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Clinical guidelines for alcohol treatment

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Introduction

This introduction sets out how to use the guidelines, their aim, who they are for, what they are and their scope. It also summarises information on alcohol-related harms and health inequalities.

Chair's preface

I am delighted to be able to write this preface to the first UK clinical guidelines for alcohol treatment. I had the pleasure of chairing a hugely talented expert reference group in undertaking this work. We were a multidisciplinary group from across the 4 nations of the UK and were informed by a group of experts with lived experience. Their voice was central in framing and reviewing the work of the expert group and I am very grateful to all those who gave their time and wisdom to this endeavour.

Harmful and dependent use of alcohol carries a substantial cost to our society's wellbeing. Deaths caused by alcohol are at an all-time high, with rates rising further since the COVID-19 pandemic. We know that illness and death related to alcohol consumption is highest in the groups of our society who live in the most socially and economically deprived areas, and those in the lowest income brackets.

Good quality alcohol treatment has a crucial role in reducing alcohol harms and wider health inequalities. I have spent my professional life working clinically in alcohol and drug treatment services and over the decades have had access to several editions of UK-wide guidelines for the treatment of drug dependence. I know therefore at first hand the benefit to clinicians and practitioners of having authoritative and comprehensive guidance in the clinic and to inform teaching and development of the workforce.

However, these guidelines are not only for people working in specialist alcohol treatment services, but for everybody working to improve the outcomes of people with alcohol dependence or harmful patterns of alcohol use. This could be in primary, community or acute healthcare, social care (children's and adult), the criminal justice system, homelessness and housing services, employment, and voluntary sector services across the UK.

These guidelines set out a person-centred and holistic standard of care, informed by the voice of people with lived experience, the scientific evidence base and professional consensus. It is the standard that we should all expect for our friends and family, and it will improve equality of healthcare provision between people with alcohol use disorders and those with other health conditions.

My hope is that these guidelines will provide a clear model for those providing services, whether clinicians, practitioners or managers. My hope too is that they will enable people in need of help, and their families, to know what they should expect.

Planning and commissioning of alcohol treatment services and the workforce has different approaches and models across the UK, and has been and continues to be subject to change. These guidelines set out a clear framework and expectation of what well planned and commissioned services and its workforce look like. They will support people in planning and commissioning roles, whatever shape these take in the future.

The aim of the guidelines is ultimately to improve outcomes for people living with harmful use of alcohol and alcohol dependence and to do this by supporting everybody who plans, commissions and delivers services in ensuring that they are of the highest quality.

Dr Louise A Sell, MRCP, FRCPsych

Chair of the alcohol clinical guidelines development group

How to use these guidelines

These guidelines are organised into 2 parts.

Part 1 covers chapters 1 to 12. It includes guidance on the core elements of alcohol treatment. All these chapters are relevant for practitioners who work in specialist alcohol treatment services or who provide specialist alcohol treatment in other settings.

Part 2 covers chapters 13 to 27. It includes guidance for providing the core elements of alcohol treatment in specific settings and for specific populations. Practitioners should use the guidance relevant to the settings and populations they work in or with.

Chapter 1 summarises the main themes identified by the experts through experience group during the development of the guidelines. Chapter 2 summarises the main principles of care that underpin alcohol treatment. Each of the remaining chapters (3 to 27) begins with a summary of the main points contained in that chapter.

To navigate the guidelines, you can browse each named chapter individually from the contents page or search for topics using the search bar at the top of the manual.

You can also search within chapters to find the words or topics you are looking for guidance on. To bring up the find bar, we recommend using the keyboard shortcuts:

- Ctrl + F (in PC web browsers)
- Command + F (in Mac web browsers)

For mobile devices (like phones or tablets), use your web browser's 'Find in page' or 'Find on page' function, generally available through the settings or additional options menu.

About these guidelines

The aim of these guidelines is to improve the quality of alcohol treatment so that people with patterns of harmful drinking and alcohol dependence get better help and support and achieve better outcomes.

Who the guidelines are for

These guidelines on treatment for alcohol dependence and harmful drinking are for:

- clinicians and practitioners working in specialist alcohol (and drug) treatment services
- alcohol treatment clinicians and practitioners working in other settings such as primary or secondary healthcare or criminal justice settings
- clinicians and practitioners whose work brings them into contact with people with problem alcohol use in other services including primary, community and acute healthcare, adult and children's social care, criminal justice, homelessness and housing, employment and voluntary sector services
- commissioners and managers responsible for planning services to meet the needs of people with problem alcohol use

What the guidelines are

These are the first UK guidelines on the clinical management of harmful drinking and alcohol dependence. They are based on current evidence and professional consensus on how to provide alcohol treatment for the majority of people, in most instances. The guidelines have the same status across England, Scotland, Wales and Northern Ireland.

The guidelines do not provide rigid protocols on how clinicians must deliver alcohol treatment interventions for all in their care. Professionals are expected to take the recommendations in the guidelines fully into account when exercising their judgement, alongside the individual needs, preferences and values of the person they are treating.

The guidelines do not override the responsibility of clinicians and practitioners to make decisions that are appropriate to the circumstances of the individual person with problem alcohol use, consulting with that person (and family members or carers, if appropriate). However, where clinicians decide to operate outside the specific recommendations in these guidelines, they should be able to demonstrate (and should record) the rationale for their decisions.

Local commissioners, strategic managers and service providers have a responsibility to develop services that apply these guidelines. They should do so in the context of local need and national priorities for funding and developing services. They must also consider their duties to:

- eliminate unlawful discrimination
- advance equality of opportunity
- reduce health inequalities

Recommendations in these guidelines are consistent with those duties.

The guidelines and other published guidance

These guidelines integrate evidence on treatment and support for people with alcohol dependence or harmful drinking patterns, including evidence from National Institute for Health and Care Excellence (NICE) clinical guidelines:

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115)
- Alcohol-use disorders: diagnosis and management of physical complications (CG100)

These guidelines provide recommendations for how NICE guidance can be put into practice. The guidelines also cover some additional areas, not addressed by NICE. For example, they include aspects of recovery and considerations for specific settings and populations.

These guidelines are not intended to replace clinical guidance and quality standards issued by each of the UK administrations or professional bodies for clinicians. This is a single set of guidelines for the whole of the UK that provides a framework of best practice upon which locally appropriate policies and procedures can be based.

Clinicians and practitioners, commissioners and strategic managers should consider these guidelines alongside national guidance. There are some examples of relevant national guidance for each of the UK administrations at the end of this chapter.

The status of the guidelines

These guidelines have no specific statutory status. However, they set out the quality of care for the appropriate treatment of alcohol dependence and harmful drinking. There are separate, defined legal obligations for prescribing controlled drugs that clinicians should act in line with.

Registered professionals providing alcohol treatment are required to follow the guidance for their own profession and also other national guidelines relevant to their work.

These guidelines are a companion to Drug misuse and dependence: UK guidelines on clinical management (the 'orange book').

The guidelines as best practice

These guidelines set out best practice for alcohol treatment, based on:

- the available evidence
- specialist clinical consensus
- the voice of people with lived experience of problem alcohol use

They describe what people with alcohol dependence and harmful patterns of drinking need.

We do not expect that all local areas will immediately fully meet all the recommendations, but they should work towards them and have a clear understanding of areas where they do not comply and the reasons why. Some services might need to make changes in culture and practice and develop more flexible ways of providing interventions. The guidelines set out ambitious best practice for clinicians and other practitioners, commissioning systems and service providers against which to measure progress.

The process for developing the guidelines

The Department of Health and Social Care led the development of these guidelines in partnership with representatives from the Scotland, Wales and Northern Ireland governments.

A group of expert clinicians and other professionals from the alcohol treatment sector met regularly to advise on developing the content. They discussed expert presentations and agreed evidence-based recommendations for each of the main topics. Alongside this, a group of people with lived experience of alcohol dependence, treatment and recovery met regularly to advise on the same content. Representatives from the lived experience group presented their recommendations at each meeting of the larger expert group meetings. There were 12 subgroups that met to agree on evidence-based recommendations for specialist topics that were then ratified by the wider expert group.

These guidelines are based on evidence. In some areas of practice, there are evidence gaps and, in those cases, guidance is based on clinical consensus from the larger expert group. Where recommendations are based on clinical consensus this is noted.

We ran a public consultation on the guidelines which received many responses from people in the alcohol treatment sector, some of which were very detailed. Many of the points suggested were incorporated into the guidelines.

You can find a list of members of the clinical guidelines development group, the lived experience group and other contributors in annex 4.

Definitions of harmful drinking and alcohol dependence

Patterns of alcohol-related risk and harm exist on a continuum and there are several ways of describing categories within that continuum.

This guidance uses definitions of harmful drinking and alcohol dependence set out in the World Health Organization's (WHO) International Classification of Diseases, 11th Revision (ICD-11).

In ICD-11, harmful drinking is defined in the entry Harmful pattern of use of alcohol and alcohol dependence is defined in the entry Alcohol dependence.

You can read more about these terms in the glossary, which also contains other terms used to describe various patterns of alcohol use.

Alcohol harms

UK chief medical officers' low risk drinking guidelines say that to keep health risks from alcohol to a low level it is safest for both men and women not to drink more than 14 units a week on a regular basis. And for adults who regularly drink as much as 14 units per week, it is best to spread their drinking evenly over 3 or more days.

A significant proportion of the UK population regularly drink above low risk levels and there is evidence of high levels of alcohol-related harm across the UK (see section on 'Alcohol-specific deaths'). People with harmful patterns of drinking and alcohol dependence experience adverse health and social consequences. Partners, children and families of people with problem alcohol use as well as their communities also often experience harm.

Alcohol health harms

The public health burden of alcohol: evidence review found that alcohol is a causal factor in over 60 health conditions, including:

- long-term conditions, such as liver disease, cardiovascular disease, various forms of cancer including breast and bowel, and diseases of the central nervous system
- acute conditions from accidental injuries, violence and alcohol poisoning

Alcohol is an important factor for mental ill health and is a risk factor for depression, anxiety and suicide.

Alcohol-specific deaths

Alcohol-specific deaths are deaths from conditions wholly caused by alcohol. Most alcohol-specific deaths are due to alcohol-related liver disease. There have been substantial increases in alcohol-specific death rates across the UK since 2019.

The Office for National Statistics (ONS) report Alcohol-specific deaths in the UK: registered in 2023 found that:

- 10,473 alcohol-specific deaths were registered in the UK, the highest number on record, but the rate of alcohol-specific deaths (15.9 per 100,000 people) decreased slightly compared with 2022 (16.6 deaths per 100,000 people)
- the rate of alcohol-specific deaths for men remained around double the rate for women (21.9 and 10.3 deaths per 100,000 people, respectively), which is consistent with previous years
- England and Wales had an increase in the rate of alcohol-specific deaths compared with 2022 (15.0 and 17.7 deaths per 100,000 people, respectively)
- Scotland and Northern Ireland continued to have the highest rate of alcohol-specific deaths (22.6 and 18.5 deaths per 100,000 population, respectively), with the rate in Scotland remaining unchanged and a decrease in Northern Ireland compared with 2022
- the North East had the highest rate of alcohol-specific deaths of any English region (25.7 deaths per 100,000) and the East of England had the lowest rate (11.5 deaths per 100,000)

These figures are only for deaths caused wholly by alcohol. Numbers of alcohol-related deaths (deaths from conditions that are wholly or partially caused by alcohol) are much higher.

Alcohol and health inequalities

Health inequalities are usually defined as systematic differences in health outcomes between socioeconomic groups. There are also systematic differences in health outcomes between other groups such as between different ethnic groups.

Alcohol harm and deprivation

Alcohol-related illness and deaths are substantially higher in people living in the most socially and economically deprived areas and people in lower income groups.

For example:

In 2023, the ONS data set Alcohol-specific deaths in the UK shows that the alcohol-specific mortality rate in the most deprived fifth of the population compared to the least deprived was:

- 3.6 times higher for men and 3 times higher for women in England
- 3.6 times higher for men and 1.9 times higher for women in Wales

The National Records of Scotland report Alcohol-specific deaths 2023 shows that the mortality rate for alcohol-specific deaths was 4.5 times higher in the most deprived fifth of the population than in the least deprived.

In Northern Ireland, the report Alcohol specific deaths in Northern Ireland, 2023 shows that looking at the most recent 5 years together (2019 to 2023), there were almost 4 times as many alcohol-specific deaths in the most deprived areas compared to the least deprived areas.

These inequalities exist even though people in the most deprived areas on average have similar or lower levels of alcohol consumption.

There is evidence of several factors that contribute to alcohol-related health inequalities for people experiencing the highest levels of socioeconomic deprivation. Factors include:

- the direct impact of the social determinants of health including poverty, poor housing and related psychosocial stress
- differing distribution and patterns of drinking
- the multiplicative effect of harmful alcohol use alongside other health risk behaviours such as smoking and poor nutrition that are also influenced by deprivation (meaning that the sum of the harms is greater than what people would experience if they only had one of these health risk behaviours)
- alcohol-specific environmental factors such as the higher density of outlets for on-sales (such as pubs and restaurants) and off-sales (such as off licences and supermarkets) of alcohol in more deprived areas

The role of evidence-based alcohol treatment in reducing alcohol harms and health inequalities

Effective, evidence-based alcohol treatment and support, delivered by competent, well-supported staff, is vital to reducing harm and health inequalities for those people who experience the highest levels of harm.

Alcohol treatment services do this by helping people with harmful drinking patterns and alcohol dependence to:

- stop or reduce alcohol use
- access other services for help with physical and mental health conditions and social needs such as benefits and debt advice, domestic abuse support
- develop and access resources for longer-term recovery through involvement with social networks and peer support, housing support and employment support

Alcohol treatment services also have an important role in ensuring that children, partners or carers who are affected by a family member with problem alcohol use can access the help they need, including child and adult safeguarding where appropriate.

Accessible and inclusive services that target and meet the needs of people experiencing the highest levels of deprivation and multiple disadvantage are important in reducing health inequalities.

Reducing harms across the population

These guidelines are about individual alcohol treatment. Interventions to prevent or reduce alcohol harm at population level are outside their scope. However, it is important to recognise that alcohol treatment alone cannot reduce the high levels of alcohol-related harm in the UK and that prevention measures at a population level are necessary to achieve this.

WHO recommends population measures that target affordability, availability (ease of purchase) and acceptability (social norms around alcohol use) as these approaches have the strongest evidence. Effective prevention at population level and alcohol treatment are both vital to reduce harm and achieve better outcomes for individuals, families and communities.

1. Priorities for alcohol treatment and recovery from the experts through experience group

Experts through experience identified their priorities for providing high quality alcohol treatment and recovery. They emphasised the importance of personalised, non-judgemental treatment within a recovery-oriented system of care.

A group of experts through experience contributed to the development of these clinical guidelines. Group members had experience of alcohol treatment and recovery and were active in recovery organisations. The group's input is integrated throughout the guidelines.

The group identified the following themes as priorities for providing high quality alcohol treatment and recovery.

Alcohol treatment should take place in the context of a recovery-oriented system of care where clinicians, support staff, people with lived and living experience and people engaged in treatment all have roles to play.

People should be able to access personalised care from any part of the treatment and recovery system.

A non-judgemental, empathic approach and staff working together with people in treatment is essential.

People with lived experience and recovery communities can play a central role in supporting recovery at all stages of the treatment and recovery journey.

Individual treatment and recovery plans should include flexible recovery goals from the start, and the focus on recovery-oriented activities will increase during treatment and after they leave.

Alcohol treatment services and mental health services need to work together so people with problem alcohol use who also have mental health conditions do not get turned away. People should be able to get help for both conditions in a shared approach.

Services need to engage and support people from diverse communities. They should co-produce service plans with diverse communities and work flexibly in a culturally sensitive way to do this.

You can find a list of members of the experts through experience group in annex 4.

2. Principles of care

These principles of care outline evidence-based approaches for supporting people with problem alcohol use. This includes building trusting relationships, reducing stigma, working with families and carers, and promoting inclusive services and a recovery-oriented system of care.

2.1 Introduction

These principles should underpin all support for people with problem alcohol use. They are relevant to staff in any health, social care or community service working with a person with problem alcohol use. References to these principles of care appear throughout the guidelines.

The principles are based on the clinical consensus of the alcohol guidelines development group.

2.2 Experience of care

Principles 2.2.2 to 2.2.5 are based on the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence and other evidence as referenced.

2.2.1 Building a trusting relationship

Practitioners should work to build a trusting relationship with people with problem alcohol use, taking a supportive, empathic and non-judgemental approach.

Practitioners should ensure that a compassionate and humanising approach is evident in every contact with people with problem alcohol use.

Over time, a trusting relationship can develop into a strong therapeutic alliance, with the practitioner and the person working together to achieve the person's goals. A strong therapeutic alliance is essential to effective treatment and is associated with better treatment outcomes.

You can read more about therapeutic alliance in chapter 5 on psychosocial interventions.

2.2.2 Reducing stigma

Services and practitioners should work to reduce stigma.

People with problem alcohol use experience stigma in society (Kilian and others, 2021) and can also internalise stigma, resulting in feelings of shame and guilt. Past experiences of stigmatising services or assumptions, and internalised stigma can deter people from approaching services.

Staff in health and care services sometimes hold stigmatising attitudes which can result in discrimination, for example, they may not offer the same length of intervention or level of contact to people with problem alcohol use (Van Boekel and others, 2013). Stigmatising service policies can also lead to discrimination in the form of inappropriate exclusion from

services. Research consistently identifies stigma as a major barrier to help-seeking and treatment engagement for people experiencing problem alcohol use (Kilian and others, 2021).

The World Health Organization European framework for action on alcohol 2022 to 2025 (PDF, 2.2MB) includes a priority action for healthcare services to reduce social stigma and discrimination that prevent people from accessing alcohol treatment. Services and practitioners should address policies, practices and attitudes that can contribute to experiences of stigma, ensuring people feel respected, heard and not judged or treated differently because of their alcohol use. Health, care and support services should not exclude people from care that they need on the basis that they are experiencing problem alcohol use.

Language used to describe people with problem alcohol use can also be stigmatising. Preferred language and terminology around alcohol use can vary between individuals and over time. It is useful for services to regularly review the language they use by speaking to people with lived and living experience to understand what language they find stigmatising and what are their preferred terms.

2.2.3 Privacy and dignity

People seeking alcohol treatment and related services have a right to privacy and can expect to be treated with respect and in a way that preserves their dignity. Practitioners should make sure that any care or treatment and conversations about treatment take place in private and appropriate settings, including by having welcoming and safe waiting areas and suitable and pleasant confidential spaces.

2.2.4 Confidentiality and information-sharing

Services and practitioners should maintain clear confidentiality policies which they should discuss with each person at the start of their treatment and recovery journey. Policies should outline the boundaries of confidentiality, including the process for seeking the person's consent before disclosing their information to any external agencies or individuals.

It is important that people seeking support understand what confidentiality means and how and when information can be shared without consent, for example if a safeguarding issue is identified.

Services should develop information-sharing arrangements with partner agencies. Information-sharing between agencies can support an integrated approach to helping people with problem alcohol use to address their health and support needs.

Local agreements between services should describe and support suitable information-sharing arrangements that are consistent with legal and ethical obligations and avoid unnecessary barriers or delays. Where possible and with the person's consent, alcohol treatment services should arrange access to relevant sections of the person's national electronic health records. This can help services to access a summary of the most recent relevant health information rapidly.

Services should set out how, with the person's consent, they will share information with families and carers.

See chapter 4 on assessment and treatment and recovery planning for more on information-sharing and details of national electronic records.

2.2.5 Access to information

All healthcare services and support services should be able to provide basic information on what the local alcohol treatment service offers and how to access the service.

Alcohol treatment services should provide appropriate information to people seeking help about:

- their service
- the nature of alcohol dependence, harmful drinking and alcohol related problems
- available evidence-based treatments including their risks and benefits

Providing this information supports shared decision making (see section 2.2.6 below).

Services should make comprehensive written information available in an accessible format considering the person's literacy, digital literacy and access, sensory ability, cognitive ability and neurodiversity (see definition of neurodiversity in the glossary). Practitioners should avoid clinical language and jargon, and if they need to use it, they should explain what it means. Where English is not the person's first language, services should offer an independent interpreter (someone not known to the person) if they need one. Services should also translate written or video information into the person's language if necessary.

Where practitioners in the alcohol treatment service communicate with other healthcare professionals, they should provide the person with copies of any letters or medical reports and check that the person understands the content.

2.2.6 Shared decision making and person-centred treatment

Services should provide care based on shared decision making and train practitioners in this approach.

Shared decision-making means practitioners and people with problem alcohol use work together to agree on the treatment and support the service will provide for the person. The person should always be at the centre of decisions about their own care as far as possible, including where they lack capacity to make care decisions (see annex 1 for legislation and guidance on mental capacity). Where the person lacks such capacity, the practitioner must make a 'best interests' decision by considering all the relevant circumstances. This includes the person's wishes and feelings and the views of family members, carers and others with an interest in their welfare, as far as practicable and appropriate.

Practitioners should:

- inform each person that they have choices about their care
- help each person to think about the treatment options

- provide each person with information on associated risks and benefits of each treatment option - consider each person's individual needs
- support each person to decide on their preferred choice of treatment

Shared decision making is the basis for developing individually tailored, person-centred treatment and recovery support. Practitioners should always take account of a person's individual needs, strengths and aspirations, and their family and social situation, when offering them treatment and recovery support.

NICE guideline Shared decision making (NG197) provides more information.

People with lived and living experience of problem alcohol use should also be involved in decisions about the design and delivery of the service.

2.2.7 A strengths-based approach

Services and practitioners should take a strengths-based approach when working with people experiencing alcohol problems. A strengths-based approach means that practitioners help people to identify their personal strengths (for example, their skills and aspirations) and assets in their community (for example, their supportive social networks). A strengths-based approach does not mean ignoring problems. Practitioners should help people identify and address problems, but this should not be the only focus of treatment. Practitioners should support people to use their personal and community strengths to support their treatment and build their recovery.

Practitioners should help people access peer-delivered and peer-led recovery support from the beginning of treatment. Recovery projects show what people with lived experience can achieve and can instil hope, resilience and a sense of community (see section 2.6.5 on accessing peer-delivered and peer-led support).

2.2.8 Trauma-informed practice

Services should offer trauma-informed practice.

A high proportion of people experiencing problem alcohol use have had experience of childhood trauma and a significant proportion have also experienced trauma as adults. The experience of trauma can be individual (for example, child abuse) or collective (for example, war). Many people use alcohol as an attempt to manage the impact of trauma on their lives.

Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively affect individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use.

The purpose of trauma-informed practice is not to treat trauma-related difficulties, which is the role of trauma-specialist services and practitioners. Instead, it seeks to address the barriers that people affected by trauma can experience when accessing health and care services.

Trauma-informed practice is based on 6 principles, which are:

- safety
- trust
- choice
- collaboration
- empowerment
- cultural consideration

You should read the full working definition of trauma-informed practice for practitioners working in the health and care sector.

In Scotland, the National Trauma Transformation Programme resource A roadmap for creating trauma-informed and responsive change provides extensive guidance, much of which is relevant for other parts of the UK.

2.2.9 Alcohol-specific interventions and staff competencies

People with alcohol dependence or harmful (high risk) alcohol use should have access to evidence-based alcohol interventions delivered by staff with appropriate alcohol-specific competencies.

Alcohol treatment can be effectively delivered by services that provide alcohol treatment only, or by integrated drug and alcohol services. Where services are integrated, staff should identify and address the distinct needs of people with:

- problem alcohol use
- problem drug use
- both problem alcohol and problem drug use

Integrated services should fully include people whose main problem is alcohol. Services should offer evidence-based interventions for alcohol dependence and for harmful drinking delivered by staff with alcohol-specific competencies.

