**Alcohol Study Transcript Notes**

**010 – Health Care Professional**

Interview Length: 40 minutes, 07 seconds.

Interview Notes:

Facilitating Access to Alcohol Dependence Treatment:

* See people presenting with mental health problems and alcohol problems in EDs.
* Screen for extent of alcohol use.
* If alcohol use not been identified before, then Alcohol Care Team at the Royal involvement.
* Managing mental health difficulties, alcohol withdrawal and alcohol related cognitive problems.
* Pathway for cognitive related problems – Montreal cognitive assessment.
* Alcohol withdrawal – agitation, if psychotic symptoms medical team in the ward would ask to advise on treatment strategies.
* Decision making capability.

Challenges:

1. Engagement

* Get people into the system and to keep them engaged in another team who has the appropriate skills.
  + Screening and assessment aren’t much of a challenge.
  + Onward referral and take up rates to alcohol care team, e.g., community alcohol service is problematic.
  + The challenge is that there are multiple services within the system each completing their independent function and perhaps doing that really well, but perhaps much less joined up.
  + Getting local authorities to provide support, to get people to be able to engage with services, as well as to carry out their day-to-day functioning at a level where they can live independently and not be in the street.

1. Mental Health Difficulties

* Tricky to manage clinically and in a supportive way.

1. Community Based Alcohol Teams

* For the alcohol care in the hospital, work very closely so can look at the system and see whether they've been seen or what's happened. With the community-based alcohol teams, it's much harder.
* So, the problem is when somebody's in hospital, we have a care episode open so we can keep going back and checking. Because of the volume of referrals is so much for us, that once they have left the hospital there is little incentive for us to follow them through and the service parameters are that you look after people within the hospital and within the boundaries of the hospital and not outside.

1. Stigma

* A turbulent life and drinking means chaos. So that chaos doesn't sit really particularly well with structured NHS systems. And it's very hard to fit somebody who's chaotic with a structured outpatient-based service. And that's kind of sort of rubs against each other and I can't see really say that services don't try or that even patients don't try.

Alternatives to Make Services Suitable: The outpatient system is very efficient because you can see lots of people and it works and but for other people it doesn't work. So, the alternative might be kind of doing a bit of a hybrid system wherein you have an outreach service that is able to sort of, if somebody is missing your actively following them up.

Facilitate Access:

1. Bringing Together Two Pathways

Things that are working really well for us is kind of bringing together the two pathways; the mental health system and the alcohol use disorders treatment system. Keeping those systems really close is what works, because each one is kind of very refined, clear about what they need to do.

1. Facilitate MDTs

Joining up working.

Commissioning arrangements currently don’t allow for this MDT working. Link hospital with community.

Specific Groups: Cognitively compromised - affected decision-making. Goes beyond gender and ethnicity, really about trauma.

What can be changed for this group?

- Screen, identify and support.

- Resources to support

- Money and funding

Provide trauma informed care within alcohol services: understanding what trauma is, understanding the influences of trauma and getting people with lived experiences to kind of work with us to set the services up, train the clinicians.

How to improve services?

There are two different systems – you’ve got a mental health system and you’ve got alcohol dependence system for managing alcohol use disorder system. The key thing is to join those two together: you would screen, identify comorbid conditions and you get all the professionals, and you treat it as a multidisciplinary way. It doesn't always happen in the multidisciplinary sort of thinking and developing treatment plans doesn't always happen.

**09 – Health Care Professional**

Facilitating Access: refer patients to NAME OF ORGANISATION REDACTED, NAME OF ORGANISATION REDACTED (more non-medical detox).

Physical health checks for detoxes.

Process for Detoxes – long, several interviews, appointments can be weeks apart, difficult to get there especially for patients who are street homeless, no money for transport, complex lifestyle (i.e., think about alcohol from moment they wake, so priority is getting alcohol, not necessarily thinking about getting to an appointment later that day) 🡪 Barrier.

