Barriers & Facilitators to Behaviour Change & Access to Treatment & Support Among Adults Experiencing Alcohol Dependence in Greater Manchester

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Substance Use and Associated Behaviours Research Group (SUAB). March 2025

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Executive Summary

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Research purpose

This research, funded by NHS Greater Manchester, aims to identify the barriers and facilitators to positive behaviour change mechanisms that could be useful in reducing alcohol consumption or achieving abstinence and facilitate access to treatment and support among adults experiencing alcohol dependence in Greater Manchester. The findings will support the development of the Greater Manchester Alcohol Harms Strategy.

Methodology

The research involved 75 semi-structured interviews with three participant groups:

1. Adults expeiencing alcohol dependence in treatment (16 participants).

2. Adults experiencing alcohol dependence not in treatment (23 participants).

3. Health and social care professionals (36 participants).

The study addresses six key research questions:

1. What are the barriers and facilitators to positive behaviour change that could be useful in reducing alcohol consumption or achieving abstinence from the perspective of people who use alcohol?

2. What contextual factors influence these barriers and facilitators from a practitioner/stakeholder perspective?

3. How do barriers and facilitators vary according to contextual differences?

4. What are the barriers and facilitators to access and delivery of alcohol treatment/support services from the perspective of people who use alcohol?

5. What are the barriers and facilitators to access and delivery of alcohol treatment/support services from a practitioner/stakeholder perspective?

6. How do contextual factors influence barriers and facilitators to access alcohol treatment/support services?

Key findings

Barriers to Positive Behaviour Change

- **Stigma and shame**: Both self-stigma and perceived social stigma deter individuals from seeking help. Stigma within certain communities, particularly among South Asian and Muslim populations, hinders access to treatment. Cultural norms and fears of community judgment can prevent individuals from seeking help.

- **Societal stereotypes:** There are often preconceived ideas of how people with alcohol dependence present, and this was shown to both delay the recognition of individual problem use and consideration of seeking support.

- **Life experiences:** Factors such as trauma, mental health issues, and socio-economic inequalities exacerbate alcohol dependence and impede access to treatment. For example, individuals with a history of trauma may use alcohol as a coping mechanism, while those with mental health issues may find it difficult to engage with treatment services.

- **Insufficient knowledge of addiction:** Limited knowledge of indicators of problem or dependent alcohol use also delays self-realisation of the need for support. This extends to incidences of alcohol-related health concerns requiring hospital treatment, where there a lack of understanding can result in patients remaining unable to identify the cause of these harms.

Facilitators to Positive Behaviour Change

- **Peer support**: Engagement with mutual aid groups like AA and SMART Recovery provides essential support. These groups offer a sense of community and shared experience, which can be crucial for individuals trying to overcome alcohol dependency.

- **Trauma-informed care**: Adopting trauma-responsive approaches helps address underlying issues contributing to alcohol dependence. This includes creating safe and supportive environments that acknowledge and address the impact of trauma on individuals' lives.

- **Social support networks**: Positive support from family and loved ones can encourage engagement with alcohol support and increase access to treatment offers such as home detoxes. Tailored support offers are required for families and loved ones to minimise impact on their own wellbeing.

Access to and delivery of services - barriers

- **Service availability**: Limited opening hours and inflexible appointment systems create barriers for employed individuals. Many services operate during standard working hours, making it difficult for those with jobs to access support.
- **Integrated services**: The integration of drug and alcohol services has led to a loss of specialist knowledge and focus on alcohol-specific needs. This can result in inadequate support for individuals with alcohol dependence.
- **Professional stigma**: Negative attitudes from healthcare providers can hinder access to support. This includes dismissive or judgmental behaviour from support staff, which can discourage individuals from seeking help.
- **Housing**: Unavailable and inappropriate housing offers for homeless clients with alcohol dependence exacerbates problem use, increases alcohol harms, and prevents effective effort to engage.

Access to and delivery of services - facilitators

- **Lived experience**: Professionals with lived experience of addiction can build trust and encourage engagement. Their personal insights and empathy can make them more relatable and effective in supporting others.
- **Community outreach**: Initiatives like satellite clinics and recovery cafes improve access to support in under-served areas. These community-based services can make it easier for individuals to seek help without the stigma associated with traditional treatment centres.
- **Alcohol-focused health interventions:** The introduction of nurse-led alcohol interventions, such as fibroscans, blood testing, plus A&E-based alcohol workers have improved treatment access and health outcomes for adults with alcohol dependence, including those who would otherwise not access traditional services.

Influence of contextual factors:

- Pub closures and loss of social spaces has increased isolation and lone drinking
- Poorer client outcomes where there is a lack of specialist support for co-occurring needs/dual diagnosis
- Dismissing or minimising alcohol harms arising from binge drinking can demotivate efforts to change and precipitate dependent use
- Insufficient knowledge of addiction and dependence coupled with limited or no continuity of support, increases likelihood of relapse

Influence of contextual factors on barriers:

- Groupwork interlinks with internalised shame for homeless/physically deteriorated clients.
- Zero tolerance housing and subsequent evictions perpetuate repeat episodes of rough sleeping and precipitate increased alcohol harms.
- Challenges supporting clients can be exacerbated where specialist, case-holding dual diagnosis teams do not exist.
- Intensive input by outreach and engagement teams facilitates clients' appointment attendance and engagement, which often ceases once support is withdrawn.
- Where professionals' expertise is devalued, clients' access to wider health services is hindered which can result in inappropriate support offers.
- Telephone-based support offers negatively affect outcomes where clients face additional barriers.
- Incidences of clients presenting for RADAR beds to circumnavigate lengthy inpatient treatment referrals.

Influence of contextual factors on facilitators:

- Efforts to reduce levels of isolation can increase access to home detoxification offers.
- Mainstream services with good understanding of addiction and complex needs improves clients' experiences of engaging with support and likely increases retention rates.
- Services can adopt a unified approach to ensure clients benefit from skills and expertise of staff, irrespective of lived experience.
- Extended opening supports employed clients and provides opportunities to reduce waiting times for referrals.
- PSI (Psychosocial Interventions) was found to have a significant impact on reducing stigma and barriers to treatment engagement.
- Satellite and GP-based alcohol clinics reduce access barriers and extends reach to under-served groups.

Tables identifying key findings

Barriers, facilitators, and contextual factors affecting behaviour change among adults with alcohol dependence

Theme	Barriers	Facilitators
Behaviour change among adults with alcohol dependence	• Co-existing substance use • Fear and shame • Held stereotypes of problem alcohol use • Isolation • Gender • Mental health • ACEs and trauma • Entrenched street-based activities (begging, rough sleeping, street drinking) • Practical and financial constraints • Insufficient addiction knowledge	• Social capital • Supportive/positive family relationships • Employment • Stable housing
Contextual factors affecting behaviour change	• Social acceptance and normalisation of alcohol use • Drinking cultures • Intergenerational problem alcohol use • Social deprivation and cost-of living • Lack of available and appropriate housing options	• Strong communities/social spaces • Community engagement • Knowledge of alcohol support provisions • Strong recovery networks • Effective prison interventions • Recovery and peer support groups • Harm reduction strategies

Barriers, facilitators, and contextual factors affecting support and treatment **access** by adults with alcohol dependence*

Theme	Barriers	Facilitators
Support and treatment access, as proposed by **both cohorts**	**Support access:** • Limited knowledge/recognition of dependence • Individual stereotyping of 'alcoholics' • Shame • Waiting times for inpatient treatment • Integrated substance use treatment model and opioid prioritisation	• Support for loved ones • Professionals with lived experience • Assertive outreach models: bringing healthcare and support to clients, including street engagement • Harm reduction focus
Support and treatment access from the perspective of **practitioners**	• Limited culturally or gender appropriate services • Rejected mental health referrals for dual diagnosis clients • Inflexible and appointment-based systems, stringent rules of engagement • 9-5 opening • High caseload • Treatment waiting times	• Improving diversity/representation among staff • Community outreach and satellite clinics • Gender-informed models • Community treatment staff meeting patients in A&E • Wet housing • Training and knowledge sharing to reduce professional stigma • Trauma-informed service design and support delivery • New tiered housing models – Care Act-led, women-only provisions, wheelchair access • Extended opening
Support and treatment access from the perspective of **adults with alcohol dependence**	• Alcohol-related health harms • Mistrust of the system • Treatment thresholds, lack of consideration of binge drinking harms	• Opportunities for peer support • Accessible mutual aid • Recovery groups

* There is some overlap where barriers and facilitators were reported to affect both access and delivery.

Barriers, facilitators, and contextual factors affecting support and treatment delivery for adults with alcohol dependence*

Theme	Barriers	Facilitators
Support and treatment delivery, as proposed by **both cohorts**	• Unsupported trauma • Professional stigma • Integrated substance use treatment model and opioid prioritisation • Inflexible and appointment-based systems, stringent rules of engagement • Treatment waiting times • Unsupported trauma	• Opportunities for peer support and recovery groups • PSI (Psychosocial Interventions), including RAMP (Reduction and Motivation Programme) • Support for loved ones • Understanding professionals (no apparent stigma) • In-person support (telephone as last resort) • Support for loved ones • Professionals with lived experience • Assertive outreach models: bringing healthcare and support to clients, including street engagement • Harm reduction focus
Support and treatment delivery from the perspective of **practitioners'**	• Lack of staff cultural competence • Limited offers when supporting non-English speakers • Difficulties identifying and accessing assessment for ABI • Lack of available or appropriate housing options • Rejected referrals & zero tolerance accommodation • Treatment naivety • 9-5 opening • High caseload capacity	• Voluntary over coercive treatment • Improved access to substance use training for non-treatment professionals • Nurse-led alcohol interventions and treatment • GP-based alcohol clinics • Wet housing • Training and knowledge sharing to reduce professional stigma • Trauma-informed service design and support delivery • New tiered housing models – Care Act-led, women-only provisions, wheelchair access, • Extended opening
Support and treatment delivery from the perspective of **adults with alcohol dependence**	• Arbitrary rules • Treatment thresholds, lack of consideration of binge drinking harms	• Continuity of care and education of addiction and recovery post-detox.

* There is some overlap where barriers and facilitators were reported to affect both access and delivery.

Summary of recommendations

Improve Access:

Extend service hours and establish satellite clinics to improve accessibility. This includes offering evening and weekend appointments to accommodate those with daytime commitments.

Enhance Pathways:

Develop standardised treatment thresholds and improve continuity of care during transitions from inpatient to community settings. This ensures that individuals receive consistent and ongoing support throughout their recovery journey.

Increase Capacity:

Expand the provision of harm reduction outreach workers and dual diagnosis support. This includes increasing the number of professionals available to support individuals with co-occurring mental health and substance use disorders.

Raise Awareness:

Implement public health campaigns to improve understanding of alcohol harms and available support. These campaigns should target diverse communities and address common misconceptions about alcohol use and dependence.

Develop Specialist Services:

Reintroduce specialist alcohol teams and increase the availability of women-only and high-tolerance housing options. This includes creating safe and supportive environments tailored to the unique needs of different populations.

Main Report

Contents

Part 1: Introduction & Method

This research was funded by the Greater Manchester NHS Integrated Care Board. **The funders commissioned a qualitative social research project with the objective of understanding the barriers and facilitators to positive behaviour change and access to treatment and support (including informal support) among adults in Greater Manchester who use alcohol in a dependent way and who may or may not access treatment or support.**

It aimed to investigate how, why, what and where adults with alcohol dependence engage or do not engage in support services in Greater Manchester. The funders posed the following six key research questions:

1. What are the *barriers and facilitators* to positive behaviour change in relation to alcohol use in adults in GM from the perspective of people experiencing alcohol dependency?
2. What are the *contextual factors*[1] which influence barriers and facilitators to positive behaviour change in relation to alcohol use in adults in GM from a practitioner/stakeholder perspective?
3. What are the *contextual factors* which influence barriers and facilitators to positive behaviour change in adults who use alcohol in a dependent way? How do barriers and facilitators vary according to contextual differences?
4. What are the barriers and facilitators to i) access to and ii) *delivery of alcohol* treatment/support services from the perspective of people experiencing alcohol dependency?
5. What are the barriers and facilitators to i) access to and ii) delivery of alcohol treatment/support services from a practitioner/stakeholder perspective?
6. What are the *contextual factors* which influence barriers and facilitators to access to alcohol treatment/support services in GM? How do barriers and facilitators vary according to the context in which alcohol treatment/support services are delivered?

The objective is to use the research findings to identify:

i) What works and what is not working,

ii) What barriers people face and what helps treatment uptake,

iii) What could be done to reduce problem alcohol use and make pathways to treatment easier, and

iii) Recommendations for improving access to services.

1.1 Context

The impact of alcohol consumption on chronic and acute health outcomes is largely determined by the total volume of alcohol consumed and the pattern of drinking, particularly those patterns which are associated with the frequency of drinking and episodes of heavy drinking. Most alcohol-related harms come from heavy episodic or heavy continuous alcohol consumption (WHO, 2025).

In September 2024, the two-year progress review of 'From harm to hope›, the Government's 10-year drugs plan to cut crime and save lives, acknowledged that there is no dedicated national strategy for alcohol treatment and that local councils must work at a local level to ensure that this group is effectively cared for (Home Office, 2024a). The review also noted that restrictions on how much of the funding can be used to fund alcohol treatment can put resource pressures on councils who need to make provisions locally to fund these services. Overall, the recommendation in the two-year progress review is for the extent of the harm to society posed by alcohol to be recognised at a national level, and more strongly reflected in strategy KPIs.

1. Contextual factors include gender, family history, comorbid psychiatric and substance use disorders, and age all influence a person's risk for alcohol dependency. Individual, social, and environmental and neighbourhood factors interact to affect individual and population health status and outcomes. Individual socioeconomic resources, knowledge, attitudes, and beliefs are factors that influence health behaviours. Social norms, social support, and resources available through a social network constitute social-level influences on individual health behaviour.

The financial cost of alcohol to Greater Manchester is significant. It has previously been estimated that expenditure on alcohol related crime, health, worklessness and social care costs amount to £1.3bn per annum - approaching £500 per resident (see Greater Manchester Drug and Alcohol Strategy, 2019-21).

1.2 Prevalence and unmet need

In 2019/20, there were an estimated 38,032 alcohol dependent people in Greater Manchester (17 per 1,000 population versus a national rate of 14). Greater Manchester locality rates varied from 12 per 1,000 to 23 per 1,000 population, with eight out of ten of our localities above the national average (OHID, 2024). In 2022/23, estimated unmet treatment need for alcohol dependency ranged from 64% to 84%, with two localities above the national rate of 80% (NDTMS, 2024).

1.3 Alcohol-specific deaths

The latest Office for National Statistics figures published in 2024 reported that there was a total of 498 alcohol-specific deaths in Greater Manchester in 2022. This was the highest total since 2001 and represented an increase of nearly a third (from 375) in 2018. These figures include health conditions where each death is a direct consequence of alcohol misuse. They incorporate a wide range of diseases, including alcoholic liver disease, alcohol-induced pancreatitis and excess alcohol blood levels, among other causes of death. Broken down by Greater Manchester borough, the data for 2022 shows the highest number of deaths were in Manchester (82), Wigan (60) and Bolton (53). The lowest number of alcohol-specific deaths was 30 in Trafford (Greater Manchester Combatting Drugs Partnership, Progress Report, 2025).

Alcohol-related mortality refers to deaths where alcohol is the main cause or is a contributing factor to the death. In GM, the alcohol-related mortality rate per 100,000 people increased from 45 in 2018 to 49 in 2022, remaining consistently higher than the national rate (OHID, 2024). Although rates vary across GM local authorities, nine out of ten had higher rates than the national average (Greater Manchester Combatting Drugs Partnership, Progress Report, 2025).

1.4 Treatment

The numbers in treatment for alcohol had declined by 28% from 7,085 in 2009/10 to 5,070 in 2018/19. While it has increased to 6,155 in 2022/23, this figure is 13% lower than 2009/10. However, non-opiates and alcohol numbers in treatment have increased by 81%, from 1,745 in 2009/10 to 3,160 in 2022/23 (Greater Manchester Combatting Drugs Partnership, Progress Report, 2025).

1.5 Treatment need and strategic priorities

Commissioners and providers of alcohol and drugs services need to respond to an increasingly complex need in the populations they serve. This requires services to be competent in identifying and responding to a wide range of health and social care needs and be able to support people to access treatment for co-existing physical and mental health issues, to enable recovery.

The establishment of the GM Drug and Alcohol Transformation Board in 2021 was preceded by an external review which made recommendations on the efficient use of available resources targeted at the highest need cohorts to deliver priority outcomes. Four key cohort measures were subsequently incorporated into the GM Outcomes Framework:

1. The proportion of people in the criminal justice system with an identified substance misuse need that receive appropriate treatment.
2. The proportion of homeless people with an identified substance misuse need that receive appropriate treatment.
3. The proportion of people experiencing worklessness with an identified substance misuse need that receive appropriate treatment.
4. The proportion of children in care due to familial drug and alcohol use.

One of six priorities stated in the Greater Manchester Combatting Drugs Partnership, Progress Report (published in January 2025) is the development of a GM reducing alcohol harm strategy, led by NHS GM ICB with the support of other organisations. The strategy will be evidence based and co-produced with a wide range of stakeholders (Greater Manchester Combatting Drugs Partnership, Progress Report, 2025:17).

1.6 Methodology

To investigate the barriers and facilitators for positive behaviour change and access to services among adults in Greater Manchester with reference to adults' alcohol dependence, we interviewed three distinct sets of participants;

1) people with alcohol dependency who are in treatment already,

2) people with alcohol dependence who are not in treatment, and

3) people who work in health and social care services with adults who have alcohol use problems.

We recruited a total of 76 participants: 36 professionals and 39 people with alcohol dependence (23 not in treatment and 16 in treatment) Data were collected through semi-structured interviews held in-person and online. In a few cases, we arranged small focus groups to accommodate participants' preference and enable contribution. Across all interview cohorts, each of the ten GM boroughs were represented as follows:

GM area	Number of interview participants	GM area	Number of interview participants
Bolton	13	Salford	7
Bury	4	Stockport	9
Manchester	16	Tameside	6
Oldham	10	Trafford	3
Rochdale	8	Wigan	6

Total = 82*

*Some professionals worked across multiple areas resulting in the figure for borough representation being higher than the number of conducted interviews.

The 16 semi-structured interviews with in-treatment adults with alcohol dependence attempted to ensure that they were representative of known key factors in alcohol harmful use to gather narrative accounts of existing service provision and experiences of treatment and support services. These were mainly accessed through treatment services.

The 23 adults with dependent or harmful alcohol use but not currently engaging in treatment were accessed through outreach and in-reach services such as homeless day centres, temporary accommodation providers, mutual aid, drug and alcohol recovery networks, voluntary sector services and acute services.

The interviews with treatment professionals and other representative services were conducted across the 10 Greater Manchester local authority areas. Treatment staff encompassed adult treatment service managers, team leaders, recovery workers, harm reduction workers, criminal justice workers, alcohol nurses, and mental health professionals. Non-treatment professionals included assertive outreach workers and managers, homeless outreach, housing support staff, and voluntary sector support services.

Combined, these three groups of participants have enabled us to identify key themes related to dependent alcohol use and the barriers and facilitators to accessing services in GM. These are detailed in sections two and three of this report.

1.7 Analysis

Interviews were digitally recorded, transcribed, and categorised thematically. Narrative analysis was carried out to document examples of good practice, what our interviewees reported works in practice and what modifiable barriers and facilitators they reported that can inform changes in local commissioning, service development, policy and practice.

1.8 Literature review

The literature review consisted of two distinct stages. Firstly, we conducted a contextual and policy analysis. This process involved reviewing local and national drug and alcohol policies and statistics (e.g., alcohol treatment, health, death, and prevalence data) and gathering and examining relevant Greater Manchester and national alcohol data, drug and alcohol strategies, policies, and guidance to understand the broader context in which this research is situated. This initial contextual analysis provided a comprehensive understanding of the factors influencing the issue at both local and national levels.

Secondly, a post-hoc narrative literature review was conducted, grounded in key themes that emerged from the qualitative data analysis. The review of international literature was used to further contextualise and interpret the findings. This enabled the research findings to be compared to previous studies, identify consistency or variation in findings, and provide a deeper understanding and interpretation of the results.

Part 2: Findings:
Context, demographics, and subpopulations

2.1 COVID-19

As Davey (2021) notes, the COVID-19 pandemic and resulting UK lockdown restrictions impacted drinking behaviours for both men and women. An online cross-sectional survey of 2,777 self-selected UK adults found that 30% of participants reported drinking more frequently in lockdown, 16% reported drinking more units per drinking occasion and 14% reported more frequent heavy episodic drinking (Oldham et al., 2021). Other studies estimated that approximately a quarter drank more (Jackson et al 2021), with young adults (Jacobs et al 2021) and in particular, young women's drinking was identified to be disproportionately exacerbated (Garnett et al 2021).

In keeping with these national findings, professionals in the annual Greater Manchester Trends survey reported that there had been a significant rise in alcohol referrals to services. These were often reported to be self-referrals from people new to treatment services – particularly young people and women (GMTRENDS, 2022).

There was a noted correlation between the social impacts of lockdown and increased alcohol use and subsequent harms:

> "[COVID had a] *major impact in relation to isolation... and more hospital admissions related to alcohol*" (Service Manager, Assertive Outreach, multiple GM areas)

Professionals working in alcohol services recalled that an increase to disposable income and atypical working patterns precipitated changes to drinking behaviours and a subsequent rise of referrals into treatment:

> *"People had a bit more money... some got into bad habits regarding drinking and have not really got out of it." (Recovery Co-ordinator, Tameside)*

> *"People drank at weekends, went to work on Mondays, didn't drink all week, and it wasn't an issue; or that was the case prior to COVID. Then [they started] working at home, being furloughed; we had a lot of people who were alcohol-specific who had started to drink more during the week because they had nothing to do and weren't going to work regularly: we had an influx of referrals from that point." (Criminal Justice Team Leader, Oldham)*

Of the alcohol clients entering treatment during this period, many had professional careers, and their lives were otherwise relatively stable. For some, it was only upon returning to work that their dependence on alcohol became apparent:

> *"I remember doing assessments during COVID; a lot of people that were referred in were alcohol-specific professionals that had never envisaged that they had an alcohol issue or would seek treatment." (Criminal Justice Team Leader, Oldham)*

> *"I was on furlough but went back to work afterwards, still functioning, but my intake was getting more. Then the last six months, I was in work rattling, withdrawing, I didn't want to accept that; I didn't know what it was at first." (Male participant, focus group 1, Bolton)*

While numbers of new referrals into treatment have mostly plateaued, it was suggested that there remains a small intake of new clients whose problem alcohol use can be traced back to the pandemic:

> *"There is an effect from COVID... we're seeing some late presentations, or that people are being referred through very late. They increased their alcohol use over COVID, and it is perhaps just catching up with them at this point." (Consultant Addiction Psychologist, multiple GM areas)*

> *"There are more people coming in with alcohol problems now; I think it's changed a lot more since COVID. A lot had to stay at home and a lot did turn to drinking." (Mental Health Support Worker, Wigan)*

The Greater Manchester NDTMS data supports these professional narratives. For example, in 2019/2020, there were a total of 5,160 alcohol only adults in treatment. This rose to 5,885 in 2021/2022 (NDTMS, 2024). While the number of people in treatment for alcohol only continues to rise, totalling 6,870 in 2023/2024. Indeed, it was noted that:

"There are more [new] presentations at services for problem alcohol use than for concerns over opioids." (Harm Reduction Lead, Oldham and Rochdale)

Despite the recorded rise of new entries into treatment, there exists a cohort of individuals with pandemic-linked problem alcohol use who remain absent from recorded figures. Post-COVID, a coroner noted that women in their 30s and 40s were dying of alcohol-related diseases, many of whom had not been known to treatment services and had only infrequently accessed their GPs prior to their deaths.

"One of the things that our local coroner has picked up and that we're working around, is that there are a lot of women who are never presenting to treatment services, who are dying in their 30s and 40s of alcohol-related liver disease, and they're never hitting treatment services." (Consultant Addiction Psychologist, multiple GM areas)

Considering the impact of COVID on alcohol use, it is important to note that the most recent Greater Manchester Drug and Alcohol Strategy (2019-2021) was developed before COVID. It also preceded the Government's 10-year drug strategy 'From Harm to Hope' (Gov.uk, 2021).

2.2 Alcohol profile

Professionals working in support and treatment services reported that their caseloads largely comprise of two distinct alcohol cohorts, each with distinguishable risks: older clients (40+), with long-term alcohol dependence, and younger clients who report poly-drug and alcohol use, characterised by patterns of binge drinking:

"We are seeing a lot of younger users who are poly substance users, where alcohol is part of the picture. It might be more binge pattern use rather than dependent use. And they've often got a variety of health and social care needs, complex mental health presentations and so on. And then there is a cohort of people who are probably in their 40s and 50s, who have had long-term alcohol issues, and are coming into treatment late on." (Consultant Addiction Psychologist, multiple GM areas)

"With alcohol dependent [clients], it's starting to affect their health, they're not able to function properly, and they have to drink from the minute wake up to alleviate their withdrawals... the young ones still don't see [alcohol] as an issue; they might be your typical binge drinkers who could be on probation for an offense at a weekend when they've had a few too many." (Criminal Justice Team Leader, Oldham)

2.2.1 Co-existing drug use

Where co-occurring substance use is reported, this includes several substances including crack and powdered cocaine, heroin/opioids and cannabis. Methamphetamine use was raised by professionals working in Salford and Manchester, although this remains confined to the chemsex scene: a professional in Stockport surmised that individuals from this group travel into Manchester to access and engage with sexual health and harm reduction services. A criminal justice treatment worker in Oldham reported a recent increase in concurrent alcohol and ketamine use and suggested that this rise relates to its low-cost relative to cocaine and the increasing ease in which it can be obtained.

2.2.2 Alcohol and cocaine

While alcohol is used alongside many other substances, including nicotine products and cannabis, particular concern was raised by professionals in relation to the concurrent use of alcohol and cocaine:

"You'll get people who've come in because they're using cocaine or other substances, and then after a session or two, you'll figure out [that] they're only using that after they've gone out drinking... it's even more dangerous, but alcohol; that's the brute of the issue." (Criminal Justice Recovery Co-ordinator, Tameside)

In particular, the normality and lack of awareness of risks associated with this combination amongst young adults was observed:

"Young adults don't really see [drug and alcohol use] as an issue right now... They can't imagine taking cocaine, 'dry sniffing' they call it, they can't imagine doing that without a drink." (Harm Reduction Outreach Worker, Tameside)

The combination of cocaine and alcohol has been reported to increase the pleasurable-related subjective effects (euphoria, well-being) compared with the effects of cocaine alone (Pergolizzi et al. 2022).

In addition, it was frequently noted that cocaine was reported to be used to 'level out' when intoxicated, which prolongs drinking sessions, and the amounts of alcohol consumed.

> *"Drinkers can drink for longer once under the influence of cocaine, due to the fact that cocaine being a stimulant and alcohol being a suppressant, using both drugs together will level the person out which in turn prevents feeling drunk. [. . .] what's known has a 'straightener' to keep the night going, allowing people to drink more alcohol and lessen the comedown from cocaine. However, because of the high intake of alcohol without getting that drunk feeling can then cause alcohol poisoning." (Recovery Coordinator, Tameside)*

Cocaethylene has a longer half-life than cocaine, resulting in a longer lasting, as well as more intense, psychoactive effect (Pergolizzi et al. 2022). Prompting Farré et al. (1997) to hypothesis that the increased euphoria may explain why this drug combination is more likely to be 'abused' than cocaine or alcohol alone.

> *"Once both substances are used together and the feelings produced by both, it then becomes so difficult to use one without the other, for obvious reasons." (Recovery Coordinator, Tameside)*

McCance-Katz et al. (1998) conclude that the enhanced psychological effects associated with concurrent use of cocaine and alcohol may encourage the use of larger amounts of these substances, placing users at heightened risk for greater toxicity than with either drug alone.