See chapter 13 on community alcohol treatment and recovery services for more on alcohol treatment delivered by integrated drug and alcohol treatment services.

2.2.10 Family involvement

Services and practitioners should involve family members or carers in a person's care where the person consents and it is appropriate. There is evidence that family involvement in a person's care can lead to better treatment outcomes (Copello and others, 2006). Services should also offer support to family members and carers in their own right.

If the person consents to a family member being involved, practitioners should discuss and agree with the person engaged in alcohol treatment, and then the family member or carer,

what is the appropriate level and type of family involvement. Practitioners should also agree with the person in treatment and their family member or carer what information will be shared and what information will remain confidential to each of them.

Services should offer family members and carers information on alcohol dependence and harmful drinking, as well as alcohol treatment interventions. They should also offer appropriate support for their involvement with the person's care.

Family and carers may have their own support needs and services should offer information on how family members can be affected by a person's problem alcohol use. Practitioners should offer initial support (including support for urgent needs) and where appropriate, offer extended support or let families and carers know about self-help resources, as well as local and national support organisations for families of people with problem alcohol use.

Practitioners should be aware what level of caring responsibility entitles a carer to a carer's assessment and they should refer the family member or carer for one where appropriate (see definition of carer's assessment in the glossary). You can find information about legislation and guidance on carers in annex 1.

Services should offer information and support to family members and friends, even where the person with problem alcohol use is not attending the treatment service (Orford and others, 2013).

You can read more about interventions involving families in chapter 5 on psychosocial interventions.

Practitioners should also consider the needs of any children in the family who are in regular contact with the person with problem alcohol use and provide information on local services for children and families. Services should have procedures for both child and adult safeguarding and practitioners should be trained to identify child and adult safeguarding needs and make referrals to children's or adult social care where indicated. They must work in line with national child and adult safeguarding legislation and organisational procedures. You can find information on child and adult safeguarding legislation and guidance in annex 1.

2.3 Equality, diversity and inclusion

Service policies, procedures and ethos, and practitioners' approach should be based on the principles of equality, diversity and inclusion and aim to reduce health inequalities. They should promote equitable access and personalised treatment that meets the diverse needs of all groups and local communities.

2.3.1 Promoting equality, diversity and inclusion

Alcohol harms and health inequalities

People with problem alcohol use have much higher levels of illness and early death than the general population (IHME, 2024; Roerecke and Rehm, 2013).

People experiencing economic and social deprivation

People who experience economic and social deprivation are disproportionately affected by the harm caused by alcohol dependence and harmful drinking. For example, the National Records of Scotland report Alcohol-specific deaths 2023 found the mortality rate for deaths caused solely by alcohol was 4.5 times higher in the most deprived fifth of the population than in the least deprived. And the Office for National Statistics report Alcohol-specific deaths in the UK: registered in 2023 shows that the mortality rate in England in the most deprived fifth of the population compared to the least deprived was 3.6 times higher for men and 3 times higher for women.

It is important that alcohol treatment services are designed to reach and to meet the needs of people in the most socioeconomically deprived areas in the locality they serve.

Alcohol treatment services need to work with partner services (including local voluntary and community services) to address barriers to engagement and issues that make alcohol harms worse for people experiencing social and economic deprivation. For example, in addition to ensuring people can access appropriate physical and mental healthcare, alcohol treatment services should provide or support access to:

- welfare benefits and debt advice
- social prescribing
- housing support
- employment support
- peer-based networks

Multiple disadvantage

Many people with problem alcohol use experience multiple disadvantage. In these guidelines, 'multiple disadvantage' is defined as the co-occurrence and interaction of adverse circumstances leading to social exclusion, marginalisation, and extreme inequality. People can experience complex, intersecting issues that can contribute and compound disadvantage, including health inequalities, poverty, housing instability and systematic discrimination.

People who experience multiple disadvantage often find it very difficult to access healthcare, including alcohol treatment services. They also tend to experience extremely poor physical and mental health compared to the general population and often have poorer health outcomes when they engage with health services.

Alcohol treatment services need to target groups that experience multiple disadvantage using flexible engagement approaches and tailor interventions to meet their specific needs.

You can read more about targeting and tailoring care for people experiencing multiple disadvantage in:

- chapter 9 on assertive outreach

- chapter 21 on people experiencing homelessness
- chapter 25 on developing inclusive services

People with protected characteristics

There is a public sector equality duty for services in Great Britain to consider the need to reduce disadvantage and meet the particular needs of people with protected characteristics.

Protected characteristics mean that it is against the law to discriminate against anyone because of:

- age
- disability
- sex
- race, including colour, nationality, ethnic or national origin
- religion or belief
- being pregnant or on maternity leave
- sexual orientation
- gender reassignment
- being married or in a civil partnership

For more information on protected characteristics, read Discrimination: your rights.

Alcohol treatment services need to promote equality in access and appropriate treatment for people with protected characteristics.

Designing inclusive services and tailoring interventions

Social and economic deprivation, multiple disadvantage, and discrimination and disadvantage based on protected characteristics can all affect how easy it is for people to access and engage with services and whether the treatment and support they offer meets their particular needs. Alcohol treatment services, working with the wider health and care system can help to promote equality, diversity and inclusion and reduce health inequalities.

They can do this by providing accessible and inclusive services which are designed to meet the needs of everyone experiencing problem alcohol use in their local area, including specific needs of people experiencing social and economic deprivation and multiple disadvantage, and people with protected characteristics. Individual treatment and recovery plans and interventions should always be tailored to each person's individual needs.

Local actions to develop inclusive services

Local commissioners and services should work with local people, communities, and organisations. In particular, they should work with representatives of groups from local areas

of social and economic deprivation, groups experiencing multiple disadvantage and people with protected characteristics to:

- assess local need for alcohol treatment using equality impact assessment processes to understand the diverse needs of their local population and to identify which people and groups are under-represented or experiencing poor outcomes in their services
- develop ways to target and increase access for each local under-represented group
- tailor services and interventions to meet the diverse needs of their local population

Services should develop an inclusive service ethos which means:

- people with lived and living experience of problem alcohol use from different groups and local communities contribute to service commissioning, planning and delivery
- there is a diverse team of practitioners and where possible, peer support workers, who are culturally competent (see section 2.3.2 below)

You can read more about developing inclusive services in chapter 25.

2.3.2 Cultural competence

Services and individual practitioners should be culturally competent. Services should make sure their staff receive training, supervision and support to develop this important competency.

The term 'cultural competence' refers to the ability of organisations and individual practitioners to effectively deliver services that meet the social, faith, cultural, and linguistic needs of people from diverse groups and communities. Cultural competence involves policies, behaviours, awareness, attitudes, knowledge and skills at an organisational and a practitioner level that promote effective interactions with, and equitable treatment for people from diverse backgrounds.

Culture intersects with other factors that shape identity and experience such as sex, sexual orientation, gender identity, age, disability, and socioeconomic resources. These combined factors affect how easy it is for each person to engage with alcohol treatment services and what kind of treatment approach will meet their needs. Cultural competence in this guideline means working effectively and equitably with people from all cultures and across intersecting identities. It also means challenging the discrimination and exclusion that people experience and the resulting impact on their treatment and recovery outcomes.

While cultural competence involves sensitivity and knowledge about other people's cultures, it is important not to label people or make stereotypical assumptions. Everyone is unique and treatment and recovery support should always be based on understanding the person as an individual and tailoring interventions to meet their specific needs.

Practitioners should also understand how their own culture and background can influence their perspective. Services should support them through training and supervision to challenge any unconscious bias that can affect their practice.

2.3.3 Accessible services

Services should make sure that they are easy to get to, welcoming and easy to engage with for everyone in the diverse local population.

Services should review their treatment processes and procedures and amend them to address any factors that might prevent people from accessing or engaging in treatment. This will include offering appointment times that can accommodate parents with childcare responsibilities and people who work in the day. Also, services should be offered at sites that are easy to access by public transport so that people in any part of the local area can get there easily. The services should be in places where people feel physically safe, for example in areas with good lighting. The cost of travel can act as a barrier and services should help people to access support with transport costs where possible.

Services should have flexible engagement arrangements to meet the needs of specific groups, including those with protected characteristics. For example, these arrangements might include:

- direct access (drop-in) sessions at treatment service sites
- satellite services in primary care for people who would not want to go to a specialist alcohol and drug service, because of their concerns about stigma
- satellite services in community services and organisations used and trusted by specific groups such as specific minority ethnic groups, LGBTQ+ groups and older people
- satellite services in areas of deprivation and in more remote rural areas
- access to services and facilities for people with physical disabilities
- initial contact and (where appropriate) further appointments online or by phone for people who find it very difficult to attend a service in person
- methods of communication and information adapted to the needs of people with physical, sensory or cognitive disabilities, neurodiversity or limited literacy

Services should make arrangements to help the most vulnerable people, including those experiencing multiple disadvantage to access treatment. Where possible, they can offer to take the service to the person in their home, or a community setting of their choice. You can read more about this in chapter 9 on assertive outreach and a multi-agency team around the person.

Pathways between prison and community or residential alcohol treatment services are vital to support access and provide effective continuing care for people on discharge from prison. Effective local pathways between acute hospitals into community alcohol treatment are also vital.

Where possible, services should employ diverse staff teams that include staff and peer support workers who are members of local groups or communities. These team members can contribute cultural perspectives on how to increase access and can support relationship

building with communities and individuals seeking treatment. Where language prevents some people from accessing treatment, services should provide independent interpreters.

You can read more about accessible services in chapters 4 (section 4.4.2), 9 and 25.

2.3.4 Better care for people with co-occurring mental health conditions

Commissioners and providers of alcohol treatment services and mental health services should work together to make sure that people with co-occurring problem alcohol use and mental health conditions can access treatment and support for both conditions.

Co-occurring mental health conditions and problem alcohol use are common among people in alcohol treatment and mental health services. But there is evidence from the Recovery Partnership that services often exclude people with these co-occurring conditions so they cannot access the care they need (see the definition of co-occurring conditions in the glossary).

Alcohol treatment services and mental health services should respond flexibly to people with co-occurring alcohol and mental health conditions to actively prevent their exclusion from services.

The 2 main principles of care for working with people with co-occurring mental health conditions and problem alcohol use are:

1. Everyone's job. Mental health and alcohol and drug use services have a joint responsibility to meet the needs of people with co-occurring conditions by working together to reach shared solutions.
2. No wrong door. Providers of alcohol and drug, mental health and other services should have an open-door policy for people with co-occurring conditions and make every contact count. Treatment for the co-occurring conditions should be available no matter which service they first contact.

No wrong door does not mean that everyone should receive ongoing care at the service they first attend, but it does mean that all services and practitioners should be:

- proactive, flexible, compassionate and anti-discriminatory in their response
- able to offer an initial rapid assessment, address any urgent physical and mental health needs and refer the person onto an appropriate specialist service if needed
- active in planning longer-term care with other services

Services should work together to develop and maintain collaborative pathways of care and a shared approach to treatment and recovery planning so multiple agencies can provide a co-ordinated response to the person's individual needs.

Healthcare Improvement Scotland's National mental health and substance use protocol is an example protocol setting out how services in Scotland should work together to provide more integrated care for people with co-occurring conditions. Some of the content will be relevant for other UK nations.

You can read more on people with co-occurring mental health conditions in chapter 18.

2.4 Quality governance

Alcohol treatment services and recovery support services must have comprehensive quality frameworks to help them deliver evidence-based treatments and care, by practitioners with appropriate competences.

2.4.1 Quality governance frameworks

Quality governance is a term used to describe processes that assure delivery of high-quality services. Quality governance may also be known as clinical governance or care governance. Health and social care organisations and some individuals are directly and statutorily accountable for elements of quality governance.

Organisational components to assure quality governance include:

- clear lines of responsibility and accountability
- quality improvement activities, including regular quality audits of services
- policies that manage risk
- procedures to identify and remedy poor performance

The main components of an effective service are:

- delivering interventions in line with the evidence base
- having a competent workforce, who are effectively supported and supervised (see section 2.5 below)
- working in partnership with other services to deliver positive outcomes

Services need to make sure they have appropriate policies and procedures in place to support these professional and organisational objectives.

Commissioners and senior clinicians in the local healthcare system should take a leading role in reviewing significant safety incidents and adverse events, including deaths of people in alcohol treatment. The purpose of reviewing safety incidents is to make sure everybody learns from the incident and that there is a structure to support system improvements and to monitor their impact.

Alcohol treatment services should also have their own internal processes for reporting and reviewing incidents affecting the safety of people attending the service.

Individual practitioners and the organisations in which they work normally have a duty for:

- safety incident reporting
- contributing to investigation and review
- risk assessment

- risk management
- safeguarding assessment and management
- infection control

Services should refer to more detailed guidance on quality governance and quality standards. For example:

- Commissioning quality standard for alcohol and drug services (England)
- NICE quality standard Alcohol-use disorders: diagnosis and management (England and Wales)
- The quality principles: standard expectations of care and support in drug and alcohol services (Scotland)

There is some content in each of the documents that is relevant across the UK.

2.4.2 Measuring outcomes

Services should routinely monitor all interventions for people with problem alcohol use, using a validated outcome measure.

These include formal tools that measure self-reported changes in alcohol use and aspects of health, wellbeing and recovery. For example:

- treatment outcome profile (TOP), included within the 'adult community combined review form' for England on the National Drug Treatment Monitoring System NDTMS data collection resources page
- Substance Use Recovery Evaluator (SURE)

Both TOP and SURE are recommended by the International Consortium of Health Outcomes Monitoring as part of its set of patient-centred outcome measures for addiction.

Where relevant, practitioners can also use tests including blood tests, liver fibrosis tests, or other health tests to contribute to measuring health outcomes.

Practitioners should make outcome measures central to a person's treatment and recovery planning process. Practitioners should plan all clinical interventions with personalised and mutually agreed outcomes in mind and routinely review progress against these outcomes with the person.

When they review the outcomes, practitioners may agree with the person to alter these outcomes or the interventions they are providing to achieve them, if it becomes clear that working towards other outcomes would be more useful.

Supervisors and practitioners should review outcomes in clinical supervision, as this can help to identify staff training and development needs.

Services should also include monitoring of treatment outcomes across all those who use the service as part of regular quality audits. Services should monitor outcomes across different

groups including people in treatment for alcohol alone and people in treatment for alcohol and other substances, and people from different demographic groups.

2.5 A skilled and competent workforce

All alcohol treatment practitioners need to have appropriate competencies for their clinical roles and receive training and supervision to achieve and maintain them.

2.5.1 Clearly defined competencies

Competencies need to be agreed and clearly defined at a local or service level for the full range of roles covered in these guidelines, based on relevant national competency or capability frameworks and national occupational standards.

2.5.2 Professional development structures

Training and professional development structures and resources are essential to develop and maintain the required competencies. Important components of this include:

- individual or peer supervision
- personal development plans
- mentoring
- other forms of professional support

2.5.3 The role of professional bodies

The professional regulatory bodies are responsible for setting the standards of behaviour, competence and education of regulated healthcare professionals. These bodies include the:

- Health and Care Professions Council
- General Medical Council
- General Pharmaceutical Council
- Royal Pharmaceutical Society
- Nursing and Midwifery Council
- social work councils and regulators across the UK, which are:
    - Scottish Services in Social Care
    - Social Care Wales
    - Northern Ireland Social Work Council
    - Social Work England

These bodies are also responsible for registering professionals who meet those standards and taking action where the standards are not met. Clinicians in registered roles who deliver

alcohol treatment need to have appropriate certification, such as specialist registration, and meet professional revalidation requirements.

2.5.4 Competencies and qualifications for non-registered staff

It is particularly important for staff who are not from one of the registered professions and do not have the additional support of a professional body (like alcohol and drug workers), to be properly trained, supported, regularly assessed and supervised by their employers to carry out their roles effectively. Locally agreed role descriptions or person specifications should set out the competencies and qualifications required for non-registered staff, based on relevant national occupational standards and capability or competency frameworks.

Volunteers and peer mentors may also have relevant qualifications for their roles and need to be appropriately supported and trained by the services they work in. It is also important that the roles of volunteers and peer mentors are clearly defined.

2.5.5 Updating knowledge and skills

All clinicians have a professional obligation to update their knowledge and skills base in line with emerging evidence and developments in practice.

2.5.6 Non-clinical skills

Non-clinical skills such as leadership and management are also important and need to be supported by employers.

2.5.7 Supervision and appraisal

Supervision and reflective practice structures are essential for effective interventions, particularly psychosocial interventions. They are an important part of good clinical governance, alongside monitoring intervention quality and outcomes.

Annual appraisal is mandatory for all clinicians working in the NHS and is established good practice in other settings.

2.5.8 A full range of competencies in each local area

Each local alcohol treatment system will need to have doctors providing treatment, ranging from those able to provide medical services for the treatment of comorbidities to those with specialist competencies in treating alcohol dependence. Other health and social care professionals with a range of competencies are also needed in a treatment system, based on an objective assessment of local need.

Multidisciplinary teams are essential to alcohol treatment and should include doctors, nurses, psychologists, peer support workers, family support workers and social workers.

2.5.9 Alcohol specific competencies

Most alcohol treatment and drug treatment is integrated into single alcohol and drug treatment services. Many of the competencies needed to treat and support recovery from alcohol dependence are the same as those needed to treat and support recovery from drug

dependence. However, some of the competencies needed to deliver the interventions in this guideline are specific to alcohol. So, it's vital to maintain a sufficient level of alcohol specialism in teams in integrated alcohol and drug treatment services. Where services are integrated, they should support individual staff to develop and maintain their alcohol specific competencies.

2.5.10 Therapeutic alliance

Evidence and feedback from people with lived experience consistently tell us that the working relationship, or the therapeutic alliance, between practitioners and the people they support is vital to the effectiveness of all interventions. This is particularly true for psychosocial interventions. Knowing this helps us to focus on relevant competencies such as:

- active listening
- giving structured feedback
- reflective practice
- a non-judgemental approach

It's also important to focus on caseload size and the staffing to patient ratio in services, to make sure staff have the time they need to develop supportive relationships.

2.5.11 Training future alcohol specialists

All alcohol treatment systems need to have the resources, time and expertise, including qualified supervisors, to support the next generation of alcohol specialists. Services should have clear development and career pathways for regulated and un-regulated staff. This includes supporting training places for psychologists, nurses (including non-medical prescribers), specialist GPs, social workers, pharmacists and addiction psychiatrists.

2.6 Recovery-oriented care and systems of care

2.6.1 Working together to support recovery

Commissioners, treatment services and recovery support services should work together with other local support services and community groups to deliver recovery orientated care and to foster a recovery-oriented system of care (ROSC). The most effective recovery-oriented systems of care contain contributions from people with learnt, lived and living experience.

2.6.2 Recovery

There are several definitions of recovery. Witkiewitz and others (2020) define recovery as "a dynamic process of change characterized by improvements in health and social functioning, as well as increases in well-being and purpose in life".

Alcohol dependence is often a long-term condition that can involve cycles of abstinence and relapse (see definitions of alcohol dependence and abstinence in the glossary). For some people, this can happen over several years and they may make many attempts to change. For many people, an episode of treatment that leads to abstinence (or low risk drinking where

appropriate) does not mean that the person has the necessary support and resources to sustain this change in the long term or to develop a life that is meaningful to them. People with alcohol dependence and related alcohol problems typically need a personal programme of sustained recovery support and management to achieve those aims. This is likely to involve a need to change behaviour, outlook and identity over an extended period to sustain recovery.

Recovery requires the person, their family and other supportive people around them to develop aspirations and hope. Recovery can be associated with different types of support and interventions or can occur without any formal external help, so it can be achieved in different ways. It is a process, not a single event, and takes time to achieve and effort to maintain. The person must sustain recovery voluntarily for it to be lasting, although the recovery journey can sometimes start or be supported by court-ordered interventions such as community sentencing requirements.

2.6.3 Recovery-oriented systems of care

A ROSC is a network of local treatment and recovery services and community groups that help people to start and sustain their recovery. It incorporates the insight and work of people with lived and living experience and their families at all levels of planning and delivery to:

- offer choice by providing a flexible and inclusive menu of services, community support and opportunities, including lived experience initiatives, recognising that there are many pathways to recovery
- provide a range of responsive and inclusive support and opportunities for people in recovery and their families
- build on the strengths and resilience of individuals, families, recovery communities and the wider community

Structured treatment services and recovery support services are organised into a framework that incorporates the whole health and social care system and related services such as housing and employment support. The support offered by treatment services and by recovery support services are both vital to a person's recovery. The interaction of services and the local community contributes to the effectiveness of a ROSC. The ROSC should be easy to navigate, transparent and respond to the cultural diversity of the community where it operates.

In an effective ROSC, the relationships between treatment and recovery services:

- are strong
- have diverse access (and re-access) points into treatment and recovery support
- have a varied and complementary offer of support

2.6.4 Recovery-oriented care

Treatment should be delivered in a way that is recovery-oriented, meaning it helps people to achieve healthier and fulfilled lives. This typically entails developing positive family and social relationships and networks, participating in meaningful activity, achieving economic and

housing stability. This enables people to make progress in treatment and improves the chance of people successfully completing treatment.

Recovery support, including peer-delivered support, is important right from the beginning of the person's treatment and recovery journey. But for people in structured treatment, there is likely to be a gradual transition from a focus on structured treatment interventions towards self-care and peer-support as the process of recovery develops. Some people prefer to first access peer-led recovery support and these services can act as a bridge, helping them to access structured treatment if and when they feel ready. Some people achieve recovery solely through peer-to-peer support and never access structured treatment.

Alcohol treatment services and peer support services are components of an integrated system and each should deliver their component to the highest level. This includes:

- peer support including buddying and social support
- meaningful activity
- 'facilitating access to mutual aid', a short, simple and effective method for increasing mutual aid participation
- employment support
- housing support

Treatment services should link with recovery support services, resources in the surrounding community and, with the person's consent, supportive family members.

Overall, outcomes improve significantly when episodes of structured treatment are combined with long-term recovery support (Simoneau and others, 2018).

You can read more about:

- structured support (which includes recovery support interventions) in chapter 5
- recovery support services in chapter 6
- employment support in chapter 7

2.6.5 Post-treatment recovery support

Alcohol treatment services should support and work together with local recovery support services to help people sustain recovery post-treatment.

It is important for a person to have ongoing monitoring to help them sustain recovery after they leave treatment. Recovery check-ups are an agreed series of scheduled in-person or phone appointments with the person after they leave a treatment service. Recovery check-ups are usually carried out by the person's keyworker.

Recovery support services can provide emotional and practical support for continuing abstinence (or low risk drinking where that is appropriate) after the person has finished structured treatment. They can also provide daily structure and rewarding alternatives to

alcohol use. Recovery support services can help people to take part in a process of gathering healthy life resources, often known as recovery capital.

There is further guidance on recovery support services in chapter 6.

2.6.6 Access to peer-delivered and peer-led support

Commissioners and providers of alcohol treatment services should work with and support local peer-delivered and peer-led projects and organisations.

Peer-delivered and peer-led projects and organisations and mutual aid groups such as Alcoholics Anonymous or SMART Recovery can help support and sustain recovery-oriented journeys for people experiencing problem alcohol use before, during and after treatment.

People can ask their keyworker and peers which groups they have heard of or find most useful and select groups to try based on these recommendations. If they do not feel comfortable in one group, they can try another until they find one they are happy with.

