Windows of opportunity: reducing alcohol-related harm in Somerset.

Evaluation of alcohol projects:

Final report, February 2013

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Executive Summary

Screening and brief intervention approaches for alcohol problems have potential in a range of settings, including hospitals, custody suites (and other criminal justice environments) and community pharmacies, although some of the research which has been done debates whether a brief intervention can bring any additional benefit over and above screening, feedback and referral to a specialist worker or service. Support from senior staff, multi agency collaborative partnerships, training and ongoing specialist support, and resources which can also support sustainability, appear to be important components for the success of screening and brief intervention work. Overall, alcohol screening and brief intervention work appear to be key elements of alcohol treatment.

As part of the ongoing development of the alcohol treatment framework in Somerset eight projects were commissioned, all of which aimed to contribute towards the overall reduction of alcohol misuse and related harms, and seven of which offered screening and brief interventions. Six projects (with the exception of the Hospital Alcohol Liaison Worker in Taunton, who has been in post since April 2010, and the community detox nurses service, which was established approximately four years ago) were established in (approximately) October 2011. The eight alcohol projects were:

1. **Hospital Alcohol Liaison Workers** at Taunton and Yeovil Hospitals.
2. **Homeless Hostels Workers** at Taunton Association for the Homeless and Barnabas Housing Association.
3. **Alcohol Arrest Referral Worker** at Yeovil Custody Suite (YCH).
4. **Lloyds Pharmacy Brief Intervention Scheme** – in 17 pharmacies across Somerset.
5. **Health Trainers** across Somerset, focusing on an extension of the work to include the provision of alcohol brief and enhanced brief interventions.
6. **Community Detox Nurses** at Turning Point, focusing on the expansion of this service from two to four nurses.

A qualitative evaluation was undertaken between May-December 2012 to consider both the individual contribution made by each project as well as their part in the overall aim of reducing alcohol misuse and related harm in Somerset. This report is not a standalone piece of work but is one of a number of pieces of work which will inform ongoing

commissioning plans in Somerset. Qualitative data were collected in a range of ways, including two half day seminars which brought together representatives from the alcohol projects and SDAP; meetings, visits and telephone calls with the projects; case studies written by project workers; interviews with key stakeholders; documentary evidence; and quantitative data for description and context.

Although there is wide variation across the projects in what they have achieved, it is possible to identify areas where the projects have made progress and seen success, and where the projects have experienced challenges. These are summarised below.

Progress	Challenges
* Screening and brief intervention work at all levels of alcohol risk being completed by project workers and other staff (who have been trained) where projects are located. * Engage wide range of people with alcohol problems and often other additional problems. * Location of projects away from alcohol (and drug) treatment. * Specialist workers with time and expert knowledge. Dedicated workers in some projects. * Offering support which can be immediate, responsive and flexible. Continuity of care while someone waits to engage with alcohol treatment or another service, or when someone re-presents (e.g. to hospital or custody suite). * Short-term evidence of ability to support people to make changes with regards to alcohol and in other areas of life. Small decrease in re-presentation rates to hospital. * Care co-ordination with other services, and the development of collaborative partnerships. * Support of senior staff (e.g. in police or hospitals) and the role of alcohol champions. * Some evidence of wider impact through engaging families or raising awareness in the community.	* Keeping to the core project remit of the delivery of alcohol screening and brief intervention work. * Time needed to set-up and deliver projects. Training and supporting staff needs to be ongoing and this can place pressure on workers. * Meeting project targets. Encouraging staff to complete screening and brief intervention work. Embedding universal screening. * Delivery of brief interventions with clients who have multiple needs and where these needs may affect alcohol work. * Defining and measuring success; ensuring that this combines quantitative and qualitative outcomes and can capture the full range of ways in which alcohol screening and brief intervention work can support clients. * Understanding the longer-term impact of alcohol screening and brief intervention work. * Missed opportunities to work with those who have drug (but not alcohol) problems. * Working with mental health services. * Securing support of senior staff. * Recruitment of detox nurses.

Overall, this evaluation mirrors findings from other research, in demonstrating the potential for alcohol screening and brief intervention work in a range of settings. However, the variation across the projects, the challenge in delivering straightforward brief interventions, and in measuring a wide range of outcomes in relation to this work makes it hard to make firm conclusions and recommendations. The projects in the hospitals, homeless organisations and custody suite offer support to troubled sub-populations who may be engaged with services but who may not be addressing their alcohol-related problems. However, the multiple and complex problems which a substantial proportion of these clients seem to present with brings challenges in following a screening and brief intervention model. This seems to be a particular challenge for the homeless organisations although the worker's role with regards to case and care co-ordination seems to be very important and beneficial. The projects located in the hospitals and the custody suite appear well placed for alcohol brief intervention work, although development and success rests very much on the extent to which other core staff take on the work, and the extent to which alcohol work is supported by other staff and prioritised throughout the organisation. While the evidence suggests that having an alcohol screening and brief intervention project in a broader healthcare setting is important, the slower progress which has been seen with the pharmacy and Health Trainer projects makes it hard to assess their future with regards to this work. There is some evidence that the Health Trainers can support individuals to make changes around alcohol as part of wider lifestyle change or of facilitating engagement with alcohol services where necessary (while still supporting someone to make change[s] in other areas).

Somerset is developing what could be described as a multi-component alcohol treatment framework. It is clear from the alcohol projects which have been reviewed in this report that screening and brief intervention is an important part of this framework. As the work continues there is a need to monitor how clients at all levels of alcohol risk are identified and supported, to recognise the multiple needs which many clients present with, and consider also how to expand the work to also support the children and families of these clients. It is important that the framework is well resourced at all levels, allows sufficient time for projects to develop and establish themselves, encourages and supports multi-agency partnership working, and is backed up by training and ongoing specialist support. This work should not sit in isolation but needs to dovetail with other parts of the treatment system and with joint working with other sectors which overlap with alcohol misuse, particularly public health, criminal justice, drug treatment and mental health.

Recommendations

1. Ensure that there is sufficient lead-in time for projects to set-up and establish themselves. Commissioners and alcohol projects (and the organisations which lead on their delivery or are the environments where projects are located) need to agree timelines which are realistic and achievable.
2. Offer a range of projects in different settings to, collectively, maximise reach and offer choice and opportunity for accessing support. Some projects need to be located away from alcohol (and drug) treatment services, but have strong and efficient links with treatment services.
3. Projects need to be able to reach those who may not otherwise be identified or be willing to engage with services, and to be pitched correctly in terms of the screening and brief intervention model which is required.
4. Maximise the involvement of staff in the environments where projects are located, in both screening and brief intervention work, and achieve a balance between what alcohol workers can do and what other staff can do.
5. Assess the impact of screening and brief intervention in a range of domains, not just alcohol. This includes health, mental health, accommodation, finances, education & employment. Build strong links with partner agencies in these (and other relevant) areas to support this work. Continue to assess change in longer-term.
6. Develop a local network of workers from alcohol projects, and consider extending this to include representative from other local partners.
7. Raise awareness that alcohol projects, through engaging directly with those with alcohol projects, have the potential to raise awareness about the needs of children and other family members. Ensure that information is available about, and referral pathways exist to facilitate access to, services which are available for families.

Overview

Somerset Drug & Alcohol Partnership, along with its partners, is committed to the reduction of alcohol-related harm to individuals and communities across the County. This will be done by targeting three areas – prevention, identification and treatment, and working with licensing authorities and trades. The numbers accessing treatment also need to be increased as a needs assessment in 2011 (unpublished) identified a gap between estimates of the number of people with alcohol problems and the numbers accessing treatment.

As part of the ongoing development of the alcohol treatment framework in Somerset a number of alcohol projects were commissioned, all of which aim to contribute towards the overall reduction of alcohol misuse and related harms in Somerset through the delivery of screening and brief interventions. The aim of this evaluation report is consider eight of these projects. Seven are new projects (two hospital alcohol liaison workers, one alcohol arrest referral worker, two homeless hostel alcohol workers, work across all Lloyds community pharmacies in Somerset, and the addition of alcohol work to the Health Trainers service), all of which aim to screen for alcohol problems and deliver brief and extended brief interventions. The eighth project is an expansion of the existing community detoxification nurses service provided by Turning Point. The evaluation, which is mainly qualitative and was undertaken between May-December 2012, aims to discuss both the individual contribution made by each project as well as their part in the overall aim of reducing alcohol misuse and related harm in Somerset.

There will be four sections to this report. The first section will give a brief literature review to provide national and local context for the report. Section Two will summarise the rationale and aims of the project, introduce the eight alcohol projects and summarise the evaluation methodology. The third section will then discuss each of the eight alcohol projects in turn. Section Four will discuss the key opportunities, challenges and learning across all of the projects.

Section One: Background

This first section of the report is a brief literature review, focusing on alcohol-related harm nationally and within Somerset, and on efforts to reduce alcohol-related harm.

Alcohol-related harm

* There are a wide range of ways in which alcohol misuse can harm individuals and communities (HM Government, 2012). It is estimated that over one quarter of adults in England (although more males than females) drink alcohol at levels which are harmful at minimum, and that 4% of adults are alcohol dependent (NICE, 2011). There were nearly 9,000 (8,748) alcohol-related deaths in the UK in 2010 (ONS, 2013).
* It is estimated that alcohol is wholly or partially responsible for approximately 6% of all hospital admissions with alcohol-related hospital admissions exceeding one million for the first time in 2009-2010. More recent hospital episode statistics suggest that the number of hospital admissions which are directly attributable to alcohol has continued to increase, totalling 304,200 in 2011-2012[1].
* It is widely recognised that the misuse of alcohol places a substantial burden on society and services. The cost of alcohol harm to the NHS (based on 2006-2007 prices) is estimated to be nearly £3 billion annually (ONS, 2012). Repeat attenders to hospitals can place particular pressure and cost on a range of hospital departments. The burden of alcohol misuse far outweighs the amount which is spent on treatment – for example, Alcohol Concern has estimated that a local area will invest, on average, £600,000 on alcohol treatment services (Ward, 2012).
* Alcohol misuse is strongly associated with deprivation; this link has been highlighted for both alcohol-related deaths (reported in ONS, 2012) and alcohol-related hospital admissions (APHO, 2007).
* Alcohol and crime and anti-social behaviour are also strongly correlated (Coulton et al., 2012). The most common reasons for an alcohol-related attendance at an emergency department are accidents and assaults (Hoskins & Benger, 2012). One study in Bristol estimated the burden of alcohol-related violence to Emergency Departments (Hoskins &

[1] http://www.ias.org.uk/newsroom/uknews/2012/news011112.html

Benger, 2012). In a typical week 14% of all patient attendances were related to alcohol, and were usually injury related, with one third requiring admission and over half identified as hazardous drinkers. From these data the authors estimate that over 7,000 patients annually present to the Bristol emergency department because of an alcohol-related injury, and that this can be extrapolated to two million such patients nationally.

* Data from the NTA's alcohol treatment monitoring system for 2011-2012 indicate that there were 108,906 adults, who reported alcohol as their primary problem, in contact with structured alcohol treatment, with a further 33,689 adults in contact with treatment who reported that alcohol was an additional problem for them (NTA, 2013)[2]. A significant minority (10%) of those for whom data were available reported housing problems with a further 4% reporting no fixed abode on entering treatment (NTA, 2013).

Alcohol-related harm in Somerset

* Somerset has an estimated total population of 523,000. The proportion of the population which is from black and minority ethnic groups is lower than the national average. There are four main urban centres in the County (Taunton, Yeovil, Bridgwater and Frome) that contain about a third of the overall population. This makes Somerset a largely rural County which raises challenges for the planning, access and delivery of alcohol treatment services for those with alcohol problems and their families.
* Alcohol Concern's alcohol harm map considers the impact of alcohol-related harm across all English local authorities. For Somerset (2010-2011 data) it is *estimated* that[3]:
    - 19% of the population are at increasing risk because of their alcohol consumption, with associated healthcare costs in excess of £20 million/year;
    - 95,975 people attended or were admitted to hospital because of an issue related to alcohol – this included 66,888 A&E attendances and 12,206 in-patient admissions.
    - The total alcohol-related healthcare costs are estimated to be over £30 million (mainly focused on the hospital setting).
    - There were 162 alcohol-related deaths.
* A local needs assessment considered socially excluded groups in Somerset (Day, 2011). A number of groups were highlighted, including the homeless and rough

[2] See http://www.nta.nhs.uk/uploads/statisticalreleasealcoholannualreport11-12.pdf (accessed 30th January 2013).
[3] See http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map

sleepers, offenders, alcohol and drug misusers, and gypsies and travellers. Day estimated that there are between 783 and 1,862 socially excluded individuals in Somerset. For the year 2010-2011 there were 622 individuals accepted as homeless although it is not known how many of these also had problems with alcohol. Day also reported that 50% of the 1,101 offenders under supervision between November 2010 and February 2011 also had problems with alcohol. In July 2011 there were 147 individuals in treatment for primary alcohol misuse; 13% of this group also had housing problems (Day, 2011).

Reducing alcohol-related harm

There is a great deal of research which has been conducted on screening and brief interventions, although most of the work has focused on primary care and hospital settings. It is not the purpose of this report to comprehensively present and critique this literature although this section will start with an overview of brief interventions research. Following this, the focus will be on recent literature which is relevant to the Somerset alcohol projects (namely, work in hospitals, homeless hostels, custody suites and community pharmacies).