NAME OF ORGANISATION REDACTED – more flexible, more understanding if someone is having a bad/emotional day. Need for wiggle room to rearrange and have that communication with patient.

Restrictions to Access – if dual drug and alcohol, what problem do you focus on first. “we've had issues where they've wanted them. I think that in fairness, this might be more than rehab, they've wanted them off the methadone completely, before doing the alcohol, which psychologically is a massive challenge, because if they've managed to stop the drug use, the methadone is the reason they've done that. And then the next challenge, but in terms of yeah, just the alcohol, it's, it's just a daunting task for them.”

Barrier 🡪 Stigma, patient feeling embarrassed. Especially homeless population.

Patient feeling like staff are judging them if they are 15 min late for appointment and staff are too busy to see patient then. So, importance of open communication, understanding pathways and explaining how bust the system is and it’s not that staff don’t care.

Reducing alcohol intake – if drinking from a bottle, try a cup. Cut down measures.

Education on food and nutrition – eating in between drinks, e.g., banana, scrambled egg on toast for nutritional value.

Education on withdrawal – if cutting down outside of detox or rehab and start to experience physical symptoms/side effects go to A&E immediately.

Regular health checks – “So, we're checking out the anaemic, if they're deficient in any vitamin D or calcium or anything like that, because sometimes if you can correct those elements, that might make them feel a little bit better and cognitively better, which might make it easier for them to face having a detox, if that makes sense. Because I suppose if, if you're deficient in iron, you can be tired, breathless, you know, a little bit foggy with your thinking. So, if you're trying to do a hard task of reducing your alcohol and thinking about what you're doing, that's hard to do when you feel rough from the other side personally, to kind of counteract a few of the other elements to put their body and then kind of mental health state in the best position we can, to do what they need to do, because it is it, you know, I can't imagine how hard it is for people to kind of with come off of alcohol, when it's been their sole dependent for many, many years, you know, usually through events through trauma drinking. So, you know, you've got the psychological elements behind that as well. So, from a physical point of view, we try and take more of that holistic view, if it makes sense.”.

Things that work well: Giving patients choice, sometimes medical is too overwhelming.

NAME OF ORGANISATION REDACTED – non-medical 🡪 “NAME OF ORGANISATION REDACTED does it all in one go, which is quite positive, it’s the same group for three months, there's no change of staff. So, they've got that almost family familiar type environment with the same group for that length of time. Other patients they prefer to go through the 12-step programme. They like that regimented routine. They like that kind of, it's quite strict. As you know, this is what we're doing today, this is what's going to happen and they like that routine, whereas others find that too claustrophobic, they don't like having someone breathing down the neck and tell them what to do every single day, whereas others benefit from that. So, I think it's just been able to give people that choice. And it's quite good, they've got an option, ‘so actually the 12 steps is not for me.”

Barrier: A lot of patients live in hostels, a lot of drinking in hostels. “And we have had cases where we were patients that managed to detox or the detox hospital. And just because there's nowhere else to go accommodation wise, they go back into the hostel environment. And they usually drinking within a day, because they're surrounded by alcohol and other people drinking, which is an issue.”.

Barrier – Transport: “biggest barriers are maybe transport to a place, it'smaybe someone that could pick them up and take them, they're just an example, our hep-C trust, and they will pick patients up and take them to appointments with the hep-C appointmentor they drop medication off. So, little things like that might make it easier.”.

“But again, this comes down to funding a lot of the time. But like I say, for some of our patients, if they're living in hostel or live in, you know, verykind of nomad kind of lifestyle, where they're in and out of hostels on the streets for a couple weeks, then they get back into a hostel, just having a single point of access, if they know someone that they can kind of call and go, oh, yeah, I do need to get to that appointment, or I can't pick the medication, because I've left the hostel. Just having a point of contact that will understand their situation, that might make it a bit easier.”.

Need for a drop-in clinic: “So, a patient knows I've got like a two-hour window that I can attend there. So, it takes a little bit of pressure off it if need be.”.