Effective peer support can:

- enhance motivation
- help members to develop a positive identity
- improve coping mechanisms and social skills
- provide benefits for both the person delivering the support and the person receiving it

Local arrangements for peer support projects will vary. They can:

- be commissioned separately from treatment services
- exist as part of the service
- exist as self-funded and managed organisations

The range of support they offer also varies. Whatever the arrangement, services should support peer-delivered and peer-led organisations by involving them in service design and working with them to offer people integrated recovery-oriented treatment and support. Practitioners should inform a person about peer support options as part of the treatment and recovery planning process and help them to access them.

Peer-delivered and peer-led projects and organisations can become more resilient and more effective where they have a voice, a role and support within the system. These projects can also have a role in promoting a positive view of recovery in the wider local community and potentially overcoming stigma.

In areas where peer-delivered and peer-led support and organisations do not exist, commissioners and services should consider developing them. You can read more about peer-led initiatives in chapter 6 on recovery support services.

2.7. Local strategic partnerships

These guidelines are about clinical practice, rather than strategic planning. However, many of the recommendations in these guidelines involve effective working between alcohol treatment services and partner services. Local strategic partnerships are essential to develop and maintain effective multi-agency working arrangements.

In each local area, there should be an active partnership across the alcohol and drug treatment system, including:

- commissioners
- system leaders
- NHS provider organisations
- third sector provider organisations
- organisations for people with lived experience

Partnerships should also include leaders of wider health, care, criminal justice systems and voluntary sector community services.

The partnership should work together to develop, implement and review joint strategic plans to meet the multiple needs of people with problem alcohol use in their local population. The strategic partnership should establish integrated care pathways, information-sharing and joint working arrangements, and regularly review their effectiveness.

The membership of local partnerships will vary according to national and local arrangements. In England, local partnerships are a requirement.

Local partnerships should usually include system leaders and service providers from:

- the local alcohol and drug treatment system
- lived experience recovery organisations, including families and carers
- primary and secondary healthcare, including mental health care
- housing and homelessness services
- child and adult safeguarding services
- adult social care
- police, probation and prison healthcare
- education and employment support services
- community services working with groups likely to experience problem alcohol use (such as domestic abuse agencies)
- organisations working with underserved groups (such as specific ethnic minorities)

An effective strategic partnership makes it possible for services to work together to provide integrated individual treatment and recovery support. Alcohol treatment practitioners, practitioners from partner services and peer support organisations should work together to offer an integrated personalised package of care tailored to the person's individual needs. They should involve the person experiencing problem alcohol use in all decisions about their treatment and recovery.

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3. Identification and brief interventions

How to use validated tools to identify health risk from alcohol use, deliver brief interventions to help people reduce their drinking or refer those with possible dependence to specialist assessment.

3.1 Main points

Staff in health and social care, the criminal justice system and community and voluntary sector services in both NHS and non-NHS settings should routinely identify people whose health is at risk from their alcohol use. To do this, they should use a validated screening tool such as the alcohol use disorders identification test (AUDIT) or a short-form of it.

Health and care staff should offer an alcohol brief intervention (ABI) to people whose alcohol use significantly increases risks to health (hazardous or 'increasing risk' drinking) or is likely to be harming their health (harmful or 'higher-risk' drinking) but who are not dependent on alcohol.

Health and care staff should offer a referral for specialist alcohol assessment to anyone with alcohol dependence or possible alcohol dependence. They should also offer a referral for specialist alcohol assessment to people who are drinking at harmful (higher-risk) levels and have alcohol-related physical or mental health conditions.

Health and care staff should not offer an ABI to people who are identified as possibly dependent, but should offer them a referral for a specialist alcohol assessment.

3.2 Introduction

These guidelines are mainly for treating people with alcohol dependence and people drinking at harmful levels who are experiencing alcohol-related physical health, mental health and social problems. But this chapter provides guidance on identifying and responding to the full spectrum of alcohol use disorders.

In these guidelines, we use the term 'alcohol use disorder' (AUD) to include any pattern of alcohol use that significantly increases risks to health, either harmful (higher-risk) drinking or alcohol dependence. See section 3.3.2 for guidance on these categories.

People with AUD use many different healthcare services and this gives health and care staff an important opportunity to identify and support them. The report Alcohol-attributable fractions for England lists alcohol use as a significant causal factor in over 60 medical conditions. Around a quarter of adults in the UK are estimated to drink in a way that incurs lifetime risk of an alcohol-related condition.

Most people who drink above low-risk levels or have an AUD do not need specialist treatment but may benefit from ABI, sometimes known as screening and brief interventions (see definition of brief interventions in the glossary). In England, the term 'identification and brief advice' (or IBA) is commonly used to describe alcohol risk screening and brief intervention.

3.3 Identification (screening) for alcohol use disorders in non-alcohol specialist settings

3.3.1 Settings for AUD identification

Identification of AUDs should take place across a range of settings, so that people are routinely asked about their alcohol use. Primary care, hospitals and mental health settings are particularly important for identifying alcohol-related risk and providing brief interventions or referring people for specialist alcohol assessment where appropriate.

Relevant health, social care and criminal justice services should include alcohol risk identification (screening) tools in standard assessment practices where possible. Where AUD identification tools are not included in standard assessments, practitioners should be trained and supported to ask the appropriate questions about alcohol use and provide simple brief interventions.

Asking everybody if they are willing to answer some questions about their alcohol use normalises the subject and maximises the chance of identifying alcohol health risk where there are no obvious signs or symptoms.

3.3.2 AUDIT scores

AUDIT is the gold standard for AUD identification. In the UK, services should use the UK version that measures alcohol use in 'units' in questions 2 and 3. Versions of AUDIT from many other countries measure alcohol use using 'standard drinks'. This is not the usual terminology in the UK and is not likely to be readily understood by long-term UK residents or easily compared to UK consumption guidelines.

The AUDIT does not give a clinical diagnosis but indicates which alcohol risk category a person falls into based on their score.

Possible scores for the full 10 question AUDIT are:

- low-risk: no current AUD
- hazardous (increasing-risk) drinking
- harmful (higher-risk) drinking
- possible alcohol dependence

0 to 7: low-risk - no current AUD

A score between 0 and 7 indicates that the person is drinking at a level that does not significantly increase lifetime risk of alcohol-related ill health.

8 to 15: hazardous (increasing-risk) drinking

A score between 8 and 15 indicates that the person is increasing their risk of a range of alcohol-related issues. You should offer them brief intervention.

16 to 19: harmful (higher-risk) drinking

A score between 16 and 19 indicates that the person is drinking in a way that presents a higher lifetime risk of an alcohol-related condition and is likely already to be causing alcohol-related harm. You should offer them brief intervention.

Some people who score between 16 and 19 will need a referral for specialist alcohol assessment or to their GP (see 'Using clinical judgement or knowledge of the person' below). People drinking at this harmful level who have symptoms of alcohol dependence or alcohol-related physical health or mental health conditions should be made aware of the link between alcohol and their condition. You should offer them referral for specialist alcohol assessment or to their GP.

20 or more: possible alcohol dependence

A score of 20 or more indicates that the person is likely to have at least some level of alcohol dependence. You should offer them referral for specialist alcohol assessment. AUDIT is not a diagnostic tool and you should not indicate a diagnosis of dependence based on AUDIT score alone. Diagnosis of alcohol dependence requires assessment by a clinician with appropriate specialist skills.

Using clinical judgement or knowledge of the person

You should use AUDIT scores to guide appropriate interventions and support, but the scores should not override clinical judgement or your knowledge of the person in individual cases. In some cases, it may be appropriate to offer a referral to a specialist service for people whose AUDIT score is below 20. For example, people:

- who have or have recently had symptoms of alcohol dependence
- with significant alcohol-related physical health conditions such as liver disease or mental health conditions such as depressive disorder
- with alcohol-related problems who have already tried to cut down their drinking and have not been able to

3.3.3 Short-form validated screening questionnaires

In a variety of settings, where time is limited, you can use short-form validated screening questionnaires such as the following.

These screens consist of selected questions from the AUDIT questionnaire and can be used to identify people who may have an AUD. A positive screen (for example, an AUDIT-C score of 5 or more) should prompt you to complete the full AUDIT questionnaire. The full AUDIT score will identify which people could benefit from brief interventions and which people might need specialist alcohol assessment or a referral to their GP.

AUDIT-C

Alcohol use disorders identification test for consumption (AUDIT-C) on the Alcohol use screening tests page is a tool that consists of the 3 consumption questions from the full AUDIT. You can use AUDIT-C to quickly identify whether the person is at risk of alcohol harm. If the

person's AUDIT-C score is 5 or more, you should use the full AUDIT questionnaire with them, because the score suggests they are drinking at a level that could cause or is causing harm to themselves or others.

ASSIST-Lite

Alcohol, Smoking and Substance Involvement Screening Tool - Lite (ASSIST-Lite) is a short screening tool for use with adults (aged 18 and over). It can help to identify alcohol, drug and tobacco smoking-related risks. You can use it during assessments, care planning, one-to-one or review sessions. There is one version of the tool for mental health services and another for other health and social care services. Both versions include the 3 AUDIT-C questions described above.

FAST

Fast alcohol screening test (FAST) on the Alcohol use screening tests page is a tool consisting of a subset of 4 questions from the full AUDIT, asked in 2 stages. FAST was initially developed for use in emergency departments but can be used in a variety of health and social care settings.

M-SASQ

Modified-single alcohol screening questionnaire (M-SASQ) on the Alcohol use screening tests page is a test to quickly assess people at risk of alcohol harm. It comprises one question from the full AUDIT and was developed for use in emergency departments but can be used in other settings where time is limited.

3.3.4 Routine identification of alcohol health risk

All relevant services should routinely identify alcohol health risk, using a validated tool such as AUDIT. For example, you should discuss alcohol health risks with patients during new registrations or when screening for other conditions.

There is national guidance and support for delivering ABI in each of the UK nations. In some parts of the UK, using AUDIT to identify alcohol health risk is a requirement for at-risk patient groups as part of primary and secondary care contracts and the NHS Health Check. Large-scale provision of ABI is part of Scotland's national Alcohol Framework 2018, which was reviewed by Audit Scotland in 2024 with recommendations for the framework to be refreshed.

Health and social care services should use initiatives like Making Every Contact Count (MECC) to identify AUDs and offer ABIs. Health and social care services should ensure that effective pathways are in place, including referral to services that can provide specialist alcohol assessment and treatment or other types of care where needed.

Making effective identification an integral part of your service provision will include organisational commitment, leadership and accountability. Staff expected to deliver ABI will require training in brief intervention approaches. Services should monitor their brief intervention provision to ensure it is taking place and that interventions offered are

appropriate to the level of risk identified. Integration of AUDIT questions and scores into electronic assessment and record systems can be particularly valuable.

Digital resources that use AUDIT can play a role in supporting identification, but you should consider and implement them carefully. Read more about digital interventions in section 5.7.3 in chapter 5 on psychosocial interventions. There is emerging evidence that apps for mobile devices can be effective in reducing consumption among people who drink at hazardous (increasing-risk) or harmful (higher-risk) levels (see resources section at the end for an example of digital AUDIT based tools).

3.4 Alcohol brief interventions in general and non-specialist settings

3.4.1 The aim of ABIs in general settings

There is a long-standing evidence base (see The public health burden of alcohol: evidence review) for the effectiveness of ABIs in reducing alcohol consumption among people who do not need alcohol treatment but whose drinking may be a risk to their long-term health and wellbeing. So, the main goal of using ABIs in general and non-specialist settings is to identify and engage with this group, which will include most people drinking at hazardous (increasing-risk) and harmful (higher-risk) levels.

ABIs focus on giving people information about risk and motivating them to reduce their drinking towards lower risk levels. Although identifying dependence is not the main purpose of ABIs, they provide an important opportunity to identify and refer people with alcohol dependence and anyone drinking at harmful (higher-risk) levels who may need specialist assessment or intervention.

3.4.2 Delivering appropriate ABI approaches

Simple alcohol brief intervention (brief advice in England) is a general approach to opportunistic brief interventions that can be easily provided in a few minutes by non-specialist staff after minimal training in a wide range of settings.

People who drink at hazardous (increasing-risk) levels usually do not currently have significant alcohol-related problems, so are well-suited to simple ABI approaches. Most people drinking at harmful (higher-risk) levels do not need specialist assessment or support and will also benefit from brief interventions.

ABIs are non-treatment interventions that are effective in prompting people to reduce their drinking on their own. Simple ABI typically involves a brief conversation about alcohol use, which:

- gives feedback on the person's level of risk (for example, explaining the meaning of the AUDIT score) and if appropriate, encouraging them to talk about the potential benefits from reducing their regular consumption
- identifying the person's alcohol reduction goals and basic strategies to support them
- providing the person with information to take away and consider in their own time (for example, see the alcohol advice and information leaflet in resources section)

It may be helpful for staff to be familiar with other simple motivational components such as those set out by the FRAMES approach (feedback, responsibility, advice, menu, empathy, self-efficacy). See definition of FRAMES in the glossary.

You should deliver ABIs in a way that aims to make the person feel encouraged and supported by using a motivational, person-centred approach. Staff delivering ABIs should be trained in a way that incorporates the basic principles of motivational interventions. You can read more about motivational interventions in section 5.5.6.

3.4.3 Referral for people who drink at harmful levels or with possible alcohol dependence

People with AUDIT score 16 to 19

You should offer ABI to people who regularly drink at harmful (higher-risk) levels (AUDIT score of 16 to 19). For people with harmful patterns of drinking, who have an alcohol-related health condition (such as liver disease, cardiovascular disease or depressive disorder), other substance use conditions or other significant health needs, you should also consider offering:

- referral for specialist alcohol assessment (see chapter 4 on assessment and treatment and recovery planning)
- information about alcohol treatment options
- referral to their GP
- referral to additional support where there are any signs of risk or complexity

People with AUDIT score 20 or more

You should not offer ABI to people you identify as possibly alcohol dependent (AUDIT score of 20 or more), but you should offer them a referral for specialist alcohol assessment. If the person is in the community, you should offer them a referral to the local community alcohol treatment service and if they are an inpatient in hospital, you should refer them to an alcohol specialist in the hospital. This is particularly important for people whose AUDIT scores are 30 and above.

If you refer a person for specialist assessment, you should do this in an encouraging way, listening to their concerns and discussing them. The person might feel stigma or fear about going to an alcohol treatment service, so it's important to be as supportive as possible when you refer them. Active referral, whereby the treatment service is expecting the person, is more likely to be taken up than if the person is expected to self-refer (signposted).

Where a person does not want to engage in treatment, you should offer information about services and try to find future opportunities to offer a referral or follow up on their alcohol use and any related problems.

3.5 Monitoring and evaluating ABI

It is not likely to be necessary, practical nor cost-effective to evaluate ABI provision by following up recipients to see if their alcohol use has changed.

Evidence shows that ABIs are effective in reducing consumption in a proportion of people who drink at hazardous (increasing-risk) and harmful (higher-risk) levels if the intervention is appropriately delivered (for more information, see The public health burden of alcohol: evidence review). So, effectiveness of ABI programmes is more likely to be optimised by evaluating the scale and quality of delivery and taking action to improve it, where appropriate. For example, you can do this by monitoring data on the proportion of a target group tested with AUDIT and the appropriateness of the intervention offered, based on the AUDIT score.

3.6 Resources

The Alcohol use screening tests page contains the UK versions of the AUDIT and short-form AUDIT tools that can be printed and used by or with people to identify their risk of alcohol-related harm. There is also an advice and information leaflet for ABI recipients and a link to free e-learning about providing AUDIT screening and simple brief advice in various settings.

AUDIT translations has printable versions of the AUDIT, translated into over 60 languages, including Turkish, Greek, Hindi, German, Dutch, Polish, Japanese, French, Portuguese, Spanish, Danish, Flemish, Bulgarian, Chinese, Italian and Nigerian dialects.

Alcohol Change UK's Check your drinking interactive tool is a free to use interactive online AUDIT form that identifies a person's level of risk and provides advice on cutting down or seeking specialist assessment.

4. Assessment and treatment and recovery planning

How to assess a person's alcohol use and other needs, and agree their treatment and recovery goals, as well as interventions and actions to meet those goals. It covers risk assessment and regular reviews of treatment and recovery and risk management plans.

4.1 Main points

Assessment should involve the assessor and the person working together to reach a shared understanding of the person's problem alcohol use and their wider needs, strengths and goals.

Services should provide straightforward access to assessment which should start as soon as possible after referral.

Assessment should include a focus on engagement. To help the person engage in treatment, the assessor should use an empathic and non-judgemental approach and integrate motivational interventions into the assessment process.

Services should use validated assessment tools to support assessment, but these should not take the place of a structured clinical interview with the person.

Assessment involves the person choosing an alcohol use goal. Severity of dependence and complexity of need provide broad indicators for appropriate alcohol use goals, but these should always be mutually agreed between the person and the assessor.

Services should offer an initial assessment that includes:

- an overview of the pattern and severity of the person's alcohol use and severity of their dependence
- any need to assess the person for medically assisted withdrawal
- identifying any other urgent treatment needs and any immediate risks
- agreeing an initial alcohol use goal and an action plan to address urgent needs and risks

Services should then offer a comprehensive assessment that builds on the initial assessment that includes:

- reviewing the severity and pattern of the person's alcohol use, the severity of dependence in more detail, and any other substance use
- assessing the person's strengths and recovery resources
- assessing needs in the areas of mental health, physical health, social factors and criminal justice
- agreeing a treatment and recovery plan that includes goals for treatment and for broader recovery

Comprehensive assessment may take place over several sessions, but this should not delay the start of treatment.

Based on the assessment, the assessor or allocated keyworker, with support from the multi-disciplinary team, should agree a treatment and recovery plan with the person based on a personalised formulation (see 4.3 for definition of formulation). The treatment and recovery plan will set out their treatment and recovery goals, as well as interventions and actions to meet those goals.

Risk assessment, including safeguarding, is an important part of any assessment and should result in a detailed risk management (safety) plan based on a personalised risk formulation (see 4.4.6 for definition of risk formulation).

The keyworker, supported by the multidisciplinary team, should regularly review the treatment and recovery plan with the person and adjust the plan at any time it is clear that it's not helping the person to meet their goals. The keyworker should also regularly review the risk management (safety) plan and adjust this at any time the risks change.

Where appropriate, assessment, treatment and recovery planning, and risk management (safety) planning should include contributions from:

- clinicians from the multidisciplinary team in the alcohol treatment service
- other professionals working with the person
- family members, partners or friends
- peer supporters who can help welcome the person to the service and support them throughout

4.2 Introduction

4.2.1 Assessment in community alcohol treatment services and other considerations

This chapter describes assessment, and treatment and recovery planning for harmful (high risk) drinking and alcohol dependence in specialist community alcohol treatment services for adults. There will be additional considerations for assessment for specific pharmacological interventions, populations and settings which you will find in other parts of these guidelines including:

- assessment for pharmacological interventions, including medically assisted withdrawal (chapter 10 on pharmacological interventions, chapter 11 on community based medically assisted withdrawal and chapter 12 on specialist inpatient medically assisted withdrawal)
- assessment and formulation for psychosocial interventions (chapter 5 on psychosocial interventions)
- primary care (chapter 15)
- acute hospital settings (chapter 16)
- criminal justice settings (chapter 17)
- pregnancy and perinatal care (chapter 24)

- parents (chapter 26)
- older people (section 25.8 in chapter 25)
- young people (chapter 23)

4.2.2 Terminology

Community alcohol treatment practitioners in several different roles can carry out an assessment depending on local arrangements, so this chapter refers to the 'assessor' rather than specifying a professional role. More than one practitioner will be involved in some assessments. For example, if the main assessor is not a clinician, clinicians may carry out some components of the assessment. In these situations, the chapter refers to the assessor who continues to carry out the core assessment and co-ordinate the involvement of other professionals as the 'main assessor'.

4.3 Aims

Assessment in community alcohol treatment services involves gathering and considering information on the person's needs, risks and strengths. This includes diagnosing the presence of alcohol dependence or harmful drinking, identifying co-occurring health conditions and social factors that need addressing, and longer-term recovery goals. The assessor and the person use the information to develop a shared formulation.

A formulation is a framework to understand how the person's alcohol problem began and developed, the factors that maintain it and potential resources to address it. It is the basis for agreeing a personalised treatment and recovery plan (also see definition of formulation in the glossary).

You can read more about formulation in section 5.4 in chapter 5 on psychosocial interventions.

Assessment also aims to engage the person in treatment. It is an important opportunity to begin building a therapeutic alliance and to address potential barriers to engagement such as personal anxieties or practical constraints.

Where appropriate, assessment should involve:

- relevant healthcare and support services and organisations
- partners, family and friends
- peer-support networks

4.4 Principles

4.4.1 Principles of care

Assessment and treatment and recovery planning should be based on the principles of care outlined in chapter 2.

In particular, the assessor should:

- build a trusting relationship and work in a supportive, empathic and transparent way

- respect the person's confidentiality, privacy, and dignity
- understand how stigma and discrimination associated with alcohol use can affect how the person comes into treatment, their self-esteem and their ability to recognise the full impact of their problem alcohol use
- work in a trauma-informed way (see section 2.2.8 in chapter 2 on principles of care)
- work in a culturally competent way (see section 2.3.2 in chapter 2 on principles of care)

4.4.2 Staff competence

Assessment for harmful drinking and alcohol dependence in alcohol treatment services is a skilled intervention. Practitioners should be trained and competent to deliver it and they should receive regular supervision from individuals competent in both the intervention and supervision.

4.4.3 Access to assessment

Services should provide straightforward access to assessment, which should start as soon as possible after referral. Studies have shown that rapid access to assessment and treatment improves engagement in treatment (Passetti and others, 2008). You can collect a person's initial information remotely by phone or online, but the assessment should involve an in-person meeting wherever possible.

You should time appointments to take account of a person's commitments, such as childcare and employment, and offer the appointments in a location they can access easily. Offering appointment windows (such as a whole morning or whole afternoon) rather than a set time can increase accessibility.

Several socially excluded groups, including people experiencing multiple disadvantage (see definition of multiple disadvantage in the glossary), are less likely to approach services or engage with standard assessment processes. Services need to develop targeted and flexible ways of helping people from those groups access assessment such as assertive outreach or 'in-reach' to services or community organisations like homelessness support services. Offering assessments in primary care settings can make them more accessible and acceptable to people who would not approach an alcohol treatment service because of fears around stigma.

The service will also need to offer home visits for people who cannot access the service due to disability, physical health conditions (including advanced liver disease) or mental health conditions.

People with lived and living experience should be involved in planning engagement and assessment pathways to increase the likelihood they will increase access for different groups of people.

You can read more about flexible engagement processes in chapter 25 on developing inclusive services and chapter 9 on alcohol assertive outreach and a multi-agency team around the person.

4.4.4 Engagement

Assessment is often the first face-to-face contact the person has with the service and it is an opportunity to begin building a therapeutic alliance. An empathic, non-judgemental approach based on the principles of trauma-informed care and cultural competence can help to build trust and support engagement.

Assessment and engagement can be thought of as the first phase of the person's treatment and recovery journey that involves the treatment service, and the person may begin to make changes during this process. The assessor can support engagement by using a motivational approach. See section 4.9.3 below on motivation, readiness and belief in the ability to change.

If you provide welcoming introductory communication before a person's first appointment, as well as clear information about the service, the process of assessment and confidentiality, it can help to encourage their attendance from the earliest stage. Friendly reminders about appointments (via text if that's useful to the person) can support attendance. There are many reasons why a person may miss an appointment. So, non-judgemental follow-up of a missed appointment, with another appointment offer and a query about what might make it easier for them to attend, can help them to stay engaged. You should communicate information avoiding clinical language and in accessible formats considering:

- language
- literacy
- sensory disability
- cognitive disability
- neurodiversity
- digital literacy and access

Interpreters (including sign language) who are not known to the person should be available to make sure there is equal access to assessment.