Overview and the role of brief interventions

- Rose et al. (2012) conducted a national survey of Tier 2, 3 and 4 alcohol treatment services in England (for the financial year 2003-2004). The survey mapped 696 services, receiving survey responses from just over half of them (388, 56%). Just over two thirds (69%) of respondents were community services, over half (54%) of which were based in the voluntary sector. Clients across all services, but particularly residential services, were more likely to be male. Community services were more likely to work with clients who were offenders or had mental health problems, while residential services were more likely to work with clients who were homeless or had brain damage. However, for community services only, non-statutory services were more likely than statutory services to work with all four of these groups of clients, although they also treated fewer dependent drinkers.
- Screening and brief interventions are a cornerstone of alcohol treatment in the UK. For example, in Scotland nearly 175,000 brief interventions (which exceeded the targets set

for the initiative) were delivered in NHS settings (primary care, emergency departments and antenatal care) between 2008 and 2011 (Parkes et al., 2011)[4].

- A major review of the effectiveness of alcohol treatment included a detailed consideration of screening and brief interventions (Raistrick, Heather & Godfrey, 2006). The authors detail a number of reasons for why the AUDIT may be the preferred screening questionnaire of choice, although they highlight that other measures, such as the FAST or the PAT, may be better in an emergency department setting.
- Lavoie (2010) writes that there have been over 50 controlled trials of screening and brief intervention for alcohol, and a number of systematic reviews and meta-analyses which have attempted to summarise this large area of research. The Mesa Grande review of alcohol treatment ranked brief interventions as most effective of the groups of interventions that it considered (in Raistrick, Heather & Godfrey, 2006). Overall, the evidence is in favour of a range of brief interventions delivered in a range of settings, although booster sessions may be an important part of sustaining positive change after a brief intervention (e.g. Heather, 2010; Raistrick, Heather & Godfrey, 2006). However, Raistrick, Heather & Godfrey (2006) conclude that, on balance, the findings about the effectiveness of brief interventions in hospital settings are stronger for the emergency department settings but inconclusive for the general hospital setting.
- It has also been recognised that there are significant challenges to implementing and sustaining screening and brief intervention work, and to making the work routine in a range of settings. One qualitative systematic review (47 papers, with just under half relating to UK based work) considered the barriers and facilitators to screening and brief interventions; the majority of the included studies were concentrated in primary care settings (Johnson et al., 2010). As might be expected resources and training (which can also target professional stereotypes around those with alcohol problems) are critical for acceptability and successful implementation while the main barriers related to workload, low support from managers and a lack of training and resources.
- Findings from some studies suggest that there are limited positive benefits to a brief intervention over and above the processes of screening, feedback and referral (SIPS trial, see p10; McQueen et al., 2011; Crawford et al., 2004).
- The need for further research in this area has also been highlighted. For example, Heather (2010) argued that the focus of research towards efficacy and effectiveness, and the proliferation of systematic reviews and meta-analyses, has not been matched by

[4] See http://findings.org.uk/count/downloads/download.php?file=Parkes_T_2.txt for a summary.

research in other areas, such as understanding how brief interventions work, how gains can be sustained, and how brief interventions might affect certain groups differently (for example, between men and women).

* In 2009 the Department of Health named the implementation of identification and brief advice as one of seven 'high impact changes' that were needed to target alcohol-related hospital admissions (Lavoie, 2010). This was followed up by the Government's Alcohol Strategy (2012) which supports the use of identification and brief advice in a range of settings, highlighting emergency departments and primary care in particular. The Strategy also recommended that alcohol liaison nurses are employed in all hospitals (although responsibility to fund these posts will lie at local level) and expressed a commitment to include alcohol in NHS Health Checks for 40-75 years olds.
* NICE (2011) guidance on alcohol use disorders recommends routine screening for alcohol problems across the NHS. The NICE quality standard 11 lists 13 standards for the treatment of alcohol dependence and harmful alcohol use[5]. Standard 2 states that, "[h]ealth and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice". Other NICE guidance (2010)[6] recommends that brief interventions with adults follow the FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy), while extended brief interventions should be based on motivational techniques.
* The Alcohol Strategy does not seem to be supported by an increased investment in alcohol treatment, despite an earlier recognition (in *Signs for Improvement*) by the Government that the key way to impact upon alcohol misuse locally would be to invest in treatment (Ward, 2012). The Strategy also lacks guidance and detail on how exactly local areas might deliver more in relation to alcohol (Nicholls, 2012; Ward, 2012) and currently it is hard to see how the changing landscape, such as the new public health agenda and the introduction of Health and Wellbeing Boards, will affect planning, funding and delivery of alcohol treatment at a local level.

SIPS alcohol screening and brief intervention research

* The SIPS (Screening and Intervention Programme for Sensible Drinking) project was the UKs largest study of alcohol screening and brief intervention, comparing delivery in three settings, Primary Care (29 surgeries), Emergency Departments (nine departments), and

[5] http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-qs11/list-of-statements
[6] See http://www.alcohollearningcentre.org.uk/_library/48984.pdf

Probation (20 probation offices)[7]. The study, which lasted just over one year, screened 10,530 patients with 2,481 recruited into the full study which compared three levels of brief intervention – feedback; feedback plus a five minute brief intervention using a brief advice tool designed for the project; and feedback plus 20 minutes of lifestyle counselling. A patient information leaflet was given to all participants.

* A number of screening tools were tested with the study concluding that the M-SASQ worked best in the hospital setting and the FAST in the other two settings.
* For emergency departments all three intervention approaches were beneficial at both six and 12 months. The five or 20 minutes sessions did not seem to offer any benefits over and above simple feedback plus leaflet. Dedicated staff, including hospital based alcohol champions, were important components of delivery in this setting.
* For primary care all three intervention approaches were beneficial in reducing alcohol use. The five or 20 minutes sessions did not seem to offer any benefits over and above simple feedback plus leaflet. Financial incentives along with training and ongoing specialist supported were found to be important facilitators of delivery in this setting.
* For probation there were some differences reported according to the category of drinker. There were no real differences across any of the three interventions for increasing risk drinkers, while higher risk drinkers seemed to benefit from either of the more intensive approaches. Managerial support and ongoing specialist support were important to support delivery.

Hospitals

* Hospitals are a key environment in which to tackle alcohol-related harm, because of the volume of alcohol-related traffic which hospitals see and the burden on care which this brings (see above). Presentation at hospital has been described as a "teachable moment" (Malone & Friedman, 2004), an opportunity for a positive intervention.
* A national survey of identification and intervention activity with regards to alcohol was undertaken across all Emergency Departments (ED) in England, with over three quarters responding (82%, 153 departments: Patton, 2012). When compared with the previous such survey (conducted in 2006), the findings indicate that routine questioning about alcohol, the use of a screening questionnaire (40% of departments used the Paddington Alcohol Test), and access to a specialist hospital alcohol worker had all increased.

[7] See http://www.alcoholpolicy.net/2012/03/sips-brief-interventions-trial-findings-released.html for an overview of the study.

Almost all responding departments said that they asked patients about alcohol, although only half did so routinely. Approximately one quarter of EDs made referrals to specialist external alcohol services and more than half had a 'champion' member of ED staff who had lead responsibility for this work.

* There have been a number of systematic reviews of screening and brief intervention for alcohol misuse in the hospital settings. Some systematic reviews have considered the effectiveness of brief interventions delivered in emergency departments. Nilson et al. (2008, 14 studies) reported that a brief intervention can positively influence alcohol intake, risky drinking, and negative consequences including injury frequency. Only two studies included in the review considered the longer-term impact of a brief intervention, finding that while improvements were seen in both intervention and control groups, a greater reduction in consumption was seen with the intervention group. Another review (13 studies) suggested that an alcohol brief intervention in the emergency department can reduce the frequency of alcohol-related injuries (Havard, Shakeshaft & Sanson-Fisher, 2008).
* Other reviews have looked at brief interventions in the general hospital setting. Emmen et al. (2004, eight studies) concluded that the evidence for the effectiveness of brief interventions was inconclusive as only one study showed any significant effect associated with brief intervention delivery. The findings from another review (14 studies) were also mixed although the authors suggest that receipt of a brief intervention can lead to a short-term reduction in consumption but this may not be sustainable in the longer-term (McQueen et al., 2011[8]).
* Groves et al. (2010) conducted a study of nurse-led screening and brief interventions for alcohol misuse on one in-patient ward (one gastro-intestinal ward, one medical admissions unit and one infectious diseases ward) at each of three London hospitals. Screening rates (using the FAST) ranged from 18-37%; rates were highest on the gastro-intestinal ward which also saw a higher number of patients screening positive for alcohol. While staff and patients were generally positive about such work, the screening rates suggest that there are important barriers to implementation and sustainability which impede the work becoming embedded and routine. The authors discuss two main ways in which barriers could be tackled – incorporating the work into routine hospital

[8] See http://findings.org.uk/count/downloads/download.php?file=McQueen_J_1.txt for a summary and discussion of this study.

processes (e.g. ward admission packs), and ongoing training, support and feedback from specialist alcohol workers.

* A randomised controlled trial of brief interventions for alcohol misuse in one London Emergency Department screened (using the Paddington Alcohol Test) over 5,000 patients (Crawford et al., 2004). Nearly one quarter (22%) were found to be misusing alcohol, two thirds of whom agreed to receive a brief intervention from the alcohol worker. In total, 599 patients (over 75% of whom were male) were randomised to receive an information leaflet with or without an appointment with an alcohol worker, with follow-up data collected at six and twelve months (64% of participants were followed-up at twelve months). The findings showed that alcohol consumption reduced significantly at six months for those who were referred to the alcohol worker (regardless of whether or not they kept the appointment), changes which were sustained (but did not drop further) at twelve months (there was a greater fall in alcohol consumption in the control group by 12 months), and that there was a small drop in hospital re-attendance rate in the following twelve months.

* The challenges of screening for alcohol misuse and delivering brief interventions in the hospital setting have been highlighted. To try and overcome some of these challenges one randomised controlled trial in Australia tested the potential of mailed personalised feedback about alcohol consumption to patients (Havard et al., 2012). Patients across five rural Emergency Departments were randomised to receive mailed personalised feedback (usually about one week after screening) or not. A total of 304 patients were randomised with 80% followed up at six weeks. The study's main finding was that there was a statistically significant reduction in alcohol consumption among the group who received the feedback compared to those who were screened only, although this was limited to patients who recognised their alcohol use as problematic or who had consumed alcohol in the six hours prior to the event which led to their attendance at the emergency department.

* Another study explored whether there was an impact between an alcohol-related hospital attendance and a follow-up appointment with an alcohol worker, reporting that there appears to be an inverse relationship between hospital attendance and alcohol worker appointment, and the likelihood the patient will keep that appointment (Williams et al., 2005). The authors conclude that, "to maximise attendance rates at AHW clinics, the delay between the identification and intervention for alcohol misusing patients must be kept to a minimum, preferably giving an appointment on the same day as the attendance in the ED" (p205).

* A major contribution to the burden associated with alcohol-related harm in the hospital setting are what have been referred to as high impact users, frequent attenders or frequent flyers. Some work undertaken with funding from Alcohol Research UK in 2012 noted that despite the recognition of the burden resulting from this group of patients they have received little specific attention[9]. The workshop discussed this group of patients in detail with the following issues raised: clarification of the term used to describe this group of patients and how the term is defined; a need for better understanding of and communication about the needs of this group of patients; building on the work which has been done to understand the most effective ways of supporting this group, and conducting more research into ways of working and their potential effectiveness; how to support the workforce to deliver this work in the hospital setting, acknowledging staff pressures and the specialist training and skills required.
* A study in Bristol highlighted the potential for a multi-agency information sharing collaboration and its impact on patients (Benger & Carter, 2008). The authors particularly highlight the practise of information sharing with the police and its impact on alcohol-related hospital attendances, recommending further research in this area.
* Despite the evidence for the major role which hospitals can play in the overall response to tackling alcohol-related harm there have been calls for a response which does not rely too heavily on hospitals but extends the role of community and primary care based services, and that this should be part of the work of the new health and well-being boards[10]. The potential role of other elements of the hospital sector, such as the ambulance service and hospital based mental health services, has also been highlighted.

Criminal justice and custody suites

* A study in one police station in the North East of England explored the potential for Detention Officers (DOs) to screen for alcohol misuse and deliver brief interventions (Brown et al., 2010). Over a three month period the ten DOs who had been trained screened 704 arrestees with one third (333%, N=229) completing the AUDIT screening questionnaire, over half of whom (59%, N=134) screened positive (approximately half were hazardous drinkers with a further third alcohol dependent). Almost all of this group (98%) agreed to receive a brief intervention from the DO. However, while these results

[9] See http://alcoholresearchuk.org/2012/05/31/summary-report-of-a-workshop-exploring-the-experiences-of-working-with-frequent-flyers/
[10] See http://www.guardian.co.uk/healthcare-network/2012/jul/23/nhs-support-alcohol-problems

are positive and indicate that the environment is an appropriate one for such work, the views of the DOs themselves were mixed. While half of the DOs were positive about the potential for the work, the other half of the DOs expressed a range of structural and attitudinal factors for why they did not think such work was appropriate.

