Alcohol Concern
Promoting health; improving lives

Alcohol Concern’s Blue Light Project

Working with change resistant drinkers

The Project Manual

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First Edition

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Mark co-facilitated and developed their Train the Trainer sessions and co-wrote the Train the Trainer workbook.

He continues to be a member of the Alcohol Learning Centre's Steering Group and moderates the IBA trainer forum.

Introduction

In 2011 a man was murdered by his former wife in Rochdale. For decades, he had subjected her to abuse and the homicide was the tragic result.

The subsequent inquiry into the case described the man as having a "chronic addiction to alcohol," and went on to say that: "Appropriate referrals were made to addiction and medical services. He had a stubborn resistance to engaging with them, preferring it seems to continue his drinking unabated whilst deliberately avoiding medication. On occasions he refused permission for referrals. Services cannot be effective unless the client wants to change..."[1]

The perception exists that if a problem drinker does not want to change, nothing can be done to help until the person discovers some motivation. This message has been repeated many times over the years and is still heard frequently.

Sometimes from specialists themselves:

+ If the substance abuser does not wish to change or does not believe that change is possible, no treatment programme, no matter how complete or excellent, is likely to yield positive results.[2]
+ If a client is in denial there is little we can do to help them.[3]

Alcoholics Anonymous's preamble states that:

+ The only requirement for membership is a desire to stop drinking.[4]

Alcohol Concern's Blue Light Project challenges this approach. It shows that positive strategies and alternative approaches can be used with this client group.

More importantly using them will target some of the most risky, vulnerable and costly individuals in society.

Why bother?

It can be argued that if people don't want to change we should: "let them get on with it". Indeed, this can be seen as therapeutic.

If we intervene before the person wants to change we are slowing their progress towards their real 'rock bottom' moment: the point at which things become so bad that the drinker decides to stop.

The problem is that at any one time the vast majority of problem drinkers are not engaged in services or even a process of change.

The Department of Health's 2005 Alcohol Needs Assessment Research Project proposed that engaging 15% of local problem drinkers into treatment would be an average level of access.[5] This begs the question: what happens to the 85% who are not changing their drinking? More recently Public Health England has refined this figure and suggests that 94% of dependent drinkers are not engaged with services.[6]

This is a very large group of needs to ignore.

More importantly this is a group of people which contains some of the most risky and vulnerable members of the community. They will include: those with criminal justice histories[7], personality disorders[8] and/or mental illness.[9]

Many of these difficult to engage clients will be the focus of concern in other parts of the health, social care and criminal justice system. They will be the frequent attender in the hospital system, the perpetrator of anti-social behaviour, the nuisance 999 caller and the repeated arrestee.

Since 2011, local authorities have been required to undertake a Domestic Homicide Review after local homicides related to domestic abuse.[10] Since their inception approximately 100 of these reviews have been undertaken nationally.

Alcohol Concern examined 24 of these reports. In this randomly chosen sample, alcohol played a significant contributory role in 75% and in most of these cases perpetrators and, sometimes victims, were treatment resistant drinkers.[11]

In tackling alcohol's impact on chronic health conditions, violence or anti-social behaviour, many of the people society most needs to target are drinkers who appear not to be ready to change.

The pinch point

This approach impacts most acutely on the pathway between frontline generic services and specialist alcohol agencies.

It is a specific and often voiced concern of non-specialist services that alcohol services do not work well with difficult to engage problem drinkers.

A series of training needs analyses with non-specialist workers in Birmingham has highlighted that the issue that they most want training on is not identification or one to one interventions but "how to work with difficult to engage drinkers". The same message has come out in consultations with housing workers in Surrey and probation officers in Wandsworth.[12]

This is not a criticism of alcohol services. In most areas, they have long been underfunded 'Cinderella' services that have managed potentially unfeasible caseloads by concentrating on those who are ready to change their drinking.

This has been supported by the argument that it is therapeutically appropriate to concentrate on this group while the others are allowed to reach their personal rock bottom.

Such an approach has always been open to challenge but it is now particularly hard to justify because:

+ Public services are very focused on particular outcomes such as preventing emergency hospital admissions, domestic abuse or crime and anti-social behaviour, all of which are highly associated with non-changing drinkers.
+ An approach which focuses on clients who are motivated will effectively perpetuate the exclusion of those who are already most socially excluded.

This begs the question:

What happens to the 85% who are not changing their drinking?

An under-developed area

Little guidance exists on how to deal with this group. Models of Care for Alcohol Misusers mentions clients who need "multiple treatment episodes" but does not provide any significant guidance on what to do with this group.[13]

Other texts such as the various NICE guidance documents on tackling alcohol misuse[14] and even classic reference works like Professor Griffiths Edwards' **The Treatment of Drinking Problems**[15] fail to provide guidance on how to deal with those who do not want to change their drinking.

An alternative approach and a starting point

This guide offers an alternative. It is not a magic solution, but it does set out strategies and approaches that specialist and non-specialist workers can consider in working with this client group.

However, this guide is just a starting point. The authors' hope is that very soon this document will be out of date as workers come up with new techniques and approaches to target this client group.

This is not meant to be the definitive statement on working with treatment resistant drinkers; its main aim is to inspire workers to explore this issue. We believe that only by developing this skillset will alcohol services achieve the central importance and enlarged funding that they deserve.

The evidence base

No single evidence base exists for this piece of work. Instead it rests on four main supports:

+ National and international evidence – this is clearly indicated through the references
+ Lessons from domestic homicide reviews, other homicide inquiries and other serious incident reviews
+ The experience of Alcohol Concern and its consultancy team, and
+ The peer input and peer review provided by the many staff from the partners to the Blue Light Project.

Acknowledgements

The authors would like to thank the very many people who have contributed to this work. These include Martyn Penfold and Michael Pierce with whom we had many discussions.

We also need to thank Carol Lyons in Wigan who was the first person to support the Blue Light Project, Christine Jackson in Hampshire and Cathy McMahon in Bath & NE Somerset who were also early adopters and all the commissioners and staff who supported the Blue Light Project.

Ian Kershaw in Sutton deserves gratitude for the term Blue Light clients. Above all we would thank the hundreds, if not thousands, of workers and clients we have encountered who have all contributed small parts to this patchwork quilt of a text. Lastly, we would thank Iain Armstrong, Don Lavoie, Julie Daneshyar, John Liddell, Sean Meehan, Alison Keating and their colleagues at Public Health England for their moral support.

The full list of the partners to the Blue Light Project is as follows:

- Aquarius
- Bath & NE Somerset
- Blackpool
- City of London
- Dudley
- Hampshire
- Herefordshire
- Lincolnshire
- Liverpool
- Medway
- Newcastle
- North Lincs
- Northumberland
- Shropshire
- Southend
- South Tyneside
- Suffolk
- Surrey
- Swanswell
- Thurrock
- Warwickshire
- Wigan
- Wiltshire

Who are the clients?

This section provides a description of the client group and some detail on the burden they place on society.

Ultimately this is a very large group i.e. anyone who is at risk of alcohol related harm but who is not ready to change. However, the focus of this guide is the 'Blue Light' clients – higher risk and dependent drinkers who are not only treatment resistant but are also placing a significant burden on public services.

How many? — An overview

The Department of Health's Alcohol Ready Reckoner estimates that a borough of 350,000[16] people with average level of needs will have:

Harmful/Higher Risk Drinkers[17]	**12,134**
Dependent Drinkers	**10,438**

If we assume 85% of the higher risk and 94% of dependent drinkers are not engaging this would equate to:

Higher risk	**10,313**
Dependent	**9,811**

The figures above provide the broad framework for the number of treatment resistant drinkers. However, the actual number of clients who are of significant concern will be far smaller. These are the Blue Light clients.

Defining the Blue Light group

Defining the Blue Light client group is important. It will:

+ Provide an indication of the size and cost burden of the group; and
+ Determine who are the target for the interventions described in this guide.

No one estimate can be developed for this group: it will depend on who is deemed to be the greatest burden. Each area of the country could have different priorities when considering this.

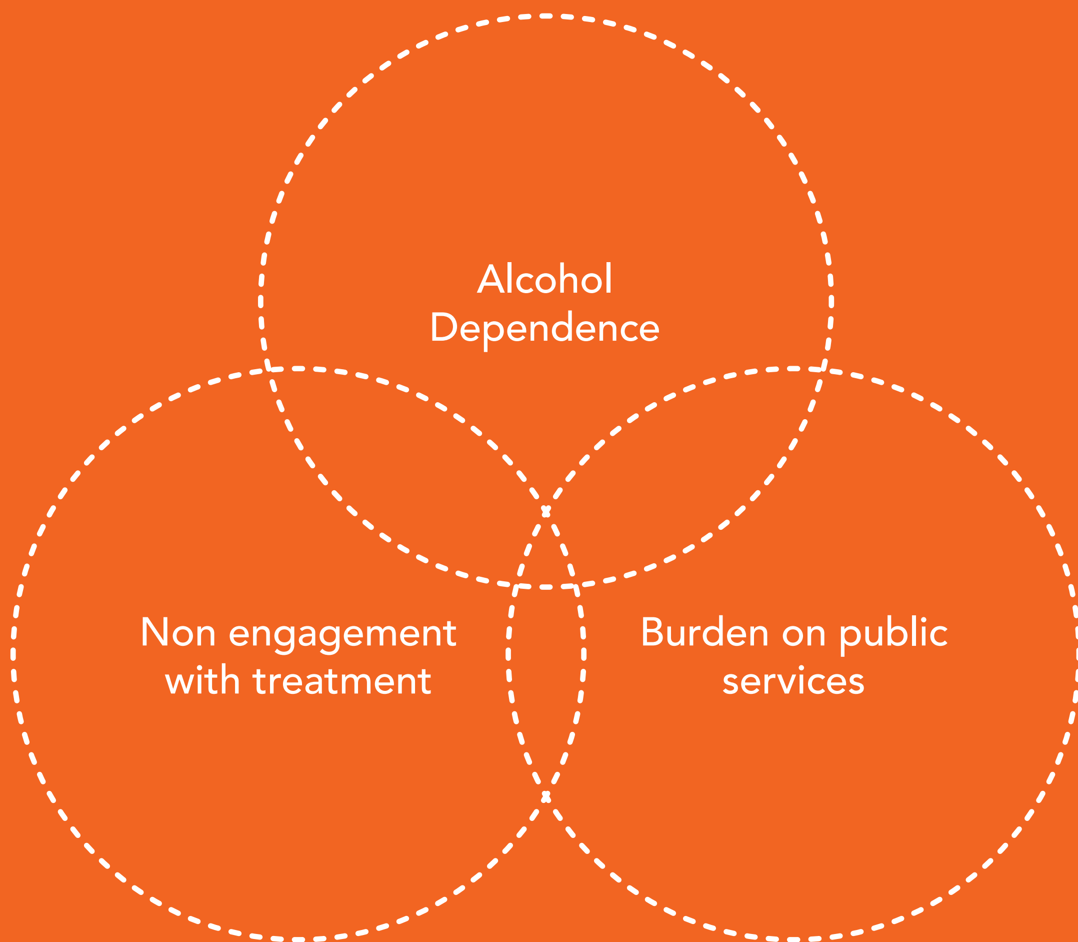
In some areas hospital admissions might be the priority, in others community safety. Therefore, the definition below is a broad brush approach that is designed to be flexible enough to allow the targeting of different priority groups.

The definition describes three aspects:

+ The alcohol problem
+ The pattern of not engaging with or benefiting from alcohol treatment
+ The burden placed on public services (either directly or via the burden they place on others e.g. their family).

Diagram 1:

The Blue Light Client



Our suggested definition is set out below:

An alcohol problem

- Have an enduring pattern of problem drinking, dating back at least ten years **&**
- Score 20+ on AUDIT **or**
- Be classified as dependent on SADQ (16 – 30 = moderate dependence/30 is severe dependence range is 0 – 60) **or**
- Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as LFT scores may also be used)

A pattern of not engaging with or benefiting from alcohol treatment

Clients will:

- Have been subject to alcohol Identification and Brief Advice (IBA) **&**
- Have been referred to services, usually on more than two occasions, and have not attended, attended and then disengaged or remained engaged but not changed.

A burden on public services

Clients will either directly, or via their effect on others e.g. their family, be placing a burden on the following services:

- Health
- Social care including adults involved with children's services
- Criminal Justice/ASB/Domestic violence services
- Emergency services (999)
- Housing and homelessness agencies

The burden will be mainly due to:

- Multiple use of individual services

but in a few cases may be due to placing an exceptional burden on these services because of a single risk (e.g. a sex offender released from prison with a pattern of problematic drinking.)

Exception — Level of risk

An exception category will be required. For example, a person may meet the first two criteria (dependence and non-engagement) but the burden on public services is due to a single exceptional risk.

Clients would be expected to meet all three criteria but the actual detail of the definition will vary between areas, particularly in terms of the level of impact in section iii.

Appendix 1 provides estimates of the level of activity, e.g. number of hospital admissions, which would generally constitute a high volume client. However, in some areas it may be decided that the target is people with three alcohol related arrests in a month, in others it would be five arrests in a year.

The number and costs of the Blue Light clients?

Using the above definition, the Blue Light Project estimated a crude minimum average of just under 400 people falling into this client group in an average need local authority of 350,000 people. This group will cost this community at least £12 – 15 million pounds a year. Both these figures are estimates and have been deliberately calculated using the most conservative calculations we can achieve. The basis for these two calculations is set out in appendices 2 and 3.

Case Studies

The three cases below are examples of the type of person we are assuming will be the target of this project and which we are attempting to capture in this definition.

Case Study 1

Jack is in his early 50's. He has been very well known to alcohol services over the past 20 years but has never engaged in meaningful interventions unless it had been ordered by the legal system.

He drinks between 25 – 35 units of alcohol per day in the form of white ciders and sherry. He lives in a hostel and has no family contact. He frequent calls 999 and can make up to 90 emergency service calls and have 18 emergency department attendances per month. He's had prison sentences for his violent behaviour where he receives alcohol detoxification. He is now medically unstable with cardiac failure.

Due to his notoriety, when he attends ED the nurses give him tea and toast and a warm welcome. His aggressive behaviour has become normalised to the point that not only is foul language tolerated but also mild physical assaults against staff go unreported. Despite an ASBO restricting this behaviour there are beliefs that pressing charges would be futile as the police also expect him to behave in this manner.

Case Study 2

Jane is a 42 year old woman with a 16 year history of on and off contact with alcohol services. She has been discharged many times through not attending appointments and is adjudged to have a lack of motivation to change her behaviour. Jane is divorced and now lives alone. Her children aged 7 and 10 live with her ex-husband and have contact at weekends. Her presenting behaviour is described as like 'Jekyll and Hyde'.

She works in the day and attends a gym at lunch. When she relapses she will drink up to one litre of vodka in the evening and will continue in this for periods of 2 – 3 months. She stops when she begins to feel physically unwell or "has had enough".

Whilst drinking she is sexually disinhibited in her behaviour and aggressive towards her neighbours. The neighbours make frequent calls to the police and council. Jane will also phone the emergency services to "buy her a drink" or to "feed her cat". She has also threatened self-harm. She is now at risk of losing her tenancy.