The environment should be comfortable and private and the service should consider varying needs. For example, whether the waiting room and room for the assessment are easily accessible and comfortable for people with mobility needs.

The assessment should take the form of a structured clinical interview (a conversation aimed at assessing the person's treatment and recovery needs). The assessor will need to record information in a structured way, but a 'checklist' approach to assessment is not a good way to engage the person. Assessment and formulation should be a collaborative process, where the assessor and the person develop a shared understanding of their treatment and recovery needs. It is more effective to use open questions, reflective listening and dialogue. If the assessor is able to respond quickly to the person's own priorities, such as the need for medically assisted withdrawal or a social need such as debt advice, this may improve their engagement.

4.4.5 Multidisciplinary and multi-agency assessment

Assessment will often require input from more than one practitioner. Where the person needs a medically assisted withdrawal or has complex, high risk physical or mental health conditions, the assessment will require input from a specialist clinician from the multidisciplinary team (MDT). Designated leads (or appropriately competent practitioners) for child safeguarding, adult safeguarding and domestic abuse should be available to advise on relevant components of individual assessments, in line with national guidelines and organisational procedures.

You can find a list of relevant legislation and statutory guidance in annex 1.

The assessor should have access to supervision and advice from the MDT or wider clinical team and will agree with the MDT when input from specialist clinicians is needed. The main assessor will usually continue with the core assessment, incorporating the specific components carried out by members of the MDT or wider clinical team.

Where the person is working with other services, the assessor should ask these services to contribute relevant information to the assessment. They may also invite a keyworker from another service to attend an assessment appointment if this will help the person to attend. Where a person has complex needs and is working with more than one service, care plans (treatment and recovery plans) will need to be aligned or integrated.

You can read more on multi-agency treatment planning in section 4.10.4 on treatment and recovery planning in this chapter.

4.4.6 Risk assessment and safeguarding

Assessing risk should be part of any assessment. The aim of risk assessment is to develop a risk management (safety) plan that prioritises and manages or eliminates risks to the person with problem alcohol use and to others. All assessors should be competent to identify immediate risks at initial assessment and to work with the person, with other services and to manage risks and support safety appropriately.

A risk assessment should be based on a person's individual needs and how to support immediate and longer-term safety. As part of assessment, the assessor should develop a personalised risk formulation with the person. A risk formulation is a collaborative process between the person and the assessor that aims to summarise the person's current risks and difficulties and understand why they are happening, to inform the risk management (safety) plan.

Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources which could be protective against specific risks, in the same way as other parts of the comprehensive assessment does.

Risks are constantly changing, so assessors should review and develop the initial action plan (see section 4.8 below) with the person following comprehensive assessment and as the person's risks change. Keyworkers, supported by the MDT or wider clinical team, should regularly review risk management (safety) plans, involving the person in reviews.

Assessors conducting risk assessments should:

- confirm the person's history with other relevant services the person has accessed
- work with any services the person is currently attending to assess risk
- make referrals to other services if needed as part of the risk assessment and risk management (safety) plan

Assessors should assess the ability of the person and any of their support networks to contribute to managing risks. Family members or supportive friends may have an agreed and specified role.

Services need organisational procedures for escalating and managing immediate risks and assessors should have access to advice and supervision from relevant members of the MDT or wider clinical team.

Services should have organisational policies and procedures for addressing child safeguarding, adult safeguarding, domestic abuse and mental capacity which are aligned with the relevant national legislation and statutory guidance. Clinical policies and processes should also include the management of self- harm and suicide risk.

You can find a list of relevant legislation and guidance in annex 1.

You can read more about risk management planning in section 4.10.5

4.4.7 Involving and supporting partners, family and friends

Involving supportive partners, family members or friends at assessment can encourage the person to attend and contribute important information. It is essential that assessors get consent from the person to contact partners, family or friends as some people will not want their family to be involved. If the person does not choose to involve them initially, the assessor can repeat the offer later in assessment because some people may become more open to this as they engage. There is evidence that involving family members in treatment is linked to improved outcomes (Copello and others, 2009).

Partners, family members and friends may have support needs in their own right and may be entitled to a carer's assessment. The assessor should offer information and support, whether or not they want to be actively involved in the person's treatment.

4.4.8 Involving members of peer support networks

People with lived experience can play a valuable role in supporting people to attend assessment. In some services, members of peer support networks or organisations meet with people informally in the waiting room before their assessment, or the assessor introduces them as part of the assessment process. The person with lived experience can share their experience of treatment and recovery and show that it is possible to move forward. In some areas, people can access peer support organisations before accessing the treatment service and the peer support organisation may introduce them to the treatment service.

4.4.9 Harm reduction interventions

Assessors should work on the principle of Making Every Contact Count (MECC) and use assessment as an opportunity to offer harm reduction information and interventions. Harm reduction information includes (but is not limited to):

- the risks of stopping drinking suddenly and advice on reducing safely for people with alcohol dependence
- the decrease in tolerance after a period of abstinence and the risks of drinking at pre-abstinence levels (see definition of tolerance in the glossary)
- increased risk of overdose when drugs and alcohol are taken together
- other harms related to mixing drugs, for example cocaine and alcohol are more toxic when taken together

People with alcohol dependence should usually be prescribed thiamine (oral or intramuscular depending on their likely risk level) to reduce the risk of developing Wernicke's encephalopathy (WE), which can cause temporary or permanent brain damage.

You can read about prescribing and administering thiamine to reduce the risk of developing WE in section 10.4.3 in chapter 10 on pharmacological interventions.

You can find guidance on harm reduction interventions in chapter 8 on harm reduction.

4.4.10 Unplanned withdrawal

All assessors in alcohol treatment services should be competent to identify withdrawal symptoms and recognise when a person is in acute withdrawal, which for some people can lead to severe complications such as:

- seizures
- delirium tremens
- Wernicke's encephalopathy

All staff should be trained and supported to recognise these severe complications and to alert emergency services where the person experiences them.

You should read guidance on identifying risk and managing complications in withdrawal in chapter 10 on pharmacological interventions.

4.5 Tools to support assessment

The National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) recommends that assessors use validated tools at assessment such as those listed below. Tools are intended to support assessment, but they should not replace a structured clinical interview, which provides more detailed information on needs, risks, strengths, and goals. A clinical interview also allows for conversation, which the person may experience as more engaging than being asked standard questions.

4.5.1 Alcohol use disorders identification test

To identify level of risk of alcohol harm and possible dependence, the assessor should use a validated tool that measures frequency and quantity of alcohol consumed, such as the Alcohol use disorders identification test (AUDIT), available on the Alcohol use screening tests page.

AUDIT is the gold standard identification tool recommended for specialist services. In wider healthcare settings, shorter or abbreviated tools may also help to identify people who need specialist assessment.

You can read more about AUDIT and shorter or abbreviated tools in chapter 3 on identification and alcohol brief interventions.

4.5.2 Tools to assess the severity of alcohol dependence

To assess presence or severity of dependence (mild, moderate or severe), assessors can use a validated tool such as the following.

Severity of Alcohol Dependence Questionnaire

The MDApp website has a version of the Severity of Alcohol Dependence Questionnaire (SADQ). It is a 20-item self-administered questionnaire measuring the severity of alcohol dependence based on drinking habits and symptoms experienced after drinking.

Leeds dependence questionnaire

The Greenspace website has a version of the Leeds dependence questionnaire (LDQ), which includes questions on alcohol and other substances. It is a 10-item, self-completion questionnaire designed to measure the presence and severity of dependence on any drug, including alcohol.

4.5.3 Alcohol Problems Questionnaire

The Alcohol Problems Questionnaire (APQ) is a validated 44-item questionnaire to assess the nature and extent of problems associated with harmful alcohol use and alcohol dependence (see definitions of harmful alcohol use and alcohol dependence in the glossary).

The APQ is available on page 486 and 487 of the full guideline for NICE CG115.

4.5.4 Withdrawal assessment tools

Specialist clinicians, competent to assess the need for medically assisted withdrawal should use a validated scale to assess the severity of withdrawal. The MD+calc website has a version of the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) you can use. This is a 10-item assessment tool that can be used to quantify the severity of the alcohol withdrawal syndrome, and to monitor and medicate people throughout withdrawal.

In acute hospital settings, the Glasgow modified alcohol withdrawal scale (GMAWS) is an example of a withdrawal assessment tool.

4.5.5 Tools to measure outcomes

To measure treatment outcomes, the practitioner should use a validated outcome measurement tool such as the following.

TOP

The treatment outcome profile (TOP) is the outcome monitoring tool used by substance misuse services in England. It is included within the 'adult combined review forms', available in the Data collection resources section on the National Drug Treatment Monitoring System (NDTMS) website. It can be used as a stand-alone outcome measure and it can be used outside England.

SURE

King's College London's Substance Use Recovery Evaluator (SURE) is a patient-reported outcome measure to measure recovery from drug and alcohol dependence.

4.6 Tests to support assessment

4.6.1 Blood tests

Blood tests should not be used routinely for identifying and diagnosing harmful drinking or alcohol dependence. However, services should consider testing service users' blood:

- as part of the assessment for medically assisted withdrawal (see chapter 11 on community based medically assisted withdrawal)
- as part of the assessment for some relapse prevention medication (see section 10.5 of chapter 10 on pharmacological interventions)
- to help identify specific alcohol related physical health needs where indicated by the healthcare assessment (see section 4.18.11 on assessing physical health below)
- as part of regular review of the person's health where they continue to use alcohol at a harmful or dependent level, and this is clinically indicated

If a community treatment service is unable to provide the required blood tests, there should be an agreed pathway for tests to be carried out in the alcohol treatment system or the wider health care system.

4.6.2 Transient elastography

NICE guideline Cirrhosis in over 16s: assessment and management (NG50) recommends that people drinking at harmful levels (35 units or more per week for women, 50 units or more per week for men) for 3 months or more should be referred for liver fibrosis assessment using transient elastography (fibro-scan). Some areas use other tests.

You can find more information on screening tests for liver disease in section 4.9.11 and in section 19.5.2 in chapter 19 on co-occurring physical health conditions.

4.6.3 Breath alcohol

Several factors influence how quickly alcohol is absorbed into and eliminated from the body. So, breath alcohol concentration can vary between different people who have consumed the same amount of alcohol. On average it takes about one hour to eliminate one unit of alcohol in adults, but this may be quicker in some people with alcohol dependence.

Breath alcohol should not normally be measured as part of an initial assessment or for monitoring outcomes. Also, practitioners should not use arbitrary cut off levels for breath alcohol concentration to determine whether a person can access health services. But breath alcohol should be measured as part of assessment for medically assisted withdrawal. It should then be measured during medically assisted withdrawal to confirm that the person has not consumed alcohol. You can find guidance on assessment for community medically assisted withdrawal in chapter 11.

Clinicians should consider the therapeutic value of breath alcohol measurement and explain this to the person before requesting a breath sample. Breath alcohol measurement can sometimes help to add information to a comprehensive assessment if it is carried out with the full agreement of the person and the results discussed with them. For example, it can help to assess a person who appears sedated, has slurred speech or is confused. A negative result will exclude alcohol as a cause, but a positive result does not exclude other possible causes such as intoxication with other substances, head injury or stroke.

Clinicians should not use breath alcohol measures to contradict a person's self-reported alcohol consumption. It is best to measure breath alcohol before asking how much the person has drunk on that day, then interpret the result together with the person.

The clinicians taking breath alcohol measurement need to understand their responsibilities as outlined in The Driver and Vehicle Licensing Agency (DVLA) general information for medical professionals about assessing fitness to drive which helps healthcare professionals and doctors understand their roles and responsibilities for assessing fitness to drive. Clinicians should also be aware of General Medical Council (GMC) guidance Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA, which advises clinicians on actions to take if the person does not report their condition and continues to drive.

You can read guidance on this in section 8.12 in chapter 8 on harm reduction and in annex 2.

4.7 Alcohol use goals

4.7.1 Setting goals

At initial assessment, the assessor and the person should agree an alcohol treatment goal which they should review together during the comprehensive assessment. Severity of dependence and complexity of need provide broad indicators for appropriate alcohol use goals, but these should always be individually tailored and mutually agreed between the person and the assessor. It is important the goal is in line with the person's wishes, as there is evidence that this is associated with positive outcomes (Henssler and others, 2020). The practitioner should provide information on the risks and benefits of different alcohol use goals in general and as they apply to the particular person. They should use an approach based on motivational intervention principles and techniques when supporting the person to choose

their alcohol use goal (see section 5.5.6 in chapter 5 on psychosocial interventions for more on motivational interventions).

The goal will then be regularly reviewed as part of the treatment and recovery planning process and adjusted where appropriate.

4.7.2 Abstinence

The alcohol clinical guidelines development group recommend abstinence as the appropriate goal for most people with moderate or severe alcohol dependence. The group also recommend abstinence as the appropriate goal for most people with mild dependence and for people drinking at harmful levels who have significant physical health or mental health conditions that can be made worse by alcohol use (for example, alcohol-related liver disease or clinical depression). Any person choosing a goal of abstinence should be supported to work towards that.

However, if the person makes an informed choice to opt for a low risk drinking goal (see below), they should be supported in that goal. If there are considerable risks involved, the assessor should advise that abstinence is most appropriate and should support a negotiated approach where the person can consider abstinence if they do not achieve low risk drinking. People initially preferring a low risk drinking goal can switch to an abstinence treatment goal at a later point.

4.7.3 Low risk drinking

Low risk drinking may be an appropriate goal for most people with mild dependence and people drinking at harmful (higher risk) levels who:

- do not have significant physical or mental health conditions
- have adequate social support

If the person meets the above criteria, a low risk drinking goal may be appropriate unless they prefer a goal of abstinence, or there is some other reason for abstinence.

Low risk drinking is defined in this guideline as drinking within the UK chief medical officers' low risk drinking guidelines. These recommend it is safest not to drink more than 14 units a week on a regular basis, and if a person drinks as much as 14 units per week, it is best to spread drinking evenly over 3 or more days. For women who are pregnant or think they could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to the baby to a minimum.

This definition of low risk applies to the general population. For some people, drinking any alcohol at all is a risk. For example, abstinence is vital for the health of people with advanced liver disease, including cirrhosis.

A goal of low risk drinking is commonly known as controlled drinking (see definition of controlled drinking in the glossary). There is some evidence that tools such as the Impaired Control Scale may be appropriate for helping to identify the suitability of a controlled drinking goal (Heather and Dawe, 2005). Low drinking goals should be regularly reviewed.

4.7.4 Harm reduction

Some people with severe alcohol dependence or with significant and complex needs might not opt for a goal of abstinence or structured treatment, even after discussing benefits and risks of different alcohol use goals. For these people, the alcohol clinical guidelines development group recommend an initial goal of harm reduction. However, the practitioner should ultimately encourage a goal of abstinence. Complex needs include co-occurring physical and mental health conditions.

People experiencing homelessness may find a goal of abstinence unachievable until they are in stable housing.

A harm reduction approach will involve advice and interventions to reduce harm to a person's safety, and their physical and mental health. It may (although will not necessarily) include some reduction in alcohol use as a specific goal. Evidence shows a reduction in health harms when people reduce consumption, even though they may still be drinking at harmful or dependent levels (Witkiewitz and others, 2020).

A harm reduction approach can be helpful in building therapeutic rapport and self-efficacy and provide an opportunity for motivational interventions (see chapter 5).

The practitioner should provide information on the health or safety risks related to continuing to drink at high levels. And at an appropriate time for the person's circumstances, the practitioner should encourage them to consider the benefits and any risks of a goal of abstinence.

You can read more guidance on harm reduction in chapter 8.

4.7.5 Reviewing goals and monitoring the person's health

Regular review of treatment and recovery goals is an essential element of the treatment and recovery planning process, and the goals should be adjusted where appropriate. There should be regular reviews of a person's health when they continue to drink at harmful levels or experience alcohol dependence, and this should inform the consideration of their alcohol use goals.

4.8 Initial assessment

4.8.1 Offering an initial assessment

Services should offer an initial brief assessment (sometimes referred to as triage assessment) to all adults referred to community alcohol treatment services, Following initial assessment, services should consider people whose AUDIT score is 16 or over for comprehensive assessment, which is the next stage of assessment. This should follow immediately after initial assessment.

4.8.2 Aims and outcomes of initial assessment

The aims of initial assessment are to:

- introduce the person to the service

- gain an overview of the pattern and severity of the person's alcohol use and severity of dependence
- gain brief information on past use of alcohol treatment services
- identify any urgent treatment needs, including the need for assessment for medically assisted withdrawal
- identify any urgent risks to be managed
- identify any co-occurring physical or mental health conditions or support needs requiring assessment or intervention from specialist clinicians

Outcomes of initial assessment should include:

- agreeing an initial alcohol use goal with the person
- deciding whether the person needs to be assessed for medically assisted withdrawal
- agreeing an initial action plan to address any urgent needs, manage urgent risks, and set out the next steps in the assessment process

With the person's consent, the assessor should contact their GP and any relevant services they are attending so they can contribute to the assessment.

4.8.3 Initial assessment of alcohol use, severity of dependence and need for medically assisted withdrawal

Assessing alcohol use and severity of dependence

The assessor should carry out a brief clinical interview to assess the person's alcohol use and severity of dependence. This should include:

- alcohol use (approximate number of units and pattern) over the last 1 to 4 weeks
- examination of a typical drinking day (number of units and pattern of alcohol use)
- features and severity of dependence including psychological dependence using tools such as SADQ or LDQ
- brief summary of the duration of problem alcohol use in the person's life
- history of withdrawal symptoms, including any complications
- past periods of abstinence or low risk drinking and previous treatment outcomes

See section 4.5 above for information on tools to support assessment.

Need for assessment for medically assisted withdrawal

Services should consider offering an assessment for medically assisted withdrawal to people drinking more than 15 units per day or scoring 20 or more on AUDIT and anyone else who experiences withdrawal symptoms when they stop drinking.

When assessing the severity of alcohol dependence and determining the need for medically assisted withdrawal, the assessor should adjust the criteria to take account of how dependence can affect different groups, including:

- women
- older people
- children and young people
- people with established liver disease who may have problems with the metabolism of alcohol

You can read more information on adjusting criteria for these groups in chapter 10 on pharmacological interventions.

Initial assessment should determine whether there may be an urgent need for medically assisted withdrawal, for example if the person is physically unwell or has previously experienced severe complications in withdrawal.

Doctors, nurses or pharmacists responsible for assessing and managing medically assisted alcohol withdrawal should be competent to diagnose and assess alcohol dependence and withdrawal symptoms. They should also be competent to use drug regimens appropriate to the setting (community or inpatient) in which medically assisted withdrawal is managed.

Treatment services should ensure there are processes to support quick and seamless internal referral for an assessment for medically assisted withdrawal by an appropriately competent clinician, if the assessor does not have appropriate competencies.

You can find guidance on assessment for medically assisted withdrawal in chapter 10 and section 11.5 in chapter 11 on community-based medically assisted withdrawal.

4.8.4 Initial assessment of risks and urgent treatment or support needs

You should read this section with section 4.4.6 on risk assessment and safeguarding above.

Assessors should carry out an assessment of immediate needs and risks at the first meeting with the person. They will need training and therapeutic competencies to ask the assessment questions and to respond sensitively to the answers, and their approach should be trauma-informed.

Assessors should record if the person is in contact with other services and any medication they are prescribed.

Assessors should identify urgent risks or urgent needs, including:

- blackouts and risky behaviour while intoxicated
- suicidal ideation, intent or attempts, self-harm or severe self-neglect
- acute mental health conditions
- malnourishment

- substance use including illicit drug use, prescribed or over-the-counter medication whether obtained legally or illicitly and herbal medicines
- child safeguarding
- adult safeguarding
- mental capacity concerns
- domestic abuse (either as a survivor or a perpetrator)
- risk to others such as serious violence, sexual violence, sexual exploitation, stalking, human trafficking and modern slavery
- social support needs, including homelessness, urgent financial and debt problems
- criminal justice involvement and continuity of care needs for people leaving prison
- physical health or mental health conditions needing specialist assessment or intervention
- pregnancy and perinatal mental health needs (see chapter 24 on pregnancy and perinatal care)

There is further information on most of these risks and needs in section 4.9 below.

Complications in withdrawal

If the person is or may be experiencing withdrawal-related complications, the assessor should arrange for the person to be transferred to a hospital immediately.

Complications in withdrawal include symptoms worsening to very severe shaking and heavy sweating and:

- seizures
- suspected incipient Wernicke's encephalopathy (WE)
- delirium tremens

There is guidance on these conditions in section 10.4 in chapter 10 on pharmacological interventions.

Information about children

The assessor should ask the person about their own children, other children in the home and children they are in close contact with, including ages, and dates of birth of children and the level of contact they have with them. They should also record information on other adults living in the home or visiting regularly. The service may need this information, for example if a safeguarding referral is necessary and the person disengages from treatment.

It will help provide a fuller picture if the assessor can confirm information with other services involved with the person.

4.8.5 Agreeing an alcohol use goal

The assessor and the person should agree an initial treatment goal for alcohol use. They can revisit this during the course of the comprehensive assessment. Alcohol use goals are described in section 4.7 above.

4.8.6 Family and support networks

With the person's consent, they can invite a supportive partner, family member or friend to contribute to the ongoing assessment and action plan. Where appropriate, the assessor should offer information and support to the person's partner, family member or friend.

If the person is in agreement, the assessor should actively support them to access local peer support networks or mutual aid (such as Alcoholics Anonymous (AA) or SMART Recovery) (see section 5.5.4 for guidance on helping people to access mutual aid and peer-based support in chapter 5 on psychosocial interventions).

4.8.7 Initial action plan

Following initial assessment, the assessor and the person should agree an initial action plan based on the person's initial alcohol use goal, immediate needs, and any risks identified. The plan will include:

- an initial alcohol use goal and a broad plan for treatment to be reviewed at comprehensive assessment
- arranging assessment for medically assisted withdrawal if needed
- specific risks, actions to manage risks, and who will take the actions
- prescribing thiamine supplementation (see section 10.4.3 of chapter 10 on pharmacological interventions)
- referrals to and communication with other services
- the date of the next appointment for comprehensive assessment
- the likely date the person will begin structured treatment if they have agreed to that

The plan should also include dates for when actions will be completed as this is important for achieving positive outcomes.

4.8.8 Information

The assessor should offer accessible information about:

- the nature and treatment of harmful drinking and alcohol dependence
- available treatment options
- harm reduction (see section 4.4.9 on harm reduction interventions)

4.9 Comprehensive assessment

4.9.1 Access to comprehensive assessment

Alcohol treatment services should consider offering a comprehensive assessment for anyone referred to the service, who scores 16 or more on the AUDIT, building on information already gathered at initial assessment.

An AUDIT score of 16 or over for a person referred to specialist alcohol treatment is a broad indication of their need for a comprehensive assessment. However, AUDIT is not a diagnostic tool, so the assessor should use their clinical judgement because some people scoring lower than AUDIT 16 may also need a comprehensive assessment. For example, this might include people with alcohol dependence who have reduced their alcohol use before accessing treatment, but who would still require treatment and recovery support.

Other people who score under AUDIT 16 may need comprehensive assessment if their alcohol use contributes to other conditions or risks, or makes them worse. For example, this might include:

- people with severe and significant mental health conditions, or at risk of suicide, who require a 'no wrong door' approach (see section 4.9.9)
- people with severe physical health conditions, including advanced liver disease
- parents whose alcohol use might cause risks to their children

Alternatively, people scoring under AUDIT 20 who do not have any co-occurring conditions or complex needs may not always need further comprehensive assessment. But they will benefit from initial assessment and a psychosocial intervention.

