Appendix 1 Questionnaire analysis in detail

**Q3: Experience**

Figure 1 Q3: How long have you been working in your current role? (92 respondents)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

**Q4: Relevance of the work**

Figure 2 Q4: Does your current work involve interacting with clients/members of the public? (92 respondents)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
Figure 1 and Figure 2 show 67% of respondents had worked in their service between 2 and 10 years and 19% had been in post for less than 6 months. 89% of respondents spent between 50% and 100% of their time with clients.

**Q5: Volume of workload**

Figure 3 Q5: Approximately, how many clients do you see on average each week? (92 respondents)

![Pie chart showing distribution of weekly client caseloads](chart.png)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

Figure 3 shows the distribution of weekly client caseloads, notably 66% interacted with 10 clients or more per week indicating respondents are well placed to represent the views of frontline staff.
Q6: Perceived prevalence of the problem

Figure 4 Q6: When a client comes to you with a problem, have you ever suspected that alcohol misuse could be a contributory factor to that problem? (92 respondents)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

Figure 4 shows 90% of respondents had suspected alcohol to be a contributory factor to a client’s problem, 18% said this happened often, 60% sometimes and 13% rarely.
Figure 5 Q6: When a client comes to you with a problem, have you ever suspected that alcohol misuse could be a contributory factor to that problem?

Third sector respondents only: (all 27 Third sector respondents)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
Respondents suspected alcohol to be a contributory factor “often” more frequently among NHS staff (38%) compared with third sector (4%) or social care/council staff (12%) (Figure 5) either reflecting higher prevalence of alcohol problems in NHS interactions or reflecting less confidence to discuss alcohol in Non-NHS respondents.

**Q7: Drinking as a subject of discussion**

**Figure 6 Q7: Have you ever talked to a client about their alcohol use? (92 respondents)**

![Bar chart showing responses to Q7](image)

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

Figure 6 shows approximately 17% of respondents had never talked to a client about their alcohol use.
Figure 7 Q7: Have you ever talked to a client about their alcohol use?

**Third sector respondents (all 27 Third Sector respondents)**

- Yes, because their alcohol use was contributing to the problem I was engaging with them to solve: 25.9%
- Yes, because their alcohol use appeared to be negatively affecting their wellbeing: 48.1%
- No: 40.7%

**NHS respondents only: (all 21 NHS respondents)**

- Yes, because their alcohol use was contributing to the problem I was engaging with them to solve: 66.7%
- Yes, because their alcohol use appeared to be negatively affecting their wellbeing: 85.7%
- No: 0.0%
Most of the staff who had not talked to a client about alcohol, where employed in the third sector and none were in the NHS (see Figure 7 subfigures).
**Q8, 9 and 10: Identification and brief advice training**

Figure 8 Q8: All respondents (all 92) Have you ever been offered / taken up training for frontline staff to undertake brief Intervention (Identification and brief advice)?

Among all respondents approximately 22% had been offered training and had taken it up, 4% had been offered it and not taken it up and 74% of staff had not been offered training in identification and brief advice (Figure 8).

82% of social care/council staff and 89% of third sector staff had never been offered training, whilst in both groups under 5% of those who had been offered it had declined to take it up. This suggests that there is an opportunity to train front-line staff in social care and third sector settings and that opportunity would be well received and taken up by them.

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
Figure 9 Q8: Have you ever been offered / taken up training for frontline staff to undertake brief Intervention (Identification and brief advice)?

NHS respondents (all 21)

- 48% I have been offered it and taken it up
- 47% I have been offered it but not taken it up
- 5% I have not been offered training

Third sector (all 27 respondents)

- 89% I have not been offered training
- 7% I have been offered it but not taken it up
- 4% I have been offered it and taken it up

Social care/council (all 44 respondents)

- 82% I have not been offered training
- 14% I have been offered it but not taken it up
- 4% I have been offered it and taken it up

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
Figure 10 Q9: If you were now offered training in alcohol misuse identification and brief advice for your clients, which one of the following mostly closely matches your opinion? (All respondent group (74/92 respondents)

- 1% I would take up the training as I think it is an important way of helping me do my job and it would also enhance my role.
- 19% I would take up the training as I think it would be good for my continued professional development (CPD).
- 70% I would take it up because I would feel I have to, but I don’t think it is relevant to my work.
- 10% Other (please specify).

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

Figure 10 shows that among those who had not already had training, 91% of all respondents would take-up training in alcohol misuse identification and brief advice. Among NHS staff 80% said they would take up training, however many said they had already had training or felt that the skills that they had were transferable, among social care staff, 92% said they would take up training and among third sector staff 88% said they would take up training. This is yet more evidence that there is recognition of the importance of identification and brief advice across sectors and also willingness among staff to engage with and participate in it.
Figure 11 Q9: If you were now offered training in alcohol misuse identification and brief advice for your clients, which one of the following mostly closely matches your opinion?