> *"Cocaethylene is also a toxic substance which can cause physical and mental health problems, however for the user, the risk of these problems happening is irrelevant due to the power and euphoria of the high." (Recovery Coordinator, Tameside)*

As noted above, when cocaine is mixed with alcohol (ethanol) it produces a psychoactive metabolite called cocaethylene which may be more cardiotoxic. It may also exacerbate cocaine induced cardiovascular disorders (Pergolizzi et al. 2022). In a clinical trial reported by Farre et al (1997), the effects of 100 mg of intranasal cocaine in acute alcohol intoxication (0.8 g/kg) were evaluated in eight experienced and nondependent healthy volunteers. They reported that the combination of alcohol and cocaine produced greater increases in heart rate, heart rate-pressure compared with the effects of cocaine. Cardiovascular changes induced by the combination caused an increase in myocardial oxygen consumption that they state, may be related to an increased risk of cardiovascular toxicity. However, a review of the literature on the effects of concurrent use of alcohol and cocaine by Pennings et al. (2002) highlighted some challenges as to whether cocaethylene is responsible for the increased heart rate, and presumed increased cardiotoxicity, arising from the alcohol/cocaine combinations.

However, several professionals reported challenges when supporting dual cocaine and alcohol clients, including identifying how the use of the two substances interrelate, risks associated with concurrent use, and measures to reduce harm:

> *"Some present with cocaine as the problem substance, but they only use when drinking. They struggle to accept that alcohol is an issue." (Family Worker, Drug and Alcohol Service, Tameside)*

> *"There is little awareness of cocaethylene among patients who use alcohol and cocaine." (Co-occurring Needs Worker, Wigan)*

> *"When we talk to [alcohol and cocaine clients] about harm reduction, they think straight away of heroin and crack users. They don't think about the problems that they might encounter." (Criminal Justice Recovery Co-ordinator, Tameside)*

In addition to the health harms to the individual, there is a common narrative that cocaine and alcohol fuels violence in a range of setting, including football hooliganism, violence and public disorder in the night-time economy and domestic violence. However, a 2023 systematic review by van Amsterdam and van den Brink on the combined use of cocaine and alcohol found no evidence of increased violence.

2.3 Religion and ethnicity

Professionals working for support and treatment providers reported that in-service client demographics are mostly white British, even in areas that are ethnically diverse:

> *"White, British, middle-aged men are more likely to come to us." (Assertive Outreach Team leader, Bolton)*

"We do get a mix, but it's predominately white British." (Criminal Justice Team Leader, Oldham)

"The majority of my caseload are white British; [it reflects local demographics] really poorly because we're quite a diverse area." (Young Adult Worker, Drug and Alcohol Service, Tameside)

The latest available NDTMS data reporting on 2023/2024 adult treatment figures supports these professional narratives. Ninety-two percent of Greater Manchester's alcohol only population were 'white' compared to a national average of 88%. For alcohol only and alcohol and non-opiates combined, this was 91% (national average 88%). This combined alcohol figure ranged from 83% for Manchester to 98% for Wigan (NDTMS, 2025).

2.3.1 Alcohol, ethnicity, and treatment access

In a recently published paper on the 'barriers and facilitators to alcohol support for South Asian communities', Jennings et al (2025) note that despite displaying pronounced alcohol-related physical and psychological harms, South Asian groups are critically underrepresented in alcohol treatment and research. This study highlighted unique barriers for diverse South Asian groups seeking support for alcohol misuse, with clear implications for culturally competent policy and practice in the UK context. Barriers such as short funding cycles, historical discrimination, 'one size fits all' approaches and training gaps on sensitive communication strategies pose challenges.

Professionals stated that a factor affecting access and engagement with alcohol services by individuals from minoritised ethnic backgrounds, specifically Black and South Asian populations, relates to apprehension that problem alcohol use will be discovered by others from within their communities:

"Some are reluctant and scared, [they think], 'I don't know what to expect, I might bump into someone that I know, and who doesn't know that I've got an issue'. I think it's just about being guarded about things." (Criminal Justice Team Leader, Oldham)

"People [from these communities] aren't confident in confidentiality." (Assertive Outreach Team Leader, Bolton)

Concerns about such exposure can subsequently result in individuals avoiding engagement with substance use and treatment services until they can no longer manage their alcohol use or the associated impacts alone:

"Some will try and go on to the bitter end, saying that it's not a problem or by dealing with it themselves... They might not come to us because those communities might try and deal with it in-house." (Assertive Outreach Team Leader, Bolton)

"Certain communities tend to not want to let people know and so they try and hold out until enough is enough." (Harm Reduction Lead, Oldham and Rochdale)

Professionals theorised that feelings of shame and difficulties seeking support may primarily arise from the fact that alcohol is the substance most unaccepted within some Muslim communities, as opposed to other issues related to addiction or dependent use:

"With a heroin problem, if you're Muslim, it's fine to come to [named substance use service], but if you've got a drink problem, you don't go. It's kind of weird, it's almost as if the social acceptability of [alcohol] makes it less acceptable to present." (Recovery Co-ordinator, Bury)

"The issue for Muslim clients [is that] drugs are perceived as bad by their community, but not as bad as alcohol. This leads to increased fear, stigma and isolation." (Family Support Worker, Tameside)

2.3.2 Alcohol and Islam

As alcohol is prohibited in Islam, shame and stigma relating to problem alcohol use were identified as a primary concern and source of the additional barriers faced by Muslims when considering accessing alcohol treatment and support:

"I think [Muslims with alcohol dependency] feel a lot of shame about it, because it is not accepted within their culture." (Recovery Engagement Worker, Bolton)

"There are bigger barriers, yeah... A colleague of mine... has made some inroads with the Muslim community [by] going

to various meetings just to dispel the myths. Unfortunately, alcoholism doesn't discriminate, does it?" (Assertive Outreach Worker, multiple GM areas)

"It's quite hard to get somebody to listen to what I have to say because there's still a lot of stigma in their cultures around drugs and alcohol." (Harm Reduction Outreach Worker, Tameside)

Noting the impacts of stigma, a professional working with young adults in Tameside described the challenges both she and a Muslim client faced during the provision of alcohol support, not limited to secrecy, diminished engagement opportunities, isolation, and inaccessible peer support:

"I've just worked with a young person who was Muslim and that was really challenging. We were speaking on Teams because he couldn't share with his family and [his contact with the service] had to remain confidential from absolutely everybody. That was really challenging because he didn't have any support, and everything I would normally encourage him to do, he couldn't do because he didn't feel that he could share [his problem alcohol use]. He has just disengaged because [his family] found out, so, yeah, I think there is a lot of stigma attached to it." (Family Worker, Drug and Alcohol Service, Tameside)

2.3.3 Overcoming barriers and improving access for diverse ethnic and religious groups

While there was recognition of previous efforts to reduce barriers and improve access for diverse ethnic and religious groups, it was acknowledged that progress to date has failed to sufficiently improve routes into treatment and support, with further efforts and adapted practice required so to reach individuals with problem alcohol use from within these communities:

"There is a lack of culturally appropriate services for people." (Consultant Addiction Psychologist, Oldham and Rochdale)

"We need to put word out that [alcohol support] is available in these areas." (Advanced Recovery Practitioner, Alcohol Team, Oldham)

The barriers faced by minoritised ethnic groups and Muslim communities were recognised as evident and pervasive, yet there is evidence of emerging change: In a notable shift in the demographics of presenting new alcohol clients, a professional working in an area with a large South Asian population recalled that two young Muslim females have entered treatment in the previous six months. However, it was noted that both women experienced delayed access to the service, only presenting following A&E presentations for serious alcohol-related health consequences:

"With the two [South Asian] ladies, I think, had they not gone to hospital, they might not have come to light to us." (Assertive Outreach Team Leader, Bolton)

2.3.4 Language barriers

A further barrier to engagement related to working with non-English speaking problem alcohol users. It was noted that this group struggle to access alcohol support. One reported example centred on a treatment provider contacting a client by phone without an interpreter, leaving him unable to understand their message. It was said that this team was "unwilling to provide" language assistance, thus creating further barriers for this client:

"The support in place for those people is just not adequate." (Rough Sleepers' Supported Tenancy Officer, Salford)

It was also observed that there is limited community-based peer support for non-English speakers. For example, one professional working in frontline services in Salford noted that a non-English speaking client found that he was required to travel into Manchester to access and benefit from mutual aid: in this case a Polish language AA meeting.

2.3.5 Identified need for improved and pro-active engagement

While professionals identified that enduring barriers affect both access to support and treatment delivery for individuals from diverse ethnic and cultural backgrounds, it was recognised that previous efforts to improve engagement among these groups have yet to result in significant change:

> *"I think a lot of services have tried a number of different approaches, but I'm not sure that any of them have been 100% successful." (Consultant Addiction Psychologist, Oldham and Rochdale)*

When discussing how drug and alcohol services can continue to further reduce barriers, other than the recruitment of substance use workers from underrepresented groups, there were few novel ideas or proposals:

> *"A drug and alcohol worker from that culture might pull down some barriers... Would it actually be better if we've got somebody from that culture to go into their community centres [to meet hard-to-reach groups]?" (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

> *"I think if we could employ somebody from that community, that would be ideal; they would have a lot more of an understanding." (Recovery Engagement Worker, Bolton)*

However, professionals were able to describe recently implemented strategies, including targeted outreach and engagement, which although currently in the initial stages, have been designed to proactively connect with under-reached communities.

2.3.6 Examples of current efforts to engage under-reached communities

A new pop-up alcohol clinic based within a GP surgery that serves a large South Asian and Muslim population has recently been established. Practice staff believe that directing patients into the onsite clinic without explicitly stating that it is run by the substance use team will be of benefit. It is hoped that these alcohol clinics will help to increase engagement and move towards overcoming the stigma and access barriers faced by this community.

> *"We've been out to a couple of GP surgeries, one of which serves primarily a South Asian and Muslim population. And [the practice said], if they didn't have to say it was Turning Point but just someone who can have a chat [with patients] about their alcohol use, then it would be much easier to engage people [in the surgery] as there's still a lot of associated stigma." (Consultant Addiction Psychologist, multiple GM areas)*

A substance use team in Tameside described how, despite slow and steady progress, they continue to make efforts to address community anxieties and reservations by visiting, engaging, and building relationships at events hosted by the Bangladesh Welfare Association:

> *"I think some ethnic minorities we struggle to engage, but we have been going to Bangladesh Welfare, doing social events and working closely with them. They are becoming more open and are interested in us doing a workshop and offer a drop-in with our concerned others worker, so we are building those links, but it's just taking time." (Family Worker, Drug and Alcohol Service, Tameside)*

Galvani et al. (2023) have produced useful policy and practice guidance focused on supporting South Asian women with problematic substance use (see also Fox and Galvani, 2024). Their dedicated website (see appendix 2) includes a model of support for best practice, that meets the needs of South Asian women developed around the four 'S's – Setting, Structure, Skills and knowledge, and Staffing. This model is South Asian woman-centric and reflects the cultural sensitives required to enable South Asian women to access services more readily. It also incorporates a process map that offers a pathway to developing new service provision for South Asian women seeking alcohol and other drug support.

2.4 Alcohol use in affluent populations

> *"We get your business owners through to brain surgeons; it doesn't discriminate, alcohol!" (Team Manager, Drug & Alcohol Team, Stockport)*

Treatment professionals discussed an increase in affluent, middle-class, individuals presenting to treatment services with alcohol concerns. This change was particularly observed in the Stockport, Bury, and Trafford areas where it was noted that those presenting to services often have social capital, notably, stable employment, housing, and supportive families. This cohort may attribute different causal factors to dependent alcohol use than traditional treatment clients, with self-reported reasons frequently relating to stress, boredom, and isolation:

> *"It's a very different demographic to what I was used to. A lot of people that have kind got social capital, they've got jobs, they've got nice*

homes, they've got families... [they think], 'it couldn't possibly happen to me'... They have a mixed bag in terms of the actual reasons [for dependent alcohol use], but blokes usually say, 'stress', and women say, 'I've nothing else to do.'" (Team Leader, Assertive Outreach, multiple GM areas)

Societal factors which affect the levels and patterns of alcohol consumption and related problems include cultural and social norms (WHO, 2025), and an identifiable challenge noted by professionals when supporting this demographic pertains to the perceived social acceptability of comparable drinking behaviours between different groups. In some cases, middle-class alcohol users were reported to employ stereotypes of dependent alcohol use among members of the street community as a benchmark from which to assess the risks and impacts of their own alcohol use:

"There are a lot of barriers; they say, 'well I'm not as bad as him, he's on the streets, and I'm [drinking alcohol] at home." (Harm Reduction Lead, multiple GM areas)

Higher levels of social capital and readily available financial resources were recognised to be evident protective factors against widespread alcohol impacts, yet these do not mitigate the risks for this group entirely:

"Middle age, middle class functioning drinkers, when you look at what's happening to their physical health, it's probably quite significant... [they] still get into trouble, they're probably more able to buy [entry into private alcohol treatment], and their lifestyle means that a lot of their other health factors are going to be protective... Money does insulate people, but it doesn't inoculate them." (Addictions Lead, Stockport)

2.4.1 Self-identification of alcohol dependence and health impacts

Affluent individuals and those with relative stability are mostly affected by physical health harms, such as alcohol-related liver disease (ARLD), but despite the notable impacts, it was reported that this cohort do not always identify their alcohol use as problematic or harmful:

"We've been to a grand mansion of a well-to-do couple who are drinking three bottles of wine a night and see no problem with it, but they've ended up in hospital because their livers' are not in a great way." (Service Manager, Assertive Outreach, multiple GM areas)

"The dinner party set': they don't come to us, but people who have got alcohol use, powdered cocaine use, and they can afford it, so they're not getting into trouble in the traditional ways, but they're still having heart attacks at 55." (Addictions Lead, Stockport)

For middle-class and affluent populations, fixed ideas of what constitutes acceptable and problem alcohol use can be an impediment to the identification of harm, subsequently delaying access to support and treatment services. Representatives from this group with experience of alcohol dependence described the moments they understood that addiction and alcohol impacts can affect all, irrespective of background:

"I wasn't how I saw typical alcoholics... I saw alcoholics walking around the street with a paper bag and a can, falling about, homeless. Then I started getting the shakes, you see, and I'm thinking, what's going on?" (Female participant, focus group 1, Bolton)

"I knew a lot of addicts and alcoholics [when I worked] in prisons, but that was their way of life, growing up from teenagers into taking drugs and the women into prostitution, all kinds of horrible lifestyles. But when I woke up in [named private detox facility], I was surrounded by professional people, and I began to realise that this can happen to any of us." (72-year-old male, Rochdale, in treatment)

2.5 Gender

Smith and Foxcroft's (2009) exploration of alcohol trends in the UK highlighted a substantial rise in women's drinking as a significant driver of the trend in increased alcohol use. An Australian study highlighted the increase in alcohol dependency amongst middle-aged women (see Miller et al. 2022). They suggest that this increase can be explained by the fact that alcohol use by women is more socially acceptable and normalised than in previous generations, where it was moralised and stigmatised. They note that increased participation in the workforce has led to more financial and social freedoms has led to less stigma and more opportunities for women to consume alcohol.

Women were said to experience unique barriers when accessing alcohol treatment and are under-represented relative to the levels of need. This was linked to females still unidentified since the COVID-19 pandemic, and the structural barriers created when the provisions offered by drug and alcohol treatment services focus heavily on opioid treatments and criminal justice:

> *"Women who became quite isolated since the pandemic because they were at home, and they'd just sit inside and curtain twitch and drink far too much; I don't think they are coming forward to services." (Recovery Co-ordinator, Bury)*

> *"I'm particularly worried about women [not entering the service], and [funding] being centred around heroin and criminal justice." (Addictions Lead, Stockport)*

Studies have consistently found that women are far less likely to seek help for problematic drinking from traditional, evidence-based treatment programs (Staddon, 2015). Davey (2021) notes that this includes 12-step approaches such as Alcoholics Anonymous (Kaskutas, 1994), CBT models such as SMART recovery (Hester et al., 2013), and those based on Recovery Capital (Bogg and Bogg, 2015). Interventions originally designed for men are not always helpful and can fail to meet women's needs, thus limiting options to available and accessible support:

> *"A lot of the fellowships are tailored towards men, and based upon how a man's brain works. and male recovery. So, when that doesn't work for a woman, she can feel like she's failed. I've seen that a lot; they just can't adapt to that environment that works for men." (Harm Reduction Outreach Worker, Tameside)*

The under-representation of women within traditional treatment programs suggests that there is a failure to recognise women's gendered experiences of alcohol and specific needs in recovery (Burman,1994; Dovey, 2021). As Dovey (2021) observes, there are a several reasons for this lack of engagement. Women may find it harder to attend treatment outside of the home, particularly residential programs, due to family and work commitments (Staddon, 2015), and experience disproportionate shame when they do access treatment due to their perceived failure to live up to society's expectations of womanhood (Staddon, 2015; Gilbert et al. 2019). The latest available NDTMS data for Greater Manchester (2023/2024) shows the ratio of men to women in service for 'alcohol only' to be three-fifths men to two-fifths women. Overall GM percentages are 60% men, 40% women, ranging from a high of 41% women in Bolton and Tameside to a low of 35% in Bury, Oldham and Salford. For 'alcohol and non-opiates', this drops to 26% (NDTMS, 2024).

2.5.1 Improving access for women

Professionals recognised that current spaces within support and treatment services are not meeting the needs of certain women and identified how service offers can be adapted to create safer spaces and encourage female access and engagement:

> *"I think [we need] a safe space for women, especially vulnerable women. I work with a lot of sex workers who drink quite a bit, [we need] a safe space for them where there's no judgement. There isn't that at the minute, which is a real shame." (Harm Reduction Outreach Worker, Tameside)*

> *"We're hoping this 'Welcome to CGL group' will encourage [group attendance] a little bit more and get more women involved." (Recovery Co-ordinator, Tameside)*

In a review of 30 years of literature, Greenfield et al. (2007) examine the characteristics associated with treatment outcomes in women with alcohol dependency and other substance use disorders. They reported that a consistent body of evidence suggests that women are less likely, over the lifetime, to enter treatment compared to men. However, once in treatment, gender is not a significant predictor of treatment retention, completion, or outcomes.

2.5.2 Pregnancy and motherhood

While only one participant discussed issues connecting alcohol dependence and pregnancy and motherhood, she offered a detailed account of the barriers she faced:

Box 1: A vignette: Pregnancy, motherhood, and alcohol dependence, and barriers to accessing to support

A 40-year-old female in Rochdale outlined her journey through pregnancy and early motherhood while struggling with dependent alcohol use. Although now accessing treatment, she was not engaged with alcohol support during this period. She firstly described efforts to reduce her use of alcohol during pregnancy:

> *"Before I found out I was pregnant, I was heavily drinking, so when I found out, I was paranoid, thinking 'oh mygod, I'm going to harm this unborn child'. But by this point, my obsession and my physical dependency was as such that throughout the rest of the pregnancy, although it was massively reduced, I was having to have little bits to stop any shakes and stuff. " (40-year-old female, Rochdale, in treatment)*

And after ceasing alcohol while breastfeeding, she explained that without knowledge and understanding of addiction and dependency, it was only upon relapse and losing custody of her child, did she fully realise that alcohol had become a problem for her:

> *"l did manage [to stop drinking] for nine-months because I was breastfeeding him, but then I thought, 'well, ifI can do this, I dont have that much of a problem... I got a bottle of wine after work, and it just progressed. When my son was six, it had become that much a problem that I lost custody of him, and I spiralled even more out of control... This is when I realised that this isn't just heavy drinking; I've really got a problem. " (40-year-old female, Rochdale, in treatment)*

Asked if there were other factors that prevented her from seeking earlier support, she described how strong feelings of guilt and shame, and awareness of stigma directed towards single mothers with alcohol dependence compounded existing fears of punitive interventions by children and families' social services:

> *"l thought, I have a beautiful child here, why cant I just stop... I didnt really speak to anybody at that point; I felt like I couldn't because I was a new mum, and then I was a single mum, and then I felt like, if I reach out for help, social services are going to take [my son] off me. So, I didn 't say anything for a long time." (40-year-old female, Rochdale, in treatment)*

When asked what support would have been helpful when she was struggling with alcohol dependency and caring for her child, she suggested a package, which may have included a temporary placement for her child while she was supported to address her alcohol use, alongside support groups for struggling mums in addiction. She also stressed the need for women to be able to access support without an immediate punitive response from social services:

> *"Oh, I needed help. And in hindsight, if that meant not being with my son for a short period of time [hesitates], I will never have been cured, but I might have found a solution a lot quicker, and it wouldn't have been as devastating as it is now... [Social Services] have a duty of care towards the child, but if there were more groups for struggling mums and services could be available without straightaway being slapped by social services and them getting heavily involved, that would have helped me connect with people and made it easier to ask for help... It's really beneficial getting connected with people, and for young mothers in addiction, [there should be] groups that they can attend and bring their child. " (40-yearold female, Rochdale, in treatment)*

She went on to note gender disparities in how parents with alcohol dependence can engage with alcohol support and treatment:

> *"It seems easy for fathers and men, because as you know, they can engage in these services and social services are not that likely to get involved. It's a sexist thing, but it seems to be the way that it goes." (40 year-old female, Rochdale, in treatment)*

Part 3: Findings:
Contextual factors affecting alcohol dependence in adults

3.1 Employment and workplace drinking cultures

Factors relating to employment and its relationship with problem drinking were raised frequently by both professionals and adults with alcohol dependence, including the prevalence of workplace drinking cultures.

Many interview participants referred to afterwork drinking sessions with colleagues as a precursor to escalated and dependent alcohol use, with some observing how the initial social elements of workplace drinking cultures contrasted with frequent lone drinking that transpired upon developing alcohol dependence:

> *"There's a big drinking culture during downtime [in the military]. Unfortunately, when their service ends, not everybody can just stop... They've become a little bit dependent, and then it gets worse because they've lost their mates and camaraderie, and they're drinking on their own." (Veterans' Tenancy Support Worker, Salford)*

> *"When you're working away, there's only one thing to do afterwards: go for a few pints. But then I'd carry on with a couple of bottles of wine, on my own, in my hotel room." (54-year-old male, Oldham, in treatment)*

Roles specifically associated with drinking cultures included, engineering, construction, accountancy, and sales industries, and interview participants described how episodes of heavy or regular drinking sessions became *"normalised"* within these environments, often delaying both their identification of alcohol harms and their recognition of a need to seek and access alcohol support:

> *"Jobs which have a culture of drinking can normalise alcohol and prevent people from identifying it as an issue." (Recovery Engagement Worker, Bolton)*

> *"The drinking culture there made it normalised, so it was hard when you want to change." (40-year-old male, Trafford, not in treatment)*

While some employers draw upon afterwork drinking to encourage and sustain positive coworker relationships, it was reported that the existence of a normalised and embedded drinking culture can also restrict understanding of problem drinking behaviours and subsequently deter employees from disclosing any concerns regarding changes to their own patterns of use:

> *"No, I didn't tell them. When you're working on building sites, [alcohol] is a big thing... I don't think mental health or drink [problems are] talked about, because there is a big stigma." (54-year-old male, Oldham, in treatment)*

3.1.1 Dependent alcohol use and periods of sustained 'functioning'

Both interview cohorts observed that drinking patterns can be shaped around the routine and responsibilities associated with structured work, and that unemployment can exacerbate problem alcohol use by allowing for longer "permitted drinking hours". However, participants most frequently referred to "functioning" and having upheld other responsibilities during long periods of dependent drinking, before becoming overwhelmed by alcohol impacts and harms:

> *"You've got a load of relatively functioning younger blokes going to the football, which is an alcohol-based undertaking, probably with families; a proportion of them are going to have an alcohol problem." (Addictions Lead, Stockport)*

> *"We're seeing a lot more professionals coming in with dependency issues as well... they didn't see [their alcohol use] as an issue, and then it did become an issue." (Harm Reduction Outreach Worker, Tameside)*

These periods were characterised by sustained stable employment, secure housing, and contact with supportive families alongside unremitting patterns of dependent alcohol use: Most notable was the consistency in which adults with alcohol dependence who self-identified as 'functioning' experienced a belated recognition of personal alcohol impacts and harms and a subsequent delayed treatment entry:

"I was functioning for years and years and years; I thought everything was fine, that I didn't need help, and that everybody [used alcohol like me]." (Male participant, focus group 1, Bolton)

"Because of the job I had I had to get up at half-past-four in the morning; I saw myself as a functioning alcoholic." (72-year-old male, Rochdale, in treatment).

"I go out, I earn my money, so my [alcohol dependence] is not a problem." (44-year-old male, Wigan, not in treatment

3.2 Socioeconomic and cultural inequalities

Socioeconomic inequalities in alcohol-attributable mortality have been documented in several, mainly high-income, countries. A meta-analysis published in 2015 found that individuals with low socioeconomic status have a two-fold to five-fold higher risk of dying from an alcohol-attributable cause of death than individuals with high socioeconomic status (Probst et al., 2020); a trend commonly referred to as the alcohol-harm paradox. One explanation for the paradox is that other behavioural risk factors (such as obesity and smoking) cluster in individuals with low SES and interact with alcohol use, resulting in exacerbated health consequences of alcohol use. Differences in access to health services, variations in the safety of the drinking context, and differential drinking cultures are additional potential factors contributing to the elevated risks related to alcohol use for individuals with low SES.

3.2.1 Social deprivation

Professionals identified multi-faceted adversities and disadvantages, including high rates of social deprivation, the cost-of-living crisis, and the prevalence of ACEs, as factors significantly impacting their clients with alcohol dependence and affecting dependent drinking patterns:

"Cost of living is a big issue, obviously." (Criminal Justice Team Leader, Oldham)

"Even the very basics in life: people can't afford to eat properly or heat their homes properly... This amount of poverty pushes people towards self-destructive patterns of behaviour; it's a much wider issue." (Dual Diagnosis Nurse, Rochdale)

"Work [is required] around social deprivation, adverse childhood experience, all of those things that we know contribute to any kind of substance use, yeah, if we could level the playing field somehow." (Consultant Addiction Psychologist, multiple GM areas)

It was noted that individuals with low SES can lack structural opportunities to recover from adversities and traumas, and that local area deprivation can exacerbate existing vulnerabilities while creating further harms:

"They haven't [learned to heal from adversity] because Salford is a very deprived area to live and work in, they've gone just down the road... the criminal one. I used to have one guy, he's 61 now, and he's probably spent 50 years in trouble." (Housing Support Officer, Salford)

3.2.2 Community impacts and pub closures

A professional in Wigan attributed local levels of alcohol use to the area's large traditional working-class population and long-standing social norms:

"It's a very working man's background here and it's [a culture] that has been around for years: you go to work, and you go have a pint." (Mental Health Support Worker, Wigan)

Professionals across multiple areas noted how deprivation, rising costs, and increased unemployment have accelerated the decline of pub closures and subsequently diminished the number of social spaces that would have traditionally been used by locals as their community's central hub:

"Society has changed hasn't it, especially in working class communities, communities aren't cohesive anymore. They're not working. There's no industry. People aren't working together and then going out socialising in the way that they used to... There seem to be less pubs around but more alcohol, which is ironic." (Dual Diagnosis Nurse, Rochdale)

They also explained how since the widespread closure of pubs, more people in local communities have taken to drinking alone, and resulting in rising levels of harmful and dependent drinking behaviours:

"You can get stuck in a rut: people that would normally drink socially are now drinking at home, on their own, then it's that tumbleweed cycle." (Recovery Engagement Worker, Bolton)

"A responsible landlord would monitor how much someone was drinking... whereas if drinking at home, it's not being monitored at all." (Assertive Outreach Worker, multiple GM areas)

Re-opening and improving local community centres would benefit attempts to reduce levels of problem alcohol use in communities: professionals in Wigan described a proposed initiative by ManLeigh – a men's peer support group – which hopes to recreate a pub environment to encourage the return of social interactions, while serving only alcohol-free drinks. It is hoped that by increasing the availability of alcohol-free spaces where individuals can socialise will provide opportunities to tackle social isolation; a factor well aligned with both harmful drinking and treatment barriers.

Drinking in solitary settings is associated with drinking to cope, which is a robust risk factor for alcohol-related problems, including alcohol use disorder (AUD) (Corbin et al. 2020). Both contextual and intrapersonal factors may explain the consistent indirect effects of solitary drinking on alcohol-related problems. A contextual explanation would posit that drinking in solitary settings results in sensitisation to the negatively reinforcing effects of alcohol. This sensitisation, in turn, may facilitate the development of tension reduction expectancies, which then contribute to coping motives. In support of this possibility, previous studies have demonstrated relations between individual contexts and specific expectancies (Ham et al. 2013, MacLatchy-Gaudet and Stewart, 2001, O'Hare, 1998, Zamboanga, 2005).