* Blakeborough & Richardson reported on the findings from two evaluations of Home Office Alcohol Arrest Referral Schemes which were delivered across 12 police force areas between 2007-2010 to nearly 7,000 offenders (2012). The offenders tended to be male, White, and aged 18-24 years. Roughly one third were arrested because of a violent offence; roughly one third were screened (using AUDIT) as dependent drinkers with roughly another third screened as hazardous drinkers. Overall the authors were cautious about their findings, which indicated that the schemes could reduce alcohol consumption but did not impact upon re-arrest rates. With regards the former point the authors suggest that this may be for two reasons – first, because follow-up data were only collected from those who had completed and intervention, and second, because a higher than expected proportion of offenders were screened as dependent drinkers (where it is believed brief interventions are less effective). With regards to the latter point Blakeborough & Richardson suggest that there was less impact upon re-arrest rates because over one half of offenders had not offended in the six months prior to their offence and did not offend in the six months after their arrest. The study highlighted the importance of good collaboration between alcohol arrest referral workers and custody suite staff, and support from senior police staff. Schemes work well if part of an existing DIP (Drug Interventions Programme). There appeared to be some differences between voluntary and mandatory referral routes – although the former were preferred and seen to be easier to implement, the latter seemed to increase attendance at the first intervention session. The cost analysis component of the study suggested that relatively small drops in re-offending would be needed for an alcohol arrest referral scheme to break even or lead to cost savings.

* A study in the West Midlands evaluated two alcohol arrest referral schemes aimed at delivering brief interventions to alcohol-related offenders (Sharp & Atherton, 2006). The findings suggest a number of areas of potential for such schemes (particularly with younger males who are under-represented in alcohol treatment), including in the areas of identification and referral, attendance and retention, and attitudinal and behavioural outcomes. The study highlighted the importance of partnership between the police and the two partner non-statutory alcohol treatment services.

* Coulton et al. (2012) conducted a study in nine criminal justice settings across England, including three police station custody suites, three prisons and three probation offices (this was part of the SIPS study summarised above). Staff (it is not clear how many) were trained in screening (using the M-SASQ and FAST) and the delivery of brief interventions, following which 205 participants (offenders) took part in the study. The results suggest that individuals who screened positive were more likely to be involved in violent offences although, overall, the sample said that they did not feel coerced to receive an alcohol intervention would not be effective. Overall, the authors reflect that the probation setting has the most potential for screening and delivering brief interventions. The study also highlighted some challenges to delivering brief interventions in the custody suite setting. First, that custody suite participants were often intoxicated which mitigated against their ability to take part in the study and second that, "Police custody suites were busy and often chaotic environments and screening at busy times was difficult in these environments" (Coulton et al., 2012 p426).

Community pharmacies

* A study with 102 pharmacy users from four pharmacies in one London borough explored their views and perceptions of alcohol screening and brief intervention (Dhital et al., 2010). Nearly half of the participants screened (using AUDIT-C) as risky drinkers. This group of drinkers were the least frequent visitors to a pharmacy and were more likely to attend multiple pharmacy establishments (rather than independent pharmacies). Overall, participants were positive about the potential for the pharmacy as an environment for screening and intervention in relation to alcohol, although there were concerns about privacy and time.
* An evaluation in the North West of England reported a positive experience of the introduction of a brief intervention approach in pharmacies across the region (Gray et al., 2012)[11]. From 2007 nearly 100 pharmacies across the region engaged at some point in the project. High numbers were reached through the project, with one in eight people reporting that they changed their alcohol consumption for the better as a result of the pharmacy intervention. However, it has also been highlighted that such work is at risk in the current climate (for example over the course of the North West project half of the pharmacy services were decommissioned) and with the introduction of the public health

[11] See also http://www.guardian.co.uk/healthcare-network/2012/nov/19/community-pharmacists-alcohol-services

agenda and a shift to increased local management of alcohol treatment the future role of pharmacies in reducing alcohol-related harm is unclear.

* Lloyds Pharmacies, who were commissioned to deliver the alcohol project in Somerset, were previously commissioned to provide community pharmacy based screening and brief intervention work in Birmingham. Service established in 2009 in 40 pharmacies with the AUDIT screening questionnaire employed. A conference poster presentation[12] on the project's progress in 2010 reported that over 5,000 people had been screened with nearly 3,000 drinking at increasing or high risk levels – 300 individuals were signposted to another service for specialist support. A four week follow-up which the pharmacy conducted with all increasing and high risk drinkers found that just over one third (35%) had reduced their alcohol consumption (the actual numbers contacted are not given). Another local feasibility project in Glasgow trained and worked with eight community pharmacies with the FAST screening tool used (Fitzgerald, undated). The pharmacists were positive about the training they had received and the feasibility of the work was further explored by collecting data from 70 clients, nearly half (43%) of whom screened as hazardous drinkers. A more detailed follow-up with 19 clients found that they were positive about the help that they had received although the nature of the study means that the impact of the alcohol work was not explored.

Homeless hostels

* There is no known research of approaches to tackle alcohol-related harm in services for the homeless.
* Auricular acupuncture has been introduced at the homeless hostel in Taunton. Another service in the South West (New Highway in Wiltshire) introduced auricular acupuncture in 2010[13]. The service is delivered by a group of trained and supervised volunteers who are ex-service users. While there has been no formal evaluation of this service the organisation reports that the intervention appears to benefit patients and to be an important part of the treatment package.
* Generally, there has been little research undertaken in the area of (auricular) acupuncture and addiction treatment and the findings of the work which has been done appear to be mixed. One review of the effectiveness of acupuncture for substance misuse (covering alcohol, drugs and tobacco) wrote that while there are methodological

[12] Poster not available online but see http://www.lloydspharmacyservices.co.uk/case-studies/birmingham-alcohol-services
[13] See http://www.newhighway.org.uk/auricular-acupuncture-services.html

weaknesses in much of what has been undertaken, overall the indications are positive as to the benefits of acupuncture as part of treatment although it is acknowledged that the evidence in relation to alcohol is particularly weak (ARRC and BAC, 2000). However, a recent systematic review of acupuncture in the treatment of alcohol dependence found that acupuncture did not benefit patients when compared to a simulated or placebo treatment (with the exception of a potential impact in terms of craving for alcohol – see also ARRC & BAC, 2000) leading the authors to conclude that there was not enough evidence to support the use of acupuncture in this way (Cho & Whang, 2009[14]). Overall it appears to be hard to isolate positive outcomes specifically to the acupuncture and it has been suggested that the benefits from acupuncture are non-specific to the treatment itself.

Summary

- Screening and brief intervention approaches have potential in a range of settings, including hospitals, custody suites (and other criminal justice environments) and community pharmacies.
- While the research which has been done indicates that screening and brief intervention approaches can bring positive benefits in terms of alcohol, less work has been done which has considered the longer-term benefits of such approaches and the impact of the work in terms of other outcomes. Moreover, some of the research which has been done opens a debate as to whether a brief intervention can bring any additional benefit over and above screening, feedback and referral to a specialist workers or service.
- Support from senior staff, multi agency collaborative partnerships and training are important to implement and deliver such approaches. Ongoing support and training, along with resources and specialist support are important for sustainability.
- Overall, it seems that there is no one solution or intervention which will successfully reduce alcohol-related harm. Rather, the solution seems to require a combination of multi-component programmes, partnership initiatives and innovative approaches (Herring et al., 2011). Screening and brief intervention approaches are, overall, a crucial component of such a model.

[14] Study summarised and discussed at http://www.findings.org.uk/count/downloads/download.php?file=Cho_SH_1.txt

The report will now go on to look at how alcohol-related harm is being tackled in Somerset.

Reducing alcohol-related harm in Somerset

The *Somerset Alcohol Strategic Statement* expresses the full commitment of SDAP, along with its partners and stakeholders, to reduce alcohol-related harm to individuals and communities. The focus is on three areas, namely prevention, identification and treatment, and working with licensing authorities and trades. The Strategic Statement has five aims:

1. Reduce level of alcohol-related harm to children and young people.
2. Reduce levels of alcohol-related chronic and acute ill health leading to a reduction in alcohol-related accidents and hospital admissions.
3. Raise awareness of sensible drinking and increase the skills and competencies of the whole Somerset community to intervene early.
4. Reduce alcohol-related crime and anti-social behaviour.
5. Improve management and planning of the night-time economy.

The lead provider of alcohol (and drug) treatment in Somerset is Turning Point. A wide range of services, primarily at Tiers 2 and 3, is provided, including open access and drop-in, community and inpatient detoxification, BBV screening, a range of counselling interventions and group work programmes, the Community Access Programme (aftercare following Tier 3 treatment), and support to families and carers. Other statutory and non-statutory providers of alcohol treatment in Somerset include Avon and Somerset Probation Trust (work with offenders), Alcoholics Anonymous, SMART recovery and other forms of mutual aid. Support is also available to children, and families and carers (including Turning Point groups, InTouch and the HHYPE group programme for children of substance misusing parents).

Screening (usually using the AUDIT) and brief interventions are at the heart of the treatment framework (Appendix 1) and will continue to be at the heart of a future commissioned services model. Outside of the alcohol projects discussed in this report, there has been a major training programme in alcohol brief interventions across the County (Layton, 2012[15]). Between 2008 and 2012 650 people were trained. A follow-up survey was conducted with 450 trainees in September 2012, 78 of whom responded. The survey suggests that there is

[15] Report provided by SDAP.

a reasonable use of the skills and techniques from the training although of course the dataset is small and cannot be generalised to all those who have been trained. It is also not clear what impact the training has on those who are in receipt of the screening and brief interventions which are delivered. The main conclusion from this work is that ongoing support for those who have been trained, and support of their managers too, is needed – training on its own is unlikely to be sufficient.

Section Two: Project Overview and Methodology

Section Two summarises the rationale and aims of the project, introduces the eight alcohol projects and summarises the evaluation methodology.

Rationale and aims

The focus of this project is the qualitative evaluation of a number of projects aimed at reducing alcohol misuse and related harms in Somerset, in line with the Strategic Statement. The evaluation considers the impact of each project both individually and overall in terms of its contribution to the reduction of alcohol-related harm in Somerset, as well as considering and discussing the successes, opportunities, challenges and areas of learning within and across the projects. This report is not a standalone piece of work. Rather, along with other pieces of work, and regular performance reviews for each of the pilot projects, the evaluation will inform ongoing commissioning plans and the development of the alcohol treatment framework in Somerset.

The Alcohol Projects

In summary, eight alcohol projects are included in this evaluation (the projects are described in more detail in Section Three). The projects are:

1. Two **Hospital Alcohol Liaison Workers** – one worker at each of Taunton Musgrove Park (TMP) and Yeovil District Hospital (YDH).
2. Two **Homeless Hostels Workers** – one worker at each of Taunton Association for the Homeless (TAH) and Barnabas Housing Association in Yeovil (YBH).
3. One **Alcohol Arrest Referral Worker** – one worker at Yeovil Custody Suite (YCH).
4. **Lloyds Pharmacy Brief Intervention Scheme** – operating in 17 pharmacies across Somerset.
5. **Health Trainers** – across Somerset. This evaluation is considering the extension of the work of the Health Trainers to include the provision of brief interventions and enhanced brief interventions where alcohol use is identified.
6. **Community Detox Nurses** – part of Turning Point's services. Two nurses have been in post for some time; additional funding has been given to expand the service

through the provision of two further nurses. This evaluation is not considering the whole service but is focusing on the impact of this additional capacity.

All projects (with the exception of the Hospital Alcohol Liaison Worker in Taunton, who has been in post since April 2010, and the community detox nurses service, which was established approximately four years ago) were established in (approximately) October 2011. All bar one project focused on models of screening and brief intervention. The community detox nurses project is different in that it offers an intensive detox service to dependent drinkers and does not screen patients or deliver brief interventions.

Evaluation methodology

The focus of this report is on the qualitative evaluation of the eight alcohol projects. The evaluation was undertaken between May and December 2012. Qualitative data were collected in a range of way, summarised as follows:

i. **Two half day seminars** were held in May 2012 and November 2012. This brought together representatives from all eight projects as well as representatives from SDAP and the researcher[16]. Fifteen individuals attended the first seminar and 20 individuals attended the second seminar. The seminars provided an opportunity for networking, to find out more about the projects, and for some small group work to discuss issues relevant to the project, to the evaluation and to the overall aim of reducing alcohol-related harm in Somerset.

ii. **Individual meetings/visits** with workers from five of the projects (both hospital alcohol liaison workers, both hostel workers, and the custody suite worker), and the pharmacy supervisor at one of the pharmacies in the Lloyds scheme (North Petherton). There were also telephone conversations with key individuals from the other three projects (community detox nurses, Lloyds and Health Trainers) and a meeting with the detox nurses project (involving two senior members of Turning Point staff and one of the nurses who has been in post since the service started).

iii. **18 case studies.** These were collected in two ways. First, during the evaluation all projects were asked to supply case studies following a template suggested by the researcher, with one case study summarising something that worked well and which

[16] The alcohol worker involved with the West Somerset primary care project attended the second seminar.

reflects the project, and a second considering a challenge which had to be overcome and the learning to come from this. 13 case studies from six projects were submitted (four from one project, two from each of four projects, and one from the sixth project). Second, as part of second seminar projects were also asked to illustrate their work with reference to case studies. A further five case studies were presented.

iv. **Six stakeholder interviews.** These were conducted towards the end of the evaluation with six individuals (not project workers) from each of the two hospitals, the police, SDAP (two interviews) and Turning Point (covering three projects).

v. **Documentary evidence.** This included performance review reports from the projects and strategic and other documents from SDAP.

vi. **Quantitative data.** While not the focus of the evaluation, some quantitative data has been used to add description and context to this report and the qualitative findings. Quantitative descriptive data came from individual (anonymised) spreadsheets made available by some of the projects and from performance review reports submitted to (and made available by) SDAP.