Case Study 3

Sal is a 48 year old woman who is divorced with four children, three live in other parts of the country, the youngest daughter, aged 16, is living between her mother's and father's houses. Sal has been 'binge' drinking since her late 20's after a very difficult, abusive childhood. She has been a victim of domestic violence for most of her adult life. She does not currently have a 'steady' relationship but is very lonely and constantly seeks male attention. She has little, if any contact with her other children and shows no affection to her youngest daughter. The daughter has been referred to Social Services and to a Young People's Substance Misuse Service as she too has started to drink alcohol.

Sal performs well when she is abstinent; she has previously owned her own business and can remain abstinent for several weeks at a time. However, when she is confronted with any type of 'challenge' she turns to alcohol and starts to dwell on her past. The binges used to last for several weeks and she would consistently ring for an ambulance, present at A&E but leave before she had been seen by the doctor. She would get a taxi back home, commence drinking again and ring for an ambulance again. She could present at A&E several times per day but always leave without being seen. This woman was due to be evicted from her privately owned home, where she had lived for 14 years, due to falling behind with her mortgage payments. As her eviction drew closer she took more and more overdoses and self-harmed.

Other case examples of these clients can be found in serious case reviews such as the reports of Domestic Homicide Reviews e.g. The death of Cydney in Medway http://www.medway.gov.uk/pdf/Final%20ReportCYD11.pdf or The death of Male 1 in Rochdale http://www.rochdale.gov.uk/the_council/delivery_strategies_and_review/reviews/domestic_homicide_review.aspx

Both these cases highlight the huge burden these clients can place on the community.

What can we do?

We can do something

At the most basic level we must challenge the notion that nothing can be done to help problem drinkers who do not want to change. This has not been true in the alcohol field since at least the early 1980's when Miller and Rollnick began to discuss motivational interventions.[18]

By perpetuating the notion that 'nothing can be done' we will:

+ Fail this client group
+ Extend the suffering of their victims
+ Increase the burden on public services, and
+ Marginalise alcohol services as agencies that have little to offer the most risky and vulnerable clients.

Nonetheless, it is fair to ask what can be done with a very entrenched group of clients. The subsequent sections set out the options.

Principles

The approach in this book is based on seven key principles:

+ **Take every opportunity** – we need to take every opportunity to engage treatment resistant drinkers and reduce the harms they pose
+ **Not everyone will change** – this guide sets out best practice but it does not guarantee success. Some people will die as a result of drinking and some people will only change after causing immense suffering to other people. The aim of this guide is to minimise this harm through driving best practice in to the system: it will not solve every problem
+ **Change is not the only option** – ideally we will work with clients to bring them to the point at which they decide to change; however, we recognise that at some point the focus will need to be on managing and containing harm
+ **Whole system approach** – the response to this client group will usually need to be the responsibility of a range of specialist and non-specialist services, not just a single agency or worker
+ **Holistic approach** – the focus cannot be solely on the alcohol, the response will need to address the range of needs presented by the client
+ **Recording unmet need** – no system of treatment and care can provide for every client need. If gaps are being identified, especially consistent or serious gaps, staff should have mechanisms for recording and reporting these to those who commission services
+ **Learning lessons** – when things go wrong staff and services should have the courage to review the case and learn lessons for future practice. Responses will only improve through being open when things go wrong.

What would a serious case review team think?

The touchstone for this guidance is "what would a serious case review team think?" Let us imagine that the worst had happened and a client has committed suicide or killed someone else and an inquiry team is reviewing the case. What would they be looking for in terms of best practice with such a client? What would suggest that all possible steps had been taken to manage the situation?

No one can expect care and criminal justice services to solve every problem. In October 2005 Anthony Rice was convicted of the murder of Naomi Bryant. At the time he was being supervised on a Life Licence by Hampshire Probation.

A number of other agencies had been working jointly with the Probation Service on this case via the Multi-agency Public Protection Arrangements. The subsequent Serious Further Offence Review report clearly sets out the expectations on those involved with risky clients:

> "When an offender is being supervised in the community it is simply not possible to eliminate risk altogether. It is also impossible to eliminate risk from Parole Board decisions. But, as we have also said, the public is entitled to expect the authorities to do their job properly, **i.e. to take all reasonable action to keep risk to a minimum."**[19]
>
> (Our emphasis)

That is the touchstone for this guide. Although the Rice report is focused on serious crime, the basic message about realistic expectations applies to all services. This guide tries to set out what it is reasonable to expect agencies to have considered with a treatment resistant drinker who is posing a significant burden on public services.

Building motivation and reducing harm

For the majority of this client group, the best option would be recovery: giving up drinking completely and working to build a constructive life that is not disrupted by alcohol. This should almost always be the ultimate aspiration.

However, this guide starts from the point that this aspiration, and the offer of help to achieve it, will be apparently rejected by many clients in either words or actions. It is at this point that services have often said: "there is nothing that can be done; the person does not want to change."

That is untrue; essentially two things can be done:

+ Work to build motivation, and
+ Work to reduce harm or manage risk.

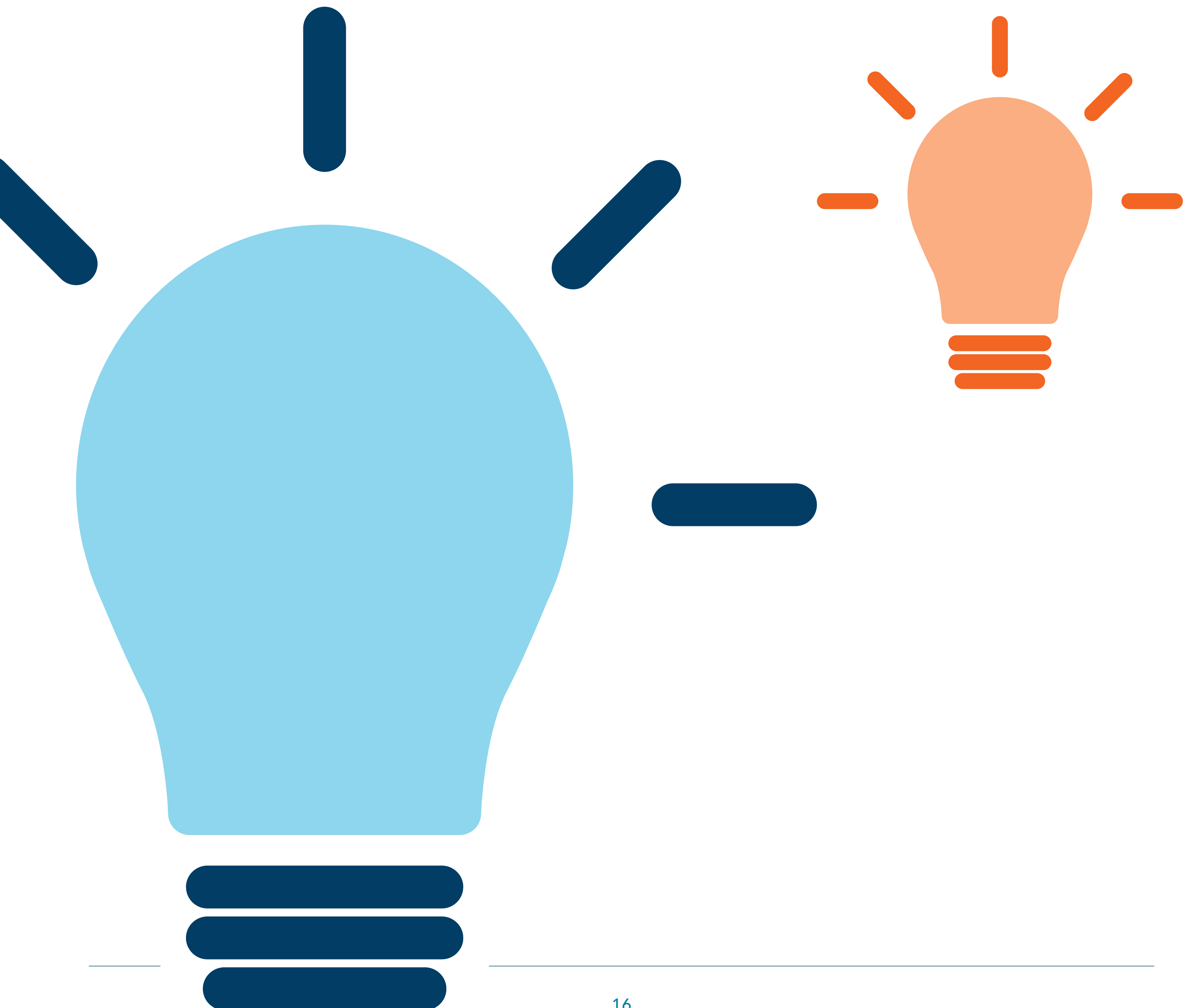
The following sections are about techniques and approaches to achieve these.

Understanding motivation and denial

Statements that drinkers do not want to change are often accompanied by comments about the clients being 'in denial.' The common perception is that this client group does not understand the need to change.

This needs to be challenged. Miller and Rollnick's work on motivational interventions is built on the recognition that denial is simply a façade.[20] Behind that veneer of denial is a person who is in a state of ambivalence. They may be uncertain about whether they can change, they may believe that family history destines them to be a drinker, they may be scared of what change entails. Other evidence has shown that 40% of apparently non-changing higher risk and dependent drinkers try and change each year.[21]

It is an underpinning belief of this guide that drinkers are not simply either 'in denial' or 'not in denial'. Like the rest of us they are more complex people with fluctuating and conflicting hopes, beliefs and aspirations. The aim is to reach that more nuanced person behind the façade of denial.



The most important message

The one thing you can do more than any other is to demonstrate that you believe the person can change. Promoting self-belief is crucial. You will help them believe they can change if you demonstrate that belief yourself.

At times this will be tough – some clients seem set on a course that will destroy their lives or the lives of others. However, people do change.

Even people who seem to have abandoned all hope of a different life can turn themselves around.

If we do not demonstrate a belief in the possibility of change then we will reinforce a sense of hopelessness in clients.[22]

The Starting Point:

Identification and Brief Advice

The first step is for staff to screen all clients with the AUDIT tool (see appendix 4), identifying those who are at risk of alcohol related harm and saying something to them: i.e. 'brief advice'.

The AUDIT tool should be used with all clients of frontline services at the earliest stage possible to avoid missed opportunities.[23 24]

Regardless of AUDIT score, all clients can be offered information about units, safe limits and the risks associated with excessive drinking. This can be achieved by handing the client an alcohol leaflet and briefly going through the main points with them.

People scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: "Your answers suggest that your drinking is within recommended guidelines – keep up the good work."

Feedback and brief advice should be offered to those scoring between 8 and 19 with the AUDIT tool covering:

+ Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
+ Clear, structured advice about risk and change
+ Goal setting: "What changes would you like to make and how are you going to do that?"
+ Statements to enhance motivation
+ Literature for the client to take away
+ The offer of further support, if desired.[25]

Leaflets are available to support this work. For example SIPS Brief Advice about Alcohol Risk (www.sips.iop.kcl.ac.uk) and Change for Life: Don't Let Drink Sneak Up On You (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

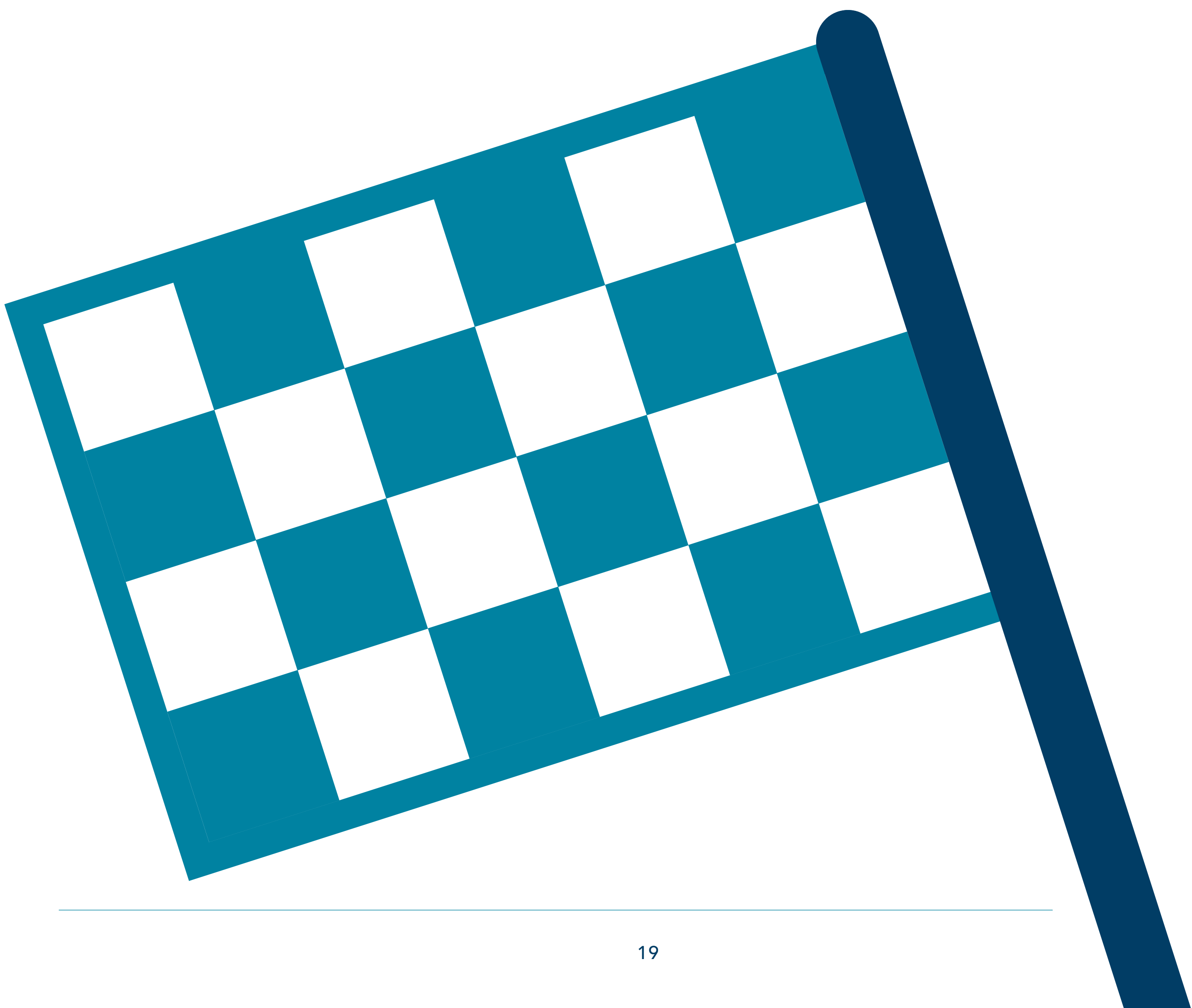
Research has proven the benefits of IBA:

+ 1 in 8 recipients of IBA (people scoring 8 – 19 on AUDIT) reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years. This compares with 1 in 20 smokers who benefit from stop smoking advice. This may be an underestimate of the benefits. Some drinkers will make reductions but not to within lower risk levels[26 27 28 29]
+ On average, following intervention, individuals reduced their drinking by 15%. While this may not be enough to bring the individual's drinking down to lower-risk levels, it will reduce their alcohol-related hospital admissions by 20% and "absolute risk of lifetime alcohol-related death by some 20%" as well as have a significant impact on alcohol–related morbidity[30]
+ IBA is an opportunity to educate a wide range of people, who may not already be aware, about units, lower-risk limits and risks associated with alcohol[31]
+ It is estimated that widespread use of IBA will result in the reduction from higher-risk to lower-risk drinking in 250,000 men and 67,500 women each year.[32]

Change resistant drinkers are unlikely to benefit from this approach. Nonetheless this remains a good starting point. It allows workers to:

+ Begin a conversation on the basis of a validated screening tool
+ Make a few simple statements about the need to change and the potential benefits.

