diagnosis Executive.</li> </ul>
<b>2. Alcohol treatment system</b>			
2.1	Develop provision that enhances privacy and dignity for female service users in specific residential services	April 2009	Alcohol Strategy Manager Head of Joint Commissioning Lead Officer (SP)
			<ul style="list-style-type: none"> <li>Newbury House capital redevelopment programme underway (will provide 2 self-contained units for women), completion scheduled for Autumn 09.</li> <li>Additional Housing Corporation funding secured for whole building refurbishment in Summer 2008, resulting in extension to work programme beyond original timescale</li> <li>ECHG developing action plan for extending service to female clients, to include full risk assessment.</li> <li>Community Alcohol Team and Brian Hore Unit service specifications and SLAs include targets for the % of service users who are female – set at 33% (CAT) and 30% (BHU) for 09/12. Performance monitoring of targets will take place via NHS Manchester contract monitoring arrangements, and will also be shared with Alcohol Joint Commissioning Group.</li> </ul>
2.2	Develop a robust alcohol commissioning strategy based on the recommendations in the needs and capacity analysis to maximise the value and effectiveness of commissioned services	April 2009	Alcohol Strategy Manager Head of Joint Commissioning Specialist Commissioning Manager
			<ul style="list-style-type: none"> <li>NHS Manchester's Commissioning Strategy is in place, which identifies priorities and commissioning intentions against Vital Signs indicators (NB Vital Signs indicator for alcohol is also LAA and PSA25 indicator). Alcohol identified as one of 10 priority areas.</li> <li>NHS Manchester commissioning priorities include investment in Identification and Brief Advice (IBA), as recommended in the Needs and Capacity Analysis.</li> <li>Over £600k new investment identified as part of Improving Health in Manchester Programme (IHIM) (NHS Manchester) and Early Implementer Programme - 3 Community Alcohol Team Criminal Justice Linkworkers, to continue Alcohol Arrest Referral (approx 550 people received IBA since pilot project began in late 2007) <ul style="list-style-type: none"> <li>- 9 Accident and Emergency Department workers across 3 hospitals (including Alcohol Liaison Nurses and Care Facilitators), building on positive impact of MRI pilot programme (50,000 people screened since pilot began)</li> <li>- IBA pilot in 17 GP practices across the city (14 trained to date – GPs/ practice nurses/ healthcare assistants)</li> <li>- IBA training for generic services (114 trained since</li> </ul> </li> </ul>

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<b>WHAT</b>	<b>WHEN</b>	<b>WHO</b>	<b>PROGRESS UPDATE (June 09)</b>
			<p>March 09 – health visitors, prison staff, probation, pharmacists)</p> <ul style="list-style-type: none"> <li>• Service Level Agreements for IHIM-funded projects will provide ongoing performance monitoring information re: numbers screened and brief advice provided</li> <li>• DAST finalising needs assessment to inform future commissioning of detoxification services (inpatient and community), with recommendations for commissioners</li> <li>• DAST completed first draft of substance misuse commissioning strategy, currently in consultation</li> <li>• Alcohol Joint Commissioning Group receive treatment system performance management information from National Alcohol Treatment Monitoring System, which will inform assessment of effectiveness and value for money, and future commissioning decisions</li> </ul>
2.3	Ensure that relevant alcohol services are compliant with the Alcohol Treatment Monitoring System	March 2009	<p>Alcohol Strategy Manager Specialist Commissioning Manager Principal Manager Physical Disability</p> <ul style="list-style-type: none"> <li>• Tier 3 and 4 alcohol treatment services reporting to National Alcohol Treatment Monitoring System since April 2008, as required by NTA.</li> <li>• NTA producing quarterly reports from April 2009 – Alcohol Joint Commissioning Group to use for performance management of treatment system and individual services</li> <li>• Initial reports from NTA indicate good compliance and good levels of data quality</li> </ul>
