East Sussex County Council

Tobacco and Alcohol Behavioural Insights

September 2025

ice
leading behaviour change
icecreates.com

Glossary

COM-B: A theoretical framework used to understand and analyse behaviour in behavioural science. It helps to identify what needs to be done to enable effective behaviour change. The COM-B stands for Capability, Opportunity, Motivation and Behaviour.

VCFSE organisations: Refers to the voluntary, community, faith and social enterprise sector who provide services often in collaboration with other health and care providers.

One You East Sussex: A free health and wellbeing service based in East Sussex that helps people to stop smoking, lose weight, move more and drink less.

Gloji: An app run in partnership with One You East Sussex that can offer residents support digitally while stopping smoking.

East Sussex Tobacco Control Alliance: A local partnership that works to reduce smoking rates and help tackle health inequalities.

Pharmacotherapy for smoking cessation: The use of medications to help individuals quit smoking by reducing withdrawal symptoms and nicotine cravings.

NRT (Nicotine Replacement Therapy): A form of pharmacotherapy that delivers controlled doses of nicotine without the harmful chemicals found in tobacco, helping to reduce withdrawal symptoms and cravings during smoking cessation.

Vapes: A device used for inhaling vapour, usually containing nicotine and flavourings. Designed to help people to stop or cut down on smoking.

CGL (Change, Grow, Live): A local drug and alcohol service that offers support to anyone who is affected by drugs or alcohol.

Individuals approaching risky levels of drinking: A pattern of alcohol consumption that is associated with increasing risk. Individuals might not be aware their drinking could be potentially harmful.

Risky drinking: A pattern of alcohol consumption that increases the likelihood of health problems or harm typically exceeding recommended daily or weekly limits.

Dependent drinking: A pattern of alcohol consumption that usually negatively affects a person's quality of life and relationships with an individual feeling unable to function or survive without alcohol.

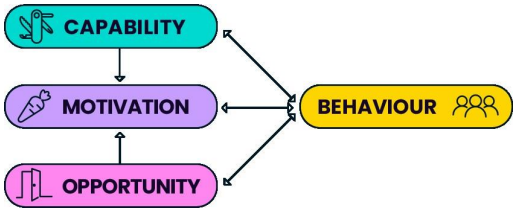
Addiction: Also known as alcohol use disorder (AUD). A chronic mental condition characterised by an inability to control or stop drinking despite negative social, occupational or health consequences.

Executive Summary

Understanding smoking in East Sussex

ICE worked with East Sussex County Council to understand why people smoke and what helps or stops them from quitting.

We engaged 120 people from groups where smoking is more common, to make sure their voices are heard when planning future support. This included Routine Manual Workers (RMW), Hastings residents, LGBTQIA+ communities, and people who are insecurely housed. The findings have been grouped using the COM-B model which shows that behaviour is influenced by 3 factors, including capability, opportunity and motivation.



CAPABILITY **What do people know?**

Most residents know smoking is bad for their health, but some still believe it helps with stress or that vaping is just as bad as smoking, which can make quitting feel less important. Many residents don't know how to quit. While some know support exists, many are unclear on what's available, how to access it, or what services like One You East Sussex involve.

OPPORTUNITY **What makes stopping smoking easier or harder?**

Smoking is often a learned behaviour from family and peers, and common in places like pubs or workplaces which can normalise the behaviour and make it harder for people to avoid temptation. For some, it's a daily habit, like having a cigarette after coffee or when stressed. Travel, cost, time, and strict rules can make it hard to go to sessions with a mentor, especially for people with housing or money problems, or those with children.

MOTIVATION **What makes people want to become smoke free?**

Many want to quit for health or financial reasons. Some want to live longer for their family. But smoking also gives people something they enjoy it, to relax or take a break, which can make it harder to stop. Some think quitting is just about willpower, which can stop them from getting help. Shame and low confidence also stop people getting help and some feel embarrassed to ask for support.

What should happen next

11 recommendations were identified driven by insights from residents and stakeholders. 4 recommendations were highlighted as higher priority. To reduce smoking prevalence, it is important for stakeholders to focus efforts to:

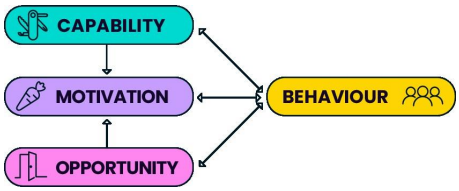
1. Raise awareness and improve communication and available support.
2. Challenge misconceptions and reduce stigma around seeking help.
3. Promote the idea of quitting smoking alongside someone else.
4. Make access to support easier and convenient.

Executive Summary

Understanding risky and, or dependant drinking

ICE worked with East Sussex County Council to understand why people drink and what helps or prevents them from cutting down or stopping.

We engaged 66 residents of Hastings or Eastbourne, including those aged 45+ from groups approaching risky levels of drinking or risky and, or dependent drinking is more common, to make sure their voices were heard when planning future support. This included people living in more deprived areas, and people who are insecurely housed. The findings have been grouped using the COM-B model which believes people must have the capability, opportunity and motivation to change their behaviour.



CAPABILITY

What do people know?

Many residents don't understand what "risky drinking" means, or don't see their drinking as a problem. While some know support is available, there's often confusion about what services offer, how to access them, or whether they're suitable for people "not yet in crisis."

OPPORTUNITY

What makes cutting down or stopping easier or harder?

Alcohol is cheap, easy to buy, and part of everyday life, making it hard to avoid. Many learned to drink at home or through family, and it remains a big part of how people socialise. Drinking alone at home can create feelings of isolation and shame about drinking. Residents discussed peer groups, drop-in support and welcoming community spaces to help make support more accessible. There is also a need to challenge drinking as socially acceptable and promoting, alcohol-free options.

MOTIVATION

What makes people want to cut down or stop drinking?

People want to cut down to improve their health and save money. But alcohol is also a way to cope with loneliness or stress. Shame, stigma, and low confidence hold many back from seeking help. Some believe change is only possible in response to when things get really bad and therefore, delay getting support.

What should happen next

15 recommendations were driven by the insight from residents and stakeholders, with 3 identified as high priority and urgent. Therefore, to help residents stop or cut down their drinking the following priories are urgent:

1. Encourage support from friends, family and peer networks
2. Increase the visibility and accessibility of lower-level or early intervention support
3. Empower and upskill professionals and community stakeholders

Acknowledgments

We would like to thank our partners at East Sussex County Council, Health Improvement Specialists Sarah Nash, Casey Ingold and Thomas Gollins-Perronne for their support during this project. Thank you to all the community leaders and stakeholders who helped facilitate engagement with the community. This includes granting us access to existing groups. Also thank you to stakeholders who gave feedback in the co-production workshops. Finally, we would like to thank the residents of East Sussex who took the time to speak to us. Without their contributions, this research would not be possible.

If you need support

This report explores sensitive topics related to tobacco use and alcohol-related behaviours, including dependence, harm, and health inequalities. We recognise that reading about these experiences may be difficult for some individuals, particularly those who are currently affected or supporting others who are. Whether you're seeking advice, looking to reduce or quit smoking or drinking, or supporting someone else, these services provide confidential, non-judgemental support tailored to individual needs. We encourage anyone affected to reach out to the appropriate service listed below.

Crisis:

Emergency support: call 999 if there is risk of immediate harm to yourself or others.

Support to stop smoking:

One You East Sussex: free health and wellbeing service, offering stop smoking support, as well as support to help you reach other wellbeing goals (losing weight, drinking less and moving more).

- Phone: 01323 404600
- Website: oneyoueastsussex.org.uk | stop-smoking

Alcohol support:

Change Grow Live: the alcohol team helps people who need support for their alcohol use.

- Website: changegrowlive.org | alcohol
- Phone: 03003038160

Alcoholics Anonymous: a place where people can share their experience and support each other to recover from alcoholism.

- Website: aa-eastsussex.org
- Phone: Local helpline: 01622 751842 / National helpline: 0800 9177 650

Mental health support:

Sussex Mental Health Line:

Phone: call NHS 111 and select the mental health option to be connected to a 24/7 mental health crisis line. The service is also known locally as the Sussex Mental Healthline. Phone: 111(and ask for the mental health line)

- Website: sussexpartnership.nha.uk | Sussex mental health crisis line

Samaritans: phone 116 123

Mind:

If you or someone you know is in crisis, you can call:

- The support line on 0300 102 1234
- The Infoline on 0300 123 3393

General wellbeing

NHS Every Mind Matters: provides tools and advice for managing mental health and lifestyle.

Website: Every Mind Matters - NHS

Turning Point: social enterprise, designing and delivering health and social care services in the fields of substance use, mental health, learning disability, autism, acquired brain injury, sexual health, homelessness, healthy lifestyles, and employment.

Website: https://www.turning-point.co.uk/

Seaview project: provides a range of support services to help marginalised people with addiction problems, mental health issues, ex-and at-risk offenders and rough sleepers achieve personal growth and fulfilment.

- Website: Seaviewproject.co.uk
- Phone: 01424 717981

Matthew 25: supports vulnerable and marginalised communities in Eastbourne.

- Phone (Eastbourne Office): 01323 726960
- Website: Matthew25mission.org | about

Homelessness:

Information, advice and support if you are experiencing or at risk of homelessness can be accessed via the East Sussex County Council website. This includes information on floating housing support services, specialist housing advice, housing offices, help for people sleeping rough, and general advice: Eastsussex.gov.uk | homelessness

1 Contents

2 Introduction

East Sussex County Council commissioned ICE to explore tobacco and alcohol related behaviours in groups with high smoking prevalence and those at risk of harmful or dependent drinking. This insight aims to ensure the experiences and views of key groups are understood and reflected in the design of any future interventions. The background and objectives for each focus area are outlined below.

Exploring smoking behaviours and support needs

Supporting the government's Smokefree Generation initiative, East Sussex County Council aims to improve stop smoking services and increase engagement with targeted interventions to help people quit smoking. A deeper understanding of smoking behaviours and experiences in key health inequality groups is needed to tailor local support. The specific objectives of this research include to:

- Identify why people in key groups started smoking and continued to smoke.
- Explore the steps people are currently taking to stop smoking, identify key enablers, and determine what additional support from smoking cessation services is needed to encourage smokers in target groups to consider quitting, make a quit attempt, and successfully quit.
- Examine personal motivations for quitting smoking, including expectations, drivers, and barriers.
- Identify how factors related to capability, opportunity and motivation can be tapped into to maximise brief stop smoking interventions to reduce smoking prevalence.

Exploring drinking behaviours and support needs

Previous data has highlighted that Hastings and Eastbourne experience significant alcohol harm and deprivation. Previous research highlighted the benefit of having more specific, targeted messaging especially for those aged 45+, as the data showed this cohort had the highest need. This approach can help inform interventions in line with the East Sussex Alcohol Harm Reduction Strategy (2021-2026) and reduce risky and, or dependent drinking. The objectives of this research include to:

- Identify reasons for drinking, emotional states before, during and after drinking, and perceived consequences of drinking.
- Identify the level of awareness and understanding of services aimed at reducing or stopping drinking and identify factors that influence awareness, perception and understanding.
- Explore the key challenges that people face when attempting to reduce or stop drinking and past attempts to reduce or stop drinking.
- Identify types of support needed to inform the design of effective interventions to reduce risky and, or dependent drinking and related harm.

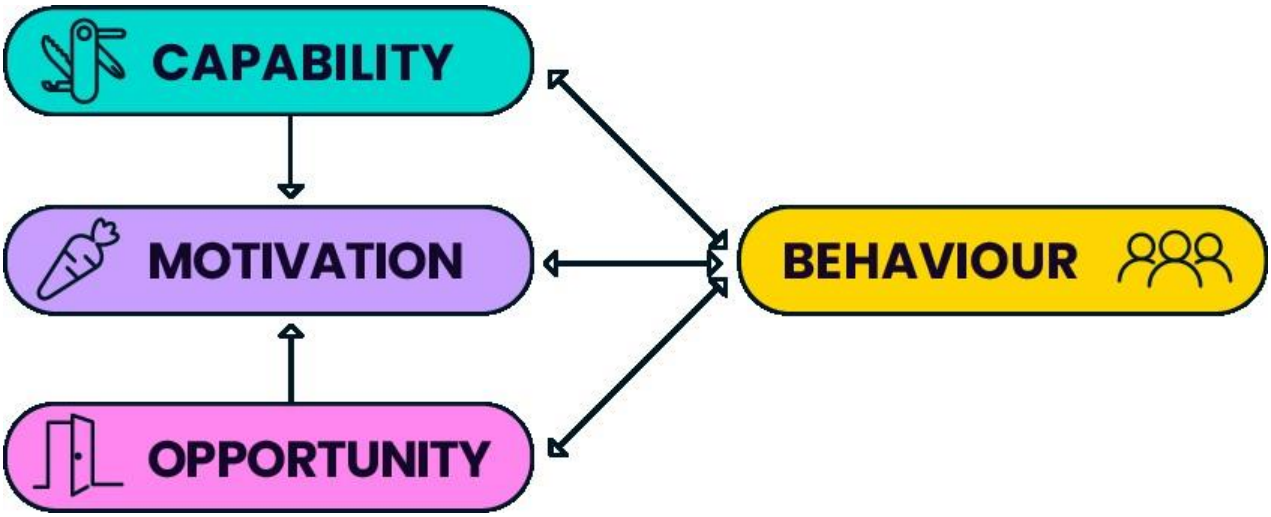
2.1 Introduction to the COM-B Model

The tobacco insights and alcohol insights are presented separately.

Across the two workstreams, the insight findings are organised using the COM-B model[1], a well-established behavioural framework that helps to identify the key drivers behind people's actions. This approach supports a more systematic understanding of the behaviours related to smoking and alcohol use and helps identify the most relevant levers for change[1].

The COM-B model explains behaviour as being influenced by three key factors: **capability** (a person's ability to engage in the behaviour), **opportunity** (external factors that make the behaviour possible or prompt it), and **motivation** (internal processes that drive the behaviour).

Behaviour is complex and influenced by many different factors, which affect individuals in different ways and to varying degrees. Each component in relation to smoking and alcohol related behaviours are outlined below.



[1]The COM-B model was applied in this research as it is more flexible than other models such as the Transtheoretical Model[2], which assumes people move through fixed stages, and it digs deeper into real-world barriers than models such as the Fogg Model[3], which focuses more narrowly on triggers, motivation, and ability.

Capability is about a person's knowledge, skills and ability to take action. It includes both physical capability (such as physical health and stamina) and psychological capability (such as knowledge and mental skills). To explore people's capability when it comes to changing smoking and alcohol behaviours we consider:

- Do people understand the risks of smoking and alcohol use?
- Do they know what support and services are available to help them stop smoking and change their behaviour related to alcohol consumption?
- Do they have the skills or confidence to access and use that support available to them?

Opportunity includes external factors that can make it easier or harder for someone to stop smoking. The more conducive the environment, the more likely it is that the behaviour will occur. These are things in the environment or in social settings that influence behaviour. To explore external factors, we consider:

- Are there social and cultural influences that encourage or discourage smoking and drinking alcohol?
- Do people feel supported by their community, workplace or family to quit smoking and reduce or stop their drinking?
- Are stop-smoking and alcohol support services, resources, and policies easily accessible and visible in people's everyday environments?

Motivation refers to the thoughts, beliefs, feelings, and habits that drive behaviour. It includes reflective motivation (conscious decisions, plans, and evaluations) and automatic motivation (emotions, impulses, and habits). To explore motives to stop smoking and drinking, we think about:

- What competing motivations influence whether people continue or stop smoking and drinking?
- Are there emotional triggers or cravings that make quitting harder?
- What beliefs do people have about smoking and alcohol and reducing or stopping smoking and drinking?

Layout of findings

The insight findings are structured using the COM-B model (Capability, Opportunity, Motivation – Behaviour). Findings are presented in two sections: tobacco insights, then alcohol insights. Differences between groups are highlighted where relevant, while shared themes are grouped together. Insights from professionals are included at the end of each COM-B component to complement the lived experience perspectives.

The findings are followed by a set of strategic recommendations aimed at reducing smoking prevalence and alcohol-related harm locally. These are informed by the qualitative insights detailed in this report, as well as a review of relevant literature[2]. Prioritisation and urgency of actioning these recommendations have been developed with local stakeholders.

[2]Full literature review which explores the prevalence of smoking and alcohol consumption and identify and address gaps in East Sussex Alcohol and Stop Smoking services and initiatives are available upon request.