Figure 12 NHS respondents (10/21)

- I would take up the training as I think it is an important way of helping me do my job and it would also enhance my role.
- Other (please specify).

Figure 13 Social care/council (39/44) respondents

- I would take up the training as I think it is an important way of helping me do my job and it would also enhance my role.
- I would take up the training as I think it would be good for my continued professional development (CPD).
- Other (please specify).
Figure 14 Third sector (25/27) respondents

- 76%: I would take up the training as I think it is an important way of helping me do my job and it would also enhance my role.
- 12%: I would take up the training as I think it would be good for my continued professional development (CPD).
- 8%: I would take it up because I would feel I have to, but I don't think it is relevant to my work.
- 4%: Other (please specify).

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
Table 1 shows responses to question 10: “*Was the training informative and have you ever used the skills you learned?*” This question was only served to those who said they had had intervention and brief advice training.

**Table 1 Q10: Was the training informative and have you ever used the skills you learned?**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>All (21) Response %</th>
<th>NHS (10) Response %</th>
<th>Third sector (2) Response %</th>
<th>Social Care (6) Response %</th>
</tr>
</thead>
<tbody>
<tr>
<td>The training was informative and I have used it many times</td>
<td>43%</td>
<td>60%</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>The training was informative and I have used it on occasion</td>
<td>57%</td>
<td>40%</td>
<td>100%</td>
<td>83%</td>
</tr>
<tr>
<td>The training was informative but I have never used the skills I learned</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The training was not very helpful</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

Respondents found the training informative but NHS respondents were more likely to use the training many times, possibly because problem drinking is more likely to occur in those consulting the NHS or else the culture of the NHS may be more open to open discussion of alcohol intake.
Q11: Attitudes of staff to addressing alcohol as an issue for their clients

Figure 15 shows the distributions of responses to each question NHS, Social Care and third sector respondents.

1) Concerning: “I feel I know enough about causes of drinking problems to carry out my role when working with drinkers”. NHS responses are distributed towards greater agreement than social care/council and third sector, which were approximately randomly distributed around the ambivalent response (neither agree nor disagree).

2) Concerning: “I feel I can appropriately advise my clients about drinking and its effects”, responses were distributed towards greater disagreement; however among NHS staff the distribution tends towards agreement, whilst both social care/council and third sector responses tend toward disagreement. This indicates confidence among NHS staff along with lack of confident among social care/council and third sector staff in advising clients about drinking and its effects.

3) Concerning: “I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship”, all groups tended towards disagreeing, indicating that they do not feel inhibited talking to clients about alcohol because of a fear it might damage their working relationship, this, in the context of statement 2) suggests a lack of confidence in ability rather than a lack of a sense of a right to enquire.

4) Concerning: “I feel I do not have much to be proud of when working with drinkers”, the three group’s response distributions tended towards disagreement with greater disagreement among NHS respondents, indicating an openness and positivity about working with drinkers in all three groups.

5) Concerning: “All in all I am inclined to feel I am a failure with drinkers”, all three group’s response distributions tended to disagree with the statement, indicating an openness to “success” with working with drinkers in all categories of the organisation.
### Table 2 Q11

**All respondents**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Quite strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Quite strongly disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general I like drinkers</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>64</td>
<td>3</td>
</tr>
<tr>
<td>In general, it is rewarding to work with drinkers</td>
<td>6</td>
<td>10</td>
<td>13</td>
<td>56</td>
<td>6</td>
</tr>
<tr>
<td>I feel that my clients believe I have the right to ask them questions about drinking when necessary</td>
<td>9</td>
<td>12</td>
<td>20</td>
<td>41</td>
<td>9</td>
</tr>
<tr>
<td>I feel I have the right to ask clients questions about their drinking when necessary</td>
<td>11</td>
<td>14</td>
<td>42</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Pessimism is the most realistic attitude to take towards drinkers</td>
<td>6</td>
<td>20</td>
<td>22</td>
<td>42</td>
<td>9</td>
</tr>
<tr>
<td>I want to work with drinkers</td>
<td>8</td>
<td>2</td>
<td>15</td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>All in all I am inclined to feel I am a failure with drinkers</td>
<td>2</td>
<td>33</td>
<td></td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>I feel I do not have much to be proud of when working with drinkers</td>
<td>3</td>
<td>32</td>
<td></td>
<td>32</td>
<td>24</td>
</tr>
<tr>
<td>I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship</td>
<td>11</td>
<td>7</td>
<td>30</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>I feel I can appropriately advise my clients about drinking and its effects</td>
<td>11</td>
<td>8</td>
<td>35</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>I feel I know enough about causes of drinking problems to carry out my role when working with drinkers</td>
<td>13</td>
<td>9</td>
<td>28</td>
<td>26</td>
<td>12</td>
</tr>
</tbody>
</table>
### NHS Respondents