3.3 Isolation and loneliness exacerbating problem alcohol use

Personal accounts of isolation as an issue affecting adults with alcohol dependence were not restricted to the impacts of pub closures, with many of those interviewed attributing their use of alcohol with feelings of loneliness. Accounts by interview participants mostly fell into two categories: some described drinking with others who use alcohol chaotically to avoid being alone, while others reported that their use of alcohol was intended to help manage the impacts of limited social interaction:

"I know that being with them makes my drinking worse, but what else can I do? There's no one else." (39-year-old male, Wigan, not in treatment)

"I live alone now, and I sit there, and my head thinks stupid thoughts." (54-year-old male, Oldham, in treatment)

"I had to get away from people that are negative, people that degrade you and always put you down, but now I'm alone... and that's how I drink." (36-year-old male, Manchester, not in treatment)

3.3.1 Isolation, treatment, and change

Isolation was identified as a significant barrier to reducing problem alcohol use it was noted that those without established healthy social support networks (e.g. friends and family) lack external encouragement to seek assistance for their alcohol needs; this then necessitates this group to independently develop insight into the impacts of alcohol, recognise the benefits of support and treatment, and motivate themselves to engage with services:

"I live alone; there's nobody to tell me that I've had enough." (Male participant, focus group 2, Bolton)

Even where adults with alcohol dependence have overcome this barrier to access services, some treatment interventions are inappropriate and inaccessible for those who are alone or isolated. This particularly pertains to home detoxes and alcohol reduction plans where provision would be unsafe without additional informal support and observation by loved ones:

"When someone is living alone in isolation with a lack of social support it is difficult to support alcohol reduction in the community due to the associated risks." (Assertive Outreach Team Leader, multiple GM areas)

Indeed, the same professional went on to suggest that service providers could work more effectively if wider contextual issues affecting levels of isolation and absent support networks were addressed:

"[People] tend to be lonely and with nobody in their life that can support them. If [they did], we might be able to do more work with people." (Assertive Outreach Team Leader, multiple GM areas)

3.4 Offending and alcohol interventions

Both interview cohorts noted that offending behaviours were frequently preceded by alcohol use, with professionals observing the pattern across their client group and adults who drink dependently offering personal anecdotes:

> *"Past offending was alcohol-related "99% of the time." (Assertive Outreach Worker, multiple GM areas)*

> *"I drink to excess; I always get in trouble and wake up in a police station, and the morning after I don't know why I'm there." (36-year-old male, Manchester, not in treatment)*

Yet there were mixed reports of the availability and quality of alcohol support offers for people in custody:

> *"[Probation] have a lot of people who are frequent flyers, if you like, doing short sentences, not getting support in custody; when they come out, they're back on that merry-go-round of addiction, criminality, and custody." (Manager, Substance Misuse Team, Manchester)*

> *"I've been in and out of hospitals and detoxes, then in April I got sentenced to prison and joined a group with CGL; I think they were a bit of an awakening [. . .] At first, it wasn't to get help; it was to get out of my cell, but [the CGL prison worker] just started to make sense... like a penny dropping, it did make a change." (56-year-old male, Oldham, in treatment)*

The ACMD's report on Custody-Community Transitions recommends that post release pathways for people with non-opioid problems and for people who have achieved abstinence in prison be strengthened (ACMD, 2019). They note the experience of the drug recovery wing pilots suggests that existing services in England do not provide sufficient responses to the needs of people who have problems with substances other than opioids. It also suggests that the benefits of abstinence-focused interventions in prisons are often lost when people are released (Lloyd et al. 2017). Greater Manchester has recently been highlighted for achieving strong continuity of care rates, with two thirds of individuals released from prison receiving support upon reintegration into the community, underscoring the region's commitment to providing comprehensive support services for vulnerable populations (Home Office, 2024b).

In the community, in recent decades, a coerced model of treatment engagement has been utilised through Drug Rehabilitation Requirements and Alcohol Treatment Requirements. This has been supported through additional criminal justice funding and is based on evidence that suggests that community-based drug or alcohol treatment can cut crime by increasing the number of people who do not reoffend in the two years after treatment to 44% (Public Health England and MoJ, 2017). The current Greater Manchester Reducing Reoffending Plan (2022-25) sets out to identify substance misuse needs at the assessment stage through pre-sentence reports and risk assessments in the community and custody. This local plan has included the co-location of treatment provider staff in all Probation Delivery Unit offices and embedding drug and alcohol audit assessment tools in all courts. In specific relation to alcohol, it set out to increase the volume of alcohol treatment requirements, which has led to increased numbers of alcohol users entering treatment through coercion rather than voluntary engagement.

However, a Criminal Justice professional reported that it can be difficult to engage people who are coerced into community treatment as they often arrive with limited insight into the relationship between substance use and offending behaviours and can lack motivation to engage with alcohol support:

> *"[Clients who self-refer] are a lot more engaged... they're a lot better at setting goals and understanding what they actually want to get out of treatment, whereas [my probation clients] don't want to be here, they're only here because they have to be, and a lot of times they do not identify that they have a problem... with alcohol, not everyone is willing to address it." (Criminal Justice Recovery Co-ordinator, Tameside)*

3.5 Families, loved ones, and carers

3.5.1 Drivers of harmful drinking: Intergenerational problem alcohol use

Where professionals referred to histories of problem alcohol use within families, they recognised its enduring consequences, with one describing it as a "*generational trauma*" (Rough Sleepers' Supported Tenancy Officer, Salford). It was suggested that children and young people who witness adults' frequent or problem alcohol behaviours can repeat generational patterns by using alcohol harmfully in their own adult lives, having normalised these observed drinking habits:

> *"People struggle to get out of that [pattern]." (Rough Sleepers' Supported Tenancy Officer, Salford)*

> *"My father was one of those guys back in the 80s who went to work, went to the pub after work; sometimes he'd even take us... I know I've got a lot of learnt behaviours from my parents, now that I'm aware of it." (46-year-old male, not in alcohol treatment, Oldham)*

> *"I grew up with my mum; she was an alcoholic and took her own life... I think genetics play a role in developing alcoholism." (40-year-old male, Trafford, not in treatment)*

3.5.2 Influence of loved ones affecting positive change

Across both interview cohorts it was reported that the presence of loved ones and concerned others has often influenced and motivated decisions to seek and access alcohol treatment for the first time. Where appropriate, practitioners encourage family involvement in clients' care planning as this can present opportunities for the provision of additional support, particularly during evenings and weekends. One example was offered by a professional who described a positive outcome after a client's 19-year-old son provided translation during an alcohol assessment for his Polish speaking mother:

> *"I think her son knowing [about alcohol consequences] has had a positive impact on [my client] in that she wants to change." (Recovery Co-ordinator, Tameside)*

Participants working towards abstinence or reduced use described the motivating effects of positive relationships when considering and sustaining alcohol change:

> *"This relationship has saved me; no doctor has been able to save me, no support worker... Maybe I didn't want to do it for myself at the time... When you meet someone that you're so compatible with, like [partner's name] is with me... that made me feel like I've been given a purpose." (46-year-old male, Manchester, in treatment)*

> *"I didn't wanna keep drinking and be the way I was [while] raising a child, because it was just gonna get worse and worse... can you imagine the stress of raising a child and already drinking in the first place, so I didn't want that; I changed the way I were thinking due to the fact that my son was in the world." (36-year-old male, Manchester, not in treatment)*

3.5.3 Impacts of alcohol use on others and the need for carers' support

At a national level, one in six 'child in need' assessments carried out by local authorities last year recorded parental alcohol problems (Home Office, 2024a). Locally, it was estimated in 2016/17 across Greater Manchester that over 15,000 children were living with adults who drink dependently (Greater Manchester Drugs and Alcohol Strategy, 2019). As one professional observed, individuals who have managed to sustain employment and appear to be "functioning" while alcohol drinking dependently are more likely to have retained contact with children and relatives. She suggested that intensive support should be offered to young people who are often negatively affected by ongoing concern over parental alcohol use and its potential for harmful consequences:

> *"[Young people worry about] going home and finding their parent passed out or that they'll end up in hospital." (Ward Manager, Acute Mental Health Inpatient Unit, Wigan)*

Similarly, adults who drink dependently also recognised the significance of ensuring families and loved ones have access to appropriate advice and interventions:

> *"There's that group called Al-Anon where families can go, because they don't understand; that's not their fault." (58-year-old female, Bury, in treatment)*

"[My partner] was panicking but just didn't know where to turn... He was screaming in the hospital trying to get me help, they [said], 'we'll put her on a waiting list', but he needed help as well in trying to find me somewhere." (Female participant, focus group 1, Bolton)

A few professionals stated that their service model includes provisions designed to support families, carers, loved ones, and concerned others, with provided examples including peer support groups and the 5-step method for family members affected by addiction. Where they exist, these sessions are often held in the evening, making it convenient and accessible for those who attend.

One professional discussed the unique challenges faced by carers, including a lack of recognition of their own needs and the impacts of addiction stigma when attending mainstream support groups for concerned others'; factors that should be considered when developing services for supporters:

"[Carers say to substance use workers], 'no just cure her or just cure him. I'll be fine. That's all I need'." (Manager, Substance Misuse Team, Manchester)

"[A carer explained], 'we're sat next to people who have adult children who are physically dependent on their parents because of a disability, or they have someone with a chronic mental illness, or they're looking after elderly parents'... And I'm sat there because my daughter sticks her pins in her groin. You don't feel valued enough to go." (Manager, Substance Misuse Team, Manchester)

Part 4a: Barriers &contextual factors affecting access, engagement, & positive change for adults with alcohol dependence

Many of the structural barriers we encountered regarding accessing treatment and successful treatment outcomes aligned with the treatment barriers previously reported in systematic and scoping reviews (see for example, Farhoudian et al., 2020; Wolfe et al., 2023). These included a lack of suitable services for people with concurrent mental health disorders, lack of suitable accommodation, lack of connectivity of referral pathway, lack of gender-suitable treatment and stigma. Wolfe et al., (2023) conducted an international scoping review of 'service-level barriers to and facilitators of accessibility to treatment for problematic alcohol use' that included 109 studies. The multiple barriers they identified included but were not limited to lack of obvious entry points, complexity of the care pathway, high financial cost, unacceptably long wait times, lack of geographically accessible treatment, inconvenient appointment hours, poor cultural/demographic sensitivity, lack of anonymity/privacy, lack of services to treat concurrent problematic alcohol use and mental health problems. As we outline in this section, we found evidence of many of these barriers at a local level.

4.1 Alcohol and physical health harms

As adults with alcohol dependence encounter barriers to support and treatment, a significant number will be experiencing concurrent serious alcohol-related physical harms.

> *"We see significant physical health concerns linked to alcohol use." (Manager, Substance Misuse Team, Manchester)*

In an evidence review of the Public Health Burden of Alcohol, Burton et al. (2016) highlighted that alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression. WHO (2024) note that alcohol consumption is found to play a causal role in more than 200 diseases, injuries and other health conditions. Drinking alcohol is associated with risks of developing noncommunicable diseases such as liver diseases, heart diseases, and different types of cancers, as well as mental health and behavioural conditions such as depression, anxiety and alcohol use disorders. An estimated 474 000 deaths from cardiovascular diseases were caused by alcohol consumption in 2019. Alcohol is an established carcinogen and alcohol consumption increases the risk of several cancers, including breast, liver, stomach, oesophageal and colorectal cancers. In 2019, 4.4% of cancers diagnosed globally and 401 000 cancer deaths were attributed to alcohol consumption (WHO, 2024). During the professional interviews, several health harms were highlighted.

From the 'Global Burden of Disease', among 15- to 49-year-olds in England, alcohol misuse is the second biggest risk factor for death and years lived with disability, and the biggest risk factor for disability-adjusted life years (DHSC, 2025).

Professionals reported a notable increase in the number of adults who drink dependently who present with serious alcohol-related health impacts:

> *"There is increasing physical harm, so gastritis and stuff to do with internal systems that alcohol affects quite badly. It's happening because people are drinking stronger alcohol a lot more heavily." (Recovery Co-ordinator, Bury)*

> *"We've been to somebody's house who was bleeding from every orifice, and we needed to ring an ambulance, it was a life-or-death situation for that person, right in front of us." (Service Manager, Bury, Bolton, Salford & Trafford)*

This prevalence was supported through interviews with adults with alcohol dependence, who often reported personal accounts of long-term dependent drinking and extensive alcohol-related physical harms:

> *"Waking up, sweating, vomiting, and then as soon as I get a drink of vodka down me, the first gulp would come straight back up, and then the rest of the bottle would just put me on a level. And then the cycle repeated every single day... I ended up in hospital with onset pancreatitis, cirrhosis; basically, my*

organs were falling apart... By the time I got into detox, I couldn't walk unaided, I was in immense pain, I couldn't eat anything; it was awful." (40-year-old female, Rochdale, in treatment)

"Now I'm starting to feel it; my body is messing up a bit. My bowels, I can't control it, and it's embarrassing." (46-year-old male, Manchester, in treatment)

"I was sat with a tube in my stomach and having fluid drained into a bag." (54-year-old male, Oldham, in treatment)

4.1.2 Limited knowledge of alcohol health harms

While adults who drink dependently are said to be concerned about the physical effects of alcohol on their bodies and many of those interviewed described experiencing personal significant harms, widespread knowledge prior to the onset of alcohol-related health crises appears to be limited or incomplete:

"They have a good knowledge of harm to the liver, but fewer people are aware of the effects on the brain, mood, memory." (Co-occurring Needs Worker, Wigan)

"[After repeated police and ambulance callouts], I only learned later how alcohol can affect you mentally." (54-year-old male, Oldham, in treatment)

Adults who drink dependently explained that their prior limited knowledge included an inability to recognise the signs of physical dependency:

"I didn't realise that I'd got a problem. I just thought it's getting out of hand, so I stopped, and the next thing I'm in CBU [Chapman Barker Unit] because I've had seizures and was carted off." (Male participant, focus group 1, Bolton)

"When I first got dependent, I didn't know because I was just drinking all the time." (56-year-old male, Oldham, in treatment)

"I'd never heard of being dependent. I thought you were an alcoholic, and you'd wake in the morning shaking and needing a drink. I had none of that. I never drank before 6pm, but then I'd have a litre of scotch before going to bed." (Male participant, focus group 2, Bolton)

Both professionals and alcohol clients noted how inadequate understanding of alcohol harms can increase barriers to accessing treatment and the delivery of support to encourage alcohol change:

"I was too far in; I wasn't functioning but making myself so unwell [through drinking]. There was no 'me' going anywhere [to access alcohol support]. The off licence was across the road and that's about as far as I could get... Asking for help was out of the question; all I managed to do was phone 999 for an ambulance." (56-year-old male, Oldham, in treatment)

"To try to explain treatment or harm reduction to somebody who doesn't see [their alcohol use] as an issue is quite difficult, because you're met with, 'I'm not an alcoholic; I don't wake up and have a drink'. You are met with these initial barriers." (Harm Reduction Outreach Worker, Tameside)

4.2 Stigma, stereotyping, and shame

"Alcoholism...is seriously stigmatised." (Recovery Co-ordinator, Bury)

Hammarlund et al. (2018) provide an overview of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug- and alcohol-use disorders. They highlight how stigma is a complex construct that can come from many sources and may manifest as a barrier in several ways. For example, perceived social stigma is one type of stigma in which a person recognises and believes that their society holds prejudicial beliefs that will result in discrimination against them (Corrigan and Rao, 2012). Perceived social stigma can act as a systematic barrier when those to whom substance users turn for help (e.g., primary-care providers) react with negative judgments and even disgust. These attitudes may also directly impact the behaviours of drug and alcohol users, as research has shown that individuals who experience discrimination are much more likely to engage in behaviours that are harmful to their health (Richman and Lattanner, 2014). Hammarlund et al. (2018) also note that perceived social stigma may become internalised and result in self-stigma. For example, the personal endorsement of stereotypes about oneself and the resulting prejudice and self-discrimination (Corrigan and Rao, 2012).

Hammarlund et al., (2018) further highlight how various types of stigmas can act as non-systematic barriers. Public stigma against substance abuse is common (Üstün et al., 2001) and can deter people from seeking help, due to feelings of embarrassment or shame (Blanco et al. 2015). Self-stigma can also deter treatment when it results in loss of self-respect and questioning the point of trying to get better (Hammarlund et al. 2018).

4.2.1 Accessing treatment

Stigma avoidance underpins the reservations some adults with alcohol dependence experience when considering seeking support and treatment. This is twofold: a fear of receiving judgement or negative treatment by others, and the stigmatised views and prejudice that they themselves hold towards other groups of clients.

A Family Drug and Alcohol Worker in Tameside explained that clients who present with alcohol dependence often impart comments such as, *"I'm not an alkie"*, statements which are then followed by observations noting that personal drinking patterns and behaviours are misaligned with common stereotypes of alcohol dependency.

Distinguishing personal experiences of problem alcohol use from held perceptions of the often-labelled "alcoholic" creates further barriers to treatment, while resistance to accessing services alongside anyone who is perceived as conforming to such stereotypes was reported to be commonplace:

> *"[Clients say]. 'I'm not like them; I don't want to go and sit with all those drunks'." (Veterans' Tenancy Support Worker, Salford)*

> *"I'm not an alcoholic because I don't look like one ... and I don't want you to think that I'm an alcoholic." (Female participant, focus group 1, Bolton)*

> *"[The term] 'alcoholic' is a barrier for some; they don't want to be tarred with that name... people's perception is someone in a dirty rain mac, a brown bag, and a bottle of spirit." (Assertive Outreach Worker, multiple GM areas)*

> *"I knew it was becoming problematic, I was aware, but I didn't want to believe it, because no one wants to admit that you might be an alcoholic." (54-year-old male, Oldham, in treatment)*

4.2.2 Shame

> *"People do feel great shame; and that's why they don't access services." (Housing Support Officer, Salford)*

Shame reportedly affects alcohol clients, irrespective of demographical differences: An Assertive Outreach Team Leader in Bolton noted that middle class adults with alcohol dependence and those employed in professional roles can be ashamed of their need to access support, believing that they *"should've known better"*, while entrenched and homeless clients may avoid accessing services due to shame over their appearance, cleanliness, and social skills. In identifying where these feelings of shame originate, professionals ascribed it to wider societal perceptions of addiction:

> *"We're in this society where we look down on people with addictions." (Housing Support Officer, Salford)*

> *"It's easy for [the public] to think that people with addiction issues have brought it upon themselves." (Volunteer Co-ordinator, inpatient detox unit, Manchester)*

Chambers et al. (2021) report on the 'self-stigma' that many of the adults they interviewed with AUD in hospital reported that centred on them feeling a burden on NHS resources, and that their problematic alcohol use was the product of a moral failure. This was most often the case for participants who reported a history of multiple alcohol-related hospital attendances.

Personal accounts of addiction stigma were frequently offered during interviews with adults with alcohol dependence, although only a minority went on to consider whether such experiences affected subsequent treatment journeys or influenced views around accessing and accepting help. A male in Bolton noted how pervasive societal attitudes embedded self-blame and prompted his resistance towards alcohol support, before then describing how internalised shame allowed a resigned acceptance of professional stigma to be viewed as recompense for the provision of uncompassionate medical care:

> *"You don't go looking for help because you've done it to yourself... There's so much shame and guilt attached to alcohol, you don't wanna be a burden to start with. So, when you're in A&E and you're not being treated great, [you think], 'well, at least I am being treated'." (Male participant, focus group 1, Bolton)*

Shame forging barriers to accessing support also extends into mutual aid and peer support provisions: A male in Wigan who is not in treatment and who relies solely on mutual aid groups for support noted how intensified feelings of shame are driven by prolonged periods of concurrent self-neglect and patterns of dependent and harmful drinking. He explained that just through imagining others bearing witness to his deterioration evokes intolerable shame and efforts to avoid this results in inconsistent attendance at his preferred 12-step meeting:

> *"I get in a real mess; they don't wanna see me like that and I definitely don't want them to see me like that either... I really love the meetings when I go, but when I'm really pissed and stinking, it's the last place I want to be; I'd be so ashamed." (39-year-old male, Wigan, not in treatment)*

4.2.3 Professional stigma in mainstream support provisions

While professional relationships between services supporting alcohol clients and those with complex needs were generally reported to be positive, some interview participants noted that poor attitudes, stigma, and judgements were often found in professionals, particularly those who do not ordinarily work within the addiction and substance use field or with people with multifaceted needs. For instance, a general needs housing worker reportedly referred to clients with dependencies as 'these people', and an assertive outreach team leader in Bolton noted that he has experienced professionals within mainstream services "*treating people like second class citizens*".

One interview participant explained that when attending a multiagency meeting, a professional from a frontline statutory service used stigmatising language and bias-informed views to describe an encounter with a mutual client. Notably, this statutory worker appeared undeterred by the presence of other professionals and service providers:

> *"You're not being compassionate towards [this client]. I'm a professional and they're not even sat here, so I can't imagine what you're like to their face." (Harm Reduction Outreach Worker, Tameside)*

Where alcohol clients described stigma and stereotyping by professionals, provided accounts, mostly occurring within primary and emergency healthcare settings, included examples of delayed treatment, practitioner hostility and judgement, and documented addiction inspiring assumptions of drug-seeking:

> *"If I go in and say I'm sick of drinking or that I'm depressed, the doctor will say, 'I'm not giving you benzos'. I didn't want benzos; I wanted some help." (54-year-old male, Rochdale, in treatment)*

> *"I've been to doctors, and you can see [their judgement]; they don't even need to say anything... or when you go to hospital [for alcohol harms] and are left 'til last to be seen." (58-year-old female, Bury, in treatment)*

> *"I was put on a side ward with all the other alkies; that's what I was told... [the nurses] were very busy, but they weren't very nice." (Female participant, focus group 1, Bolton)*

4.3 Mistrust of 'the system'

> *"I found it hard to tell people about things, serious stuff, you know... because I thought they'd use it as a weapon against me." (54-year-old male, Rochdale, in treatment)*

For some interview participants with experience of alcohol dependency, a chronic mistrust of the system arising from a previous negative experiences was in part contributing to their resistance towards accessing support. This included a male in Stockport who stated that his experience of being failed by the justice system led to extensive mistrust which subsequently extended into systems of care, treatment, and support, and a male in Wigan who lost trust in treatment services after a previous bad experience as a former client:

> *"Nobody cares. The government doesn't care. System doesn't care...I don't trust anybody, nobody." (69-year-old male, Stockport, not in treatment)*

> *"They were never there, cancelled all the time, didn't give a shit when I did speak to them"... The staff couldn't care less, so judgy and up themselves... I won't go back there, I refuse, but there's no other place [to access support] ... I know I'd need help [to make changes], but no one will do that, and I wouldn't trust 'em to do it anyway." (39-year-old male, Wigan, not in treatment)*

4.3.1 Arbitrary rules

Adults who drink dependently identified inflexible rules within support systems as a barrier to sustained engagement, noting that adhering to restrictions and rules they perceive to be arbitrary can be especially difficult when their purpose has not been explained. This was primarily identified to be an issue in inpatient detox and residential rehab settings; in the three examples below, all participants self-discharged after struggling to comply with restrictions they did not understand, two of whom departed and became street homeless:

"It were a nice place but [they said] 'you can't do this, can't do this, can't do this'... no judge, no jury will tell me what to do mate; leave me to my own devices." (54-year-old male, Stockport, not in treatment)

"It was like being reprogrammed: 'You can't watch this TV show', 'you go to bed at this time', 'you can't read red top newspapers', I wasn't getting any answers as to why. I couldn't understand why, and I couldn't understand how this was helping me." (56-year-old male, Oldham, in treatment)

"You're not allowed out for your first week, what, am I in jail, what are you on about? Unless you're accompanied, by who? Someone that's been there just a little bit longer." (39-year-old male, Stockport, in treatment)

> *"People are being missed and are falling through the cracks." (Mental Health and Substance Use Worker, voluntary sector-criminal justice, Manchester)*

The findings in this section relate to issues affecting alcohol clients with additional complex needs: histories of entrenched rough sleeping and engagement in street activities, chronic dependencies, severe alcohol-related health impacts, mental health challenges, experiences of significant or complex traumas, and safeguarding and vulnerability needs.

4.4 Alcohol-related acquired brain injury

> *"I do get very forgetful, and I know that's due to alcohol damaging my brain." (54-year-old male, Oldham, in treatment)*

A particular concern raised by several professionals related to adults with alcohol dependence presenting with symptoms of brain injury, which may include memory difficulties arising from reoccurring falls or issues associated with Korsakoff syndrome. One professional working with veterans in Salford observed that clients are developing and presenting with such symptoms from younger ages, i.e. during their 40s.

Professionals also reported a notable increase in concurrent crack cocaine use among this cohort, particularly in those who are homeless, vulnerably housed, or otherwise participate in street activities, such as drinking or begging. They also observed that clients presenting with ARBI are almost always impacted by chronic mental and/or physical health conditions and are highly vulnerable to safeguarding risks, such as financial exploitation and self-neglect:

> *"Everybody knows who the most chaotic and most vulnerable people are. That's really sad because they're the ones are exploited the most." (Veterans' Tenancy Support Worker, Salford)*

Combined with difficulties in performing daily living tasks and reduced participation in care planning, clients with alcohol-related brain injury may exhibit behavioural issues caused by a loss of executive functioning; one professional working with entrenched rough sleepers in Manchester described how this can lead to the breakdown of temporary accommodation placements, creating further challenges in rehousing clients who subsequently present with a documented record of evictions or exclusions:

> *"The loss of executive functioning may cause behavioural issues that lead to breakdown of their temporary accommodation placement. [. . .] Often the current options are unsuitable and yet clients are blamed for the breakdown. This subsequently presents challenges of rehousing following a record of eviction and creates a loss of faith in the process and ultimately disengagement." (Senior Social Work, Entrenched Rough Sleepers Team, Manchester)*

4.4.1 Fluctuating capacity

It was noted that irrespective of a diagnosed ARBI, some adults with alcohol dependence experience fluctuating capacity and are unable to retain information, leaving them without a reference point from which to recall appointment dates or other significant details pertaining to their support plan:

> *"Working with someone with fluctuating capacity or who is close to losing all capacity is challenging due information not being retained." (Social Worker, Entrenched Rough Sleepers Team, Manchester)*

> *"Alcohol clients can lose days, so they have no reference point for remembering appointment dates." (Team Leader, Assertive Outreach, Salford)*

> *"I've done a couple of capacity assessments [with named client] because it's difficult when there are substances involved. When somebody's in a car accident or ends up with Alzheimer's, it's pretty ongoing, but with our clients, capacity tends to be fluctuating." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

Sanvisens et al. (2017) conducted a review of patients with a diagnosis of alcohol-related Wernicke–Korsakoff syndrome. They found that survival is poor; concluding that pursuing treatment of alcohol use disorder and early diagnosis of thiamine deficiency is a priority for improving clinical outcomes.

4.4.2 Assessment and diagnostic challenges

Interviewed professionals reported facing challenges when assisting clients with fluctuating capacity to receive appropriate assessment, diagnosis, and where relevant, treatment and support packages. They noted how disagreements can occur between staff who regularly support and can evidence the impacts on clients' daily function, and consultants and other medical staff who can be disinclined to factor in professionals' knowledge and expertise. Furthermore, reported symptoms are often dismissed as attributable to alcohol intoxication.

> *"Every time he went to the hospital, I would ask them to do a capacity test; he passed those tests easily because he could retain information; it was like muscle memory really. It took a long, long time to work out that he lacked capacity and that it wasn't due to his drinking... In hospital, I tried to get the assessment done when he was at his optimal and I knew that he hadn't had access to alcohol, but then [the challenge] was convincing the hospital and other services that this man lacks capacity in certain areas... I asked for a frontal lobal battery test; they wouldn't do it. You're fighting the NHS sometimes, to say this person lacks capacity that is ongoing. and it's permanent." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

Resistance from medical practitioners to consider brain injury in clients who use alcohol dependently can result in lengthy assessment periods and delay implementation of appropriate treatment and support. It was suggested that increased availability of and improved access to diagnostic frontal assessment battery (FAB) testing would progress healthcare provisions and shape subsequent care packages to truly meet clients' needs.

These findings correspond with Brighton et al. (2013) review of international literature on the needs of people with alcohol-related brain injury (ARBI). Four main themes were identified: under-recognition and lack of a timely diagnosis, inadequate service provision and limited care pathways, stigma, and homelessness.