2.4	Ensure that relevant alcohol services are compliant with the NTA Treatment Outcome Profile	March 2009	<p>Alcohol Strategy Manager Specialist Commissioning Manager Principal Manager Physical Disability</p> <ul style="list-style-type: none"> <li>• NTA guidance states that in principle, the TOP is validated for alcohol use and therefore can be used as a clinical and outcomes monitoring tool and NDTMS will accept a TOP completed for alcohol clients. In practice, it is recognized that while NDTMS is being extended into alcohol services, this may take longer to achieve. Therefore alcohol services were not required to report to TOPs in 2008/9.</li> <li>• Locally it was decided that the initial focus should be on ensuring compliance with ATMS, as outlined above; particularly given that TOPs information would not be collated and analysed by the NTA in 2008/09, and so would not be available for use as a performance management tool.</li> <li>• TOPs monitoring begun in April 2009, and relevant alcohol services are compliant.</li> </ul>
<b>3. Service users and carers</b>			
3.1	Establish a co-ordinated approach across service user groups (substance misuse) and develop peer support networks, pathways to volunteering, and an involvement strategy	Sept 2008	<p>Head of Joint Commissioning Service User Involvement Project (ASC)</p> <ul style="list-style-type: none"> <li>• Manchester Substance Misuse Involvement Network (MSMIN) established January 2009. Framework of full network meetings and smaller forums established.</li> <li>• Network meetings to be held twice yearly – topics agreed in advance with members. Approximately 200 users and carers expected to attend next meeting.</li> <li>• Service User Forum also in place – to meet 3-4 times yearly (next meeting June 09), to discuss DAST plans and issues identified by members.</li> <li>• The distribution list for the MSMIN now numbers 186, of whom approximately 72 are service users and 40 are carers. Around 40 Network Champions have been recruited from among service users, carers and professionals to help the flow of information between the DAST and, in particular, people who are less likely to attend Network meetings.</li> <li>• DAST Treatment Plan 09/10 outlines substance misuse user involvement strategy – includes continued development of Substance Misuse Involvement Network, development of standard service user satisfaction audit for use across commissioned services, establishment of mentoring and volunteering opportunities across the city to support recovery, develop and consult on model for peer support and advocacy, and identifying options for including service planning and review for commissioned services.</li> <li>• Users and carers handbook in development – to be piloted with carers initially (see 3.2, below).</li> <li>• Service specifications for CAT and BHU include targets for service user experience – 30% of users to undertake user satisfaction survey, target of 80% positive responses. To be monitored quarterly. Annual action plan to be developed based on complaints and user feedback.</li> </ul>
3.2	Develop interventions for carers, including peer support networks, specific support forums, increase in carers' assessments, information about coping with substance misuse, family interventions etc.	April 2009	<p>Head of Joint Commissioning Family and Carers</p> <ul style="list-style-type: none"> <li>• See above re: MSMIN and network meetings.</li> <li>• MSMIN Carers and Families Forum in place, to meet 3-4 times per year, next meeting due July 2009.</li> </ul>

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WHAT	WHEN	WHO	PROGRESS UPDATE (June 09)	
		Development Service (ASC)	<ul style="list-style-type: none"> <li>DAST Treatment Plan for 09/10 outlines strategy for developing support for carers and families – includes actions to pilot and evaluate a programme of training for carers in conjunction with the development of peer support mechanisms, design and publish a “Help” manual to support and guide Carers and Service Users (with the involvement of carers, family members and service users), agree processes with commissioned substance misuse service to ensure that appropriate approaches are taken to sharing information with carers and involving them in developing, implementing and reviewing care plans, continue to work with the Carers’ Strategy Team and other carers’ organisations to ensure that the needs of carers and families of those with substance misuse are recognised and properly considered in strategic planning, commissioning, care planning and the delivery of services.