3 Exploring smoking behaviours

3.1 Method

3.1.1 Sample characteristics

We engaged 29 professionals from across Health, VCFSE organisations and Public health, and 120 residents across several key groups:

Target Group	N	%
People with experience of smoking		
· People who currently smoke	47	39%
· People who used to smoke but now vape	15	12%
· People who used to smoke but have now quit	23	19%
· People who vape only and have never smoked	3	2%
· People who don't smoke but have family/ friends that do	32	26%
LGBTQIA+ communities	15	12%
Routine and manual workers	26	22%
People living in deprived areas (IMD 1-4)*	35	29%
People living in targeted communities*:		
· Hastings	47	39%
· Eastbourne	30	25%
People of different ages		
· Under 18	3	3%
· 18-24	9	8%
· 25-34	10	9%
· 35-44	31	25%
· 45-54	21	17%
· 55-64	17	14%
· 65+	10	9%
· Prefer not to say	19	15%
Gender		
· Male	63	52%
· Female	39	33%
· Non-Binary	1	<1%
· Prefer not to say	17	14%
People from different ethnic backgrounds		
· White / White British	101	84%
· Ethnic minority groups	19	16%

*This was calculated based on postcode. However, not everyone provided their postcode information. However, the proportion of residents likely to be from areas of deprivation is likely to be higher given the areas we targeted

*Please note, not everyone provided their postcode. Of the residents who did provide their postcode, 29% lived in deprivation. It is likely that many other residents did live in areas of deprivation given the majority of all groups and vox pops were conducted in venues located in deprived neighbourhoods.

3.1.2 Engagement approach

We took the research out into community settings such as community centres, coffee mornings and wellbeing groups. Working closely with community leaders, we conducted a mix of workshops, groups, and individual interviews as well as opportunistic interviews in a variety of public and community spaces, such as LGBTQIA+ nightlife venues, gyms, high streets (e.g., Hastings and Eastbourne), building sites, recovery cafés, colleges, superstores, doctors' reception areas, and venues supporting people experiencing homelessness.

We engaged professionals through a mix of webinars, interviews and in-person discussions as well as by joining the East Sussex Tobacco Control Alliance meeting.

3.2 Insight findings

3.2.1 Capability

This section looks at the knowledge and skills that may be holding some residents back from stopping smoking (e.g. not knowing how to quit or what support is available) and considers ways to help close these gaps.

Do people understand the risks of smoking?

Most residents reported an awareness of the physical risks linked with smoking. However, some highlighted doubts about the severity of these risks, and sometimes even highlighted the benefits of smoking, such as it reducing appetite and healing the body. Although this suggests that general awareness of the risks exist, there are competing beliefs that may influence behaviour.

Cognitive dissonance
Many smokers hold conflicting beliefs, i.e. they know smoking is harmful but still highlight perceived benefits. To resolve the discomfort from this contradiction, they may downplay risks or justify smoking as a coping mechanism.

"Tobacco heals things in the body as it's carbon based."

Male, aged 35-44, currently smokes, Hastings

Perceptions around vaping also highlighted uncertainty and knowledge gaps. Although some recognised that vaping is likely less damaging to health than smoking, others conflated it with smoking and sometimes even considered vaping worse than smoking, seeing it as 'the lesser of two evils' (e.g. because of popcorn lungs). These beliefs – and ultimately lack of knowledge – leads residents to justify their smoking habits and suggests a need for clear, accessible information about the relative safety of vaping.

"People talk about popcorn lung and such. People are constantly talking about vaping being worse than smoking."

Male, aged 55-64, previously smoked now vapes, routine manual worker, Hastings

Do people understand how they can stop smoking?

Many residents noted various steps to help them stop smoking, for example, confiding in friends and receiving social support, removing cigarettes from their environment, avoiding being with other people who are smoking, accessing alternative products such as NRT and vapes. This suggests a theoretical understanding of strategies to stop smoking, yet residents often struggled to personally apply these methods in practice, leading people to feel unsure of how to stop for good.

"I'm not sure how to stop, everything I've tried so far doesn't work."

Female, aged 55-65, currently smokes, homeless

There was also limited knowledge of specific strategies for managing withdrawal symptoms and breaking the habitual patterns of smoking, particularly during the early stages of a quit attempt. This highlights a knowledge gap, not just in understanding what to do, but in knowing how to do it effectively in the long-term.

Stopping smoking without behavioural and pharmacotherapy support, such as NRT, is the least effective way to remain smokefree. However, a small number of residents believe that stopping smoking is heavily reliant on willpower and that success depends on personal determination.

"If you fully want to stop smoking you will be successful."

Male, aged 55-64, currently smokes, routine manual worker

Do people know what support and services are available to help them stop smoking?

Awareness of stop smoking support and services widely varied across residents. Some people could cite the *One You East Sussex* service, while others recognised the concept of support but couldn't name the service. Some residents mentioned sources like pharmacies, GPs, or were aware of local organisations such as Warming Up The Homeless (WUTH) that provided free vapes (through the national Swap to Stop scheme). However, few were able to describe the full range of support available. This suggests that while some residents know that support exists, many lacked a clear understanding of what services are available, how to access them, or what they offer.

"Is there any support? I've never heard of it. They don't offer the same level of support as quitting alcohol."

Small group at The Hart pub, mix of genders, aged 35-44, LGBTQIA+

Those who were vaping often weren't aware of any support to help them stop using vapes entirely. This reflects the current lack of commissioned services for vape cessation, despite this being recognised by stakeholders as an emerging need (see 3.2.1).

Residents highlighted the need for more consistent and widespread promotion of dedicated stop smoking services, using trusted people (like health care professionals) and accessible channels, such as social media, TV, NHS settings, and other public spaces to ensure the message reaches those who need it most.

"If stop smoking support and services were advertised like for like with vaping stores then so many people would know and tell friends. Finding support is hard, people are lazy."

Male, aged 35-44, previously smoked, routine manual worker

Beyond simply knowing that a service exists, residents stressed the importance of understanding how to access them and what help is available. It is therefore important that advertisements, communications and messaging ensure residents understand that the service will support them in a flexible way which can adapt to the way that they want to

quit. This includes giving them the knowledge that there are plenty of options to support them to stop, e.g. 121 in person or telephone support, NRT, tablets, vapes. Flexible stop smoking support and a range of ways to access are important because many people have tried to quit before and may feel that certain methods don't work for them. Offering alternative approaches gives individuals the opportunity to find what suits them best. Additionally, we found that a lack of confidence, as well as feelings of anxiety and embarrassment, can be significant barriers to seeking help. Flexible, accessible support can help reduce these barriers and make it easier for people to take the first step.

Participants also highlighted the value of proactive outreach. Bringing services (or access to patches and vapes) into community organisations, public venues, or workplaces could help reduce barriers and improve access to support for key groups. This is something that is currently working well at WUTH.

"Hand out leaflets about the service. Get people together - get more people to talk about it and give their opinions."

Female, aged 45-54, currently smokes, vulnerably housed

Stakeholders in health, care, and the VCFSE sector can play an important role in raising awareness of stop smoking support by improving signposting and referral pathways. Residents who are homeless or vulnerably housed noted that talking about becoming smokefree and advertising in trusted, familiar spaces makes support easier to find and encourages people to engage.

Support people to build confidence and autonomy to quit smoking

Many residents emphasised the value of receiving help to stop, they also stressed the need to develop the skills and confidence to stay smokefree independently, particularly after formal support ends. Developing practical tools and knowledge, for example how to use vapes or NRT correctly, was considered important to preventing relapse.

"Provide an in-depth explanation about how to use vapes properly and their NRT dosage etc."

Female, currently smokes, Temporary housing

What did professional stakeholders say?

- Many people have limited awareness of the support available to them, resulting in lower uptake of services for specific groups.
- To increase public awareness and understanding of support, wider services such as police, fire and health services, need to be well informed about available support, and proactively share this information in daily interactions (increasing signposting and referrals).
- It's important to improve visibility of support via a range of marketing materials e.g. via posters in trusted community venues.
- People have limited understanding of how to effectively use NRT products, noting that NRT is frequently used in isolation rather than in combination, reducing its effectiveness.
- To address controversy and misunderstanding about the relative safety of vapes, it's important to increase public awareness about the role of vaping when stopping smoking (e.g. that while it's not risk free, it is significantly less harmful than smoking).

3.2.1.1 Opportunity

In the COM-B model, opportunity refers to external factors that make a behaviour possible, including environmental factors (e.g. accessibility of stop smoking services) and social factors (e.g. whether smoking is considered the social norm). This section highlights how stopping smoking can be limited by these factors, and what can be done to influence them.

What are the social and cultural influences associated with smoking?

Wanting 'to fit in', and feeling pressure from other people to start smoking, was the most common reason residents gave for why they started smoking. Smoking was considered 'cool', and socially acceptable due to everyone else doing it.

Social norm
People tend to conform to what they perceive as normal or typical within their social group, which can delay attempts to stop smoking due to fear of social exclusion.

"I started at 13 to be cool as my friends did it."

Male, aged 55-64, currently smokes, vulnerably housed

Children witnessing their family (parents and grandparents) smoking further reinforced the belief that smoking was a normal behaviour that they should engage with.

Individuals highlighted that the people they spend time with can reinforce their smoking habits. For example, some communities, such as those experiencing homelessness, have a higher smoking prevalence, which reinforces smoking as a social norm and makes it harder for individuals to stop.

Given the powerful role of social influence, many residents emphasised the importance of non-judgemental social support in helping people to stop smoking. For many, encouragement from friends and family can help them stay motivated and make healthier choices. Some suggested that stopping smoking would be easier if they were to tackle this alongside a friend, meaning they felt accountable to someone else, and avoided smoking triggers together.

Several people emphasised the importance of receiving support from someone who has stopping smoking, as they understand the challenges associated with stopping, helping them to provide both practical and non-judgemental support.

Building on this, those in alcohol recovery suggested that support should mirror alcohol recovery services, such as Change Grow Live (CGL), and meet others in a community setting and chat with people who are in a similar boat.

"Having people around you that have experienced it before and can understand what you're going through."

Female, aged 35-44, previously smoked but has now quit, Hastings

It is not necessary that support is limited to friends and family. Some residents said it's important to have someone to talk to and encourage them. Support from a third party can be even more helpful, as they're often less judgmental and can give more neutral advice.

Environmental and workplace cultures also contributed to smoking behaviours. Settings such as pubs, RAF bases, and universities, were described as places where smoking was socially acceptable and sometimes encouraged, again making it harder for people to avoid temptation. Although the 2007 ban on smoking in public spaces helped reduce acceptability of smoking in many workplaces, some environments, particularly in hospitality, still expose people to smoking, making it more difficult for those trying to stop. Simply seeing someone smoke, or smelling the smoke, was described as triggering for some residents.

"I work in a bar so I'm constantly around people who have just been out for a fag, so can smell it. Hard not to go out for one too."

Male, aged 25-34, currently smokes, Hastings

Residents highlighted the need to remove prompts/visual cues related to smoking, such as cigarettes, ashtrays and lighters. Physically being unable to smoke in your current environment makes it more difficult to fall back on old habits, forcing people to go out of their way if they want to smoke. Residents who were either smokefree, or had successfully stopped smoking prior to relapse, said that environments that restrict smoking made it easy for them to stop smoking, from public places to being in hospital, prison, or overseas. Therefore, creating environments that limit access and reduce exposure to smoking cues can play a powerful role in supporting people to stop smoking and preventing relapse.

Despite social and cultural norms being a significant driver in starting smoking, these factors play less of a role in maintaining these habits due to the changes in public attitudes, legislation, and increased awareness of health risks. However, these social pressures appear to have shifted towards vaping, especially among those under 25. Residents suggested that many young people see vaping as the new social norm, which is widely adopted and more socially acceptable than smoking.

"90% of people in college vape, there aren't any smokers."

Female, aged 25-34, previously smoked but now vapes, Hastings

These insights illustrate the powerful influence of social norms and peer pressure in shaping smoking and vaping behaviours, particularly during adolescence or in social environments where smoking and/or vaping is perceived as the norm.

Stop smoking products are expensive

Despite smoking being an expensive habit, various residents highlighted that the cost of products that help people cut down or stop their tobacco intake, such as 'heat not burn products' and vapes respectively, represent a barrier to stopping smoking. They have noticed an increase in price recently which is off-putting, and can prevent them from stopping smoking, or cause them to relapse.

A couple of individuals experiencing homelessness highlighted that smoking currently does not cost them any money, so any expense requires for stop smoking products represents a barrier to them stopping with pharmacological support, hence reducing their chance of successfully stopping.

Loss aversion
People may focus more on what they might lose than what they could gain. Even though stopping smoking saves money in the long-term, the upfront cost of stop-smoking products can feel like a loss and put people off, especially if they have low self-efficacy and think they might relapse.

"Smoking doesn't cost us, we pick them up from the ground."

Male and female, aged 35-44, currently smoke, homeless, Hastings

To remove practical barriers, residents noted the importance in providing free nicotine products to support those who are trying to stop smoking. These residents were unaware that such products are already available through existing services, highlighting the need to raise awareness and promote what is on offer.

As well as products being free, residents considered it important to be able to access a range of products, including NRT (such as patches and gum), vapes, and lesser-known alternatives such as nicotine-free cigarettes, toothpicks, or even sensory tools like whistles. Residents highlights that everyone is different, and therefore there isn't a one-size-fits-all solution.

Ensure easy access to flexible support

Raising awareness of support and making it easy to join services via trusted members of the community is a key enabler. In terms of the support they received, residents acknowledged that there is no one-size fits all approach to supporting people to stop smoking. While some expressed a preference for online and individualised support, others emphasised the value of face-to-face and group interactions. This highlights the need for the delivery of the service to be flexible and tailored to peoples wants and needs.

To ensure people can commit to services, such as those which offer a 12-week service, some residents highlighted the importance of ensuring that support is convenient and adaptable. For example, ensuring people can access support remotely/online where they have competing commitments such as work or childcare. The option for online and remote support (e.g. WhatsApp/telephone call) was also said to be important.

"Offer online or telephone help for people who are not confident."

Male, Aged 65+, Previously smoked but has now quit, Social housing

What did professional stakeholders say?

- There are practical barriers to accessing One You East Sussex clinics due to travelling long distances, cost of travel, reliance on public transport, limited parking, and the need to access appointments during working hours. Suggesting that considering remote appointments and availability out of hours may help improve access among key groups.
- Rather than services being reliant on residents self-referring or being referred, services should meet people where they are, particularly populations who are underrepresented in services, e.g. attending settings where those who are vulnerably housed may attend.
- Outreach efforts should be increased to engage underrepresented groups e.g. mobile outreach in a branded minivan.
- There is opportunity to improve joined up working between professionals to ensure residents receive the same messages and seamless support.
- Workplaces should directly support, or at least enable, employees to commit to their stop smoking goal, e.g. allowing protected time to attend appointments.
- Communicating that relapse is normal and doesn't mean the service will strike you off is important.

3.2.1.2 Motivation

The following section highlights factors – such as a person's beliefs, feelings, and concerns – that reduces peoples' motivation to stop smoking, and what can be done to influence and motivate them to successfully stop smoking in the future.

What are the main reasons people give for wanting to stop smoking?

Many residents we spoke with reported having previously tried to stop smoking, and reported many negative associations with smoking, such as the unpleasant smell, high cost, and the negative impact on their physical and mental health. Both current and former smokers identified key motivations for wanting to quit, including improving health, saving money, and doing so for the sake of their families, for instance, setting a good example for their children, being healthy enough to spend more quality time with loved ones, or supporting partners or friends who are also trying to quit.

Those who had never tried to stop smoking saw health concerns as the main reason someone might consider stopping smoking. However, those who have successfully stopped smoking were more likely to cite financial reasons as their primary motivation. This suggests that while health may initially motivate someone to want to stop smoking, financial incentives may play a stronger role in initiating and maintaining that behaviour change.

"I watched every penny which motivated me."

Male, aged 65+, previously smoked but now quit

However, awareness of the risks associated with smoking, and wanting or intending to stop smoking is often not enough for people to change their smoking behaviour. Competing motivations influence whether people continue or stop smoking, such as the perceived benefits of smoking, which are explored in more detail below.

What are the perceived benefits of smoking?

Many residents believe smoking helps them manage stress, despite few acknowledging that it might increase stress over time. This indicates a widespread knowledge gap in this area, which may contribute to fewer people trying to stop. The immediate, short-term nicotine hit that people feel when smoking reinforces the perception that smoking relieves stress, making it difficult for residents to imagine coping without it, creating a psychological barrier to stopping.

Hyperbolic discounting
People may give stronger weight to immediate rewards over long-term benefits. For example, prioritising the immediate stress relief or enjoyment of smoking over long-term health or financial gains.