Interestingly, having observed that the term 'alcohol-related brain injury' can affect both the perceptions of medical personnel and the treatments they offer, the Senior Social Worker quoted above explained that they now opt to use the phrase 'possible acquired brain injury' to navigate the alcohol addiction stigma and stereotypes that continue to exist in healthcare.

Brighton et al.'s (2013) review also highlighted service disconnection and the need for specific, tailored treatment approaches for people with ARBI. They also found that the identification of ARBI in clinical practice has been protracted by the lack of systemised and standardised screening tools to use in the assessment of those who display signs and symptoms of these conditions.

4.5 Housing

> *"Our clients come from all over [Greater] Manchester, and we do get a lot of people who are homeless. That seems to be a factor with a lot of our homeless clients; that the drinking and the drugs is a problem for them." (Mental Health Support Worker, Wigan)*

Periods of rough sleeping, homelessness, and living in temporary housing were identified by professionals as factors affecting client engagement and progression towards positive change. Although participants with alcohol dependence frequently reported experiencing housing precarity, they rarely made explicit connections between this experience and their alcohol use. One exception was a male in Stockport who described using alcohol to cope with street homelessness:

> *"I've got nowhere to live, so that's what I do, I drink, cos hopefully it'll knock me out of my head." (54-year-old male, Stockport, not in treatment)*

4.5.1 Lack of available supported housing options

Housing provisions were frequently raised as a significant barrier to the delivery of effective

support for alcohol clients, many of whom present with housing needs, including requiring temporary accommodation placements, entrenched rough sleeping histories, and prison releases when of no-fixed-abode (NFA).

> *"Homelessness is a massive thing in Rochdale and Oldham... and there's not enough hostel beds to house everybody." (Harm Reduction Lead, Oldham and Rochdale)*

> *"A big barrier to alcohol support and change is that homeless and entrenched rough sleepers are excluded from appropriate accommodation... We don't have anything that we actually need. We're just firefighting in the community." (Rough Sleepers Support Worker, Salford)*

The shortage of suitable women-only housing leaves professionals with little option but to refer female clients into limited availability bed spaces within projects that are unable to accommodate such wide-ranging presenting need:

> *"Actually, for women, they are put more at risk by going into temporary accommodation than they would be on the streets; they're a hidden minority." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

> *"At the [named female housing project] one thing we manage is the risk of people starting to sex work there, which sounds insane, but... We've had quite a few women who go in, never engaged in sex work before, [but find that] all the other women are... and they give it a go. So now we only put women who are already sex working in [the project]. You can't put [a non-sex working woman] in there because it is a huge issue, but it's not fair to not put the women in there [because there are few alternatives]." (Rough Sleepers' Supported Tenancy Officer, Salford)*

4.5.2 Lack of appropriate supported housing options

Professionals working in non-substance use sectors identified addiction as a primary support need among their client group. For example, one Housing Support Officer in Salford suggested that 99% of their clients have drug or alcohol dependencies. Yet the current housing offer for people who use alcohol dependently was often criticised as not-fit-for-purpose. For example, we received several reports of housing placements refusing referrals for clients with multiple needs and/or risks. In addition to substance use and mental health support needs, this also included insufficient accommodation for people with disabilities such as a lack of wheelchair access:

> *"We need options for people in wheelchairs... [A client] was in a wheelchair on the seventh floor of a high rise flat, [but] to find him the most appropriate placement; it's like nigh on impossible." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

The same professional described how an inappropriate housing placement affected a client with multiple needs, and the subsequent difficulties in responding to his worsening circumstances within a system that lacks appropriate resources to complex and co-occurring needs:

> *"We have had a client in a care home who was in his 40s. People in the care home were in the 60s, 70s, 80s with severe dementia. He was there for two and a half years. He got frustrated, wanted to continue to use substances, he left, was street homeless in a wheelchair, unable to care for himself, self-neglect, double incontinence, and being exploited by others. This is recent, the guy has been in hospital for five months because we cannot find a placement for him." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

It was also noted that available, mixed-gender homeless accommodation is often inappropriate for female clients, and for some will fail to consider their needs from a trauma-informed perspective. A professional described how male-dominated environments can be intimidating, observing that some women will feel daunted when they have no option but to reside in such a placement:

> *"Homeless accommodation is very male dominated... It's intimidating as a woman to go into that environment. And I'm a professional; I can leave whenever I want. For somebody to stay there for weeks on end as a young woman, it must be really, really scary and very daunting." (Harm Reduction Outreach Worker, Tameside)*

4.5.3 Rejected housing referrals and evictions

A Ward Manager at a mental health unit discussed the challenges facing patients as they prepare for discharge, including the prevalence of supported housing providers rejecting referrals due to the presence of multiple support needs:

> *"[Supported housing providers] won't take them and do that [intensive support] work in their setting... they're excluding a massive percentage of our clients because a lot of them do have co-occurring needs." (Ward Manager, Acute Mental Health Inpatient Unit, Wigan)*

Similar reports emerged of homeless and rough sleeping clients receiving evictions and notices to quit (NTQs) from emergency, temporary, and supported housing providers, often linked to vulnerabilities that were previously disclosed during the initial referral. It was also observed that housing offers were originally designed to cater for specific single-issue support needs, and may not appreciate or be in a position to accommodate the vast range of complex needs experienced by those presenting for housing support:

> *"[Rough sleepers'] needs are very different. It's not always around their substance misuse, so the skills needed for that are not just around drug and alcohol, it's around diversity. There are a lot of people there with acquired brain injuries or trauma-informed injuries, stuff like that. ADHDs and things." (Manager, Substance Misuse Team, Manchester)*

4.5.4 Zero tolerance

Most emergency and supported housing provisions operate under zero-tolerance policies, whereby the use of onsite alcohol and drugs is prohibited, and any breach can result in an eviction. Professionals discussed the resulting challenge of sustaining engagement and providing effective alcohol support once clients have been excluded from accommodation that operate under these policies:

> *"Clients are often evicted or issued a notice to quit [NTQ] for antisocial behaviour related to their drug and alcohol use [. . .] this lack of stable housing makes it difficult to effectively support people to reduce harms and make change." (Social Worker, Entrenched Rough Sleepers Team, Manchester)*

An adult with experience of dependent alcohol use suggested that such exclusions may not be linked to inappropriate alcohol-related behaviours, but are instead attributable to violations of no-alcohol rules:

> *"I might be walking and acting completely straight, but if they say you smell of alcohol, then you'll have to leave... I've learned that alcohol is not good in excess, and to the point that it's made me homeless, continually losing temporary accommodation for whatever reason." (47-year-old male, Manchester, not in treatment)*

When supported housing provisions operate under a zero-tolerance model, it perpetuates repeated episodes of homelessness and rough sleeping, thus exacerbating problem alcohol use, while leaving people who drink dependently with no place to use alcohol safely. While it was noted that some emergency and temporary accommodation providers "may turn a blind eye" to onsite drug and alcohol use, but with no formal agreement, clients' housing status is often precarious, and this instability was again reported to harm efforts to effectively support clients with meaningful goal setting and change.

4.5.5 'Wet housing'

With few alternatives to zero-tolerance housing, clients with multiple or complex needs are often excluded from existing offers and lacking options and access to appropriate accommodation. For clients who use alcohol dependently, professionals reflected upon the closure of 'wet houses'[2] a move considered to be counterintuitive to effective alcohol support. It was suggested that the housing model should undergo widescale reintroduction:

> *"We don't have any accommodation options where you can use drugs and drink on site, you know, like we used to have wet houses all across Salford; we used to have a lot more options... They'll never come back; every time we mention them, they get knocked back." (Housing Support Officer, Salford)*

Interviews produced one account of a 'wet house' still in operation; yet unlike previous provisions, it was reported that prospective residents are required to commit to a long-term objective of achieving abstinence should they choose to accept the housing offer:

"It's really difficult, I've got to be honest. We've got the [project name]; it's a wet house, but the client's got to say that he wants to give up drinking." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)

4.5.6 Shared housing provisions

Where alcohol clients have been referred and accepted into temporary housing provisions, both interview cohorts described the challenges arising from shared housing offers. These were mostly brought about by decisions to accommodate groups who arrived with diverse support needs which when placed together, were found to incompatible for shared living:

"In A Bed for Every Night accommodation you might have a refugee, someone who has just come out of prison, and a 19-year-old that's been thrown out by his mum, and then you go and throw a military veteran in there who might have alcohol issues. It's not a good mix of people... We found that military veterans were leaving and found two sleeping in a car; they said they felt safer sleeping there than in the [shared] accommodation we provided." (Veterans' Tenancy Support Worker, Salford)

"I was in there with people who were drinking whenever they could, and I was away from my children: I just started drinking again." (Female participant, focus group 1, Bolton)

4.6 Trauma and mental health

When describing the profile of clients who present with alcohol dependence, professionals almost universally identified trauma to be a significant factor affecting present-day dependent drinking:

"Really vulnerable military veteran, he's got complex PTSD that's directly attributed to his service. He's got complex, long-standing, drug and alcohol issues." (Veterans' Tenancy Support Worker, Salford)

"Some people have gone through some real, horrific traumas, a lot of intimate abuse, you name it, there's a whole list of traumas. And I think [alcohol] is a coping mechanism." (Social Worker, Entrenched Rough Sleepers Team, Manchester)

"[Clients use alcohol] to numb the pain, more often than not, from adverse childhood experiences." (Housing Support Officer, Salford)

"There's just so much trauma. An unbelievable amount of trauma... Every conversation I'm having with someone, there's something horrific they're telling me from their past." (Co-Occurring Needs Worker, Wigan)

A New Zealand study into the association between exposure to stressful life events found that persons with the highest exposure to stressful life events were more than twice as likely to have alcohol dependence than those at the lowest level of exposure (Boden et al. 2014).

Akin to the professional interviews, the prevalence of trauma was notable when speaking with adults with alcohol dependence, who often disclosed how past trauma continues to affect their lives and has been a primary driver of their use of alcohol:

"[I drink] to try and forget about it. There are things when you're young that you try to forget about, but they surface again as you get older." (46-year-old male, Oldham, not in treatment)

"I've had a few bad things that happened to me, some bad beatings, you know. So, I drink mainly for a bit of courage and to stop the anxiety." (54-year-old male, Rochdale, in treatment)

"[I drink] for escapism, [hesitates] for getting over stuff." (40-year-old male, Trafford, not in treatment)

"There's only so much a human being can take in this world, and after that you switch off. Nothing matters anymore. People wonder why I drink; it's amazing I'm still alive." (69-year-old male, Stockport, not in treatment)

4.6.1 Trauma as a barrier to engagement

With trauma present in many alcohol clients' backgrounds, it was reported that the impacts and continued experience of trauma responses can affect engagement by causing individuals to emotionally withdraw, resist, or disengage from meaningful supportive conversations. A professional described how trauma can be visibly detected on a client during support sessions:

Box 2: A vignette: Trauma, dependent alcohol use, and barriers to accessing to support

Having worked towards and sustained a successful career and established family life, a 69-year-old male in Stockport described how trauma in adulthood significantly impacted his life, accumulating in homelessness, dependent alcohol use, and mistrust of systems designed to provide support. He recalled that prior to reaching his early 30s, he had never had reason to use alcohol:

> *"All through my 20s, I never drunk at all. Didn't need it. I was busy and had a lot going on. Lovely girlfriend, everything was running smooth. Good job, no problems. Didn't need it. I never felt a need for it." (69-year-old male, Stockport, not in treatment*)

Later describing the significant impacts and consequences on his life trajectory and experiences, he began by outlining how one initial trauma proved to be a catalyst for several further traumatic events:

> *"If you've ever seen photographs of your youngest brother with his head splattered all over the wall that's enough to set you off; that's the end of your life. All you want is justice, but then you don't get that either. It's pointless after that, life means nothing if somebody can walk into a shop and blow somebody's head off. Life's nothing; it don't mean anything. Then to watch your mum stop eating and then wither away and die. He didn't just kill one person; he's killed us all." (69-year-old male, Stockport, not in treatment)*

Although finding alcohol to be effective at managing his mental state by slowing his thoughts and providing temporary relief from emotional pain, he described feeling chronically numb, disconnected, and consumed by the profound and devastating effects of trauma:

> *"I think you get to a point in life where you just give up. There's only so much a human being can take in this world, and after that you switch off. Nothing matters anymore... I might as well sit on the street and drink myself until I'm dead." (69-year-old male, Stockport, not in treatment)*

Having identified that an inherent mistrust of the system originated from having been failed in his pursuit of justice, he later described significant barriers to accessing both wider support services and treatment for his alcohol use which have arisen from his lack of trust in organisations and providers:

> *"I don't trust anyone, I don't care about people, they say one thing and do another... The system is supposed to work, but I'm done with it; absolutely done with it." (69-year-old male, Stockport, not in treatment)*

Discussing his resistance towards accessing trauma-specific support, he explained how previous experience has left him unable to see any possibility of positive change; he believes that he cannot be helped, thus accepting offers of support is considered unworthwhile:

> *"They're all nice. I don't want people to be nice to me. I want them to tell me the truth: 'You're never going to get over it, pal; there is no nice ending. The trauma has happened, live with it. Go and have a drink and then you can forget for a couple of hours.'" (69-year-old male, Stockport, not in treatment)*

"You can see the fear in his eyes... it's almost like he's intoxicated, but he's not." (Mental Health and Substance Use Worker, voluntary sector- criminal justice, Manchester)

Unaddressed trauma can also affect access to healthcare for alcohol-related impacts, for instance, one male with alcohol dependence described his reluctance to undergo an investigative colonoscopy in line with medical advice due to associating the procedure with past sexual abuse.

While there is certainly increased awareness of trauma-informed practices, a professional noted that the legacy of substance use treatment systems and service models that were not originally built to be trauma-responsive can pose a challenge for delivering effective support:

"A lot of people with drug and alcohol are mitigating a whole myriad of life circumstances... which aren't going to be cured by a detox. It's about getting them in, getting them better, getting them out, [we're asked], 'how many successful completions?'... What you get is compassionate and humanitarian workers delivering transactional services" (Addictions Lead, Stockport)

4.6.2 Specialised trauma support: inadequate and inaccessible

Where clients have achieved positive alcohol change, they often live with continuing trauma symptoms, rendering them vulnerable to relapse or reverting to previous drinking behaviours, yet access to trauma-specialised psychological support through NHS Talking Therapies is currently hindered by a protracted referral process and lengthy waiting lists. A mental health professional observed that the time between sending the initial referral and receiving the first appointment with an appropriate therapist inhibits clients' access to effective trauma support:

"I can't say there's a good trauma support network because the waiting list is so high. If you are waiting on a psychology referral in the community, it could be years; the waiting list is insane." (Co-Occurring Needs Worker, Wigan)

While easier and faster access to trauma therapy would be welcomed by professionals, it was also noted that current trauma-focused support provisions, whether provided by CMHT or psychological therapies, are often ill-equipped to provide supportive interventions to those presenting with co-existing, diverse, and complex needs, particularly those with histories of homelessness and addictions:

"The amount of trauma and the levels of the things they've had to go through are never really fully comprehended... I find that other professionals across all the services don't understand [our client group's trauma histories] and don't understand what they need... These services are still not designed to accommodate our clients." (Rough Sleepers' Supported Tenancy Officer, Salford)

"[It can be] hard and difficult understanding from a trauma-informed response what they've experienced. [It requires] taking small steps. and just staying with them, treating them as a person and not just another case load." (Social Worker, Entrenched Rough Sleepers Team, Manchester)

4.6.3 Alcohol use and mental health

Adults who drink dependently frequently attributed their use of alcohol as a means of coping with trauma and mental health challenges:

"It was my emotional crutch, so I didn't have to worry about anything; I was so low and down... Alcohol doesn't solve anything, but you don't have to worry about anything because you're always off your head." (56-year-old male, Oldham, in treatment)

"If I didn't have a drink, I was skittish and curtain twitching and all that, I didn't want to go out, but soon as I'd have a drink, I was all right. And so, it's sort of like I was self-medicating..." (54-year-old male, Rochdale, in treatment)

However, this client then continued by noting that the benefits of drinking were temporary and later worsened existing mental health challenges:

"... My drinking and my mental health; I think they go hand in hand... [when I drink], my paranoia sets in, my mental health sets in." (54-year-old male, Rochdale, in treatment)

Another participant agreed and acknowledged that although he initially found alcohol to be a helpful

coping mechanism, the cumulative effects of enduring mental health symptoms and untreated trauma has forged an apathy that has impacted any consideration of positive change:

> *"I don't see the point anymore; I've got no reason [to stop drinking] ... Everything feels meaningless now, so why would I bother?" (39-year-old male, Wigan, not in treatment)*

4.6.4 Challenges in mental health

Professionals acknowledged the wide-ranging pressures impacting mental health services across Greater Manchester and suggested that they should be prioritised within future commissioning decisions, believing that increased and targeted funding is necessary to improve supports for patients and alcohol clients:

> *"Mental health is lacking big time - they do the best with what they've got, but it seems to me like they could do with an unlimited pot of money." (Assertive Outreach Worker, Salford)*

> *"More funding for mental health services [is required], because that always crops up as a factor in why people are started using alcohol in the first place." (Criminal Justice Recovery Co-ordinator, Tameside)*

4.6.5 Accessing mental health support for alcohol clients

As Wolfe et al. (2023) note, a lack of treatment programmes that offer both mental health and dependent alcohol use interventions is a barrier for those who have concurrent mental health conditions (see also Roberts et al. 2020; Dorey et al. 2021). They highlight how siloed mental health and alcohol services requiring abstinence to receive mental health therapy and stable mental health to receive treatment for alcohol dependency resulted in people with concurrent disorders not being accepted for either program (McCallum et al. 2016; Roberts et al. 2020; Dorey et al. 2021). A key theme that arose in the two-year progress review of From Harm to Hope (see Home Office, 2024a) was the interconnectedness between physical and mental health and drug and alcohol treatment services. Subsequently, the review recommends the wider adoption of dual diagnosis pathways, ensuring that treatment services take a joined-up approach to both mental health and drug treatment.

In the previous Greater Manchester Drugs and Alcohol Strategy, it was stated that: "We are clear that our drug and alcohol services need to better integrate with other provision in a place" (Greater Manchester Drugs and Alcohol Strategy, 2019-21:9), to effectively impact the root causes of drug and alcohol problems, including mental health. Yet five years on, despite the prevalence of co-occurring mental health and problem alcohol use, professionals participating in this research supported the findings above, offering accounts of the continuing difficulties and barriers faced when referring clients with alcohol dependence into community mental health support:

> *"[Mental health services] won't work with most of my clients because of the dual diagnosis aspect." (Assertive Outreach Worker, Salford)*

> *"[CMHT tell us], 'they need to sort their drinking out, then we'll look at their mental health'." (Harm Reduction Lead, multiple GM areas)*

A professional in Salford described her efforts to successfully involve CMHT in a client's care, noting that it was only upon highlighting prior and continued pressures on frontline services and the arising financial costs of not offering a service, that they agreed to accept the referral:

> *"Mental health services were closing him, saying that he needed to sort his alcohol out first. I referred him to an armed forces-specific mental health service who said the same. I sent an email to them all, [having] worked out how many hospital admissions he'd had, and just queried, 'how much is this man costing services when he needs mental health support?' As a result of that, he was given a care coordinator." (Veterans' Tenancy Support Worker, Salford)*

Beyond the impacts of inadequate mental health support for clients with alcohol dependence, enduring access barriers have also left mainstream mental health practitioners with little experience of supporting clients with complex needs, including those with substance use and homelessness backgrounds. Consequently, this generates further challenges for support delivery should clients ever be accepted into mainstream provisions:

> *"Mental health professionals that work for [mainstream community] teams are not*

trained to understand our client group. They don't know them, because they don't really come into contact with them, and our clients can't engage with the way that their support works." (Rough Sleepers' Supported Tenancy Officer, Salford)

4.6.6 Insufficient dual diagnosis support

The lack of dual diagnosis support was also frequently viewed as a key barrier for engagement and positive outcomes. This was said to leave some clients bouncing between (inappropriate) services and teams. The presence of co-occurring psychiatric and other substance use disorders is the rule rather than the exception in AUD (Grant et al. 2015) and is a known risk factor for relapse (Yule and Kelly, 2019). Hence the lack of support for co-occurring needs was considered a barrier to successful outcomes.

It was noted that where dual diagnosis teams exist and have caseload capacity, the teams are often small and cannot accommodate levels of need:

"I think we're really fortunate because we do have a dual diagnosis mental health team attached to my team [...] but people can only be introduced if they've got the capacity to do so." (Rough Sleepers' Supported Tenancy Officer, Salford)

However, with the primary GMMH dual diagnosis model designed to support professionals in their work with clients, the addition of caseload capacity to the advice and consultancy provision was felt necessary by treatment professionals:

"[GMMH dual diagnosis teams] do training and advice, but I don't think they're case holders; you need case holders from the drug and alcohol service to go in and deliver our part of the service into the mental health teams" (Addictions Lead, Stockport)

Commenting on the existence of specialist homeless mental health teams, professionals considered these provisions to be an asset, however it was also noted that the lack of bed availability to take unwell clients can prevent those who require such support from receiving adequate or appropriate treatment and care. A homeless male in Manchester who uses alcohol dependently described how insufficient mental health support precipitated his disengagement and a prolonged episode of rough sleeping:

"I was sectioned... but they let me out too early; when I got out, I only lasted for about four weeks... That's when I walked away and went on the street for about two years." (47-year-old-male, Manchester, not in treatment)

4.7 Entrenched and challenging lives

A significant number of interview participants either had personal experience or supported people with extensive experience of rough sleeping, chronic homelessness, and complex, street-based daily routines.

4.7.1 Street homelessness and begging activities

Many of those interviewed with experiences of alcohol dependency had also lived or associated for significant periods within local street communities. They described how familiar behaviours and lifestyles such as begging and rough sleeping introduced further challenges at points where they were considering change:

"I was begging in town, and I was homeless, so getting sober was a scary prospect because then I've got to start taking responsibility for myself." (54-year-old male, Rochdale, in treatment)

"I beg for money, I always have done, so it's something I can't stop because it's been my way of life generally." (46-year-old male, Manchester, in treatment)

"I've been living this life for so long; I don't know how to do it any other way." (39-year-old male, Wigan, not in treatment)

4.7.2 Relationships within the street community

Professionals observed that members of the street community with entrenched patterns of dependent alcohol use are more likely to be found sitting and drinking alone rather than belonging to a group and spending time with others. This can occasionally facilitate initial engagement efforts in the absence of distraction or influence by third parties, yet it is said that such isolation is mostly of detriment to support efforts:

"The underlying reasons for isolation can be a barrier when first approaching and trying to engage." (Rough Sleepers Support Tenancy Officer, Salford)

Those with long histories of rough sleeping reported on their positive experience of forming connections, both with others in the street community and "kind" members of the public, yet they also expressed that one of the barriers to positive change has been their unwillingness to leave behind these relationships:

"I used to get drunk all the time; I'd be found sleeping outside of Tesco... I find it hard to get away from that life because of the [positive] relationships I have with people." (46-year-old male, Manchester, in treatment)

"I knock about with the drinkers, they're my peers, so I didn't want to leave my mates." (54-year-old male, Rochdale, in treatment)

4.7.3 Engagement with support providers

When discussing access barriers for entrenched and hard-to-reach clients, professionals reported that issues predominantly centre around the inflexible approaches to support delivery and limited understanding of the client group that exists within mainstream or universal services, i.e. organisations and support providers that were originally designed to cater for the general populace or offer single-issue-focused support. Although housing services, primary health care, and mainstream drug and alcohol teams were identified most often, issues affecting the ease at which this group can access and sustain engagement with support providers were reported to extend across statutory and non-statutory service provisions and found within services addressing wide-ranging health and social care needs.

Although this was a barrier predominately identified by professionals, one participant with experience of alcohol dependence described how service providers can have a shallow comprehension of factors affecting addiction and clients' ability to engage with support:

"If these services took the time to find out what the underlying problems in addiction are, the socioeconomic factors, a lack of access to the internet, transport... They don't take the time to find out what your limiting factors are. They give you information, fact sheets, and numbers in a little folder, and [say], 'there you go'" (male participant, focus group 2, Bolton)

4.7.4 Stringent rules of engagement

Due to poor representation within its core client group, a universal support provider can be inexperienced and have poor understanding of the unique issues impacting multiply disadvantaged clients. Professionals suggested that limited expertise can foster an ethos whereby hard-to-reach clients are expected to successfully manage and adhere to rules that are unsuited to their circumstances or support needs:

"These services have really stringent rules of engagement. If you miss an appointment, you get one more, and then you can't access anything again. I don't think the options for people are great... I find that professionals across all the other services don't understand our client group and don't understand what they need... They bat them back and say, 'this person's missed their appointment, come back to us when they're ready'. They don't see it like we do." (Rough Sleepers' Supported Tenancy Officer, Salford)

4.7.5 Attendance at in-service appointments

Professionals discussed the challenges of supporting vulnerable and hard-to reach clients to access and engage with external, non-specialist services. It emerged that universal providers frequently necessitate clients to attend in-service appointments to undergo initial assessment and engage with continued support.

However, professionals believed that attaching conditionality to support and treatment offers demonstrates a failure by mainstream services to neither consider nor accommodate this groups' needs, individual barriers, nor the contextual factors which affect them. For instance, clients who are street homeless, with chronic drug and alcohol dependencies, and impacted by other chaotic and entrenched difficulties, were reportedly most likely to find support inaccessible when the offer is restricted to pre-arranged and inflexible time allocations: this was said to include entry into structured alcohol treatment.

One professional highlighted how only through increased intervention and with extraordinary efforts to facilitate attendance can individuals from this cohort remain engaged with mainstream support provisions. Another observed that demands by service providers for attendance at in-service appointments not only obstructs clients' access to support but excludes those who are most vulnerable and in need:

> *"Unless we take [clients who drink dependently] to every appointment, their treatment and recovery can fall down." (Service Manager, Assertive Outreach, multiple GM areas)*

> *"There's still this concept of getting people to appointments. Yet it's an identified cohort of people that simply cannot adhere to appointment driven systems... The irony of services and the solutions that we're trying to provide for people [is] the poorliest people are the ones that can't attend." (Team Leader, Assertive Outreach, multiple GM areas)*

4.7.6 Practical barriers and perceived non-engagement

Entrenched and excluded clients with alcohol dependence also frequently face practical barriers during their efforts to attend appointments and engage with support, for instance lost or stolen mobile phones, or insufficient funds for travel may disproportionately hinder the capacity for homeless or entrenched alcohol clients to attending pre-arranged appointments:

> *"[Clients] might struggle to get to Ashton for their appointment if they don't have the money... [or] if every time they get paid and they're spending it all on alcohol, they might not have the money for the bus." (Criminal Justice Recovery Co-ordinator, Tameside)*

It was further reported that universal and mainstream services can fail to consider how this client groups' presence at appointments may be affected by practical and circumstantial barriers, instead attributing non-attendance to 'non-engagement, with incidences of subsequent referral closures said to be commonplace.

> *"A real barrier for [this client] was that he just wasn't turning up. He was constantly losing his phone so [named drug and alcohol treatment service] were saying, 'we can't get hold of him, he's not engaging'." (Veterans' Tenancy Support Worker, Salford)*

Practitioners working in mainstream or non-specialist services practice varied approaches that benefit engagement efforts with their core client group, for instance preferences for utilising non-assertive interventions to encourage clients' responsibility and self-motivated proactive engagement. While these approaches are not considered transferrable due to being inadequate for supporting those with complex needs, the issues identified by professionals' evidence that it continues to regularly occur in practice.

4.7.7 Devaluing professionals' experience and knowledge

When entrenched alcohol clients are faced with these structural access requirements, those who are engaged with a team with experience of supporting multifaceted and challenging needs, have the backing of professionals who will advocate tirelessly to overcome such barriers.

Yet these professionals have observed that their relevant experience and expertise in supporting and engaging vulnerable and entrenched clients is not always appreciated by mainstream practitioners. Referring to joint efforts to plan and facilitate effective and responsive care, professionals recalled facing hostility from mainstream practitioners as their input was devalued and their informed contributions dismissed as unworthy of note and irrelevant to clients' support.