A comprehensive assessment of need may take place over several sessions, but this process should never delay the person receiving treatment that they need as identified at initial assessment.

Services should prioritise people based on risk and urgency of treatment need and should ensure that people get treatment immediately where necessary. Examples include someone urgently needing medically assisted withdrawal, or a mental health crisis intervention. Where this is the case, the assessor can schedule appointments for ongoing comprehensive assessment around urgent treatment interventions. Where the person has no urgent treatment needs, comprehensive assessment should follow immediately after their initial assessment.

4.9.2 Aims and outcomes of comprehensive assessment

The comprehensive assessment builds on the initial assessment and provides an opportunity to explore the person's goals and develop a package of support that provides structure and care to maximise their recovery.

The aim of comprehensive assessment is to gather and consider information, so the assessor and the person can agree a treatment and recovery plan (see section 4.10).

The assessment process will involve developing a shared formulation. Formulation provides a framework to understand:

- the person's problem alcohol use
- how it began and developed
- the factors that maintain it
- potential resources to address it

You can read more about formulation in section 5.4 in chapter 5 on psychosocial interventions.

With the person's consent, it is helpful to collect information from other professionals they are involved with, and where appropriate from family members. One benefit of this is that it can reduce the number of questions the assessor needs to ask the person, who may already have been asked to go over painful aspects of their life on several occasions. People with lived experience often report that they get asked the same questions about their life repeatedly by different services, and that this can be difficult and off-putting.

The outcomes of comprehensive assessment will include a:

- collaboratively agreed personalised treatment and recovery plan
- risk management plan

Both plans should be regularly reviewed and adjusted to take account of the person's progress through treatment and changes in their circumstances.

4.9.3 Motivation, readiness and belief in the ability to change

It is important to consider a person's motivation and readiness for change at assessment and throughout treatment. The assessor can gain some understanding of the person's motivation by asking what has led them to seek treatment and what they hope to get from it. This information can help to inform the treatment and recovery plan.

Exploring motivation and readiness for change can help to:

- set goals and select interventions that reflect the person's priorities, and their current level of motivation
- inform how the assessor might enhance the person's motivation
- identify specific barriers to readiness for change and actions to reduce them

Since motivation is continually changing, practitioners should continually review a person's priorities, plans and goals.

The World Health Organization's International Classification of Diseases (11th revision) defines alcohol dependence by including features such as impaired control, physiological changes, and increased prioritisation of drinking behaviours. It is common for people entering treatment to believe that they will not be able to change. This might mean they seem to be initially resistant to recovery or even engagement in treatment.

Assessment should be based on the principles and techniques of motivational interviewing.

The main elements of motivational interviewing include:

- helping people to recognise problems or potential problems related to their drinking
- helping to resolve ambivalence and encourage positive change and belief in the ability to change
- adopting a persuasive and supportive rather than an argumentative and confrontational position

4.9.4 The areas of need and strength that comprehensive assessment covers

Comprehensive assessment involves the assessor working with the person using a clinical interview approach to explore multiple areas of need, including:

- motivation, readiness and belief in ability to change
- alcohol use
- substance use, including illicit drug use, prescription and over-the-counter medication (whether obtained illicitly or prescribed), herbal medicines and smoking tobacco
- individual strengths and recovery resources
- gambling harm
- mental health, including cognitive function
- physical health
- pregnancy and the perinatal period
- criminal justice involvement
- social factors, for example housing, income and debt
- employment support needs
- partner and family relationships including domestic abuse
- support needs of adult family members
- impact of parental alcohol use on children and young people and children's support needs

We expand on each of these areas of need in the following sections.

4.9.5 Alcohol use

Reviewing changes in alcohol use

The comprehensive assessment should explore any changes in the person's alcohol use since the initial assessment or last appointment. The assessor should review:

- the person's alcohol use (approximate number of units per day and pattern) over the last 1 to 4 weeks (see chapter 8 on harm reduction for information on units)
- a typical drinking day for the person (number of units and pattern of their alcohol use)
- features and severity of dependence including psychological dependence using tools such as SADQ or LDQ (see section 4.5 on tools to support assessment above)
- alcohol use throughout the person's life
- history of withdrawal symptoms, including any complications (including seizures, delirium tremens and Wernicke's encephalopathy)
- alcohol-related problems, using an appropriate tool such as APQ (see section 4.5 on tools to support assessment above)
- past periods of abstinence or moderate drinking and any previous treatment outcomes

The assessor should review any risks related to their alcohol use identified at initial assessment and include them in the risk management (safety) plan.

Using a drink diary

Regularly completing a retrospective drink dairy can help to provide a fuller picture of the person's alcohol use. This involves the assessor and the person in treatment recording the number of units per day and pattern of alcohol use over the preceding week or weeks before each appointment. Services in the UK also find it helpful to use a prospective drink diary where the person monitors their own drinking by completing it each day. However, there is no research evidence on using a drink diary in this way, so its reliability and validity is unknown.

There are also online and phone apps that people can use to record their daily alcohol use. For example, the free Alcohol Change UK Try Dry app.

Exploring the context of alcohol to develop a formulation

The assessor and the person can explore the following elements to develop a shared formulation to understand the person's alcohol use.

Factors that may:

- predispose the person to harmful drinking or dependence (for example, adverse childhood experiences, family history of alcohol use)
- trigger alcohol use (for example, depressed mood, interpersonal conflict)
- maintain alcohol use (for example, social networks where harmful drinking is the norm, ongoing stress from social circumstances or discrimination)
- be protective and support recovery (for example, supportive family and social networks, rewarding activities as alternatives to drinking)

Reviewing past attempts at abstinence or moderate drinking can help identify factors linked to past successes and identify obstacles to maintaining change. Exploring previous periods of

abstinence may also provide insights into withdrawal symptoms and whether the person experienced these when taking withdrawal medication.

You can find further guidance on clinical formulation in section 5.4 of chapter 5 on psychosocial interventions.

4.9.6 Co-occurring substance use or dependence

The assessor should collect information on:

- types of substances and medications the person uses (whether legally or illicitly obtained) including illicit drugs, prescribed medications, over-the-counter medication and herbal medicines
- quantity, frequency and pattern of use
- routes of administration (including injecting)
- sources of drugs obtained
- past and current harmful use or dependence (including any experience of withdrawal symptoms)
- tobacco use and any smoking cessation support offered (see section 19.6 on smoking-related diseases and lung health in chapter 19 on people with co-occurring physical health conditions)

You should identify a person's use of illicit drugs or prescribed or over-the-counter medications at initial assessment and review this throughout their treatment. Common substances used in the alcohol treatment population are cannabis, powder cocaine and prescription medications such as benzodiazepines. As well as the harms specific to the substance, their combined use can increase specific risks such as fatal overdose as well as other health harms (for example, cocaine and alcohol are more toxic in combination) (Pennings and others, 2002).

It is important to establish any need for interventions targeted at the person's substance use, as well as interventions for their alcohol use. The formulation should enable this process and help to understand the function of the substance use for the person. It is not unusual for people to substitute one substance for another, so you should undertake ongoing review of alcohol and other substance use throughout treatment.

If you establish a treatment need for other substance use, this should generally be managed in the team providing the alcohol treatment. However, if the person has an opiate dependence and requires opioid substitution treatment (OST), then the team managing the OST should take over the person's care managing their alcohol treatment as well as their drug treatment.

It is not in the person's interests to have dependence on different substances managed in different teams. Where services are not integrated drug and alcohol treatment services, joint working with the local drug treatment service and aligned treatment and recovery plans will be essential.

If the person uses other substances, you should consider this when planning pharmacological interventions. You can find guidance on pharmacological interventions for people in alcohol treatment with co-occurring drug use or dependence, including benzodiazepine dependence, in chapter 10 on pharmacological interventions.

The assessor should offer relevant harm reduction advice on the risks of concurrent problematic alcohol and drug use. You can find guidance on this in chapter 8 on harm reduction.

Drug misuse and dependence: UK guidelines on clinical management provides extensive guidance on treating people with drug problems, including section 6.5 on alcohol in drug treatment.

4.9.7 Assessing strengths and recovery resources

Assessing the person's strengths and recovery resources (sometimes called recovery capital) is an important part of assessment. Recovery resources are health life resources, such as:

- health and wellbeing
- education and training
- employment
- financial and housing stability
- supportive family relationships, friends
- social and cultural networks
- recovery oriented peer networks

Evidence shows that most people with alcohol dependence make attempts to reduce or stop using alcohol without the help of specialist services (Tucker and Simpson, 2011). The person may already be drawing on their recovery resources to make changes or have experience of doing so. Assessment should identify strengths and resources that could help them to stop or reduce their drinking and support them to make longer-term changes during and after they complete treatment.

Areas to consider include:

- individual resources (for example, coping strategies, past successes in making changes in alcohol use or in other areas of their life, levels of personal responsibility, mental and physical health, skills and interests such as education, training and volunteering)
- employment or interest in future employment
- economic and social stability (for example, stable finances, safe and stable accommodation)
- family and social network resources (for example, support from and obligations to family, partners, children and friends, or other supportive social networks)

- cultural or faith-based resources (for example, values, beliefs, attitudes, practices and communities)
- participation in peer-support networks, organisations or mutual aid groups

Research suggests higher levels of social support may mitigate poor outcomes for people exposed to stress, including people with problem alcohol use (Moak and Agrawal, 2011).

While there may be more focus on treatment interventions at the beginning of the person's treatment and recovery journey, the process of helping the person to identify and develop recovery resources begins at assessment and continues throughout their treatment.

Helping people develop recovery resources is an important part of the structured support that keyworkers offer. You can read about structured support in section 5.5 in chapter 5 on psychosocial interventions.

4.9.8 Gambling harm

The Gambling-related harms: evidence review showed that there is evidence of a clear association between increased weekly alcohol consumption with gambling harm. This supports the rationale for screening for gambling as part of a comprehensive assessment. Services should consider using a brief screening tool such as the 3-item short-form Problem Gambling Severity Index (PGSI-SI mini-screen), one of 5 brief screening tools identified by a meta-analysis as having satisfactory diagnostic accuracy for detecting harmful gambling (Dowling and others, 2019).

The relationship between gambling and alcohol use can be usefully explored and understood through the process of formulation and can inform the appropriate intervention. This may include referral to a local or regional specialist gambling service and practical support such as debt counselling may also be required. There are a number of NHS specialist treatment service for people experiencing gambling harm and people with co-occurring alcohol use should not be excluded from these.

The assessor should offer information on the spectrum of harms that can be associated with gambling. You can find further information at the Chapter One website. They should also signpost to treatment and support, such as the National Gambling Helpline (Great Britain only), and gambling self-exclusion tools, including blocking software (for more information see the Self-exclusion page of the Gambling Commission website).

4.9.9 Mental health

The importance of assessing mental health needs for people with problem alcohol use

It is common for people with problem alcohol use to experience problems with their mental health. One study found that 70% of a sample of people from community substance use treatment in England also met criteria for common mental health problems (Delgadillo and others, 2012).

The service and the assessor should act on the principle of 'no wrong door'. This means that nobody should be turned away from an alcohol treatment service (or from a mental health service) because they have co-occurring problem alcohol use and mental health conditions.

It is important that an assessment of the person's mental health is always included in a comprehensive assessment for alcohol treatment. A person's mental health conditions may be undiagnosed or untreated and the assessor should ask questions about their mental health even if the person has no formal diagnosis.

Urgent mental health needs

The main assessor, who may not be a clinician, should be competent and supported to identify any immediate risks including mental health problems that need an urgent response. The assessor should involve the MDT or wider clinical team in any decisions about referring the person for an urgent mental health assessment through local urgent and emergency mental health care pathways.

Section 4.8.4 on initial assessment of risks and urgent treatment needs describes urgent mental health risks.

Ongoing mental health needs

The assessor should confirm the person's:

- past or current mental health conditions
- involvement with mental health services, including any crisis services and any inpatient admissions
- current mental health risks
- current medication

With the person's consent, where relevant the main assessor should ask their GP and any mental health service working with the person to contribute relevant information to the assessment.

If the main assessor does not have specialist competence in mental health and have any concerns, they should discuss the person's needs with the MDT or wider clinical team. Where the person's mental health requires further assessment, a member of the MDT with specialist mental health competence should carry this out, or the person should be referred to local mental health services. If the person has a severe and significant mental health condition and is not involved with a mental health service, a clinician should offer a mental health assessment and make a referral to mental health services as quickly as possible.

If a member of the MDT with relevant mental health competencies carries out a further assessment of the person's mental health, they should ask in more depth about:

- any current diagnosis
- history of mental health conditions and any current symptoms or concerns

- existence of any historic or current trauma
- past and current contact with mental health services
- current prescribed medication
- common mental health conditions, including non-severe depression and anxiety
- suicidal thoughts, intentions or suicide attempts, self-harm and severe self-neglect
- symptoms of severe mental illness, such as psychosis and bipolar mood disorder
- protective factors and strategies to manage mental health condition

Where assessors are trained and supervised to use formal assessment tools for mental health conditions, these may be helpful to support assessment. For example, they can use the:

- patient health questionnaire (PHQ-9) to screen for depression
- generalised anxiety disorder assessment (GAD-7)
- eating disorder examination questionnaire (EDE-Q)
- primary care post-traumatic stress disorder screen (PC-PTSD)

Having a co-occurring mental health condition can increase the person's level of risk. The assessor should consider how alcohol intoxication and withdrawal interact with aspects of the person's mental health. For example, research has shown that intoxication can increase the risk that a person may act on their suicidal ideation (Kaplan and others, 2013; Ledden and others, 2022). See section on suicide risk and self-harm below for guidance.

Planning treatment for both alcohol use and mental health conditions

People with co-occurring alcohol use and mental health conditions should receive treatment for both conditions. Depending on the competencies of staff in the alcohol treatment service and in the mental health service, and on the severity of mental health condition, treatment for both conditions may be offered by:

- the alcohol treatment service
- the mental health service
- both services working together with the person

The assessor, supported by the MDT, should agree a clear plan with the person and any relevant services for how both conditions will be treated. If the alcohol treatment service and a mental health service will both be working with the person, it is important that they co-ordinate care, share information and align or integrate treatment and recovery plans (care plans). See section 4.10.4 on multidisciplinary and multi-agency treatment and recovery (care) plans and section 4.10.2 on risk management (safety planning).

There should be a named person responsible for leading on and co-ordinating the person's care. NICE clinical guideline Coexisting severe mental illness (psychosis) and substance

misuse: assessment and management in healthcare settings (CG120) recommends that if the person has a severe mental health condition, the keyworker from the mental health service should usually lead on co-ordinating care.

There is more detailed guidance on joint working between mental health services and alcohol treatment services in chapter 18 on people with co-occurring mental health conditions.

Monitoring a person's mental health need while they are in treatment

In some cases, mental health conditions (particularly anxiety or depression) may begin to improve after a few weeks of abstinence or significant reductions in alcohol use. However, for some people, mental health conditions do not improve and there is a risk that if they are not offered mental health support when they need it, they may return to problematic drinking.

The period after medically assisted withdrawal or a significant reduction in alcohol use is best described as one of 'watchful waiting'. The appropriate member of the MDT in the alcohol treatment service should provide:

- ongoing assessment of the person's mental health need
- support to manage continued low mood or feelings of anxiety
- a quick start to treatment for the co-occurring mental health condition if it is needed

People who need quick access to mental health treatment

For some people, comprehensive assessment of both their alcohol dependence and their mental health will clearly indicate that waiting to start treatment for mental health is not appropriate. These people will need a mental health support package to be in place before they start medically assisted withdrawal. The main assessor or clinician in the alcohol treatment service and the mental health clinician will need to closely co-ordinate the mental health support and the medically assisted withdrawal.

For people with immediate mental health needs who do not require a medically assisted withdrawal, the same principles apply. The clinicians from both services will need to co-ordinate care, involving the person in planning and decisions about interventions, including any decisions about sequencing interventions.

Pharmacological interventions for co-occurring mental health conditions

There will be specific considerations when delivering pharmacological interventions for some people with co-occurring mental health conditions.

You should read about prescribing for people with co-occurring mental health conditions in section 10.6.5 in chapter 10 on pharmacological interventions.

4.9.10 Suicide risk and self-harm

Risk factors for suicide and self-harm

Research has shown that alcohol, both through intoxication and dependence, is a factor in a significant proportion of deaths by suicide (Kaplan and others, 2013; Ledden and others, 2022).

The National Confidential Inquiry into Suicide and Safety in Mental Health Annual report 2024: UK patient and general population data 2011 to 2021 found that 47% of people in contact with mental health services who died by suicide between 2011 and 2021 used alcohol problematically.

The Office for National Statistics report Suicides in England and Wales: 2023 registrations found that men are about 3 times more likely than women to die by suicide.

England, Scotland, Wales and Northern Ireland have national suicide prevention strategies:

- Suicide prevention strategy for England: 2023 to 2028
- Creating Hope Together: suicide prevention strategy 2022 to 2032 (Scotland)
- Suicide prevention and self-harm: strategy and delivery plan (Wales)
- Protect Life 2 - Suicide Prevention Strategy (Northern Ireland)

Services should be aligned with their national suicide prevention strategies which include information on risk factors for suicide.

People with problem alcohol use often experience other risk factors for suicide which include but are not limited to:

- socioeconomic deprivation, financial difficulty and economic adversity
- a history of self- harm or suicide attempts
- long-term physical health conditions
- mental health conditions
- gambling harm
- drug use
- domestic abuse
- social isolation and loneliness
- bereavement
- interpersonal difficulties

People in alcohol treatment services often experience several of these risk factors.

Staff competencies for identifying and responding to risk of self-harm or suicide

Services should provide training and support for staff so they are competent to:

- understand risk factors for suicide

- ask sensitively about suicidal thoughts, intentions or attempts, and incidents of self-harm
- identify and respond appropriately to incidents of self-harm, suicidal thoughts, intentions or suicide attempts
- understand that self-harm, suicidal thoughts, intentions or behaviour should always be taken seriously, regardless of whether the person is or was intoxicated at the time
- understand how to escalate concerns about the person within their organisation and act in line with organisational procedures
- make sure people can access suitable care, including mental health crisis services, emergency care and a place of safety where necessary

Assessing and responding to risk of suicide and self-harm

Comprehensive assessment should include questions on self-harm and suicide and self-harm, including but not limited to:

- past history of self-harm and suicidal behaviour
- mental health conditions related to self-harm or suicidal behaviour
- current thoughts or plans of suicide
- current thoughts of self-harm or plans to self-harm
- engagement with online suicide-related content
- current or recent pattern of self-harm or suicidal behaviour
- current stressors that may contribute to self-harm or suicidal behaviour

Services and practitioners should work in line with NICE guideline Self-harm: assessment, management and preventing recurrence (NG225), which provides detailed guidance on self-harm, including suicide risk and suicide attempts.

Services and practitioners should always personalise risk management (safety) plans and tailor them to the specific needs of the person and risks they experience. NICE NG225 states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment, or who should be discharged. Risk assessment should focus on the person's needs and how to support their immediate and long-term psychological and physical safety.

Identifying and managing immediate risk of suicide or self-harm

Services should have agreed pathways and processes for responding to people who are assessed as at immediate risk of suicide or self-harm. Staff should follow organisational procedures and seek support from the MDT, or an appropriate experienced clinician with mental health competencies.

The assessor should identify whether the person has access to the means of self-harm (for example, tablets) and discuss removing this or reducing other forms of immediate risk with the person.

The assessor or supporting clinician should arrange an assessment from an age-appropriate specialist mental health professional as soon as possible through local urgent and emergency mental health care pathways which will vary across different areas. Where possible, the alcohol treatment service should arrange for the person to be accompanied by a staff member, family member or support person to the emergency setting. If this is not possible, they should arrange for the person to go in an ambulance.

NICE NG225 states that assessment for people at risk of self-harm or suicide should not be denied because the person is intoxicated or has been drinking. Services sometimes turn away people whose safety is at risk and who are intoxicated due to stigma or misunderstandings about suicide and alcohol use. This exclusion in turn increases the risk to their safety. The alcohol treatment service may need to act as an advocate with professionals in the urgent and emergency mental health care pathway to help people access appropriate care, including when intoxicated. NICE NG225 recommends that if the person is not able to participate in the assessment due to intoxication, the mental health professional should provide regular reviews and complete an assessment as soon as possible.

Chapter 16 on alcohol care in acute hospitals provides more guidance on managing self-harm in an acute setting, including when the person is intoxicated.

Where appropriate, the assessor should ask the person for consent to involve family members. If the person does not consent, the assessor and MDT should follow organisational procedures on information sharing and suicide prevention.

The assessor should also tell the person, and if relevant their family member, about local support that they can access in an emergency.

Ongoing treatment and support

The assessor or keyworker should be supported by the MDT when planning care and assessing risk. The alcohol treatment service should try to involve mental health services if the person is considered at risk of self-harm or suicide. Self-harm may indicate that the person has difficulty managing their emotions and they may need specialist treatment from a mental health service, such as dialectical behaviour therapy. The alcohol treatment service and mental health service will need to co-ordinate care. For people with ongoing problems with self-harm, suicide risk or a severe or significant mental health condition, the lead professional should be the mental health professional.

Chapter 18 on people with co-occurring mental health conditions provides more guidance on integrated and co-ordinated care.

4.9.11 Cognitive function

The most common cause of alcohol related brain damage (ARBD) is WE, a serious complication of deficiency of thiamine (vitamin B1), for which the most common cause is alcohol

dependence. WE can cause lasting brain injury. There are also other forms of ARBD, such as alcohol related dementia and cognitive impairment as a result of traumatic brain injury.

Assessors should be able to identify potential signs of acute WE, which is a medical emergency.

People with acute WE can have one or more of the following symptoms:

- impaired eye movements (ophthalmoplegia)
- unsteady walking (ataxia)
- confusion and memory disturbance

You should arrange for a person with suspected WE to go to hospital immediately.

You can find guidance on preventing and managing WE in section 10.4.3 in chapter 10 on pharmacological interventions.

Some people accessing treatment with alcohol dependence will have a degree of chronic (non-acute) ARBD. Assessors should ask about signs of memory loss and difficulties with day-to-day functioning. These may be signs that the person has short or long term brain damage.

Trained practitioners should consider using brief measures of cognitive functioning, such as the mini Addenbrooke's Cognitive Examination (mini ACE) or Montreal Cognitive Assessment (MoCA) test for dementia and should refer people whose scores indicate a need for more specialist cognitive assessment. These referrals could be either within the service if there is a clinician with appropriate competencies, or through standard pathways for neurological conditions or cognitive impairment. People with ARBD should not be excluded from these pathways.

A clinician with relevant specialist competencies should carry out a thorough multidisciplinary assessment of the person, which considers their day-to-day functional ability as well as any cognitive test score. Cognitive testing in a person who is acutely intoxicated is of no value. But clinicians can test a person who is currently drinking as long as they recognise that there will be some acute effects of alcohol such as acute memory impairment that should resolve when the person stops drinking.

People with a cognitive disability that is not caused by alcohol use, such as learning disability or dementia, may also present for assessment. Services may need to adjust assessment and interventions for people who have problems with memory, learning new things, or planning. These problems can be experienced by people with ARBD and by people with a cognitive disability which is not related to alcohol use.

Family members or practitioners from support services should contribute to the assessment where the person agrees. Assessors should work with practitioners from other services and the person to develop a treatment and recovery plan tailored to the person's needs in a way they can understand.

You can find comprehensive guidance on ARBD, including about adjusting interventions and assessing mental capacity in chapter 20 on people with ARBD.