Residents often associate smoking with specific daily routines, and people often look forward to smoking at times such as first thing in the morning, after coffee or meals, and are often the moments which are the hardest to resist, and these habitual associations can make abstinence more challenging.

"I enjoyed a cigarette after work, had my tea and really enjoyed it. It was the hardest to give up."

Male, aged 55-64, previously smoked but now quit, routine manual worker, Hastings

Beyond stress relief, smoking is considered enjoyable and key to having personal time. For some, the ritual of smoking, such as rolling a cigarette, going outside or taking deep breaths, can feel therapeutic. Others describe it as a moment to unwind, take a break, or take a break from social situations.

Cognitive dissonance
People may feel discomfort when holding conflicting beliefs or having conflicting behaviours. People who smoke may recognise the harms of smoking but continue due to habit or stress relief, leading to rationalisations e.g. “I need it to cope”.

"It's a way to relax, unwind and get away from people."

Small group at The Hart pub, mix of genders, aged 35-44, LGBTQIA+

To strengthen motivation to stop smoking, it was considered important to address the perceived benefits of smoking and help show residents how they can still achieve outcomes in healthier ways, such as how to relieve stress, take breaks, or practice mindfulness practices such as breathing techniques.

It's also important to reassure people that quitting smoking is associated with reduced anxiety over time, and to emphasise that mental health support is available for those concerned about the psychological impact of quitting.

"Make sure that misinformation is addressed, for example highlight that stopping smoking can help reduce anxiety."

Female, aged 35-44, previously smoked but have now quit

Withdrawal symptoms, emotional triggers and cravings make it difficult for people to stop smoking

While reasons for starting smoking, such as peer pressure and stress, vary, the habit is often sustained by the addictive and habitual nature. Withdrawal symptoms, such as mood swings, stress, cravings and weight gain can undermine residents' resolve to stop smoking. These withdrawal symptoms can feel even stronger when facing personal triggers (e.g. being around others who are smoking) and when experiencing emotional trauma, such as bereavement, which can result in relapse.

"Cravings, mood, and putting on weight make you want to go back."

Male, aged 45-54, previously smoked but now quit, routine manual worker

Creating new habits/distraction techniques was considered key to managing potential triggers. Many residents highlighted specific times which are particularly challenging, such as mornings, after coffee or alcohol, or when socialising with others who smoke. Residents offered various suggestions for distraction and coping techniques, such as going for a walk, playing games, keeping your hands busy – e.g. eating fruit or veg, and taking up a new hobby, suggesting it's important to create action plans for addressing triggers or challenging times.

"Swapping it out with another behaviour when triggered by stress."

Male, under 18, currently smokes, Hastings

Some residents in recovery from risky and, or dependent drinking, expressed caution about stopping smoking. This group were concerned that stopping smoking could trigger mental health issues like their experiences with alcohol withdrawal, representing a barrier to trying to stop smoking. This suggests a need to make it easy to access NRT which is discussed in section 3.2.1.1.

Beliefs about willpower and stigma around support

Some residents suggested that stopping smoking is largely associated with willpower, with the idea that ‘if you really want to stop, you will be successful’ and ‘if you don’t want it enough, you will fail’, highlighting a belief that support is not necessary. These views can reinforce the stigma around accessing support and can prevent people from engaging with services.

"Depends on if they're serious about stopping smoking or not. If they’re serious, they'll just stop."

Male, aged 65+, previously smoked but now quit

What did professional stakeholders say?

- Recognising some communities are hesitant to engage with health services, e.g. One You East Sussex or local pharmacies, services need to be sensitive and appropriate to underserved communities, such as those experiencing vulnerable housing, living in areas of deprivation, and LGBTQIA+ communities. To do this, services should adopt a trauma informed approach
- There is a need to reassure residents that support is gentle, kind, and non-judgemental e.g. by using gentle language when communicating and advertising the service.

3.3 Smoking-related strategic recommendations

Insights from local communities and stakeholders have highlighted several factors to help residents become smokefree. Informed by the insight findings and literature review, a set of practical recommendations have been made and should be considered collectively rather than in isolation. These actions are not intended to suggest starting from scratch; rather, they are designed to build on and strengthen the good work already underway to reduce smoking prevalence in East Sussex.

These recommendations have been prioritised in collaboration with stakeholders across East Sussex during a coproduction workshop (see Appendix, Section 7.2, Table 2 for details of who was involved).This has allowed us to determine what are the most urgent recommendations alongside identifying which stakeholders can be involved in the delivery of these recommendations to ensure they are as effective as possible. While some recommendations can be led by East Sussex County Council, many will require collaborative action across the whole system. Stakeholders identified the high priority recommendations by selecting those they viewed as the most urgent and important. The remaining recommendations have been categorised based on the insights found through the research phase.

It is important to note that some actions were prioritised based on the perspectives of the stakeholders present in the workshops. While the priority ranking provides a useful indication of perceived urgency, it does not diminish the value of the other recommendations. All actions are considered important, as they are grounded in the insight gathered throughout this project.

A summary of the smoking-related recommendations, mapped onto the Behaviour Change Wheel (BCW) can be found in Section 0, Table 3. Further descriptions of intervention types can be found in the Appendix, section 0.

Recommendation 1: Increase awareness and improve communication of support options – harness the role of community leaders.

What does the insight say? Many residents lack awareness of the types of support available to help people become smoke free. Key professional and community leaders play an influential role in reaching underserved communities and represent a trusted and accessible channel for delivering targeted health messages (sections 3.2.1).

COM-B: Capability, Opportunity

Priority: High – increasing awareness was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate - stakeholders acknowledged that progress is already underway to raise awareness but agreed that continued and enhanced efforts are needed.

Action 1a

How: Clearly communicate the full range of support available through stop smoking services, e.g. including what One You East Sussex provide, as well as other providers such as pharmacies and maternity services (where relevant). Do this by ensuring messaging is consistent across websites, social media, posters, leaflets and community outreach. Communicate using simple language and avoid use of terms such as 'behavioural support' or 'pharmacotherapy' which can be ambiguous and misunderstood. The language used on the One You East Sussex website is a good example of the use of simple language, which is displayed in Figure 1.

Intervention types: Education, Enablement

Who to activate: Organisations which promote and support individuals to become smokefree, such as One You East Sussex, pharmacies, maternity services, East Sussex County Council and the South East Smokefree alliance.

Who to target: All priority groups

Evidence base: Clear, consistent messaging increases engagement with stop smoking services. The *Stoptober* campaign led to over 2.5 million quit attempts, with a 50% rise in October quits[4,5]. Greater Manchester's simple, multi-channel approach saw a 45% increase in service traffic[6]. This highlights the value of accessible, jargon-free communication across platforms.

Action 1b
How: Equip key professionals and community leaders with resources and skills to be able to play a key role in promoting available services – this includes equipping them to have personalised conversation about a person's smoking and then signposting them to services effectively, passing on the information people need to make an informed choice and help plug knowledge gaps. Do this by ensuring professional and community stakeholders are aware of what support includes, and can confidently communicate this with residents, particularly those in transient communities such as residents in temporary housing or those in construction jobs. Given the sensitivity of this topic, ensure trusted stakeholders, such as health care professionals, community leaders, and support workers are equipped to share this message in an empathetic and reassuring manner. Emphasise that seeking support is a strength, not a failure, and that personalised support is available at every step. Promote pharmacies as convenient and trusted services to help people stop smoking. **Intervention types:** Training, Enablement
Who to activate: Local organisations, such as One You East Sussex, that deliver behaviour change training to community organisations and system professionals. This training to be delivered to all professional and community stakeholders who interact with priority groups.
Who to target: All priority groups
Evidence base: Making Every Contact Count (MECC) is an evidence-based approach shown to improve health behaviours such as smoking cessation through brief, opportunistic conversations during routine interactions. Research highlights that MECC interventions are cost-effective and can help reduce health inequalities by reaching individuals who may not access traditional health services[7].

IN PERSON SUPPORT

- **1-to-1 appointments** with an experienced stop smoking mentor at clinic near you.
- **Free quit aids** like e-cigarettes and nicotine patches, given at each session.
- **Regular carbon monoxide testing** to measure your progress as you quit.
- **Consistent support** from understanding mentors who know how hard it can be to quit.

Figure 1 An example of simple language used on One You East Sussex's website

Recommendation 2: Challenge misconceptions and normalise seeking support.

What does the insight say? Residents often suggested that stopping smoking without social support and nicotine products (otherwise known as 'cold turkey') as a successful method to become smokefree (section 3.2.1) and anxiety or embarrassment can prevent seeking help.

COM-B: Capability, Motivation

Priority: High – challenging misconceptions was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate - stakeholders agreed that raising awareness of support options (recommendation 1) would help challenge misconceptions and normalise seeking support.

Action 2a
How: Challenge the belief that quitting 'cold turkey' is most effective by developing a communications campaign to debunk this myth. Consult with target groups, particularly routine and manual workers (RMWs), who have previously been hard to reach (e.g. during the 'It's Well Worth It' campaign)—to test and refine message framing. Use humour, visuals, and simple messaging to boost cut-through and recall. Equip stakeholders to confidently explain the benefits of combining nicotine products (e.g. patches or vapes) with 1:1 support. Make quitting success rates relatable and easy to understand. Address common concerns about nicotine replacement therapy (NRT) and vaping, clearly positioning vaping as a harm-reduction tool for smokers—not for non-smokers. Ensure all messaging is clear, evidence-based, and tailored to the needs and concerns of different audiences. **Intervention types:** Education, Persuasion
Who to activate: To create a campaign: Public health teams in partnership with local stop smoking services, priority groups such as RMWs. To relate messages to residents/compare success rates of quitting cold turkey/address reasons people might have to avoid nicotine products: All professional and community stakeholders who interact with priority groups.
Who to target: All priority groups, particularly RMW (as evidence has highlighted challenges in ensuring messages resonate with them).
Evidence base: Evidence suggests that co-designing stop smoking messages with communities makes them more relevant, respectful, and engaging. This approach can improve uptake of services and lead to higher quit rates[8,9].

Figure 2 An example of stop smoking campaign messages and concepts that were tested in previous research with populations who smoke in Southwark.

Recommendation 3: Encourage people to become smokefree with someone else.

What does the insight say? Social influence is particularly influential in smoking behaviour. Residents suggested that stopping smoking would be easier if they could do this with a friend.

COM-B: Opportunity (social)

Priority: High – encouraging people to become smokefree with someone else was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate

Action 3a
How: Review the One You East Sussex model/pathway to check if the smokefree pathway enables residents to attend in pair/buddy up and attend appointments together. Consider the creation of online/virtual peer support, such as via WhatsApp chat or Facebook groups. Create communication and messaging which promotes becoming smokefree alongside somebody else, for example a friend, partner, family member, or colleagues. Communicate the benefits of stopping with someone else, for example feeling supported by someone close to you, feeling accountable to someone else, tackling challenges together and avoiding smoking triggers together. **Intervention types:** Persuasion, Environmental Restructuring
Who to activate: One You East Sussex and East Sussex County Council.
Who to target: All priority groups
Evidence base: Research has consistently found that peer-support interventions enhance smoking cessation[10].

Action 3b

How: Create communication and messaging to normalise multiple quit attempts, communicating that it often takes many attempts, but success rates improve after each attempt. This includes highlighting residents' stories about their quit attempts.

If people are concerned about accessing support by themselves, let them know they can engage with someone they trust.

Intervention types: Education, Persuasion

Who to activate:

To create communications and messaging: public health teams in partnership with local stop smoking services and other partners in the East Sussex Tobacco Control Partnership. Consider the role of the South East Smokefree Alliance.

To communicate that people can access support with someone they trust: all professional and community stakeholders who interact with priority groups.

Who to target: All priority groups

Evidence base:

Previous Stoptober campaigns have explicitly acknowledged that quitting smoking often requires multiple attempts and that each quit attempt increases the likelihood of eventual success. Stoptober continues to effectively drive smokers to make a quit attempt[11]. Enabling people to access services with someone they trust, such as a friend, family member, or community worker, aligns with evidence on the importance of social support in quit success[12].

Recommendation 4: Support accessibility and flexibility - make it easy to get support.

What does the insight say? Both residents and stakeholders highlighted practical barriers for residents to attend support services such as One You East Sussex, including travel, cost and difficulty finding time to attend sessions. Stakeholders suggest that maintaining strict attendance rules for people accessing services can alienate those with complex needs, such as those who are vulnerably housed (section 3.2.1.2).

COM-B: Opportunity (physical)

Priority: High – making it easy to get support was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate

Action 4a
How: One You East Sussex currently offers flexible telephone support, advertising that they offer evening and weekend calls to meet residents' schedules. It appears that residents have limited knowledge of this. It is therefore important to ensure this information reaches those who are eligible for this support. However, it is important to ensure that in person clinics are available for those who would prefer them. To do this, consider offering flexible clinic hours, across a range of locations, which are not limited to traditional working hours and are suitable for those with childcare responsibilities (e.g. outside of 9am-5pm). Ensure clinic times (121 and drop in) are clearly advertised on the One You East Sussex website, detailing the clinic times and where they are. Continue to aim to deliver support where people currently are, reviewing current clinic locations to understand the venues that are working well. Do this by collaborating with stakeholders to identify potential venues, and arrange to use familiar, trusted and local settings, such as community centres, faith settings, and spaces within retail environments. Increase proactive outreach, visiting people where they already are, for example in LGBGTQIA+ spaces such as The Hart and The Forbidden Fruit, construction sites, retail spaces, and community centres etc. **Intervention types:** Environmental restructuring, Enablement, Education
Who to activate: One You East Sussex and East Sussex County Council, working alongside community/professionals' stakeholders.
Who to target: All priority groups, particularly those who struggle to attend existing clinics.
Evidence base: Flexible service delivery improves accessibility and engagement, especially among underserved groups. Outreach in trusted community spaces enhances reach and trust, leading to higher quit rates[13,14].

Action 4b
How: Ensure services are trauma-informed, and sensitive to those with complex needs. For example, empathise when someone misses multiple appointments, and adopt a more flexible, non-judgemental approach for individuals dealing with issues such as housing, mental health issues and financial hardship. This may include One You East Sussex staff participating in trauma informed training. **Intervention types:** Enablement, Training
Who to activate: Organisations which support individuals to become smokefree such as One You East Sussex, pharmacies, and maternity services.
Who to target: All priority groups, particularly those with complex needs.
Evidence base: Trauma-informed approaches increase engagement and treatment retention among vulnerable populations[15].

Recommendation 5: Frame messages to focus on the immediate benefits of becoming smoke free.

What does the insight say? Insights in section 3.2.1.2 suggest residents give increased weight to short-term benefits of stopping smoking (e.g. more money), compared to long-term (e.g. live longer). This suggests messaging should focus on the immediate benefits of stopping smoking.

COM-B: Motivation

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 5a
How: Through advertising and communication, emphasise immediate financial gains of becoming smokefree.
Intervention types: Education, persuasion and incentivisation (indirectly)
Who to activate: Organisations which promote and support individuals to become smokefree such as, the South East Smoke Free alliance, East Sussex County Council, NHS Sussex, East Sussex Healthcare Trust, Sussex Partnership Foundation Trust, One You East Sussex and pharmacies.
Who to target: All priority groups.
What is the evidence base to support this action? The NHS Quit Smoking campaign uses real-time calculators to show how much money people can save daily/weekly by quitting. According to Public Health England campaign summaries (2019–2022), financial gain messaging had the highest recall and motivation among younger adults and low-income groups[16]. A report by Action on Smoking and Health (ASH) highlighted smokers are more motivated by cost-of-living pressures than by long-term health concerns[17].

Action 5b
How: Consider promoting other short-term physical benefits, such as better taste and smells, improved performance in physical activities and sports – do this using temporal framing as highlighted in Figure 3. **Intervention types:** Education, persuasion, incentivisation
Who to activate: Any organisation which promotes and supports individuals to become smokefree such as, the South East Smoke Free alliance, East Sussex Healthcare Trust, Sussex Partnership Foundation Trust, East Sussex County Council, NHS Sussex, One You East Sussex and pharmacies.
Who to target: All priority groups.
Evidence base: Stoptober campaigns exposing people to short-term (48 hrs) physical and sensory benefits were found to be more likely to encourage people to set quit dates and engage with support services[11]. These outcomes align with research applying the Health Belief Model, which shows that perceived short-term, concrete benefits (e.g. enhanced physical performance or social confidence) are more effective in motivating smoking cessation than abstract long-term health outcomes[18].