There are a number of strengths and limitations to the evaluation. While some descriptive data about each project is given, this evaluation is not focused on quantitative data, nor does it offer a detailed analysis of service usage and outcomes. It should be acknowledged that most of the projects (with the exception of the hospital alcohol liaison worker in Taunton and the community detox nurses) have been operational for about one year so it is not possible for the longer-term benefits of the project to be considered. Further, many of the project workers have been in post for different amounts of time, progress has varied across the projects, and there are some differences in the focus and details of the project. Together, these variables make it difficult to make direct comparisons across the projects, for example, in terms of the number of clients seen and the outcomes of the work. Hence, as will also be discussed in the section below, the focus of the evaluation is qualitative. There is strength in an approach, particularly when projects are less well established, which is not narrowly focused on quantitative data and the outcomes associated the projects, but which offers an opportunity to consider the qualitative detail of the projects, and the opportunities and successes of each project along with the challenges which are encountered.

Section Three: The Alcohol Projects

This section of the report focuses on the eight alcohol projects. The table in Appendix Three summarises some of the key features for each of the alcohol projects. Each project is discussed here in more depth, focusing on some of the details of the day to day running of the project, a summary of descriptive data in relation to each project, and a consideration of the main successes, challenges and areas of learning for each projects.

Hospital Alcohol Liaison Workers

About the project

- The focus of these projects is the Emergency Department although as both projects have developed the work has extended across both hospitals. There are a number of aspects to the work, including screening (and supporting other hospital staff to screen for alcohol problems), delivery of brief/enhanced brief interventions (either in the hospital or other community locations), support for in-patient detox, case management with patients (including liaison with and referral to community based services), and staff training.
- At the start of the evaluation both projects screened for alcohol problems with an adapted version of the Paddington Alcohol Test (the Musgrove Park Alcohol Test [MPAT] and the Yeovil Hospital Alcohol Test [YHAT]). In August 2012, informed by the findings of the national SIPS evaluation project (see Section One), a revised version of the PAT was introduced in the two hospitals (see Appendix 2). The 'Modified Single Alcohol Question' (M-SASQ) asks one question only – how often have you had 8 [for men, 6 for women] or more units of alcohol on a single occasion in the last year? The worker also ticks a box to indicate what they did depending on the category of risk of the drinker – no action, give patient information leaflet, give leaflet and brief intervention, or referral to the alcohol liaison worker.

Project progress - Taunton

- Over 1,000 (1,041) patients were screened between April 2011 and September 2012[17]. The project has a target of 60 screenings/month, with the data showing that the project

[17] Descriptive data are taken from performance reports for both projects prepared by SDAP (November 2012).

has exceeded this target for every month between February and September 2012 (bar July 2012, the month before the M-SASQ was introduced).

* Of 158 patients screened between April and July 2012 (using the PAT), 93 screened positive. All received brief advice and/or referral to the alcohol worker. There were 158 patients screened in August and September 2012 (using the M-SASQ), with 72 screening at a level of consumption which should trigger referral to the alcohol worker. However, the data suggest that the number of referrals to the alcohol worker is lower than might be expected – the reasons for this are currently unclear.
* Under half (43%) of screenings were completed in the A&E department and it is noted that establishing the work in this part of the hospital is an ongoing challenge (and this is discussed later). There has been an increase in screenings done in the orthopaedic outpatient clinic (which the hospital alcohol worker attends).
* Patients who are screened are more likely to be male, although the age range of all patients is relatively even across all age groups. Patients who are screened are more likely to live in a highly deprived area of Somerset (low numbers of patients come from outside of the County).
* Work has focused on key entry points to the hospital, namely A&E, MAU and SAU. The worker feels that she has been successful in working with the Medical Assessment Unit, Orthopaedic outpatients and Gastroenterology. The screening process is now part of the A&E admission screening card and of the admission package for the short stay assessment unit for the MAU. Training has been an important part of progress which has been made, along with the introduction of the brief M-SASQ. Discussions are ongoing with the surgical ward to explore how screening tools can be part of their admission packs.

Project progress - Yeovil

* 316 individuals were screened between November 2011 and September 2012. The project has a target of 60 screenings/month, with the project exceeding this target in just one month to date (August 2012 – the month the M-SASQ was introduced).
* Of 71 patients screened between April and July 2012 (using the PAT), 52 screened positive). All received brief advice and/or referral to the alcohol worker. There were 130 patients screened in August and September 2012 (using the M-SASQ), with 50

screening at a level of consumption which should trigger referral to the alcohol worker. However, the data suggest that the number of referrals to the alcohol worker is lower than might be expected – the reasons for this are currently unclear.

* Under half (43%) of screenings were completed in the A&E department. Other areas where screenings are being completed include the emergency admissions unit, and the surgical, gastroenterology and orthopaedic wards.
* Patients who are screened are more likely to be male, and nearly two thirds of all patients screened were aged between 20-49 years. Patients who are screened are more likely to live in a highly deprived area of Somerset (low numbers of patients come from outside of the County), with patients coming in the main from two districts of Somerset or from Dorset.
* The worker feels that the project is well established in a number of wards, including Gastroenterology, the Intensive Care Unit, the Emergency Medical Unit and with the specialist midwives. The worker has also highlighted collaboration with the Pain Sister, who will take over all substance misuse related work in coming months – this is a significant collaboration at the hospital and will be important in terms of sustainability. The recent training of some hospital staff in alcohol brief interventions with a focus on motivational techniques and the potential role of Health Care Assistants are areas where there is potential for development in terms of the project. Other areas where there is scope for development include obstetrics, gynaecology, midwifery, and pre-assessment and intake clinics/wards.

At both hospitals re-presentation data (for the six months before and after screening) indicate that there has been a small decrease in the number of A&E alcohol related re-attendances and re-admissions to the hospital although of course it is not possible to directly attribute this outcome to the hospital alcohol liaison project. There are no other outcome data available about the number of completed brief interventions or outcomes associated with the work which has been delivered.

Areas of success and learning

* Targets were set for the each of the projects once the work was underway. The targets were to complete 60 screens/month in the A&E Department. It has been a struggle for both hospitals to meet these targets, both within A&E and across the wider hospital environments. The introduction of the M-SASQ may be increasing screening but it is

hard to know if this is directly the case or whether the increase in screening is also a result of other factors, such as staff training and the increased acceptability of this work in the hospital setting.

* The work is not mandatory for hospital staff, and has mixed support from senior staff at both hospitals; this presents significant challenges which limit progress and the speed of development. The support of senior hospital staff is an important factor in the success of the projects and it needs to be recognised that the support which is needed from senior staff must come from management and administrative levels as well as clinical staff. The role of alcohol champions could be expanded to ensure that there is coverage across the whole hospital and that there are enough champions to ensure availability at all times.
* The day to day work of the projects has been hampered because neither worker has a formal base, with both workers facing challenges in terms of desk space and accessing telephone, computers and hospital computer systems. There are both strengths and limitations in having one worker only at each hospital. For example, there is no or limited cover for the project at time of illness or holiday.
* At both hospitals there have been more screenings completed on weekdays than at weekends. Reasons for this include the increased pressure placed on A&E staff over a weekend which makes it harder to complete the screening tool with patients and the fact that the alcohol workers do not work over the weekend. On the other hand, a possible strength of the number of screens which are completed on weekdays is that patients are identified who might not otherwise come to the hospital's attention and who may not have received a brief intervention, or any other intervention regarding alcohol, before. Both workers are trialling the provision of 'out of hours' delivery (particularly at weekends) but it is too soon to be able to comment on the impact of this.
* Several people highlighted that worker selection, in other words getting the right person for the job, is critical to the success of the post. Both workers have highlighted the importance of having a regular daily (on weekdays) presence across the hospital although this is a time consuming aspect of the work and needs to be ongoing. Nevertheless, such efforts appear to be crucial to raise awareness of the project and to develop relationships and trust with a range of hospital staff. An important aspect of these ongoing relationships is to provide feedback to hospital staff on patients who are

> "we've been very lucky with the staff we've got"
>
> "to have the right person in post has been really really important"

referred, so that hospital staff can see the benefits to the work that they are doing in completing screening tools and making referrals.

* At both hospitals there have been challenges in working with A&E, most commonly related to the volume of work, the high numbers of staff and the rate of staff turnover. One stakeholder suggested that the focus of the work at both hospitals should move away from A&E and towards other areas of the hospital where the projects have achieved success. The role of alcohol champions may be particularly important in supporting the work in A&E.

* At both hospitals the amount of screening which is completed by hospital staff is lower than desired, suggesting that it is hard to develop a model, be it targeted or universal, of screening across the hospitals. Furthermore, it appears that there is a mis-match between the remit of each hospital project and the brief intervention models which are developing. This mis-match appears to be at two levels. First, hospital staff are undertaking less screening and brief intervention work which is placing increased pressure on the alcohol workers who, as a result of undertaking more screening and paperwork, have less time for (extended) brief interventions and care co-ordination with other hospital and community services. Second, there appears to be a focus towards higher risk and dependent drinkers, who are more obviously affected by alcohol or who tell staff that they have a problem but where there is less evidence for the effectiveness of brief interventions, and away from increasing risk drinkers. Overall, there appears to be an over-reliance by hospital staff on the alcohol liaison workers. There is a need for clarification of the roles of all staff, the pathways for screening and brief intervention, and how the projects can achieve the right balance between screening and intervention, and across all levels of alcohol consumption. As one stakeholder said it is important to get to a place where, "workers do less of the things that others could do and more of the things that only they can do".

> ".....I was alerted very quickly to the client attending the hospital...client believes this follow-on support has been important to her achieving her abstinence....through being in hospital the client was prevented from slipping through the net of treatment.....the client's treatment was continued even through relapse"

* Currently, while there is some evidence about the impact of the project in terms of re-presentation rates to hospital, there are limited other outcome data available. The qualitative data highlight the complexity and severity of many of the patients who come to hospital and are seen by the alcohol worker. While there are numerous challenges here for the hospital alcohol workers, it also seems that the work can facilitate liaison within the hospital and between alcohol and community services, and support for patients who are frequent attenders, are relapsing and have multiple other problems. The workers can offer a continuity and immediacy of service (particularly at times of admission and discharge, or when someone is waiting for an appointment with another service), and are in a position to swiftly to re-engage with frequent attenders. This care management role can also speed up access to services. One area of possible development for the projects is to complete assessments on behalf of other services while a patient is in hospital but where perhaps a worker from another agency has been unable to complete such an assessment However, despite the importance of having a worker who can act as a liaison between hospital and secondary/community care services, there is a risk that this work will spread them too thin if it is not well resourced and supported by hospital/primary and community/secondary care partners.

> "[the] client needed significant support but other services were unwilling to see her when she was drinking which prohibited any other support which might have been available.....[I was able to provide] a service where otherwise there would have been significant gaps in provision for this individual"
>
> "The role of the ALW provided three key opportunities to build a rapport with the client while they were in hospital.....[this] enabled the client to see the same worker throughout the treatment process.....the client did not feel so overwhelmed and could see a way forward.....[they] may not have received the same support if [they] did not have the initial intervention from the ALW at the hospital"

* Both projects have had mixed experiences in working with hospital and community based mental health services, and of working with patients who also have mental health problems. Despite the overall challenges, both workers have examples when they have been able to develop good working relationships with hospital based psychiatric liaison services and undertake joint assessments with some patients but this is an area which needs further attention.
* Some cases at both hospitals have highlighted the importance of dovetailing the psychological focus of the support offered by the alcohol workers with the clinical treatment delivered to patients by hospital staff, particularly related to detox.

* Both workers have highlighted the potential for their work to facilitate communication with families and carers (when permission to talk to families is given by the patient), and for this to raise awareness of what support is available to them.

Conclusion

The hospital is an ideal environment to access a wide range of the population and to target those affected by alcohol problems. It seems that the hospital alcohol projects can successfully engage with patients who might not ordinarily access alcohol treatment as well as those with more serious and longstanding problems who place a burden on a range of healthcare settings. There is some evidence that the hospital projects can influence hospital re-presentation rates. The presence of an alcohol worker with specific expertise and the ability to co-ordinate care between a range of primary/acute care and secondary/community services is an important part of the package of care which needs to be available. Having the right worker in post appears to be vital to the success of projects. The project can successfully operate at key entry points to the hospital although screening needs to increase, more work is needed to improve and embed the screening and brief intervention work undertaken by hospital staff, and there is a need for clarification about the remit of both hospital staff and the alcohol workers. Overall, alcohol is becoming increasingly recognised by hospital as a priority issue, and the hospital alcohol projects appear to be an important part of this response. Within the community, the hospital alcohol projects are viewed by Turning Point as a core element of their treatment model.

Homeless Hostel Alcohol Workers

About the project

* Both hostel alcohol workers offer support across their organisations (Taunton Association for the Homeless and Barnabas Housing Association), including move on or satellite accommodation. There are a number of aspects to the work undertaken in each location, including supporting homeless alcohol users to access treatment (including alcohol detox), delivery of brief interventions, and offering enhanced care co-ordination for issues associated with alcohol misuse and accommodation.

Project progress

* Based on data from January-October 2012 (provided by the workers) the project in Taunton has received 82 referrals to the project while the worker in Yeovil has received

95 referrals to the project. Table 2 shows that the majority of referrals were male and White British, although the proportion of referrals who were female was slightly higher in Yeovil (35%) than in Taunton (25%). There was wide variation in age with referrals most likely to be aged 30-50 years, although a higher number of referrals in Yeovil were aged 24 years and under. A high proportion of the referrals to both projects reported problems with other drugs alongside their alcohol use (41% in Taunton and 53% in Yeovil). Just under one third of referrals at each project (30% in Taunton and 28% in Yeovil) reported having children under 18 years of age.