> *"We're on par with the statutory service... It's just deemed, sometimes, as a lesser role. But we're working with the most complex and challenging people; I don't know if that's fully understood." (Service Manager, Assertive Outreach, multiple GM areas)*

Part 4c: Barriers and contextual factors affecting access to alcohol treatment provisions

4.8 Opening hours, telephone provision, and time-limited support

Wolfe et al.'s (2023) review of barriers to accessing alcohol services found 26 studies that had highlighted the inconvenient or inflexible appointment hours as a barrier to accessibility by participants (Scarfe et al. 2023; Seddon et al. 2022; Gilburt et al. 2015; Black et al. 2020; Haeny et al. 2021; Wieczorek, 2017; Allen and Mowbray, 2016; Green, 2011; Lee et al., 2014), especially those who were employed (Ekstrom and Johansson, 2020; Roberts et al. 2020; Tarp and Nielsen, 2017; Villalba et al. 2020; Burnett-Zeigler et al. 2011).

4.8.1 9-5 Opening and access for employed clients

Many professionals identified service opening times as a barrier to accessing alcohol treatment for employed clients with alcohol dependence. Substance use services are typically open for drop-ins, appointments, and group work during the standard working-week of Monday to Friday, and are open during core hours of 9am and 5pm; this renders alcohol interventions inaccessible to those who work or have other daytime responsibilities:

> *"Opening times, support groups often run during the day 9-5, preventing access and early support to those with work commitments." (Ward Manager, Acute Mental Health Inpatient Unit, Wigan)*

> *"Alcohol services opening times are inaccessible to those who work 9-5, creating further barriers to those who are managing to hold down a job." (Substance Use Worker, Community Rehab Team, multiple GM areas)*

> *"Access between 9-5 is not accessible to all!" (Housing Support Officer, Salford)*

4.8.2 Caseload capacity

Treatment professionals explained that team members frequently support colleagues to manage busy caseloads by covering each other's appointments, but those accessing treatment described the challenges of being required to meet with unfamiliar support workers and withstand previously broached conversations and questions, some of which may be sensitive or difficult:

> *"I've been a few times for help and [my worker] wasn't there all the time and they were flipping me between people... and I hate all that, because you have to keep repeating yourself." (46-year-old male, Manchester, in treatment)*

In considering measures to prevent overwhelming treatment staff with further increases to their caseloads, one professional suggested that commissioners reconsider which service interventions are prioritised for funding. Instead of introducing new referral teams, it was suggested that future investment focuses upon treatment delivery, and money is directed towards existing alcohol provisions:

> *"I need feet on the street. I need people that are going to manage a caseload and solve the damn problem that's in front of them, not assess it and refer it on." (Addictions Lead, Stockport)*

4.8.3 Telephone-based support sessions

Maintaining large caseloads and attempts to manage capacity demands have resulted in service providers offering alcohol clients telephone appointments, in lieu of face-to-face support; a move that originally gained traction as social distancing regulations were implemented during the COVID-19 pandemic.

Reliance on this method of engagement was identified as a factor affecting treatment and recovery efforts, with telephone support viewed as inadequate for encouraging accountability and engagement or confronting ambivalence towards change:

> *"It was all phone calls; so, I could kid myself and kid them by saying that I wanted to change." (Female participant, focus group 1, Bolton)*

> *"It's hard trying to keep that motivation and work going [over the phone]. It doesn't; it falls apart most of the time." (Assertive Outreach Team Leader, Bolton)*

> *"I used to be enrolled with [named drug and*

alcohol service] but I just got a phone call once every two weeks; that wasn't enough help for me." (40-year-old male, Trafford, not in treatment)

Alcohol clients commented on the distance telephone contacts left between themselves and their substance use workers, with some stating that it has led to inaccessible and tokenistic support offers:

> *"I could never speak to him. I'd never get him on the phone. It was just horrible." (Female participant, focus group 1, Bolton)*

> *"I literally felt like it was a box ticking exercise and he couldn't get me off the phone quick enough." (40-year-old female, Rochdale, in treatment)*

Providing in-person support sessions was recommended and deemed most effective at building strong professional-client relationships:

> *"You're not building those really strong relationships by talking to someone on the phone all the time." (Assertive Outreach Team Leader, Bolton)*

4.8.4 Time limited support and expected change

Some professionals described the challenges of supporting clients through their treatment journeys, when working within the restrictions of time-limited support provisions.

From the standpoint of engaging clients with alcohol dependence, it was considered unrealistic to rely upon episodes of time-limited support to encourage clients to consider and successfully achieve positive change. One professional observed that within structured residential rehabilitation programmes, it can take "months" for individuals to break through addiction-related denial, and yet some service providers are expected to facilitate the same degree of change during an hour-long weekly support session, and within a much shorter timeframe:

> *"We're expecting people who are drinking, are still in their same environment, getting an hour's worth of time a week from a worker, and there's an expectation that they'll draw those conclusions by themselves: it's just unrealistic to remove all barriers [through short-term interventions]." (Team Leader, Assertive Outreach, multiple GM areas)*

Another professional compared how interventions vary between alcohol and opioid clients, with demands on capacity leaving individuals engaged with treatment for alcohol dependence potentially facing discharge should they not achieve positive change during a 12-week programme:

> *"Some alcohol pathways do tend to be much more time limited: we're often looking at a 12-week intervention and depending on where people have got up to at that 12-week point, they might be discharged from the service if they haven't been able to make the changes in that time. That's tricky, and obviously very different than the opiate offer, where people are in long-term maintenance treatment; and again; it's a capacity issue." (Consultant Addiction Psychologist, multiple GM areas)*

A professional also explained that clients who have progressed during initial or time-limited interventions, may find that problem behaviours rebound upon completion, thus affecting the capacity for ensuring sustained change:

> *"Behaviours are very sticky, and when you stop the intervention, the behaviours reassert themselves." (Addictions Lead, Stockport)*

4.9 Integrated drug and alcohol services

The loss of distinct alcohol services since the emergence of integrated treatment provisions was often identified by interview participants as negatively affecting the alcohol treatment offers. In particular, the loss of alcohol related specialist knowledge was highlighted by both professionals and people who used alcohol dependently.

> *"I also think that there was a big knowledge loss, specific to alcohol-related skills." (Consultant Addiction Psychologist, multiple GM areas)*

> *"[Named drug and alcohol service] didn't know anything about helping me with my alcohol problem." (Male participant, focus group 2, Bolton)*

It was also suggested that in comparison to other drugs, alcohol dependency is not taken as seriously by some treatment workers in integrated drug and alcohol services.

"When we went from being drug workers and alcohol teams and then making everybody do both, because a lot of people who work in treatment drink, it means that [alcohol dependency] is not taken anywhere near seriously enough." (Recovery Co-ordinator, Bury)

4.9.1 Prioritisation of opioids

Alcohol treatment was perceived as the 'poor relation' in comparison to the emphasis on opiate use. The two-year progress review of From Harm to Hope (Home Office, 2024a) noted that councils highlighted that there is no dedicated national strategy for alcohol treatment and that they must work at a local level to ensure that this group is effectively cared for. It highlighted how restrictions on how much of the government funding can be used to fund alcohol treatment can put resource pressures on councils who need to make provisions locally to fund these services. These recently highlighted national concerns were echoed locally:

"When there have been new monies injected, there's still a real focus around opiate numbers and treatment, drug related deaths, and so on. Although we do get data and the figures around alcohol related deaths, there's not the same focus . . . Funding for alcohol has been left behind." (Consultant Addiction Psychologist, multiple GM areas)

Referring to commissioning priorities, professionals noted that alcohol provisions receive comparatively less funding than in-service drug (particularly opioids) and criminal justice interventions; a financing decision that in some areas is disproportionate to the respective levels of local drug and alcohol use:

"Funding prioritises working age opioid users from a criminal justice background; that's the top and bottom of what our funding is. [Yet] the top and bottom of our need is alcohol; it's a huge mismatch... [Clients who drink dependently] are left behind because no one will pay for treatment for them." (Addictions Lead, Stockport)

The over-emphasis on opiates was suggested to create a barrier for people entering treatment for alcohol support, particularly where services fail to give equal weight alcohol harm reduction messaging in waiting areas. This lack of inclusion was said to have been a factor leading to disengagement by atypical clients with alcohol dependence who were reported to have felt uncomfortable attending an environment where drug use dominates, some of whom depart before having an opportunity to engage:

"As soon as you walk in [to the service], everything on the walls is about drug overdose, naloxone, and Hep C; for a lot of alcohol users who are functioning and working, they don't feel included in that. [They think], 'this is the wrong place for me'. It's very clinical, it's not comfortable, and the waiting rooms are too small, so you're forced to sit next to people talking about injecting in their groin or things like that: people have just left, before even having their appointment, [asking themselves], 'what am I doing here?'" (Assertive Outreach Team Leader, Bolton)

Similarly, there was also a perception among treatment-experienced that substance use services demonstrated less interest in clients presenting with dependent alcohol use:

"I got the impression that [named drug and alcohol service] were more interested in heroin addicts than our problems; alcohol was seen as a minor problem and not very serious." (Male participant, focus group 2, Bolton)

4.9.2 Reconsidering integrated teams

Considering both the previous model of independent drug and alcohol services, and envisaging the potential for change, professionals noted the changes between old and new. Highlighted losses included targeted support for alcohol clients, including day centres and easy-access community detoxes, while preference was expressed for a move towards detached drug and alcohol treatment services. Several professionals expressed that they would prefer dedicated alcohol teams and specialist alcohol workers and suggested revisions to the treatment model included locating each service at different sites, and ensuring they are staffed by professionals specialising in the provision of either drug or alcohol support:

"If I started the service again... I would have two teams, one specifically working with people who use substances and one specifically working with people who use alcohol, because the demand is so varied and complex." (Service Manager, Assertive Outreach, multiple GM areas)

"In an ideal world, I'd go back to the way things used to be, where there were standalone services, specialist, rather than generic [which] lump everybody together. Day services used to be available on people's doorstep that were very inclusive and holistic; they ran groups, activities, and a lot more social events... but all there is now, is an alcohol worker in the drugs team." (Dual Diagnosis Nurse, Rochdale)

Similarly, there were calls for a dedicated alcohol focused clinical team who could manage alcohol detox in the community.

"We're not doing as many community alcohol detoxes... I think this is a capacity issue; if we had a clinical team whose focus was entirely on alcohol that would work much better." (Consultant Addiction Psychologist, multiple GM areas)

4.10 Treatment waiting times

4.10.1 Waiting periods and delayed access to community-based treatment

Professionals reported that systemic barriers and long waiting periods for assessment can lead to missed opportunities to engage clients who may be considering positive alcohol change. Similarly, entry delays into structured treatment were said to risk demotivating clients, provoking disengagement from services and a return to heavier alcohol use:

"[After initially requesting support] clients could be waiting up to six weeks for an assessment, by which time they have changed their minds... You've got to strike while the iron is hot; when they're ready to make those changes." (Assertive Outreach Worker, multiple GM areas)

"Clients tell me, 'the moment has been and gone; I've been waiting two and a half weeks, and I've still not heard from them.'" (Veterans' Tenancy Support Worker, Salford)

"Sometimes I think it'd be more effective if we could shorten that process and offer it to more people." (Recovery Co-ordinator, Tameside)

"It takes so long to get support, people can be waiting weeks and weeks, and I think they can become disheartened by that and wonder why they're bothering." (Mental Health Support Worker, Wigan)

While treatment professionals recognised the impacts of high caseload numbers and staff sickness on waiting times, it was also asserted that clients most at risk are prioritised and continue to be unaffected by these barriers:

"Our current waiting list is probably a little bit longer than that because of staff absence and high caseloads, you know, it happens, but high risk [clients] are always dealt with." (Recovery Co-ordinator, Tameside)

4.10.2 Delayed access to inpatient treatment

An Assertive Outreach Team in Salford described how many referrals and successful funding applications had resulted in the depletion of the annual residential treatment budget; an outcome that was celebrated by commissioners, who subsequently asserted that they would support measures to ensure more clients could enter treatment by expanding the budget. Another professional working in another local service described the same incident, however, while their client waited for this additional funding to be released, they deteriorated, disengaged, and did not ultimately enter residential treatment.

Professionals also spoke of the frustration of being unable to support clients to access inpatient and residential alcohol treatment while they are willing and motivated to make changes:

"There might be [an available rehab bed], but it's in six months' time... You feel like you're letting someone down when there isn't a place for them, and they really, really want that support." (Co-Occurring Needs Worker, Wigan)

A professional working in an outreach and engagement team, contracted to support treatment entry, explained how after lengthy entry delays, some clients no longer require structured treatment after the protracted motivational interventions supplied by her team:

"We're working with people for so long because of the waiting length, they're reaching a point where they don't need that assessment any longer: we've done the work." (Service Manager, Assertive Outreach, multiple GM areas)

Adults with alcohol dependence also commented on facing lengthy periods between their initial requests for inpatient referrals and ultimately

being admitted into treatment, with some noting that there is a perceived need for deterioration and subsequent admission via hospital following increased alcohol harms:

> *"I needed to [detox] there and then, I didn't need to wait until I ended up in hospital again to get referred: that's no good for anybody. It's not good for the hospital. It's not good for your health. It's not good for your mental health. You've got to be a death's door before you'll get shipped onto [named detox unit]." (56-year-old male, Oldham, in treatment)*

Another described how he has used A&E pathways to circumnavigate these delays and secure fast access to inpatient detox in moments of crisis:

> *"The only way to get any kind of quicker, sooner treatment for alcohol dependency is to go to A&E and get in through a RADAR bed. You have to present yourself with no money and no access to alcohol to get one, so then they have a duty of care... I've had to do this a few times." (Male participant, focus group 2, Bolton)*

This finding echoes the findings of Chamber's et al. (2021), with many participants in their study voicing discontent at the lack of support available in the community and admitted to using hospital services for accessing help for their drinking.

4.11 Alcohol use and treatment thresholds

As Melia et al. (2021) note, alcohol policy and guidance in the UK creates a binary framing based on an objective measure of quantity of units consumed or scores on assessments. The Alcohol Use Disorders Identification Test (AUDIT) (see appendix 3) scores drinking into categories of 'low-risk', 'hazardous', 'harmful', and 'dependent drinking' (Room, Babor, & Rehm, 2005). Low-risk drinking is defined as 14 units or less per week, hazardous drinking is defined as 14–35 units for women or 14–50 units for men, and higher-risk drinking as 35 or more units for women and 50 or more units for men (National Institute for Health and Care Excellence, 2011, Department of Health, 2016). However, with alcohol use commonly depicted using a binary framework of dependent or non-dependent use, public understanding can often overlook the diversity found within drinking behaviours and the broad spectrum of alcohol associated harms, p (Melia et al. (2021).

Interviews with participants with alcohol dependence revealed that eventual dependence was at times preceded by patterns of binge drinking. This group referred to periods of significant and repeated alcohol harms yet described being denied entry into structured treatment, either at point of referral or during the initial assessment stage, after practitioners determined that early-stage non-dependent use rendered them ineligible for alcohol support. Individual accounts suggest that substance use and medical practitioners may not always consider the severity of alcohol-related harms and instead assess treatment eligibility using binary indicators of dependent and non-dependent alcohol use.

4.11.1 Participant examples of denied access

A woman in Bolton described how over a long period, having broken her pubic bone and hip on during separate alcohol-induced falls, she was denied referrals into community alcohol services by hospital staff and later after seeking assistance from her GP; both times with the stated reason that she was not physically dependent. It is noteworthy that only having progressed from damaging patterns of binge drinking into dependent alcohol use was she referred into drug and alcohol treatment services:

> *"They said I wasn't bad enough because you're not addicted to it because you binge drink, even though when I binged there was probably 10 days when I was going through vodka like it was water. There was nothing they could do for me because I wasn't an addict [. . .] I got diagnosed with breast cancer, so I was basically going through a detox while having chemo, which was horrendous, and then, as soon as they stopped the chemo, I started drinking again... My husband went to the doctors for me, but again, they said there was nothing they could do for me. Then I turned up very, very drunk at radiotherapy, and they're the ones that got me into detox." (Female participant, focus group 1, Bolton)*

It is unclear whether in this instance, alcohol dependence was a threshold requirement imparted by the community drug and alcohol service, or whether referring partner organisations perceived that an eligibility threshold was in place and must be reached for referrals into structured treatment services to be permitted.

A second interview participant described early patterns of binge drinking which were associated with episodes of violence, hospital admissions, and health harms:

> *"I was trying to stop a fight, thinking that I was 10-men. Everything backfires, and obviously I get my head kicked in. But because I was drinking, that's what made me slip into a coma so quick. If I wasn't drinking, it wouldn't have happened, according to the nurses." (36-year-old male, Manchester, not in treatment)*

Having been directed towards community drug and alcohol services by the police following reoccurring alcohol-related incidences and arrests, his account again notes the distinction between harmful binge drinking and dependent alcohol use being used to assess treatment eligibility:

> *"[At assessment, the substance use worker] said, 'you've not got a drinking problem, you're just a binge drinker' because I was still young-ish. They said, 'you're just drinking too much at certain times', and I said, 'but it's always happening', and they said, 'well that's your choice to do that; it's not an addiction'... I used to black out and not know what'd happened; that's a scary prospect. I used to wake up sometimes, not knowing where I am... to crashed cars parked outside my house." (36-year-old male, Manchester, not in treatment)*

4.11.2 Perceived need for deterioration and discouraging change

Interview participants who had been denied access into treatment services for support with binge drinking and alcohol harms felt that the impacts and negative consequences of their problem alcohol use were disregarded and perceived that treatment services required their further deterioration to be eligible for alcohol intervention and support:

> *"You've got to get so low to be able to get some help." (36-year-old male, Manchester, not in treatment*)

Noting how difficult it can be to recognise and accept that individual alcohol behaviours have been the cause of serious social and health harms, participants observed that when professionals have dismissed the severity of impact, it can demotivate initial efforts to make positive change and prevent or delay subsequent efforts to access support:

> *"I think that when you're that desperate and need help that badly, a little bit of help is better than no help... If you're in need of something and you're not getting nothing, you feel like there's no point." (54-year-old male, Rochdale, in treatment)*

4.12 Post-admission community transitions and continuity of support

Participants in Chamber et al.'s (2021) study often described a difficult transition back to their home environment following discharge. Despite high levels of readiness to change in hospital, an unsupportive home environment increased risk of relapse back to heavy drinking, particularly for those with multiple and complex needs, including homelessness and mental illness. Disjointed pathways between hospital and community treatment were also said to undermine participants' efforts to sustain change. National guidance emphasises the importance of functioning pathways between the acute, community and mental health services, to prevent a loss of momentum around the motivation to change and support for comorbid conditions (Public Health England, 2018).

Continuity of support when transitioning between providers was identified as a factor affecting adults with alcohol dependence, with returns to the community following mental health admissions, hospital treatment for alcohol-related physical harms, and following detoxification and rehabilitation all identified as transitions susceptible to interrupted or discontinued support: as evidenced below, this heightened their subjective feelings of vulnerability, while also increased the risk of - and often precipitated– relapse into dependent alcohol use.

4.12.1 Limited aftercare following inpatient detox

Identified as a primary concern, adults with alcohol dependence discussed their experiences of interrupted support when transitioning into community treatment services following admissions in inpatient detoxification units.

Frequently reported concerns focused on the limited availability of aftercare and lack of follow-up upon returning home, and the resulting challenge of navigating this vulnerable period without support:

> *"There's no aftercare. I think I was seen once after [leaving detox], and then I was left to me own accord." (54-year-old male, Oldham, in treatment)*

> *"At the time I was under [named drug and alcohol team], but basically, I had to white knuckle it." (Male participant, focus group 2, Bolton)*

One participant queried December admissions into detox, noting that his discharge coincided with the closure of the community alcohol team over the Christmas period:

> *"They're fully aware that Christmas is the critical period, so there should be extra resources in that period, not less... I was completely left to my own devices." (Male participant, focus group 2, Bolton)*

A similar account of insufficient aftercare was also recounted following departure from a residential rehabilitation setting:

> *"After a few days [named community alcohol service] called to see how I was getting on, and then I was basically dismissed from the service, because they've done their job: I've been to rehab now." (40-year-old female, Rochdale, in treatment)*

As Day et al. (2015) note, relapse to drinking is common in the first year after stopping drinking, but psychological treatments, mutual aid groups, and relapse prevention drugs increase the likelihood of remaining abstinent. Several studies have reported that engaging in treatment after a detoxification admission, especially in the immediate period following discharge, is associated with lower risk of relapse and re-hospitalisation as well as improved psychosocial functioning (Moos and Moos, 2007; Lee et al. 2014; Acevedo et al. 2016). Therefore, more immediate contact and support by services is required to reduce the risk of relapse that will illustrate below:

> *"If there's nothing there when you come out of detox, well you're feeling okay again, so you go and get a drink." (56-year-old male, Oldham, in treatment)*

4.12.2 Insufficient post-detox knowledge

Interview participants also reported returning home following inpatient detox with insufficient knowledge or understanding of the concepts of dependency, relapse, and abstinence; this was a particular concern for those unsupported by community alcohol services.

> *"I came out of detox, I'd had no preparation, and I didn't know anything about [addiction]. I came out and I thought they'd pressed the reset button, so I had a bottle of wine with me tea. I got my first phone call from [named treatment provider] three days later . . . They told me that I shouldn't be drinking, I stopped again, and that was the last time I heard from them." (Male participant, focus group 2, Bolton)*

Unfortunately, more than half of patients do not obtain any form of support after detoxification (Spear, 2014; Timko et al. 2016), which creates a 'revolving door' phenomenon in which patients are repeatedly readmitted for detoxification over relatively short periods of time (Kertesz et al. 2003; Van den Berg et al. 2015).

> *"With addiction, it seems to be a revolving door: you're addicted to drugs or alcohol, you detox, then it's straight back into the same environment, the same situation." (Male participant, focus group 2, Bolton)*

Livingston et al. (2022) conducted a systematic review into the effectiveness of Interventions to Improve Post-Detoxification Treatment Engagement and Alcohol Recovery. They note that most inpatient alcohol detoxification patients do not receive treatment post-discharge, which increases the risk of relapse and re-hospitalisation. The following account illustrates how a lack of post-detox aftercare led to relapse and multiple hospitalisations:

> *"[I thought] 'I've cracked it now, I can have a drink and just stop' . . . this was the beginning of a downwards spiral, many, many, many hospital visits; I was straight back into the groove of drinking." (54-year-old male, Oldham, in treatment)*

Asked what information would have been useful to assist the transition between in-patient detox and the community, participants firstly stated that while a seven-day detox was long enough to address physical withdrawal symptoms, an additional week *"to educate"* patients would be preferrable, especially when there is little planned follow-up, either via community-based aftercare or residential rehabilitation. They then

prioritised education on the physiological aspects of dependency and relapse, alongside improved signposting to appropriate and available support providers:

> *"[I wanted to know] that you're not supposed to drink; that you're very likely to get alcohol dependent again, and relatively quickly." (Male participant, focus group 2, Bolton)*

4.12.3 Aftercare eligibility

A participant described his efforts to engage with alcohol services following his planned discharge from inpatient detox, and as with the findings relating to treatment eligibility thresholds discussed in section 4.8, he shared a similar account, noting that he was not accepted into community services as he was no longer physically dependent. He recounted the challenges of receiving little support during his early recovery:

> *"[A named community alcohol service] told me, 'We can't offer you a service because you're not in addiction'. I said, 'but I'm trying to get into recovery; I just left [detox] three days ago', but no, they couldn't help; so, that was the end of that... I couldn't cope with anything without a drink, everything was brand new, and you have to face it sober; that was frightening cos you don't have the tools to do it." (56-year-old male, Oldham, in treatment)*

Recovery extends beyond medical treatment such as inpatient detox. Continued care helps to connect patients with essential community resources, including counselling services, vocational training, employment support, housing assistance, mental health support, creating a holistic recovery approach.

The need for ongoing monitoring and follow-up beyond treatment was also noted, including regular follow-ups and check-ins to continue to monitor the recovery progress, addressing any potential issues proactively.

4.12.4 Mutual aid reliance in the absence of adequate aftercare

Through discussing their experiences of limited post detox aftercare, participants noted that prior to discharge, they received little information on recovery pathways and community alcohol support beyond mutual aid.

> *"I don't know what I expected, because I had no idea what recovery was. Nobody had ever talked about it and people had only ever suggested AA and NA; the [community drug and alcohol services] were never mentioned while I was in detox." (56-year-old male, Oldham, in treatment)*

Participants in Bolton described how receiving little information prior or post discharge from inpatient alcohol detox necessitated a reliance on their peers with experience of addiction and recovery to advise and signpost into community support groups:

> *"The integrated drug and alcohol service haven't really done anything. Everything I've found out has been word of mouth, off my own volition, my own research, help of friends and family: that's what's changed me this time around." (Male participant, focus group 2, Bolton)*

> *"I've had to do that on my own" [. . .] Once you find a [community] group, it's quite easy to find others because everybody's tried different things. But it is usually through your peers that you find out what's going on." (Female participant, focus group 1, Bolton)*

> *"Everything I've done [to work towards positive change] has been because [other peers] have said, 'why don't you come along to this group.'" (Male participant, focus group 2, Bolton)*

Kuruvilla et al (2004) found mutual-aid participation during and after detoxification was associated with improved alcohol outcomes, however we found evidence that when people with alcohol dependence have limited engagement with formal aftercare via treatment providers, they often feel alone and struggle to sustain abstinence upon discharge from detox.

Part 5a: Facilitators and contextual factors strengthening access, engagement, and positive change

5.1 Reducing professional stigma and promoting understanding

As discussed in section 4.2, we found that stigma towards addiction and people with challenging lives exists within mainstream or universal services. A Harm Reduction Lead working across multiple GM areas identified the need for greater addiction knowledge across the health and social care system, where staff have been previously heard suggesting that clients 'should just stop drinking', unaware of the associated risks. It is believed that incomplete or inadequate knowledge of dependency, addictive behaviours, and associated support needs can exacerbate existing stigma and permit cultures where poor or unresponsive treatment of adults with alcohol dependence is normalised and accepted:

> *"The workers weren't as knowledgeable about our client group, not as willing to take additional measures to make sure that they do engage." (Rough Sleepers' Supported Tenancy Officer, Salford)*

Professionals suggested that improved cooperation when working in partnership with wider support services provides an opportunity to share knowledge and challenge stigma among other professionals. It was asserted that challenging professional stigma would ease entry into services and bring improvement to marginalised clients' experiences of support:

> *"[If professionals] became a bit more caring towards people, they'd stick with [alcohol clients] for extra five minutes to signpost or discuss things." (Assertive Outreach Team Leader, Bolton)*

> *"[Mainstream services] are made up of civilians . . . if more people understood what was happening, they'd be more interested in helping people, and they would work in a different way." (Rough Sleepers' Supported Tenancy Officer, Salford)*

> *"I'd have us go and deliver some training to Greater Manchester Police... [at multiagency meetings], the way police speak about the people who we work with... is horrendous [...] I would happily go and [provide] the training, but it's getting in there; it's such a big service; are they going to listen? It's such a big organisation, so how they view people with addictions is probably going to snowball across society." (Harm Reduction Outreach Worker, Tameside)*

5.1.1 Raising awareness through training

With the prevalence of stigma within mainstream support provisions, improving understanding of addiction across all service providers was identified as an essential requirement to improve outcomes for alcohol clients. A mental health professional in Wigan noted that access to training opportunities can be affected by siloed treatment offers:

> *"[Dependent drug and alcohol use] is not something we have a lot of training in... It been like, 'well, we'll get your mental health okay here, and then you'll go on to see [named community substance use service] and they'll deal with the addiction side.'" (Mental Health Support Worker, Wigan)*

Implementing measures to bridge this knowledge-gap and ensure a baseline competence across GM service provisions would mitigate risks associated with erroneous health and harm reduction advice. In referencing their own limited knowledge, professionals advised that receiving addiction and substance use training would enhance their abilities, confidence, and capacity to provide supportive interventions and facilitate change when supporting clients who drink dependently

> *"When you're dealing with such a high number of people that are using drugs and alcohol, I think everybody should be offered that training, because a lot of the staff would say that they don't feel they know enough about it to be able to have those conversations." (Ward Manager, Acute Mental Health Inpatient Unit, Wigan)*

Establishing an extended knowledge base across GMCA would provide a multitude of opportunities for drug and alcohol awareness raising while facilitating attitude and cultural change within support and treatment services. It was suggested

that drug and alcohol training become mandatory for all front-line workers, irrespective of their role, while proactive moves to engage professionals would galvanise cross-sector efforts to engage adults with alcohol dependence and who services traditionally find hard-to-reach

5.2 Building trust through lived experience

While interview participants with alcohol dependence spoke of their difficulties trusting 'the system', professionals reported that building trust was integral to reducing barriers and improve engagement:

> *"Keep trying, keep turning up... give someone a reason to trust you, then don't mess it up." (Mental Health and Substance Use Worker, voluntary sector- criminal justice, Manchester)*

> *"You've got to earn [clients'] trust... Just because you're in a professional job doesn't mean you're the most trustworthy person, does it?" (Mental Health Support Worker, Wigan)*

Alongside many offered examples of effective engagement efforts, recruiting staff with lived experience was reported to be central to many alcohol support and treatment provisions: these professionals were reported to bring personal insight and unique understanding of the challenges encountered by clients.