4.9.12 Physical health

Why physical health assessment is important

People with alcohol dependence and people who drink at harmful levels have more physical health problems and die at an earlier age than the general population. Alcohol use disorders can cause over 60 serious physical health conditions or make existing conditions worse. This includes:

- alcohol related liver disease
- cardiovascular disease
- several cancers, including cancer of female breast, the oral cavity and pharynx, oesophagus, colorectum, larynx, liver, stomach, pancreas, lung and gallbladder
- alcohol related brain damage (see section 4.9.11 on cognitive function above)

You can find a comprehensive list of alcohol related health conditions in chapter 19 on people with co-occurring physical health conditions.

People presenting for assessment may also have physical health conditions unrelated to their alcohol use. Physical health conditions may be undiagnosed or untreated. It is important that people with problem alcohol use can access a thorough assessment of their physical health. Stigma and poor experiences of health services can mean that people with problem alcohol use have not accessed the healthcare they need.

With the person's consent, the assessor should ask their GP and any other healthcare services working with the person to contribute relevant information to the assessment. They should confirm:

- any past or current significant health conditions
- current medication
- any allergies

Liver screening test

NICE NG50 recommends that anyone drinking at harmful (high risk) levels (35 units or more per week for women, 50 units or more per week for men) for 3 months or more should be referred for transient elastography. Some areas use alternative tests for detecting cirrhosis.

The assessor should refer the person for a liver screening test if they meet those criteria.

You can read more about liver screening tests in section 19.5.2 in chapter 19 on people with co-occurring physical health conditions.

Services should be aware of the local pathway for liver screening and the assessor should refer people where necessary. Where community alcohol treatment services provide transient

elastography, they should make sure that staff are trained in performing the scan and interpreting the results. Screening for alcohol related liver disease should include a measure of liver fibrosis (such as transient elastography), in addition to liver function blood tests, because normal liver blood tests do not exclude advanced fibrosis.

Referral to primary care

The main assessor, who may not be a clinician, should be able to recognise physical health conditions that need urgent assessment and treatment and refer the person to a clinician within the service, their GP, or the hospital emergency department as appropriate. Section 4.8.4 on initial assessment of risks and urgent treatment or support needs describes urgent physical health risks.

If the person is not registered with a GP, the assessor should help them to register. In some areas, a member of peer-based support networks may accompany the person to GP appointments for support. Alcohol treatment services and practitioners should be aware of current guidance about eligibility for primary care, so they can advocate on behalf of vulnerable migrants and people who are experiencing homelessness.

You can read more about people's right to register with a GP in section 21.4.4 in chapter 21 on people experiencing homelessness.

Healthcare assessment

Once a person's urgent physical healthcare needs have been addressed, the assessor should arrange for them to have a full healthcare assessment (unless they have already recently received one). Some or all of the healthcare assessment may be carried out in the alcohol treatment service.

People with problem alcohol use may be reluctant to approach healthcare services due to past negative experiences, stigma or difficulties in keeping appointments. Some people may find it easier to engage with a healthcare assessment in the alcohol treatment service and the clinician may be able to offer the assessment over several sessions. Depending on local arrangements, clinicians in alcohol treatment services will be able to carry out most of the healthcare assessment but may need to request that the GP or specialist healthcare services carry out some of the relevant tests. Referrals to specialist healthcare services will usually be requested through the person's GP.

The questions, examinations and tests below are not all that needs to be done. The assessing clinician will need to account for the person's individual medical history and current circumstances.

Medical history

There is some overlap between the questions asked to assess physical health needs and the questions in an alcohol (and drug use) assessment (including assessment for medically assisted withdrawal).

The clinician may need to ask some urgent questions about the issues below, for example before the person can access a medically assisted withdrawal. They can ask other questions at a later stage. Urgent questions may be about:

- symptoms that are a physical health concern when the person presents for assessment
- past or current medical history, including liver disease, cardiovascular disease, cancers, pancreatitis, respiratory disease, injuries, operations and hospital admissions
- any prescribed medication
- any history or symptoms of cognitive impairment (ARBD or cognitive impairment due to other causes)
- any history or symptoms of malnutrition or poor diet
- tobacco smoking (see section 19.6 on smoking-related diseases and lung health in chapter 19 on people with co-occurring physical health conditions)
- types of substances and medications the person uses (whether legally or illicitly obtained) including illicit drugs, prescribed medications, over-the-counter medication, and herbal medicines
- any allergies or sensitivities
- any current oral health problems and recent dental check-up or treatment
- menstrual and pregnancy history, contraception history and cervical screening, if this is relevant
- concerns about sexual health or (if appropriate) blood-borne viruses, HIV or hepatitis B and C
- history of screening and vaccinations received

General health examinations and assessments

The clinician should carry out the following general health assessments or examinations early in the assessment process:

- gastrointestinal system, including the liver
- cardiovascular system
- respiratory system

The clinician should carry out additional examinations where indicated by the healthcare assessment. These examinations include:

- neurological examination (indications include loss of sensation, forgetfulness, convulsions, blackouts)
- dentition examination (to assess the arrangement or condition of a person's teeth)

The clinician should measure weight and blood pressure. Baseline measurement can be useful in monitoring a person's progress and may be needed where there are concerns.

Additional testing

The following investigations may sometimes be required. They may be provided within the alcohol treatment service, by the GP or by specialist healthcare services, depending on local arrangements.

Based on the person's history, risks, symptoms or findings of previous general physical examinations and MDT discussions, appropriate testing required may include:

- screening for liver stiffness via transient elastography or alternative screening tests (see section on testing for cirrhosis above)
- electrocardiogram (ECG)
- chest X-rays and pulmonary function tests such as measures of peak flow and forced expiratory volume (FEV) and forced vital capacity (FVC)
- pregnancy testing
- blood tests to assess liver function, renal function, thyroid function and haematological indices
- formal cognitive testing and assessment
- urine testing for markers of conditions such as diabetes and infection and where appropriate drugs of dependence

Health information and harm reduction

The clinician should encourage the person to consider the impact of their alcohol use on their health. Test results may be an opportunity to discuss health goals and strengthen motivation to change their alcohol use.

Using the principles of MECC, the clinician or main assessor should offer the person clear, accessible information on health risks related to alcohol use, as well as general health information.

You can find information on health risks related to alcohol use in chapter 8 on harm reduction. This should include information and advice for pregnant women and other people who are pregnant or could become pregnant (see section 4.9.13 below and chapter 24 on pregnancy and perinatal care).

General health information would include:

- nutrition and diet
- smoking cessation and harm reduction and referral to smoking cessation service (see section 19.6 on smoking-related diseases and lung health in chapter 19 on people with co-occurring physical health conditions)

- contraception, safer sex, and referral to sexual health service where appropriate
- information about local NHS dental services or direct referral to special care dental services if appropriate

Pharmacological interventions

Clinicians will need to consider the impact of physical health conditions when delivering pharmacological interventions for medically assisted withdrawal and relapse prevention. For example, the impact of advanced liver disease.

You can find guidance on pharmacological interventions for people with liver disease in section 10.6.6 in chapter 10 on pharmacological interventions.

Joint working with primary care and secondary care health services

Good communication between keyworkers and clinicians in the alcohol treatment service and clinicians in primary and secondary healthcare services is essential. Alcohol treatment service clinicians can provide specialist knowledge about alcohol dependence and can act as an advocate for the person, challenging stigma where necessary.

Arrangements for information sharing should be in place between alcohol treatment services and relevant healthcare services. In some areas, alcohol treatment services can access a person's national electronic health records to make information sharing quicker and more effective.

4.9.13 Pregnancy and the perinatal period

Services should treat pregnant women and other people who are pregnant as a priority for assessment and for treatment. Any delay in starting treatment may increase the risk to the mother and the fetus. They should urgently assess the needs of women and those who are pregnant, even if they are currently drinking below the usual threshold for accessing an assessment, or if they have a history of problematic alcohol use but are not currently drinking. This is to reduce risks to the fetus and the mother.

The assessor should provide information on the risks of alcohol in pregnancy as set out in the UK chief medical officers' low risk drinking guidelines, which says that:

- if you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum
- drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk
- the risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy

However, it is important to advise anyone who is pregnant or think they could be, not to stop suddenly as this could cause harm to the baby or to them. The assessor should arrange an assessment for medically assisted withdrawal as soon as possible.

You should read guidance on assessment of pregnant women and other people who are pregnant in chapter 24 on pregnancy and perinatal care.

4.9.14 Criminal justice system involvement

Criminal justice considerations in the assessment

This section provides guidance on assessment in specialist alcohol treatment services in the community.

You can read guidance on considerations for assessment and treatment in criminal justice settings in chapter 17 on alcohol treatment in the criminal justice system.

The assessor should ask about any involvement with the criminal justice system. This may include previous or current:

- arrests
- fines
- outstanding charges and warrants
- engagement with probation, including community treatment orders
- licence conditions
- imprisonment
- recent release from prison

Where the person is working with a criminal justice worker or being supervised by the Probation Service, those staff should contribute information to the assessment and treatment and recovery planning.

The assessment should consider the nature of offences as part of risk assessment. For example, if the person committed violent or other serious offences, and whether they might pose risks to other people using the service or staff. The assessment should also include information about child safeguarding or adult safeguarding concerns and whether the person is subject to multi-agency public protection arrangements (MAPPA).

The assessor should consider any links between alcohol use, alcohol dependence and offending. For example, if a person committed offenses when intoxicated or whether their current period of problem alcohol use followed release from prison without adequate support. Treatment and recovery planning may include goals on alcohol use and related offending and will need to take account of any alcohol treatment orders issued by the court, or license conditions.

Continuity of care

People leaving prison should be treated as a priority for assessment, so there is continuity of care between custody and the community. Alcohol treatment services should have agreed care pathways with treatment services in prisons so there is continuity of care which:

- supports treatment engagement
- ensures referral to relevant services
- reduces re-offending
- reduces homelessness
- reduces alcohol related harm

It's important there is good communication and information sharing between prison services and the local alcohol treatment service before the person is released. This is so they can be offered an assessment appointment immediately after release. Some alcohol treatment services provide in-reach into prisons to strengthen continuity of care. Ideally, there should be a transition meeting for each person leaving prison, involving relevant services for the person to support continuity of care.

The Department of Health and Social Care manages the criminal justice and community single point of contact directory. This consists of contact details of criminal justice organisations and community drug and alcohol treatment providers throughout England and Wales. The main purpose of this directory is to promote successful communication and pathways between organisations, for people moving from criminal justice organisations to community providers and the other way round, as well as supporting effective continuity of care across the system.

You can request access by registering to use the NDTMS website. You can send any further information queries to spoc-ohid@dhsc.gov.uk.

The person may have practical and social needs that should be assessed to help them reintegrate into the community after release from prison. When continuity of care is working well, prison treatment services will be in contact with other relevant services for the person before their release, including mental health services, so their care in the community can be planned. However, the assessor in the alcohol treatment service should identify any urgent unmet needs the person has at assessment and help to address these as quickly as possible.

The alcohol treatment service should have links with statutory, voluntary, community and social enterprise organisations that provide recovery focused services for people who have recently left prison and their families.

The assessor should check whether the person has registered with a GP and should help them to do this if they have not.

Assessors should provide harm reduction information including information about:

- decreased tolerance to alcohol following a period of abstinence and the risks of consuming at the level they did before going to prison
- risks of combining alcohol with other substances, such as increased risk of overdose and increased toxicity of alcohol and cocaine when these are taken together
- increased risk of overdose for people who also use heroin or other opioids

If the person uses heroin or other opioids (including prescribed opioid medication) the assessor in the alcohol treatment service should provide the person with naloxone if they do not have any. If the person has an opioid dependence and requires OST, then the team managing the OST should take over the person's care and manage their alcohol treatment as well as their drug treatment.

You can read guidance on harm reduction in chapter 8.

4.9.15 Social and economic factors

The public health burden of alcohol: evidence review found that alcohol dependence and alcohol health harms are strongly associated with socioeconomic deprivation.

Poverty and social exclusion may be a cause and a consequence of alcohol dependence and related health harms. These factors can prevent people engaging in treatment, for example if the person has basic unmet needs such as for food, shelter or access to transport to attend the service.

Assessors should ask about:

- debt, financial and welfare benefits problems
- homelessness and housing needs, including unhealthy or unsafe housing conditions, risks to their tenancy or rent arrears
- any community safety problems, such as harassment or anti-social behaviour directed at the person by neighbours
- any use of the person's accommodation by other people for illegal activities
- employment status and any employment problems

Assessors should identify any social care needs, including:

- the person's need for a care assessment, for example for home care or personal care (see annex 1 for national legislation and guidance on care assessments)
- what support they have to help reduce social isolation

Assessors should have a wide range of links to local support services and community organisations. This will help them make effective referrals to services and organisations that can help people address the needs listed above.

Wherever possible, alcohol treatment services should invite services providing advice and support to offer in-reach sessions in the alcohol treatment service. This will help increase accessibility for services such as:

- housing
- welfare rights
- debt

- employment

Stigma around problem alcohol use can sometimes affect the service a person receives from support services. So, the alcohol treatment service may need to act as an advocate to make sure people can access the help they need from local support services.

In some areas, members of peer-based support organisations may be able to accompany people to services and help them to do things like fill out forms and attend appointments.

Employment support

People who are not employed may not be well enough or confident enough to seek employment when they are at the assessment stage of their journey. However, it is still useful to ask about any longer-term wishes or goals they have in relation to employment. This can help people access specialised employment support if and when they are ready.

You can find guidance on employment support in chapter 7.

You can find guidance on supporting people experiencing homelessness in chapter 21.

4.9.16 Relationships with partner, family, friends and community

Considering partners, family and friends in the assessment

Assessment should include consideration of:

- relationships with partner, family and friends
- the impact of the person's alcohol use on relationships with partner, family and friends
- the impact of relationships with partner, family and friends on the person's alcohol use
- the person's supportive family and social networks
- risks, including domestic abuse and adult safeguarding

For some people, improving family relationships, including with children, is an important goal and motivating factor.

Reviewing supportive family and social networks

It is important to review the person's supportive family and social networks early on in the assessment. Research shows that the nature and extent of this can be a significant influence on the person's recovery journey (Litt and others, 2007). Family and social networks can be protective factors for the person on their recovery journey, support the development of their social functioning and reduce isolation. They can be a source of hope.

The assessor should help the person identify:

- members of their social network (partner, family, friends and community) that could be involved in supporting treatment and recovery
- family members (including children and young people) who may need support

- any contact the person has with people in recovery, peer support organisations and mutual aid (such as AA or SMART Recovery)

This process should begin at assessment and continue throughout treatment. It is an important element of structured support which is normally provided by a keyworker.

With consent of the person with problem alcohol use, there are several ways that family members, partners and friends can be involved in their treatment.

The treatment and recovery plan should address any gaps in the person's support network, or areas they would like to develop. If the person has very limited social support, it is important that they access a peer support network or mutual aid group as soon as possible. The assessor should help the person to attend one of these organisations. In many areas, a member of one of these groups will be available to accompany the person to a group if the person agrees to this. Some areas have peer mentoring schemes which may provide additional support for the person.

Chapter 5 on psychosocial interventions provides guidance on:

- structured support (section 5.5)
- assessing and strengthening supportive social networks, facilitating access to mutual aid and peer support networks (section 5.5.4)
- involving family, partners and friends in treatment (section 5.8)

Domestic abuse

This section includes guidance on considering domestic abuse as part of assessment. There is more detailed guidance on working with people experiencing or perpetrating domestic abuse in chapter 22.

England, Wales, Scotland and Northern Ireland each have national legislation that defines domestic abuse. The legislation is:

- England and Wales: Domestic Abuse Act 2021
- Wales: Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Northern Ireland: Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021
- Scotland: Domestic Abuse (Scotland) Act 2018

You can find information on this legislation and related guidance in annex 1.

Treatment services should be aware of the definition in their relevant national legislation and associated guidance.

Domestic abuse can include:

- physical or sexual abuse

- violent or threatening behaviour
- controlling or coercive behaviour (see glossary)
- economic abuse
- psychological, emotional or other abuse

The term domestic abuse includes abuse between intimate partners or ex-partners, as well as abuse between adult family members. For example, sons or daughters abusing their parents. Other forms of abuse carried out by or at the request of family members include 'honour' based abuse (including forced marriage and female genital mutilation). Young people under 18 may also use abusive behaviour in their own intimate relationships or towards their parents.

Women, men and non-binary people can be victims of abuse and violence in heterosexual and LGBTQ+ relationships.

There is a high prevalence of domestic abuse among people with problem alcohol use. People attending treatment services may be experiencing domestic abuse or be perpetrators of domestic abuse.

Services should make sure that questions about domestic abuse are routinely part of assessment, whether or not there are potential indicators of domestic abuse.

Alcohol treatment practitioners should ask about and respond to domestic abuse as a routine part of their work and will need training to do this. Trained practitioners should know how to ask and respond sensitively and in a way that prioritises people's safety. They should also be able to recognise potential signs of domestic abuse and to respond appropriately.

Any questions or discussions about domestic abuse should happen when the person is alone and in a completely private setting. A victim is unlikely to disclose abuse and can be put at greater risk if they are asked about their experience in the presence of the perpetrator, or in some cases other family members or members of their social network.

If a service is using interpreters, these should be independent from the person's family and social network so that victims can speak confidentially and potential risks from family members are avoided. Human traffickers can pose as family members and offer to interpret to intimidate the person and control what they disclose.

The practitioner should explain the service's duty of confidentiality and should reassure people that their attendance at the service and their treatment and support will never be discussed with the perpetrator. Practitioners should also explain the circumstances when information can be shared without consent.

Victims of abuse may find it hard to disclose because they are afraid of the perpetrator finding out, being judged, or intervention from local children's services. They may also (wrongly) believe the abuse is their own fault or they might not recognise the perpetrator's behaviour as abusive. However, they may appreciate the chance to disclose. When alcohol treatment practitioners use a sensitive, empathic, trauma-informed approach and make efforts to build

a trusting relationship, a victim is more likely to disclose their experience and consider accessing specialist support.

People often do not disclose abuse when they first contact services. Practitioners should ask them again as they build a relationship and review treatment and recovery plans or if they see indications that the person might be experiencing domestic abuse. For example, a person may refer to their partner not allowing them to do something or appear fearful.

When a victim discloses current or past experience of domestic abuse, practitioners should:

- respond with empathy and understanding
- identify whether the person and any children are likely to be at immediate risk
- complete the service risk assessment process for domestic abuse in a sensitive way
- offer referral to specialist domestic abuse services for managing immediate risks and/or longer-term specialist support
- discuss the situation with their manager and the accountable person in the organisation (for example, the domestic abuse lead or safeguarding lead, member of the MDT) - they should discuss the risk assessment (safety plan) and what to do next

You should read the guidance on risk assessment and management in section 22.4.9 of chapter 22 on people experiencing or perpetrating domestic abuse.

If a victim and any children are currently at risk, their safety is the priority. Specialist domestic abuse services can intervene to help the person to create a safety plan, provide specialist advice and access to support.

People may be anxious about contacting domestic abuse services, so practitioners should offer to make the initial referral or support the person to make contact. With the person's consent, they should make referrals to:

- a specialist domestic abuse service
- the multi-agency risk assessment conference (MARAC) or similar multi-agency risk management forum for people at high risk
- other relevant support organisations

If the person does not agree to a referral, the assessor can return to the offer again in a subsequent session. They should offer the person contact details for domestic abuse services, including helplines in a format that the person can conceal easily.

If the person does not agree to access specialist domestic abuse services or give consent to share information, the practitioner should inform their manager and the accountable professional (such as the domestic abuse lead and/or safeguarding lead) and discuss next steps.

It is always best if a person consents to their information being shared. But in some cases, the practitioner or accountable person will need to share information without the person's

consent. This includes situations where children are at risk or an adult is at serious risk of harm.

The practitioner must follow:

- child and adult safeguarding legislation and organisational procedures
- organisational risk management procedures
- information-sharing protocols
- multi-agency domestic abuse risk management procedures

They should inform the victim they will be sharing information and explain their reasons, unless doing so would put children at further risk.

Established referral pathways and effective joint working with domestic abuse services and relevant partner services will be essential to identify and manage risks, and to help the victim and their children access ongoing support. Increasing safety for adults experiencing domestic abuse and their children requires a multi-agency approach.

Domestic abuse and child safeguarding

This section provides guidance on child safeguarding in the context of domestic abuse. Section 4.9.17 provides guidance on other aspects of child safeguarding.

Children may experience domestic abuse directly. Seeing, hearing or experiencing the effects of domestic abuse also puts children at risk of significant harm. National safeguarding legislation and related guidance in all 4 UK nations takes account of the harmful effects of domestic abuse on children. Practitioners must follow national child safeguarding legislation and guidance and organisational procedures.

In the Domestic Abuse Act (2021) (England and Wales), children and young people in England and Wales are recognised as victims of domestic abuse in their own right. This includes children who have seen, heard or experienced the effects of domestic abuse, and are related to either the victim of the abusive behaviour, or the perpetrator.

It is always best to have consent to share information, but information can be shared without consent for child safeguarding. A practitioner should involve the domestic abuse lead and child safeguarding lead if they are deciding to share information without consent. They should inform the victim and explain their reasons unless doing so would put children at further risk.

NICE public health guideline Domestic violence and abuse: multi-agency working (PH50) includes recommendations for assessing concerns about domestic abuse.

Adult safeguarding

Where a vulnerable adult is at risk of harm, services must act in line with the safeguarding principles in the relevant national legislation and guidance and local organisational adult safeguarding procedures.

You can find links to statutory guidance on adult safeguarding in annex 1 on relevant legislation and guidance.

The assessor should identify any risks to the person as a vulnerable adult, including:

- abuse or neglect by family members or carers
- severe self-neglect
- abuse or exploitation from others, such as financial or sexual exploitation
- modern slavery and human trafficking
- stalking

Assessors should also consider whether the person could be a safeguarding risk to vulnerable adults they care for or are in contact with, in any of the ways listed above.

If the assessor identifies adult safeguarding risks, they should make a referral to adult safeguarding services and work closely with them and other relevant partner services. Staff in alcohol treatment services should know how to make an adult safeguarding referral.

The service should provide accessible verbal or written information on:

- the circumstances in which the service would make an adult safeguarding referral
- what is likely to happen after they make a referral to statutory adult safeguarding services

Assessors should work to maintain engagement with the person and offer support following an adult safeguarding referral if the person does not agree with the referral.

4.9.17 Assessing the impact of parental alcohol use

Assessing the needs of children of alcohol using parents

This section is a short summary about assessing the impact of parental alcohol use on children and young people.

You should read detailed guidance on assessment of the needs of children and young people affected by parental alcohol use in chapter 26.

Although most assessors in adult alcohol treatment services will not meet with the children of the person they are assessing, they should consider the needs of these children, because they are required to do so by statutory guidance.

You can find relevant legislation and statutory guidance under ‘child safeguarding’ in annex 1.

Child safeguarding

All practitioners should be trained to understand, recognise and respond to child safeguarding concerns. They should be aware of their organisational safeguarding procedures and know how to make a child safeguarding referral.

Services should make an initial assessment of the risks to children cared for by the person, or in contact with them, as soon as possible. Parents often have fears about involving statutory safeguarding services or losing their children, so it is crucial that assessors ask questions sensitively, explain why they are asking these questions and why it is their duty to ask them. Services should provide parents with information on the circumstances in which the service would make a child safeguarding referral and what is likely to happen after a referral to children's social care.

Where a child may be at risk of significant harm as defined by the relevant national legislation and guidance, assessors must act according to relevant national statutory guidance and organisational child safeguarding procedures.

You can find links to legislation and statutory guidance on child safeguarding in annex 1.

Assessors should work to maintain engagement with the person and offer support after a child safeguarding referral.