If no one talks about the drinking, opportunities to change will be missed and the pressure on the person to change will be minimised. Indeed if workers say nothing it may be seen as a statement that nothing is wrong with the drinking.



Referral to specialist services

+ People scoring 20+ on AUDIT should always be offered referral to local alcohol services: "I can put you in touch with a service that can support you to make the changes that will really make a difference to you and your family."[33]

+ The same offer should be made to people who score 8 – 19 and are having problems making a change following advice.[34]

Enhancing service take up

+ Some clients may believe that changing drinking requires total abstinence. This is not the case. With the exception of 12 step organisations like AA, most specialist services offer the option of controlled drinking. It is true that clients with high levels of physical damage will need to stop completely in order to prevent potentially fatal problems. However, telling clients that treatment may not require total abstinence may encourage some to visit a service. It is for the specialists to then make an assessment as to whether controlled drinking is possible

+ Some people may be deterred because they believe that alcohol treatment always involves groupwork – this is not usually the case but you should check with local services

+ Others may have had previous negative experiences of services and this may need to be addressed

+ Some services may require self-referral. In such cases it may be useful to smooth the pathway with the service by asking them to be very welcoming and encouraging if the client makes contact

+ If a client is someone who is causing particular problems, it would be worth asking if services can offer a speedier appointment or perhaps even an appointment in the community. Services may also need to be more flexible and not immediately turn someone away if they arrive late or mildly intoxicated. These requests may require input at the managerial level

+ With such clients it will be important to ensure that treatment services speedily follow clients up if they disengage and report this back to the referrer

+ It is worth considering whether volunteers or mentors could be used to accompany people to their first appointments

+ Community Care Funding may offer a route into care for some clients in this group. It is important that staff familiarise themselves with the national framework for this funding to ensure that clients are receiving fair access. Lack of sobriety should not necessarily be a barrier to funding.

IBA and referral to services are basic good practice and should be a routine part of the work of all frontline staff. The challenge arises when people do not want to change. The rest of this pathway focuses on that client group.

Beginning to work with the resistant drinker

If non-specialist staff have screened a client, given brief advice and, when appropriate, referred to services, they have done a good job. However, we know that the majority of people will continue to drink.

Some people have argued that if the person does not want to change there is nothing we can do. That is untrue; however, further action is not required with everyone who is not pursuing change.

If someone is continuing to drink but there is a low risk of harm to self or others associated with the drinking, staff may be justified in doing no more than IBA and perhaps returning to the issue from time to time.

At intervals, it would be helpful to:

+ Remind clients of the risk they run with their drinking in a non-judgemental manner
+ Offer leaflets or new insights about the impact of drinking and services available
+ Encourage a belief that change is possible.

However, if the continued drinking poses significant risk (i.e. is a Blue Light client as defined above), workers will need to consider further action in order to:

+ Encourage change and/or
+ Reduce harm.

The options are explored in more detail in the next sections.

Identifying barriers to change

The real first step on this journey is to understand why this person is not changing.

It is easy to dismiss the person as simply 'unmotivated' or 'in denial'. Yet if a person is placing a significant burden on public services, their family or community the least that can be done is to try and understand why they do not change or engage with services.

It is important to understand that the things which pushed someone to drink are not necessarily the same as those that prevent change. For example:

+ Evidence from clinicians is beginning to suggest that alcohol related brain injury is present in a far greater proportion of drinkers (35% of dependent drinkers post mortem) than previously considered and that other patterns of head injury may contribute to this.[35] Both will make it difficult for clients to motivate themselves
+ Poor nutrition not only contributes to brain injury but also reduces energy levels[36]
+ Conditions like liver disease can reduce energy and encourage a pattern of sleep problems[37]
+ A large proportion of drinkers will be in depressed states as a result of alcohol's effects on the central nervous system.

Putting these factors together we can see that the problems of engagement are not simply 'denial' but the fact that the person is at the centre of a 'perfect storm' of conditions which make it harder and harder for them to organise and motivate themselves. Requiring motivation of such clients is as sensible as requiring the drowning person to swim to shore for help.

Explaining this to clients will also help them to understand why they are finding it hard to change. It is not simply that they are 'weak people' they have real barriers that impede change.

Physical health is not the only barrier. Another powerful example was a client who resisted going to services because he was worried that he smelled and the staff would dislike him as a result.[38]

Therefore, assessments should try and identify barriers to change and engagement. Other barriers could include low self-esteem, mental health problems or peers who sabotage change. The checklist overleaf is not designed as an assessment form. It is a prompt for workers to encourage them to think widely about potential barriers.

Checklist of potential barriers to change

Is there evidence of:	Y	N
Depression?		
Anxiety disorders, phobias (esp. agoraphobia), panic attacks?		
Other mental disorders e.g. bipolar disorders or schizophrenia?		
Alcohol related brain injury?		
Borderline learning disabilities?		
Foetal Alcohol Syndrome/Foetal Alcohol Spectrum Disorder?*		

Does the client:		
Lack self-belief e.g. due to previous lapses and relapses?		
Believe that they will always be an "alcoholic" because his /her parents were "alcoholics"?		
Have peers or family members who are subverting efforts to change?		
Have physical health problems which impede change e.g. liver problems can reduce energy?		
Have literacy or numeracy problems which reduce confidence to change?		
Have poor nutrition – e.g. liver disease can reduce appetite, and poor nutrition can then lead to depression?		
Have mobility problems e.g. liver disease can reduce mobility?		
Have sleep disorders, sleep reversal can be a symptom of liver disease i.e. the person sleeps during the day?		
Have accommodation problems?		

Is the client:		
Isolated?		
Fearful of change?		
Ignorant about services?		
Unable to access services due to transport problems of poor mobility?		

Does the client have:		
Previous negative experience with services?		
Anxieties about how they will appear to others e.g. do they smell or are they dirty?		
Money worries?		
Concerns that going into services affect their benefits?		

Are there:		
People who have abused them, or who they owe money to etc. in or near the services?		
Problems with the timing of the sessions?		

* Damage to the unborn child due to the mother's drinking during pregnancy. It is associated with e.g. poor organisational ability and impulsive behaviour in adulthood.

This assessment could also usefully look at what strengths and motivations the client possesses. These will be useful both in understanding the client's support needs but also in giving positive feedback e.g. reminders of past achievements. Assets could include:

- A supportive family member
- A previous successful career or achievement
- Current good health.

Workers could ask questions such as: "what does the client want from life?"

We have not turned these positive questions into a checklist: we do not want to create a situation where clients work through a list which reminds them how little they have. Nevertheless, it is important to focus on the positives as well as the negatives.

Other assessment tools are available. TIP35 which is a US government guidance document on Motivational Interviewing contains a number of useful assessment questionnaires e.g:

- Alcohol (and Illegal Drugs) Decisional Balance Scale
- Readiness To Change Questionnaire (Treatment Version) (RCQ-TV)
- Situational Confidence Questionnaire (SCQ-39)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A, 8D).

This guide can be accessed at http://www.ncbi.nlm.nih.gov/books/NBK64967/

It may be useful to develop an engagement plan with the client. This is a plan to help people to think through what will help them to engage with interventions and identify how they can overcome any potential barriers.

The former National Treatment Agency (now part of Public Health England) recommended that a client who is deemed at risk of disengagement from treatment should have an engagement plan included in the overall care plan.

The engagement plan would detail the following:[39]

- The reason for the engagement plan and any risks associated with disengagement
- The degree of outreach work and time limited sessions
- The agreed method of communicating with the client
- The clients responsibilities and the key worker responsibilities
- The support to be offered by the service to encourage engagement.

A sample plan

Identify what will help engage the client with the service

Sample targets:

Keep an up to date appointment card

Advise your family/friends when your appointments are so they can remind you

Agree mutually suitable appointment times with your key worker

What has affected your attendance in the past?

Do you want us to text or call you to remind you of appointments? **Y** **N**

What do you want us to do if you fail to attend an appointment e.g. phone you, text you, visit you?

Foetal Alcohol Syndrome/Spectrum Disorder

Adults (as well as children and adolescents) with Foetal Alcohol Syndrome/Foetal Alcohol Spectrum Disorder are a group of clients who may have particular difficulty organising themselves, keeping appointments, maintaining boundaries and avoiding impulsive behaviour.[40] They are likely to do poorly in services and, therefore, appear treatment resistant. This is blaming the person for a condition that they have no control over.

Efforts should be made to recognise the impact of this problem and service responses adjusted accordingly.

This framework is not the place for a detailed analysis of this problem. The US Substance Misuse and Mental Health Services Administration has published a useful guide on this issue which can be found at http://store.samhsa.gov/product/TIP-58-Addressing-Fetal-Alcohol-Spectrum-Disorders-FASD-/SMA13-4803

Assessing risks

specifically associated with problem drinking

If we cannot immediately generate motivation we can at least try and reduce harm. This will require a thorough and appropriate risk assessment.

Risk assessments can be very generic and concentrate on headline risks such as violence and self-harm. These are important but there are other risks which are specifically associated with drinkers and are easily overlooked.

The test that we have often used of the adequacy of services' risk assessment is the simple question: "do you ask if they have a smoke alarm fitted?" The association between fire and alcohol use is so powerful that this question should be routine with any problem drinker. However, too often it is ignored. At the other extreme are apparently small risks which may have very negative consequences. Does the client fall asleep while running a bath and flood the neighbour's flat below? This is not life-threatening but if repeated it could lead to eviction as an anti-social neighbour.

A specific assessment of the risks particularly associated with problem drinkers, e.g. fire risk, trip hazards in the home, noise nuisance, should be undertaken. This risk assessment would be enhanced by a home visit. If this is not possible for one agency, another agency in contact with the client could be asked to undertake a risk assessment visit.

The checklist below will assist in undertaking the risk assessment. This is designed as a support to existing risk assessments not as a replacement.

Checklist of specific risks associated with drinking

Health	Y	N
Do they require vitamin therapy?		
Are there dangerous drug combinations?		
Are they stockpiling medications?		
Is alcohol reducing the effectiveness of any medication?		
Have they had a recent physical and dental health check?		
Have they attempted suicide or have histories of self-harm?		
Is there a smell of urine or rotten flesh which may indicate health problems?		
Is their diet adequate?		
Are they smoking?		
Is there adequate heating in the home?		
Is there a risk of hypothermia?		
Is there a risk of sunburn/dehydration from street drinking?		

Practical risks		
Are they drinking and driving inc mobility scooters?		
Are they using any other machinery?		
Are they drinking in isolation? Will anyone know if they come to harm?		
Are they drinking in risky locations?		
Do they have a smoke alarm fitted?		
Are there other indicators of a fire risk?		
Are they cooking in dangerous ways e.g. deep frying when intoxicated?		
Do their heating methods suggest a fire risk?		
Are there trip hazards in the house?		
Do they allow baths to overflow or fall asleep in the bath?		
Are there any other environmental hazards such as an unstable television or simply the risks of general clutter?		
Is there noise nuisance to neighbours?		
Are there cigarette burns on clothes or carpet indicating a fire risk?		

Practical risks (continued)

Is there glass or bottles littered in the home?		
Are there bodily fluids in the house?		
Is the way they are buying alcohol putting them at risk?		
Are they a nuisance on public transport?		
Do they use gas in their house?		
Is their disposal of refuse causing neighbour nuisance or putting their tenancy under threat?		

Abuse and exploitation

Is alcohol safely stored if young people have access to the property e.g. grandchildren?		
Are they at risk of exploitation e.g. for their benefits? Sexual exploitation?		
Do they have safe storage facilities for drugs or cash?		
Is their property used by others for drug dealing etc?		
Does someone else hold keys to the property, so that they can access their home if they lose keys when drunk?		
Are they responsible for children or grandchildren?		
Do they have any animals under their care?		

Assess physical health

The client should always be encouraged to have a physical health check with their GP and a dental check.

The latter will also help identify oral cancer risks and may improve self-confidence in those concerned about bad breath or damaged teeth. This will have a range of benefits:

+ It will help the early identification of diseases which may later represent a considerable burden on both the person and health services
+ It may provide motivators to change
+ It may help to reduce harm.

The client may well need support to attend:

+ "I understand you don't want to stop drinking, so let's make sure you stay a healthy drinker for as long as possible."
+ "I am happy to come with you to the appointment."
+ "I can try and arrange for the doctor to see you at a relatively quiet time in the practice."

The latter two will require worker input to arrange appointments.

Monitoring the person's drinking via a drinks diary will also be a useful assessment tool e.g. http://www.nhs.uk/livewell/alcohol/documents/drink_diary.pdf

An alternative approach for non-medical staff is to use the '12 questions for generic workers to ask about a client's physical health' which is included in this guide. This sets out questions that someone with no medical training can ask which will help identify health problems which could be potentially serious. (See next page).

Some people have questioned whether non-medics should ask these; we have consulted with clinical staff who support the idea that this approach will aid early identification of health problems. If generic workers don't ask these questions and the client does not consult a doctor then serious and costly problems will remain unidentified or unaddressed.

Many clients live for long periods with chronic pains, coughing blood or passing blood from the back passage without seeking help. Workers need to create the opportunity for clients to discuss this if only to reduce the future burden on health services.

A consultation with a dietitian or nutritionist could also be a useful way of reducing harm. "I understand you don't want to change your drinking but if we could get you eating more you will be healthier."

See section 14 for more on diet and nutrition.

12 Questions

for the Generic Worker to ask about alcohol related physical ill health

Workers' questions to Service Users

Below is a list of 12 questions that will be useful to ask when speaking to a service user about their physical health. We are not expecting you to be a medic but here are some simple questions to ask. Please refer to the explanatory notes and encourage them to see their GP with any health issues. Some people have suggested that this is a task for doctors or nurses. However, if we only wait until they see a clinician we will be missing real opportunities to prevent health problems.

It is suggested that an open ended question is used at the beginning of the conversation such as: Alcohol increases the risk of over 60 different diseases. Have you had any recent health problems? Then get permission to ask the further 12 questions: Can I run through some other health related questions?

1. Do you ever experience a painful feeling of heaviness or tightness, usually in the centre of your chest, which may spread to your arms, neck, jaw, back or stomach?
2. Have you coughed up blood or noticed blood in your vomit?
3. Have you ever noticed or has someone else commented that the whites of your eyes or your skin have turned yellow?
4. Have you passed any blood from your back passage?
5. Do you have a sensation of numbness or pins and needles in your feet or hands?
6. Have you ever experienced fits (seizures)? Have you a history of head injuries (Including non alcohol related and as a child)?
7. Have you lost or gained weight unexpectedly recently?
8. Have you noticed that you bruise more easily than normal?
9. Do you experience or have you experienced a severe, dull pain around the top of your stomach that develops suddenly?
10. Have you or a relative/carer expressed concerns about your memory?
11. Are you practising safe sex? (Applies to males and females) Are you using contraception? (Applies to males and females) Are you thinking about or considering becoming pregnant? (Females only)
12. Have you recently had your blood pressure checked or had a blood test?