5.2.1 Trusted relationships and encouraging engagement

Both interview cohorts advised that when professionals disclose their own relevant experiences within the boundaries of support worker-client interactions, it can be effective in encouraging entry into services and facilitating the formation of trusted relationships with alcohol clients:

> *"We do have quite a lot of people that have been through services and that [now] work for us, and they're all quite open about their own history... [this helps] in terms of encouraging people to come in." (Addictions Lead, Stockport)*

> *"When workers come with their own experience and it's not from a textbook, that makes a difference. They can empathise and connect because they've been there, so they know." (58-year-old female, Bury, in treatment)*

> *"[Professionals' lived experience] plays a great role in relating with the clients and giving them a little bit of motivation." (Assertive Outreach Worker, Rough Sleepers Drug and Alcohol Team, Salford)*

> *"[To help people think about alcohol change] people need this place, most of the staff and volunteers [at the Wellspring] have been through it or they're going through it; they now sit here sober. They'll help you with anything." (39-year-old male, Stockport, in treatment)*

Lived experience was said to be of particular asset in assertive outreach and when supporting entrenched alcohol and homeless clients who may be hard to engage:

> *"It's not something that we lead with but when you can see that it has had a positive effect with the client, lived experience seems pretty valuable in assertive outreach, in my opinion." (Assertive Outreach Worker, Rough Sleepers Drug and Alcohol Team, Salford)*

> *"The good side of CGL is the people that I go to see when I'm not going to see the doctor. I've been lucky in this regard, because I've got a really cool guy who's an ex-user and I can speak to like I'm speaking with you. That's rare." (47-year-old male, Manchester, not in treatment)*

Professionals' experiences of addiction were not only said to be effective in engaging alcohol clients but appear to attract trust and belief in the staff member's understanding and capacity to secure desired support and treatment offers:

> *"It was only because [my substance use worker] had history himself and knew that I was not talking shit that he [could advocate for me] with the doctor." (47-year-old male, Manchester, not in treatment)*

5.2.2 Confronting stigma and visible recovery

It was suggested that professionals appropriately referring to their own past experiences can be impactful in challenging internalised stigma held by clients; these exchanges help to establish a foundation from which conversations centred around clients' alcohol support, treatment, and recovery needs can emerge:

"Staff with lived experience become more comfortable talking about own issues, thus helping to challenge stigma – it helps clients to open-up and have conversations over their own issues." (Support Worker for ex-prisoners, GM wide)

"Sometimes doctors' kind of frown if you've got a drink problem. I was lucky with my doctor. He understood and was quite open [with me]; his mum died an alcoholic, so he had that empathy." (58-year-old female, Bury, in treatment)

Further to supporting access and facilitating engagement, employing staff with lived experience was said to provide valuable role models for adults with alcohol dependence who may be inspired by encountering instances of *visible recovery:*

"Workers with lived experience are role models. It is important for visible recovery and beneficial and inspiring to clients." (Recovery Engagement Worker, Bolton)

"We are living, breathing, walking proof that [recovery] can happen." (Volunteer Co-ordinator, inpatient detox unit, Manchester)

"You go to rehab to learn from the people who are in there learning from your peer mentors who have all had addictions in the past. Learn from them because they've seen it and been through it." (54-year-old male, Oldham, in treatment)

These views are consistent with the two-year progress review of the current 10-year From Harm to Hope strategy (Home Office 2024a) that reports that connecting with people with lived experience of drug and alcohol use and treatment services was consistently cited as key to making local implementations more relatable and aligned with real world contexts.

5.2.3 Valuing the experience and skills of all team members

Although embedding lived experience within support and treatment services was highly valued by both professionals and participants with alcohol dependence, some challenges were also identified. Notably, where professionals do not have – or choose not to disclose – past addiction experience, it was reported that some clients may query whether they are in the best position to provide appropriate support:

"There were two young girls straight out of university... Fair play if that's what they want to do in life, but it's hard to speak to an addict or someone vulnerable in addiction if you're just reading off a handbook. It wasn't doing anything at all, it was just taking up an hour of my life." (56-year-old male, Oldham, in treatment)

"[Some clients say], 'I've got more life experience than you' and they don't want to really listen to what I have to say." (Criminal Justice Recovery Co-ordinator, Tameside)

A treatment professional described how his workplace – an inpatient detox unit - approaches this viewpoint, noting how the efforts, knowledge, and experience of all team members collectively ensure clients receive appropriate and responsive support:

"Some clients say, 'unless you've been there and done it yourself, you don't know what you're talking about... I'm not interested in talking to you'. But there's a lot of people that work in recovery that haven't been addicted themselves and can really help them... Our response is that it really doesn't matter if someone's in recovery or not... one person may not have all the answers; we work as a team." (Volunteer Co-ordinator, inpatient detox unit, Manchester)

5.3 Peer support and mutual aid

As identified in section 3.3, where individuals are isolated or without positive social connections, the impacts and related challenges are considered to drive levels of harmful drinking, while also inhibiting structured treatment efforts and hindering efforts to enact positive change. It was therefore notable that during interviews with adults with alcohol dependence, they referred frequently to peer support and mutual aid, often speaking with enthusiasm as they describing the experienced benefits.

The advantages of building healthy relationships with a group of peers through mutual aid was acknowledged, as was the increased availability of support during evenings and weekends when community drug and alcohol treatment services are closed. Further to the many in-person meetings that take place daily, mutual aid meetings are also accessible online, and as they are hosted globally, provides those with internet

access and appropriate technology opportunities to connect with supportive others at times when otherwise they would struggle alone. Wolfe et al. (2023) noted that telehealth options provided greater flexibility in timing and, therefore, greater accessibility for participants (Scarfe et al. 2023; Seddon et al. 2022; Black et al. 2020; Ekstrom and Johansson, 2020; Tarp and Nielsen, 2017).

5.3.1 12-step fellowships

Interview participants with experience of alcohol dependence evidenced much awareness of 12-step fellowships, with most knowledge arising from prior personal attendance or through having heard word-of-mouth from other attendees. Opinions on the benefits of attending and engaging with the programme were generally polarised:

> *"There are times that getting to a meeting has literally saved me and dragged me out of total despair that is caused by drink. They're all over, so people should get to one and it see if it helps them like it helps me." (44-year-old male, Wigan, not in treatment)*

> *"I don't find AA meetings any good at all; I feel like committing suicide when I come out." (Male focus group participant, Bolton)*

It was reported by professionals that some alcohol clients are immediately resistant to suggestions of 12-step engagement and at times, rely upon third hand criticisms and common myths to justify their stance. We found evidence of this position during interviews with adults with alcohol dependence:

> *"No, no point, it's not for me at all... I haven't been but we have enough of our addictions put down our necks; we're trying to get away from it." (54-year-old male, Oldham, in treatment)*

By questioning the myths that surround Alcoholics Anonymous and other fellowship meetings, professionals encourage informed decision-making and challenge unwarranted attendance barriers; this allows clients to consider further options for accessing available out-of-hours peer support. One professional explained how he encourages clients who drink dependently to utilise the useful aspects of 12-step meetings, while disregarding anything that does not suit their needs:

> *"I'll say to clients, 'put aside the religious aspects, you're saying that you're lonely and here is a community of people in similar situations to yourself... you never know, you might bloody well like it'." (Assertive Outreach Worker, Salford)*

A female in Rochdale was accompanied to an NA meeting during an inpatient alcohol detox and described the moment she first experienced a connection with her peers and felt that she was part of a community:

> *"Something happened in those meetings, and I thought, 'you know what, I want to be around these people'." (40-year-old female, Rochdale, in treatment)*

Establishing an emotional connecting with others was later shown to be pivotal when the newly found positive relationships proved stronger than her fears of returning to meetings during an alcohol relapse; having become aware of this, she was impelled to return to her regular 12-step meetings and seek continued support from her community of peers:

> *"I was full of fear, and actually there was no need to be full of fear, because everybody in that room is very aware of lapses and relapses... The connections that I'd made with the people there [encouraged me to return after relapsing]." (40-year-old female, Rochdale, in treatment)*

5.3.2 SMART Recovery

The Self-Help Addiction Recovery Programmes or SMART Recovery was also reported to be of benefit by those who have engaged with the structured mutual aid programme. Professionals noted that SMART meetings are hosted both in-person and online, although availability is comparatively lower, and they run less frequently than 12-step fellowship meetings. It was also suggested that SMART may be preferrable for female clients who struggle with the disparate gender ratio found in other mutual aid programmes:

> *"SMART recovery is quite good for a lot of the girls I've worked with. They really enjoy that; it takes more of a CBT approach." (Harm Reduction Outreach Worker, Tameside)*

While some participants considered SMART as a more desirable alternative to 12-step meetings, others observed that the programmes can be worked in unison and provide complementary benefits:

"I do go to AA as it's a reminder of where I could go if I do carry on drinking... SMART's brilliant, it's really good, and it's a bit more relaxed than AA." (Female participant, focus group 1, Bolton)

5.3.3 Sustaining change through peer support

Frontline support and treatment professionals actively promote and encourage alcohol clients to attend and engage with mutual aid to supplement formal support offers and facilitate recovery, whereas peer support was often valued most highly and considered central to efforts made by those aiming to achieve and sustain positive alcohol change:

"My peers have carried me through; what would I have without them?" (39-year-old male, Wigan, not in treatment)

"I enjoy peer support groups, and they keep me well." (Female participant, focus group 1, Bolton)

"Because I'm in early sobriety, I've got to try to be around people who are in the same situation and the same thinking as me." (54-year-old male, Oldham, in treatment)

"One of the keys to getting out of addiction is social interaction; to be of value." (Male participant, focus group participant 2, Bolton)

5.3.4 Service proposal: Telephone buddy service

An Assertive Outreach Team Leader working across multiple boroughs posed a solution to the interrelated challenges posed by alcohol dependence, pervasive isolation and loneliness, and potential barriers when accessing mutual aid. Drawing from a similar service offered by Age UK and combining it with the AA helpline model, he suggested the development of a telephone buddy scheme to expand the availability of out-of-hours support. This he suggested, would provide opportunities for dependent alcohol users to connect with others, reduce the impacts of loneliness, and facilitate engagement with mutual aid:

"If we had some kind of buddy service where you speak to somebody who's lonely and isolated... that would be really, really beneficial. We suggest that clients go to AA, but we're not working at seven at night. If somebody could give them a call or go round the next day and say, 'did you go?'... Like for many people, going [to mutual aid] with somebody else gives me a prompt, and I actually do go." (Team Leader, Assertive Outreach, multiple GM areas)

As outlined in section 3.3.1, such efforts to tackle isolation and foster supportive networks would also strengthen the position of alcohol clients who wish to access community and home-based detoxifications.

Part 5b: Facilitators and contextual factors strengthening support for people with complex needs

5.4 Housing models: temporary and supported accommodation

Professionals identified in section 4.2 that temporary housing provisions for entrenched alcohol clients is frequently inadequate and ill-equipped to accommodate complex needs, however, they also proposed solutions, including the introduction of new and accessible housing models, designed specifically to cater for this group.

5.4.1 Overcoming access barriers: referral rejections and evictions

Reintroducing 'wet houses' or increasing the availability of temporary and supported accommodation offers which operate under a model of harm reduction would prevent the high numbers of rejected referrals and evictions for onsite drug and alcohol use that have been reported by professionals. It would also ensure that support staff have greater understanding of behaviours linked to substance intoxication, and possess the skills to manage and respond appropriately thus reducing repeated episodes of homelessness following evictions for alcohol-related antisocial behaviours:

> *"[Alcohol clients] need a place of safety where they're allowed to drink and that shows some leniency towards crack use, because a lot of dependent drinkers also use crack." (Social Worker, Entrenched Rough Sleepers Team, Manchester)*

Using a harm reduction ethos to underpin homeless accommodation provisions would end requirements and expectations for clients to quickly reduce and then cease their use of alcohol and other drugs:

> *"We need housing options which recognise that overcoming problematic drinking is not going to happen overnight... Not everyone wants to quit drinking, but it's about [creating an environment] where they can learn how to stabilise it and maybe manage on just a couple of drinks." (Social Worker, Entrenched Rough Sleepers Team, Manchester)*

Removing zero-tolerance policies will halt the trend of entrenched alcohol and homeless clients from being placed in unsuitable housing due to necessity and lack of alternative options. Increasing availability of appropriate housing offers will also prevent alcohol clients from being supported into accommodation which under its design, will inevitably result in negative outcomes:

> *"I got offered to move into a place that had all these rules, don't drink, don't do this, don't do that, and I said 'yeah', cos what else was I gonna say. But it didn't last long. I'm an alcoholic, so what did they expect? I was always going to drink." (44-year-old male, Wigan, not in treatment)*

5.4.2 Supportive housing models for entrenched alcohol users

Adopting new models of supported housing will tackle the housing precarity that arises from an inappropriate placement and eviction cycle, reduce instability and the anticipation of future disruptions, and enable support and treatment professionals to work with clients to identify support needs and goals:

> *"Emergency accommodation are not great environments to even be considering [alcohol] reduction work... it's something that we consider at a later date when they've got more settled accommodation." (Assertive Outreach Team Leader, multiple GM areas)*

Imagining an ideal housing placement for clients who drink dependently, professionals identified built-in provisions deemed essential when creating an environment best suited for providing this cohort with high quality and much required care.

Entrenched alcohol clients may already be supported by the Care Act 2014 or otherwise meet the vulnerability threshold for which they would be eligible for assessment. However, it was suggested that suitable housing for this group should be built upon the Act's key principles and be responsive to safeguarding needs. Only upon establishing a safe environment can clients benefit from personalised and trauma responsive support that is designed to empower and prioritises wellbeing:

"There should be more [accommodation] facilities where people are allowed to use and drink with the right support network in place, Care Act-led, that's a psychologically informed environment." (Social Worker, Entrenched Rough Sleepers Team, Manchester)

This professional suggested a tiered model, noting that effective housing provisions must deliver optimum support while also being responsive to diverse and changing needs:

"There should be tiers where, as people reduce their use, they can move up the tiers to be around peers that are like-minded. If they've got drinking buddies, they're going to drink themselves into oblivion. So, sometimes it's about having that step-up approach." (Social Worker, Entrenched Rough Sleepers Team, Manchester)

5.4.3 Supportive housing models for women

As professionals identified in section 4.2.1, additional challenges exist within current housing provisions that pose unique barriers for women; to counter this, they agreed that an improved system would include increased availability of women-only spaces, and focus particularly on housing models for vulnerable and sex working women:

"[We need] female specific support and should maybe try a different approach with women [who sex work]. Those I speak to, they hold a lot of shame, and they don't recognise what they are sacrificing to make money... We need to create softer environments, where it's caring, kind, and compassionate, and builds that person back up, rather than stripping them of everything" (Harm Reduction Outreach Worker, Tameside)

"We should have women-only [accommodation], for street workers and the hidden population that's never, ever going to be seen or verified as a rough sleeper because they stay with punters and remain hidden. Yes, a women-only place would be good." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)

5.5 Trauma-informed practice

Greater Manchester is on the journey to become an Adverse Childhood Experiences (ACE) aware and trauma-responsive system. The Greater Manchester Combined Authority (GMCA) and GM Reform Board, Violence Reduction Unit (VRU) and Integrated Care Board (ICB) aim to promote a shared understanding of the concept of trauma-responsive care. This includes a recognition of the prevalence of trauma in people's lives and acknowledging potential effects that this can have on individuals, families, networks & communities (for details see: Trauma Responsive Greater Manchester).

Noting that there has become greater understanding how trauma underpins many people's harmful substance use, some services have adapted in response, including refocusing structural support offers and in the delivery of individual care:

"[We understand] that clients have a lot of trauma involved, so we're looking at a different way of working with people. [We] can no longer say, 'right, here are the 12 steps, off you go, we'll see you when you're cured'; you have to look at the whole holistic person and see what their needs are. When I first came into the job, rehabs were rehabs, and it was around sorting out your addiction. Now we're all a bit wiser; rehabs have also realised that they need to work and use their counselling in a more trauma-informed way, and we will [refer clients into] those rehabs more." (Manager, Substance Misuse Team, Manchester)

5.5.1 Examples of trauma-responsive design

Professionals offered examples of diverse and creative approaches to delivering trauma-responsive support:

A psychologically and emotionally safe welcome

A community substance use service has recruited a dedicated 'meet & greet' volunteer with lived experience who is situated in the reception/waiting area with the purpose of creating a safe space for clients as they wait for their appointments. This initiative is reported to have been successful in reducing access barriers for clients, including those with trauma histories, who may otherwise be dissuaded from entering a drug and alcohol treatment service:

"It's to make our waiting room somewhere that is psychologically and emotionally safe for people to come into and sit and have

some confidence on the worst day of their life. [The volunteer will] make a cup of tea and give biscuits while [clients] wait. If they're panicking, then they have someone there to support them... it's to try and make it more welcoming." (Addictions Lead, Stockport)

Removing symbols of power

A professional who supports individuals following their release from prison described how simple acts such as removing his lanyard and ID prior to meeting clients can support engagement. Many have experienced abuse by someone in a position of authority and may consider these items to be symbolic of power. Similarly, he referred to a probation worker who, adopting the same rationale, wears hoodies instead of formal attire during in-person client work:

> *"It's being trauma informed. Some people freeze when they see a lanyard.... if it's got a police badge on it, that's even worse. I was working with a lad... and he saw a police badge... and he just froze; it was a trauma response to being beaten up by heavy-handed police." (Mental Health and Substance Use Worker, voluntary sector- criminal justice, Manchester)*

Safe spaces

Ultimately, within current provisions and without easy access to specialist trauma support, professionals agreed that the best way they can offer support and work towards establishing trust is by taking measures to help increase clients' feelings of safety:

> *"I would say, from a trauma-informed response, it was about trying to create a place of safety for [the client] to be able to sit and chat." (Social Worker, Entrenched Rough Sleepers Team, Manchester)*

However, it was also noted that for some groups, there is a need for services to be established that are designed and operate from the outset using trauma-informed principles:

> *"There needs to be a safe place which women can access, especially vulnerable women. I work with a lot of sex workers who drink quite a bit, and so, a safe space for them [to access], and where there is no judgement. This doesn't exist right now, which is a real shame; I feel like that's something that we kind of need." (Harm Reduction Outreach Worker, Tameside)*

5.6 Assertive outreach models

It was outlined in section 4.4 that entrenched alcohol clients are often confronted by innumerable barriers to positive change and can find the prospect of engaging with support or treatment overwhelming and unmanageable. Professionals working with this group advocated the effectiveness of adopting assertive models of engagement and support delivery:

> *"Some people are not in a place where they're ready to address their recovery... but evidence is showing that there's a big benefit to [our assertive outreach model]." (Service Manager, Assertive Outreach, multiple GM areas)*

A randomised control trial across five South London NHS Trusts found that assertive outreach with alcohol dependent patients demonstrated significant reductions in alcohol consumption and use of unplanned National Health Service (NHS) care, with increased engagement with alcohol treatment services, compared with patients receiving care as usual (Blackwood et al. 2020).

It was noted that successful and effective engagement efforts are often reliant upon the persistence and flexibility of outreach workers:

> *"A lot of the people that we work with, they've got these massive risk factors. They don't really respond very well sometimes, but if you pester them..." (Team Manager, Drug & Alcohol Team, Stockport)*

> *"If somebody doesn't feel like having a conversation with me that day, that's absolutely fine; I can come back in a couple of days." (Substance Use Worker, multiple GM areas)*

Adults with alcohol dependence and who had histories of entrenched rough sleeping spoke positively of their experiences with street outreach and engagement teams. In fact, when asked which helpful support interventions should be expanded and made more accessible, this group consistently suggested increasing outreach provisions:

> *"[Named support workers] came into town every day to see if I were alright... they showed that they wanted to help [...] There could be a few more agencies: people that come out and see people that are drinking on the street a couple of days a week." (46-year-old male, Manchester, in treatment)*

"You could have more workers going out looking for people, [asking], 'where have the drinkers gone?' Not just to get them help, but so in the future when they're ready, they'll have someone's contact details." (54-year-old male, Rochdale, in treatment)

Contrasting support offers from mainstream substance use services with a drug and alcohol team working specifically with people who are – or are at risk of - rough sleeping, a professional reflected on how a client with alcohol dependency had benefitted from workers that were knowledgeable and had the skills to effectively engage with those who are excluded and present with multiple and complex needs, and surmised the following:

"That was the only way that he really got clean and sober, through having our team of recovery coordinators go to his address, you know, lots of handholding and... physically, putting people in the car, 'come on, we're off here, we're going there, let's get you to the GP.' It's not just about alcohol, it's about everything, it's about their whole health in general but I think with [mainstream drug and alcohol providers] [pauses], for this guy, he wouldn't be where he is now if he hadn't gone through that other [dedicated] service." (Veterans' Tenancy Support Worker, Salford)

5.6.1 Street outreach and engagement: bringing support to clients

Entry into support and treatment provisions is often contingent on clients' readiness and capacity for attending in-service appointments, with such requirements impeding access and affecting outcomes for clients with complex needs. Responding to these obstacles, professionals have made efforts to re-define traditional access and entry points into services through developing outreach and street engagement provisions.

Street engagement: accessible doctor

A professional noted that a doctor has recently joined an assertive outreach team 'on loan' where he been accompanying workers on street visits and meeting with entrenched rough sleeping clients. Preventative healthcare, blood testing, and physical health checks are now easily accessible, and clients can be advised on health concerns and referred into further treatment when necessary.

Taking primary care to the street community and avoiding the requirement for in-service appointments has helped to facilitate health interventions where they were previously out of reach:

"Specifically with our core clients who are so poorly, we've been thinking, 'I can get them into structured treatment, I can signpost them crisis management services, and encourage them to see the GP, but actually, they're not going to go for any of this. But when you've got a doctor sat there [on the street] telling you that you need to go to hospital, you're probably going to go to hospital." (Team Leader, Assertive Outreach, multiple GM areas)

Street engagement: alcohol treatment professionals

Similarly, it was noted by several professionals that when alcohol workers use opportunities for street engagement in lieu of requiring attendance at services, this approach has shown to be more effective in supporting hard-to-reach clients into alcohol treatment:

"We're not forcing someone to go to a busy office or [attend] a group, [or] to get to an appointment every week. We're saying, 'someone will come and see you, just like I do'. And it works out really well." (Rough Sleepers' Supported Tenancy Officer, Salford)

This entry route into treatment was corroborated by an alcohol client whose contact with substance use services has primarily centred around street engagement. He noted that drug and alcohol workers offered regular outreach support and later referred him into Chapman Barker Unit for inpatient detox just when his physical and mental health had deteriorated:

"[Named homeless drug and alcohol outreach workers] got me into CBU. At the time, I was in a bad place." (46-year-old male, Manchester, in treatment)

A social worker supporting entrenched rough sleepers outlined how a positive collaboration with an inpatient treatment nurse supported personalised engagement and facilitated a client's journey into detox. The value of treatment professionals engaging clients through outreach and participating in offsite support delivery is exemplified through this account:

"[My client] was accepted at detox, [but on the] day, he couldn't go through with it and everything fell apart. So, we talked through his anxieties, and I scheduled for him to go to CBU. I got the nurse involved. She was part of the safeguarding to come and meet me on the streets, get to know him, have a chat with him. We took him in a taxi to CBU, showed him around, sat down with tea and toast, and... talked it all through; he basically gave us the thumbs up. We scheduled [his admission] the week later and did exactly the same: the nurse met us on the street, we ordered a taxi, took him in, and settled him down... He lasted four or five days in detox." (Social Worker, Entrenched Rough Sleepers' Team, Manchester)

Although bringing healthcare and alcohol treatment into street and community settings can facilitate access for those who are hard-to-reach, it was suggested that to counter the existing structural barriers within services as reported in section 4.4, outreach efforts should continue beyond first contact with a client to protect against rapid disengagement:

"We've racked our brains as to what we can put in place to ensure that somebody can [access and attend treatment] for themselves in the long term. But the trouble is, when they're really, really poorly with alcohol, they're literally too poorly to go to appointments . . . and that was the biggest barrier we faced. I think structured treatment services have recognised this [and have started] going out themselves more often to see people as well." (Team Leader, Assertive Outreach, multiple GM areas)

Part 5c: Facilitators and contextual factors strengthening access into alcohol treatment and support provisions

5.7 Accessible alcohol support via community spaces

The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk (NICE, 2011). However, based on the evidence we found, we propose that such efforts should be expanded outside the NHS and be adopted by service providers supporting clients with alcohol needs.

Responses from treatment professionals suggested that offering alcohol assessments, support sessions, and treatment clinics from several diverse and spatially dispersed localities would improve access for individuals living in remote areas.

Similarly, allowing new clients to enter treatment from satellite clinics situated in general-purpose buildings and independent from recognisable drug and alcohol provisions was reported to reduce barriers arising from stigma and stereotyping, thus facilitating access among clients who are ordinarily disinclined to approach or engage with treatment services.

Professionals reported that further to the present availability of in-service support offers, a growing number of providers consider community outreach and engagement as integral to future service developments.

A selection of the varied examples of community-based engagement by drug and alcohol services include:

- Satellite alcohol clinics for people who would not ordinarily access traditional substance use services
- Holding public drop-in sessions for drug and alcohol information, signposting, and referrals
- Stalls and tables at day events, fetes, and festivals for awareness raising and service promotion
- Facilitating drug and alcohol groups for clients of partner agencies
- Use of social media for service promotion, alcohol messaging, and harm reduction efforts
- Open access recovery café
- Harm reduction promotion in social spaces, such as pubs and clubs

5.7.1 Example: Recovery Cafe

Hosted by the local area's substance use service, the Recovery Cafe in Tameside is a community hub where visitors can meet weekly to connect and socialise in a safe and welcoming environment.

Each session is facilitated by substance use professionals who provide supportive engagement, assist with structured treatment enrolment, and offer advice, information, and signposting to local area wellbeing and recovery networks:

> *"For a lot of people in the community, you can come for your breakfast, you can have a cake, have a chat with one of our workers, and then enrol yourself in the service if you want to, if you just want harm reduction advice, you can just get that." (Harm Reduction Outreach Worker, Tameside)*

The Recovery Cafe encourages and facilitates clients' first contact and engagement with alcohol support and treatment services from a location independent and detached from the main provisions. This offers an alternative access route into structured treatment and benefits first-time alcohol clients who either resist or are deterred from support when required to enter and access via large and busy integrated drug and alcohol services.