Need to develop understanding in clinicians and health professionals – particularly in relation to homeless and people living in hostels.

Specific Populations: Eastern European large group – issue of funding to go through detox programme. Syria – drug related. British and European drinking culture.

English as second language – language barrier, use of language line but now this is over the phone, fear of miscommunication.

\*Need for information, leaflets/resources in different languages – what is safe limits, non-drinking days in between, drink normal fluids.

Mental Health Patients – undiagnosed MH, MH team won’t assess while still drinking.

**01 – Health Care Professional**

GP – sees people with complications of alcohol dependency, e.g., mental and physical health.

Job role involves discussing issues, refer as appropriate/signposting to community services, starting medication for alcohol dependency.

Homeless population significant proportion with alcohol dependency, mental health issues – complicated and chaotic group to reach and support.

Barrier: Engagement

- Harder if homeless or comorbidities

- Hard to take first steps in accessing services

- Once person is engaged easy to guide and support, but initial challenge is engagement.

- People have a ‘sweet spot’ when engagement is possible, e.g., for some people first priority of the morning is getting alcohol so this time may not work, but also later in the day may be too intoxicated to engage.

- Strict appointments don’t work – need to be flexible.

Barrier: Current services require opt-in service

- This puts an initial barrier in place

- NAME OF ORGANISATION REDACTED sends a letter out, person then has set amount of time to make an appointment, if they don’t contact within this time they are essentially discharged.

- Restart process again if this happens – makes access more difficult for those with chaotic lives.

Barrier: Resources and letters from services in English – barrier for those with English as a second language, or if literacy levels are low, cognitive impairments.

Cognitive Impairment – additional barrier to support. Hard to get this recognised by professionals. People tend to be younger and struggle to get their care needs understood.

Barrier: Issue of access for females

- Alcohol dependency seen more as a male condition

- Research more on men? How generalisable this is.

Barrier: Stigma and shame adds additional barrier to access.

Barrier: Patient views towards medication

- Acamprosate been around for a while, people may have bad view towards this and believes it doesn’t work so won’t try again.

Barrier: Prescribing medication for alcohol dependency in general practice – some staff not comfortable.

- Some medication requires additional health checks/liver checks before starting.

- Baclofen needs to be recommended by specialist service to be prescribed.

Barrier: General Practice services

- First contact with general practice is with reception, this can be difficult to talk about misusing alcohol with someone you don’t know/trust. Saying it out loud can be difficult.

- At practice reporting issues with alcohol at front desk while waiting room is full.

Facilitator: Alcohol nurse providing patient centred support – would actively follow-up with patients, give number out so people could contact her. Visits to hostels or homes.

- Regular staff so patient doesn’t have to re-tell story and history.

Facilitators: Trying to implement things in general practice to improve adherence to medication.

- Actively prescribe medication without patients requesting

- Pharmacy doing medication deliveries (daily, weekly/monthly).

Facilitator: Patient centred care

- Understanding where patient is at – what is priority stopping or reducing

- Talking about journey so patient understands its long and never straight forward

- Continuity of care important so services are there when people are ready to engage.

Facilitator: Drop in clinic

- Works well

What works well: Services with good psychological models. Psychoeducation. Empowering people to take control. Lots of engagement after un the community, next steps, relapse prevention. Offering complete package – housing, ongoing support. Not just treating the condition, treating everything that is associated with it.

Private detoxes available in Liverpool – aren’t great.

Shows level of need for services if people are willing to spend £1000s on detox. Need for more NHS services.

Lack of timely and good services which offer people proper treatment.

**16 – Service User**

First contacted alcohol support team 2019 – talked through a checklist that was consistent with having alcohol use disorder.

Barrier: Initial phone call to access support

Tricky to make call at first – feels weird saying out loud and admitting issue with alcohol.

- Wondered if being overdramatic as you tend to picture alcoholism as antisocial behaviour, being sacked from job but didn’t fit this picture.