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Quite strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Quite strongly disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, I like drinkers</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>In general, it is rewarding to work with drinkers</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I feel that my clients believe I have the right to ask them questions about drinking when necessary</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I feel I have the right to ask clients questions about their drinking when necessary</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pessimism is the most realistic attitude to take towards drinkers</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>I want to work with drinkers</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>All in all I am inclined to feel I am a failure with drinkers</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>I feel I do not have much to be proud of when working with drinkers</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I feel I can appropriately advise my clients about drinking and its effects</td>
<td>6</td>
<td>2</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>I feel I know enough about causes of drinking problems to carry out my role when working with drinkers</td>
<td>6</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
### Social care/council respondents

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Quite strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Quite strongly disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general I like drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, it is rewarding to work with drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that my clients believe I have the right to ask them questions about drinking when necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I have the right to ask clients questions about their drinking when necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pessimism is the most realistic attitude to take towards drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want to work with drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All in all I am inclined to feel I am a failure with drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I do not have much to be proud of when working with drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I can appropriately advise my clients about drinking and its effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I know enough about causes of drinking problems to carry out my role when working with drinkers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quite strongly agree

Agree

Neither agree or disagree

Quite strongly disagree

Strongly disagree

100
## Third sector respondents

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Quite strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Quite strongly disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general I like drinkers</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>In general, it is rewarding to work with drinkers</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>19</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>I feel that my clients believe I have the right to ask them questions about drinking when necessary</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>15</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>I feel I have the right to ask clients questions about their drinking when necessary</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>11</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Pessimism is the most realistic attitude to take towards drinkers</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>I want to work with drinkers</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>17</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>All in all I am inclined to feel I am a failure with drinkers</td>
<td>1</td>
<td>3</td>
<td>13</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>I feel I do not have much to be proud of when working with drinkers</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>I feel I can appropriately advise my clients about drinking and its effects</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>I feel I know enough about causes of drinking problems to carry out my role when working with drinkers</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>12</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
**Figure 15 Distribution of responses (strongly agree far left to strongly disagree far right)**

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>NHS</th>
<th>Social Care</th>
<th>Third Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel I know enough about causes of drinking problems to carry out my role when working with drinkers</td>
<td><img src="image1.png" alt="Bar Chart" /></td>
<td><img src="image2.png" alt="Bar Chart" /></td>
<td><img src="image3.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>2</td>
<td>I feel I can appropriately advise my clients about drinking and its effects</td>
<td><img src="image4.png" alt="Bar Chart" /></td>
<td><img src="image5.png" alt="Bar Chart" /></td>
<td><img src="image6.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>3</td>
<td>I feel that I can NOT talk to my clients about alcohol because it might damage our working relationship</td>
<td><img src="image7.png" alt="Bar Chart" /></td>
<td><img src="image8.png" alt="Bar Chart" /></td>
<td><img src="image9.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>4</td>
<td>I feel I do not have much to be proud of when working with drinkers</td>
<td><img src="image10.png" alt="Bar Chart" /></td>
<td><img src="image11.png" alt="Bar Chart" /></td>
<td><img src="image12.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>5</td>
<td>All in all I am inclined to feel I am a failure with drinkers</td>
<td><img src="image13.png" alt="Bar Chart" /></td>
<td><img src="image14.png" alt="Bar Chart" /></td>
<td><img src="image15.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>6</td>
<td>I want to work with drinkers</td>
<td><img src="image16.png" alt="Bar Chart" /></td>
<td><img src="image17.png" alt="Bar Chart" /></td>
<td><img src="image18.png" alt="Bar Chart" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>NHS</th>
<th>Social Care</th>
<th>Third Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Pessimism is the most realistic attitude to take towards drinkers</td>
<td><img src="image19.png" alt="Bar Chart" /></td>
<td><img src="image20.png" alt="Bar Chart" /></td>
<td><img src="image21.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>8</td>
<td>I feel I have the right to ask clients questions about their drinking when necessary</td>
<td><img src="image22.png" alt="Bar Chart" /></td>
<td><img src="image23.png" alt="Bar Chart" /></td>
<td><img src="image24.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>9</td>
<td>I feel that my clients believe I have the right to ask them questions about drinking when necessary</td>
<td><img src="image25.png" alt="Bar Chart" /></td>
<td><img src="image26.png" alt="Bar Chart" /></td>
<td><img src="image27.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>10</td>
<td>In general, it is rewarding to work with drinkers</td>
<td><img src="image28.png" alt="Bar Chart" /></td>
<td><img src="image29.png" alt="Bar Chart" /></td>
<td><img src="image30.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>11</td>
<td>In general I like drinkers</td>
<td><img src="image31.png" alt="Bar Chart" /></td>
<td><img src="image32.png" alt="Bar Chart" /></td>
<td><img src="image33.png" alt="Bar Chart" /></td>
</tr>
</tbody>
</table>