Further to well-developed, effective, and engaging support offers proving beneficial to increased treatment uptake, it was suggested that ensuring community spaces are designed to be welcoming holds equal importance, as it prompts clients to participate in word-of-mouth awareness raising with their peers, while encouraging first-time visitors to return and continue engaging with treatment and support:

> *"I think offering community venue support is massive. If word gets around quite quickly that we are there and it's free. It's a warm space where people can come and sit, have a brew and a chat about substance misuse." (Harm Reduction Outreach Worker, Tameside)*

5.8 Extended opening and addressing caseload and capacity issues

Having identified the barriers arising from operating within a service structure built around core hours of between 09.00 am and 5.00 pm in section 4.5.1, introducing or expanding evening availability was suggested to enable support and treatment access to those who either work or require options for attending outside of the traditional core hours:

> *"We need a couple of different late-night openings, maybe one Saturday a month or more often. We already go into community venues, but we need more of that, like satellite clinics. Bolton is a big geographical area and if there was a clinic that ran for three hours, once a week of an evening for people to go for their appointments, that would be beneficial, especially to those that work." (Assertive Outreach Team Leader, Bolton)*

5.8.1 Example: New Beginnings Check-Up

One service has recently implemented such change. CGL in Tameside have developed a new pathway for the check-up sessions. These sessions run twice a week on Tuesdays and Thursdays between 12pm and 8pm. The new engagement pathway was introduced because of increased waiting times for lower risk people who had been referred to the service but due to staffing levels and the emphasis being directed to high-risk referrals, had not yet received an appointment for a triage and assessment. Those invited to the sessions consisted of mainly alcohol and non-opiate referrals:

> *"We decided to introduce a 'New Beginnings Check-Up.' We'd implemented something similar in the past known as drop-ins or open access that were not successful. With the collaboration of the data team, we have been able to invite people by letter, text or email who are waiting for triage and assessment to these sessions that are deemed lower risk i.e. not opiate users, no risk of suicide, have a fixed abode, no social services involvement, to speed up their entry into service. These sessions have been running since 28/01/25 and we have already 149 people and triaged and assessed over 30 people." (Project Manager and Harm Reduction Lead, Tameside)*

Additional data provided by the service indicated that of the 251 people who had been invited to 'New Beginnings' almost half (124) were alcohol referrals with an additional 45 alcohol and non-opiate referrals. Referrals are given four weeks to attend a session before they are closed. The sessions run twice a week, providing a total of eight opportunities to attend. At the end of February 2025, this had already resulted in seeing 20 alcohol and nine alcohol and non-opiate referrals.

5.8.2 Addressing caseload and capacity issues

Local services providing fixed-length and short-term support reported that interventions are withdrawn quickly from clients as they are discharged from the service, and that increasing capacity would enable closures to be less abrupt and help prepare clients for reduced input from support services.

Professionals identified the need to improve the capacity of alcohol treatment services and discussed how this would positively affect their support offers. It was proposed that reducing waiting times and increasing staffing levels would allow professionals to provide in-depth and more frequent support interventions. Other suggested improvements included faster detox admissions, expanding community outreach, and extending the benefits of work already in action to a wider population.

As illustrated below, many professionals highlighted the fact that if there was more funding for increased staffing and service capacity, caseloads would reduce, and improved outcomes for alcohol clients would ensue:

> *"We're doing everything we can for the clients... so if funding wasn't an issue, we'd want to expand by getting more staff in." (Harm Reduction Lead, multiple GM areas)*

> *"If I had a lower caseload, I could do much more meaningful work." (Team Leader, Assertive Outreach, multiple GM areas)*

> *"If we had more workers and the clients could be seen more regularly, they'd get into detox and rehab quicker, because they'd be seen more [frequently]." (Recovery Co-ordinator, Tameside)*

"[If we had capacity] we'd run a shared care model in a few places... We'd go straight into all the GP surgeries and hang about there, looking for the people that presented with a whole myriad of things that are dressed up as musculoskeletal, depression, all sorts of things which are actually probably alcohol use or alcohol fuelled or alcohol mitigated, and be able to offer them a compassionate service, as opposed to a transactional service." (Addictions Lead, Stockport)

Although interview participants identified that reduced capacity, heavy caseloads, and restricted opening hours to be factors creating structural barriers for some wishing to access and engage with alcohol support and treatment services, alongside the suggestions offered above, professionals and adults who drink dependently also offered plenty of examples of what is currently working well.

Part 6: Facilitators and contextual factors strengthening alcohol treatment delivery

6.1 Specialist alcohol-focused interventions

In consideration of the integrated drug and alcohol treatment model discussed in section 4.6, it was recognised that the loss of specialist alcohol teams has affected the provision of community detox offers for adults who drink dependently:

> "*We're not doing as many community alcohol detoxes. There's often a lot of work to be done; this is a capacity issue; if we had a clinical team whose focus was entirely on alcohol that would work much better." (Consultant Addiction Psychologist, multiple GM areas)*

However, as outlined below, treatment professionals also reported on several alcohol-focused interventions, noting how they advantage clients' treatment access, while outlining the challenges faced during their implementation and how their responses and proposed solutions will benefit future service development.

6.1.1 A&E Alcohol Care Teams

Webb et al. (2024) note that chronic alcohol disorder hospital admissions are increasing in England and present a huge cost to England's health and social care costs. Hospital-based alcohol care teams (ACTs) aim to better meet these patients' complex needs through assessment and targeted referral. This has the potential to work effectively within England's newly established integrated care system. The National Health Service (NHS) 10-year plan aims to develop optimised Alcohol Care Teams within hospitals as part of reducing health inequalities (National Health Service, 2019). In an English study of the outcomes of patients with alcohol use disorders following an alcohol intervention during hospital attendance, Chamber et al. (2021) noted that patients with alcohol use disorder AUD have high levels of morbidity and mortality, yet many made substantial changes following intervention in hospital for their alcohol use. They report that hospital attendance often marked the first realisation for participants that alcohol intake had caused physical harm, often failing to recognise the association between physical ill health and alcohol use until this was made explicit during hospital attendance. They found that an increased awareness of their morbidity and mortality often prompted participants to re-evaluate their alcohol use.

Attendance in hospital for treatment for alcohol-related heath concerns was also found in our research to be the point in which many participants first realised the extent to which their own drinking patterns were causing detriment. Adults with alcohol dependence spoke of frequently reoccurring A&E presentations:

> *"I was waking up, shakes, sweats, being sick... Even when I was being sick, I still wanted to put the wine back in. This is when the hospital visits started." (54-year-old male, Oldham, in treatment)*

> *"I went to the hospital, more ill than I've ever been. I was detoxed in there and stayed for two weeks, but it was 85-days until there was a place in rehab." (40-year-old female, Rochdale, in treatment)*

> *"I woke up in Manchester Royal Infirmary two days later; I was nearly a goner." (36-year-old male, Manchester, not in treatment)*

> *"I wanted to stop drinking, so I rang an ambulance, and it took me to hospital, but they sent me home on the condition that I drank. But I thought, that's no better, I'll do what I want; I'll stop drinking. But I ended up back in hospital with seizures and toxic shock." (72-year-old male, Rochdale, in treatment)*

It was recognised that in an ideal situation, first contacts would occur earlier and before individuals require emergency assistance at A&E for severe and deteriorating health concerns:

> *"We in-reach them but they've already had that crisis; we want to get there before that." (Assertive Outreach Team Leader, Bolton)*

However, in keeping with the research by Chamber et al. (2021), several professionals discussed how emergency alcohol-related health crises are an opportunity to provide timely interventions and refer into treatment services. Initiating contact while an individual remains in A&E is said to be a critical moment and one from which interventions can be most persuasive:

"They've presented at A&E for some alcohol-related health crisis and that's a consequence that's hard to hide from." (Assertive Outreach Team Leader, Bolton)

It was identified that despite support for and the advantages of having hospital-based ACTs, GM provision is inconsistent, with some areas lacking a commissioned service:

"I don't think Stockport ever got an Alcohol Care Team...There's one person who works for the hospital trust in A&E for alcohol [support]. That's not even a full shift; three and half people is a full shift." (Addictions Lead, Stockport)

Staff from Hospital Alcohol Liaison Services (HALS) engage patients undergoing treatment for alcohol-related health concerns, and upon obtaining consent, will initiate onwards referrals into community drug and alcohol treatment services. One challenge identified was that not all alcohol clients accessing treatment via this pathway are motivated towards positive change and may resist engagement:

"I think clients [agree to the referral] just to get out of [hospital], but then we struggle to engage them because they don't really want to engage." (Recovery Co-ordinator, Tameside)

6.1.2 Service development: Community treatment engagement in A&E

Considering the challenge of alcohol referrals for A&E patients who do not wish to engage, we were made aware of a community harm reduction and outreach worker in Tameside who was about to start visiting the hospital to meet with A&E patients. They will offer referrals into the local community substance use service and provide harm reduction advice relevant to patients and the context of their admission:

"I'm starting a drop in at A&E on Monday mornings for people who were brought in over the weekend and are due to be discharged." (Harm Reduction Outreach Worker, Tameside)

However, no additional funding was obtained for this service development, and the service is currently only able to employ the one dedicated harm reduction outreach worker. This is consistent with the findings of Webb et al. (2024) who identified a lack of systemic funding and commissioning. A well-resourced ACT with clear operational remit can create links between diverse agencies and enables improved wraparound care for alcohol dependent patients (Webb et al. 2024). They reported that effective pathways were enabled by the presence of an ACT, multi-agency community initiatives, assertive alcohol outreach and frequent-attender team meetings. Webb et al. (2024) concluded that community outreach and in-reach between hospitals and community services enable effective care pathways when ACTs provide the point of contact. We found similar supporting evidence of the benefits of closer working between A&E departments and local treatment providers.

The HALS team welcomed the proposed initiative and having requested further training on how to support patients who access the hospital for drug-related harms. Having agreed to provide naloxone training, the professional from the community drug and alcohol team discussed the mutual benefits that arise from developing strong and positive relationships with external partners:

"Our young people's team have built such a [good] relationship with the YP A&E staff, [the adult department] want that for themselves as well. It takes a bit of work off them if we're there to do Monday's referrals; it's a morning where they don't have to do them." (Harm Reduction Outreach Worker, Tameside)

Chamber et al. (2021) provide further evidence of the potential benefits of alcohol care teams in facilitating positive change. At the six month follow-up, almost half (46%) reported no heavy drinking days in the week before follow-up, one in six (13%) maintained abstinence over the whole six-month period since their hospital admission and two-fifths (43%) stated that it was the first time that this link between their health and alcohol use had been made clear, suggesting that opportunistic alcohol interventions can act as a 'teachable moment' for behaviour change.

6.1.3 Nurse-led alcohol interventions

Clancy et al. (2017) produced a useful resource for commissioners, providers and clinicians on 'The role of nurses in alcohol and drug treatment services.' It describes the many possible roles of nurses in alcohol and drug treatment in England, including the contribution they can make to health and social care outcomes and the added value nurses can bring to alcohol and drug treatment. It notes that experienced nurses will be able to provide advanced clinical interventions and respond to more complex physical and mental health needs, forming a key part of a multidisciplinary team through responding to locally identified need.

Substance use services provide nurse-led interventions to alcohol clients, such as fibroscans and blood testing. The aim is to facilitate early detection and prevent subsequent hospital admissions for alcohol-related illnesses. These alcohol clinics have also been extended into GP surgeries in many areas in efforts to improve and increase access to alcohol-related health support. This has meant that patients no longer must wait for a GP's hospital referral. Noting its dual purpose, professionals described how the results of repeated liver scans can be used to encourage and motivate clients towards alcohol change:

> *"After his scan, we spoke about the effects alcohol has on your body [and] how your liver can recover if it doesn't get too [damaged]. I think it opened up his eyes and gave him a bit of motivation." (Co-Occurring Needs Worker, Wigan)*

> *"[We can say to clients], 'this is the condition of your liver, if you stop drinking or reduce your drinking now, this is going to improve'. It helps clients to understand what they're doing to themselves and [enabling them to] see the damage through the liver scans." (Recovery Co-ordinator, Tameside)*

6.1.4 Extending access via GP-based alcohol clinics

Having the capacity to engage alcohol clients in other community settings, including GP surgeries, was identified by professionals as either a current or aspired to initiative within treatment services.

> *"In the days when there was a lot more money and we had an alcohol shared care model run like the drugs clinics used to be. We used to have workers go into GP surgeries and assess people for alcohol and see them there every week or every fortnight there." (Addictions Lead, Stockport)*

While GPs can currently refer directly, it was acknowledged that both a high degree of addiction knowledge and engagement skills are required to adequately respond to the vastly different presentations, risk profiles, and support needs of individuals who use alcohol dependently.

> *"The skillset that is required to cover [such diverse alcohol client profiles] is high. I don't think people realise that you really need to change your hat each time you [speak with a new client]." (Service Manager, Assertive Outreach, multiple GM areas)*

In view of limited appointment availability and time pressures experienced by doctors working within GP practices, it was suggested that substance use nurses would be better equipped to reduce identified access barriers and ensure that access to alcohol interventions, treatments, and support is available to those who require it:

> *"I can guarantee that if we had a worker sat in the GP [surgery] with the receptionist and who was pally with the nurses and the GPs; their clinic would be full within the first three months." (Addictions Lead, Stockport)*

The following case study provides an example of the benefits of developing more nurse-led alcohol clinics in primary care practices.

Box 3: A vignette: Access to nurse-led alcohol clinics via GP surgeries

New community alcohol initiatives are often responsive to a deficit within existing provisions or an identifiedlocal need In Oldham, the introduction of community-based nurse-led alcohol clinics followed several alcohol-linked deaths and the discovery that none had prior contact with substance use services. Held in GP surgeries, this community outreach response removes barriers for those who would ordinarily not access drug and alcohol services in traditional settings:

> *"A lot of alcohol related deaths [were identified] who were not known to services, and they commissioned my role to look at how we can change this... Generally, the first point of call when somebody is struggling is they might go to the GP, so to try and bring down barriers for people coming into treatment, we're taking our service out into the community." (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

This nurse-led clinic accepts clients presenting with alcohol-related health concerns, and provides identical support and treatment offers to those available from substance use services, however, access via the GP-based clinic is said to operate reduced waiting times from referral to initial appointment:

> *"It's not just a case ofhaving a presence in the surgery; it's far more that we have to offer. It's the clinical side of things, we would do bloods, fibroscans, home detox... what we offer in service, we can take out into the GP practice... It cuts down the time that people have to wait to come into service: I can receive the referral, contact the client, and get them into the next clinic." (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

Establishing the clinics has posed some initial challenges, including with circulating information and raising awareness among medical practitioners and practice staff. The first influx of referrals was reportedly limited and infrequent, and it was queried whether nationwide pressure and demand on GPs has unwittingly impacted the growth of this new initiative:

> *" The GPs want me in there, they say 'we want a bit of that', but then nothing's happening, so I'm now looking at what else we can try and asking why referrals aren't coming through... How difficult is it to get an appointment with your GP? Perhaps that's why referrals aren't coming through." (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

However, to overcome these initial hurdles, the provider has adapted in response to many of the challenges:

> *"We're looking at all different ways that we can get this up and running." (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

- **Examples of efforts introduced after the initial inception of the alcohol clinics, include:**
- **Raising GP awareness: Efforts to overcome early-stage setbacks has involved concerted efforts to bring in surgeries across the borough and engage the doctors working in practice.**
- **Encouraging GP engagement by favouring in-person attendance at surgery team meetings over communication via email.**
- **Producing promotional flyers to assist with the clinics' promotion.**
- **Widening accepted referral sources to include self-referring patients.**
- **Engaging practice staff to support access: one surgery will send a mass text to patients containing information about the alcohol clinic.**

6.2 Utilising treatment delays with psychosocial interventions (PSI)

Professionals observed that alcohol clients often adopt and utilise the medical or biological model from which they interpret, consider, and comprehend all associated factors of addiction and dependency. Subsequently, the degree to which the medical or biological model influences and affects decision making and outcomes is often evident, as clients prioritise and assign most value to closely associated treatment offers, such as inpatient and medical detoxifications.

It was therefore reported to have been necessary for professionals and providers to support clients to shift focus through encouraging their consideration of psychological and contextual drivers of addiction and recovery.

6.2.1 Superficial understanding of alcohol dependence and addiction

It was reported that a further and complicating factor relates to the high number of alcohol clients who present with little understanding of their own needs and can be less knowledgeable of the treatment system and language of addiction:

> *"There's a whole plethora of uneducated people around who are extremely treatment naive when it comes to alcohol; I don't see that with opiate users [who are] quite treatment savvy." (Team Leader, Assertive Outreach, multiple GM areas)*

> *"There are so many people at the engaged stage that don't have a clue what's going on, and don't know what their options are." (Harm Reduction Outreach Worker, Tameside)*

This lack of knowledge and understanding creates challenges for alcohol workers, particularly where clients present with a superficial understanding of 'needing a detox, so I won't drink again", but otherwise with little understanding of why they have been referred into treatment or what the process entails (Assertive Outreach Worker, multiple GM areas)

> *"Hospital referrals, GP, mental health team referrals, social services are not always straightforward to engage if [the client's] not ready or they don't see why they've been referred." (Recovery Co-ordinator, Tameside)*

> *"I didn't understand recovery; I didn't know anything about it at all." (56-year-old male, Oldham, in treatment)*

6.2.2 Opportunities to inform and educate

While high rates of 'treatment naivety' in alcohol clients can affect understanding and engagement, professionals observed how lengthy waiting periods for inpatient detoxification offers can be reframed as an opportunity to ensure clients engage with PSI to gain understanding of the treatment process and demonstrate commitment, effort, and desire for change:

> *"It's almost a blessing in disguise that it takes so long to refer people into detox, because it gives them that chance to prepare and that chance to demonstrate the willingness to engage." (Criminal Justice Recovery Co-ordinator, Tameside)*

> *"The danger of just giving someone a detox who has not made any changes is that they'll just come out and start drinking again." (Advanced Recovery Practitioner, Alcohol Team, Oldham)*

> *"We have to say why this person deserves detox and rehab: what have they done to show that they're ready, that they will engage, and this is what they want 100%." (Recovery Co-ordinator, Tameside)*

Next to available treatment options for opioid users, support for alcohol clients can appear less tangible, and it was suggested that further resources should be directed towards PSI provision. New introductory groups, developed specifically to advise on available support and treatment were suggested, aimed to ensure alcohol clients' expectations are realistic and align with the available support offers.

6.2.3 Psychosocial interventions and group work

> *"PSI is where it's at... we can't give them a prescription or magic tablet." (Team Leader, Assertive Outreach, multiple GM areas)*

Psychosocial interventions (PSI) are widely provided and feature as a core aspect of alcohol treatment and support provisions, including frequently offered in-person groups for different cohorts, for instance, dependent alcohol use;

non-dependent use; and pre-detox clients. Professionals working in support and treatment services advised that sessions should be designed to allow for adapted delivery in one-to-one or smaller cluster groups, ensuring they are responsive to clients' needs:

> *"Many prefer one-to-ones, so, we just go with the needs of the patients at that time." (Co-Occurring Needs Worker, Wigan)*

> *"If somebody needs an alternative method of support, I think we're pretty good at trying to create something that would let them receive what everybody else receives." (Assertive Outreach Worker, Salford)*

6.2.4 Challenges of engaging with PSI

PSI is frequently centred around group work, which can be challenging for some clients and inaccessible to others. The issues that were reported to cause most concern related to fears of appearing vulnerable while in the presence of others and a parallel reluctance to participate in groups that encouraged personal disclosures or expected group members to verbally explore their emotions or difficult experiences:

> "*I don't like talking with people, especially a group who I don't know. I don't want to tell them my business, it's private, you know, I've just always been that way." (54-year-old male, Rochdale, in treatment)*

> *"A lot of [clients are] scared of groups.... they fear sitting and talking about themselves." (Recovery Co-ordinator, Tameside)*

> *"'I'm better on a one-to-one basis; it makes it a lot easier for me." (46-year-old male, Manchester, in treatment)*

> *"I want one-to-one sessions... I don't want loads of people sitting around listening to what I'm saying, they don't need to listen to what I'm saying about myself, [and then] spreading it around Stockport. I know most of the people that go in there; I'm not telling [the group facilitator] about me in front of all these." (39-year-old male, Stockport, in treatment)*

Another identified issue related to actual or perceived intoxication in other participating group members, while concerns included fear of clients' own use being triggered when in close proximity to others who are under the influence, or feeling that the supportive process is undermined by those who present when visibly inebriated:

> *"When I was at RAMP, there were two girls ... you could tell that they'd had a drink; they would bounce off each other and they were just really loud. and in your face. I didn't like it at all, so I stopped going to RAMP." (40-year-old male, Stockport, in treatment)*

It was recognised that support offers which are predominately focused upon group-based PSI can inadvertently affect client motivation and commitment to continued treatment engagement. It was reported to mostly impact clients with existing reservations or who find group participation to be challenging, or those who may not understand the purpose or expected outcomes resulting from their attendance and engagement with PSI:

> *"I know lots of people cannot cope with a group session. So, they're not getting the one-to-one, the motivation, [or have] anyone working alongside them." (Housing Support Officer, Salford)*

> *"I went [to the groups] and just sat there; I didn't do anything, and I didn't take any of it in. I was being told to do this and do that, but I just carried on drinking." (Female participant, focus group 1, Bolton)*

6.2.5 Overcoming drug stigma with PSI

Another prominent issue that was reported to affect engagement with PSI arises from the challenges of accessing integrated treatment services where groups accommodate mixed client cohorts. For instance, as evidenced in section 4.2.1, drug stigma and stereotyping may hinder access by alcohol-only clients, who may also experience discomfort should opioid clients open discussions on substance use and practices. A professional who has witnessed this concluded that despite initial reservations, should impacted clients work to overcome these challenges, mixed cohort groups can benefit greatly from PSI, leading to positive outcomes for all clients who engage with the programme:

> *"Once they realised that everybody in [the group] was a person with a problem, the conversations that came out of these groups with different [cohorts] was amazing." (Recovery Co-ordinator, Tameside)*

6.2.6 Advantages of PSI for alcohol clients

Although there will be some clients who will be unable to participate with PSI, those who have benefitted from group work and engagement believe it to be an effective intervention which has assisted their efforts to achieve self-identified goals and progress towards positive change. Alcohol clients noted that group interactions, opportunities for reflection and feedback, and learning how the use and apply tools and strategies taught within PSI have all benefitted their recovery efforts:

> *"I [began to make positive change] by understanding and talking to people in groups: when I understand things, the problem seems to dwindle away... I find that groups which teach tools and strategies help me a lot more than AA does." (56-year-old male, Oldham, in treatment)*

> *"[PSI groupwork] helped with my confidence and self-esteem, because that was on the floor. I'm now also more confident sharing in meetings, and I'm more comfortable in group settings." (40-year-old female, Rochdale, in treatment)*

Engaging with PSI programmes alongside peers was frequently identified to be an effective support offer and alcohol clients reported how they appreciated opportunities to connect with others in a non-judgemental environment:

> *"I've met some lovely, supportive people... it's that connection [that has helped me]." (58-year-old female, Bury, in treatment)*

> *"I've been to PSI groups and SMART, and met some amazing people; I've embraced it... What helps me the most is the connection, being with amazing, inspiring people every week." (Female participant, focus group 1, Bolton)*

The use of PSI to encourage peer support and progress recovery for attending clients was backed by a professional who has witnessed individuals benefit from groupwork:

> *"I understand the anxiety of it... but the groups are so successful, and you see clients developing because of that peer support." (Recovery Co-ordinator, Tameside)*

6.2.7 Examples of effective psychosocial interventions

Reduction and Motivation Programme' (RAMP)

> *"[In my current service], we've always said, it'd be great if we could offer a version of RAMP, but we can't, as under the Achieve model the PSI offer is conducted by GMMH, our lead provider [...] If I had unlimited funds, I'd do some work around that, although not necessarily copy RAMP, because I think it's copyrighted." (Team Leader, Assertive Outreach, multiple GM areas)*

The 'Reduction and Motivation Programme' (RAMP) consists of 24 group work sessions for those in active addiction to explore their addiction, its impact on them and others, and the life changes needed to gain recovery from substances. It allows individuals to learn about addiction, ask questions, gain support from others going through the same experiences, and offers clear goals, focus and structure, that helps people to make the first steps towards recovery.

> *"I'd love to see some kind of organic delivery of something not that dissimilar to RAMP in people's own homes. You can kind of talk about the cycle of addiction, denial, fear, the ripple effect ...] I've done some one-to-ones with [a team member], so that she can begin discussing [the topics] organically with her clients, and she said it's been really effective. She said there's been a couple of them, particularly with the cycle of addiction, where she has explained that this is what they're stuck in. How would anyone know that? Unless somebody tells them, they just think,' I drink, I drink too much, and I need to stop, that's it'. I'll always say to somebody,' you can't change nothing you don't know about.'" (Team Leader, Assertive Outreach, multiple GM areas)*

In areas RAMP exists, professionals spoke highly of the programme and advocate for their clients to attend. However, as highlighted here, one professional's response demonstrated his passionate belief in the importance of its availability and described how he witnessed former group members receive significant benefits from accessing and engaging with the sessions:

"RAMP was so effective... It's a really good community tool, which made a lot of difference. The feedback from people was amazing. The difference it made in people's lives was amazing; not everybody went on to go to detox and rehab. It was incredible. The amount of people that kind of like just turned their life around, just by attending 12 sessions."

Exploring how the RAMP model could be adapted for individual engagement, he suggested that the structured programme could similarly be delivered to clients on a one-to-one basis by allocating topics to single support sessions. Noting that consideration of potential risks for people who are isolated or live alone would need to be considered, he concluded that such programme provides the most effective treatment offer for alcohol clients:

"There might be certain aspects of it you don't want to do [during home visits]. Because I remember there being a group on consequences; I'm not sure I'd go down that route in somebody's home [...] I think you'd need to be careful doing it in the community, particularly as a one to one. Where somebody who's still drinking and living on their own... You'd have to be careful with it, but I think that's where it's at for alcohol clients." (Team Leader, Assertive Outreach, multiple GM areas)

Dayhab, CGL

As a new addition to CGL Tameside's structured treatment provisions, Dayhab offers a community rehabilitation programme for post-detox clients who require support to maintain abstinence. The programme runs three mornings each week over a duration of 12 weeks:

"Once the client's worker has accessed a detox for their client - typically for alcohol - or assisted them towards abstinence they can access the Dayhab, which is a commitment to 12 weeks, three mornings a week, three hours each." (Recovery Coordinator, Tameside)

Each day is underpinned by a different recovery focus, as described below:

"We explore themes on Mondays – values/ ethics role in recovery, managing shame and stigma, the brain- what happens in addiction and how to utilise awareness of the nervous system to enhance recovery - two sessions. Relapse prevention tools, communication, resentments, compassion and two sessions on trauma. On Wednesday it is a mindfulness-based relapse prevention course where we learn and practice different meditations and they learn mindfulness theory to assist recovery. Friday is a more light-hearted group. We go out sometimes. We visit other agencies that might be beneficial in various ways, and we invite agencies to come and give talks. This group is focused on developing recovery capital." (Recovery Coordinator, Tameside)

Feedback from clients who have attended the programme has been extremely positive, indicating that this newly implemented programme has been an initial success:

"It's early days, we have only run this three times and the first was a pilot, but the feedback is extremely positive with I would say around 50% of those initially invited to the group have been making it to the final graduation. Those that stick it out then move into their own post-treatment group and develop their own recovery community." (Recovery Coordinator, Tameside)

Professionals supporting the Dayhab programme have observed that it has been proven to work particularly well for engaged female clients:

"Dayhab has proved really successful for women: one from the first [cohort] suggested setting up an [additional] post-dayhab group that they run themselves. Once women feel comfortable enough to attend groups, to see it through and go week after week, they're okay; and they will encourage other women." (Recovery Coordinator, Tameside)

Upon completion of the first 12-week programme, female clients initiated a post-treatment recovery group to provide and facilitate access to continuing peer-led support. That these women had been inspired and motivated to nurture a fledgling recovery community may offer further contributory evidence in support of the programme's success.

6.3 Extending reach with harm reduction

"Harm reduction is as important or sometimes more important than recovery. It's that initial stepping stone for people [where they realise], 'this is an accepting space. I can make a choice. I'm a human again.'" (Harm Reduction Outreach Worker, Tameside)

A Recovery Co-ordinator in Bury suggested that for individuals who are not engaged with alcohol support or healthcare, the assorted language and measures associated with alcohol monitoring, intake reduction, and experienced harms (for instance, 'dependent', 'harmful', 'unit calculations', 'weekly intake') are often ill-defined; a factor which can confuse and limit public capacity for assessing and identifying personal alcohol impacts. It was suggested that by simplifying the approach for self-assessing negative alcohol impacts, more people may be encouraged to consider their alcohol consumption levels before self-motivating to reduce patterns of harmful drinking. For instance, rather than public health messaging advising the public to focus on unit counting, they may simply be asked to reflect, "does my alcohol use cause me problems? Do I want to do something about it?"