Table 2: Profile of clients seen by homeless hostel alcohol workers

	Taunton	**Yeovil**
Characteristic	**No. of clients**	**No. of clients**
Gender	67 male, 15 female	70 male, 25 female
Ethnicity	76 White British	85 White British
Parental status (children under 18)	24 report having children under 18	27 report having children under 18
Primary drug profile	7 reported a primary problem with another drug (alcohol was also an issue for 6 of these 7) 27 with primary problem with alcohol also reported problems with other drugs	13 reported a primary problem with another drug (alcohol was also an issue for 7 of these 13) 37 with primary problem with alcohol also reported problems with other drugs

* Table 3 summarises the outcome for each referral in terms of the main reason for the client's discharge from the project. A relatively low number of brief interventions have been completed, particularly in Taunton, and quite a high number of referrals disengaged from both projects for a range of reasons. This will be discussed later.
* The Taunton project has found it beneficial to have good links with the local rough sleepers service and with a range of other TAH services including the volunteer co-ordinator and the outreach team. The project has now been extended to the TAH hostel in Bridgwater. Auricular acupuncture is part of the service available in Taunton.

Table 3: Reason for discharge (for whom data are available)

	Taunton	Yeovil
Reason for discharge	**No. of clients**	**No. of clients**
Intervention complete – brief intervention	13	32
Intervention complete – alcohol free	4	6
Intervention complete – alcohol consumption reduced	7	11
Intervention not complete – client disengaged	23	14
Intervention not complete – other reason	10	13
Total	**57**	**76**

* The project in Yeovil has established good links with a wide range of local services. The worker has had a number of Polish clients and it has been important for the worker to develop links with other services so that this can support this sub-group of residents in ways which might not otherwise have been possible. This has included making links with a local interpreter and translator, getting project documents translated into Polish, providing leaflets about alcohol in Polish and learning about the role of alcohol in the Polish culture. The worker has attended Polish AA meetings with some clients and has also supported some of this group to enrol in English language courses at college.

> "I attended the Polish AA meeting with him and for once the language barrier had been reversed and I started to understand what it must be like for [him] not understanding what is being said, I could really empathise with him"

Areas of success and learning

* Both projects have seen a good level of engagement with both clients and other staff. Communication with staff and residents at both projects is important. However, one area where clarification is needed is around the decisions which are made about eviction (where alcohol misuse is a factor in the decision which is made about eviction). One worker described a case where a resident was evicted twice (in the

> "By maintaining contact with [him] via phone and also at the Open Door project for street homeless....I tried to continue my supportive role for [him] even when he had been evicted and so was not a current TAH service user"

period that she was engaged with them) because of alcohol-related aggression and had another period of homelessness. While the hostel's decision to evict this resident was understandable the worker felt that it had affected the trust she had built up with him and interrupted the support she was offering. Suggestions as to what might be needed include improved communication between hostel staff the alcohol projects in decisions which are made about eviction and to offer alternatives to eviction such as behavioural contracts.

* Having a regular presence across the organisations, and being able to offer continuity, flexibility and immediacy of support, are important aspects of the service. Both workers run weekly drop-ins at various sites and supplement this with a regular presence across the hostel sites. The worker in Yeovil is involved with group activities for residents, such as a boxing group. Together, these approaches seem to increase opportunities for engagement and to build trusting relationships with clients, thereby providing a responsive service to a population which is transient, chaotic and vulnerable. In Yeovil each new resident automatically gets a letter from the worker, introducing herself and the project, which provides an opportunity for self-referral as well as awareness of the project for residents when they meet the worker at other times. This can increase the speed with which a client can engage with the project. Morning appointments appear to work better with those who are regular and heavy drinkers (this is useful learning as well in terms of what might work best for engagement of this group with other services).

* It appears to be important that the work is not necessarily time limited even though, due to the chaotic and transient nature of the client group, the workers often work on the assumption that they may only see a client once and hence 'treat every session like it's the only one that they will have' with a client. This approach has also seen some successes such as one resident who, after almost daily contact with the worker for some time, expressed motivation for residential rehabilitation, something which the worker and the hostel was able to offer support with.

> "[he] was very grateful that someone had taken an interest in him and seen his potential"

* The discharge status and other data currently collected do not accurately or adequately reflect the challenges in working with this client group, the detail and breadth of the work that is done with clients who are complex and vulnerable with multiple problems and needs, or the positive work which it is possible to undertake and which will not be reflected in basic discharge statistics. Both workers record the outcomes of their work with clients in a number of areas, which include alcohol consumption, accommodation

status, contact with children, and contact with other services. The workers also add some qualitative statements to their spreadsheet to further describe some of the details of the work that they do. Both projects highlight the benefits which they can have with these clients, in a range of areas (not just alcohol), regardless of the 'discharge' outcome. In some cases the worker has had a positive impact on accommodation status, although the numbers of cases where this has occurred are small. Importantly, the data suggest that the work with this client group is often about more than alcohol, but requires attention to and support with resolving other serious issues. In many cases, in order to maximise the chance of a positive outcome in relation to alcohol, these other issues need to be resolved or addressed alongside the alcohol problem or, as can sometimes be the case, before a client is able to address their alcohol problem. Furthermore, a categorisation of someone as disengaged or evicted may mask positive change which may have been seen in some areas.

* The care co-ordination role provided by the two hostel workers appears to be central to the service. Both workers have been able to offer a continuum of service while a client is waiting to engage with another service, and also to support joint working with clients who are engaged with a range of other services. This has included Turning Point (including to support clients who temporarily reside at one of the hostels for an alcohol detox), street pastors, Health Trainers and PCSOs. However, a challenge remains in working with local mental health services who usually want a client's alcohol problem to be addressed before they are taken on as a client and where joint working has not always been possible. The workers have also been able to engage with residents who are ready for change or who do not wish to engage with other services, and who otherwise would receive limited support in relation to alcohol and other problems.
* It may be a characteristic of the client group, who by definition are often at the very limits of vulnerability and chaos, but both workers appear to have engaged with higher numbers of higher risk or dependent drinkers and hence with lower numbers of increasing risk drinkers. Understanding this, and exploring what might be needed to increase work with a wider range of drinkers, will be important for the development of this project. One stakeholder suggested that there may be too much cross-over between Turning Point keyworkers and the hostel alcohol workers, suggesting that there needs to be clarification of the two roles and a better alignment of the hostel workers within the wider alcohol treatment framework.
* Both projects have engaged with clients who have also had drug problems. However, there have been missed opportunities to support a resident where alcohol was not

involved and both projects feel that the service could have greater reach by being extended to be able to offer support for clients who have problems with alcohol and/or drugs.

* There are some examples of the wider ripple effect of their work in terms of other family members. In one case the support offered benefitted both the young person involved and his mother while support to another resident helped her contact with her children.
* The auricular acupuncture service, which is available as group or individual sessions, appears to be a potentially useful part of the project in Taunton although numbers using it are low and feedback is largely qualitative and anecdotal. Feedback from clients suggests that they find the service relaxing and calming and that it can reduce cravings for alcohol. The worker thinks that the service can help to facilitate engagement although there is not the evidence to make a direct link between the acupuncture service and change or positive outcomes for clients.

Conclusion

The way in which the project is offered to residents across both organisations is an important part of its success. This is an incredibly chaotic, vulnerable and transient population who are hard to reach and who may require quite a specific service, and where continuity, flexibility and immediacy of support are necessary. An important aspect of the work in Yeovil has been to offer a specific service to Polish residents. Responding to multiple needs, either directly or through collaboration with partner agencies, is important. This can mean that the workers are not able to offer brief interventions or to focus on alcohol; often more intensive or co-ordinated support in response to other issues is needed, and this may be needed before or alongside support in relation to alcohol. The work is focused towards higher risk and dependent drinkers and there is a need to explore the extent to which the project is able to meet its brief intervention remit or whether this needs to be interpreted differently for this population in this setting. Considering alternatives for clients who are at risk of eviction as a result of their alcohol misuse is necessary.

> ".....[ear acupuncture] it has given me an opportunity to engage with people who may not otherwise wish to talk, but can still take a positive step"

Custody Suite Alcohol Arrest Referral Worker

About the project

- The worker is based at the Custody Suite in Yeovil Police Station. The work involves both screening and the delivery of brief and extended brief interventions. Screening and brief intervention work is supported by the Detention Officers who are part of the custody suite team and who have received training in this work and have ongoing support from the alcohol worker. The alcohol worker is also able to carry a small caseload to undertake some extended work (over about six sessions) with a small number of clients.
- The project screens for alcohol problems using and adapting the Paddington Alcohol Test (PAT) to make the Custody Alcohol Test (CAT).

Project Progress

- Table 4 shows that, based on data provide by the project (for the period November 2011 to June 2012), 890 CATs were completed between November 2011 and June 2012. However, it should be noted that it is currently not possible to identify who might be repeat visitors to the custody suite and so it is not known how many individuals the number of completed screening questionnaires relates to. The proportion of arrestees who are screened is increasing, from 29% in May 2012 to 50% in October 2012.
- The number of CATs completed has ranged from 74 in November 2011 to 159 in June 2012, with over 100 a month completed each month from April 2012. In 65% of cases the CAT score was positive.
- A high number of CATs have been completed by the Detention Officers, and there has been a general increase in this over the course of the project to date. From 32 in November 2011 to 134 in May 2012 and 143 in June 2012 (based on data supplied by the worker). This demonstrates the level of support which the project has within the Custody Suite and the level of engagement of the Detention Officers.
- Currently there are no targets for this project although it is clear the volume of work is consistently high and the increase in the number of screening questionnaires being completed by the Detention Officers is an area of significant progress for this project.
- Data from another report prepared by SDAP (based on data for the period October 2011 to April 2012) shows that, of 464 screening questionnaires completed, 48 arrestees were dependent drinkers, 57 were higher risk, 88 were increasing risk, and 64 were lower risk, with the drinking risk profile of the remaining 207 arrestees unknown. Some level of brief

intervention was delivered to quite a high proportion of clients who had a positive CAT score, although there are few details on the nature, detail and outcome of these interventions. Table 5 summarises the link between level of drinking risk and whether the arrestee was referred to the alcohol worker or was offered brief advice.

Table 4: Custody Suite Alcohol Worker, CAT Scores and Interventions

Month[1]	CAT Score		Intervention	
	CAT +ve[2]	CAT -ve	Brief intervention	Referral
November 2011	55	19	27	5
December 2011	65	31	55	19
January 2012	57	35	45	13
February 2012	64	23	62	11
March 2012	66	28	52	8
April 2012	64	51	70	19
May 2012	95	68	114	20
June 2012	108	51	118	16
Totals	**574**	**306**	**543**	**111**

[1]October 2011 – not included as first month, numbers small and spreadsheet a work in progress.

[2]CAT +ve – units drunk and/or drinking days and/or offence related to alcohol.

Table 5: Drinking risk and alcohol referrals[1]

	All Arrestees	Referred to alcohol worker	Offered brief advice
Dependent	48	31	41
Higher risk	57	20	49
Increasing risk	88	14	69
Lower risk	64	3	37
Unknown	207	26	105
Total	**464**	**94**	**310**

[1]Based on data between October 2011 and April 2012, table taken from SDAP report (May 2012).

Areas of success and learning

* The involvement and commitment of the Detention Officers (DOs) is an important part of the work and as time has gone on the work has become more embedded within the team. It has been important for the alcohol worker to give feedback to the DOs about offenders who are referred – through this the officers can see something of the impact of the work that they are doing. Something which has facilitated the engagement of the DOs has been the inclusion of this work as part of the appraisal process and the assessment of an officer's performance and development. The support of senior officers in Avon & Somerset Constabulary has also been critical to the success of the project to date. However, one challenge to the involvement of DOs with this project is that they are seen by offenders as police staff whereas the alcohol worker is employed by Turning Point: this may affect offender engagement.

> "[he] was screened by a Detention Officer at a time when I wasn't available. I was able to follow up....and [he] was able to access the treatment he needed"

* It is still the case, however, that while the amount of screening being done by the DOs has increased, there is a need for this to be matched by an increase in brief intervention work. The screening process, which is well embedded into custody suite administration processes such as taking fingerprints, is somewhat formulaic. While this has had a positive impact in embedding the work within the custody suite and on the number of CATs which are completed, the bulk of the intervention work is still being completed by the alcohol worker. It was suggested that some further training may be helpful, as the training which has already been delivered in relation to this project was not specific enough to DOs and has therefore not positively influenced their intervention work.

> "As a result of his arrest and subsequent time in custody I was able to offer him an appointment far earlier than the waiting list allows.....being screened for alcohol use in custody and his subsequent assessment opened up an opportunity for [him] to talk about issues that he hadn't discussed before.....as [he] began to feel listened to he began to relax and seemed to enjoy the intervention"

* The project is able to offer an immediate intervention to those in custody who wish help, which can increase engagement either within the custody suite or subsequently with other services. A positive aspect of the service in the custody suite is that it can allow fast-track access to Turning Point services for clients, particularly dependent drinkers, and can also offer continuity of support while a client waits for an assessment and/or further support from Turning Point.

* Engagement with arrestees when they have left the custody suite has been a challenge for this project. Drop-ins, including a session at Barnabas House, have been piloted to try and shorten the time between offering and attending an appointment but these do not seem to have had an impact on engagement. The screening form now includes a contact telephone number for an arrestee, with anecdotal feedback from the worker suggesting that this has led to an increase in those attending follow-up appointments.