The 12 questions were developed by Mike Ward & Mark Holmes with clinical input from Dr Stephen Ryder Consultant Hepatologist at Nottingham University Hospitals NHS Trust.

12 Questions for the generic worker to ask about alcohol related physical ill health

Explanatory notes

If there are health concerns you need to encourage them to see their primary care team and in certain circumstances to seek urgent medical attention:

1. **Do you ever experience a painful feeling of heaviness or tightness, usually in the centre of the chest, which may spread to the arms, neck, jaw, back or stomach?**

   This question explores if there have been any symptoms of a heart attack. If they answer yes it would be worth asking when they last experienced this and how long did the pain last for. If the symptoms are active this will lead to an emergency call. Previous symptoms should be discussed with a health care practitioner.

2. **Have you coughed or noticed blood in your vomit?**

   A relatively common gastroenterological reason for alcohol related hospital admissions is called a Mallory-Weiss tear which can occur following prolonged and forceful vomiting, coughing or convulsions. Typically the mucous membrane at the junction of the oesophagus and the stomach develops lacerations which bleed, evident by bright red blood in vomit, or bloody stools. Large amounts of blood maybe due to ulceration or oesophageal varices. The amount and colour of blood (coffee grounds to bright red) will be helpful information for a medical practitioner.

3. **Have you ever noticed or has someone else commented that the whites of your eyes have turned yellow?**

   The aim is to identify potential alcoholic liver disease. Even in advanced liver disease there may be no symptoms, so these questions are markers to pick up potential or actual problems. The speed of noticing the colour change is important as this could be potentially life threatening alcoholic hepatitis.

4. **Have you passed any blood from your back passage?**

   If the answer is yes we suggest asking about the colour of the blood. A bleed in the area from the mouth to the stomach can be digested by the stomach. This tends to be black with a consistency of tar. Bright red blood that appears on toilet paper after wiping maybe a symptom of haemorrhoids (piles). Lower bleeds in the bowel will appear 'blood red' or light red. This will also require medical advice as it can be a symptom of other physical disease. The loss of large volumes of blood can indicate complications of liver disease and prompt action will be required.

5. Do you have a sensation of numbness or pins and needles in your feet or hands?

This question aims to detect Peripheral Neuropathy. This is a problem with the nerves that carry information to and from the brain and spinal cord. This produces pain, loss of sensation, and inability to control muscles. The pain is sometimes a shooting pain in the arms or legs. This is a largely treatable condition affecting the nerve endings which can be managed with a combination of pain relief, vitamins and abstinence from alcohol. However, it could cause clumsiness and accidents e.g. cigarette burns.

6. Have you a history of head injuries (Including non alcohol related and as a child)?

A history of head injuries can be a precursor to alcohol related brain injury. There is also research suggesting that head injuries in childhood may affect personality traits leading to impulsive behaviours. If the service user has a previous history of alcohol withdrawal seizures, there is a 10-fold increase in risk of seizure in withdrawal. Alcohol related seizures are not only caused by withdrawal. For example alcohol beverage consumption can change the chemistry of minerals in the blood stream or trauma to the head can lead to seizure.

7. Have you lost or gained weight unexpectedly recently?

Another symptom of liver disease is ascites. This is fluid that is retained and may be noticeable around the liver and abdomen and ankles. However often smaller amounts are not noticed. Weight gain may be a sign of this. Weight loss may also be a sign of muscle degeneration or symptom of an underlying medical condition.

8. Have you noticed that you bruise more easily than normal?

Another symptom of liver disease is bruising caused by the person not making enough clotting factors in the blood. The bruises may appear without injury or be worse than expected when injury has occurred.

9. Do you experience or have you experienced a severe, dull pain around the top of your stomach that develops suddenly?

This question aims to detect acute pancreatitis. "Often people experience pain in a different place than the area affected – this is often called 'referred' pain." Service users sometimes confuse this as stomach ache or back pain.

10. Have you or a relative/carer expressed concerns about your memory?

There is growing evidence about the effects of alcohol on the brain, in particular the frontal lobes. This can cause not only memory problems but personality changes and poor energy levels. Consideration should be given to how this may impact on accessing treatment services. These questions are also a good prompt to remind service users and carers of the importance of a balanced diet and in particular the need to take vitamin B. If vitamin supplementation is not prescribed then this should be considered/arranged.

11. Are you practising safe sex? (Applies to males and females) Are you using contraception? (Applies to males and females) Are you thinking about or considering becoming pregnant? (Females only)

All age groups and both genders need to have information about safe sex. NICE advice on drinking in pregnancy is that women should abstain from alcohol completely during the first three months of pregnancy because of the risks of miscarriage; and to drink no more than one or two units of alcohol once or twice a week for the rest of the pregnancy.

12. When was the last time you had your blood pressure checked or had a blood test?

These questions open up discussion with the service user about recent contact they have had with health professionals and what concerns have been raised. If the service user has not had bloods taken recently (last 3 months) then steps should be taken to approach a health care practitioner to see if further tests are required. There is a clear link between high blood pressure (hypertension) and alcohol.

The 12 questions were developed by Mike Ward & Mark Holmes with clinical input from Dr Stephen Ryder Consultant Hepatologist at Nottingham University Hospitals NHS Trust.

Enhanced personalised education

Workers could offer enhanced personalised education about the impact of alcohol on that person.

This extends the brief advice model (section 5). The worker can offer simple statements to encourage the client to think about the impact of alcohol. The sentences:

+ Will contain information about the impact of alcohol on that specific person
+ Will be non-judgemental and factual feedback about risks they are running
+ May cover physical, psychological or social risks
+ Will make the link between current lifestyle and potential harm.

This could use information given in answer to both the risk assessment and the '12 questions about physical health.'

The following are some examples:

+ Long term heavy alcohol use prevents your body absorbing sufficient vitamins and minerals. This can lead to vitamin deficiency including anaemia. In particular, it causes brain damage. B vitamins are essential for brain repair and as a result of low intake of these vitamins the brain deteriorates until people begin to experience alcohol-related dementia
+ Alcohol misuse makes people far more vulnerable to suicide. Alcohol is a depressant drug and long term drinkers may become very low in mood. The suicide risk is worsened because not only are people depressed, but the alcohol is also likely to make them act impulsively
  Drinkers may wake up in the night feeling low, begin to drink and in a state of increasing despair attempt to kill themselves
+ Alcohol can damage the pancreas. As a result it becomes enlarged and very painful. This damage can also lead to diabetes. The combination of alcohol plus diabetes is very risky and can lead to blindness and death
+ In some heavy drinkers alcohol will lead to peripheral neuropathy: loss of sensation and damage to the nerves in the hand and feet. You may develop pins and needles in your hands and feet or lose sensation there altogether
+ Long term drinking may make people vulnerable to financial abuse and exploitation. It is not uncommon to see young drug users using drinker's flats or houses to store drugs, use drugs or to see other drinkers exploiting people for their benefits
+ People who drink heavily and smoke are much more liable to oral cancers.

Another example is giving clients a chart about urine colour. Hydration will help a drinker's health and current status is readily seen when someone urinates. Knowing about the need to keep hydrated will be a personalised education message every time they go to the toilet!

Urine colour charts are readily available on the internet. Just search "what colour is your urine meant to be?"

Building motivation/ promote self-belief

Workers should ensure that any interventions have a positive tone and attempt to build self-efficacy — developing the person's belief that change is possible.

This is a powerful and evidence based intervention.[41] At the least workers should ensure that the client understands that the door is always open for change.

Again this approach offers workers the chance to make simple statements that the client will take away. The list below gives some examples, but the possibilities are endless.

Sample statements to build self-efficacy:

- Thank you for coming to this appointment.
- I appreciate how hard it must have been for you to discuss this. You took a big step.
- I think it's great that you want to do something about this problem.
- That must have been very difficult for you.
- It must be difficult for you to accept a daily life so full of stress.
- You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
- That's a good suggestion.
- I'm sure you can do this once you put your mind to it.
- You managed to give up smoking, so this will be a breeze.
- I bet you've made bigger changes than this before.
- I know how determined you can be – this will be really good for you.
- You're doing nice work on your community service requirement.
- Thanks for telling me about that.
- It's clear that you have thought a lot about this.
- It seems like that will really work for you.
- You care a lot about your kids and want to make sure they're safe.
- Your willingness to respond to the hard questions shows that you're really thinking about this.
- You're the kind of person who speaks up when something bothers you, and that's a real strength.
- You have a lot of leadership qualities. It's clear that people listen to you.

Taken from:

+ Motivational Interviewing: Preparing People to Change Addictive Behaviour – William Miller & Steve Rollnick – 1991
+ Walters S.et al. A Guide for Probation and Parole Motivating Offenders to Change – U.S. Department of Justice National Institute of Corrections – 2007.

Staff working with resistant drinkers should attempt to build motivation to change. This will be greatly helped by having staff who are trained in **motivational interviewing** (MI).

This is a technique that can be used by both specialist and non-specialist services. The aim of MI is to move the client from ambivalence to change.

The approach emphasises:

+ The importance of not entrenching people in negative positions by trying to persuade them to change
+ Encouraging the client to believe that change is possible and to non-judgementally develop reasons why change should be tried.

These skills should be used to encourage engagement or change; but they can also be used to promote harm reduction.

Two simple motivational interviewing approaches to consider are:

+ Asking permission to talk about the drinking and offering permission to disagree with your view. This gives the client a sense of control in the process
+ If the client denies a problem: roll with the resistance. Accept the client's decision and move on to exploring other issues e.g. wider health concerns.

This guide is not a MI training manual. Training in this approach should be available to non-specialist services as well as specialist services. Training is readily available via agencies such as Alcohol Concern.

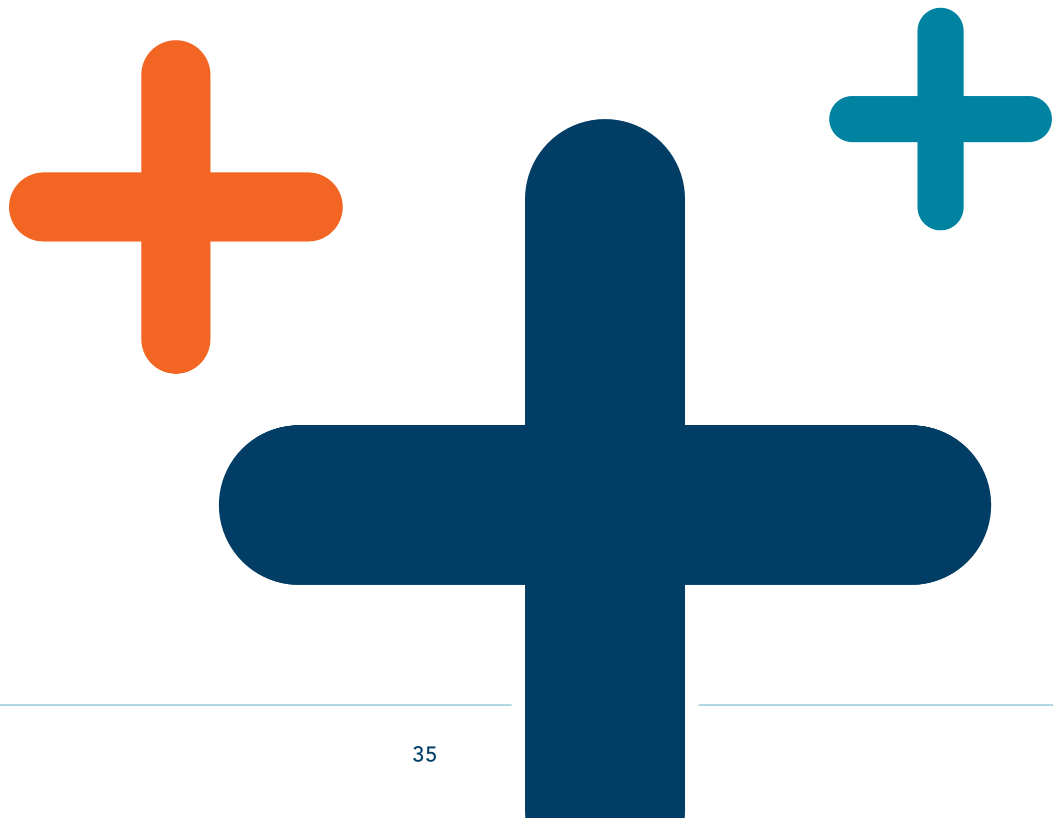
Miller & Rollnick's book is the key text (see above) but two free resources are available on the internet:

+ Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35 is a 200+ page US government guidance document on using MI with problem drinkers which is available for download at[42] http://www.ncbi.nlm.nih.gov/books/NBK64967/
+ The Motivational Enhancement Therapy guidance booklet used in the large and influential US research programme Project Match is available for download at http://pubs.niaaa.nih.gov/publications/ProjectMatch/match02.pdf

This approach is advocated as a next step in NTA – Medications in recovery: Re-orientating drug dependence treatment[43] http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

Another tool which could be used to develop motivation is the **Outcomes Star™ for Alcohol Recovery** structure. This was designed as an outcome monitoring and care planning tool.

However, its focus on a range of needs which are measured using a series of scales allows workers to set small targets for change in areas other than alcohol use. It, therefore, provides a framework for an intervention which is both motivational and looks at the whole person rather than simply the alcohol. These tools can be found at http://www.outcomesstar.org.uk/alcohol-star/



Harm reduction:

General

If workers have attempted to encourage abstinence or control and the client is not making changes, then they should focus on reducing harm.

Harm reduction is an approach which has been much used by drugs services where methadone prescribing and needle exchange are among the best examples of harm reduction to be found in any field. Although a minority may still question such approaches, they have been accepted parts of the response to drug misuse since at least the 1980s.

However, the approach is less common and less standardised in the alcohol field. Nonetheless, harm reduction advice can be given to drinkers. This will be dependent on the risk assessment but could include, for example:

+ Dietary advice and vitamin supplementation to prevent nutritional deficiencies that can lead to alcohol related brain injury
+ Reducing suicide risk
+ Eating while drinking
+ Ensuring the client is not using dangerous drug combinations
+ Exploring whether heating or cooking methods suggest a fire risk?
+ Considering if there are trip hazards in the house, e.g. holes in the carpet at the top of stairs?

Each client is different and the advice they need will be different. Therefore, this guide cannot offer a structured hierarchy of advice which should be followed with all clients. Instead it offers key issues which should be considered with all clients and then offers a range of other ideas and examples. Professionals will find it useful to review these options when working with a treatment resistant client in order to remind themselves of possible approaches.

Do not forget that:

+ Information sharing is harm reduction
+ Engagement is harm reduction
+ Consistency of worker and response is harm reduction.

Approaches that should be considered with all clients

The following table sets out a range of harm reduction techniques. The first five should be used as a bare minimum with all treatment resistant drinkers.

Harm reduction techniques with drinkers

Have you encouraged these core techniques:	Y	N
Vitamin therapy to prevent malnutrition that leads to dementia and other conditions?		
Drinking water alongside the alcohol?		
Eating (preferably nutritiously) while drinking?		
Having a home fire safety check?		
Having a physical health check?		