Action 5c
How: Encourage people who have quit to share their stories – providing relatable testimonials for others on the immediate benefits they gained. This consideration is closely linked with action 4. **Intervention types:** Modelling and persuasion.
Who to activate: Any organisation that supports residents in becoming smokefree (e.g. One You East Sussex, community pharmacists, midwives)
Who to target: All priority groups
Evidence base: Narrative-based interventions, like peer testimonials and digital stories, consistently show positive effects on behaviour change. A 2022 scoping review of digital storytelling in health promotion found that such interventions enhance intention to change across topics including smoking cessation[19]. Pilots delivering real-person quit stories via text messages in 2022 reported increased engagement and self-efficacy among pregnant smokers[20].

Recommendation 6: Conduct further research with communities to understand what messages resonate with them.

What does the insight say? Insight highlighted that few people are aware of/can recall information about becoming smokefree.

COM-B: Capability

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 6a
How: Conduct further research with communities who have not engaged with recent communication and awareness campaigns (e.g. the 'it's well worth it' commissioned by Hitch) to understand what messages resonate with them, what stories reflect their personal experiences and to decide on the tone, placement and delivery method of these communications. This should include qualitative methods such as community-led focus groups, peer interviews, and participatory workshops that centre the voices of underrepresented or hesitant groups. **Intervention types:** Education (for campaign designers), Persuasion (generating persuasive messages)
Who to activate: Understanding the importance of trusted people engaging with priority groups, ensure involvement from stakeholders already working with priority groups such as community health workers, local voluntary and community sector (VCS) organisations, LGBTQIA+ support groups, housing support charities, and frontline service providers. Consider collaborating with researchers to co-design inclusive methodologies, analyse insights, and support the development of communications that are both evidence-informed and community-approved.
Who to target: All priority groups.
Evidence base: The literature review highlights that the 'it's well worth it' campaign in East Sussex in 2023 identified the need for more tailored messaging and for stories within campaigns to reflect target groups', such as RMWs' personal experiences.

Recommendation 7: Consider strengthening and expanding current interventions which include providing residents with financial incentives to become smoke free.

What does the insight say? Residents who have previously stopped smoking reported they were often motivated to become smokefree for financial reasons.

COM-B: Motivation, Capability

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 7a
How: The national maternity scheme launched in December 2023 incentivises all pregnant people to stop smoking with a £400 reward. Promote access to incentives for those eligible for the maternity incentive scheme. Ensure resources are clear and accessible, raising awareness of the scheme and explaining how to enrol.
Intervention types: Incentivisation, Education
Who to activate: Stakeholders who routinely communicate with pregnant women who are eligible for the maternity incentive scheme (including but not limited to GPs, midwives and nurses). Partner with marketing and communications professionals.
Who to target: Pregnant women and their partners across all priority groups.
Evidence base: The scheme provides support to pregnant people and their partners who are smokers to quit through financial incentives. In the last 12 months preceding May 2024, 18 women received the full incentive and successfully achieved their quit attempt. This is supported by a recent systematic review that found strong evidence that financial rewards help more pregnant people quit smoking, with about 13 more quitters for every 100 people compared to those who didn't receive incentives[21].

Action 7b

How: Consider expanding the current incentive programme beyond maternity schemes and piloting this in groups with higher smoking prevalence.

Intervention types: Incentivisation, Enablement

Who to activate: Stakeholders across East Sussex County Council and those who engage people who are vulnerably housed.

Collaborate with researchers to design the pilot in partnership with communities, making sure it reflects their needs and experiences. Evaluate how well it helps people quit smoking, how many take part, and whether it offers good value for money.

Who to target: People who are vulnerably housed.

Evidence base:

Pilot studies with people who are vulnerably housed found that small financial rewards helped more people quit smoking in the short term, for example, up to 48% quit compared to just 8% without incentives[22]. A 2024 review showed that these schemes work especially well for people on low incomes[23].

Recommendation 8: Encourage healthier ways to cope, highlighting that being smoke free is associated with lower stress levels.

What does the insight say? Residents highlighted that they often use smoking as a stress relief method.

COM-B: Capability, Motivation

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 8a
How: Recognising that some people view smoking as a way to manage stress, reframe the message by highlighting that support is available to help manage stress right now, and that many people feel calmer and more in control within days of quitting. Reinforce that healthier coping strategies develop quickly and can be just as effective, without the long-term harm. For example, this message can be shared by healthcare professionals during conversations about smoking behaviours and reinforced by local stop smoking services when promoting their support. **Intervention types:** Education, Persuasion
Who to activate: Any organisations who support and promote residents to become smokefree such as the South East Smoke Free alliance, East Sussex County Council, NHS Sussex, East Sussex Healthcare Trust, Sussex Partnership Foundation Trust, One You East Sussex and pharmacies.
Who to target: All priority groups
Evidence base: Smokers often report using cigarettes to cope with stress, boredom or negative emotions. A common barrier to quitting is anxiety about losing this perceived emotional support[24].

Recommendation 9: Reframe quit support for 'independent quitters'.

What does the insight say: Some residents don't want to, or feel they don't need to, access formal stop smoking support, believing they can quit cold turkey and just need to do it using will power alone (section 3.2.1).

COM-B: Motivation, Capability

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 9a

How: Recognise some people don't want to access formal support and feel that they should be able to stop smoking by themselves without the need for formalised support by re-framing quit support for 'independent quitters'.

Promote the Gloji App as a personal tool for goal setting and independent progress tracking – not as professional support – language/terms are important here.

Position quitting as a personal challenge, not a call for help. Use motivational messaging that reinforces autonomy and achievement.

Trojan Horse Approach

Inspired by Greek mythology, this refers to offering something in a concealed form. Just as the Greeks hid soldiers inside a wooden horse to enter Troy, stop smoking support is disguised so that it appears to be something else - disarming, unthreatening, and more likely to be accepted.

Intervention types: Persuasion, Education

Who to activate: All professional and community stakeholders who interact with priority groups.

Who to target: All priority groups, particularly residents who value independence, are sceptical of formal support, or have previously disengaged from traditional stop smoking services, including men in manual jobs, residents with low trust in health systems, and those expressing a desire to "do it alone."

Evidence base: A recent UK study used a smartwatch to deliver discreet quit-smoking prompts triggered by smoking gestures. With many users finding it acceptable, this Trojan Horse approach embedded support into everyday technology without overtly framing it as formal help, appealing to those who prefer to quit independently[25].

Figure 3 an example of temporal framing, highlighting the short and long-term benefits of becoming smokefree

Recommendation 10: Facilitate collaboration among stakeholders.

What does the insight say? Professional stakeholders acknowledged the potential benefits of working together with vape specialists (e.g. retailers), towards a shared goal of reducing tobacco use across East Sussex.

COM-B: Opportunity (physical)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 10a
How: Establish working groups linking vape retailers and formal stop smoking services to recognise shared goals and values, enhancing the effectiveness of vaping as a smoking cessation tool. Recognise training opportunities for both parties, for example up-skilling health coaches on vaping and vape retailers on stop smoking pathways and referral options and providing behavioural support. Review current levels of involvement between stop smoking services and vape retailers. Utilising existing resources, review opportunities for collaboration between One You East Sussex and vape retailers[26]
Intervention types: Environmental Restructuring, Education, Training, Enablement
Who to activate: Vape retailers, stop smoking service providers
Who to target: Residents who use vaping or are considering quitting smoking, including those in priority groups with higher smoking prevalence.
Evidence base: Collaborative models that embed vape retailers within formal cessation services show strong promise. In Essex, vape-store–delivered CO-verified quit support led to over 900 verified quits and substantial cost savings[27].

Action 10b
How: Working with One You East Sussex, vape retailers, and residents across East Sussex, co-produce a pathway that will support residents to stop using nicotine entirely.
Intervention types: Enablement, Environmental Restructuring
Who to activate: Vape retailers, stop smoking service providers, residents (including priority groups).
Who to target: Residents who use vaping or are considering quitting smoking, including those in priority groups with higher smoking prevalence.
Evidence base: Previous studies show that working together with service users to design nicotine reduction support makes services more relevant, improves how they work, and helps more people engage and quit successfully[28,29].

Recommendation 11: Promote smokefree and supportive environments.

What does the insight say? Residents, particularly RMWs, highlighted the importance of having smokefree environments (section 3.2.1.2).

COM-B: Opportunity (physical)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 11a

How: Support workplaces to get on board with the promotion of smokefree environments/stop smoking support.

Leaders and senior management can play pivotal roles in actively encouraging and promoting available support. Consider tailored sessions for managers and HR leaders to highlight how supporting staff to stop smoking can benefit both employees and the workplace (improved health and quality of life, reduced irritability, sickness absence, increased productivity).

Consider the importance of building relationships with employers and approaching the topic of smoking through a wider lens of discussions around workplace wellness/productivity.

Consider the role of nominated staff advocates/wellbeing champions to promote smoking cessation support and celebrate smoke-free success stories, to create a supportive environment for those looking to quit.

Encourage employers to offer protected time and incentives to access support.

Support community stakeholders/those in VCFSE organisations to implement and sustain smokefree policies/smokefree sites where this is not already mandatory.

Intervention types: Education, Enablement, Environmental Restructuring, Persuasion.

Who to activate: Employers, senior managers, HR leads, workplace wellbeing champions, VCFSE leaders and the East Sussex Wellbeing at Work programme/East Sussex County Council.

Who to target: Employees who smoke, particularly in sectors with higher smoking prevalence (e.g. construction, retail, hospitality, care).

Evidence base: There is substantial evidence supporting the effectiveness of workplace interventions in promoting smoking cessation[30,31].

4 Exploring drinking behaviours

4.1 Method

4.1.1 Sample characteristics

We engaged 13 professionals from across Health, VCFSE and Public health, and 66 residents across 7 key groups:

Target Group	N	%
People's drinking status*		
· Risky and, or dependent drinkers	50	75%
· Those approaching risky levels of drinking	16	25%
People living in deprived areas (IMD 1-4)**	35	53%
People living in targeted communities:		
· Hastings	16	24%
· Eastbourne	23	35%
People who are insecurely housed or homeless	20	30%
People of different ages		
· 18-24	6	9%
· 25-34	7	10%
· 35-44	18	27%
· 45-54	17	26%
· 55-64	10	16%
· 65+	6	9%
· Prefer not to say	2	3%
Gender		
· Male	43	65%
· Female	20	30%
· Non-Binary	2	3%
· Prefer not to say	1	2%
People from different ethnic backgrounds		
White / White British	57	86%
Ethnic minority groups	9	14%

*This was calculated using AUDIT-C

*Please note, not everyone provided their postcode. Of the residents who did provide their postcode, 53% lived in deprivation. It is likely that many other residents did live in areas of deprivation given the majority of all groups and vox pops were conducted in venues located in deprived neighbourhoods.

For a further breakdown of the sample characteristics please see the Appendix.

4.1.2 Engagement approach

We took the research out into community settings such as recovery café mornings and wellbeing groups. Working closely with community leaders, we conducted a mix of

workshops, groups, and individual interviews as well as opportunistic interviews in public and community spaces, such as LGBTQIA+ nightlife venues, gyms, high streets (e.g., Hastings and Eastbourne), building sites, recovery cafés, colleges, superstores, doctors' reception areas, and venues supporting people experiencing homelessness. Most residents that we engaged with who were risky and or dependent drinkers that were already accessing support such as CGL.

We engaged professionals through a mix of webinars, interviews both virtual and face to face and in-person discussions.

4.2 Insight findings

Participants in this insight fell into one of two categories which are underpinned by the evidence-based AUDIT-C (Alcohol Use Identification Test) screening tool[32]:

1. **Those approaching risky levels of drinking:** Individuals who consume alcohol in a way that increases the risk of harmful consequences to themselves or others. This group often do not recognise their drinking as potentially harmful as they are not yet risky or dependent drinkers. They can benefit from brief interventions.

2. **Risky and, or dependent drinkers:** This group includes individuals whose alcohol use is above recommended guidelines (14 Units a week or scoring 8+ on Audit -C) and may lead to health or social issues if it continues. Sone Individuals in this group have experience of alcohol dependence and currently or have previously accessed specialist support. This group often includes people with overlapping complex needs such as homelessness or insecure housing.

Differences between these two groups are teased out in the following report sections.

4.2.1 Capability

This section explores the knowledge and skills that may be preventing some residents from cutting down or reducing their alcohol consumption. Findings are split between risky and, or dependent drinkers and those approaching risky levels of drinking where differences occur.

Do residents understand the risks associated with alcohol?

Many residents who were increasingly-at risk drinkers had limited knowledge about the effects of alcohol on the body and brain. This applied both to long-term dependence and to short-term episodes of heavy drinking. The issue often went unrecognised, in part because such drinking behaviour was deeply normalised within their community – when excessive drinking is widespread, it can appear typical and unproblematic. As a result, many residents did not perceive their alcohol use as risky and saw little reason to change their drinking habits.

'Not sure – I don't understand how you can have a drink problem?'

Male, aged 55-64, approaching risky levels of drinking

Residents also expressed uncertainty about recognising harmful drinking in others. Some felt it was difficult to spot because changes in behaviour can be subtle or hidden. Others believed they could identify problematic drinking through signs like acting out of character, declining mental health, or prioritising alcohol over other activities. This mixed confidence suggests that understandings of alcohol-related harm are inconsistent, even when it comes to observing others. As with their own use, normalisation of drinking appeared to reduce the perceived risk and impact of harmful or dependent drinking in those around them.

In relation to addiction[3], most residents were aware that alcohol can be addictive and understood many of the associated consequences — including physical symptoms like cravings and withdrawal, as well as psychological impacts such as low mood and memory problems. However, for those who were approaching risky levels of drinking, this knowledge didn't feel personally relevant. They tended to view addiction as something that affected "other people" and believed their own drinking wasn't serious enough to warrant concern. This suggests that awareness of addiction alone is not sufficient to prompt reflection or motivate change.

On the contrary, risky and or, dependent drinkers often spoke about a family history of addiction or described themselves as having an 'addictive personality'. For them, addiction felt more personal and immediate, and they identified this as a key reason why cutting down or stopping felt particularly difficult.

"But my dad was 59 and then he died from liver cancer because he was an alcoholic. And so, I thought I'd never end up being like him, but it happens. So again, is that genetics?"

Male, aged 62, risky and, or dependent drinker, Hastings

In light of these findings, residents who were increasingly-at risk drinkers highlighted the importance of clearer education and awareness about what risky, dependent drinking looks like, including the behaviours and signs associated with it. They felt this could help individuals more readily recognise problematic, addictive patterns in themselves and others, and identify when support might be needed.

Residents also stressed the need for alcohol guidelines to feel relevant and meaningful — using language and examples that resonate with people's lived experiences, making it easier to understand personal levels of risk. Many residents said they didn't understand

[3] Alcohol addiction, also known as alcohol use disorder (AUD) is a chronic mental condition characterised by an inability to control or stop drinking despite negative social, occupational or health consequences[5]

how many units are in a drink. In practical terms this limited their ability to gauge how their drinking compared to recommended limits.

Do people understand how they can reduce their drinking?

Many residents felt that they could reduce or stop their drinking at any time, viewing it as a matter of willpower and something they could manage on their own. Those approaching risky levels of drinking reported that it was easy to find alcohol-free alternatives, even at the pub and that they taste as nice as their alcoholic counterparts. This highlights how residents felt able to take control of their drinking.

However, some residents who were approaching risky levels of drinking highlighted that they would seek medical advice from a doctor or attend NHS free screening programmes if they became concerned about their drinking.

Reduced capability to stop drinking among risky and, or dependent drinkers

It is important to recognise that many people within the risky and, or dependent drinkers' group will have experienced the harmful effects of drinking first hand (e.g. liver disease, seizures) and face additional challenges when it comes to having the psychological and physical ability to stop drinking. Challenges include reduced cognitive function (as a consequence of their drinking), substance misuse, poor mental health, and insecure housing. These issues can lead to difficulties such as forgetting appointments and struggling to cope with day-to-day demands, all of which can undermine their ability to sustain any efforts to quit drinking. Some residents described how, at times, feeling unwell or the severity of their addiction made it physically or mentally impossible to attend appointments. This underlines the importance of flexible support options to ensure that services remain accessible when individuals are at their most vulnerable.

For residents who are risky and, or dependent drinkers, they did not see cutting down or reducing their drinking as a realistic option. Instead, many viewed complete abstinence as the only viable route.

"It's a straightforward choice between addiction or abstinence, because we don't have that moderation. I think most of us will say, over the years, we've all tried to cut down and failed to do so on a long term."

Female, aged 45, risky and, or dependent drinker, vulnerably housed, Hastings

These findings suggest that this cohort of risky and, or dependent drinkers require highly specialist support, such as that provided by Change Grow Live (CGL), alongside broader help to address their complex, interrelated challenges. Many residents from this group experience strong urges to drink and distressing withdrawal symptoms, including nausea, shaking and insomnia. This highlights the importance of providing support that helps people address the physical aspects of addiction.