> "I think the most important part of this 'journey' was being able to see [him] in custody following his second arrest. At this point he was feeling pretty low and was very down on himself, feeling that he had failed regarding his alcohol use"

* The impact of the project, in terms of outcomes around alcohol, offending and any other related issues, is largely unknown. There is anecdotal evidence from a small number of cases that the alcohol worker has been able to engage with, and help stabilise, multiple (and sometimes even prolific) offenders. There is a need for the project to establish ways in which such data, particularly in relation to recidivism, can be collected.
* Moreover, it seems that offering support around alcohol misuse is just part of the work of this project because of the associations between alcohol misuse and other problems (including the offending behaviour), and so an important part of the alcohol worker's role has been to facilitate engagement with other services as required. For example, the work has provided some useful opportunities to work with mental health services and Health Trainers. The input offered by the alcohol worker has also been highlighted at local MARACs (multi agency risk assessment conferences), which is a specialised co-ordinated response to high severity cases of domestic violence. The alcohol worker also highlighted that in a small number of cases issues related to children's safeguarding have arisen, but that there are good links to the local senior police offer who deals with such cases.

Conclusion

This project is achieving a good level of screening, and the increase in screening by the DOs is a positive outcome of the project to date. However, most of the brief intervention work is being undertaken by the alcohol worker, and this work is also biased towards higher risk and dependent drinkers. Ongoing work is needed to understand this imbalance and to increase the amount of brief intervention which is done, by DOs and with increasing risk drinkers. While there is some anecdotal evidence of the positive impact of the project (with regards to alcohol, offending and other co-existing problems) there is a need to develop mechanisms

so that these outcomes can be routinely measured. The project appears to be well positioned, both its setting in the custody suite, and in terms of joining up support between police and other community services although there is a need to increase engagement with arrestees when they leave the custody suite. Turning Point sees this project as a core part of its treatment model in Somerset.

Lloyds Pharmacy Brief Interventions Scheme

About the project

- This project operates in 17 pharmacies across Somerset. A reduced version of the AUDIT is used with pharmacy visitors who agree to take part in an 'alcohol survey' (the way the work is explained in one pharmacy). The reduced AUDIT (called the Alcohol Intervention Questionnaire by Lloyds) asks five questions related to alcohol (with a score range of 0-20). The questionnaire also asks about smoking, physical activity and three other long-term conditions (high blood pressure, diabetes and cardiovascular disease).
- Pharmacy staff, who have received specific training in alcohol brief interventions, offer a brief intervention to those who screen as increasing or high risk risk. For those who screen as dependent the client is offered an appointment with the pharmacist, who will deliver an extended intervention and/or onward referral to Turning Point through the single point of contact. Theoretically there is a private consultation room at each pharmacy for the delivery of the brief interventions.
- A follow-up telephone call is conducted by the pharmacy roughly four weeks after a brief intervention has been completed (if consent and a contact number are given). Three questions are asked: how useful the person found the alcohol information they were given, whether reading the information has helped them to identify safe drinking levels, and whether reading the information has resulted in their drinking increasing, decreasing or staying the same.

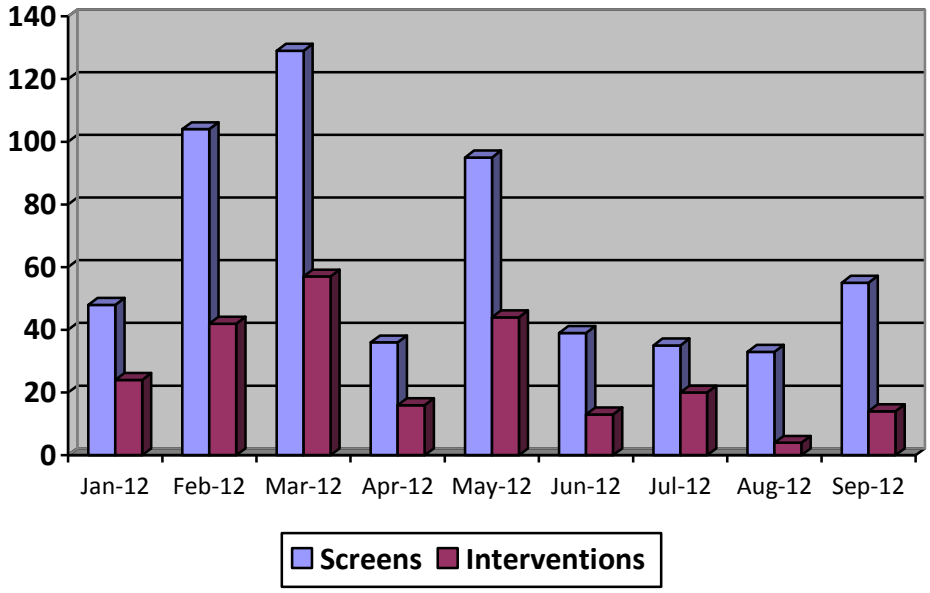
Project Progress

- Figure 1 summarises project activity for the period January-September 2012 (the data for September 2012 is not a full month). In total over this period 574 screening questionnaires and 234 interventions have been completed, with 41% of those who are screened receiving an intervention. The project has a monthly target to complete 222 brief interventions; the data show that the project has not reached this target in any month to date. There is also very wide variation across the 17 pharmacies with some of

the pharmacies having undertaken no screening or brief intervention work, and a small number of the pharmacies having completed the majority of the project's work over the period reported.

* Based on 323 completed screening questionnaires it can be seen that three quarters of the clients are female, the majority (94%) are White and there is wide variation in terms of age. Furthermore, just over three quarters (78%) are non smokers, 69 people reported problems with blood pressure, 29 with diabetes and 18 with cardiovascular disease. In terms of drinking risk 136 people identified as increasing risk and 21 as high risk although there are no data available on the number of completed brief or extended brief interventions by alcohol risk category. There is also a very small amount of data available from the follow-up telephone calls and so these data are not summarised here.
* There have been 21 referrals to the Somerset SPOC (single point of contact) with 16 of these referrals made in one month. However, there is no further information on these referrals and information provided for the evaluation indicates that the SPOC service itself has no record of these referrals having been received.

Figure 1: Screens and Interventions across Lloyds Pharmacies (January-September 2012)[18]



[18] The data reported are taken from the barcodes which are scanned by staff when a questionnaire is completed and are collated weekly by Lloyds HQ. Data for September is incomplete.

Areas of success and learning

- Overall, progress with this project has been slow with very wide variation in the work across the Lloyds pharmacies in Somerset. The project is not on track to meet its target of identification and brief advice or intervention to 4,000 individuals. There is little information available on the intervention work which has been completed, on the impact of that work in terms of follow-up telephone calls and on the referrals which have been made to the single point of contact. Clarification around data monitoring and referral pathways is needed.
- A challenge for this project has been the training of pharmacy staff to undertake the alcohol work. At the start of the project the selection of staff for brief intervention training, which focused more towards staff at management level rather than frontline staff, did not maximise the potential of this project and affected the level of work which has been completed. A second round of training was planned but was then cancelled by Lloyds about one week before the training was due to take place.
- Another challenge which the project has faced has been a staff restructuring exercise within Lloyds. During the evaluation period there were three different Area Managers in post, with the most recent coming in to post in November 2012. These changes appear to have affected the time and support which senior management level staff have been able to give to the project and to communication between Lloyd's senior management, pharmacy staff and SDAP.
- A representative from one pharmacy said they were surprised to see that the data for that pharmacy showed that 57% of 113 completed AUDITS were at increasing risk because of their drinking. It seems that this work can make pharmacy staff more aware of the prevalence of these issues and of the potential for positive intervention in the pharmacy setting. The pharmacy environment is a setting where it is normal to be asked about a range of health issues, with alcohol another important issue which can be added to this list. Pharmacists and their staff are trusted and respected professionals in local communities and this can facilitate engagement. However, it can be hard for pharmacy staff to see alcohol as another healthcare issue which they can discuss with their customers.
- The project has an opportunity for wider education and awareness raising among local communities about alcohol-related harms and risks. Examples include events linked to the Olympic Torch relay and tables in GP surgeries (and other places with high footfall) which can offer advice, information and interactive activities to engage people while they

are waiting or passing through. SDAP feel that frontline pharmacy staff have been keen and enthusiastic to engage with such health promotion activities.

Conclusion

It is hoped that a project review between SDAP and the new Area Manager will provide an opportunity to discuss the challenges and progress with this project and agree a way forward. Unfortunately, the challenges with, and slow progress of, this project, and the wide variation of the implementation of the project across the 17 Lloyds pharmacies in Somerset, make the future of this project uncertain. This is despite the strong feelings of several that the pharmacy setting has an important contribution to make to the reduction of alcohol-related harm because of its community based location which mean that the service can target those who may not otherwise access other healthcare settings.

Health Trainers Enhanced Alcohol Service

About the project

* Health Trainers are part of the NHS Integrated Lifestyle Service who work in a range of community locations, often in areas of high need or deprivation. They offer free advice and support to individuals, as well as other things such as goal-setting, motivational support and signposting to other services, about a range of issues (for example, diet, weight management, physical activity, smoking, alcohol, anxiety and stress), with the overall aim of improving health and well-being. The AUDIT is used, with all Health Trainers trained to offer advice (and signposting) around alcohol as required. All those who receive support from a Health Trainer are followed-up at 16 weeks, with the AUDIT re-administered to those who receive an enhanced alcohol intervention.
* The alcohol project focuses on an enhanced service whereby Health Trainers complete additional brief/enhanced brief intervention training enabling them support those who screen positive for alcohol problems. Increasing or higher risk drinkers can be supported directly by the Health Trainer (a referral to Turning Point may be part of this work). Dependent drinkers should automatically be referred to Turning Point. Health Trainers have been allocated additional hours to undertake this enhanced alcohol service.

Project Progress

- Quantitative descriptive data are available, via a report prepared by SDAP, for April-September 2012. There were 30 referrals to the Health Trainers in this time where alcohol was identified as the primary problem or one of the reasons for why the person was seeking help). 17 were defined as low risk drinkers, five as increasing risk, four as higher risk and four as dependent drinkers. In terms of the enhanced alcohol service it seems that three individuals received extended alcohol sessions but no further data are available. While the data available indicate that, more widely, the Health Trainers are identifying, engaging with and supporting drinkers, the project has undertaken very little of the enhanced alcohol work.

> "....together we used the alcohol wheel.....the wheel also showed the calories. The calorie intake shocked her....the client made changes to all areas of life in a short time"

- This project has faced a number of delays and challenges which have slowed down progress regarding the delivery of the enhanced alcohol service. This has included staff changes (meaning that the number of Health Trainers available to undertake the enhanced alcohol work is smaller than anticipated), delays in preparing and disseminating publicity materials about the enhanced service, ensuring that the work can be recorded in the service's monitoring database, and clarifying referral pathways with other professionals particularly primary care and Turning Point.

> "....I was not putting pressure on her to reduce drinking....it was her choice....I had simply helped her to look at her drinking in a new way.....the main thing about the opportunistic clients like this one is that they come to the service ready to make changes (even if it is in a different area to alcohol)"

- However, in recent months the project has taken some important steps forward in all of these areas. There is increasing confidence that the Health Trainers are now a skilled workforce with regards to alcohol and that a large programme of promotion and awareness raising will benefit the progress which is needed in the coming months.

Areas of success and learning

- From the small amount of alcohol work which has been done, it is possible to see the potential for the service to support individuals to make changes with regards to alcohol (either with support from the Health Trainer or through engagement with alcohol treatment) as part of wider lifestyle changes. The service can offer an alternative for clients who do not wish to engage with alcohol (or drug) treatment services.

* It seems that the Health Trainers find alcohol work challenging (particularly where an individual is identified as a higher risk or dependent drinker, and where there may be a wait for an appointment with alcohol treatment), and that clarification is needed (particularly with partner agencies such as primary care and Turning Point) about the work which the Health Trainers should be doing and the referral and care pathways which need to be in place with other services. Further, the number of relevant referrals to the Health Trainers service has been low and some work may be needed to ensure that other organisations (again, particularly primary care and Turning Point) are aware of, and have the pathways in place, to be able to make appropriate referrals to that service.

> "Once at [Turning Point] they explained that there was a 1-2 month waiting list.....the client said that he needed to see me in a weeks time and said that he understood that I couldn't work with him on alcohol [because he was a dependent drinker] but wanted me to support him with thinking about the other areas in his life that he could work on in order to 'not feel bored'"

Conclusion

Despite the challenges and slow progress which has affected this project it is hoped that progress will be quicker in the coming months and that the Health Trainers will be in a position to successfully engage with and support drinkers. It should be noted that there is evidence that the Health Trainers are able to positively engage and support drinkers at a range of levels of consumption and that there is consensus that the Health Trainers are ideally placed to support those with alcohol problems as part of wider lifestyle considerations, thereby engaging with some individuals who may not otherwise come to the attention of, or approach, other services. Unfortunately, the project has so far undertaken very little enhanced work with regards to alcohol which makes the future of this project uncertain.

Community Detoxification Nurses

About the project

* This project has been in place for approximately four years since Turning Point were awarded the lead provider contract for drug and alcohol treatment across Somerset. Two full-time nurses have managed the project for the whole County but once the service became known and established referrals have increased. Additional funding has been provided to employ two further full-time nurses, with the aim of having one nurse

providing the service in each of the four areas of Somerset. It is the impact of this additional capacity which is the focus of its inclusion in this evaluation report.

* The project offers a comprehensive detox service, including assessment, planning and support of detox (medical support, liaison with medial and other professionals and family members, and psychological support), and putting an aftercare plan in place. While the majority of detoxes are undertaken in the community (usually the client's home) the service is also able to support detox in other circumstances (such as clients who undertake their detox with the support of a GP, or at a hostel or rehab). The focus is on dependent drinkers, although according to need and capacity the service wishes to be able to offer detox support to other categories of drinker as well.