Other approaches to consider

Medication:

Are there dangerous drug combinations?		
Is alcohol reducing the effectiveness of any drugs?		
Are medications being taken as prescribed?		
Do they need dosette boxes for medication regimes?		
Do they need locked boxes for specific medications?		
Are they hoarding medication?		
Are other drugs over the counter, legal highs or illicit substances being used?		
Have they had a flu jab?		
Have they had a TB vaccination, Hep A & B vaccination?		
With people who have stopped, has there been a conversation with a doctor about the use of relapse prevention drugs such as acamprosate, antabuse, nalmafene and naltrexone?		

Has the family been educated about:

The risks they may face?		
The impact of diet and vitamins?		

Diet

Is the person having a nutritious diet?		
Can the drinker change the type of alcohol consumed?		
Can they be encouraged to cook before drinking not the other way round?		
Do they need a nutritionist referral?		
Can their cooking skills be improved?		

Physical health

Have they had an oral health check: a visit to the dentist which may be a way of detecting other oral problems such as cancers?		
Do they carry identity, ICE details and details of any medical conditions in case of collapse?		
Are they drinking in isolation? Will anyone know if they come to harm?		
Has exercise been considered as a way of reducing depression?		
Have they had an exercise referral?		
Have you talked about any smell of urine or rotting flesh which could indicate ill health?		
Have you given enhanced personalised education – how does alcohol really affect you?		
Do they need help with sleeping?		
Could they change to electronic cigarettes to potentially reduce the risk of oral cancers and other tobacco related health problems?		
Have you considered whether there may be alternative reasons for apparently intoxicated behaviour e.g. head injury?		
Have you considered their sexual health and contraception needs?		
Could you use blood pressure monitoring for health?		
Could you monitor weight for health – obesity increases the risk of liver disease?		

Fire safety

Do they have a smoke alarm fitted?		
Do they use gas?		
If smoking and drinking presents a fire risk, have they considered using a sand bucket as an ashtray? A bucket is harder to miss than a small ashtray balanced on the arm of a sofa.		
Are they cooking in dangerous ways e.g. deep frying chips when intoxicated?		
Do their heating methods suggest a fire risk?		
Do they put a timer on when they cook?		

Other practical hazards

Is drinking and driving an issue?		
Do they have safety catches on high windows to prevent falls?		
Are they using any other machinery?		
Are there trip hazards in the house, e.g. at the top of stairs?		
Are there any other environmental hazards such as an unstable television or simply the risks of general clutter?		
Does someone else hold keys to the property, so that they can access their home if they lose keys when drunk?		
Are there animals in the house?		
Do they run baths and then fall asleep?		
Do they fall asleep in the bath?		

Abuse and exploitation

Are both alcohol and drugs safely stored if young people have access to the property? This is not simply about the drinker's own children. Grandchildren and other relatives may visit the house. In some areas vulnerable drinkers have been exploited by local young people who have stolen drink or drugs.		
Does cash require safe storage to avoid exploitation or theft?		
Are they using taxi drivers to access alcohol?		

Nuisance

Are they playing televisions or stereos loudly and annoying neighbours? This can be alleviated by putting noise limiting devices on equipment or timers which shut the equipment off if they fall asleep.		
Are any animals making a noise, making a mess etc?		
If a client is making inappropriate 999 callouts, can you arrange for emergency service staff to come along and talk about it with them?		

Money

Have they considered taking less money when they go out?		
Have they considered not taking a bank card when they go out?		

Drinking style

Could they try:

Putting their drink on the table between sips?		
Leaving the bottle in the kitchen so that they have to get up for another drink?		
Not getting involved in rounds?		

Support

Could you:

Send daily text messages and other telehealth contact? Evidence exists that simply keeping in regular text contact can help clients maintain reductions in their drinking.[44]		
Involve any members of the family in care planning?		

Incentives to engagement

Could you:

Offer food vouchers?		
Offer alternative therapies?		
Is a behaviour contract possible?		

Monitor alcohol

Could you:

Ask them to keep a drink diary.		
Ask them to put empty bottles into a plastic bag, or a bag for each day, so that the number can be monitored?		
Use breathalysers to monitor change?		

Workers

Remember the importance of a positive attitude: promote self-belief. **Change is possible!**

Consider the timing of sessions so that the person is more sober.		
Use home visits instead of requiring an office visit.		
Don't set unrealistic goals.		
Be consistent and persistent.		

Contingency

Encourage the client to write a postcard/letter for him or herself to be posted at a time of lapse or crisis.		
Develop a contingency plan for when things go wrong.		

In a couple of areas agencies have shown video of the person while drunk to encourage change. This footage may be available from security cameras in an agency.[45]

Harm reduction:

Diet and treatment resistant drinkers

People with alcohol problems may be poorly nourished:[46]

+ The calories absorbed in alcohol can reduce the stimulus to eat
+ Alcohol may be purchased instead of food
+ Lifestyle may interfere with cooking and eating
+ As alcohol related damage progresses the body will find it harder to absorb nutrition
+ Smoking is an appetite suppressant and leads to a loss of taste – reducing the desire to eat.

This will:

+ Increase the likelihood of a variety of health problems; but will also
+ Make it harder for people to engage with treatment.

Diet and engagement

A number of nutritional issues will impact on engagement. Various deficiencies will:

+ Reduce energy levels and, therefore, motivation to engage; and
+ Worsen low mood and depression which again will impact on engagement.

Poor nutrition generally is associated with depression and poor motivation.

+ Drinking instead of eating will lead to the use of the calories in alcohol for energy. These are of almost no nutritional value and are harder to break down. This takes a lot of energy which leads to fatigue
+ Magnesium is also needed in energy production. It is poorly absorbed even in a normal diet and a lack of magnesium in the diet will again reduce energy levels
+ The risk of dehydration exists with some drinks, e.g. spirits, wine and fortified wines. The body needs fluids to help combat confusion and lethargy
+ Dehydration also increases the likelihood of urinary tract infections. UTIs will lead to the prescription of antibiotics which can lead to diarrhoea which will lead to more dehydration. Regular vomiting will also reduce hydration
+ In the long term, vitamin B1 (thiamine) deficiency can result in alcohol related brain damage leading to confusional states which can appear similar to dementia. This will make it hard for clients to structure themselves to engage with interventions. This has been seen as a state which is associated with a small group of very heavy and lifelong drinkers. However, it is possible that alcohol related brain damage may affect heavy drinkers earlier than was previously understood and, therefore, affects a larger number
+ Vitamins B2 and B6 can lead to stomatitis (cracks in the sides of the mouth) and glossitis (an inflamed tongue). Cracked mouths and enlarged tongues make it harder to eat again leading to the problems above.

Diet and other health problems

+ Vitamin D deficiency is important for calcium absorption. This deficiency can be due to a lack of sunshine. Therefore, the body may be unable to absorb calcium and bones don't renew themselves. This increases the risk of fractures and, therefore, hospital visits
+ Magnesium is also important for cardiac health. Its lack can lead to cardiac arrhythmias and shakes. So some apparent alcohol related shakiness can be due to magnesium deficiency. It may also cause tingling in the hands
+ Peripheral neuropathy is also the result of thiamine deficiency.

Addressing poor nutrition and dehydration

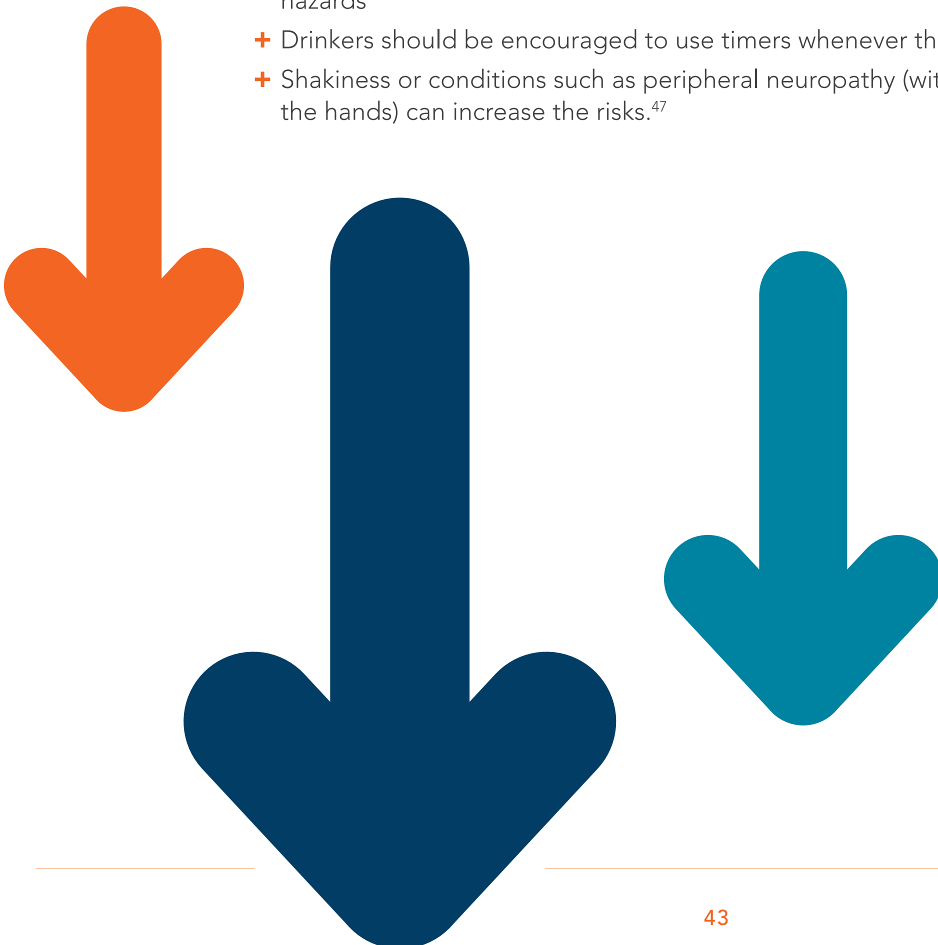
Many approaches will help address these problems:

+ GPs can provide vitamin therapy
+ It would be beneficial to provide vitamin pills. These can be purchased over the counter.
+ Bread has vitamin B and B1 can be found in spreads like marmite, cheese spread and peanut butter.
+ Vitamins B2 and B6 can be found in meat, fish and eggs
+ Magnesium can be secured in over the counter medications
+ Liquids may be easier to consume for some people
+ Ice lollies can help with hydration
+ Even Pot Noodles could be a start, as they contain carbohydrate albeit in small quantities.

Other safety issues

It would be ideal if drinkers were regularly cooking themselves a nutritious meal. However, even if they were able to do this, cooking may pose risks:

+ Before recommending cooking, workers should consider risks such as chip pan fires and similar hazards
+ Drinkers should be encouraged to use timers whenever they are cooking in case they fall asleep
+ Shakiness or conditions such as peripheral neuropathy (with consequent loss of sensation in the hands) can increase the risks.[47]



Family involvement

Family involvement should be considered wherever possible.

Evidence exists that family or carer involvement in care planning can help improve engagement and increase the likelihood that a care plan will succeed. For example, NICE clinical guideline 115 recommends encouraging families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.[48]

Family members will also find it useful to understand the barriers and challenges that the drinker experiences (see section 8).

This needs to be undertaken with a realistic recognition that a minority of family members are inappropriate for involvement because they may subvert the drinker's attempt to change. Some family members may also have feelings of guilt e.g. the mother who drank during pregnancy.

Family Group Conferencing could be used with people involved with Children and Families services. This allows the children to have a voice and speak about the impact the drinker's behaviour is having on them. This can be a very powerful tool but should only be put in place by someone with appropriate skills and who can offer the children real support.

The voices of adult children may also be powerful, as may letters, drawings or recordings from children of any age. Nonetheless, these approaches should only be used after consultation with colleagues and other experienced professionals. For example, a letter from an adult child may motivate but may also increase feelings of low self-worth or create a risky tension within the family.

Family members should always be encouraged to seek help via Al-Anon (www.al-anonuk.org.uk) or local alcohol services. Supporting family members is important in itself, but it can also change family dynamics and encourage change.

At the very least workers should consider whether any family members or informal carers are at risk from the drinker. If so, risk management strategies need to be considered.

> Recent domestic homicide reviews have highlighted how potentially dangerous the combination of two drinking partners can be. The combination appears to significantly increase the risk of violence and the seriousness of the outcomes.[49]

Incentivising engagement

Staff could consider whether it is possible or appropriate to incentivise engagement with services e.g. offering complementary therapies. This is also called contingency management.

Contingency management is an evidence-based treatment intervention recommended by the National Institute for Health and Care Excellence (NICE) for drug users.

It is based on principles of behaviour modification and aims to incentivise and then reinforce changes in behaviour with the aid of vouchers, privileges, prizes or modest financial incentives that are of value to the client. It is seen as a way to 'nudge' people to change their behaviour in a positive direction across a wide range of health and social policy domains.

NICE has recommended that: "Drug services should introduce contingency management programmes…to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment."[50]

This model has, however, not been widely used in the alcohol field. It can also be seen as controversial by 'rewarding negative behaviour.'

It is unlikely, in the foreseeable future, that workers will be able to give vouchers or financial incentives to engage. This is despite the fact that it could reduce the five or six figure cost burden imposed by some clients.

However, it may be worth thinking about alternative incentives:

+ Complementary therapies in services may incentivise engagement
+ Probation staff could reduce reporting requirements if a person attends treatment
+ JobCentre Plus staff could reduce their requirements if a person attends treatment
+ Staff could offer food vouchers or access to food stores
+ Funds could be sought from local charities which will give small amounts to clients for clothing etc.
+ Some services have offered clothes washing or storage facilities as incentives.

Dual diagnosis

A common factor in many change resistant drinkers is mental health problems (dual diagnosis).

This combination is a real barrier to change and help will be required from mental health services.

The following documents provide the framework within which that care should be provided:

+ Psychosis with coexisting substance misuse – NICE Clinical Guideline 120 – 2011[51]
+ Dual Diagnosis Good Practice Guide – Department of Health Policy Implementation Guide – Department of Health – 2002[52]
+ A guide for the management of dual diagnosis for prisons – 2006[53]

Staff in many services report finding it difficult to access help from mental health services.[54]

Nonetheless, these documents make it clear that mental health services have the lead responsibility for, at least, some of this client group.

In particular, the documents make clear that requiring someone to be free of alcohol before entering mental health services is not a clinically validated response. It will place a real barrier in the way of clients accessing vital help:

+ Staff should seek help from mental health services and be persistent if they feel they are not receiving a response that meets the client's needs
+ Accessing help will be much easier if managers and their teams have taken time to previously build a relationship with local mental health services
+ If problems persist in securing help, staff should talk to their managers and they should talk to managers and commissioners in mental health services
+ If help cannot be secured it is vital to record unmet need.

Multi-agency care planning or care coordination role

In the majority of cases, the options above will represent an appropriate response.

Not everyone will change but reasonable efforts have been made to engage the drinker and reduce the harm posed.

However, some change resistant drinkers are so complex and risky that further action will be required. A decision on whether a client reaches this threshold will require a case by case approach.

These clients are likely to be in contact with a number of agencies, therefore, **a multi-agency care planning or care coordination role** will be essential. A care coordinator will need to be nominated to ensure that the work of all agencies is integrated into a single multi-agency plan. The decision on who will lead the process and develop the plan will need to be determined locally.

Consistency is an important part of the response. People should not pinball around the system. Multi-agency planning will help ensure a consistent approach (i.e. know who is involved and who is meant to do what, when and why), help to identify risks and facilitate sharing information.