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)
6) Concerning: “I want to work with drinkers” The distribution of all respondents was approximately symmetrical showing a range of agreement and disagreement. The NHS respondents response distribution tended towards agreement with 37% (7/19) expressing ambivalence, the social care/council and third sector workers response distributions showed a greater degree of ambivalence (}
Table 2, 66% (29/44) social care/council and 65% (17/26) third sector respondents expressed ambivalence to working with drinkers.

7) Concerning: “Pessimism is the most realistic attitude to take towards drinkers”: All groups tended disagree, and the strength of disagreement was greater in NHS respondents.

8) Concerning: “I feel I have the right to ask clients questions about their drinking when necessary”: There was greater agreement among NHS respondents than, social care/council respondents, who agreed marginally more than third sector respondents.

9) Concerning: “I feel that my clients believe I have the right to ask them questions about drinking when necessary”: NHS respondents response distribution was more positive than social care/council, or third sector respondents whose distribution of responses tended towards more disagreement. This is likely to manifest as less willingness to question and less actual questioning of clients about alcohol in these two groups.

10) Concerning: “In general, it is rewarding to work with drinkers”, NHS staff responded more positively (over 50%) than social care staff and third sector staff who mostly reported ambivalence.

11) Concerning: “In general I like drinkers”: NHS staff were more likely to respond positively and the vastly most frequent response among social care and third sector staff was ambivalence.

**Conclusions from Q11 of the staff questionnaire**

The NHS responses to questions about perceived knowledge, attitudes and behaviour to issues of alcohol drinking in clients was consistently more positive towards the issue of drinking itself and towards the willingness to address the issue with clients. However there was an acknowledgement in the other two group so lack of confidence through lack of knowledge and a willingness to train in IBA. There is considerable opportunity to increase levels of IBA and attitudes towards alcohol in clients in frontline staff in social care/council and the third sector through IBA training. This would help to change perceptions and remove stigma around alcohol consumption in general and particularly in the over 50s.

We asked respondents, “how can the county council and public sector partners working across health and adult social care engage more effectively with people over 50 to promote better awareness regarding alcohol related harm?”. They were offered a number of options across the spectrum of public health activities of health prevention and protection.
Q12: Enquiry about opinions as to the best actions for the CC to take to tackle alcohol misuse in over 50s

Figure 16 Q12: How can the County Council and public sector partners working across health and adult social care engage more effectively with people over 50 to promote better awareness regarding alcohol related harm?

<table>
<thead>
<tr>
<th>Answer Reference number</th>
<th>Answer</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Addressing licensing laws</td>
<td>18.5%</td>
</tr>
<tr>
<td>2</td>
<td>Stronger local rules on licensing new alcohol outlets</td>
<td>29.6%</td>
</tr>
<tr>
<td>3</td>
<td>More social marketing towards front line staff encouraging them to offer brief advice</td>
<td>38.3%</td>
</tr>
<tr>
<td>4</td>
<td>More guidance on harmful drinking levels rom licensing and partnership</td>
<td>39.5%</td>
</tr>
<tr>
<td>5</td>
<td>By leafleting and point of sale signage e.g. leaflets in GPs</td>
<td>43.2%</td>
</tr>
<tr>
<td>6</td>
<td>Local marketing/advertising campaigns about the dangers of alcohol</td>
<td>44.4%</td>
</tr>
<tr>
<td>7</td>
<td>Warnings of the danger of alcohol misuse on alcohol products. Warnings of the dangers of alcohol misuse in place of sale of alcohol products e.g. alcohol aisle of supermarkets</td>
<td>45.7%</td>
</tr>
<tr>
<td>8</td>
<td>Evaluation of the delivery of brief intervention and advice from local front line staff</td>
<td>48.1%</td>
</tr>
<tr>
<td>9</td>
<td>Marketing of local services from both the LA and charities that support people with problematic drinking</td>
<td>58.0%</td>
</tr>
<tr>
<td>10</td>
<td>More joining up between services across the patch</td>
<td>70.4%</td>
</tr>
<tr>
<td>11</td>
<td>Support groups for people who would like to cut down</td>
<td>72.8%</td>
</tr>
<tr>
<td>12</td>
<td>Better training of GPs and frontline staff to deliver brief intervention and advice</td>
<td>72.8%</td>
</tr>
<tr>
<td>13</td>
<td>Better joined up services</td>
<td>82.7%</td>
</tr>
</tbody>
</table>

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

The most popular responses mirror the findings of the other parts of this needs assessment. Respondents most frequent selected activities where support groups for people wanting to cut down, better training for frontline staff to deliver brief intervention and advice and better joined up services (Figure 15). Other responses
are also pertinent including social marketing/leafleting and local marketing as well as more guidance on harmful drinking.