Project Progress

* Unfortunately, the recruitment of the additional two detox nurses has been extremely challenging. Appointments were made to both posts but one nurse resigned very soon after taking up their post while contact was lost with the other candidate once a job offer had been made. Two further appointments have now been made with the third nurse due to start in December 2012 and the other early in 2013. Given these challenges, it is not possible to provide and discuss any data relating to the additional capacity for this service which was funded and which was the focus here.

Areas of success and learning

* Given the challenges with the recruitment of the third and fourth detox nurses Turning Point has given a great deal of thought to how else they could offer additional support to the detox nurses project given the ongoing and increasing demand for the service. It is important that the organisation continues to plan how it will expand this specialist service.
* Recruitment of the two additional nurses has been a significant challenge and there are a number of reasons for this. First, a detox nurse is a specialist post which requires specific expertise and experience, and unfortunately in the addiction field generally it is incredibly hard to recruit to such a post as there is a small pool of candidates to recruit from. Second, it is hard to appoint to such a post in a large and predominantly rural County which does not have transient workforce or a major urban centre.

Conclusion

This appears to be a vital service and one which is seeing increasing demand in Somerset. It has been extremely difficult to recruit the two additional nurses for which funding was provided, and this has led Turning Point to think laterally about how to expand the service so that the needs of this group of clients can be met. An expanded detox nurse service is needed although the exact impact of additional nurses is yet to be seen.

Section Four: Learning and Next Steps

This final section of the report will consider the successes and opportunities from the work to date, discuss some of the main challenges which the projects have experienced, and summarise the areas of learning to come from the work to date. Parts of this section of the report will be less relevant to the community detox nurses project because it is a specific service aimed at dependent drinkers.

Progress

Despite the different settings and variation in how the projects have developed and operated there are a number of common areas where the projects have made progress. These are summarised below.

1. All the projects (with the aforementioned exception of the community detox nurses project) have been able to screen for alcohol problems, to identify problems at all levels of risk, and deliver brief or enhanced brief interventions. However, there is variation across the projects in how much work has been completed.
2. The projects (although again there is variation) have engaged with a wide range of individuals with alcohol problems (at all levels of risk) who are often also experiencing a range of other problems. Many of these people are chaotic and vulnerable with multiple needs, some are 'in and out' of services, some are reluctant to engage with alcohol treatment or need support until they can or will engage with alcohol services, and some have not thought about or had an opportunity to seek support in relation to alcohol.
3. Engagement with clients has been critical and there are a number of characteristics of the projects which seem to increase engagement. This includes continuity, immediacy, flexibility and creativity in delivering a service which can be both proactive and reactive and which workers can deliver with patience and perseverance. Engagement needs to reflect and respond to both the environments in which the projects are located and the nature of the client group. It also seems be important that the projects operate away from alcohol (and drug) treatment services.
4. In addition, there are a number of components to a brief intervention which seem to be important. This includes the specialist and expert knowledge of the workers, and the continuity and co-ordination of care. The speed with which people can engage

with an alcohol project appears to be part of the success which is seen. Clients can be supported while they are waiting for an appointment at another service (which can facilitate engagement and sustain motivation) or where another service is not able to work with a client (for example, a mental health service which will not assess or accept a client if they are still drinking). The presence of the alcohol project in some settings can also mean that clients can be quickly identified and re-engaged with when they re-offend, return to a homeless hostel or have another attendance or admission to hospital. Care co-ordination can increase and sustain engagement where multiple needs co-exist and where a client needs to access a range of services.

5. Some projects have a dedicated worker which appears to be an important feature of their success although it can place pressure on those workers at times of holiday and sickness and in terms of out of hours provision. Making the right appointment to these posts seems to be vital.
6. There is qualitative data from most of the projects (although again there is variation) about the work which is possible with clients and the positive change which it is possible to effect through brief intervention and/or care co-ordination. These data illustrate the range and depth of work which has been undertaken, the time which may be needed for change to take place, and the need to focus on issues other than just the alcohol problem. This includes physical health and well-being, mental health, employment, accommodation, financial management, engagement with education (including accessing English language courses), relationships with family, and engagement with other services to meet other needs and to offer longer-term support. It is important that the projects understand that reducing alcohol-related harm needs to also consider this bigger picture. However, it should be noted that it is not known how the projects may support change in the longer-term.
7. The projects have all brought opportunities for workforce development. This has been seen in a range of ways, through the direct training of staff (e.g. Health Trainers or pharmacy staff) to do the screening and brief intervention work, or through working with and training other staff in the settings where a project is located (e.g. hospital staff or Detention Officers) to support the screening and brief intervention work. To facilitate the engagement of other staff the alcohol project workers have paid attention to their presence in the particular environment, to the paperwork they are asking other professionals to complete, to training and ongoing support needs and to providing feedback on individuals who they have seen so that other workers can see

the impact of work that they are doing and see that it is worthwhile. The projects have also been able to demonstrate positive relationships and joint working arrangements with a range of other local services.

8. Some of the projects (such as the community pharmacy project) have had opportunities to raise awareness and offer education about alcohol and its risks and harms to organisations and local communities. This can help to 'normalise' alcohol as a problem to be addressed which can facilitate an improved response and engagement with services.
9. Finally, there are indications from some of the projects (for example, the hospital and homeless hostel projects) that they can have a positive impact beyond the focal client, by also recognising the impact that such problems can have on the family, supporting family members to access support, and improving relationships within families.

Overall, each project seems to highlight a different 'window of opportunity', within the context of alcohol screening and brief intervention, in terms of the contribution that they are making to the reduction of alcohol misuse and alcohol-related harm in Somerset (see Table 6).

Inevitably all of the projects have experienced several challenges in their set-up and delivery and these will be summarised in the next section.

Table 6: Windows of opportunity for alcohol pilot projects

Project	Window of opportunity
Hospital Alcohol Liaison Workers	Opportunity for intervention with a captive audience at a time when they have experienced a crisis in relation to their use and misuse of alcohol. A 'teachable moment' for those who may not have thought about their alcohol use and misuse, or considered treatment in relation to this. High status of the alcohol worker within in a medical environment which normalises opportunities to ask about alcohol in the same way as other common health issues are approached. Service is positioned in an environment which is removed from alcohol (or drug) treatment.
Alcohol Workers – Homeless Hostels	Specific support to a vulnerable, at risk and marginalised client group who have complex needs and face multiple barriers. Location, flexibility and expertise of workers allows for relationships of trust to be built and for formal and informal support to be offered. Recognition that it is a very difficult environment to facilitate change in. Often time is needed to move towards positive change; usually multiple issues need to be addressed in parallel, sometimes issues about alcohol cannot be address wholly or immediately.
Alcohol Worker – Custody Suite	Offers an opportunity to support those who come in to contact with the police but may not have engaged with alcohol services. Address offending behaviour as well as crime related risks and harms associated with problem drinking. Sometimes multiple issues need to be addressed in parallel, sometimes issues about alcohol cannot be address wholly or immediately.
Health Trainers – part of Integrated Lifestyle Service	Setting offers a first point of contact for patients who may not have thought about alcohol but who can be supported to make changes while tackling other health-related problems.
Lloyds pharmacy alcohol scheme	Access support in a community setting for those who may not be accessing support (or thought about alcohol or treatment) and who are accessing a pharmacy for other healthcare needs. Pharmacies well placed for this work because they are community settings with wide community reach and high footfall. Offering support around alcohol is an obvious extension of their natural remit.
Community detox nurses	Delivery of a safe and dedicated alcohol detox which meets both medical and psychological need, where an aftercare plan is developed and where the involvement and needs of family members are also considered. A range of detox options, and the involvement of a multi-disciplinary team in addition to the nurses, allows the delivery of a flexible and responsive service.

Challenges

There are six areas where the projects have experienced challenges. These are: the remit of the project, the set-up and delivery of the project, screening, delivery of brief interventions, workforce development and working with others, and outcomes and measuring success. Each of these will be discussed briefly below (again with the aforementioned exception of the community detox nurses project).

Project remit

- There has been variation in the extent to which the projects have developed in line with their original aims and in how much progress has been possible in developing and delivering a model of screening and brief intervention. There are perhaps two main reasons for why this has been the case. First, less screening and brief intervention is being done by other members of staff in some cases, which places more pressure on the project workers who have to do more of this work at the expense of other core tasks and the delivery of brief and enhanced brief intervention work. Moreover, there are reports that staff (particularly in the hospital settings) tend to focus their attention on those with 'obvious' alcohol problems and are identifying and engaging with a narrower range of patients, meaning that broader work has to be covered by the alcohol project worker. The second reason relates to the nature of the client group – overall, the projects appear to have engaged with a higher number of people with multiple and complex (often entrenched) problems. This has also placed pressure on project workers who are sometimes taking on more of a care co-ordination role and supporting clients with both alcohol problems and one or more additional co-existing issues, again at the expense of core brief or enhanced brief intervention work.
- While the projects should not be criticised for the way in which they have developed, their experiences suggest that there is a need to understand and review these challenges and consider where change and ongoing development is needed so that the projects can increase alcohol screening and brief intervention work and balance this with care co-ordination for those who need support with other issues. Engagement with a wide range of local partners, including in the settings where the projects are located, is critical for the projects to be able to develop in this way. It is necessary to establish which projects are best placed to undertake alcohol screening and brief intervention work and which are not able to fulfil this remit, because, for example, the nature of the client group means that screening and brief interventions are not the correct response. Part of

this review could also consider which alcohol brief interventions projects sit within specialist alcohol treatment and which can be delivered by other services.

Set-up and delivery

- All of the projects have experienced challenges in the time needed to set-up their projects. In some cases, such as the pharmacy and Health Trainers projects, the delays have significantly affected progress. It is important to highlight that, even where projects have achieved less, it does not mean that this work is not possible or effective but rather it reflects the challenges and time involved in setting up such projects. A challenge for commissioners and services is to agree a set-up and delivery model for alcohol projects that is realistic and achievable.
- It is also important to understand that it can take time to train and get the support of key staff (in the environment where an alcohol project is located) with screening and brief intervention work. Having the support of senior organisational staff is vital for the success of alcohol brief intervention projects.

Screening

- For those projects who had screening targets associated with them, it was very difficult for these targets to be met. This is partly because of the time needed to set-up the project and secure the engagement of staff. For example, it has taken time within the two hospitals and the custody suite for more screening to be done by hospital staff and Detention Officers and more progress with this is needed.
- There is an ongoing challenge in all settings in making screening and brief intervention routine. Achieving a model of universal screening, particularly in the hospital setting, is a continuing challenge. Ongoing training backed up by ongoing specialist support (from, for example, alcohol workers or location based alcohol champions) is required. The time and resources needed to maintain and sustain the work cannot be underestimated and it seems that this is a critical and ongoing aspect of the work which needs to be incorporated in to the location based screening and brief intervention models.

Delivery of brief interventions

- The complex nature of presenting clients (who often have multiple needs and who may be vulnerable and chaotic) can put pressure on the workers in terms of how the projects

can respond. In turn, this can affect the amount of brief intervention work which can be done and whether it is even possible or appropriate with some clients.

* Some of the projects have identified contact with clients as a challenge and how this can affect attempts to remain in contact with clients to offer continued support and/or access to other services. The custody worker has revised the CAT form to be able to take a telephone number to facilitate contact once an individual leaves the custody suite. Follow-up is an important part of the work of the community pharmacy project but staff do not ask for a telephone number in order to make that follow-up call.

Workforce development and working with others

* Partnerships with a range of local services are important to success and sustainability. The two half day workshops which were held as part of this evaluation seemed to be helpful in bringing people from all of the alcohol projects (and from SDAP) together. Establishing some kind of local network, to offer further such opportunities for alcohol projects (and potentially also staff from key partner agencies) to come together might be a helpful future development.
* While some of the projects have established good partnerships with both community and hospital based mental health services, this is still an area which requires attention. It is significant given the strong association between alcohol misuse and mental health problems.
* Other projects (Lloyds and the Health Trainers) are training existing workers to be able to take on specific alcohol work. This can be an advantage in terms of the reach of those workers to their communities but there have been challenges with these projects in terms of both staff training and then commencing the alcohol work.

Outcomes and measuring success

* An important finding from this qualitative evaluation, which has perhaps been less explored in the academic literature, has been the potential for models of screening and brief intervention to effect positive change in a range of areas in addition to alcohol. In Somerset this may be because the projects have worked more with a group of clients who have multiple, often longstanding and entrenched problems. It would be interesting to see if attention to this 'bigger picture' is as important in working with larger numbers of increasing risk drinkers or whether with that group it is the focus on alcohol which is most important. Following on from this, it may be necessary to consider how success is

defined and measured, and how this may need to be broader than focusing on alcohol alone. The qualitative focus of this evaluation suggests that defining and measuring success needs to combine both quantitative and qualitative domains. For example, a positive outcome may be a joint assessment with a hospital or community based mental health team (which may facilitate both mental health and alcohol services being able to support a client), accessing a translator to work with a Polish client (which in turn increases their engagement with an alcohol service), or organising transport (so a client can attend an appointment at an alcohol service).