This care planning process could also involve the user and their carers.

Information sharing arrangements will need to be in place to support this (see appendix 5).

This group can consider further use of the approaches outlined above but will also consider more intensive approaches set out below:

+ Fast track treatment and planning for lapse
+ Outreach
+ Tackling elements which support someone in a drinking lifestyle
+ Compulsory powers (see subsequent sections).

Nottingham has developed a multi-agency Street Drinkers Case Conferencing Group ensuring that the most problematic street drinkers are identified and receive the support required to exit their lifestyle.

Fast track treatment and planning for lapse

Local alcohol agencies will often have waiting lists or at the very least a small delay before entry.

This is inevitable but will be a barrier for clients who would benefit from speedy help. Therefore, if a particular person is a very high burden client, prior arrangements should be made for fast tracking the client into care if they show an interest in change.

Remember: in any one year 40% of higher risk and dependent drinkers will try to make a change.[55]

If a client does enter treatment, it is important to develop a contingency plan stating what will happen if the client disengages or lapses. This should consider issues such as:

+ Identifying potential triggers and risk situations for lapse
+ Thinking about what to do if faced with a risk situation
+ Planning for what the client should do if they lapse
+ Clarifying what the agency should do in this situation e.g. should they call, visit, contact a friend or relative.

In some cases clients may benefit from long term accommodation in a residential setting which allows them to continue to drink – wet houses. Such facilities are available as part of the national network of alcohol rehabilitation services. However, they may be hard to access due to expense or location and real questions remain about whether this approach is suitable for any but the most seriously damaged drinkers e.g. people with alcohol related brain injury.

Planning for lapse: An interesting example of efforts to improve engagement comes from Community Drug Services for South London. They ask all new clients to write themselves a letter which will be kept on file and sent if the person drops out of treatment. The letter is encouraging the person him or herself to keep going or try again. Other services use a postcard.

Outreach

Staff should consider whether outreach/ befriending/peer mentoring approaches could improve the situation.

The key element in a local approach to difficult to engage clients will be outreach capacity within or alongside alcohol services. Services cannot knock on the door of every client who drops out, but those about whom local stakeholders are most concerned should be followed up.

Whether they are frequent attenders in the hospital system or repeat offenders in the criminal justice system, evidence exists that this approach has an impact:

+ A commissioner in one area set up an outreach post to knock on the door of anyone who dropped out of treatment. Over 70% of those contacted re-engaged[56]
+ The evidence of the effectiveness of this approach has been long evidenced in the mental health field[57]
+ Miller and Rollnick's Motivational Interviewing quotes evidence supporting this approach[58]
+ More recently, data from Wigan's Active Case Management Team, which works to engage frequent attenders in the hospital system, shows very marked reductions in hospital use by people who receive outreach.[59]

This will involve someone visiting the client at home or in the community, spending time with them and attempting to build a positive relationship which encourages change. This is time and resource intensive and is not usually something that can be provided by most agencies.

However, if someone is a cause of significant concern, efforts should be made to try and identify a service in the community that could undertake this role.

In some cases this could be appropriately trained and supported volunteers or peer mentors.

Ongoing Support

If individuals do make a change, it is important to ensure that they have aftercare.

Ongoing support and access to opportunities to continue their personal development.

Tackling elements which support someone in a drinking lifestyle

It may be worth considering whether there are people, organisations or other aspects of their life which support or enable the drinking behaviour:

+ Are there family members who are providing alcohol or money to buy alcohol?
+ Is there a day centre which is putting up with unreasonable behaviour?
+ Are local shops providing alcohol on credit?
+ Is there a pub selling to the client when intoxicated?

Efforts could be made to reduce the impact of these factors, e.g. talking to family members, reminding licensees of their legal responsibilities.

In both Brighton and Suffolk efforts have been made to encourage off licences not to sell high strength beers and ciders (6%+) to reduce the impact on street drinkers.[60]

Containment powers for problem drinkers

If all other steps are failing, staff in combination with other services should consider whether further compulsion is possible.

Compelling people into treatment is a controversial area. Some would argue that compelled treatment for substance misusers is an abuse of people's human rights. At the other end is Article 5 (e) of the European Convention on Human Rights which allows for "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics and drug addicts or vagrants." (It should be noted that this section was not enacted into English law).

This guide is not the place for a debate about the rights and wrongs of compelled treatment. However, if a person poses a significant risk of harm to themselves or others and voluntary approaches, such as motivational interviewing, harm reduction and outreach, do not seem to be working, the ultimate step is to consider whether compulsion is appropriate.

A number of powers exist which may be used to constrain risky behaviour e.g. Civil Injunctions (which replaced ASBOs)/Drink Banning Orders or Alcohol Treatment Requirements.

None of these provide a perfect solution but if services are faced with a client who poses significant risk and is treatment resistant, then compulsory powers will need to be considered.

Options include:

+ The Mental Health Act – if they also have a mental disorder or the suspicion exists that they have a mental disorder[61 62]
+ The Mental Capacity Act – this may be applicable to people with alcohol related brain damage[63]
+ Drink Banning Orders – again similar to an ASBO but enables the person to be barred from licensed premises in named areas[64]
+ Civil Injunctions and Criminal Behaviour Orders (which replaced Anti-social Behaviour Orders/ Anti-social Behaviour Injunctions)[65]
+ Alcohol Treatment Requirements (ATR) – i.e. a Probation Orders with Conditions of Treatment[66]
+ Conditional Cautioning – a custody sergeant can choose not to pursue with a prosecution if a person attends a named service. If the person does not attend the prosecution can be pursued[67]
+ Appointeeships – a person can be appointed to receive a person's benefits on their behalf – this can be a harm reduction measure allowing the payments to be spread out over e.g. a week[68]
+ Child Protection powers – these may encourage clients to engage with treatment in order to avoid further action to protect their children[69]
+ Vulnerable Adults – some drinkers are vulnerable adults and could be treated as such. They may be being exploited or abused because of their drinking and lifestyle[70]
+ MAPPA (Multi-agency Public Protection Arrangements) – people who reach a certain threshold of risk to others should be managed through the multi-agency MAPPA framework[71]
+ Fire and Rescue Services Act 2004 – prosecution is possible for making hoax calls to the fire and rescue services.[72]

The most important of these may be civil injunctions and criminal behaviour orders.

These not only ban behaviours but also provide the opportunity to impose requirements e.g. to receive support and counselling or attend alcohol awareness classes. These offer an opportunity to empower responses to the treatment resistant and disruptive client group.

A guidance document is available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332839/StatutoryGuidanceFrontline.pdf

Powers also exist to deal with accommodation which poses a threat to public health:

+ Public Health Act 1936 – Contains the principal powers to deal with filthy and verminous premises[73]
+ The Public Health Act 1961 – Section 36 Power to Require Vacation of Premises During Fumigation[74]
+ Housing Act 2004 – Allows the local authority to carry out risk assessment of any residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm[75]
+ Building Act 1984 Section 76 – Available to deal with any premises which are in such a state as to be prejudicial to health[76]
+ Prevention of Damage by Pests Act 1949 – Local authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice[77]
+ National Assistance Act 1948 Section 47 – The local authority can apply to a Magistrate's Court for removal of a person to suitable premises for the purpose of securing necessary care and attention if the person is suffering grave chronic disease or is living in unsanitary conditions, and is unable to look after him or herself and is not receiving proper care from others.[78]

The risk of eviction or loss of benefits may also be considered in this context by relevant agencies.

Improving practice in specialist agencies

Although treatment resistant drinkers will be having limited contact, specialist services still have a vital role to play.

If such a client does make contact, maximum effort should be made to keep them in services and work should be undertaken to reduce harm.

Specialist services should, therefore, audit their practice:

- Regarding assessment, risk assessment, care planning and risk management to ensure it is sensitive to treatment resistant clients and the specific risks they present
- Against the standards in Public Health England's (PHE) recent publication 'Helping service users to engage with treatment and stay the course.'[79]

Local alcohol services should have a clear and up-to-date procedure on managing treatment resistant/difficult to engage clients. This will be consistent with local priorities and will:

- Identify any clients who need to be fast tracked into treatment
- Encourage engagement and contingency planning within care planning
- Set out the standard procedure to be followed by specialist alcohol agencies when clients disengage from a service at whatever point in their care
- Set out the level of risk or vulnerability of clients who will require further follow-up beyond the standard procedure
- Provide guidance on the nature and intensity of follow-up for clients who disengage
- Encourage the use of harm reduction
- Identify when and how contingency management (incentivisation) can be used with treatment/change resistant clients
- Specify when and how clients should be referred to multi-agency planning meetings and the involvement of specialist staff in that process
- Specify monitoring arrangements to ensure data is collected, collated and reported on numbers of treatment resistant clients and evidence of unmet need.

Public Health England (PHE) has published 'Helping service users to engage with treatment and stay the course.'[80] This focuses on what specialist treatment services can do to help those who want change but are unsure whether they can change or are finding help hard to access. It offers a range of characteristics of services which can be used to judge the adequacy of the response.

This guide will not repeat the content of this PHE document, however, a sample includes:

- Promoting what services offer
- Improving first contact
- Inviting environments that don't stigmatise users
- Encouraging reminders and cues
- Waiting times and rapid access,
- Making services accessible e.g. transport
- Flexible access
- Childcare options
- Considering quality and diversity issues,
- Formal inductions
- Accompanying entry and reaching out to service users
- Using motivational approaches and incentives.[81]

The full text is available at http://www.nta.nhs.uk/uploads/teip_engagement_jan2013.pdf

Implementing the process

A local strategy

To be most effective, any work on this client group will need to be set in the context of a local strategy. This section sets out a framework for implementing the Blue Light process.

Principles underpinning the strategy

+ **Recovery through abstinence is the best solution but change is not the only option** – ideally we will work with clients to bring them to the point at which they decide to change and choose abstinence; however, it is recognised that at some point the focus will need to be on managing and containing harm
+ **Take every opportunity** – we need to take every opportunity to engage treatment resistant drinkers and reduce the harms they pose
+ **Not everyone will change** – this strategy supports best practice but it does not guarantee success. Some people will die as a result of drinking and some people will only change after causing immense suffering to other people. The aim of this strategy is to minimise this harm through driving best practice into the system: it will not solve every problem
+ **Whole system approach** – the response to this client group will usually need to be the responsibility of a range of specialist and non-specialist services, not just a single agency or single worker. The response requires a network of integrated and interdependent services providing a coordinated and consistent approach
+ **Information on risky clients should be shared** – it is unhelpful to risky and vulnerable clients, their families and the wider community if information is held by a single agency and not shared
+ **Recording unmet need** – no system of treatment and care can provide for every client need. If gaps are being identified, especially consistent or serious gaps, staff should have mechanisms for recording and reporting these to those who commission services
+ **Learning lessons** – when things go wrong staff and services should have the courage to review the case and learn lessons for future practice. Responses will only improve through being open when things go wrong
+ **Celebrate and publicise success** – It is important to share examples of success with other agencies. This will need to be within the boundaries of confidentiality and client consent but, where possible, publicising success helps to build belief in the possibility of change among both workers and clients.

Success – a vision statement

A successful system will have:

+ A joint strategic agreement on the need to target this group
+ A nominated strategic leader: a champion
+ A clear definition of the client group to be targeted
+ Local adoption and adaptation of the Blue Light framework for working with this client group
+ Non specialist services that believe they can do something and take every opportunity to work with this group
+ Specialist services that are willing, able and skilled to work with this group
+ Specialist services that support non-specialist services in a positive way
+ Workers who communicate about this client group in the context of clear information sharing agreements
+ Local training and staff development that supports services
+ Multi-agency planning for specific clients
+ Outreach and support to clients when appropriate
+ Outputs and outcomes that are monitored
+ Lessons being learned when things go wrong.

Implementing the vision

This vision will be implemented across three phases:

+ Setting the strategic framework
+ Implementing the approach in local services
+ Monitoring the impact.

The following sections describe these phases in detail.

Setting the strategic framework

A sound strategic framework will require:

+ Publishing **a multi-agency strategic statement** which underlines the priority to be accorded to this group of clients and highlights that this client group is a shared responsibility
+ Identifying a **strategic champion** who will ensure that this group is appropriately prioritised
+ **Defining** the priority groups to be targeted.

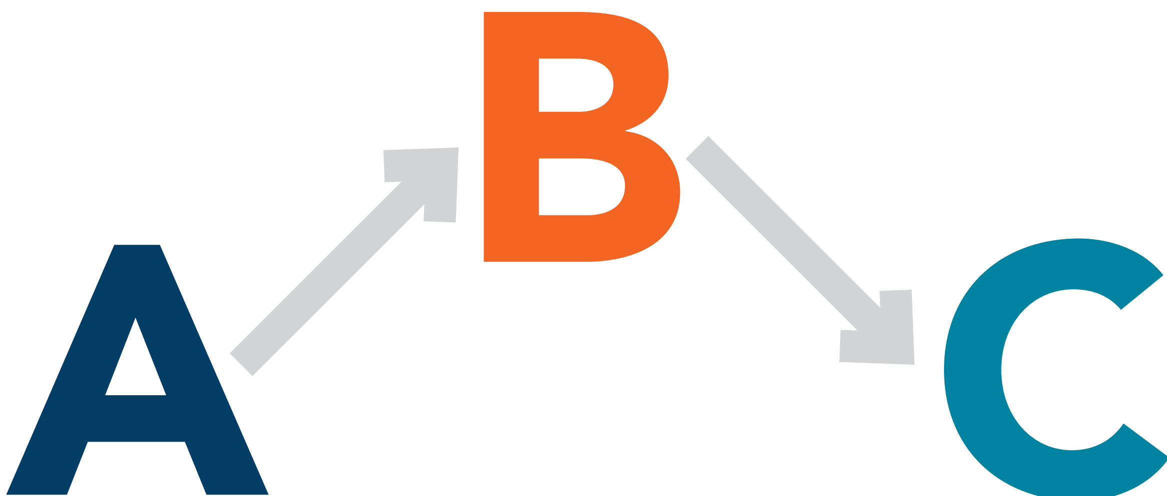
A multi-agency strategic statement

The response to treatment resistant drinkers should be built on the foundation of a clear strategic statement about the importance of targeting this group.

This should come from a multi-agency body such as the community safety partnership or the Health and Wellbeing Board.

The strategic statement should:

+ Commit to a multi-agency approach to working with these clients
+ Reflect the information-sharing arrangements which will support multi-agency working
+ Identify the priority groups who should be targeted e.g. repeat attenders in the hospital system, repeat offenders, people who misuse 999, people who place others at risk through violence, abuse or anti-social behaviour
+ Commit to the dissemination of these priorities to workers and associated training/professional development
+ Ensure data collection systems are in place to gather information on both the size of this group and the level of unmet need.



A strategic champion

The lead body, i.e. community safety partnership or health and well-being board, should identify a member who will have the strategic oversight for this client group.

The role will be to:

+ Oversee the implementation of the action plan
+ Regularly report to the group on progress and problems
+ Ensure this client group remains a focus of the group's agenda.

Develop a clear statement of the priorities within this client group

The strategy will be focused on clients who place a significant and repeated burden or pose a significant risk to themselves or others.

The lead body will need to agree a local definition of the client group. Each area of the country will have different priorities when considering who places the greatest burden on public services. In some areas hospital admissions might be the priority, in others community safety or anti-social behaviour.