COVID added additional barrier – longer waiting times, lack of staff, services moving remote.

Found accessing services frustrating as knew what they wanted to achieve.

- Had done research to what medication to try.

- Wanted to strike while they still had the willpower to do something, but access was long and drawn out (may be partly due to COVID).

Found services tended to talk you through the same things, e.g., have you tried reducing drinking, counting drinks per day. This may work for some people, but they knew how their mind worked and that this wouldn’t be effective. Felt frustrating services getting them to try these things when they were confident, they wouldn’t work for them, and they knew medication would work.

Barrier to access counselling: two counsellors available, one worked 9-5 Monday to Friday, other evenings and weekends but this counsellor had very long waiting list.

Difficulty with 9-5 counsellor as they would call during work, hadn’t told people in work so couldn’t openly talk and get most out of it.

Services set up for extreme end of those who had lost their homes/jobs and they were not at that stage yet so didn’t feel services were set up to support those functioning with alcohol dependency.

Needed to be sat with clinical fairly early on and told what was available psychosocial support and medication and to have open conversation.

Felt like medical help should have been on the table earlier, took over a year to be put on medication they wanted – big frustration.

Knew what medication wanted to be on, had all health checks but still staff wanted them to try other medication first – had to fight for what they wanted.

Barrier: Wouldn’t speak to same person consistently so had to keep explaining situation.

Only one nurse could prescribe, other people didn’t have a lot of power so lots of obstacles.

Felt very invalidating.

Felt like they couldn't really kind of have a proper conversation about what I wanted and stuff like that, because they kind of they have their list of things that they're able to offer me and anything else was kind of just dismissed.

Issue of giving up counselling due to frustration so by the time they started medication didn’t have any ongoing support, hadn’t told family about situation yet. Hadn’t told partner so thought can come off medication to go on a date and drink alcohol, set them back.

Things got easier once started to tell people – boss in work supportive, felt better not having to hide it from people, more support and compassion.

Putting it out there and not being met with judgement was huge for support and motivation to seek treatment.

Services didn’t push to tell people or convince them to tell people. Conversations always felt like they were running through a checklist, never really took the time to have an open conversation about mental state or addiction.

Structured list of things to try being medication. This was an issue due to transitory nature of willpower, scary to want to resolve issue but feeling like you may not be able to. Would have appreciated more of a personal discussion and collaborative working with services – felt like a fight and to be assertive to get what they wanted (medication).

Paid for private counselling which helped - allowed me to get a better grasp of, you know, what's dangerous for me, like kind of where perhaps my addictive behaviours come from, and what I can do to maybe try and address the sort of underlying cause. And a big part of it, again, has been kind of just being a fairly non-judgmental voice on it. So, like, the stigma of alcoholism is something that's kind of always made me shy away from a lot of treatment. So just the simply, the act of talking about it, and not being judged, is a huge thing. Because I think if you kind of get me to feel guilty about something like this, the first approach can be to kind of just hide in a bottle or something like that.

Facilitator: Single point of access for alcohol treatment. Given one person who deals with your appointments and actively checks in. Having someone who can have more of a direct role and less formal relationship with.

More work needs to be done for support of functional drinkers – this side of things gets neglected, services more set up to deal with extreme end.

Need for more counsellors to be available on NHS services.

More preventative work.

**22 – Healthcare Professional**

People tend to bring up medication – don’t think they are on the right one/need more but maybe med seeking? Need to explain why they are on that medication.

Working on ward a lot easier compared to previous job roles – this ward more relaxed and easy going, patients more settled.

Impressed with way ward runs – extremely positive.

What makes it good?

- If patients want to smoke they are allowed to – takes pressure off of patients who are already fighting drug and alcohol addictions.

- Garden area to relax in

- Can make a cup of tea, coffee, make toasts whenever they want – other wards have set times.

- Informed as to what they can and cannot do – e.g., respect patients, no drugs on wards.

Barrier: Funding

“I think maybe one issue is funding, maybe people could stay here for longer if there was more funding.”.