**Q13: Respondents view of the quality of the alcohol service in Suffolk**

Figure 17 Q13:

Q13 Responses to the question: How would you rate the quality of intervention of the alcohol services as a whole and interventions in Suffolk?

![Bar chart showing responses to Q13](chart1)

Note: 0 = Ineffective 10 = Excellent

**To what degree do you feel your role is effective in contributing to the delivery of alcohol related interventions in Suffolk?**

![Bar chart showing responses to question on role effectiveness](chart2)
How effective is the partnership’s approach to reducing levels of drinking amongst at risk groups of people over 50?

![Bar chart showing responses to Q15 and Q17 on gender and ethnicity]

Note: 0 = Ineffective 10 = Excellent

Source: Online alcohol frontline staff attitudes and behaviour survey (capture 8th Dec 2015)

**Q15 and 17: Gender and Ethnicity**

Figure 18 Gender and Ethnicity of respondents

Gender
The majority of front-line staff was female (86% female v 14% male) and the vast majority identified ethnically as white 94.4%.

### Appendix 2 Models of care in Suffolk

**Models of care**
A wide range of interventions of different intensity have been developed and researched to respond to the wide range of alcohol use disorders and risks.
Population approaches
These include regulating availability and access to alcohol, raising public awareness, improving enforcement and supporting families. Many of these measures are part of the 2008-2010 Suffolk alcohol harm reduction strategy. Some of these include:

- A trading standards program to reduce the level and frequency of underage sales of alcohol. It features education and training for vendors, the establishment of the ‘Explore’ card as a valid proof of age identification and a poster campaign to help reinforce the messages around underage sales and the purchase of alcohol for minors.

- The Suffolk Crime and Disorder Partnership (CDRP) training scheme for local entertainment outlets and public houses to train door staff to intervene early in alcohol related violence.

While important, it is not within the scope of this health care needs assessment to evaluate these population level interventions. The health care needs assessment will focus on individual based approaches to alcohol use disorders, specifically alcohol treatment services.

Individual based approaches

A useful way of conceptualising alcohol interventions for individuals is laid out in the Department of Health Models of Care for Alcohol Misuse (MoCAM). This is a four-tiered model that assumes that in general terms, less severe alcohol use disorders are likely to respond to less intensive interventions and more severe alcohol use disorders will require more intensive interventions (See Figure 8). However, this is not a hard and fast rule: some people with more severe alcohol dependence will respond to less intensive interventions, and indeed many recover without any formal intervention. Equally some harmful drinkers will require more intensive interventions, including specialist treatment. Nevertheless, MoCAM is a useful starting point to describe interventions and the target group for whom they are largely intended.

Tier 1 services:
- Provided by mainstream services
- Targeted screening
- Information and brief advice to hazardous drinkers
- Referral
- ‘Shared care’ with those providing higher tiers

Tier 2 services:
- Provided by those with defined competency in alcohol misuse treatment. These could be trained mainstream services or alcohol specialists.
- Open access support
- Alcohol specific assessment
- Shared care with those providing higher tiers
- Mutual aid e.g. Alcoholics Anonymous

**Tier 3 services:**
- Community based specialised alcohol misuse assessment
- Comprehensive assessment
- Care planning and co-ordination
- Range of psycho-social therapies and support within a care plan
- Range of interventions for assisted withdrawal (detoxification) and other drug based interventions.
- Shared care services and training for Tier 1 and 2 providers

**Tier 4 services:**
- Alcohol treatment in a residential or in-patient setting
- Comprehensive assessment
- Care planning and co-ordination
- Range of psycho-social therapies and support within a care plan
- Range of interventions for assisted withdrawal (detoxification) and pharmacotherapies
- Shared care and training for Tier 1 and 2 providers

**Figure 19 Models of care for alcohol misuse**

*Source: Department of Health Models of Care for Alcohol Misuse (MoCAM)*

Within these four tiers are two broad ‘types’ of treatment: screening and brief interventions, and more specialist alcohol treatment.
Opportunistic screening and brief interventions (SBI): this refers to the use of screening or case identification tools (such as the AUDIT questionnaire) applied opportunistically in non-specialist settings (e.g. primary care, A&E departments, maternity services, criminal justice agencies) followed by a brief intervention usually delivered by a non-specialist health or social care professional. Interventions delivered in this context can vary from five minutes of structured advice, to an extended brief intervention of 20 to 40 minutes involving motivational principles. SBI is largely intended for hazardous and harmful drinkers who are not seeking help for an alcohol use disorder.