Despite the barriers they face, residents who were risky and, or dependent drinkers demonstrated a relatively high level of awareness of the structured support available to them, including CGL, Alcoholics Anonymous and Self-Management and Recovery Training (SMART) recovery groups. This included most residents who were risky and, or dependent drinkers accessing support (46 out of 50)[4]. Many shared positive experiences of these services, suggesting they are effective and well regarded. As such, it is vital that these services remain visible, easily accessible and appropriately resourced to continue supporting those most in need.

Knowledge of available support and services

For those approaching risky levels of drinking, there was limited awareness or knowledge about the types of support services available to help people wanting to change their drinking habits. Residents were not aware of services, where to find them or how to access them. They also reported that they were more familiar with the stop smoking support available in East Sussex. This may be partly because some residents don't recognise their drinking as problematic, and therefore didn't feel they needed support, making them less likely to notice or engage with the services available.

This suggests a need to ensure that available support is well advertised in ways that resonate with people who don't see their drinking as "that bad" or serious enough to warrant services like AA or CGL. Communications should be designed to catch their attention and present support as relevant, approachable, and suited to a range of drinking behaviours—not just those in crisis. It's vital that people know where to go if and when they feel ready to seek help, and that the support on offer is clearly positioned as something meant for them. There is a need to promote lower-level support in a way that resonates with people who are at-risk, but who may not perceive themselves to be.

Conversely, risky and, or dependent drinkers had some awareness of CGL but said feelings of shame and stigma alongside reluctance to admit to having a problem prevented them from accessing support. Suggesting that support should be visibly non-judgemental, empathetic, and grounded in understanding rather than blame.

"See if we want people to make the right choice, which is to seek help, then we need to remove the stigma attached to alcohol and drug addiction, getting better conversations

[4] This might be an overrepresentation of the true number of residents who are risky and, or dependent drinkers accessing support due to our engagement approach where we reached out to support groups to help us gain access to risky and, or dependent drinkers.

at high level, in the media, on TV, so that stigma is reduced, once people realise that it's perfectly normal to have an alcohol use disorder. It is a condition that affects people."

Male, aged 44, risky and, or dependent drinker, Hastings

Overall, residents expressed a need for clearer, more accessible information about the full range of support options available—from low-level interventions to more specialist services. Greater clarity would help individuals make informed choices about the type of support that best aligns with their needs, circumstances, and preferences.

What did professional stakeholders say?

- Limited awareness of recommended alcohol consumption guidelines, and social acceptability of drinking, can result in residents not recognising their drinking to be problematic.
- Further attention is needed for residents who struggle to recognise when their casual, social drinking shifts into risky and, or dependent drinking.
- To reduce feelings of shame or denial about alcohol dependency and make support more accessible, there is a need to challenge stereotypes and increase awareness of the ways problematic drinking can present itself.
- There is an opportunity to improve the detection of early behavioural warning signs of risky and, or dependent drinking, rather than relying on reactive support for those at crisis point.
- Workplaces are often overlooked as an option for support, and stigma within the workplace can discourage residents from seeking help.
- Limited integration between services such as health, housing, financial services and VCFSE services results in residents not getting the support they need.
- Alcohol education should be included in the school curriculum and targeted education is required to reach people who are drinking at risky or increased levels.

4.2.1.1 Opportunity

This section examines the external factors that influence residents' ability to reduce or stop drinking, with particular attention to elements of the physical environment (such as the widespread availability of alcohol) and the social environment (such as the normalisation of drinking within social settings). It will also consider what changes or supports might be required to address these barriers and enhance opportunities within the external environment to enable and encourage the desired behaviour change.

What external factors influence people's drinking behaviours?

Ease of accessing and drinking alcohol

Currently alcohol is easy to access and cheap to buy. Both those approaching risky levels of drinking and risky and, or dependent drinkers reported being able to access alcohol from various places, with almost unlimited access, most hours of the day. This creates a physical environment that is conductive to harmful levels of drinking.

"You can get hold of alcohol [all the] time, I was able to even when I had falls from being too drunk. I was ordering it on Uber because I damaged all my legs. And that goes to the shop. It's so easily accessible."

Female, aged 45, risky and, or dependent drinker, vulnerably housed, Hastings

Residents who were risky and, or dependent drinkers described how easy it is to drink alone at home, where their behaviour is hidden from the judgement or scrutiny of others. The accessibility of alcohol within the home allows them to drink in private, without the social cues or feedback that might otherwise prompt reflection on their drinking. While this privacy enables continued drinking, it can also lead to feelings of isolation and shame, as their drinking becomes more secretive. These insights highlight the importance of considering how to identify and engage with individuals who may be drinking at risky levels in the home, where their behaviour may not be visible to services or support networks.

"And then you're by yourself. You're so lonely. You just decide, let me just sit down somewhere and have a drink. And then after that, you just start crying by yourself. Yeah, it is very hard."

Male, aged 41, risky and, or dependent drinker, Homeless

Social acceptability of drinking

For many, drinking alcohol is a key part of social life and is widely seen as normal and acceptable in many settings. In terms of the COM-B model, there is the *opportunity* to drink, which is shaped by these social norms that encourage drinking and make it harder for people to cut down or stop.

For instance, many residents talked about the pub as a key place for socialising. For some, the idea of drinking less or stopping altogether raised worries about missing out on social opportunities or feeling excluded. In this way, the social environment plays a big role in maintaining drinking habits and can make change more difficult.

Some residents went on to say that drinking had been normalised from an early age. Residents reported that they often grow up in a household where their parents drank. This early exposure can create expectations around drinking well before legal drinking age, which are then reinforced through social experiences with peers once individuals begin going out themselves. In this way, family influences, peer pressure, and broader societal norms all combine to reinforce drinking as both desirable and expected. This can lead to expectations around drinking from a young age, which is reinforced when people reach the legal age and can go out drinking themselves.

"The attitude of society towards drinking, how it is deemed to be so normal and conversely, abnormal not to drink."

Female, aged 67, risky and, or dependent drinker

Overall, the widespread social acceptance of drinking, means it's viewed as being "everywhere" which can make it difficult for those who do want to stop or reduce their drinking, as they are frequently exposed to reminders and triggers. This was especially true of risky and, or dependent drinkers given the drug and alcohol culture they were exposed to.

"It's everywhere, so being in any of these places; the pub, a friend's house, the supermarket, it creates reminders of drinking."

Male, aged 55-64, approaching risky levels of drinking

"Those people around you that are alcoholics, drug addicts, stuff like that. You have to be willing to change yourself for it to actually work."

Male, aged 24, risky and, or dependent drinker, Hastings

What external factors would make it easier to cut down or stop drinking?

For those approaching risky levels of drinking, several external factors can make a real difference in helping people reduce or stop their alcohol use. One important factor is easy access to alcohol-free alternatives. When a good range of alcohol-free drinks is available in pubs, restaurants and other social spaces, it becomes easier for people to make different choices when out with others. These options need to be readily available in the key places where people regularly socialise.

It is also important that people have access to alternative activities and environments that do not revolve around alcohol. It is important people have other ways to spend time—such as through walking groups, men's sheds, community sports, arts or craft activities—providing opportunities for healthier and more positive routines to develop.

Making alcohol less cheap and less available at all times of day can also have an impact. Measures such as restrictions on the hours when alcohol can be sold, and increasing taxation, can help reduce the ease of excessive drinking.

Social environments matter too. People are more likely to succeed in cutting down when they can change their social settings and surround themselves with supportive friends or family members. For many, buddying up with someone else who also wants to cut down can provide the encouragement and accountability needed to stick with their goals.

For risky and, or dependent drinkers, a different set of external support is often required. Access to peer support groups where people can meet others who have been through similar experiences is crucial. Groups led or attended by people with lived experience

were seen as particularly valuable, as they offer understanding and empathy in a non-judgemental space. One participant described it this way:

"And we can say stuff here in the groups that wouldn't feel comfortable to say, the people that are not in a similar life experience like we have. I always think when you come to groups like this, these people are my tribe."

Male, aged 62, risky and, or dependent drinker, Hastings

Informal community-based services, such as recovery cafés, also play an important role in ongoing support. These welcoming and accessible spaces provide opportunities for connection and continued recovery outside of formal treatment settings.

Accessibility of support

Risky and, or dependent drinkers highlighted that support services are not always easily accessible. This is due to residents having limited resources, including money or feasible transportation options to travel to services for support. It can be especially difficult for residents to travel to support due to the rurality of East Sussex outside of the towns and cities, presenting barriers to travel. This was especially important to those who were insecurely housed, experiencing homelessness or living in areas of deprivation.

"Live up well, Hollington, which is quite a distance from here walking, because obviously I don't have a car now with my driving ban."

Female, aged 67, risky and, or dependent drinker, Hastings

Even when services are available, residents reported that there is often a lack of flexibility in how and when support is offered. Recovery requires consistent commitment and can take over someone's life. Therefore, residents highlighted their desire for more support in the day to help them stay busy and to help give residents choice about when they receive support, enabling them to fit it around their other commitments. Additionally, there is a need to help people make the first step when they have the intention to access support.

"I had the number in my drawer for ages [AA], yeah? I thought, no, it was there. I knew I had a problem, but it was difficult to get that yourself and face it, yeah. It's yeah, it's just trying to be honest with yourself."

Female, aged 45, risky and, or dependent drinker, vulnerably housed, Hastings

Some residents who are risky and, or dependent drinkers with overlapping complex needs highlighted that when dealing with extreme addiction people can become too ill to leave the house to access support. This can include being physically unable to attend appointments or unable to remember to attend appointments due to their drinking. This highlights the need for flexible support options and outreach.

It is important to remember, however, that none of these external supports will be effective unless people have some level of personal motivation to want to cut down or stop drinking. Strengthening this motivation remains a vital foundation for making change.

4.2.1.2 Motivation

What did professional stakeholders say?

- Many residents must actively self-refer themselves to access support.
- Limited awareness of services beyond CGL means some residents may fall through the cracks if they're not eligible for this service.
- Alternative forms of support are limited, e.g. pharmacy support, making it difficult to people to get the help they need.
- Limited funding for outreach services and low-level support is a barrier for residents when seeking support.
- The strong "drinking culture" in areas of Hastings (e.g. Hollington, St Leonards and the town centre), across routine and manual occupations, including the fishing industry can normalise drinking behaviours. This drinking culture is linked to high levels of deprivation and contributes to increased health and social equalities. However, risky and dependent drinking can affect all social classes, and this should not be overlooked.
- There is a need to treat the whole person, not solely focusing on alcohol use, but addressing wider circumstances and the reasons people might drink.
- Support should be convenient for residents.

This section will explore what motivates people to drink now and what could motivate them to stop drinking or cut down in the future.

What motivates and causes people to drink?

Drinking alcohol can be enjoyable

Residents who were approaching risky levels of drinking reported that they enjoy the feeling of being drunk, and the taste of alcoholic drinks. Additionally, they reported that they plan social activities around drinking. This includes using the pub or other night life venues as places to meet new people or to socialise with friends. This can reduce residents' motivation to reduce or stop their alcohol consumption because the alcohol becomes associated with positive feelings and experiences of socialisation.

Residents went on to question how they would be able to go out and enjoy themselves when drinking is such a central part of socialising. Many were unsure how they would cope in these situations, what an alcohol-free social life might look like, or how others would react. This suggests worry about how they would fit in and cope around others drinking is a key barrier to stopping.

Additionally, residents felt unsure about how they could live an alcohol-free life due to uncertainty about what this might look like. Therefore, there is a need to raise awareness about sober venues and activities to reassure people they can have fun without alcohol.

Drinking offers a form of escapism

Risky and, or dependent drinkers reported that they use alcohol to help them avoid feeling complex or unwanted emotions. These emotions were often associated with difficult times in their lives which evoke negative feelings or memories, and residents used alcohol to stop themselves from thinking or feeling about these situations.

"Because it's like you say, it just sort of dampens all of the emotions you don't want to deal with."

Male, aged 41, risky and, or dependent drinker

Additionally, risky and, or dependent drinkers said that they drank to help them cope with their stress and anxiety, with some using it to help them to sleep at night. This further illustrates how alcohol can become integrated as a coping mechanism, serving multiple functions in response to negative emotions and experiences. This can quickly become part of residents' routine and gradually build unhealthy relationships with alcohol.

Drinking becomes habitual

Risky and, or dependent drinkers reported that they turn to alcohol even without planning to drink, highlighting that it has become a habit and automatic response. Once drinking alcohol becomes part of residents' routine, they are more likely to engage in the behaviour without considering the harms or impact that it might be having on their mental or physical health.

Additionally, residents reported there can be emotional or environmental triggers that illicit the urge to drink. This takes away the conscious decision from an individual leads them to drink without consciously thinking about it. This can create conflict between their motivation to stop or reduce their alcohol consumption and their habitual response to being in certain settings or emotional states.

Risky and, or dependent drinkers said they regularly experience triggers in their environment. Therefore, while they might believe that drinking is bad for them, they struggle with low self-confidence, so they are able to ignore these triggers. This can reduce their motivation to make changes to their drinking habits, due to wanting to make changes but feeling they can't.

Behaviour - intention gap
This gap reflects the disconnect between what people are motivated to do compared with what they do. For example, when residents say that they want to stop drinking but never take the first steps to change their behaviour.

Believe they don't have a problem

Those approaching risky levels of drinking are motivated to drink because they do not view their drinking behaviours as harmful or problematic. As discussed in section 4.2.1 there is a prevailing sense of "it's not that bad," which contributes to normalising their alcohol consumption. As a result, seeking support is often seen as unnecessary — accessing

services could feel like an admission of having a problem they do not believe applies to them. This perception can act as a barrier to engaging with available support, as many feel their level of drinking does not warrant intervention.

In contrast, for risky and, or dependent drinkers, strong feelings of shame, embarrassment, and the stigma associated with addiction reduced their willingness to access support (rather than feeling like they didn't have a problem). While these emotions may not directly influence their motivation to drink, they play a significant role in lowering their motivation to seek help, reinforcing a cycle of avoidance and isolation.

"Embarrassed, feel ashamed, impact of people finding out, Sacred to admit it. Scared they can't stop, fearful of losing something. Shame of going to AA."

Female, aged 65+, approaching risky levels of drinking

The nature of addiction can make it difficult to stop drinking

Residents who were risky and, or dependent drinkers, highlighted the role that withdrawal plays in their attempts to stop drinking. Residents said experiences of cravings and physical or emotional triggers during withdrawal make it difficult to stop. Additionally, some residents who tried to quit by going cold turkey reported extreme withdrawal symptoms such as seizures which were more damaging to their health than their drinking. This overrides their motivation to stop drinking to avoid experiencing these side effects. Therefore, it is important that risky and, or dependent drinkers receive tailored support, including medical treatment to help them through their detox and quit attempt. It is important for this group to feel supported outside of the detox period to help keep them motivated to stop drinking.

"Tried so hard to begin with (2 weeks cold turkey- then had seizures.) Doctor told me to still drink but take it lightly. Fits and seizures if going cold turkey."

Male, aged 55-64, risky and, or dependent drinker, vulnerably housed

4.2.1.3 What would motivate people to reduce or stop drinking?

Health consequences of alcohol

Those approaching risky levels of drinking were aware of the negative impact of alcohol on their mental and physical health. This includes acknowledging that drinking alcohol can exacerbate existing mental health conditions such as anxiety or depression. This increased their motivation to stop or reduce their drinking because they were aware it was having a negative impact on their mental and physical health. Therefore, health messaging presents an opportunity to prompt individuals to reconsider their drinking behaviours and make positive changes.

"And this is the problem with alcohol. It doesn't matter how much you drink, how often you drink, it will have an effect on your health."

Female, aged 45, risky and, or dependent drinker, vulnerably housed, Hastings

Financial implications

Those approaching risky levels of drinking reported that they found drinking alcohol expensive. This was especially associated with those who were going out to drink, rather than drinking at home. Risky and, or dependent drinkers who have successfully quit drinking reported that only when they stopped drinking, they realised how much they were saving by not drinking. This suggests that promoting how much money people could save by not drinking could help motivate residents to change.

"When you stop drinking, stop doing drugs, you realise you have more money to put towards good things."

Male, aged 41, risky and, or dependent drinker, homeless

Resident findings indicate that one of the key drivers of risky and, or dependent drinking is its habitual and addictive nature. In the COM-B Model, this is known as automatic motivation (behaviours driven by impulses and cues) rather than reflective motivation (conscious decision-making and reflection). Residents experiencing automatic motivation find it difficult to change their behaviour.