Support needs of parents, children, young people and families

Assessors should still consider support needs for parents and children, even if the assessment finds no risks to children that meet the threshold outlined in relevant legislation and guidance for a safeguarding referral. Effective support can prevent risks from escalating, promote children's wellbeing and strengthen family functioning.

Families might benefit from:

- parenting support
- social or therapeutic support for children and young people (including young carers) or for the whole family
- practical support with social and financial needs

The alcohol treatment service should have agreed pathways to targeted support for vulnerable families (early help) and young carers services. It should also provide information on universal services such as children's centres or youth activities.

There is more guidance on support for parents, children, young people and families affected by parental alcohol use in chapter 26 on parents in alcohol treatment services.

Support for partners, adult family members and friends

Alcohol treatment services should provide information and support to partners, family members or friends affected by a person's alcohol use, including when the person with the problem alcohol use is not attending treatment. Assessors should offer family members, partners and friends an appointment to discuss the impact of the person's alcohol use on their own wellbeing and on other family members. The family, partners or friends should have their own appointment separate from the person in treatment, so there is a space for them to disclose information confidentially. The assessor should make it clear that there will be

confidentiality for the partner, family member or friend, and for the person with the problem alcohol use.

NICE CG115 recommends that:

"when the needs of families and carers of people who misuse alcohol have been identified:

- offer guided self-help, usually consisting of a single session, with the provision of written materials
- provide information about, and facilitate contact with, support groups (such as self-help groups specifically focused on addressing the needs of families and carers)"

Where family members and friends spend a significant amount of time caring for a person with problem alcohol use, they are entitled to a carer's assessment to assess their eligibility for support. Staff in alcohol treatment services should know how to make a referral for a carer's assessment and should refer the relevant person with their consent. The NICE guideline Supporting adult carers (NG150) provides further guidance on this.

You can find links to relevant national legislation and guidance on carer's assessments in annex 1.

Some partners, family members and friends may only need information or a single support session, but others may be experiencing significant strain and may need further assessment of their needs and support.

You should read section 5.8 in chapter 5 on psychosocial interventions, which describes an evidence-based approach to offering support to partners, family and friends affected by a person's problem alcohol use.

4.10 Treatment and recovery planning

4.10.1 Overview

Treatment and recovery planning is an essential part of organising and reviewing personalised treatment interventions and recovery support for a person with problem alcohol use.

Treatment and recovery planning in alcohol treatment services is usually co-ordinated by a keyworker with oversight from an MDT. It is a collaborative process (between the keyworker and the person), which can help to build and strengthen the therapeutic alliance.

Treatment and recovery planning may also involve:

- other professionals from the alcohol treatment service or from external agencies
- people from peer support networks
- partners, family members and friends

4.10.2 The role of the keyworker in treatment and recovery planning

The keyworker is a single named practitioner who:

- meets regularly with the person in treatment
- co-ordinates their treatment and recovery planning and delivery of care
- provides structured support

Structured support involves using specific psychosocial interventions that are common to evidence-based psychological treatments for alcohol and drug use.

You can read guidance on structured support in section 5.5 in chapter 5 on psychosocial interventions.

The keyworker is generally the practitioner in most regular contact with the person. The keyworker may be an NHS or third sector alcohol practitioner, or sometimes a nurse, doctor or other appropriate professional.

In some cases, or at certain times, other clinicians in the MDT will deliver the main interventions, such as medically assisted withdrawal or specialised psychological treatments. However, the keyworker will normally still co-ordinate and monitor the overall treatment and recovery plan.

4.10.3 Developing a treatment and recovery plan

After the comprehensive assessment, the assessor and the person should agree a broad treatment and recovery plan. If the assessor does not continue to work with the person, the service will allocate a keyworker, who will further develop the treatment and recovery plan with the person.

The keyworker should be supported by the MDT to develop and regularly review the treatment and recovery plan. The person should be fully involved in the planning process through regular discussions with the keyworker. The keyworker should use a collaborative, trauma informed approach when working with the person on the treatment and recovery plan.

A treatment and recovery plan is a constantly evolving record and action plan that has the following core components:

- the person's agreed treatment and recovery goals
- specific, clear interventions and actions to help achieve the goals
- clear information on who is taking which actions
- monitoring progress, identifying where actions and goals have been achieved and resetting these as needed
- list of services and community organisations that are or will provide support to the person

The keyworker and the person will agree the person's treatment and recovery goals and the interventions and actions to help achieve those goals based on the comprehensive

assessment of the person's needs. They will prioritise these needs using a formulation. A formulation is a framework to understand:

- the person's problem alcohol use
- how it began and developed
- the factors that maintain it
- potential resources to address the problem

If the plan includes pharmacological interventions and the keyworker is not the prescribing clinician, the clinician will need to contribute to the plan.

The formulation and the treatment and recovery plan should be highly personalised, taking into account the person's individual needs, any risks and strengths. It should also take into account things that shape the person's experience and their preferred approach to addressing their problem alcohol use, including:

- ethnicity and culture
- faith
- age
- sex
- gender identity
- sexual orientation
- disability

Commissioners and services should make sure that each local system can offer a menu of evidence-based interventions including:

- psychosocial interventions
- pharmacological interventions
- recovery support interventions

Keyworkers should be familiar with the range of treatment options and be able to provide accurate information on each of these in a way that the person can understand. They should discuss the aims of each intervention, and any risks and benefits in the context of the person's circumstances and their preferences. This should include both verbal information and written information in accessible formats. The keyworker can then support the person to make an informed choice about their preferred treatment and recovery support interventions.

NICE provides a useful guide on information for the public about treating harmful drinking (high-risk drinking) and alcohol dependence. It describes evidence-based interventions and focuses mainly on treatment interventions offered by alcohol treatment services. Although the guide is for England and Wales, it will still be useful in Scotland and Northern Ireland.

The keyworker will also need to provide information on and help people to access local recovery support services and community resources including peer support services.

You can read more about recovery support services in chapter 6.

The person should have access to a copy of their treatment and recovery plan. This will usually be a written document. But keyworkers can also use an audible format (such as a recording) or offer the information visually (such as, node link mapping, videos, or easy read formats). It is important that the plan is easy for the person to understand and contribute to. Treatment is likely to be more effective if the person plays an active role in agreeing goals and designing and reviewing their own treatment and recovery plan.

4.10.4 Multidisciplinary and multi-agency treatment and recovery plans

There may be several professionals involved in helping to address the person's identified goals in their treatment and recovery plan. This may include other staff in the alcohol treatment service or professionals from other services. Each professional should be named and their contact details included in the plan, along with the keyworker as the primary point of contact.

The keyworker will often need to communicate and share information with several different services and organisations including:

- mental health services
- primary and secondary healthcare services, including liver specialists
- hospital alcohol care teams
- housing and homelessness services
- children's services
- maternity services
- adult social care services
- probation services and prisons
- financial, benefits and debt advice
- domestic abuse and sexual violence services
- community and voluntary services
- education, training and employment support services
- peer support services and networks

Keyworkers should make sure they have consent from the person before communicating with other professionals. In situations such as safeguarding, where consent is not required, it is still good practice to ask for consent unless this would put a child or adult at further risk. But the keyworker must share relevant information even if the person does not give consent.

Professionals from different services will need to communicate with one another to make sure everyone has clear expectations and to ensure good care co-ordination. They will need to clearly agree who is the lead practitioner, responsible for co-ordinating the person's care. This will usually be the keyworker from the alcohol treatment service, but in some situations another professional will be the lead practitioner. For example, if the person has a severe and significant mental health condition, the keyworker from the mental health service should usually be the named lead.

Services will need to work together and with the person to integrate treatment and recovery plans (care plans) and risk management (safety) plans (see sections below) so there are no contradictions. They will also need to co-ordinate timetabling of appointments to make it possible for the person to attend them all.

When the keyworker from the alcohol treatment service reviews the treatment and recovery plan with the person, they should involve other professionals who are working with the person. All professionals involved should have information sharing arrangements and should share information in between reviews if there are relevant changes in the person's situation. Information sharing and care co-ordination can be supported by shared record keeping, so agencies can consider whether it is possible and appropriate to have a single shared set of case records. In each UK nation there are some national shared electronic health records although most of these systems are still developing. Shared electronic health records can make information sharing quicker and more effective Details on electronic care records can be found at the end of the chapter in section 4.11.

The keyworker (or where appropriate, a specialist clinician) from the MDT should contribute to multi-agency case conferences, such as child protection conferences or mental health care planning reviews.

4.10.5 Risk management (safety planning)

Risk assessment is an essential part of any assessment and is the basis for risk management (safety planning). Risk assessment (safety) plans will build on initial action plans (see section 4.8) and are likely to be expanded following comprehensive assessment and adjusted throughout treatment.

The keyworker is normally responsible for co-ordinating risk management (safety) planning with the oversight of the MDT or wider clinical team.

A risk assessment and risk management (safety) plan should be based on a person's individual needs and how to support immediate and longer-term safety. As part of assessment, the assessor should develop a personalised risk formulation with the person. Wherever possible, a risk formulation should be a collaborative process between the person and the assessor that aims to summarise the person's current risks and difficulties and understand why they are happening. This will inform the risk management (safety) plan.

Formulation typically includes considering historical factors and experiences, more recent problems, and existing strengths and resources which could protect against specific risks.

The keyworker will carry out risk management (safety) planning alongside treatment and recovery planning. Wherever possible, the person should be involved in the process of developing their individual risk formulation and agreeing to goals and actions to manage risks. Sometimes the keyworker and MDT will identify risks (such as safeguarding or offending risks) that they have a duty to act on even if the person does not agree. The keyworker should discuss these risks and the actions they will take with the person, unless informing the person of proposed actions would increase the risks to the person or others (some cases of child abuse, for example) and follow relevant organisational procedures on sharing information without consent.

A risk management (safety) plan is usually a separate plan to the treatment and recovery plan. It should be clearly accessible on the person's records to relevant staff. Agreed actions in the risk management plan should normally inform the treatment and recovery plan. If the person continues to disagree with the actions, these will remain part of the risk management (safety) plan but not form part of the treatment and recovery plan, which should be collaboratively agreed.

Where risks are identified, assessors and keyworkers conducting risk assessments and risk management (safety) planning should:

- confirm the person's history with other relevant services the person has accessed
- work with any services the person is currently attending, to assess risk
- make referrals to other services if needed
- involve family members where appropriate

Risk management (safety) plans should clearly identify the:

- actions to manage the risks and who will take them
- people and factors that can help in managing risk

The risks to a person can constantly change, so keyworkers will need to regularly review a person's risk assessments and risk management (safety) plans. Changes in any of the risk areas (such as alcohol and drug use, physical health, mental health or social factors) may affect the level of risk in another area. For example, increased risk related to a person's mental health might increase a child safeguarding risk, even where the person's alcohol use has not changed. A sole keyworker might not be able to see the interaction of risk across all areas, so it is important that the service provides supervision and involvement of the MDT or senior clinician in reviews. Keyworkers will need to amend the identified risk management actions if risks or related factors change, or if the actions have not been effective.

Where the person is involved with other services, there should be information sharing arrangements and keyworkers and staff from involved services should update one another on changes to risks when they occur. They should seek input from professionals in these other services as part of regular reviews of the risk management (safety) plan. The services that the

assessor might need to involve in the risk assessment will vary with each person, but they might include (for example):

- GPs
- mental health services
- child and adult safeguarding services
- domestic abuse services
- criminal justice services
- homelessness and housing support services

Assessors and keyworkers should assess the ability of the person and any of their support networks to contribute to managing risks. Family members or supportive friends may have an agreed and specified role.

Services need organisational procedures for escalating and managing immediate risks and keyworkers should have access to advice and supervision from relevant members of the MDT or wider clinical team.

Services need processes for following up people with complex needs where there may be particularly high risks to health and safety if they disengage from treatment. Follow-up might initially involve phone, text or email contact. If there is no response from the person, services should contact the nominated next of kin, family members or support people (with prior consent). And if there is still no response from the person, services should carry out a welfare check involving a home visit:

- by staff from the service
- with a professional from another involved service, where appropriate
- through a request to emergency services, if necessary

4.10.6 The treatment and recovery planning process

Duration of treatment episode and interventions

The needs of people who engage with alcohol treatment services are very varied, so the length of treatment episodes and specific interventions should always be based on individual need and not on a standard length of time. Arbitrary time limits are not helpful and may increase the likelihood of poor outcomes for the person. A person with personal and social recovery resources who is mildly dependent without additional complex needs, will likely need a much shorter treatment episode than someone with few recovery resources, severe dependence and complex needs.

While services and practitioners should avoid arbitrary or premature decisions about the length of an intervention or a treatment episode, structure and timeframes are still helpful. The practitioner should agree clear and ambitious treatment and recovery goals with the

person, with planned timescales for action and regular reviews. This helps the person understand that they can reach their goals and that behaviour change is achievable.

As the practitioner and the person regularly review progress towards their treatment and recovery goals, the appropriate duration for the intervention or treatment episode will become clear. Then they can agree a date for ending, and allocate adequate time to plan for this and also arrange post treatment support.

Goals and goal setting

Goals in a treatment and recovery plan will include alcohol use goals (see section 4.7 on alcohol use goals).

These goals are broadly based on the severity of dependence and complexity of need, but they also need to be discussed and agreed with the person, so they are tailored to individual need and take account of the person's preferences.

Practitioners should approach goal setting and reviewing based on the principles and techniques of motivational interventions, which can strengthen engagement (see chapter 5 for motivational interviewing).

As well as setting goals related to alcohol use and other substance use, treatment and recovery planning will involve setting several wider goals. So, treatment and recovery goals commonly include:

- withdrawing safely and achieving abstinence
- achieving low risk (controlled) drinking where appropriate
- reducing harmful or risky behaviours associated with the alcohol use (for example, sexual risk taking or gambling)
- addressing any other substance use including illicit drug use, prescription medication and over-the-counter medication, whether obtained illicitly or prescribed
- reducing health (physical and mental) problems
- reducing various health social, family or crime problems
- reducing economic and housing instability (for example, unsuitable housing, homelessness income or debt)
- strengthening relationships with partners, improving parenting skills and strengthening family relationships
- building recovery oriented social networks
- engaging in activities that are meaningful to the person
- engaging with peer support networks and mutual aid organisations such as AA or SMART Recovery

- achieving longer-term personal recovery goals (for example, education, training and voluntary work)
- achieving good quality employment

At the start of the treatment process, it can be helpful for treatment and recovery planning to focus on goals that are an immediate priority for the person. The person can help to make their treatment more effective by choosing goals that enable them to see small or incremental changes in specific areas in a reasonable time. This can:

- promote a sense of achievement
- increase motivation
- enhance self-esteem and self-efficacy
- help to build the therapeutic alliance

Effective treatment and recovery goals are usually SMART (specific, measurable, agreed, realistic and time-limited) and reflect individual personal preferences.

Setting and working towards treatment and recovery goals is a central element of the structured support provided by a keyworker.

You can read detailed guidance on providing structured support in section 5 in chapter 5 on psychosocial interventions.

Reviewing the plan and monitoring outcomes

The keyworker should regularly review the treatment and recovery plan with the person. Where partners, family members or friends are involved in a person's treatment, it may be helpful for them to contribute to reviews, if the person consents to this. The keyworker should also ask other relevant professionals to contribute (see section 4.10.4 on multidisciplinary and multi-agency treatment and recovery plans). The results of any health investigations and results of outcome measures can also be included.

Keyworkers need to routinely use outcome measures to monitor the effectiveness of the treatment and recovery plan. They should use screening tools, such as AUDIT, or outcome monitoring tools, such as TOP or SURE. See section 4. 5 for a description of these tools and outcome measures.

The practitioner should also seek qualitative feedback from the person on their experience of treatment. This should involve offering a range of feedback options including a:

- verbal conversation
- semi-structured written form
- semi-structured online form (you can give the person a QR code to access this)

The feedback can help to adjust goals or interventions.

Reviewing progress using the treatment and recovery plan and agreed outcome measures can help to engage the person and enhance their motivation. The plan can then be revised or updated based on the review. The keyworker should arrange formal reviews at regular intervals.

As well as conducting these regular formal reviews, the keyworker and the person should monitor progress session by session. Working together on a shared agenda at the start of each session may be helpful so that goals and actions can be adjusted as they go along.

The frequency of reviews will vary according to individual need and stage the person is at in their treatment and recovery journey. For example, if they have complex needs associated with high risks, it will be appropriate to review their treatment more regularly than if they had much lower levels of need and risk. In general, it may be more helpful to review progress at shorter intervals at the beginning of treatment, to see whether the treatment and recovery plan is appropriate for the person or if it needs adjusting. It will also be helpful to review the treatment and recovery plan if the person is clearly not meeting their goals or is experiencing a crisis. The keyworker and the person should agree the date of the next review, so the person has a structured timeframe to work within. But they can make adjustments at an earlier time if these are clearly needed.

At the beginning of treatment, the treatment and recovery plan will normally focus more on interventions offered by the alcohol treatment service and other professionals. The keyworker may be more active in helping the person to access early recovery support such as peer networks and rewarding activities. As the person's recovery journey progresses there is often a transition, and the person may take on more actions and responsibility for their recovery. These could include engaging in education, training or employment or becoming more active in peer-based networks.

Planning for leaving treatment and recovery check-ups

The treatment and recovery planning process includes preparing the person for leaving treatment. The length of treatment should be tailored to a person's individual needs and their treatment should not normally end until they have met their treatment and early recovery goals and established support networks. While some people may be able to achieve treatment and recovery goals relatively quickly, those with more severe dependence or more complex needs may need to be in treatment for longer and their progress may not be straightforward.

It is important that the treatment end date leaves time and space to prepare the person for the end of their treatment or for moving on to another stage of their treatment and recovery journey. People can be at increased risk of relapse at transition or ending points without appropriate preparation and support.

You can find more information on recovery in chapter 5 on psychosocial interventions.

Planning for leaving treatment should include agreeing actions for the person as they continue their recovery journey. Keyworkers should arrange with the person for recovery management check-ups, with their consent. Recovery check-ups are regular appointments by phone, online or in person, offered by the keyworker for a period after the person has left treatment. The

keyworker and the person should agree a period of time based on individual circumstances, but this will normally be for at least 6 months, and may be for longer. The aim of these recovery check-ups is to provide support and encouragement, acknowledge progress and respond quickly if the person returns to problematic alcohol use or is at risk of it, or has any other significant problems.

It can be helpful for the keyworker and the person to agree a re-engagement plan, with the person's consent. This can include actions the person can take and who they will contact if they begin to use alcohol problematically again. For example, actions might be to contact the keyworker and attend an AA meeting. It can also include actions the keyworker can take if they are not able to contact the person (such as contacting a family member or another professional or making a home visit). Services should make sure that anybody getting back in touch to re-engage in treatment gets seen as soon as possible, so they can get quick help to stop drinking and maintain their recovery.

Core keyworker skills for treatment and recovery planning

There are several core skills that keyworkers need for assessment and treatment and recovery planning. These include:

- assessment skills
- skills in treatment and recovery planning and care co-ordination
- risk assessment and risk management (safety) planning
- knowledge of harmful drinking and alcohol dependence
- motivational, clinical and planning skills, underpinned by active listening
- ability to build a trusting relationship and therapeutic alliance
- cultural competence (see chapter 2 on principles of care)
- a trauma-informed approach (see chapter 2 on principles of care)
- knowledge of alcohol interventions and ability to choose and recommend appropriate interventions
- knowledge of local pathways and local health, care and community services
- skills in multidisciplinary and multi-agency assessment and treatment and recovery (care) planning
- ability to work effectively with peer support organisations

4.11 Resources: national electronic care records

Each UK nation has some electronic systems for sharing summary healthcare records, although these are mostly still developing. In some areas, alcohol treatment services or clinicians can arrange to have access to these shared records, which will aid information sharing.

In England essential health information is shared electronically through the summary care record held by National Care Records Service.

NHS Scotland services share health information electronically through the Key Information Summary (unless the person has opted out) and anticipatory care planning when those have been discussed with the individual person and put in place by the GP team.

In Wales, nurses have access to information on the Welsh Nursing Care Record and a limited number of clinicians can access the Welsh Clinical Portal.

In Northern Ireland, Encompass is being rolled out so that health and social care trusts will have access to digital health and care records.

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5. Psychosocial interventions

How to provide evidence-based psychosocial interventions for people with alcohol problems. It covers formulation to identify appropriate psychosocial interventions for the person, structured support, psychological treatments and interventions for family members.

5.1 Main points

Psychosocial interventions are an essential part of treatment for everyone. They should always take place in the context of a broader personalised treatment and recovery plan.

Psychosocial interventions include effective psychological treatments and structured support. These evidence-based practices should be underpinned by a positive therapeutic alliance.

Structured support involves using specific psychosocial interventions which are common to evidence-based psychological treatments for alcohol and drug use. These common factors include:

- a strong therapeutic alliance
- session structure and goal direction
- interventions to develop alternative rewards and activities to alcohol use
- engagement with social networks that are recovery-oriented
- building self-efficacy and coping skills to maintain abstinence or low risk drinking

Structured support is generally delivered in community alcohol treatment services by a keyworker.

Services should offer formal psychological treatments focused specifically on alcohol-related cognitions, behaviour, problems and social networks according to individual need. Formal psychological treatments include:

- cognitive behavioural therapies
- behavioural therapies
- social network and environment-based therapies

These treatments are generally provided by a specialist member of the multidisciplinary team (MDT), alongside a keyworker who provides structured support.

The assessment and formulation determine the choice of psychosocial intervention. Formulation is a framework for understanding information gathered in the assessment. It helps the person to make sense of their situation and informs treatment and recovery planning.

Practitioners need to monitor interventions to see it they are effective, and if they are ineffective, they should adjust them based on a revised formulation agreed with the person.

A person's involvement with treatment services is part of a treatment and recovery journey that extends beyond treatment and sits within a recovery-oriented system of care.

Recovery can be thought of as a journey. Treatment and recovery services can support people through engagement, behaviour change and early recovery with the formulation determining the selection of interventions to support this process.

The intensity of support practitioners offer should be based on the severity of the person's alcohol dependence and any co-occurring complex needs. Most people can receive appropriate support in the community, but inpatient or residential services may be required for those with the most severe and complex needs.

Peer support and mutual aid have been found to be effective in supporting recovery. Practitioners should support people to engage with these groups and organisations throughout their recovery journey, during their time in treatment and once they have left structured treatment.

Practitioner competence affects the effectiveness of psychosocial interventions. Services should provide training and clinical supervision to all practitioners in the interventions they provide. Practitioners will need varying levels of specialist training depending on whether they deliver structured support or formal psychological treatments. Supervisors should be trained in supervision and trained in the psychosocial interventions they are overseeing.

5.2 Introduction

This chapter describes how practitioners can deliver psychosocial interventions for harmful drinking and alcohol dependence, consisting of structured support and formal psychological treatments. It focuses on how practitioners can develop personalised treatment and recovery interventions based on assessment, formulation and working with the person, and where appropriate, their family.

This chapter focuses on psychosocial interventions provided as part of structured treatment.

See chapter 4 on assessment, treatment and recovery planning for the context in which practitioners deliver these psychosocial interventions.

People with alcohol dependence often have complex needs or experience multiple disadvantage and some people will need more flexible approaches to engagement and delivering these interventions. For example, see:

- chapter 8 on harm reduction
- chapter 9 on assertive outreach
- chapter 21 on people experiencing homelessness

Some people require more specialist approaches that focus on alcohol dependence and co-occurring conditions.

For example, see:

- chapter 18 on co-occurring mental health conditions
- chapter 20 on people with alcohol related brain damage

You can find guidance on targeting and tailoring psychosocial interventions to meet needs related to culture or identity in chapter 25 on developing inclusive services (with guidance on tailoring Interventions to specific cultural needs).