However, any definition is likely to encompass those who:

+ Have a history of repeated violence to other people
+ Are at high risk of suicide or serious self-harm
+ Are regularly made homeless through alcohol use or are repeatedly found street drinking
+ Have a history of frequent alcohol related presentations to A&E or admissions to hospital
+ Have a history of repeated alcohol related offending or anti-social behaviour
+ Raise significant and repeated concerns regarding the welfare of children or vulnerable adults.

Section 2 and appendices 1 – 3 provide a guide to defining this client group which can be used to set specific parameters such as the number of arrests: in some areas it will be decided that the target is people with three alcohol related arrests in a month, in others it would be five arrests in a year. Other indicators can also be adopted e.g. ASB incidents or hospital admissions.

These priorities will need to be disseminated to local workers who will encounter these client groups. This could be assisted by developing a leaflet which explains the rationale for the approach.

Implementing the approach in local services

The key challenge will be to build this approach in to everyday practice. It can be implemented in local services in a number of ways but it is important to recognise that it may be best to build slowly. We do not have to eat the whole cake at once; we can take it piece by piece. This may mean focusing on a few key clients and key services at the outset. The choice of service will depend on local client priorities.

The key steps are:

+ Agreeing and disseminating **the frameworks** for working with this client group
+ Ensuring **organisational ownership** in key agencies
+ Running a coordinated programme of **workforce development** to improve practice and staff skills in specialist and non-specialist agencies via training
+ Agreeing **multi-agency management** frameworks
+ Considering the development or commissioning of **outreach/support services** which target this group.

Agreeing and disseminating the frameworks for addressing this client group

The Blue Light Project has produced a series of frameworks for different professional settings:

+ Children and families services
+ Adult social care
+ Mental health services
+ Police custody staff
+ Probation staff
+ Hospital staff
+ Emergency departments
+ Job Centre Plus staff
+ Housing/Anti-social behaviour staff
+ Fire service home safety check officers
+ Multi-agency groups e.g. MARAC and MAPPA
+ Primary care staff.

These set out how different groups of professional staff can manage these client groups and set out the approaches and techniques which constitute good practice with this client group.

These need to be disseminated to all relevant staff via their managers. They are available from consultancy@alcoholconcern.org.uk

Ensuring organisational ownership in key agencies

Each of the key agencies should review and adopt:

+ The client priorities identified as a part of the local strategy; and
+ The relevant good practice framework for treatment resistant clients described in the previous section.

They should ensure that both are disseminated to all staff with clear managerial support to embed it in practice in order that every opportunity can be taken to engage clients and reduce harm.

In order to maximise the long-term use of this approach the following support needs to be in place:

+ Organisations and individual managers should show an understanding of the importance of embedding this approach into everyday practice
+ Managers or senior officers should raise the use of these approaches in management or supervision settings to ensure it is being used
+ Information sharing protocols and communication systems need to be in place
+ Agencies should provide access to the resources needed to deliver this approach (e.g. training, leaflets, supervision).

Managers should ensure that services record and collate unmet need when they find it hard to access help for a treatment resistant client. This data should be reported to commissioners on a quarterly basis.

Improving practice and staff skills in non-specialist agencies

Professional development needs should be reviewed in the light of the requirements of the pathway with consideration being given to running training inputs on working with this client group e.g.:

- Assessment and risk assessment for this client group
- Motivational interventions
- Engagement techniques
- Harm reduction approaches
- Other approaches to working with this client group which were identified in the Blue Light Project.

Some of this training could be linked to training in alcohol Identification and Brief Advice.

Improving practice in specialist agencies

Alcohol services are responsible for:

- Clients who have been referred to the service or have sought help from the service but who disengage by not attending subsequent sessions or appointments.

Alcohol services cannot be expected to apply the same degree of follow-up to every client who disengages or is difficult to engage. The response will be differentiated by the priorities set out in the local strategy.

Therefore, each specialist agency should review and adopt:

- The client priorities identified in their local strategy
- This manual on working with treatment resistant clients that has been provided as an outcome of the Blue Light Project

and ensure that both are disseminated to all staff with clear managerial support to embed it in practice.

Specialist services should audit their practice:

- Regarding assessment, risk assessment, care planning and risk management to ensure it is sensitive to treatment resistant clients and the specific risks they present
- Against the standards in Public Health England's (PHE) recent publication 'Helping service users to engage with treatment and stay the course.'

Local alcohol services should have a clear and up-to-date procedure on managing treatment resistant/difficult to engage clients.

This will be consistent with the local strategic statement and will:

- Encourage engagement and contingency planning within care planning
- Set out the standard procedure to be followed by specialist alcohol agencies when clients disengage from a service at whatever point in their care
- Set out the level of risk or vulnerability of clients who will require further follow-up beyond the standard procedure
- Provide guidance on the nature and intensity of follow-up for clients who disengage
- Encourage the use of harm reduction
- Identify when and how contingency management (incentivisation) can be used with treatment/change resistant clients
- Specify when and how clients should be referred to multi-agency planning meetings and the involvement of specialist staff in that process
- Specify monitoring arrangements to ensure data is collected, collated and reported on numbers of treatment resistant clients and evidence of unmet need.

Professional development needs should be reviewed in the light of the requirements of the pathway with consideration being given to training inputs on:

- Harm reduction
- Contingency planning
- Other approaches to working with this client group which were identified in the Blue Light Project.

Multi-agency management

A local structure for the multi-agency management of treatment resistant clients should be agreed.

Commissioners and providers will need to consider whether a further multi-agency framework is required to manage treatment resistant clients or whether existing structures serve this need. Commissioners should ensure multi-agency management occurs, irrespective of the structure.

Commissioning services which target this group

Commissioners and services jointly will need to determine whether an expansion or development of outreach capacity is required. Outreach services will follow up high risk individuals being identified in the hospital, custody or other setting but who are not in the treatment system.

This service could usefully be modelled on High Volume Service User services found elsewhere, e.g. The Active Case Management approach in Wigan. This is based on a partnership delivery approach which includes The Wigan & Leigh Drug & Alcohol Recovery Partnership and Wrightington Wigan & Leigh NHS Foundation Trust.

This has proven successful in reducing hospital re-attendances. The Wigan team consists of two workers who target around 30 – 40 frequent alcohol hospital attenders every 6 months.

Such a system will require:

+ Criteria to identify the clients to be targeted by the service
+ Staff in hospitals, custody settings or other key settings being able to identify priority clients and seeking consent for the outreach team to contact them
+ Swift pathways into treatment services for clients that have been engaged and then require help in order to ensure the outreach service does not become clogged with clients.

Consideration could be given to the use of appropriately trained volunteer peer support or befriending services as part of the outreach service.

Monitoring the impact

The impact will be monitored by:

+ Adopting appropriate **data collection** systems and performance indicators
+ Gathering data on unmet **need**
+ **Learning lessons** from serious incidents to inform future action.

Performance indicators

Commissioners will need to agree a set of outcomes/performance indicators relevant to this client group.

A number of performance indicators can be used monitor the performance of this strategy:

+ The number of clients who disengage from specialist services who are re-engaged
+ An increase in the number of successful referrals between specialist and non-specialist services
+ The number of non-specialist workers trained in motivational interventions
+ The proportion of specialist care plans which include engagement plans and contingency plans
+ The number of clients managed in a multi-agency framework.

Gathering data on unmet need

It is important that all agencies record, collate and report data on unmet need related to the priority client groups. Commissioners and strategic leads should review this data on a quarterly basis.

Learning lessons from serious incidents

Each area should use serious incident reviews in the substance misuse field as a means of learning lessons about this group of clients and review lessons from other inquiry processes e.g. serious incidents in mental health services, domestic violence homicide inquiries or child death reviews when they relate to this client group.

It is important that effort is made to learn lessons from alcohol related deaths. This has two aspects:

+ Learning lessons about the adequacy of care for problem drinkers from local critical incidents
+ Developing inquiry processes into alcohol related deaths which mirror those into drug related deaths.

Many of these incidents will concern people who have been difficult to engage. This may require work to develop or update the current local drug and alcohol death review structures.

A number of acts of violence or self-harm will be subject to inquiry processes e.g:

+ Part 8 Child Death Inquiries
+ Internal Serious Untoward Incident (or Critical Incident) Inquiries in mental health services (covering homicides, suicides, violent acts and serious self harm)
+ Drug death reviews
+ Independent mental health homicide inquiries
+ Domestic homicide reviews.

Many of these may involve significant levels of alcohol misuse as a contributory or causative factor and the reports may highlight specific failings in the local response to treatment resistant clients. The lessons from these reports should be used to inform the commissioning of alcohol services.

The needs of people with mental disorders

Two linked groups of clients require particular attention in this strategy:

+ People with a dual diagnosis of mental health and alcohol misuse
+ People with alcohol related brain damage/injury.

The dually diagnosed, in particular will form a significant proportion of the change resistant drinkers.

This document is not, and should not be a strategic statement about either of these groups. However, commissioners will need to ensure that there is a strategy for the management of both of these groups and clear care pathways.

Local interviews have been clear that they find it difficult to access appropriate help from statutory mental health services with this group. This is despite national guidance which gives mental health services the lead responsibility for this client group.

Gaps in the response to dually diagnosed clients must be resolved by joint working between commissioners of both groups:

+ Commissioners should jointly review the national guidance on the response to dual diagnosis and ensure it is being applied in the boroughs
+ Commissioners should review serious incidents to see if they can identify cases which highlight failures in the care for this group
+ When serious incidents are identified they should be used as the focus for workshops between the services to improve pathways
+ Services must report all cases of dual diagnosis and alcohol related dementia to commissioners who will keep and publish a record of the numbers identified.

Two final points

Staff support

Staff support is vital.

Many treatment resistant clients will be challenging to work with, perhaps because they are directly confrontational, because of their risks or vulnerability or because of their impacts on others. Staff will need good managerial and peer support to deal with this client group.

Celebrate and publicise success

It is important to share examples of success with other agencies. This will need to be within the boundaries of confidentiality and client consent but, where possible, publicising success helps to build belief in the possibility of change among both workers and clients.

Appendix 1

Markers of the burden on public services

Each area will require a definition or description of the clients who will be targeted as "Blue Light" clients. To make this definition usable it will be necessary to agree markers of service usage. In some settings this is straightforward: in hospital, admissions and attendances provide the marker. A measure such as 3 alcohol related admissions per year can be used as the indicator of repeated usage. However, in areas such as social care the marker is more complex.

The table below sets out possible markers identified following discussions with the many partners to the Blue Light Project. Each marker has an endnote which indicates the source of the information. Once established, these measures can be adjusted up or down to make more or less people eligible.

	Marker	Indicative level at which the person can be seen as a significant burden
Health		
Emergency Department	Attendances per annum[82]	12 attendances per annum[83]
Hospital	Admissions per year[84]	3 or more admissions per annum[85]
Primary care	+ Appointments/ callouts per year + PARR (Patient at Risk of Readmission) score + Number of agencies involved	12+ appointments per year[86]
Ambulance and Fire Service	Callouts per month[87]	10+ callouts per month[88 89]

Crime

Police	Repeated arrests/ reoffending rate	3 arrests or Fixed Penalty Notices in a 3 month period[90]
Probation	Non-compliance with order including further offending	All clients who meet the first two elements of the definition and are non-compliant[91]
MAPPA	All alcohol related Category 2 & 3 MAPPA clients	All clients who meet the first two elements of the definition alcohol related Category 2 & 3 MAPPA clients[92]

Domestic violence/MARAC

Repeat abuse	+ Incidents per annum + Alcohol related MARAC clients	All clients who meet the first two elements of the definition and are high risk cases on the DASH risk assessment[93]

Social care

Adult Services	+ Level of risk plus either + Multiple referral or + Number of agencies involved[94]	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite[95]
Adults involved with Children and Families Services	+ Level of risk plus either + Multiple referral or + Number of agencies involved[96]	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite[97]
Housing and homelessness Services	+ Failed tenancies + Excessive rent arrears + Repeated abuse of accommodation or ASB	+ 3 failed tenancies in 5 years[98] + 3+ complaints or referrals for ASB per year[99]

Anti-social behaviour	+ Complaints or referrals about ASB per year + Length of time case is worked by ASB team	+ 3+ complaints or referrals per year (NB The Anti-social Behaviour bill identifies 3 incidents in 6 months as a trigger for a more serious response)[100] + 1 year plus involved with ASB team[101]

Street drinkers	The number of street drinkers in area[102]	All regular street drinkers[103]

The markers above are only suggestions. Beyond this, a 'political' decision is required about where each partnership 'cuts the line' in determining who is regarded as a Blue Light client. Is it three hospital admissions per year or four? Is it 10 ambulance service callouts or 20? This will allow the most effective targeting of local resources.

Appendix 2

The cost burden of the Blue Light group of clients in England

A costing has been attempted of the burden of the Blue Light group using national data and data from partners in the project. However, in order to enhance the reliability of this data we have attempted to triangulate it with other estimates. This will provide some sense of the validity of the data.

We have attempted to triangulate our estimate by:

+ Applying a simple percentage to the national estimates of the costs of alcohol misuse
+ Comparing the estimates with other estimates of the costs of national problems such as mental health and domestic abuse
+ Comparing the estimates with projections based on the costs of individual clients.

A simple cost estimate 1

The simplest approach to estimating the costs of the Blue Light population is to take the estimates of the total national cost of alcohol and then use a simple calculation of the proportion that is attributable to treatment resistant drinkers.

Alcohol-related harm is now estimated by the Government to cost society £21 billion annually.[104] The OECD provides an even higher estimate of £33 billion per annum.[105]

A number of studies suggest that around 6 – 7% of all alcohol related hospital admissions are by high risk repeat attenders.[106 107 108 109] If this figure is used as an estimate of the impact of resistant drinkers generally, this would suggest a figure of £1.36 billion per annum or about £9,000,000 per local authority per annum on the Government estimate and £2.1 billion annual cost £13,800,000 per local authority on the OECD estimate. (NB: the UK's Gross Domestic Product is £2,471 billion).

This figure is a very crude estimate of impact but provides a baseline to compare with other analyses. It also does not allow for the differences between local authorities in terms of population or need.

Comparative large scale costs

In 2004 Professor Sylvia Walby produced: The Cost of Domestic Violence.[110] This estimated the cost of domestic violence in England and Wales in 2001 as £23 billion. In today's prices this would equate to over £30 billion.

This estimate was based on £1,017 million for the criminal justice system (of which £487 million was for the police), £1,396 million for health care, £228 million for social services, £158 million for housing, £312 million for civil legal, £2,672 million for lost economic output, and £17,086 million for human and emotional impact.

In 2009, this estimate was reduced because of the decrease in the rate of domestic violence. This reduced the overall cost to £15.7 billion, but the key falls were in the area of emotional and economic costs; the service costs rose slightly.[111]

Another comparison is provided by the NHS itself which estimates that mental health conditions cost approximately £105 billion a year, due to loss of earnings and associated treatment and welfare costs. They argue that the cost to an individual with a mental health illness can also be high because, left untreated, such conditions can result in unemployment, homelessness, the break-up of families, and suicide.[112]

Most recently and perhaps most crucially, Louise Casey, head of the government's Troubled Families programme has estimated that 500,000 problem families are estimated to be costing the taxpayer more than £30 billion a year.[113]

In the context of both these costings the estimates for alcohol misuse below can be argued to be relatively conservative.