In light of this, what did professional stakeholders have to say?

- Dependent drinking is often rooted in past trauma or used as a coping mechanism. Despite this, dual diagnosis and co-occurring mental health conditions are poorly understood and stigmatised.
- Early interventions are important – stakeholders such as VCFSE organisations, employers and gyms should proactively engage people early in their relationship with alcohol, before dependency develops.
- A holistic approach should be taken, addressing individuals unique needs to prevent people reaching crisis point, including specialist support and counselling where appropriate.

4.3 Alcohol-related strategic recommendations

Insights from local communities and stakeholders have highlighted several factors to help residents to cut down and stop their risky and, or dependent drinking. Informed by the insight findings, a set of practical recommendations have been made and should be considered collectively rather than in isolation. These actions are not intended to suggest starting from scratch; rather, they are designed to build on and strengthen the good work already underway to help residents cut down and stop their risky and, or dependent drinking in East Sussex.

Given the differences in experiences and needs between risky and, or dependent drinkers and those approaching risky levels of drinking, recommendations for each group are provided. Recommendations do not appear to change according to age group, for example there were no clear differences between those under and over age 45.

These recommendations have been prioritised in collaboration with stakeholders across East Sussex during a coproduction workshop (see Appendix, Section 7.2, Table 2 for details of who was involved). This has allowed us to determine what are the most urgent recommendations alongside identifying which stakeholders can be involved in the delivery of these recommendations to ensure they are as effective as possible. While some recommendations can be led by East Sussex County Council, many will require collaborative action across health, community, and voluntary sectors. Stakeholders identified the high priority recommendations by selecting those they viewed as the most urgent and important. The remaining recommendations have been categorised based on the insights found through the research phase.

It is important to recognise that prioritisation was shaped by the perspectives of those present at the workshop. While the rankings offer insight into perceived urgency, they do not suggest that other recommendations are less important. All are grounded in the insight gathered and are considered valuable to achieving smokefree outcomes in East Sussex.

A summary of the alcohol-related recommendations, mapped onto the Behaviour Change Wheel (BCW) can be found in the Appendix (Section 0, Table 4).

4.3.1 Recommendations for those approaching risky levels of drinking

Recommendation 1: Encourage the involvement of friends, family and peer networks.

What does the insight say? We know that social norms are influencing people to drink, and there is a need for social support to stop drinking to be amplified (section 4.2.1.1).

COM-B: Opportunity (social)

Priority: High – encouraging the involvement on friends, family and peer networks was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate

Action 1a
How: Promote the benefits of cutting down or stopping drinking with support from others e.g. friends, partners, family members or colleagues. Public messaging and services should encourage people to enlist support from those close to them and highlight how shared activities (such as new hobbies or group membership) can help replace drinking as a central social activity. Support family members and friends to recognise signs of hidden drinking and know how to offer support or signpost help. **Intervention types:** Persuasion, Education
Who to activate: Public health teams, and stakeholders who identify that people are drinking above low-risk levels, e.g. health and care professionals.
Who to target: Priority groups, including adults drinking above low-risk levels, their family members, and close social networks.
Evidence base: Social support is strongly linked to successful reductions in alcohol consumption and sustained behaviour change. Interventions that engage social networks increase motivation and provide practical help for cutting down[33].

Recommendation 2: Increase visibility and accessibility of lower-level support options.

What does the insight say? People don't believe their drinking is bad and believe formal services are "not for me". This is particularly relevant for hidden drinkers, who might experience increased amounts of shame and hesitancy in accessing formal services (section 4.2.1.2).

COM-B: Capability, Motivation (reflective)

Priority: High – increasing the visibility and accessibility of lower-level support options was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate

Action 2a
How: Improve public awareness of low-level alcohol support services (e.g. online resources, helplines, brief interventions, GP-based advice) and consider developing a tiered support pathway with visible "light touch" entry points. Framing and language is important. Promote these options as relevant for anyone who wants to cut down, not just those with serious addiction. Clearly differentiating between those approaching risky levels of drinking and dependent drinkers in public messaging is important, to avoid stigmatising or alienating those who don't identify with the term "problem drinker." Framing it as getting advice for health and lifestyle rather than alcohol problem. This relates to the Trojan Horse Approach, which refers to offering something in a concealed form. Just as the Greeks hid soldiers inside a wooden horse to enter Troy, cutting down or stopping drinking is disguised so that it appears to be something else - disarming, unthreatening, and more likely to be accepted. **Intervention types:** Environmental Restructuring, Education, Persuasion
Who to activate: Stakeholders such as public health terms, health care professionals, VCFSEs, providers who currently support people to cut down/stop drinking.
Who to target: All priority groups, including those who are drinking above low-risk levels.
Evidence base: Framing alcohol support around general health and wellbeing, rather than problem drinking, boosts engagement, especially among those approaching risky

levels of drinking. Positive, non-stigmatising campaigns like DrinkCoach and Drink Free Days help people reflect and take action without feeling judged[34].

Recommendation 3: Improve education, awareness and understanding of alcohol-related risks.

What does the insight say? Many of those approaching risky levels of drinking are not aware their drinking is risky, because everyone around them drinks. As such, their level of drinking is not viewed as harmful, but as typical and unproblematic (section 4.2.1.1).

COM-B: Capability (psychological)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 3a
How: Target children and early education settings in schools, colleges and community groups to provide education about risky behaviours and information about the risks in a tangible and meaningful way. This approach can challenge the perception that drinking is a social norm and equips young people to socialise without it.
Intervention type: Education
Who to activate: Children, Young People and Families Team and Children Services.
Who to target: Children and young people
Evidence base: School and family-based education interventions are found to make a positive contribution to alcohol related harm reduction. To further increase the effectiveness of these interventions, there is a need for them to be personally relevant to the target audience and to be integrated within community interventions to help build community ownership and improve intervention acceptability[35]. Additionally, the start well, live well, age well initiative in Greater Manchester has targeted these interventions for vulnerable young people who are at greater risk of risky dependent drinking to increase harm reduction[36].

Action 3b
How: Develop clear, accessible educational campaigns about what constitutes risky drinking, the short- and long-term harms of alcohol use, and what "safe" drinking looks like in practise. For adults, increase awareness of the warning signs of when casual, social drinking shifts into risky, dependent drinking so people can easily spot the signs in themselves and others, and what they can do next if they have any questions or would like to find further information. Use relatable messaging, not just units, linking guidelines to everyday experiences (e.g. how many drinks over an evening). Recognising that alcohol units are not well understood, create infographics that residents can relate to (e.g. equating the number of units in drinks). Ensure campaigns are visible in community spaces, GP surgeries, pharmacies, workplaces, and across social media. **Intervention types:** Education, Environmental Restructuring
Who to activate: Public Health to lead on making the resources, co-designed with partners across healthcare settings and with people from lived experience backgrounds.
Who to target: All priority groups, particularly those who regularly consume alcohol above low-risk guidelines, as well as the wider community for awareness raising.
Evidence base: Mass media health campaigns about alcohol are often recalled by individuals, and have achieved changes in knowledge, attitudes and beliefs about alcohol[37]. The Drink Free Days campaign showed positive impacts, especially among those drinking above low-risk guidelines, by motivating people to take alcohol-free days and attempt cutting down[38].

Recommendation 4: Raise awareness through Identification and Brief Advice (IBA).

What does the insight say? Many of those approaching risky levels of drinking are not aware their drinking is risky, because everyone around them drinks. As such, their level of drinking is not viewed as harmful, but as typical and unproblematic (section 4.2.1.1).

COM-B: Capability (psychological)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 4a
How: Implement IBA, which is a short face-to-face or digital intervention with individuals to identify their level of drinking (AUDIT-C) and provide advice on how they can reduce alcohol consumption. Advice can include information about the risk of alcohol consumption and some simple, actionable advice on how to reduce consumption (e.g. non-alcoholic drinks and avoiding buying rounds). **Intervention types:** Education, Persuasion
Who to activate: Frontline professionals, such as those in housing, homelessness services, policing, social work, and VCSE's.
Who to target: People who drink at increasing or higher risk levels
Evidence base: Brief Alcohol Interventions (IBA) have strong evidence showing they help people drink less and feel more motivated to change[39]. Further evidence suggests digital versions also work well to reach more people[40].

Recommendation 5: Develop targeted communications that tap into peoples' motivation.

What does the insight say? People are motivated to cut down and stop drinking for financial and health reasons (section 4.2.1.2).

COM-B: Motivation (reflective and automatic)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 5a
How: Messages that hook attention and prompt people into action (e.g. whether that be reflecting on their own drinking behaviour or to get support) should tap into what will motivate them to want to change, for example: When discussing financial savings, make it relatable by highlighting what they could buy with this money. When discussing health, use lessons from hyperbolic discounting to focus on short-term health benefits (such as being less tired and more energetic and saving some money or by making the long-term health benefits feel closer to them rather than further away in the future). **Intervention types:** Persuasion, Incentivisation
Who to activate: Stakeholders committed to reducing alcohol prevalence across East Sussex, who are equipped to create communication and messaging, such as public health teams and community outreach teams. All stakeholders who interact with priority groups can contribute to benefits such as financial gains and short-term health benefits.
Who to target: People drinking above low-risk levels.
Evidence base: Evidence suggests that focusing on immediate rewards over long term gains can improve motivation for behaviour change[38,41]Drinkaware's evaluations show increased engagement when short-term benefits, e.g. improved sleep, skin health and mood are clearly communicated.

Recommendation 6: Encourage and promote 'alcohol-free friendly' venues across the community.

What does the insight say? Being in certain social environments can be a big trigger – there is a need to influence the environment so it's more conducive to the desired behaviour.

COM-B: Opportunity (social and opportunity), Capability (psychological)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 6a
How: Develop an Alcohol-Free Friendly scheme to encourage local venues (e.g. pubs, cafes, restaurants, community spaces) to offer and promote alcohol-free options. This could be modelled on approaches like the breastfeeding-friendly scheme. Participating venues would display a badge to signal they are supportive spaces for people reducing or stopping drinking. The Council should co-design and promote the scheme in partnership with businesses and residents, helping to normalise alcohol-free choices and reduce social barriers to change. **Intervention types:** Environmental Restructuring, Enablement
Who to activate: eDistrict and borough licensing authorities, public health teams, hospitality businesses, community and leisure venues, VCFSE sector.
Who to target: All priority groups, specifically focusing on venues they attend.
Evidence base: While large-scale, formal evaluations of "Alcohol-Free Friendly" schemes specifically are limited, emerging real-world evidence and market trends suggest that creating supportive environments through visible promotion and normalisation of alcohol-free drinks is an effective strategy to encourage reduction in alcohol consumption[42].

Recommendation 7: Create and promote alternative ways to socialise.

What does the insight say? A big barrier to change is how much drinking is a key part of social life. There is a need to support people to see how they can socialise and still cut down their drinking (section 4.2.1.1).

COM-B: Opportunity (physical and social)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 7a
How: Support and promote alcohol-free social activities e.g. community events, walking groups, men's sheds, gym passes, particularly held in communities where drinking is highly normalised as we know travel costs would be a barrier for many. **Intervention types:** Environmental Restructuring, Enablement
Who to activate: Stakeholders such as social prescribers/community connectors, VCFSEs, public health teams, leisure centres.
Who to target: All priority groups, specifically in areas where people may face socioeconomic challenges.
Evidence base: Promoting alcohol-free social activities creates supportive environments that reduce drinking pressures and helps to build social support needed for change. Research shows such activities encourage lower alcohol consumption and support recovery, especially in communities where drinking is common[43].

4.3.2 Recommendations for risky and, or dependent drinkers

Recommendation 8: Ensure access to high-quality, specialist treatment and recovery support.

What does the insight say? Findings in section 4.2.1.1 suggest that this group need specialist support that is flexible and mindful of complex and overlapping needs. There is a need to remove practical barriers to access e.g. travel, working hours, self-referral.

COM-B: Opportunity (physical)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 8a
How: Maintain and expand funding for specialist services like CGL, AA, SMART Recovery, ensuring they can continue offering flexible and responsive support. *"CGL are brilliant, told doctors that they need to send people to CGL, can't keep me away from the place."* **Male, Aged 52, Risky, dependent drinker** **Intervention types:** Enablement, Environmental Restructuring
Who to activate: Stakeholders such as local authorities, healthcare commissioners, specialist service providers, healthcare professionals.
Who to target: Adults with risky or dependent drinking behaviours, including those from priority groups with higher prevalence.
Evidence base: Specialist alcohol treatment services, such as CGL, AA and SMART Recovery have strong evidence supporting their effectiveness in reducing alcohol consumption, improving recovery rates, and enhancing quality of life[44].

Action 8b
How: Ensure accessible, flexible, and trauma-informed pathways for dependent drinkers by doing the following: Remove reliance on self-referral or reaching crisis point by increasing proactive outreach, visiting people where they already are to inform them about available support. Enable people to engage with support in a way that suits them, enabling them to choose how to access support e.g. via telephone, messaging (e.g. WhatsApp) or in-person. Ensure services are trauma-informed, particularly for dependent drinkers, ensuring services are sensitive to those with complex needs. For example, empathise when someone misses multiple appointments, and adopt a more flexible, non-judgemental approach for individuals dealing with issues such as housing or mental health issues. **Intervention types:** Enablement, Environmental Restructuring, Training
Who to activate: Stakeholders such as specialist treatment providers (e.g. CGL), health and care professionals (e.g. social prescribers), outreach workers, VCFSEs.
Who to target: Dependent drinkers, particularly those facing additional barriers to accessing support (E.g. housing, mental health, homelessness).
Evidence base: There is strong evidence that trauma-informed, flexible and outreach-based models increase engagement with dependent drinkers who are typically underserved by traditional services[45].

Recommendation 9: Offer flexible and outreach-based models of care.

What does the insight say? Many people experience barriers to travelling to specialist support and benefit from having support in the community, in trusted places (section 4.2.1.1).

COM-B: Opportunity (physical)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 9a
How: Deliver support where people already are. Do this by collaborating with stakeholders to identify potential venues, and arrange to use familiar, trusted and local settings, visiting people where they already are, for example in foodbanks, community centres and gyms across the most deprived areas of Hastings and Eastbourne, e.g. the Clifton Centre, Deerfold Centre, Seaside community hub. **Intervention types:** Enablement, Environmental Restructuring
Who to activate: Stakeholders involved in supporting risky, dependent drinkers, such as CGL and AA, as well and social prescribers, and other professional/community stakeholders who can review appropriate venues.
Who to target: People drinking at risky or dependent levels, especially those not currently engaged with services; residents in deprived communities who face access barriers (e.g. transport, stigma, digital exclusion); people with co-occurring needs (e.g. mental health, housing, unemployment).
Evidence base: Delivering alcohol support in community-based, familiar venues (such as foodbanks, community centres, and gyms) improves engagement, particularly among people in deprived areas and those with complex needs[46].

Recommendation 10: Promote peer-based recovery communities.

What does the insight say? Findings suggest peer support is important in sustaining recovery. Many people in recovery express a desire for safe, non-judgemental environments where they can connect with others who understand their experiences. These spaces help build resilience, reduce relapse risk, and provide social connection without the pressure or stigma often found in mainstream environments (section 4.2.1.1).

COM-B: Opportunity (social)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 10a
How: Consider the role of East Sussex County Council in supporting the setup of Lived Experience Recovery Organisations (LERO). Invest in community-based support led by people with lived experience, who can truly understand what someone in recovery is going through. Empowering Recovery Champions to 'give back' and deliver peer support in safe, welcoming, and non-judgemental spaces allows people to share their journeys openly and access the help they need without judgement. Support the development of informal community hubs and drop-in centres where people can sustain recovery and reduce feelings of isolation. Inclusive spaces should offer both peer-led recovery support and opportunities for social connection through non-clinical activities, such as gardening, coffee mornings or creative workshops. Helping people build a sense of belonging and purpose. To maximise impact, these services should be integrated with wider systems of care, including drug and alcohol services, primary care, mental health, probation, employment and housing support. **Intervention types:** Environmental Restructuring, Modelling, Enablement
Who to activate: Public health teams, alcohol service providers, people with lived experience of risky dependent drinking, social prescribers, VCFSEs.
Who to target: People in recovery from alcohol use.
Evidence base: Lived Experience Recovery Organisations (LEROs) have been shown to improve engagement, reduce relapse, and increase wellbeing among individuals in recovery[47].

Recommendation 11: In all communications, take a non-judgemental approach.

What does the insight say? We know that barriers to accessing support include feelings of shame, embarrassment, and stigma, and there is a need to address these issues. (section 4.2.1.2).