“Other than I guess if people need a bit more time, but they aren’t allowed, is it funding and they can’t stay or it is because we’ve got such a back log of people waiting to get in. So, we do have a high turnover so that I think.”.

“…but from what from what I hear on the grapevine funding is an issue whether you get it and you’re allowed it and whether you don’t get it and you know its cast aside, which is sad. But I suppose that’s a case with everything I think, definitely within the NHS.”.

Difficulties with engagement? Depends on the person and their mindset. Some people have come in and lasted a few hours but will try and sit down with them and talk before they decide to leave.

For the 5% of people who do leave usually because they’ve been on drugs for that long and struggle to stop. In general heroin and methadone addictions tend to leave, alcohol dependency tends to stay.

How to improve willpower? Up medication but that’s on their Dr. Funding to allow for more time.

Specific Characteristics: Age (older patients tend to struggle more) – maybe because older so think what’s the point now. Older patients tend to come in due to family reasons or to access children.

Anti-Craving Medication: first few days worst time, then cravings stop. People walk out a different person.

Positive experience of people – cards on the walls, thank you.

Revolving door – lots of same faces back months later.

Relapse – caused by different factors e.g., outside issues, family, in with a bad crowd, mental health, willpower, addictive personality.

**27 – Healthcare Professional**

- ROLE REDACTED

Involved in Facilitating Access: mainly people referred through GP or LCAS and from hospitals if they have come through A&E or on the wards.

Barrier: Location

- Can’t make it to hospital, can’t leave house for whatever reason

- People who live closer to LOCATION REDACTED get referred to their alcohol care team but they don’t provide the same service as the one at the Royal.

- Patients travelling from LOCATION REDACTED.

Barrier: Engagement

- People starting treatment and not finishing.

- Not sure why people go back to drinking

- Need for willpower

- People think medication is a quick fix but need to work on mental health – people find that difficult to tackle.

Barrier: Housing Benefits

“A few people as well, I’ve found, when you refer to places like the NAME OF ORGANISATION REDACTED, you'd have to pay for that or if you're on housing benefit to have and benefits get taken away. So, you lose your property while you go in there for 18 weeks. And then when you come out, they do try and rehouse you but it's the thought of having to lose your property in the first place that puts a lot of people off doing rehab. So yeah, maybe price, money worries things like that might be an issue.”.

Team at the Royal:

Alcohol care team at the Royal provides a really good service. Royal is permanently overbooked. Staff meant to be finishing at 12 but will be in until 1 with 2/3 nurses running in.

Success rates high – patients abstinent. Receive positive feedback. Clinics really good.

Clear up beds in A&E – positive feedback from Drs in A&E.

Team works well because they are small. Can get to know the patients.

Brief interventions important – lots of lifestyle, attitudes. Lot of care they give isn’t just medication, it’s like therapy, sit down and talk to patients. Give advice and talk about issues even staff aren’t completely sure about e.g., finances.

Important to not just fix alcohol dependency but also get a grip on patients mental health and why they drink. This can prevent relapse.

Anti-Craving Medication – differs what medication patients prefer. Mixed messaged on whether patients like it. Guidelines state patients should only be on it for a year but have seen patients be on it for longer.

Information comes from patient leaflets, individual own research.

Lots of people cautious about taking medication in general – need for education alongside medication. Down to patient choice.

Issues of ROLE REDACTED not prescribing medication: “I think a lot of the time patients do complain about the ROLE REDACTED, not prescribing, the medication that we start them off. And I know that anti craving medication is specific to alcohol, and we prescribe it and therefore, you know, we're happy to continue that. But we have patients that complain about the cost of that, because they're getting prescriptions from the ROLE REDACTED, which cost, you know, nine pounds every time and then we're providing them with a separate one. And they say, oh, can the ROLE REDACTED not just prescribe that as well, and it all go in as one. And some ROLE REDACTED s will, a lot will actually, but the few that won't, that can be a bit of a pain for patients. And the only thing I can think of would maybe be another clinic in a different location for the patients that can't access here. Again, that would take a lot more nurses to cover that.”.