</li> <li>The DAST lead on Service User and Carers Development Project and fund a dedicated Substance Misuse Service User and Carers Development Officer located in MCC Adult Social Care to carry out this work</li> <li>Carers’ Peer Support Project in development. An introductory day has been held for carers considering applying to join the peer support programme. They will apply for places by application form and interview. The training is scheduled to take place in July 2009. Those successfully completing training will be matched to carers requiring peer support and supervised by MCC Adult Social Care.</li> <li>Users and carers handbook to be piloted as part of Carers’ Peer Support Project.</li> <li>Alcohol Z cards have been distributed to a range of carers groups, including for use during Carers’ Week, to the Carers’ Team at Adult Social Care, and via the Service User and Carers Development Project.</li> <li>Carers’ assessments are available through the Alcohol Care Management Team, as part of a wider approach to identifying needs and providing a range of support for carers, outlined above.</li> </ul>	
3.3	Ensure service level agreements for alcohol treatment services recognise the need to identify and offer information and advice to carers	April 2009	Alcohol Strategy Manager Head of Joint Commissioning Specialist Commissioning Manager	<ul style="list-style-type: none"> <li>Service specifications for Community Alcohol Team and Brian Hore Unit include requirement to give information to carers about services and support available, and information about carers’ rights to have carers’ assessment if they wish</li> <li>Alcohol Care Managers refer for carers assessments and provide information on services available, including support and advice from Substance Misuse Service User and Carer Development Officer (Adult Social Care).</li> </ul>
<b>4. Alcohol and domestic abuse</b>				
4.1	Explore how alcohol treatment services best assess issues of domestic abuse with service users who may be victims	April 2009	DAMG – Training Sub-Group Team Manager – Organisational Development (CEx) Alcohol Strategy Manager Head of Joint Commissioning	<ul style="list-style-type: none"> <li>Community Alcohol Team (CAT) Manager is a member of Multi-Agency Risk Assessment Conference (identifying and developing multi-agency care package for highest risk victims of DA as identified by GMP).</li> <li>Short term pilot jointly funded by GMP and MCC ran from Feb – April 09, worker based in ASC, MARAC/GMP identify victims/perpetrators who misuse alcohol, project provides intensive outreach/ access to services. Evaluation of project revealed concerns about method of delivery, so repeat funding not currently being sought but discussions underway to identify alternative options for engaging victims/ perpetrators with treatment services.</li> <li>Manchester Community Health (MCH) currently writing Domestic Abuse staff guidelines to introduce selective enquiry (with appropriate training) for MCH staff, which will include CAT staff. Guidelines will be ratified through Domestic Abuse Management Group to become multi-agency guidelines.</li> <li>Likely that CAT will move to routine enquiry because of the overlap between domestic abuse (victims and perpetrators) and alcohol.</li> <li>Some CAT staff currently make routine enquiries re: DA, advise on safety planning, and make onward referrals to Independent Domestic Violence Advisors (IDVA)/ Women’s Aid/MARAC as appropriate. CAT staff have opportunities to raise concerns via supervision and line management. This approach to be standardised following production of guidance and training (see above).</li> </ul>
4.2	Emphasise the link between alcohol and domestic abuse in	April 2009	Alcohol Strategy	<ul style="list-style-type: none"> <li>Alcohol strategy represented on Domestic Abuse</li> </ul>

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<b>WHAT</b>	<b>WHEN</b>	<b>WHO</b>	<b>PROGRESS UPDATE (June 09)</b>
the promotion of both strategies		Manager DAMG – Comms SubGroup	Management Group sub-groups <ul style="list-style-type: none"> <li>• Domestic abuse strategy represented on Alcohol Strategy working groups.</li> <li>• MCC domestic abuse and alcohol lead officers, NHS Manchester domestic abuse and alcohol leads, and Supporting People currently developing paper on alcohol and domestic abuse for consideration by DA Commissioning Group and Management Group, to include options for provision of voluntary perpetrators programme</li> <li>• Alcohol strategy publicised via Domestic Abuse Strategy communication channels i.e. newsletter and website; IDVA invited to alcohol strategy working group to make presentation on referring to services</li> </ul>