Specialist alcohol treatment: this refers to a wide range and intensity of interventions from, for example, one or more sessions of Motivational Enhancement Therapy through to intensive residential rehabilitation lasting up to 12 months. What these interventions have in common is that they are provided for patients actively seeking help for an alcohol use disorder, and the interventions are provided by specialist staff trained to provide them. Specialist treatment is primarily targeted at people with alcohol dependence, and the more intensive forms (e.g. inpatient or residential treatment) are generally reserved for people with more severe alcohol dependence and/or significant psychiatric co-morbidities or social problems.
Appendix 3 Turning Point treatment pathways

TP ALCOHOL PATHWAY TO SERVICES – TIERS 2 and 3

Adult attends a service that provides Alcohol Brief Interventions

Requests help with their alcohol use

Is offered screening as part of routine assessment for new service users

Presents with a related condition prompting an opportunistic screening

AUDIT screening tool completed with a trained and competent worker

AUDIT screening tool scored by administrator (if not already scored by worker)

**Step 1:**
- AUDIT score less than 8
- Low risk drinking

Encourage continued safer drinking. No further action required.

Evidence indicates that a brief harm reduction intervention is sufficient to promote change in this group

See Tier 2 pathway

**Step 2:**
- AUDIT score 8 – 15
- Increasing risk drinking (Tier 2)

Deliver single face to face brief intervention appropriate to your role, e.g.:
- A 10 min. simple advice session.
- Unfacilitated “Guided self-help” and signposting to mutual aid
- Face to face sessions only if ARPOV clients

See Tier 2 pathway

**Step 3:**
- AUDIT score 16 – 20
- High risk drinking (Tier 2)

Guided self-help & deliver several face to face brief interventions appropriate to your role ± medication e.g.:
- A 10 min. simple advice session, or MET if ambivalent ± opioid antagonist.
- A 45 min extended intervention session with a change plan.
- Up to 3 follow up sessions

See Tier 2 pathway

**Step 4:**
- AUDIT score 20+
- Possible alcohol dependence or complex case (Tier 3)

Referral to Turning Point keyworker or community detox nurse for full assessment, including SADQ, risk, priority assessment and care plan

Referral for assessment by TP doctor and to plan type of detox or controlled drinking and group work ± aftercare medication

See Tier 3 pathway
TP ALCOHOL PATHWAY – TIER 2

Service User attends Drop-in

Complete SADQ & AUDIT and Self-referral Form

Referral Received from GP or self-referral from Service User

Send SADQ & AUDIT to be returned within 14 days

AUDIT and SADQ screening tool scored by a trained & competent worker and send appt with text reminder prior to appt

AUDIT score ≥ 20

Initial Appointment Triage (at Drop-in if possible)
(Enter on CIM, modality-case work Tier 2)
- Do “Check Your Drinking” (also MyCrew.org.uk for drugs and for cannabis the Frank cannabis program)
- Request complete 1-2 weeks Drink Diary
- Give information about Mutual Aid & other self-help
- Provide Educational Session if ARPOV or AUDIT ≥ 16

AUDIT score < 20

Doesn’t want service

Wants service or no contact

Offer appt and tell about Drop-in. Ask about difficulties with transport. If no contact speak to referrer or others involved

Send another appt if likely to be fruitful or if indicated. Otherwise send a 7 day letter

No contact or DNA

Discharge and inform referrer
(Discharge if was entered on CIM)

Service user discussion with keyworker about need for more intensive intervention or high ‘Readiness to Change’ score (within first 8 weeks)
- Give information about Breaking Free Online
- Offer guided self-help
- 45 min extended intervention session and up to 3 follow up sessions
- Initiate aftercare medication (naltrexone, nalmefene, acamprosate, antabuse)

If no contact for 6 weeks, Keyworker telephones or sends letter requesting client contact within 2 weeks, otherwise will discharge. If contact made, given appt

Tier 3 Pathway (Enter Tier 3 CIM)
- Full assessment with risk, priority, SADQ result, recovery capital (at Drop-in if possible)
- Formulate Care Plan, aftercare plan & do TOPS
- 6 MI sessions, group work, detox etc.
- Review after 8 weeks
TP ALCOHOL PATHWAY – TIER 3

Does Service User want detox or controlled drinking?