COM-B: Motivation (reflective and automatic)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 11a
How: Ensure all services are framed as compassionate and non-judgmental, reflecting this in how services are named, branded and described. When promoting services, use messaging that is compassionate, and promotes holistic support for dependent drinkers, acknowledging relapse, complexity and life pressures. **Intervention types:** Persuasion
Who to activate: Communications teams, professional and community stakeholders promoting support for risky, dependent drinkers (including those signposting, referring and delivering).
Who to target: Dependent drinkers across all priority groups, particularly those hesitant about seeking support.
Evidence base: Trauma-informed and person-centred communication improves engagement, retention, and outcomes, especially for people with complex needs[48-50].

Recommendation 12: Support people with overlapping complex needs.

What does the insight say? We know capability to quit is reduced due to complex needs (section 4.2.1).

COM-B: Capability (physical and psychological)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 12a
How: Strengthen partnerships between alcohol services and housing, mental health, social care and employment services. Embed alcohol support within wider wraparound care models for people facing homelessness, poor mental health, or other vulnerabilities. **Intervention types:** Environmental Restructuring, Enablement
Who to activate: Frontline services who routinely support/interact with groups at higher risk of being risky, dependent drinkers.
Who to target: Priority groups with complex needs.
Evidence base: Research shows that multi-agency collaboration leads to better engagement and outcomes for people facing multiple disadvantage[51,52].

4.3.3 Recommended actions for both groups

Recommendation 13: Empower and upskill professional and community stakeholders.

What does the insight say? Stakeholders highlighted an opportunity to improve the detection of early behavioural warning signs of those approaching risky levels of drinking or risky dependent drinking, rather than relying on reactive support for those at crisis point (section 4.2.1.1.)

COM-B: Capability (psychological), Motivation (reflective)

Priority: High – empowering and upskilling professional and community stakeholders was widely recognised as a key priority by participants in the co-production workshop.

When: Immediate

Action 13a

How: Offer training for professional and community stakeholders on tools and techniques to identify risks and give very brief advice. This may include:

Introduction to evidence-based screening tools such as Audit-C (simple 3 question screener).

Conversational skills to use screening tools in a conversational way, rather than simply reading from a sheet which appears tick box and damages rapport.

Recognise the warning signs of risky, dependent drinking.

Motivational interviewing to support conversations with both at-risk and dependent groups.

Use practical learning approaches, such as role play and real-world scenarios, to build confidence in knowing when and how to refer someone, and how to make that referral effective.

Identifying the relationship between wider risk factors like mental health, isolation, and substance use.

Intervention types: Training, Education

Who to activate: The Integrated Care Board (ICB), and other stakeholders, such as those across VCFSE and employees, including teams that routinely visit people in their homes who might encounter 'hidden drinkers'.
Who to target: All priority groups who are approaching risky levels of drinking and risky/dependent drinkers.
Evidence base: All healthcare professionals are trained to screen and deliver brief advice for alcohol use for inpatients[53]. It is important that this training is frequently updated, and that other professionals who come into contact with groups who are approaching risky levels of drinking and risky/ dependent drinkers receive this training, so that they feel properly equipped to deliver these interventions[54].

Recommendation 14: Increase awareness of support and highlight professionals' key role in helping people identify risky drinking and access services.

What does the insight say? Residents and stakeholders have limited knowledge of the full range of support available to them, from help for those who simply want to cut down their drinking to feel healthier, to more structured support for those who recognise their drinking is problematic e.g. risky, dependent drinkers (section 4.2.1).

COM-B: Capability (psychological), Opportunity (physical)

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 14a
How: Improve awareness of resources, information, advice and clearly communicate the full range of support available and communicate the different levels of support: For those wanting to cut down (e.g. One You East Sussex, and digital tools). For those who need more structured, wraparound support (e.g. CGL, AA, recovery hubs). Ensure professional and community stakeholders are aware of these distinctions and feel confident directing people to the most appropriate support. Reduce the burden on individuals by minimising the need to repeat their story and ensuring continuity of care across services to prevent people from falling through the cracks. Ensure this information reaches target communities who are often underserved in services. **Intervention types:** Education, Training, Enablement
Who to activate: All stakeholders involved in promoting/supporting residents to cut down/stop drinking; including those who signpost/refer residents to support. For example, health and care professionals, social prescribers and public health teams.

Who to target: All priority groups who are approaching risky levels of drinking and risky/dependent drinkers, including their social networks.
Evidence base: Existing interventions such as the Spark Initiative run by Blackburn with Darwen Borough Council have dedicated outreach services to ensure the groups who need the most help and support can receive it. This includes engaging with those most at risk of illness or early death, such as those experiencing homelessness or commercial sex workers, and meeting people where they already are[55].

Recommendation 15: Take a holistic, person-centred approach.

What does the insight say? Alcohol is used as a coping mechanism to deal with difficult emotions and life stressors, and drinking can become habitual over time. Addressing these factors is important to sustain behaviour change.

COM-B: Capability, Opportunity, Motivation

Priority: Medium

When: While not identified for immediate action, this recommendation was grounded in resident and stakeholder insights and should be integrated into longer-term planning.

Action 15a
How: Support for people who want to cut down or stop drinking should take a holistic approach, addressing the underlying reasons they drink. Recovery cafés are valued not just for abstinence support but for offering safe, welcoming spaces where people can connect, reduce loneliness, develop skills, and access help with wider issues like mental health or finances. Sustained funding and expansion of such community-based spaces are essential, especially for those who may avoid clinical settings. While these spaces are typically aimed at people in recovery (and likely abstaining from alcohol), a similar model could also support those at risk who don't view their drinking as problematic but are looking to cut down. In such cases, developing a separate, more inclusive wellbeing space, framed around connection and general health rather than "recovery", could help reduce stigma and engage people earlier in their journey. **Intervention types:** Environmental Restructuring, Enablement
Who to activate: Stakeholders committed to promoting general wellbeing of residents, who are currently providing holistic support, such as local cafes, and those who may be able to provide similar support for those approaching risky/dependent levels of drinking, such as CGL and Sussex Partnership NHS Foundation Trust.
Who to target: Priority groups approaching risky levels of drinking/dependent drinkers.
Evidence base: Evidence supports the benefits of community-based spaces in boosting general health and wellbeing of residents[56].

5 Discussion

5.1 Strengths of the research

We gathered 186 insights (120 on tobacco, 66 on alcohol) from 153 East Sussex residents, and from a range of professional stakeholders across different organisations. Some residents provided insights on both topics, hence why the total number of insights exceeded the number of participants. This captured a wide range of perspectives. Our sample included strong representation from groups at higher risk of health inequalities, such as residents from low IMD areas, those in social housing, and people experiencing homelessness, helping to amplify underrepresented voices.

We used a flexible engagement approach, meeting people in familiar settings by attending existing groups and conducting interviews in community spaces. Strong relationships with local professionals and trusted community members enabled us to access these groups. These relationships were important for allowing us to engage and carefully navigate discussions around sensitive topics with residents. This flexible approach also allowed us to conduct opportunistic interviews in the community, enabling us to engage with those who may not usually come forward to take part in traditional research methods.

Using the COM-B model to structure our findings allowed us to pinpoint what aspects need to be addressed to change behaviour. It provided a clear structure for analysing behaviours, identifying both barriers and enablers to change. This approach offers practical, actionable insights that can inform the design of future interventions, bridging the gap between theory and practical intervention design.

5.1.1 Limitations of the research

Despite targeted outreach, participation from the LGBTQIA+ community (n=15) was lower than other groups. As a result, while we gathered valuable insights from this community, it was not possible to tease out differences due to the small sample size.

Our sample of routine and manual workers (n=26) was weighted towards construction and trade workers, with fewer participants from other occupations. This was due to limited opportunities to engage with this group and members being hesitant to come forward to participate.

Our overall sample was also more weighted towards males (52%) than females (33%), although it's worth noting 14% preferred not to say. Therefore, some of the findings may not accurately reflect patterns, behaviours or experiences of the female population.

Nevertheless, males are found to consume higher number of units and are a target group for alcohol reduction.

5.1.2 Reflections on the Research Process

Understanding tobacco and alcohol-related behaviours in East Sussex required more than a structured approach, it required empathy, adaptability, and collaboration. This section reflects on what it felt like to do this work: the emotional impact of hearing people's stories, the value of local relationships, and the importance of meeting communities where they are.

Engaging Stakeholders

Early engagement through a stakeholder webinar helped build trust and ensured the research was shaped by local insight from the outset. Community partners played a vital role, connecting us with residents, organising focus groups, and providing access to trusted spaces. Their commitment, despite competing demands, highlighted the shared motivation to reduce harm and improve health outcomes.

Engaging Communities

Engaging participants in this research required careful planning and ongoing reflection. Many of the residents we spoke to shared deeply personal stories about addiction, recovery, loss, and resilience. These conversations were often raw and emotional, highlighting the importance of creating spaces where people feel heard, not judged.

To support this, we developed safeguarding protocols, used flexible interview formats, and prioritised post-engagement debriefs supporting both participants and researchers throughout.

This work was emotionally demanding, and we were reminded that ethical research involves care on both sides. Making space to reflect and support one another as a team was important throughout the research process.

Listening to LGBTQIA+ residents

While participation from LGBTQIA+ residents was lower than hoped, those who did engage shared powerful stories about stress, and exclusion. These insights were difficult to hear but important. They highlighted how coping behaviours like smoking often stem from environments that feel unsafe or unwelcoming. This reminded us that true inclusion requires more than open invitations. It requires long-term, trust-based relationships and outreach developed with and by LGBTQIA+ organisations.

Meeting people where they are

Face-to-face engagement proved far more effective than online promotion. Approaching residents in public spaces and community settings led to more authentic interactions, though engaging certain groups, like routine and manual workers outside of the construction sector, remained challenging. This reinforced the need for embedded, flexible outreach and highlighted the importance of showing up consistently in spaces where people feel comfortable.

We know the public health team is committed to building trusted relationships with all the priority groups engaged in this research process, making efforts to ensure their voices are not just included in population health improvement. This research highlights the value of this and the importance of ongoing, proactive engagement, meeting communities on their own terms, and ensuring that interventions are shaped by the realities of those they aim to support.

5.1.3 Implications for further research

The recommendations in section 3.3 and 4.3 lay out key actions informed by this research. During co-production workshops we re-engaged stakeholders to prioritisation of actions, highlighting 9 that are considered urgent.

However, bringing them to life requires coordinated effort. We recommend:

- Mapping out potential delivery partners across statutory, community, and voluntary sectors
- Continued collaboration with stakeholders to determine ownership and accountability of the actions.
- Conducting targeted follow-up research in areas identified as gaps (e.g. with communities who have not engaged with recent communication and awareness campaigns to understand what messages resonate with them).

The co-production workshops illustrated the importance of continued collaboration between stakeholders to ensure they are aligned, informed, and working collectively to serve the public to the best of their ability.

5.1.4 Concluding remarks

This research gathered key insights from residents on their experiences, attitudes, and behaviours around tobacco and alcohol. These insights reflect a wide range of lived experiences, highlighting the complex personal, social, and environmental factors that shape smoking and drinking behaviours.

Using the COM-B behaviour change model helped generate practical, actionable recommendations grounded in lived experience and behavioural theory.

Together, these findings provide a strong evidence base to guide future tobacco and alcohol-related work in East Sussex. They highlight the importance of early intervention, non-judgemental support, and holistic approaches that reflect the wider context of people's lives. Progress is dependent on collaboration, bringing together local authorities, health services, community organisations, and residents to design more person-centred solutions. This work will help shape more equitable, accessible, and effective support for those who want to cut down or quit smoking or drinking.

6 References

1. Michie, S., van Stralen, M. M. & West, R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement. Sci. IS* 6, 42 (2011).

2. Prochaska, J. O. & DiClemente, C. C. Stages and processes of self-change of smoking: Toward an integrative model of change. *J. Consult. Clin. Psychol.* 51, 390–395 (1983).

3. Fogg, B. A behavior model for persuasive design. in *Proceedings of the 4th International Conference on Persuasive Technology* 1–7 (Association for Computing Machinery, New York, NY, USA, 2009). doi:10.1145/1541948.1541999.

4.).

26. NCSCT. *Working with Vape Shops: A Guide for Commissioners and Stop Smoking Services*. (2024).

27. Essex County Council delivers stop smoking support via vape shops. *GOV.UK* https://www.gov.uk/government/case-studies/essex-county-council-delivers-stop-smoking-support-via-vape-shops.

28. Rahman, N., Sebar, B. & Sofija, E. Co-designing a Vaping Cessation Program for Australian Young Adults: A Conceptual Model. *Nicotine Tob. Res. Off. J. Soc. Res. Nicotine Tob.* 27, 457–465 (2025).

29. Dyson, J., Skinner, J., Crick, J. & Crooks, M. G. Designing an intervention to help the quitters quit: A qualitative, intervention co-design study. *PEC Innov.* 2, 100141 (2023).

30. Cahill, K. & Lancaster, T. Workplace interventions for smoking cessation - Cahill, K - 2014 | Cochrane Library.

31. Kava, C. M. *et al.* A qualitative assessment of the smoking policies and cessation activities at smaller workplaces. *BMC Public Health* 18, 1094 (2018).

32. Alcohol-use-disorders-identification-test-for-consumption-AUDIT-C_for-print.pdf.

44. Kelly, J. F., Humphreys, K. & Ferri, M. Alcoholics Anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database Syst. Rev.* 3, CD012880 (2020).

45. Public Health England. Better care for people with co-occuring mental health and alcohol/drug use conditions. (2017).

46. Porthé, V. *et al.* Community-Based Interventions to Reduce Alcohol Consumption and Alcohol-Related Harm in Adults. *J. Community Health* 46, 565–576 (2021).

47. Part 1: introducing recovery, peer support and lived experience initiatives. *GOV.UK* https://www.gov.uk/government/publications/recovery-support-services-and-lived-experience-initiatives/part-1-introducing-recovery-peer-support-and-lived-experience-initiatives.

48. Person-Centred Care in Addiction Treatment. *Rehab 4 Alcoholism* https://www.rehab4alcoholism.com/alcohol-treatments/person-centred-care.

49. Mills, K. L. The importance of providing trauma-informed care in alcohol and other drug services. *Drug Alcohol Rev.* 34, 231–233 (2015).

50. Bradley, K. A. & Kivlahan, D. R. Bringing Patient-Centered Care to Patients with Alcohol Use Disorders. *JAMA J. Am. Med. Assoc.* 311, 1861–1862 (2014).

51. Public Health England. Better care for people with co-occuring mental health and alcohol/drug use conditions. (2017).

52. Luchenski, S. *et al.* What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The Lancet* 391, 266–280 (2018).

56. Jones, M., Kimberlee, R., Deave, T. & Evans, S. The role of community centre-based arts, leisure and social activities in promoting adult well-being and healthy lifestyles. *Int. J. Environ. Res. Public. Health* 10, 1948–1962 (2013).

57. Understanding the Wheel - The Behaviour Change Wheel Book - A Guide To Designing Interventions. https://www.behaviourchangewheel.com/about-wheel.

7 Appendix

7.1 Resident sample characteristics

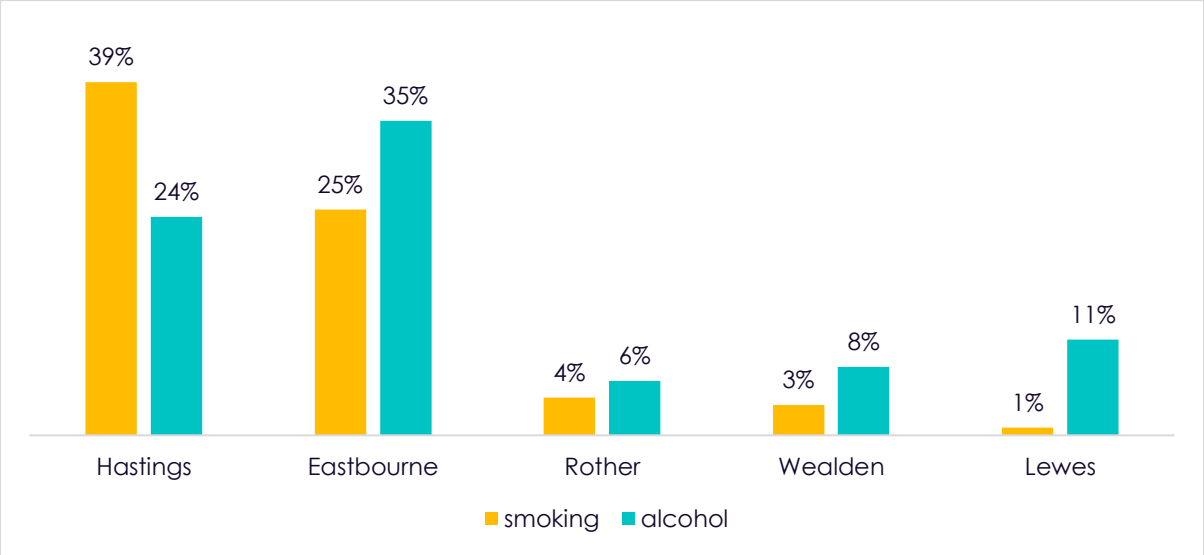


Figure 4 Areas represented by residents for smoking sample (n=120) and alcohol sample (n=66)

N.B Some residents did not provide a postcode. The total for the samples is smoking (n=33) and alcohol (n=11). These have been omitted from the chart, leading to charts not equalling 100%.