* Currently, there is limited quantitative evidence about the impact of the projects in terms of alcohol use and other issues. There is a need to develop such a tool, something which can be used across a range of projects while at the same time being sensitive to measuring things which may be unique to or subtly different between projects. However, it is important to understand that quantitative measurement of success may not accurately reflect the nature and full picture of change, the nature and diversity of the client group, and the complex and multiple needs which many of them present with. Joint work between projects and commissioners is needed throughout this whole process. Representation, for example to hospital or a custody suite, will be an important indicator to include in any measurement. This area of the work could also support client involvement, for example to set goals and assess individual success.
* Some workers commented that having a project which is alcohol specific has meant that they have not been able to accept some referrals or work with some clients (because they misused illegal drugs with no alcohol involved) and that there have been missed opportunities with some clients as a result. Furthermore, it has also been difficult to record outcomes for some cases where alcohol is involved but where positive change has been seen in other areas including drug misuse. The Alcohol Strategy (HM Government, 2012) advocates jointly delivered arrest referral schemes in custody suites to cover alcohol and drugs. This support the view of the alcohol workers in some of the projects that drugs should be included in the screening and brief intervention model.
* Currently, it is hard to isolate which are the most beneficial components of screening and brief intervention. Following on from some of the findings summarised in Section One, which have questioned whether a brief or enhanced brief intervention has ‘added value’ to a client, further work in Somerset could explore the different or cumulative benefits of the various components be it screening, brief feedback, referral, or a brief or extended brief intervention. Finally, there is also the need to assess the longer-term benefits (in relation to both alcohol and other issues) of screening and brief intervention work.

Recommendations

1. Ensure that there is sufficient lead-in time for projects to set-up and establish themselves. Commissioners and alcohol projects (and the organisations which lead on their delivery or are the environments where projects are located) need to agree timelines which are realistic and achievable.
2. Offer a range of projects in different settings to, collectively, maximise reach and offer choice and opportunity for accessing support. Some projects need to be located away from alcohol (and drug) treatment services, but have strong and efficient links with treatment services.
3. Projects need to be able to reach those who may not otherwise be identified or be willing to engage with services, and to be pitched correctly in terms of the screening and brief intervention model which is required.
4. Maximise the involvement of staff in the environments where projects are located, in both screening and brief intervention work, and achieve a balance between what alcohol workers can do and what other staff can do.
5. Assess the impact of screening and brief intervention in a range of domains, not just alcohol. This includes health, mental health, accommodation, finances, education & employment. Build strong links with partner agencies in these (and other relevant) areas to support this work. Continue to assess change in longer-term.
6. Develop a local network of workers from alcohol projects, and consider extending this to include representative from other local partners.
7. Raise awareness that alcohol projects, through engaging directly with those with alcohol projects, have the potential to raise awareness about the needs of children and other family members. Ensure that information is available about, and referral pathways exist to facilitate access to, services which are available for families.

Conclusion

This evaluation mirrors findings from other research, in demonstrating the potential for alcohol screening and brief intervention work in a range of settings, and of the potential for these projects to benefit those they engage with in the short-term. However, the variation across the projects, the challenge in delivering straightforward brief interventions, and in measuring a wide range of outcomes in relation to this work (in relation to both alcohol and other issues) makes it hard to draw firm conclusions and recommendations from the work which has been summarised in this report. What is clear is that alcohol screening and brief

intervention work is, and should continue to be, a central component of Somerset's alcohol treatment framework. This work should not sit in isolation but needs to dovetail with other parts of the treatment system and with joint working with other sectors which overlap with alcohol misuse, particularly public health, criminal justice, drug treatment and mental health.

The projects in the hospitals, homeless organisations and custody suite offer support to troubled sub-populations who may be engaged with services but who may not be addressing their alcohol-related problems. However, the multiple and complex problems which a large number of these clients seem to present with brings challenges in following a screening and brief intervention model. This seems to be a particular challenge for the homeless organisations although the worker's case and care co-ordination role seems to be important and beneficial. The projects located in the hospitals and the custody suite appear well placed for alcohol brief intervention work, although development and success rests very much on the extent to which other core staff take on the work, and the extent to which alcohol work is supported by other staff and prioritised throughout the organisation. Without this support such projects are at risk of not being able to deliver the required level of alcohol screening and brief intervention work. While the evidence suggests that having an alcohol screening and brief intervention project in a broader healthcare setting is important, the slower progress which has been seen with the pharmacy and Health Trainer projects makes it hard to assess their future with regards to this work. There is some evidence that the Health Trainers can support individuals to make changes around alcohol as part of wider lifestyle change or of facilitating engagement with alcohol services where necessary (while still supporting someone to make change[s] in other areas).

Somerset is developing what could be described as a multi-component alcohol treatment framework. It is clear from the alcohol projects which have been reviewed in this report that screening and brief intervention is an important part of this framework. As the work continues there is a need to monitor how clients at all levels of alcohol risk are identified and supported, to recognise the multiple needs which many clients present with, and consider also how to expand the work to also support the children and families of these clients. It is important that the framework is well resourced at all levels, encourages and supports multi-agency partnership working, and is backed up by training and ongoing specialist support.

Section Five: References

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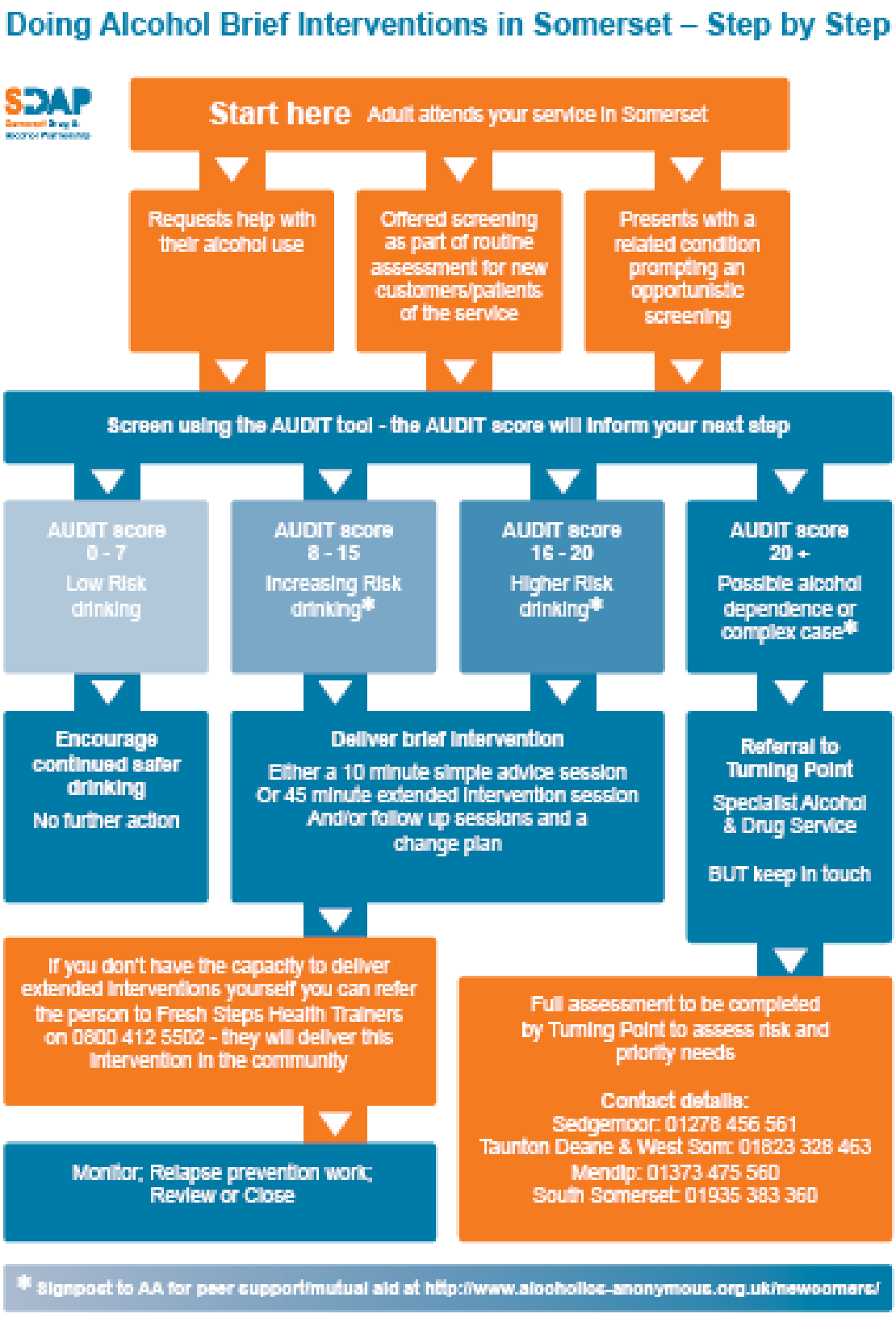
Section Six: Appendices

Appendix 1: Doing Alcohol Brief Interventions in Somerset – Step by Step

Appendix 2: Modified Single Alcohol Question (M-SASQ)

Appendix Three: Overview of Alcohol Projects

Appendix 1: Doing Alcohol Brief Interventions in Somerset – Step by Step



Appendix 2: 'Modified Single Alcohol Question' (M-SASQ) (Yeovil Hospital)[19]

Complete or Affix Patient ID sticker:
Name:
Date of Birth:
Postcode:
NHS Number:

Yeovil District Hospital NHS
NHS Foundation Trust

Yeovil Hospital Alcohol Test (YHAT)

Gender? Male ☐ Female ☐

Please tick appropriate boxes below:				
Women	**How frequently have you had 6 or more units of alcohol on a single occasion in the last year?**			
Men	**How frequently have you had 8 or more units of alcohol on a single occasion in the last year?**			
Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
No Action	Give "Your Drinking and You"	Give brief advice and "Your Drinking & You"	Refer to Alcohol Liaison Worker Referral accepted ☐ Referral declined ☐	

If referred to Alcohol Liaison Worker (ALW), patient details will be given to ALW who will contact you with a view to see you.

Consent given? Yes ☐ No ☐

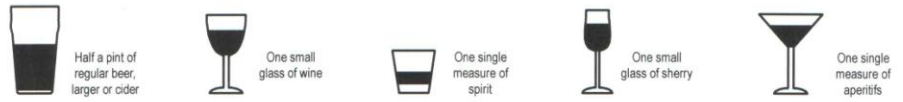
The information provided by you will be summarised and stored to help us plan services in the future. Any reports from this information will be anonymous and you will not be identified or contacted again.

Consent given? Yes ☐ No ☐

Patient signature:

Referrer Name (please print): Department:

One unit of alcohol is...



...and each of these is more than one unit of alcohol

[19] The same form has also been introduced at Taunton Musgrove Park Hospital, with only names and logos etc. changed as relevant.

Appendix Three: Overview of Alcohol Projects

Project	Worker(s) and location	Date worker started	Aim(s)	Target	Screening
Hospital Alcohol Liaison Workers	One full-time worker at each of Musgrove Park Hospital in Taunton and Yeovil District Hospital (both employed by Turning Point).	Taunton early 2010. Yeovil early 2012.	Reduce alcohol-related repeat attendances & admissions to A&E/hospital. Build increased capacity for alcohol screening, assessment and delivery of brief interventions across each hospital.	Target for each hospital of a minimum of 60 people a month screened in A&E.	Adapted Paddington Alcohol Test to make MPAT and YHAT), with the shorter one question M-SASQ introduced at both hospitals August 2012.
Alcohol Workers – Homeless Projects	One full-time worker at each of Taunton Association for the Homeless and Barnabas Housing Association in Yeovil (employed by each respective supported housing provider).	Taunton January 2012. Yeovil March 2012.	Increase access to alcohol treatment, reduce disengagement with services, and minimise alcohol-related risks and harms (including relapse). Improve outcomes related to accommodation.	No targets set. Focus towards dependent and increasing and higher risk drinkers.	AUDIT
Alcohol Worker – Custody Suite	One full-time worker based at Yeovil Police Station (employed by Turning Point).	October 2011	BI work to reduce offending, re-offending (and re-arrest) and alcohol-related harm. Worker can carry a small caseload to work with people for up to 6 weeks post arrest) including liaison with and referral to other services. Build capacity for Police staff to identify, screen, and deliver brief interventions.	Currently no targets for the service, to be set after six months.	Adapted MPAT to create CAT (Custody Alcohol Test) used by Worker and also by Detention Officers.

Project	Worker(s) and location	Date worker started	Aim(s)	Target	Screening
Lloyds pharmacy alcohol scheme	Operates in 17 pharmacies across Somerset.	Service has been running in the pharmacies since early 2012.	Delivery of brief and extended brief interventions with increasing and high risk drinkers. Also aiming to raise community awareness about alcohol.	Target of 10,000 completed AUDITS or 6,000 brief interventions, whichever is the sooner, in an 18 month period.	Adapted AUDIT C.
Integrated Lifestyle Service – Health Trainers – enhanced alcohol project	Operates across Somerset. Currently there are approximately 15 part-time HTs, all able to undertake basic alcohol intervention work. About 13 of this group have received training to deliver extended brief interventions.	The Health Trainers already use the AUDIT and undertake some brief intervention work around alcohol. While some Health Trainers have received the additional training to enable them to deliver extended brief interventions this aspect of the work has not yet started.	A range of community locations often in areas of high or higher need. Development of an enhanced role to deliver extended brief interventions.	Target setting after initial 6 months as baseline activity established. Focus on increasing risk and higher risk drinkers	AUDIT – plus repeat AUDIT for follow-up/outcomes.
Community detox nurses	Currently 2 nurses who work across Somerset. Nurses are full-time and employed by Turning Point.	Two nurses have been in post for about 4 years; the additional two nurses were due to be employed in 2012.	Aim of service is to provide a comprehensive community alcohol detox service to dependent drinkers – involving medical and psychological support, and an aftercare plan. Service will also support detox in other settings (e.g. homeless hostel, primary care or local rehabs).	No targets.	Not applicable to this service.