Detox if physically dependent

- High intensity treatment provided by nurse
- Detox nurse performs comprehensive assessment (Tier 3) including:
  - Assessment of aftercare plan and level of internal (psychological) and external (environmental) recovery capital
  - Discussion of options including controlled drinking or detox, settings for detox, and use of medications for detox and aftercare
  - Service user attends 1 to 1 keyworking, predetox group, and builds robust aftercare plan and good recovery capital

Controlled drinking or dependency syndrome without physical dependence

- Low intensity treatment provided by Recovery worker
- Detox nurse to arrange appointment with TP doctor and request GP summary of health information and medication (with LFT’s and GGT)

TP Doctor assesses Service User to make decision on type of detox in conjunction with Service User, and after discussion with detox nurse (and possibly team manager)

- Rehab
- In patient
- Home

If controlled drinking offer a trial of controlled drinking to see if Service User can maintain it. Arrange 4 sessions of MI with keyworker. If dependent may 1st need planned reduction (or detox if poor control) before starting naltrexone or nalmefene

Does Service User want to continue controlled drinking or abstinence?

- Abstinence
- Controlled drinking

Prepare for discharge:
- Ensure good aftercare support
- Ask GP if willing to take over naltrexone or nalmefene
- Provide Harm Reduction advice
- Provide info on re-referral
- Provide mutual aid info (assist to attend AA etc)

Tier 4 lead takes to Residential Rehab Panel for funding

- Enter Aftercare Pathway Discharge (Discharge on CIM)

Refer for 2 week inpatient detox at contracted rehab / unit (or other spot purchased bed)

Refer to TP Nurse for assessment and home screening

Discharge (Discharge on CIM)
Appendix 4 Recommendations for 2013 Suffolk Alcohol treatment service Needs Assessment

Recommendation 1
This report proposes the formation of an alcohol healthcare partnership comprising the local authority, CCGs, and healthcare provider partners, the police and crime commissioner and Suffolk Constabulary. The group will be responsible for sharing information between partner organisations, exploration of ways of joint commissioning and further integration of the various services currently provided in Suffolk.

Recommendation 2
The Suffolk alcohol healthcare partnership would also be responsible for monitoring the quality of services offered in Suffolk.

Screening and brief interventions
Despite considerable evidence which indicate that opportunistic screening and brief advice and interventions offered in a healthcare setting can result in individual behavioural change and reduce rates of harmful and hazardous drinking, there exists considerable opportunities for further service development in this area. With regards to GP screening of new patients, considerable variation exists between practices in Suffolk – and 25% of all Suffolk practices do not partake of this service agreement. Importantly of those patients who do receive an initial screen, much fewer than expected go on to receive a full screen and brief advice. Alcohol screening has been incorporated into the NHS Health Checks programme from 2013/14, and the directly enhanced service agreement for alcohol new patient registrations continues between NHS England and GP practices.

Recommendation 3
CCGs to increase awareness among GPs and practice nurses on the benefits and practice of screening and brief intervention using the AUDIT tool through information distribution in the GP newsletter and discussion at the Local Medical Committee. Public Health to work with services commissioned and provided by the local authority to promote “Making Every Contact Count” and to ensure alcohol screening is available where appropriate.

Recommendation 4
GPs to ensure practice staff are aware of the need for screening of new patients, and highlight the importance of appropriate follow up for patients who are screened and found to be positive. Apart from primary care, screening should also be carried out in the hospital and other healthcare setting. Both West Suffolk and Ipswich Hospital have alcohol health liaison workers who are able to coordinate screening in
A&E and on the wards. Nationally, some evidence exists as to the benefit of alcohol liaison workers located in acute trusts. Despite this however, few referrals for specialist services are made directly from the hospital.

**Recommendation 5**

CCGs to consider outcome-based commissioning for alcohol screening from hospital trusts.

A CQUIN introduced as part of MECC last year obliged acute trusts to ensure staff in A&E were trained in PAT screening and to deliver brief interventions, and also to increase the number of referrals from A&E to specialist services in the community. Both Ipswich Hospital and West Suffolk Hospital were able to train staff to deliver PAT screening, however were unable to identify a greater proportion of harmful and hazardous drinkers or to refer them on to specialist services.

A similar CQUIN was put in place last year for the Norfolk and Suffolk Foundation Trust, however fulfilment of this CQUIN depended upon staff training only with no requirement to demonstrate delivery of screening or onward referral.

For the 2013/14 cycle, no contractual arrangement is in place between acute trusts and the CCGs to deliver screening in those settings.

**Recommendation 6**

CCGs to explore contractual arrangements between hospital trusts and mental health trusts to identify if alcohol screening and reporting would be an appropriate addition to a future contact.

Improvements in screening processes are likely to result in greater pick up rate of harmful and hazardous drinking behaviour and correspondingly increase demand for community based specialist services. This report demonstrates that current services are operating at 63 – 68% capacity. As such there is the capacity to cope safely with an approximately 20% increase in demand for the services.

**Recommendation 7**

Community based alcohol specialist providers to monitor service activity and capacity and report on this regularly to the local authority commissioners.