Individual costings

Making Every Adult Matter (MEAM) is a project working to target people facing multiple needs and exclusions. Their publications have estimated that in England approximately 60,000 people fall into this category. They have estimated a cost of between £36,000 and £48,000 per year per client.

Resolving Chaos – a Big Lottery funded project working on individuals with multiple needs provided the following case study and estimate of costs incurred by this client:

George, 38, lives alone in South London. He's agoraphobic, so he won't willingly leave his flat. He's a chronic alcoholic – two bottles of fortified wine a day, as well as whiskey mixed with the codeine he's also addicted to. Unsurprisingly, he has liver damage, with fluid on the lungs, which leads to him needing a two-week hospital admission on a monthly basis. He has painful fungal infections.

George doesn't receive any social care support – he doesn't meet their criteria. He has been 'red-flagged' by the local PCT, meaning he is not able to use their services due to his aggressive/abusive behaviour. So, he has no GP and he's banned from respite care.

George rings an ambulance two or three times a week. The police have to accompany the ambulance crew when they attend his house. He has attacked ambulance staff, police and taxi drivers, leading to arrest, court appearances and fines. No local taxis will take him to A&E, so the ambulance is his main method of transport. He has a wide range of medication for his conditions, but does not take them. His condition deteriorates until he requires re-admission.[114]

Resolving Chaos estimate that George's behaviour costs the tax payer £71,000 a year.[115]

Similar estimates have been found elsewhere: a single high volume service user in Nottingham was estimated to be costing local services over £100,000 per annum. Such a case might be exceptional but gives a sense of the potential cost impact. The same team identified four clients for whom average cost savings of £20,000 per annum were achieved.

An Australian study looked at the average lifecourse institutional costs for 11 complex individuals, aged between 23 and 55. The lifetime costs ranged from £495,000 to £3 million.[116] The average period engaged with services was 27 years giving an average annual cost of between £18,000 and £100,000.

The data above suggests that the MEAM estimate of between £36,000 and £48,000 per year per client is realistic. On the basis of their estimate of 60,000 such clients national, this would give an annual costing of £2.4 billion pounds for this client group. These are costs across health, social care, criminal justice and housing services.

The Blue Light costing methodology

In developing the costing for the Blue Light Project the methodology has been to:

+ Identify the key areas of client impact e.g. policing or primary care
+ Identify the markers of that impact e.g. admissions or the percentage of the workload attributable to the client group
+ Identify service costings
+ Undertake a calculation.

Costings data is readily available for all the identified services. However only in health services has it been possible to identify data which is specific to the impact of Blue Light clients:

+ In services such as policing and social care the data is not specific enough
+ Moreover, using a marker such as arrests or Fixed Penalty Notices underestimates the considerable impact that these clients have on routine policing activities e.g. pacifying an argument between a couple, which does not end in a penalty of any kind.

In these latter services we have used a combination of national impact data and evidence from services within the Blue Light partnership to make estimates of the burden on these services. In all cases we have erred on the side of caution: underestimating rather than over estimating the cost burden. The table overleaf sets out the costs.

The Blue Light Costing National

Health

Area	Marker	Calculation	Cost indicator	Proportion attributed to Blue Light clients	Cost
Primary care	Repeat consultations	Number of relevant consultations x cost per consultation	£36 tariff per consultation	3,787,000 consultations by Blue Light clients	£136,332,000
Emergency department	Repeat attendances	Number of relevant attendances x cost per consultation	£110 tariff per attendance	178,080 attendances by Blue Light clients	£19,588,800
Hospital	Repeat admissions	Number of relevant admissions x cost per consultation	£1,500 average cost per admission for alcohol repeat attenders	84,000 admissions by Blue Light clients	£126,000,000
Ambulance	Callouts	Number of callouts x national tariff	£450 call and transport tariff	178,080 attendances by Blue Light clients	£80,136,000
Alcohol services	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£204,800,000 national cost of alcohol services	5% of national cost attributed to Blue Light clients	£10,240,000
Mental health	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£12,100,000,000 national cost of mental health services	3% of national cost attributed to Blue Light clients	£363,000,000

Criminal justice

Area	Marker	Calculation	Cost indicator	Proportion attributed to Blue Light clients	Cost
Police	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£13,500,000,000 national cost of police services	2% of national cost attributed to Blue Light clients	£270,000,000
Probation	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£820,000,000 national cost of probation services	5% of national cost attributed to Blue Light clients	£41,000,000
Anti-social behaviour	Service usage	National cost of ASB divided by proportion of attributable to Blue Light clients	£3,400,000,000 national cost of anti-social behaviour	10% of national cost attributed to Blue Light clients	£340,000,000

Social care

Area	Marker	Calculation	Cost indicator	Proportion attributed to Blue Light clients	Cost
Adult social Services	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£14,736,000,000 national cost of adult social services	2% of national cost attributed to Blue Light clients	£294,720,000
Children and Families Social Services	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£6,513,000,000 national cost of Children and Families Social Services	10% of national cost attributed to Blue Light clients	£651,300,000

Housing

Area	Marker	Calculation	Cost indicator	Proportion attributed to Blue Light clients	Cost
Housing and Homelessness Services	Service usage	National per annum cost divided by proportion of usage by Blue Light clients	£2,122,000,000 national cost of Housing and Homelessness Services excluding benefits	2% of national cost attributed to Blue Light clients	£42,440,000

Emergency Services

Area	Marker	Calculation	Cost indicator	Proportion attributed to Blue Light clients	Cost
Fire Service callouts		Building fire callouts cost x proportion attributable to Blue light clients	£56,800,000	5% of national cost attributed to Blue Light clients	£2,840,000
Fire Service false alarms		Cost of non-faulty equipment false alarms x cost x proportion attributable to Blue Light clients	£41,200,000	5% of national cost attributed to Blue Light clients	£2,060,000

Total **£2,379,656,800**

This table has excluded separate costings for the impact on services of Domestic Abuse which would have led to double counting with police, social care and many other of these costing areas. The national cost of domestic abuse to services is estimated at £4.3 billion. It is estimated that each domestic abuse incident costs around £9,000.[117] The national cost of local authority community safety services which is assumed to be included in the wider cost of anti-social behaviour. The national cost of these services is £288,000,000.

The Blue Light Costing National – comment

The costing produced by this methodology is consistent with that provided by MEAM. However, this figure is clearly a bare minimum. The Blue Light estimate is probably an underestimate: having chosen very low estimates for the impact on some of the services e.g. policing.

Appendix 3

The number of people in this client group

Alongside the costings it is useful to have some sense of the number of clients in this group. The MEAM data recorded above would suggest a crude average of just under 400 people per authority, making no allowance for different sized areas or levels of need it is simply indicative. The table below sets out the evidence and projections of the size of the group in an average sized, average need local authority (350,000 population).

Service area	Evidence/rationale	No. of Blue Light clients per average authority
Primary care	Based on the number repeat hospital admissions	50 – 100
Emergency department	Evidence from around the country gives an accurate picture of the size of this group (see 5 above)	50 – 100
Hospital	Evidence from around the country gives an accurate picture of the size of this group (see 5 above)	50 – 100
Mental health	Data in section 9 below suggests an average of 94 people in mental health services who are dependent on alcohol. All of these clients could be included but we have chosen to include half this number.	40 – 50
Police	1.2 million arrests nationally. 30 – 40% alcohol related. In one study 1.3% of arrests were by people who had 2+ alcohol related arrests in one month period.	30 – 40
Probation	174,000 community orders and post sentence supervision each year. Approx. 40% of OASys assessments show alcohol as a criminogenic factor. Discussions with officers suggest at least 5% of case load will be Blue Light clients.	50 – 60 per LA
MAPPA	4,349 people nationally at category 2 & 3 who are managed at risk level 2 & 3. If 25% of these have significant alcohol related problems.	7
MARAC	In 2011/12, the police reported nearly 800,000 incidents of domestic violence 1.28 cases per 1000 pop.[118] If 20% have alcohol component.	80

Service area	Evidence/rationale	No. of Blue Light clients per average authority
Anti-social behaviour	2.7m incidents of ASB 2012 according to police.[119] Approx. 3000 adult ASBOs in force at any one time in England.[120] Use number of ASBOs as a proxy.	20
Adult Social Services	878,000 clients in England had a care package in 2012 – 13.[121] Alcohol is a significant factor in 20 – 40% of all social work cases.[122] A large proportion will be older clients, physical and learning disabilities. Assuming a proportion as low as 2% are dependent Blue Light clients. This is based on discussions with staff.	100
Children and Families Social Services	247,000 Children in Need at 31/3/13 due to abuse, neglect or family dysfunction.[123] This may represent 120,000 families assuming 2 children per family on average. Evidence suggests up to 50 – 60% of child protection is related to alcohol use by parents. Using a much smaller proportion 20% and assuming only one problematic parent per family. This is based on discussions with staff.	160
Housing and Homelessness Services	2,414 rough sleepers on any night in England.[124] 38,000 hostel places for single homeless people.[125]	16
Street drinkers	Government data for the alcohol strategy.[126] Brighton, a high impact area estimates a number in the 100's as a result of counting exercises.	60

NB

+ The analysis has removed clients of alcohol services because it is their task to work with this client group
+ Ambulance callouts and fire service callouts/hoaxes have been removed because they are highly likely to be counted elsewhere e.g. in ASB, policing or hospitals.

The number of clients – comment

The total number of clients identified in this table is just over 700. Again the estimates have been cautious and erred on the lower sider. However, some of these will be the same person counted twice. So far it has not been possible to accurately eliminate the double counting but there will be very limited overlap between categories such as Children and Families and Adult Social Services, between inpatients and arrests which tend to be different age groups. This suggests that 4 – 500 individuals per average authority is a realistic baseline estimate.

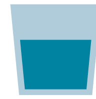
Appendix 4

AUDIT Tool

These are ONE unit of alcohol

Half pint of regular beer, lager or cider

1 small glass of wine


1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

Each of these is MORE THAN ONE unit of alcohol

Pint of regular beer, lager or cider

Pint of premium beer, lager or cider

Alcopop or can/ bottle of regular lager

Can of premium lager or strong beer

Can of super strength lager

Glass of wine (175ml)

Bottle of wine

Scoring:

0 – 7	Lower risk
8 – 15	Increasing risk
16 – 19	Higher risk
20+	

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Your score: ______

Appendix 5

Information sharing

The Data Protection Act 1998 makes it clear that organisations of all types cannot share information that they hold with a third party or use it for any purpose other than that for which it was collected, unless they have obtained the person's consent. This is clearly right and proper in a democratic society.

The NHS Constitution for England, established under the Health Act 2009, places a legal duty on all NHS bodies, private and third-sector providers supplying NHS services to take account of the Constitution in their decisions and action. In particular it gives a right and pledge to patients that their confidentiality will be upheld.

Other relevant legislation includes:

+ Common law – not enacted by Parliament but instead established over a long history of cases heard in court where judgements have established legal precedents
+ Freedom of Information Act 2000
+ Access to Health Records 1990
+ Mental Capacity Act 2005 & the Mental Capacity Act Code of Practice 2005.

However, during the research for Alcohol Concern's Blue Light Project it became clear that some agencies believed that the current legislative framework prevented them from any sharing of information about clients who pose a risk or place a significant burden on services. This is not necessarily the case.

This paper is not advocating a disregard for data protection, but it is saying that in working with higher risk and dependent drinkers who pose a particular burden on public services, circumstances do exist where information can be shared without consent.

As a general principle consent should always be sought to share information: this may be beneficial in the work with the actual client. However, even where consent is not available to share confidential information, it may lawfully be shared if this can be justified in the public interest: reporting of infectious diseases, reporting gunshot wounds to the police; because of a court order; medical research; serious crime; to protect children: risk to the public or NHS staff: terrorist related activity; natural disaster or when the public good is thought to be of greater importance than confidentiality.

For independent advice about data protection, privacy and data-sharing issues, you can contact the Information Commissioner at:

Wycliffe House, Water Lane,
Wilmslow, Cheshire SK9 5AF

Phone: 08456 30 60 60 or 01625 54 57 45
Fax: 01625 524 510

www.ico.gov.uk

Frameworks within which information sharing may happen

Where there is concern that a child may be suffering, or is at risk of suffering harm, the child's safety and welfare must be the first consideration. In these circumstances the Safeguarding Children Boards Child Protection Procedures, must be followed.

Where there is concern that a vulnerable adult may be suffering, or is at risk of suffering harm, the individual's safety and welfare must be the first consideration. In these circumstances the local Multi Agency Safeguarding Policy and Procedure, must be followed.

If the purpose is:

+ Primary or secondary health care use and
+ The care and treatment of the patient is central to the purpose and
+ The patient identifiable data is shared only between those responsible for the delivery of that care and treatment then consent can be reasonably implied.

Three pieces of legislation allow information sharing in different settings:

The European Convention on Human Rights, incorporated into English law from October 2000, by the Human Rights Act 1998: Article 8: Right to respect for private and family life states that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The Crime and Disorder Act 1998 – Section 115 as amended by the Police Reform Act 2002. This gives power to any person to disclose information to police authorities and chief constables, local authorities, probation committees, various health authorities, various fire and emergency authorities, and (since 2005) registered social landlords, or persons acting on their behalf so long as such disclosure is necessary for the purposes of any provision of the CDA.

These purposes include a range of measures, such as: local crime audits, anti-social behaviour orders, sex offender orders and local child curfew schemes. In addition, the CDA requires local authorities to exercise their own functions with due regard to the need to do all that it reasonably can to prevent crime and disorder in its area.

The Criminal Justice Act 2003. This extended the scope of MAPPA by imposing a duty on public bodies outside the criminal justice system, including NHS Trusts, to co-operate with the responsible authority for MAPPA. In practical terms this duty imposes the following obligations:

+ A general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management
+ A duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPA criteria
+ The need to develop protocols between agencies for exchanging information and other forms of cooperation.

Practice

This legislative framework does not imply a carte blanche to share information:

+ Agencies should strive to keep the individual concerned fully informed about the intention to share their personal information with others and should always seek their consent to disclosure
+ If the person gives verbal consent, this should be documented. If consent is not obtained or refused, the referring agency is responsible for informing the other agencies. They must provide a reason why it has not been obtained and must justify their decision if they wish to proceed with sharing personal information
+ Information sharing is strictly limited to that required to achieve the specific purpose e.g. reducing the risk of harm
+ Decisions need be justified on a case by case basis using professional judgement.

It would be good practice for the parties to the information sharing sign an agreement to that effect or at the very least record the information shared, the purpose and the legal framework used in the client's records.

If there is any doubt as to whether or not the information should be shared, advice should be sought from the Caldicott Guardian, if in the health sector, or appropriate senior person in other organisations.

Key Principles for Information Sharing

+ Any information which is shared must be accurate and up to date
+ Information should be relevant and no more than is necessary to meet the needs for disclosure
+ Information should not be kept for longer than is necessary for the purpose for which it was acquired
+ Information no longer required should be destroyed confidentially and in accordance with retention guidelines
+ All partner agencies will ensure the safe storage of information by operating information security and data protection controls.

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    • Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
    • Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels.
    Higher risk (or harmful) drinkers (who have a high risk of alcohol-related illness) are defined as:
    • Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week.
    • Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week
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