Barrier: Patients who aren’t aware of the service

- Paying for rehab as don’t know about service.

“Because I think when people maybe do google, you know, detoxes or rehabs, maybe all the private ones come up first, probably, maybe, you know, are linked to the hospital could be top search. I mean, I know that's not going to happen. But yeah, I think people don't really know about us until they come into hospital. And see us, so if there was a way of letting people know. I mean NAME OF ORGANISATION REDACTED do know about us, they can refer to us. And I don't think every ROLE REDACTED knows that was really we have a few ROLE REDACTED referrals. But I think if you know, patients went to their doctors, and, asked you know, what can we do? And then they get referred to us? Because it's just I've seen quite a lot of people now that just paid absolutely 1000s of pounds for detoxes, when we could offer it for free. And they just didn't know.”.

Specific Patient Characteristics: unemployed, white, more males but that’s a close one.

Lots of mental health issues – anxiety or depression.

Behavioural issues – ADHD.

People who have been in prison – arrested for violence or aggression.

Learning difficulties – can be a barrier to treatment.

- “…the first time he came in with his mom, and it's really, mom really trying to help him. But he still didn't finish. And the second time he came in, he came in by himself. And it was really difficult to explain the regime to him, you know, we had it written down. And we explained it quite a few times and he managed the first few days, but after that, I don't know. Well, we don't know what happened. I think he just maybe gave up. So yeah, that can be quite difficult.”.

**28 – Healthcare Professional**

Facilitate Access: Answer referrals (telephone, patient directly involved, GP, family, community services), book them into clinic or give appropriate advice.

Barrier: “We've got a barrier of one person at the moment he's trying to access, we, we gave him a detox last week, but unfortunately he drunk on it, we didn't know that he was homeless, because he failed to mention, and we've just tried to get him into the local, well NAME OF ORGANISATION REDACTED and they basically, that barrier, is that he doesn't have a mobile phone or address they just discharged. So that's obviously a barrier for him.”.

Barrier: Money/Funding

“In the past I’ve seen money being a barrier. Postcode lottery can be a barrier. In Liverpool, you can only be referred to certain places, if it depended on your postcode, so there's like other services other than NAME OF ORGANISATION REDACTED, if you're not in the NAME OF ORGANISATION REDACTED postcode area, you will be referred to a different service. Well, they might not be, they might not support detoxes as much so they have to pay.”.

Barrier: “Yeah they have to go through NAME OF ORGANISATION REDACTED, so then what happens is when you go to LCAS, they then send you a letter out, you then have to respond. So that's another barrier to treatment because how many people read letters, you know, a lot of people don’t if they’re in debt or whatever. So they have to read that letter and then contact NAME OF ORGANISATION REDACTED. If you don't contact NAME OF ORGANISATION REDACTED, then you just the case is closed.”.

What works well: having good relationship with patient, so they feel heard, supported and not judged.

Barrier: funding and timing

“Well, the problem, one of the big problems is having to go through NAME OF ORGANISATION REDACTED to get the funding just to get somebody in . So that's difficult. Er, no. Er, sometimes, we do two rehabs and they one of them as a waiting list. And one of them only takes in every 12 weeks, or sometimes that can be a barrier if they've just taken their intake in and the person's got to wait for another 11 weeks. There was a barrier that if you work, you can't access rehab, which is quite difficult, although my colleagues did have one, one where he got into who was an employment sport that few and far between. So if you if you are employed, you're not you're not entitled to the same access to rehab as somebody who's on housing benefit.”.

Barrier: mental health

“A challenge is sometimes the people for the mental health. Sadly, a lot of the time people just put them having mental health problems down to alcohol. Sometimes real difficulty because the mental health team are like no it's all alcohol. And I feel sometimes the patients aren't listened to. A lot of the patients that we see are drinking to self-medicate for their mental health problems. They understand that it can cause depression, can cause anxiety. However, the majority of people that we see are self-medicating to manage that. It’s also a barrier at the moment ROLE REDACTED, nobody can see a ROLE REDACTED so there’s more turning up at hospital so they pressure is here.”.