**Equity in specialist service provision**

The survey of specialist providers and patient engagement focus group reported significant difficulties for certain groups of the population in accessing alcohol specialist services due to geographical isolation. Service locations tend to be based in the main urban areas and satellite or outreach clinics are not widely used. Evidence presented in this report does not suggest that there would need to be increases in staffing in order to enhance provision of outreach clinics. This report
presents a service model of 1 outreach clinic a week in a rural GP practice, and estimates transport and overhead costs to be approximately £100 per session.

**Recommendation 8**
Specialist providers to explore their capacity for delivery of outreach clinic.

**Recommendation 9**
Assessment of future tenders for community based alcohol specialist services should take into account access for individuals in geographically isolated locations. This could be in the form of an equality impact assessment.

**Improving access to psychosocial interventions**

There is a high demand for structured psychological services in Suffolk with long average waiting times for those who require it. Further, the proportion of harmful drinkers and people with mild alcohol dependence who currently access specialist services who receive psychological interventions is estimated to be only 39%. The NICE guidance recommends that this should be 100%.

At present, SATS employ 1.0 wte psychologist. This report shows that the expected cost increase of the addition of 1.0 wte cognitive behavioural therapist in staffing is approximately £30,000 annually. This would assist in waiting times for access to structured psychological therapy, and enable services to increase the proportion of harmful drinkers and people with mild alcohol dependence provided with evidence-based specialist treatment receiving psychological interventions.

**Recommendation 10:**
Specialist providers to estimate the likely requirements needed to improve access to structured psychosocial interventions.

**Recommendation 11:**
Commissioners to consider likely increase in cost required to meet the NICE guidance and balance against potential savings. As potential savings likely to be seen most demonstrably in the NHS, joint commissioning could be considered as an option for this scenario.

Ensuring appropriate pharmacological interventions are used.

Successful community-based medically assisted alcohol withdrawal is dependent on prior assessment and preparation of the patient and regular monitoring to pre-empt complications and ensure appropriate drug dosages. This report demonstrates that the majority of community-based medically assisted alcohol withdrawal is initiated by the GP without input from specialist services.
Based on GP prescribing data, of the estimated 2,000 episodes of underwent community based medically assisted alcohol withdrawal in the last year, only 55 (3%) of these episodes benefited from specialist provider input in the last year. This means that there is variation in standards of care for such patients across the county. In addition to patient safety concerns that this finding raises, the lack of specialist input for such individuals and the administration of community detoxification regimes without appropriate aftercare could impact upon the clinical effectiveness and success of the treatment.

This report also finds through the patient engagement focus groups, that a number of respondents found it difficult to access specialist services through their GPs, and that there is a lack of aftercare following detoxification programmes conducted by the GP.

**Recommendation 12**
CCGs to raise awareness of alcohol specialist service provision for community based detoxification programmes through the GP newsletter and discussion at the local medical committee.

**Recommendation 13:**
Providers to write to GPs to publicise their services in community detoxification.

**Recommendation 14**
CCGs to consider adoption of standardised clinical protocol for community based detoxification including clear criteria for individuals that are likely to be appropriate and those that may require inpatient detoxification. Should there be an increase in the number of referrals for the assessment, monitoring and aftercare of community detoxification programmes, specialist services will need to be able to manage this increased demand. In the majority of cases, the GP should be expected to remain the lead clinician in charge of the patient’s care, with alcohol services providing specialist input as necessary. This will require liaison between specialist services and the GP, and in some cases a point of contact that the GP can ask for advice on treatment protocols. In complex cases that are still considered suitable for community detoxification, there may be also be small degree of clinical risk involved and specialist services may wish to get more involved with the patients care. At present, this is hampered by the lack of medical staffing at the specialist services. This report notes that there is a business case in development that would see SATS recruit a consultant psychiatrist to provide medical oversight, and to treat complex cases for 2 sessions a week.

**Recommendation 15**
Commissioners to consider the 0.4 wte consultant psychiatrist model presented in this report and determine whether it is able to fulfil considerable cost implications of this.
Pharmacotherapy is most frequently used to facilitate withdrawal from alcohol in dependent drinkers; many fewer individuals receive medication such as acamprosate, disulfiram or naltrexone for relapse prevention. Triangulation of available data suggests that only 5% of eligible patients receive this treatment in Suffolk. It is important to note that these medications are expensive. In order to bring current practice up to 30% of eligible patients (i.e. 93 patients per year on relapse prevention medication), the total cost of the drug plus the additional monitoring equates to additional upfront investment of £33,209. Additional savings could be generated from the reduction in relapse rates, however the model presented in this report notes that only 6 fewer patients would relapse than would otherwise have under the current scenario (equating to an investment of £5,534 for each person who did not relapse).

**Recommendation 16**
Commissioners to consider whether the benefits outweigh the costs of increased prescriptions of anti-relapse medication.