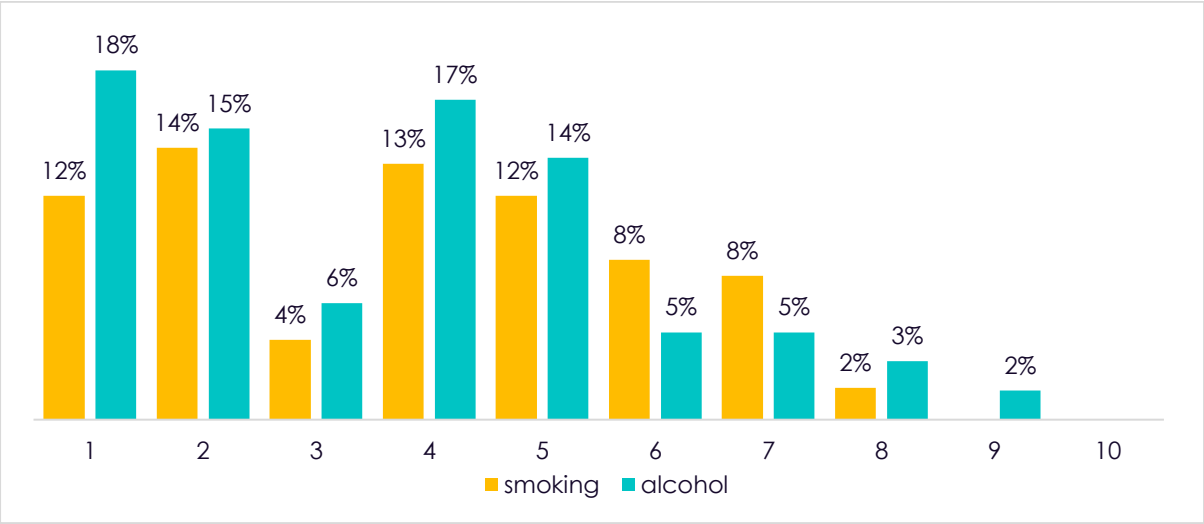


Figure 5 IMD areas represented by residents for smoking sample (n=120) and alcohol sample (n=66).

N.B Some residents did not provide a postcode. The total for the samples is smoking (n=33) and alcohol (n=11). These have been omitted from the chart, leading to charts not equalling 100%

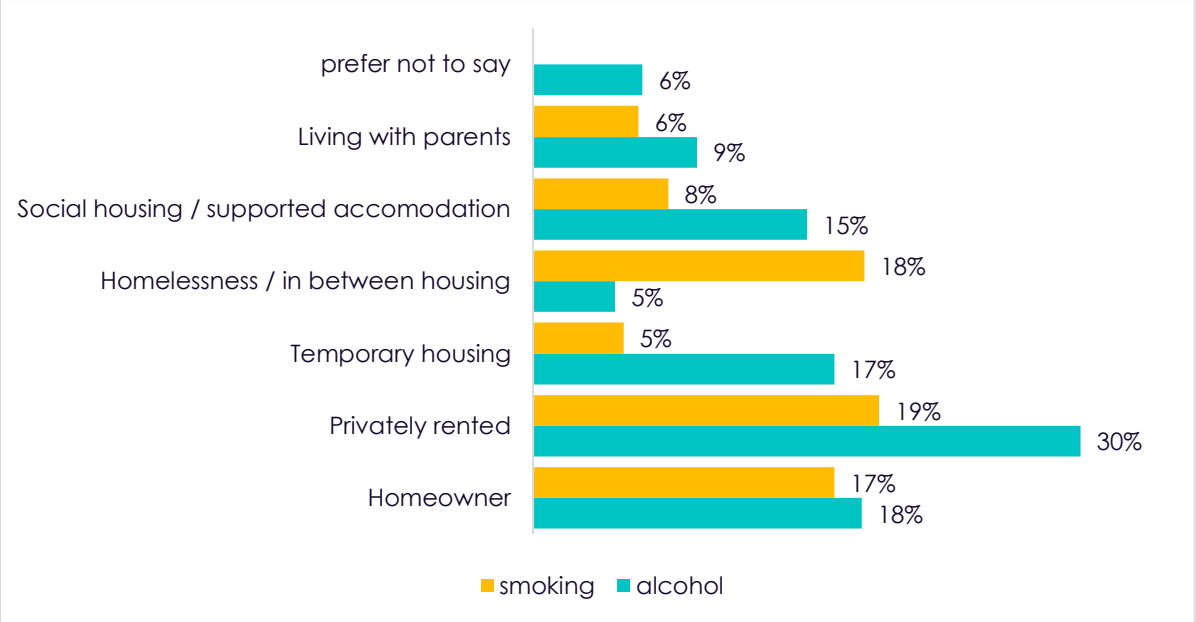


Figure 7 Housing status of residents who engaged in discussions around smoking (n=120) and alcohol (n=66).

N.B Some residents did not provide their hosing situation. The total for the samples is smoking (n=33) and alcohol (n=11). These have been omitted from the chart, leading to charts not equalling 100%

7.2 Professional sample characteristics

Table 1 Professional stakeholder's organisations, roles and involvement.

Organisation	Job role	Provided insights relating to…	
		smoking	alcohol
Community Pharmacist	Deputy Chief Officer	✓	✓
Trading Standards	Enforcement and Investigations Manager	✓	
Seaview	Chief Officer		✓
	Business Manager		✓
	Alcohol Outreach Team		✓
One You East Sussex (OYES)	Stop Smoking Lead	✓	
	Health Coach	✓	
East Sussex Council	Team Lead - works with at risk of homelessness or temporary accommodation	✓	✓
East Sussex Public Health	Smoking Cessation	✓	
NHS Health Checks and Alcohol	Health Improvement Specialist		✓
ADFAM	East Sussex Family Support Lead		✓
CGL	Lead nurse for the drug and alcohol services		✓
	Deputy Services manager		✓
Children's integrated therapies and school health service	Programme Manager		✓
East Sussex Healthcare NHS Trust	Strategic lead midwife for tobacco dependency	✓	

Alcoholics Anonymous	Public information Liaison Officer		✓
Vape retailer	Local vape retailer in Priory meadows shopping centre	✓	

Table 2: Co-production Workshops Attendance

Organisation	Job role	Engaged in the following co-production workshops…	
		tobacco	alcohol
East Sussex County Council	Health Improvement Specialist (Physical Activity, Obesity and Tobacco)	✓	✓
	Health Improvement Specialist (Tobacco Lead)	✓	
	Health Improvement Specialist (NHS Health Checks and Alcohol)		✓
	Health Improvement Specialist (Children, Families and Schools)	✓	
	Project Manager Apprentice (Tobacco Team)	✓	✓
	Project Manager (Respiratory Conditions)	✓	
CGL	Team Leader in Eastbourne	✓	
	Consultant Psychiatrist		✓
	Business Development Manager		✓
	Deputy Services Manager		✓
East Sussex Recovery Alliance	Executive		✓
	Chair		✓
One You East Sussex (OYES)	Stop Smoking Lead	✓	
	Head of Service		✓
	Stop Smoking Advisor	✓	
	Stop Smoking Advisor	✓	
	Primary Care Liaison Officer	✓	

Clinical Outcomes and Effectiveness team, NHS Sussex	Manager (Tobacco Dependency Programme)	✓	
Niche CBS	Housing Support Officer	✓	✓
	Housing Manager		✓
Sussex Partnership NHS	Mental Health Nurse		✓
University Hospitals Sussex	Clinical Nurse Specialist		✓
NHS Sussex	GP		✓
East Sussex NHS Trust	Strategic Lead for Tobacco Dependence Treatment Services	✓	
Eastbourne Foodbank	Safeguarding Lead		✓
Black Butterfly	Co-founder		✓
Hastings Voluntary Action	Director		✓

7.3 Intervention types

Intervention type	Description
Education	Increasing knowledge or understanding
Persuasion	Using communication to induce positive or negative feelings or stimulate action
Incentivisation	Creating an expectation of reward
Coercion	Creating an expectation of punishment or cost
Training	Imparting skills
Restriction	Using rules to reduce the opportunity to engage in the target behaviour (or to increase the target behaviour by reducing the opportunity to engage in competing behaviours)
Environmental restructuring	Changing the physical or social context
Modelling	Providing an example for people to aspire to or imitate
Enablement	Increasing means/reducing barriers to increase capability (beyond education and training) or opportunity (beyond environmental restructuring)

*Descriptions are lifted from Michie et al (2014) The Behaviour Change Wheel: A Guide to Designing Interventions[57]

7.4 Recommendations

Table 3: Summary of the smoking-related recommendations mapped onto the BCW

Smoking-related recommendations	COM-B criteria	Actions*	Intervention types
1. Increase awareness and improve communication of support options – harness the role of community leaders	Capability, Opportunity	1a. Clearly communicate the full range of support available through stop smoking services	Education, enablement
		1b. Equip key professionals and community leaders with resources and skills to be able to play a key role in promoting available services	Training, enablement
2. Challenge misconceptions and normalise seeking support	Capability, Motivation	2a. Develop a community-informed campaign to debunk the 'cold turkey' myth, using clear, relatable messaging and stakeholder support.	Education, persuasion
		2b. Create communication and messaging to normalise multiple quit attempts	Education, persuasion
3. Encourage people to become smokefree with someone else	Opportunity	3a. Review the One You East Sussex pathway to support buddy-based quitting, explore virtual peer support options, and promote the benefits of quitting with someone close.	Environmental restructuring, persuasion

4.	Support accessibility and flexibility – make it easy to get support	Opportunity	4a. Ensure residents are aware of flexible telephone and in-person support options from One You East Sussex, while expanding outreach.	Environmental restructuring, enablement, education
			4b. Ensure services are trauma-informed, and sensitive to those with complex needs.	Enablement, training
5.	Frame messages to focus on the immediate benefits of becoming smoke free	Motivation	5a. Emphasise immediate financial gains of becoming smokefree.	Education, persuasion and incentivisation
			5b. Consider promoting other short-term physical benefits such as better taste and smells, improved performance in physical activities and sports	Education, persuasion, incentivisation
			5c. Encourage people who have quit to share their stories	Modelling, persuasion
6.	Conduct further research with communities to understand what messages resonate with them	Capability	6a. Conduct further research with communities who have not engaged with recent communication and awareness campaigns	Education, persuasion
7.	Consider strengthening and expanding current interventions	Capability, Motivation	7a. Promote access to incentives for those eligible	Incentivisation, education

	which include providing residents with financial incentives to become smoke free.		for the maternity incentive scheme.	
			7b. Consider expanding the current incentive programme beyond maternity schemes and piloting this in groups with higher smoking prevalence	Incentivisation, enablement
8.	Encourage healthier ways to cope, highlighting that being smoke free is associated with lower stress levels	Capability, Motivation	8a. Highlighting that support is available to help manage stress right now, and that many people feel calmer and more in control within days of quitting.	Education, persuasion
9.	Reframe quit support for 'independent quitters'	Capability, Motivation	9a. Reframe quit support for ‘independent quitters’ by promoting tools like the Gloji App as self-guided aids, using autonomy-focused messaging.	Education, persuasion
10.	Facilitate collaboration among stakeholders	Opportunity	10a. Establish collaborative working groups between vape retailers and stop smoking services to explore shared goals, training opportunities, and referral pathways	Environmental restructuring, education, training, enablement
			10b. Co-produce a pathway that will support residents	Enablement, Environmental Restructuring

		to stop using nicotine entirely	
11. Promote smokefree and supportive environments	Opportunity	11a. Engage workplaces and community stakeholders to promote smokefree environments by equipping stakeholders to offer tailored quit support and integrate smoking cessation into broader workplace wellness strategies.	Education, enablement, environmental restructuring, persuasion

*Further details about the actions and recommendations are found in Section 3.3.

Table 4: Summary of the alcohol-related recommendations mapped onto the BCW

Recommendations	COM-B criteria	Actions*	Intervention types
Recommendations for those approaching risky levels of drinking			
1. Encourage the involvement of friends, family and peer networks	Opportunity	1a. Encourage using shared activities to replace drinking and help loved ones recognise hidden drinking signs.	Persuasion, education
2. Increase visibility and accessibility of lower-level support options	Capability, Motivation	2a. Increase awareness of low-level alcohol support with clear, stigma-free messaging for anyone wanting to cut down	Environmental restructuring, education, persuasion
3. Improve education, awareness and understanding of alcohol-related risks	Capability	3a. Educate children and young people about risky behaviours, empowering them to share this knowledge at home	Education
		3b. Create clear, relatable campaigns explaining risky drinking, its harms, and what safe drinking looks like	Education, environmental restructuring
4. Raise awareness through Identification and Brief Advice (IBA)	Capability	4a. Implement IBA—brief face-to-face or digital sessions using AUDIT-C to assess drinking levels and offer practical advice	Education, persuasion
5. Develop targeted communications that tap into peoples' motivation	Motivation	5a. Use attention-grabbing messages that motivate change by connecting to personal values	Persuasion, incentivisation

6. Encourage and promote 'alcohol-free friendly' venues across the community	Capability, Opportunity	6a. Participating venues to signal they are supporting spaces for people reducing or stopping drinking	Environmental restructuring, enablement
7. Create and promote alternative ways to socialise	Opportunity	7a. Promote alcohol-free social activities like community events, walking groups, and gym passes	Environmental restructuring, enablement
Recommendations for risky and, or dependent drinkers			
8. Ensure access to high-quality, specialist treatment and recovery support	Opportunity	8a. Maintain and expand funding for specialist services like CGL, AA, SMART Recovery.	Enablement, Environmental Restructuring
		8b. Ensure accessible, flexible, and trauma-informed pathways for dependent drinkers	Enablement, environmental restructuring, training
9. Offer flexible and outreach-based models of care	Opportunity	9a. Deliver support where people already are	Enablement, Environmental Restructuring
10. Promote peer-based recovery communities	Opportunity	10a. Consider the set up of lived experience recovery organisations and support the development of informal hubs and venues.	Environmental restructuring, modelling, enablement
11. In all communications, take a non-judgmental approach	Motivation	11a. Ensure all services are framed as compassionate and non-judgmental	Persuasion

12. Support people with overlapping complex needs	Capability	12a. Strengthen partnerships across organisations to embed alcohol support within holistic care for vulnerable individuals	Environmental restructuring, enablement
Recommendations for both groups			
13. Empower and upskill professional and community stakeholders	Capability, Motivation	13a. Offer training for professional and community stakeholders on tools and techniques to identify risks and give very brief advice	Training, education
14. Increase awareness of support and highlight professionals' key role in helping people identify risky drinking and access services.	Capability, Opportunity	14a. Improve awareness of resources, information, advice and clearly communicate the full range of support available and communicate the different levels of support	Education, enablement, training
15. Take a holistic, person-centred approach	Capability, Opportunity, Motivation	15a. Support holistic, community-based recovery spaces that offer safe, welcoming environments for connection and wellbeing,	Environmental restructuring, enablement

*Further details about the actions and recommendations are found in Section 4.3.

make better happen

For further information please contact us:

insight@icecreates.com

ice

+44 (0)845 519 3423
ideas@icecreates.com
www.icecreates.com
@ice_creates
ice creates ltd
ice

Northwest
2 Abbots Quay, Monks Ferry
Wirral. CH41 5LH
+44(0)151 647 4700

Northeast
Brookside Farm, Croglin
Cumbria. CA4 9RZ
+44(0)1768 896 017

Coventry
2nd Floor, John Sinclair House,
Canal Basin, Coventry. CV1
4LY +(0)800 122 3780

Devon
Taddiforde suite, 3rd Floor,
Exeter Community Centre, 17
St. Davids Hill, Exeter. EX4 3RG
+44(0)800 122 3866

West Midlands
YMCA, 38 Carters Green,
West Bromwich B70 9LG
+44(0)800 612 4580

Registered in England
ICE Creates Ltd No 3881965