Increased pressure following COVID:

“Well, our numbers raised, we saw more. Since COVID, we saw new presentation so people that didn't. Or hadn’t been in alcohol treatment before or people who alcohol was never a problem. So now, working from home is a problem for people because they've told us they can be on a team's call and what looks like a cup of tea is actually a cup of wine. You know, they're feeling isolated, but working from home can also enhance their alcohol use.”.

Frequent Attenders:

“Yeah, we have we have what we would call frequent attenders. And there’s a frequent attenders meeting, I think it's once every month, and we do attend that. And we try and put things in place to support a patient to reduce hospital admission, to reduce presentations. There are also patients that we do see that may not present a hospital, but they present to us quite frequently, having relapse. So, we're all, you know, quite experienced in trying to find a more thorough aftercare plan that will support this patient to try and reduce them to relapse.”.

“…we just advise them more than we would advise that you I think you need to consider rehab, that maybe your detox is not the answer. So, you know, and it's maybe being a little bit more stern. So, it's not a different treatment plan. It's just maybe saying it in a different way. I'd really strongly advise that you take this on board.”

Signpost to services: “we can signpost them like if they need bereavement therapy, we signpost them for domestic violence, abuse services, rehab. Whatever is appropriate to them. It's an individualised plan. So we work out the reasons as to why, some people is just simply signposting back to the ROLE REDACTED and saying there's got long term anxiety, we’ve taken away the alcohol, they need managements of the anxiety.”.

Individualised plan: “Yeah, yeah not one plan suits all. The only plan that suits all is the medication for somebody that is if they are alcohol dependent. That's the only thing that we use is the same for every patient, if their alcohol dependence or the anti-craving, again, the anti-cravings is individualised to that patient, they may have tried something they may not have not taken to it, they've tried something else. They may not be able to have one due to blood results or health or something like that. Very much individualised and tailored for that patient.”.

Anti-Craving Medication: “anti-craving works really well as a tool, a little toolbox full of all the different tools. But it's got to come hand in hand with other things. So, whatever that is, so keep them busy. There's no point taking anti-craving and sitting at home all day bored and isolated. Because the chances of relapse and a high. And that's not because it's the anti-cravings fault. That's just because you're not making changes to your lifestyle. So, I feel anti craving is really, really positive. We've had some really good results and people remain abstinent for long periods of time with it. But It's got to be about a lifestyle change.”.

What can effect willingness to engage: “Depression. For some people, some people really can't be bothered. Some people lack the ability, so whether they can't read, they can’t write. Financial, some people haven't got the money to ring services. Some people may not have the support from people to do that. So, you know, if you haven't got a good support network or family or friends around you that can be quite difficult.”.

If could change anything it would be to have direct access for certain patients from hospital into inpatient detox.

“If I had a pot of money maybe have, maybe some rehab place it like couple of rehab places. Yeah, we've got some, just so that sometimes there's more really complex individuals that need a little bit quicker attention from other services, not necessarily from themselves from us because we can get them detox. But if they've got no plan afterwards, it's pretty pointless if they're just going to go back onto the streets then there’s no point detox. Because we'd all drink if we lived on the streets.”.

“I'd say probably access into mental health services. We all know that they're struggling. If we could have direct access to, we tell people to ring the bereavement service. Yeah, so we tell them to ring them and then the next thing there's a 12 week wait.”.

“If we had a pot of money, maybe a little counselling team, because there's no way you could have one counsellor. Not with the amount of people that we see.”.

Need for more advertising so people know about service:

“if you put into Google, you know, help with alcohol. I think it comes up with the private places.”.

“I don’t think it’s advertised on the internet at the NHS has its own services in the hospital. And this is where you can find your local team.”.