Within services, both adults with alcohol dependence and professionals reported that agreed treatment goals rarely focus upon efforts to achieve and sustain abstinence but rather support more realistic goals to reduce both the levels and severity of experienced alcohol harms. Adopting a harm reduction focus ensures that clients who have affirmed no desire for significant alcohol change can be supported to minimise health impacts and receive safeguarding support and intervention for alcohol-related vulnerabilities. A professional in Manchester described how backed by legislative changes, the underpinning ethos of his team's support offer moved from recovery-focused to harm minimisation and safeguarding in response to client needs:

> *"Our work has changed from recovery-focused to more harm minimisation... and I'd say 50% of our work is now safeguarding. Over the last 10-15 years, since things like self-neglect has become part of the Care Act and alcohol and drug use is classed as self-neglect, we do a lot more support and social work around people's alcohol use. People who don't necessarily want to change or are not ready to change their alcohol use but are in a mess; they'll be doing a lot of safeguarding work around their alcohol use and their vulnerabilities." (Manager, Substance Misuse Team, Manchester)*

6.3.1 Harm reduction approaches in practice

While the ethos and principles of harm reduction are often embedded within support offers, conviction in the model's efficacy was considered essential for ensuring that harm reduction messaging is effective and far-reaching:

> *"Putting people like us in place, who are passionate and have the information at hand." (Assertive Outreach Worker, Salford)*

> *"Every face-to-face encounter is an opportunity to reduce harm and risk." (Senior Social Worker, Entrenched Rough Sleepers Team, Manchester)*

Professionals discussed how they have supported clients to identify appropriate strategies and apply the principles of harm reduction to their individual drinking patterns and behaviours. For instance, encouraging clients to change the type and strength of alcohol products to facilitate further reductions in harm were both practices widely reported during interviews:

> *"[The client] was drinking white cider [which is] apparently just chemicals and alcohol. Achieve were able to support this chap to start drinking apple cider and reduce. He didn't want to stop [completely], so they were led by him." (Veterans' Tenancy Support Worker, Salford)*

The use of drink diaries

The distribution of alcohol or drink diary templates to record alcohol triggers, consumption levels, and patterns of use is widely promoted across a range of health and social care contexts and is a mainstay of both self-help and supported alcohol interventions. However, professionals reported occasions where the drink diary tool was unsuited for unusable, with clients affected by heavy intoxication, acquired brain injuries, or memory and capacity issues said to find meaningful engagement with the tool most challenging:

> *"[Clients say], 'why are you asking me to do this? I don't even know what I drink. I don't know what I'm doing from one day to the next, and you're asking me to keep track; I can't even keep track of my own thoughts, let alone what I'm drinking'." (Team Leader, Assertive Outreach, multiple GM areas)*

It was noted that wherever possible clients should be supported to engage with alcohol diaries both during support sessions and through independent activities as it serves a further purpose due to being incorporated into the assessment and decision-making process as funding panels consider clients' applications for inpatient and residential treatment. However, responding to the difficulties some experience when presented with this tool, the same professional described how his team have acquired breathalysers which they have found to be an effective tool for determining clients' weekly alcohol intake in preparation for considering both harm and alcohol reduction plans.

> *"[Breathalysers] are just used to get a bit of a yardstick... People have a tendency to minimise [their alcohol intake] and if we try to reduce too low, it's going to be unsafe, they're going to suffer, and we don't want that. This helps us to get a good estimate of where they're at, with the caveat that I know that sometimes people will have more money and will then buy more alcohol. It's not an exact science... I'm just after a little bit of a baseline so that we can move forward." (Team Leader, Assertive Outreach, multiple GM areas)*

Managing withdrawals

Other examples of harm reduction advice provided to clients with alcohol dependence included suggestions on how to mitigate the risk of withdrawals by freezing alcohol in ice cube trays so that they always have access to alcohol, should they be unable to purchase or obtain it later in the financial month:

> *"A lot of our harm reduction advice is around making sure clients have got alcohol throughout the month. And so, one of the suggestions is to put it in the freezer or freeze alcohol as ice cubes so you've always got it; freezing is really good, until your electric money runs out." (Rough Sleepers' Supported Tenancy Officer, Salford)*

This professional also advised that since the introduction of Universal Credit and the resulting move to a monthly payment schedule, those supporting clients with high levels of risk can petition for payments to be returned to fortnightly issue, or weekly in special circumstances; thus, reducing risks associated with unplanned withdrawals:

> *"All the people that I work with have fortnightly payments now and that means they only have to go a few days without drinking now, at worst. A couple of people I'm really worried about get their benefits every week. You have to ask for this under special circumstances... It can become a bit complicated*
>
> *[to manage outgoing utility bills], but generally speaking, it does help with the withdrawals because people don't have to wait very long to receive their next payment." (Rough Sleepers' Supported Tenancy Officer, Salford)*

6.4 Addressing levels of alcohol use through community engagement and expanding recovery networks

6.4.1 Contextual need for community engagement

Both professionals and adults with alcohol dependence frequently and consistently agreed that an increasing social acceptance of alcohol use has arisen from contributing factors such as its widespread availability, the ease in which it is accessed, positive media portrayals, and dominant advertising and low-cost promotions. It was also noted that collectively, these driving factors significantly outweigh health labelling and sole focus campaigns designed to raise awareness of alcohol harms, with the resulting normalisation posing significant problems for easy recognition of dependent alcohol use, unchallenged addiction stigma, and barriers to those who wish to seek support or sustain recovery:

> *"People struggle to identify [alcohol as] a problem because it's legal and it's readily available; [people] don't really see it as a drug or something that they're doing wrong." (Criminal Justice Recovery Co-ordinator, Tameside)*

To counter this cultural normalisation and the related barriers to alcohol change, there was a consensus among both interview cohorts who identified that through facilitating conversations, dominant narratives could be challenged, and improved knowledge, awareness, and understanding could extend across the wider community. In turn, it was suggested that this move would develop and expand recovery

networks by offering further resources and sources of available support:

> *"The more we kind of all work together as a community, the more awareness we can build and the more resources there are... That's the way forward, for me." (Volunteer Co-ordinator, inpatient detox unit, Manchester)*

6.4.2 Increasing knowledge of local alcohol support and treatment

Local area knowledge of available services was thought to be lacking among the public thus posing a barrier for people giving initial thought to accessing support for alcohol dependence or harmful drinking.

Participants from a focus group in Bolton felt strongly that they had not received sufficient formal information and that it was only through the willingness of their peers to share knowledge that they had been able to learn of available and local support networks:

> *"If you meet like-minded people, you do find that you hear about [alcohol support] word of mouth. But it shouldn't be down to this happenstance; we shouldn't have to be in the right place at the right time to find something out." (Male participant, focus group 2, Bolton)*

The need to promote and raise awareness of alcohol support provisions across communities and organisations was identified, while improved service knowledge was said to increase the number of people accessing support and treatment:

> *"The help is there, but obviously it's not advertised, is it?" (Male participant, focus group 1, Bolton)*

> *"Once people know we're here, we get that flood of referrals." (Assertive Outreach Team Leader, Bolton)*

6.4.3 Raising awareness of community support among professionals'

Professionals in both treatment and support services recognised that their knowledge of community resources was often incomplete and suggested that they could do more to identify and communicate the wealth of available formal and informal support networks to clients:

> *"It's about getting to know your community and having the time to go out and see what's out there." (Manager, Substance Misuse Team, Manchester)*

> *"There was a local event to which a lot of community groups came; we were surprised at how many we didn't know about." (Ward Manager, Acute Mental Health Inpatient Unit, Wigan)*

> *"There are lots of diverse, recovery orientated activities and groups in the area that offer choice, so people can find an approach that works for them rather than feeling shoehorned into a one size fits all approach, but we all need to come together in some way." (Recovery Engagement Worker, Bolton)*

They also imagined that promoting available support and treatment provisions to external medical providers would help to increase the identification of people with alcohol dependence, including those who may not present or disclose alcohol-related support needs:

> *"The change-resistant drinkers are always going to be quite difficult. We might not always know who they are. They might present at A&E or at their GP with different issues and therefore might not be getting the real support that they need where alcohol is the presenting problem... So, I guess it's about recognising how alcohol factors in someone's overall health." (Manager, Substance Misuse Team, Manchester)*

It was also suggested that further benefits would include strengthened connections between different services and improved awareness of alternative routes towards recovery for those who traditional treatment pathways do not work.

6.4.4 Raising the profile of alcohol support and treatment provisions through service promotion

Social media was reported to be used to raise the profile of support and treatment services', as was leaflet distribution in pubs, probation offices, and prisons. Leaflets have also been used to re-establish a relationship between a drug and alcohol service and local GP practices and strengthen the pathway into alcohol treatment:

"We handed out our leaflets that say who we are and what we do, just to reintroduce ourselves. Lots of them know that we're a drug and alcohol service, but [we outline], what do we actually do, what's an appropriate referral, what's the most appropriate pathway for a patient." (Harm Reduction Outreach Worker, Tameside)

Some treatment professionals highlighted that demands on workload can be exacerbated by inappropriate referrals for people who either did not explicitly consent to the referral or never intended to access alcohol support; they noted that time taken attempting to engage with the client before the referral is closed often takes them away from supporting others. Therefore, disseminating tangible information to external agencies, including GPs, hospitals, and other non-sector organisations, that assists practitioners to determine referral appropriateness and advises on alternative pathways and sources of support, may benefit both in-service treatment delivery and ensure adults who drink dependently are directed towards support most suited to their needs.

Professionals suggested that outreach and local engagement efforts assists in raising alcohol support and treatments services' public profile and benefit goals to reduce access barriers and improve messaging on alcohol harms. For instance, providing brief interventions and health promotion to the public was said to forge trust with both the local community and wider service providers, while engaging with events outside the field of substance use and related support needs, e.g. International Women's/Men's Day has allowed alcohol services a wider reach.

While there are many examples of innovative and responsive practice tailored towards engaging with people affected by existing alcohol harms, extending service delivery to focus on reducing levels of preventative harm would provide all round benefits:

"We should have a presence in arenas that are not necessarily at the end point... We have a social media presence, but it's quite limited. I'd like to be able to offer more social nudges around drinking. I guess that's a much wider perspective; prevention rather than treatment." (Consultant Addiction Psychologist, multiple GM areas)

Another adopted measure to increase the public profile of a drug and alcohol treatment provider involved promoting the service using advertisements to be displayed on television screens in GP surgery waiting rooms:

"One thing that they looked into and has been actioned: [Our service] will be advertised on all the TV screens in [local] GP practices." (Advanced Recovery Practitioner, Oldham)

Where initial efforts have been instigated to promote a service, a Family Support Worker in Tameside reflected that with high levels of staff turnover across the sector, it can be necessary to continue wider engagement to ensure forged relationships and momentum gained while raising professional and public awareness is not lost.

Proposed initiative: Community information hubs

One suggestion related to the development of a community information hub, either building-based or online, to offer a central location from which the public could access information on all locally available services, support groups, and informal activities that may assist people seeking assistance for their alcohol use.

Similarly, it was also suggested that a method of storing, updating, and publicising details of wide-ranging local resources was required; this would enable professionals to signpost appropriately. By ensuring stored details included diverse support offers to meet vast interests and needs, adults who drink dependently would have greater choice when considering their care and recovery plans.

6.4.5 Creative solutions: engaging communities in efforts to reduce problem alcohol use

"Our attitude towards alcohol is quite unhealthy in this country... it'd be wonderful if we could collectively look at that." (Volunteer Co-ordinator, inpatient detox unit, Manchester)

Strengthening connections and raising awareness with local communities was said to aid the development of recovery networks and enhance opportunities and resources for adults who drink dependently. We highlight three diverse examples of wider community engagement as reported

during interviews; these aim to address some of the barriers faced by those wishing to seek and enact positive alcohol change.

Beer goggles and alcohol conversations in Tameside

A Harm Reduction Outreach Worker described the use of fun and interactive games at community-based events to encourage conversation and raise awareness of alcohol harms, plus steps taken to reach out into social environments to offer harm reduction to the wider public:

> *"We do a lot of events where we have a stand, we talk about harm reduction, we have games that are really interactive: [people put on] beer googles and have to measure a single, and then a double measurement blind, and then we pour it in the cup and it shows them whether they've got it right. I think this is good for young adults who often go, 'oh gosh'; it really shocks people when their measurement is completely off. We're also communicating with Pub Watch and trying to get harm reduction resources and staff training into pubs." (Harm Reduction Outreach Worker, Tameside)*

Enlisting bartenders to support alcohol change in Manchester

An example of micro level work involved a social worker, with consent, engaging with bar staff a client's local pub to encourage cooperation and enlist support as he made efforts to reduce his alcohol intake. A joint agreement was reached that after a couple of drinks, bar staff would stop serving his usual choice of lager, instead exchanging it for low or zero percent alcohol. All parties benefitted: the pub was not affected by loss of income and the client - supported by staff - was able to reduce his alcohol use while retaining the social element of drinking alongside others in a familiar environment.

> *"We did a capacity assessment and discussed what he wants to do about his drinking, and about 0% lagers. I said, 'how do you feel about going to your local and having a word with the landlady [and saying], when you've had a couple of beers, you're switching over to 0% and having that conversation that she switches you over to 0%. And he said, 'yes, let's try it'. So, I think that's probably where we can use communities, where someone has got a local, we can [ask], 'can you be a support network here?... How about we all, as a community, take action to help reduce [problem alcohol use]." (Social Worker, Entrenched Rough Sleepers' Team, Manchester)*

Recovery walks in Bolton

A Recovery Engagement Worker in Bolton described a new event he has initiated, which invites individuals with experience of problem and dependent substance use, professionals, and people from the local community to come together and join a planned walk. Designed to open dialogue, challenge stigma, and improve understanding between the groups, it is hoped that by increasing community engagement with recovery networks, levels of individual shame will reduce as public understanding of the issues faced by those with a dependency widens.

Part 7: Conclusions and recommendations

7.1 Conclusion

So far, we have highlighted the key barriers and existing gaps in relation to adult alcohol services and support in Greater Manchester and outlined several facilitators to positive behaviour change. This has incorporated the perspectives of both people who use alcohol dependently and a range of treatment professionals and stakeholders' views who work closely with them. Apart from client demographics, substance presentations, and inconsistent provisions of specific support and treatment services, the barriers, facilitators, and contextual factors are similarly found across all GM areas; this was confirmed by professionals who work in multiple boroughs.

The next section presents a set of research-led recommendations that set out to facilitate improvements to how adults with alcohol dependence access treatment, strengthen and develop pathways into alcohol support, and enhance the current support and treatment delivery. The section continues with recommendations on how to address the needs of alcohol clients within an integrated drug and alcohol treatment model, develop services for people with multiple and complex needs, and increase the knowledge and awareness of alcohol support offers across service providers and wider communities.

7.2 Recommendations

7.2.1 Improving access to alcohol treatment

- We recommend that availability of structured alcohol support and treatment is extended by designing weekend and evening access into current service models.
- We recommend reviewing the coverage and reach offered by alcohol treatment provisions, and where necessary, establishing satellite clinics to provide alcohol support in areas currently under-served.
- We recommend collaborating with under-represented demographics such as South-Asian, and Eastern European communities to co-produce effective outreach models aimed at improving access and engagement for under-reached demographics.
- We recommend continuing with efforts to improve the experiences of women accessing alcohol support by offering more in-reach and opportunities to engage in non-drug and alcohol services locations, plus through ensuring that existing treatment models are gender-informed.
- We recommend establishing a GM-wide treatment threshold that frames problem alcohol use and treatment eligibility around a continuum of harm. We recommend its consistent application when assessing treatment access for individuals presenting with harmful but non-dependent alcohol use.

7.2.2 Pathway developments

- We recommend that the completion of alcohol assessment for instance, during contact with primary care and upon admissions into hospital and mental health units.
- We recommend providing a standardised treatment presence in A&E departments to improve current engagement with patients as they present with alcohol-related health harms.
- We recommend expanding the provision of nurse-led alcohol clinics, based in GP surgeries and other community settings, to offer engagement opportunities to those who would not otherwise approach substance use services.

- We recommend that the current service offer is enhanced by linking existing treatment systems to key support services (e.g. mental health, housing and homelessness support services, employment, education and training). This should include the co-locating of health clinics and treatment services to strengthen partnerships and better identify and support individuals with co-occurring mental, physical and alcohol and other drug treatment needs.

- We recommend improved access to diagnostic frontal assessment battery (FAB) testing and consideration of acquired brain injury for patients presenting at hospital with symptoms of reduced or fluctuating capacity. We also suggest that determining eligibility and access should consider concerns identified by community support providers.

7.2.3 Enhanced support and treatment delivery

- We recommend a GM-wide review of the continuity of alcohol support for individuals transitioning from inpatient detox, custody, and hospital admission back into local communities, with actions taken to improve any identified shortcomings.

- We recommend the continued integration of lived experience into local implementation plans through creating employment opportunities within both statutory and voluntary services for people in recovery.

- We recommend increasing the provision of dedicated harm reduction outreach workers.

- We recommend developing further opportunities for peer support, including expanded access to SMART Recovery and facilitating client efforts to develop peer-led social spaces and recovery networks.

- Recognising the benefits of structured provisions such as Acorn's RAMP, we recommend measures to enable adults with alcohol dependence to access similar motivational programmes across all GM areas.

- We recommend developing support networks and peer groups that are specifically tailored for loved ones and carers of people with dependencies.

7.2.4 Alcohol needs within an integrated drug and alcohol treatment model

- We recommend increasing representation of specialist and alcohol-only workers within substance use teams.

- We recommend service promotion and encouraging access for non-traditional alcohol clients via targeted outreach in community spaces.

- We recommend the re-design of service environments to be more inclusive of individuals presenting for alcohol-only support. This may include displaying alcohol-focused posters and harm reduction literature in waiting areas and creating safe spaces to reduce anxiety and perceived intimidation.

- Furthermore, we recommend proactive efforts to reduce access barriers for alcohol-only clients, by addressing drug stigma. This may be through facilitated discussions, mixed cohort social groups, and through providing opportunities to access alcohol treatment and support from service-detached community locations.

- We also recommend further research to examine the strengths and limitations of the integrated drug and alcohol treatment model including its impact on key areas: access and entry into drug and alcohol services; client engagement; treatment outcomes; funding and service priorities; and practitioner and client experience.

7.2.5 Service development for people with multiple and complex support needs

- We recommend further expansion of the already successful assertive outreach model to encourage atypical opportunities to improve access healthcare and alcohol treatment. This may include joint efforts by outreach teams and medical and treatment staff to reach excluded clients via street engagement.

- We found evidence of limited trauma support and recommend further investigation into improving availability of specialist provisions. This may include easy and fast access to trauma responsive therapy, professional training to ensure trauma support providers are knowledgeable and competent in working with excluded and marginalised groups, and widespread training across services for consistent delivery of trauma-informed support.

- We recommend expanding the provision of dual diagnosis support for adults with alcohol dependence with coexisting mental health concerns across all GM areas.

- Furthermore, we recommend mandatory drug and alcohol training and increased resources for mental health practitioners, including those in CMHTs and acute hospital units, to improve access and responsive support offers for clients with multiple needs.

- We recommend efforts to improve and extend supported housing offers, including access to high tolerance accommodation, or provisions developed upon the 'wet house' model. We suggest adopting Care Act principles to inform service design and support delivery.

- We also recommend the development of enhanced housing offers, including a range of women-only accommodations for diverse and varied needs, tailored housing for people with disabilities, particularly facilities with wheelchair access, and new tiered housing models that are responsive to clients' changing needs.

7.2.6 Increasing knowledge and awareness across service providers

- We recommend the roll out of standardised training to mainstream and non-specialist support providers who work with people with alcohol dependence. We suggest that this training offers a baseline knowledge of alcohol-related support needs and is tailored to reduce in-service and professional stigma, plus facilitate the expansion of support and recovery networks.

- We also recommend offering training to support services to raise professional awareness of acquired brain injury and equip services to develop informed support offers for clients with fluctuating and reduced capacity, or where ABI affects behaviour, for instance, within supported housing provisions.

7.2.7 Increasing public knowledge and strengthening community support

- We recommend transforming health messaging to support wider public awareness of alcohol harms. To improve earlier recognition of problem drinking and reduce the associated barriers to treatment, we also recommend targeted campaigns, designed to be tailored and contextually pertinent to distinct demographic groups. We suggest that efforts aim to address common myths and stereotypes and educate on the range, complexity, and varying levels of alcohol harms.

- We recommend the development of a targeted public awareness campaign around cocaine and alcohol use. This should challenge the reported social norms around alcohol and cocaine consumption and highlight the increased harms arising from concurrent use of the two substances.

- We recommend further efforts to raise awareness of local alcohol support provisions via dedicated and continued community engagement, for instance, using social media, pop-up stalls, attendance at local events.

- We recommend establishing local recovery hubs, providing a single point of access for information and signposting, up-to-date community resources, local service information, and formal and informal support and recovery networks. Recovery hubs may also provide opportunities for adults with alcohol dependence to connect with others, access peer support, and offer a base from which they can plan and host social events to tackle levels of isolation among the community.

7.2.8 Strategy

- We recommend the development of a Greater Manchester reducing alcohol harm strategy.

7.3 Strengths and limitations

This research provided a platform to gain valuable insights from a diverse group of professionals whose viewpoints covered a range of service types and contexts in which adults with alcohol dependence access support. Similarly, in interviewing people who drink dependently, both in and out of treatment, the research team have obtained a broad socioeconomic representation that ensures that the findings reflect different personal contexts in which individuals may consider change and engage with treatment and support.

The research sought viewpoints from all 10 Greater Manchester areas; however, participant numbers varied by area and were low for Trafford (3) and Bury (4). Furthermore, reflecting the picture within local treatment figures, racial and ethnic diversity among participants with alcohol dependence was limited and not representative of levels of alcohol need.

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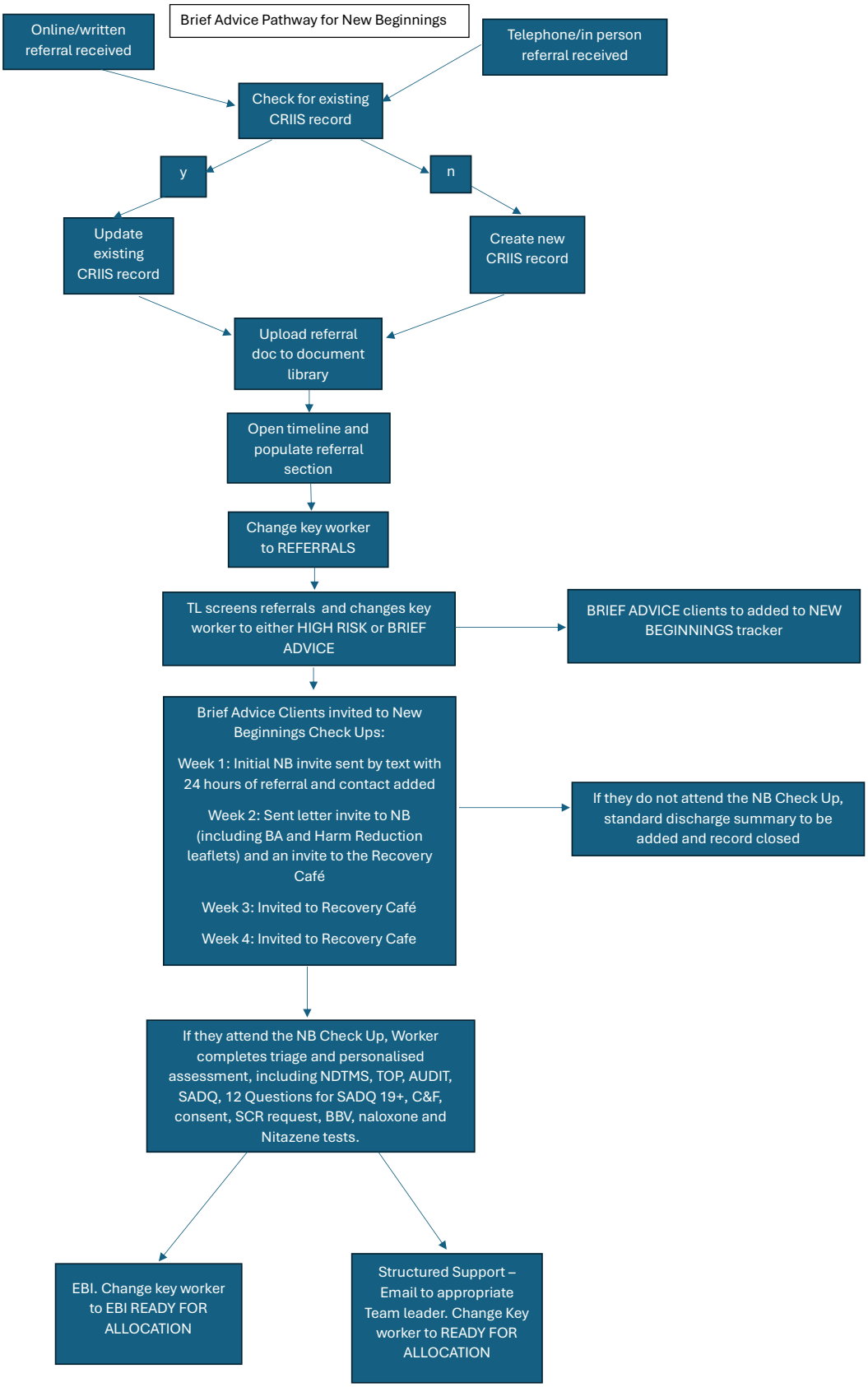
Appendices

Appendix 1: Tameside Brief Advice Pathway



Appendix 2: South Asian Substance Use - *South Asian Substance Use*

This website has been designed for anybody who identifies as South Asian and are unsure where to turn to for support, or if you are a family member concerned about your loved one's substance use, or a health or social care professional who supports individuals impacted by problematic substance use, or for commissioners of substance use services and/or professionals who develop substance use strategies. Key resources including:

a compendium of specialist alcohol and drug support services for people from minority ethnic and migrant communities (Holmes and Galvani, 2023),

a free booklet, *Alcohol Izzat and Me: South Asian Women in Recovery* (Galvani et al., 2023), presenting the lived experiences of South Asian women's substance use and support.

policy and practice guidance focused on supporting South Asian women with problematic substance use (Fox and Galvani, 2024).

a model of support for best practice, that meets the needs of SA women developed around the four 'S's – Setting, Structure, Skills and knowledge, and Staffing. It is a model that is SA woman-centric and reflects the cultural sensitives required to enable SA women to access services more readily,

a process map that offers a pathway to developing new service provision for SA women seeking alcohol/drug support.

a research report '*Keep it to yourself' Supporting Solutions for South Asian women*' (Galvani et al., 2023), detailing key findings and recommendations following the completion of our Alcohol Change UK funded project.

Key messages

- The following key messages come from our research (Galvani et al., 2023) following a comprehensive literature review, interviews with South Asian women in recovery for substance use, South Asian women from the community, and specialist substance use practitioners:
- Alcohol and other drug use carries high levels of stigma in South Asian communities.
- People who deviate from these proscriptions can be ostracized and stigmatised by both their families and their wider communities.
- For South Asian women there is cultural disparity and double standards between men and women's substance use, with a perceived tolerance of men's alcohol use and an intolerance of women's drinking.
- South Asian women are keepers of the family image, carrying the *izzat,* or honour of the family. Actions that deviate from gendered and cultural expectations such as problematic alcohol use, are believed to taint the family image and are seen as bringing shame on the individual, the family and the community.
- Experiences of domestic and sexual violence, and controlling behaviour, are common for South Asian women who have problematic substance use.
- Shame and stigma are common feelings resulting from women's substance use and are often worsened by family fears of community disapprobation.
- Improved knowledge and education about alcohol and other drugs is needed for the South Asian community particularly where to go to seek help for themselves or a relative.
- There is lack of service provision for both men and women from minority or migrant communities in the wider service landscape. Where some specialist services exist for migrant communities in England, no services were identified that support South Asian women specifically
- Discrete, separate, services are needed for South Asian women seeking substance use support. This should be in the local communities and would be best placed within a service that women would frequent for a range of reasons, for example, a women's centre or health centre.

Appendix 3: Alcohol Use Disorders Identification Test

Alcohol use disorders identification test (AUDIT)

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total AUDIT score	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk,
- 20 or more indicates possible dependence

Giving feedback and advice

If the score is lower

If the score is 8 or above, give brief advice to reduce risk for alcohol harm. If the score is 20 or above, consider referral to specialist alcohol harm assessment.

Alcohol unit reference

NHS
Greater Manchester

SUAB
Substance Use and Associated Behaviours Research at Man Met

Manchester Metropolitan University