5.2.1 Aims of psychosocial interventions

Psychosocial interventions are used to support people to:

- initiate and sustain changes in their alcohol use, including abstinence, low risk drinking (see definition of low risk drinking in the glossary) and reducing harm
- maintain engagement with pharmacological interventions
- address social or psychological issues that are contributing to, or made worse by alcohol use
- prevent a return to problematic alcohol use
- build recovery resources and strengths to sustain long-term change

5.2.2 Principles of care

You should read this chapter with chapter 2, which provides more detail on the principles of care that are essential to delivering alcohol treatment. These principles are the basis for this chapter and are vital for delivering psychosocial interventions.

There is evidence that the approach and style of delivering alcohol treatment is equally (if not more) important than the specific content of the interventions (Ashton and Witton, 2004 to 2006). There is more about this in the National Institute for Health and Care Excellence (NICE) clinical guideline Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (CG138).

The following principles of care are vital to establishing a therapeutic alliance between the practitioner and the person and for agreeing a personalised treatment and recovery plan. They should inform the service ethos and the approach of individual practitioners providing psychosocial interventions.

1. Build a trusting relationship, and work in a supportive, empathic, and transparent way.
2. Respect the person's confidentiality, privacy and dignity.
3. Understand how stigma and discrimination associated with alcohol use can affect how the person comes into treatment, their self-esteem and their ability to acknowledge the full impact of their dependence.
4. Work in a trauma-informed way (see section 2.2.8 in chapter 2 on principles of care).
5. Work in a culturally competent way (see section 2.3.2 in chapter 2 on principles of care).

5.3 A framework for delivering psychosocial interventions

5.3.1 Framework overview for delivering psychosocial interventions

Figure 1: framework for delivering psychosocial interventions

Figure 1 shows the context for an effective personalised treatment and recovery plan.

Treatment takes place within a broader recovery-oriented system of care. It starts with engaging a person with an assessment of their treatment and recovery needs. An allocated keyworker is essential to build and maintain a therapeutic relationship, while providing structured support to the person to enable them to overcome their problem alcohol use and work towards long term recovery. Keyworking takes place throughout a person's treatment journey.

There are 3 main phases to this journey, which are:

- assessment, formulation and engagement
- behaviour change, which includes interventions tailored to severity of dependence (mild, moderate or severe) and complexity of need (including mental health, physical health, other drug use and social factors)
- early recovery, which includes interventions to maintain behaviour change and build the foundations of longer-term recovery

Assessment and formulation include a person's physical and mental health and social needs and assessing and managing complexity continues throughout the treatment and recovery journey.

You can find more information on each of the phases in section 5.3.3.

5.3.2 Delivering psychosocial interventions in a recovery-oriented system of care

This chapter focuses on psychosocial interventions which are delivered by practitioners. However, this is just one element within a broader range of support and activities that could be integral to the person's recovery journey.

Recovery is a process that is more than achieving abstinence or low risk drinking. There are several definitions of recovery. Research by Witkiewitz and others (2020) defines recovery as "a dynamic process of change characterized by improvements in health and social functioning, as well as increases in well-being and purpose in life".

A wide range of services and organisations can contribute to a person's treatment and recovery journey at different stages and together these services can form a recovery-oriented system of care. A recovery-oriented system of care is a network of local treatment and recovery services and community groups that help people to start and sustain their recovery. Peer-delivered and peer-led support are an important part of a recovery-oriented system of care and can be central to the person's recovery journey.

See section 2.6 in chapter 2 on principles of care for guidance on recovery and recovery-oriented systems of care and chapter 6 on recovery support services.

5.3.3 Treatment phases

Services may find it helpful to see treatment for alcohol dependence or harmful drinking as part of a recovery journey. This journey through treatment and recovery can be thought of as having 3 broad phases which can be described as:

- assessment, formulation and engagement
- behaviour change
- early recovery

These phases can help to inform the psychosocial interventions and level of support the person needs at different points of the journey. The practitioner and the person should agree on the interventions and priorities for action during the ongoing assessment and formulation process. The practitioner should understand which interventions are likely to be useful as the person progresses through their recovery journey.

At the start of the treatment journey, interventions are likely to be focused on stopping or reducing drinking and will be delivered by practitioners. As the journey progresses, the person is likely to be more active in directing their own recovery, participating in a range of activities outside of treatment, including peer support.

The phases are only broad indicators and not rigid categories. For example, although there is likely to be more focus on recovery-oriented activities in the 'early recovery' phase, establishing recovery-oriented social networks and meaningful activities is important right from the beginning of the journey. Helping people to access peer support activities and mutual aid groups can contribute to developing these.

5.3.4 Assessment, formulation, and engagement

Everyone who has been referred to community alcohol treatment services with an alcohol use disorders identification test (AUDIT) score of 16 or more should be offered a comprehensive assessment of their alcohol use, severity of dependence, complexity of need and their strengths.

You can read about comprehensive assessment in chapter 4 on assessment and treatment and recovery planning.

Building on the assessment, the practitioner and the person develop a shared formulation. This is a way of making sense of the person's problem alcohol use. They look at factors that may have made them vulnerable to developing the problem, what may have triggered it, what helps maintain it and what resources the person can use to address it (BPS, 2011).

The shared formulation informs the choice of interventions included in their treatment and recovery plan. This process helps to involve the person in decisions about their treatment and can support engagement with their treatment and recovery plan.

An initial formulation is based on findings from the assessment. Formulation is then reviewed and amended to reflect the person's response to specific treatment interventions and their progress towards recovery goals.

A good formulation allows the practitioner and the person to evaluate which evidence-based psychosocial intervention may help and why. It is also a chance to identify potential barriers that could prevent progress. By using the formulation to explain how the intervention should work, the practitioner can instil hope that things can change for the better and help the engagement process.

A personalised formulation should:

- be developed together with the person receiving treatment
- be based on a shared understanding of the issues
- normalise the person's life experiences
- respond to individual needs
- consider a person's social and cultural needs
- be communicated avoiding unnecessary clinical terminology and in an accessible format, considering language, literacy, sensory disability, cognitive impairment and neurodiversity

The formulation explains why particular diagnoses or interventions are indicated and which treatment and recovery goals are important to the person. Formulation should also identify how a person's strengths can be best used to support their recovery.

You can read about a clinical approach to formulation in section 5.4 of this chapter.

5.3.5 Severity of dependence and complexity

Assessment and formulation should identify the severity of alcohol dependence and complexity of a person's need and should determine the choice of interventions to address these.

In many cases, the intervention intensity will increase according to the severity of dependence or complexity of need. People with harmful drinking but low dependence severity and low complexity (for example, strong social support and no mental health conditions) may respond to a less intensive intervention focused on motivational enhancement and goal setting.

People with moderate and severe dependence and complex needs (for example, physical and mental health conditions or additional drug use) are likely to need medically assisted withdrawal and psychosocial interventions will need to be integrated around this. They are more likely to benefit from ongoing structured support, more intensive interventions, multi-agency working and facilitated access to recovery services including peer networks to support recovery outcomes. The highest treatment intensity programme is inpatient medically assisted withdrawal followed by intensive therapeutic support in a residential setting. This is suitable for a small number of people with the most complex needs.

Severe dependence and greater complexity will often, but not always, occur together. People with mild dependence may not need pharmacological interventions but may still have highly complex needs. For example, a person with a depressive disorder may not have an alcohol dependence but heavy drinking episodes may exacerbate their depression and increase risk of self-harm. So, they may require a more intensive intervention and joint working with mental health services to help them manage their drinking and associated risks.

Assessing complexity will include an assessment of the person's resources for long-term recovery (sometimes called 'recovery capital'). Broadly, this will include assessing their level of individual health and wellbeing, family, social and peer support, economic and housing stability.

5.3.6 Duration of interventions or treatment episodes

The needs of people who engage with alcohol treatment services are very varied and so the appropriate duration of a psychosocial intervention (or complete treatment episode) will also vary. You should always base the duration of an intervention on individual need and not on a standard length of time. Arbitrary time limits on interventions are not helpful and may increase the likelihood of poor outcomes for the person. A person with personal and social recovery resources, with mild dependence without additional complex needs is likely to need a psychosocial intervention and treatment episode of much shorter duration than someone with little recovery resources, severe dependence and complex needs.

While you should avoid arbitrary or premature decisions about duration of intervention or treatment episode, structure and timeframes are helpful. As set out in section 5.5.2, practitioners should agree clear and ambitious treatment goals with the person, with planned timescales for action and regular reviews. These elements are essential parts of individualised treatment and recovery support.

As the practitioner and the person regularly review progress towards treatment and recovery goals, the appropriate duration for the intervention or treatment episode will become clear. You can then agree a date for ending the intervention or treatment episode and allocate adequate time to plan for this, as well as arranging support for the person after they leave treatment. See section 4.10.6 in chapter 4 on assessment and treatment and recovery planning for post-treatment recovery check-ups.

It is important that the end date leaves time and space to prepare the person for the end of their treatment or for moving on to another stage of their treatment and recovery journey. People can be at increased risk of relapse at transition or ending points without appropriate preparation and support.

5.3.7 Alcohol use goals

Identifying appropriate alcohol use goals

Identifying the appropriate alcohol use goals is vital to effective alcohol treatment. Alcohol use goals should be informed by assessment and formulation and you should regularly review these with the person as part of the treatment and recovery planning process.

You can read more about identifying and agreeing alcohol use goals in section 4.7 in chapter 4 on assessment and treatment and recovery planning.

Severity of dependence and complexity of need are broad indicators of what alcohol use goals are most appropriate. However, following discussion of the benefits and risks of different alcohol use goals, these should be aligned with what the person wants and should be regularly assessed at review. The practitioner should use an approach based on motivational interviewing principles and techniques when supporting the person to choose their alcohol use goal (see section 5.5.6 for more on motivational interventions).

Using psychosocial interventions with different alcohol use goals

In general, you can use the psychosocial interventions set out in this chapter whether a person's alcohol use goal is:

- abstinence
- low risk drinking
- cutting down drinking to reduce harm

However, some approaches may be more appropriate for certain goals (for example, behavioural self-control training for low risk drinking goals). The practitioner should consider the person's alcohol use goal when choosing appropriate psychosocial interventions.

5.3.8 Psychosocial interventions: what they are

The term 'psychosocial interventions' refers to a broad range of structured interventions, techniques and practical help that support people to achieve their treatment and recovery goals. Psychosocial interventions address both psychological and social needs, which are often interconnected.

Psychological interventions include interventions focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Social interventions include practical help with immediate social needs such as accommodation and debt, as well as helping people to engage with support for longer-term recovery.

The specific focus of a psychosocial intervention will vary according to the:

- person's needs and goals
- setting in which a psychosocial intervention is delivered
- practitioner's role and training

However, both psychological and social elements are essential in most people's treatment.

Psychosocial interventions include structured support and formal psychological treatments. In community alcohol treatment services, a keyworker (see definition of keyworker in the

glossary) is allocated to provide structured support and co-ordinate recovery-oriented care throughout the person's treatment journey.

Formal psychological treatments are generally provided by a specialist member of the MDT alongside a keyworker providing structured support.

You can read about formal psychological treatments in section 5.6.

Where a person needs pharmacological interventions, psychosocial interventions should also be provided as part of an integrated personalised treatment and recovery plan. The person will need additional psychosocial interventions to address complexities often associated with harmful drinking and alcohol dependence, such as co-occurring mental health conditions, cognitive impairment, drug dependence or gambling.

5.3.9 Structured support

Providing structured support

Alcohol treatment services in community and residential settings should allocate a keyworker to each person to help their treatment and recovery process and to co-ordinate their care. The keyworker will be responsible for providing structured support.

Structured support involves using specific psychosocial interventions that are common to evidence-based psychological treatments for alcohol and drug use (Moos, 2007). Section 5.5 sets out these common factors and describes how the keyworker provides structured support.

Using these common factors to frame the use of specific interventions is a pragmatic and flexible approach to providing treatment and supporting recovery. These psychosocial interventions can be described as evidence-based practices to highlight the distinction from a comprehensive formal psychological treatment approach (Manuel and others, 2011).

Keyworkers should adapt structured support to a person's needs based on assessment and the formulation. This should account for the severity of dependence and any associated physical health, mental health or social complexities.

Structured support may include practical help and co-ordination of care from an MDT, and across agencies. Alongside a keyworker providing structured support, a specialist member of the MDT may provide a formal psychological treatment where required.

Structured support can be delivered by alcohol workers in their keyworking role. Services should provide training and regular clinical supervision to practitioners who provide structured support, which should be underpinned by a quality governance framework.

You can read more about structured support in section 5.5.

Structured support and recovery-oriented care

Treatment should be recovery oriented, helping people to build healthier fulfilling lives. Structured support is central to helping people meet their alcohol use goals and related short-term goals. It also helps people engage with support for longer-term recovery. Outcomes

improve significantly when treatment engagement is combined with long-term recovery support (Simoneau and others, 2018).

All 5 elements of structured support described in section 5.5 can help the person build longer-term recovery. Supporting people to engage in rewarding activities (section 5.5.3) and supporting people to engage with social support and recovery-oriented networks (section 5.5.4) are particularly relevant and you should read the relevant sections for more detailed guidance.

The keyworker may continue to support the person's long-term recovery after they have completed their treatment through a mutually agreed schedule of recovery check-ups (see section 4.10.6 in chapter 4 on assessment and treatment and recovery planning).

5.4 Clinical formulation

5.4.1 Clinical formulation: aims and objectives

A clinical formulation builds on the comprehensive assessment (see chapter 4) and provides a framework for the practitioner and the person to understand how the person's problem alcohol use began and developed, the associated difficulties and the person's strengths and resources. It is also a way to identify the appropriate interventions to help the person change their alcohol use and build the foundations of their recovery.

So, clinical formulation is a way to further understand the person and their relationship with alcohol, while organising the information gathered as part of assessment. Information to develop a formulation can also be collected from:

- existing clinical reports
- clinical interviews
- observations
- standardised questionnaires
- referral information
- previous treatment summaries
- knowledge of possible diagnoses

Clinical formulation allows practitioners to understand the person's problems, which are often multiple and complex, but also to identify skills and strengths that they can develop. The clinical formulation is also a chance to review a person's response to interventions and adjust the treatment plan if the interventions are ineffective (BPS, 2011).

The formulation should be personalised, accounting for the person's individual needs, strengths and preferences. Aspects of a person's identity such as ethnicity, culture, faith, age, gender, gender identity, sexual orientation and disability will shape the person's experience and understanding of their problem alcohol use, so the formulation and plan should take this into account.

5.4.2 Formulation framework

The '5 Ps' model is one way of structuring a clinical formulation. It involves looking at how different factors in a person's life affect their alcohol use. Alcohol use is the presenting problem and the first of the 5 Ps. The other 4 are:

- predisposing factors (vulnerability factors)
- precipitating factors (triggers)
- perpetuating factors (maintaining factors)
- protective factors (modifying factors)

Predisposing factors

Predisposing factors are background factors that may have contributed to the development of a person's problem alcohol use. This might include biological, family, and socioeconomic factors and adverse childhood experiences. For example, factors such as poverty and lack of social and economic opportunities, family patterns of problem alcohol use, experiences of physical, sexual or emotional abuse can make it more likely a person develops an alcohol problem.

Precipitating factors

Precipitating factors are those that have triggered an episode of problem alcohol use. Internal precipitating factors can include:

- negative mood states
- difficult memories
- intrusive thoughts
- withdrawal symptoms
- cravings

External precipitating factors relate to the person's social and environmental situation, and can include:

- unstable housing
- loss of role or employment
- conflict with others
- experience of discrimination or marginalisation

Perpetuating factors

Perpetuating factors are those that maintain problem alcohol use. Internal perpetuating factors might include beliefs about the positive effects of using alcohol. They could also include a strong desire to get rid of or escape from unwanted:

- cognitive events (for example, intrusive memories, negative thoughts or low self-esteem)
- physical sensations (for example cravings and withdrawal symptoms, pain, insomnia, or tiredness)
- emotional feelings (for example, depression and anxiety symptoms)
- social responsibilities (for example, social contact, parenting, or sustaining jobs)

Environmental factors like unstable housing, poverty and relationship difficulties may also be important perpetuating factors. Formulation can be used to show the person how alcohol use, intoxication and dependence can maintain these perpetuating factors and make them worse.

Protective factors

Protective factors are those that help to limit a person's alcohol intake or have the potential to support a reduction in alcohol use. Internal protective factors include:

- personal strengths
- abilities, such as coping skills
- individual and cultural values

External protective factors include:

- close family or social support networks
- employment
- meaningful activities
- cultural and faith organisations
- peer support and mutual aid
- stable housing
- financial stability

Identifying these factors can help build hope and self-efficacy (or confidence in their ability to change behaviour). Exploring previous periods of low risk alcohol use or abstinence can be a useful way to identify protective factors and coping skills. A lack of protective factors also highlights areas that need to be developed, for example, linking the person with peer support and recovery communities.

5.5 Structured support: common factors in effective treatment

As outlined in section 5.3.9, structured support involves using psychosocial interventions which are common to evidence based psychological treatments for alcohol and drug use (Moos, 2007; Manuel and others, 2011). These common factors (or change mechanisms), include:

- a strong therapeutic alliance
- session structure and goal direction
- interventions to develop alternative rewards and activities to alcohol use
- engagement with social networks that are recovery-oriented
- building self-efficacy and coping skills to control drinking or maintain abstinence

This section provides guidance on each of these factors.

5.5.1 Therapeutic alliance

A strong therapeutic alliance is vital to treatment. Evidence shows that a strong alliance between the practitioner and person is associated with significantly better outcomes relating to treatment goals and a range of quality of life measures (Maisto and others, 2015; Connors and others, 1997).

Confrontational approaches are not effective and are likely to lead to treatment disengagement (Miller and others, 2001). An empathic and supportive approach and working towards shared goals is important to develop a therapeutic alliance.

Core competencies in building a therapeutic alliance include being able to:

- work together
- engage a person appropriately while showing warmth and care
- build trust and adopt a personal style suitable to the person
- adjust the nature and intensity of the intervention to reflect where the person is in their journey
- understand and work with a person's emotional context and motivation
- work in a culturally competent way

Services need to make sure they have regular clinical supervision to help practitioners develop their therapeutic engagement skills. Services should ensure that they prioritise these competencies and values when recruiting staff.

5.5.2 Support, structure and goal direction

Psychosocial interventions should be structured and goal-directed, while open to review. Setting and working to a clear session agenda linked to a treatment and recovery plan is essential to this process. The choice of Interventions is informed by assessment and formulation.

Practitioners should support the person to identify their own goals, and regularly review and adjust these where necessary. Supporting people to set and achieve goals can support the person's aspirations, instil hope, help improve mood, and encourage greater self-efficacy. The practitioner should use an approach based on motivational interviewing principles and

techniques when helping the person to identify their treatment and recovery goals and reviewing progress with them. See section 5.5.6 for more on motivational interventions.

Structure and goal direction should not come at the expense of the therapeutic alliance. The person should feel supported to make progress with their goals while developing autonomy and self-efficacy.

There is more information on treatment and recovery planning, including goal setting, in section 4.10 in chapter 4 on assessment and treatment and recovery planning.

There are tools or techniques to support keyworking. For example, mapping (sometimes known as node-link mapping) is a simple technique for presenting verbal information visually (with diagrams or maps). Research has shown mapping can support positive treatment engagement and outcomes (Beckwith and others, 2019).

You can read more about mapping in Routes to recovery from substance addiction, which is a manual to help healthcare practitioners build an effective plan for recovery.

Examples of interventions a keyworker can provide include:

- forming a collaborative agenda at the start of every session
- agreeing goals to work on between sessions and ensuring these are reviewed at the next session
- modelling problem-solving when setbacks happen and the person does not achieve their goals
- encouraging the person to develop a daily routine that promotes mental and physical wellbeing (such as exercising and eating well)
- identifying additional support needs and arranging referrals to other professionals and agencies

5.5.3 Rewards and rewarding activities

Developing positive and meaningful alternatives to alcohol use is a central part of recovery. Alcohol and behaviours related to alcohol use are likely to have formed a significant part of a person's life. They will often need to find new ways of spending their time and new sources of meaning and enjoyment.

A person-centred and strengths-based approach can support the person to identify and develop rewarding activities that are most meaningful to them.

Keyworkers can use the behavioural principle of positive re-enforcement to support change. This can include:

- reflecting back the person's positive comments about change, and affirming their strengths and resources
- helping the person's support network to reward them when they achieve their alcohol use goals

- providing direct rewards or incentives for remaining abstinent (see section 5.6.3 on behavioural approaches)
- planning for a more rewarding, recovery-oriented lifestyle

Planning for a more rewarding recovery-oriented lifestyle could include:

- family activities
- education or training
- volunteering
- employment
- hobbies
- sports
- cultural and faith-based activities
- peer support

There are several measures that the keyworker can use to assess recovery strengths and resources. These measures include tools such as the King's College London SURE: Substance Use Recovery Evaluator.

It can sometimes take time for a person to build confidence and motivation to engage with new activities or groups, but the keyworker should discuss various recovery support options from the start and throughout treatment. This is particularly important as the person moves toward leaving treatment (Humphreys, 1999).

If the person wants to volunteer to offer peer support while they are still in treatment, the keyworker should help them to consider whether the timing and the role are right for them and find out what support will be available to them in their role. There is evidence that people benefit from offering peer support, but they need to have clarity about the role, and training and supervision to prevent a negative impact on their own health and wellbeing (Greer and others, 2021).

Examples of interventions a keyworker can provide include:

- identifying alternative activities to drinking that connect with the person's values and have intrinsic meaning and purpose to them
- identifying and encouraging contact with friends and family members who can provide practical assistance and company to engage in alcohol free activities
- providing practical assistance to help the person reconnect with past valued activities that are not related to drinking and encouraging them to try new things
- encouraging the person to explore and engage in educational, vocational or volunteering opportunities

- helping people to access employment support

There is strong evidence that being in good quality employment supports a person's health and wellbeing. So, alcohol treatment practitioners should ensure that people in treatment can make informed choices about employment and accessing employment support.

You can find detailed guidance on accessing employment support in chapter 7.

5.5.4 Social support and recovery-oriented networks

People with alcohol dependence and those drinking at harmful levels may have developed social networks and relationships in which heavy alcohol use is the norm. This can lead to a loss of contact with supportive people or being excluded from activities and events where heavy drinking is less acceptable. In turn this can undermine a person's efforts to change. Some people with alcohol dependence are very isolated and have no social networks at all. An essential part of structured support is helping people to establish or re-establish connections with people or groups who can provide useful support. There is evidence that changes in a person's social network from one that reinforces drinking to one that reinforces abstinence significantly increases the probability of abstinence (Litt and others, 2007).

Evaluating and adjusting these social networks can help the person to:

- make changes in their alcohol use
- achieve their alcohol use goals
- support longer-term recovery

Identifying strengths and deficits in the person's social support should be part of ongoing assessment. The keyworker should regularly encourage the person to use the helpful support available to them and to develop new support networks.

Support from family, partners and friends can be very useful where this is available. You can read more about this in section 4.10.1in chapter 4 on assessment and treatment and recovery planning and in section 5.8 below.

Keyworkers should help people to consider other sources of support. For example, culture or faith-based communities and local community groups. There is increasing recognition of the impact of isolation on wellbeing and various local projects may exist to support social connectedness.

Peer support and mutual aid

Support that is specifically recovery-oriented can play a vital role in a person's recovery. Peer-delivered and peer-led projects and mutual aid groups such as Alcoholics Anonymous (AA) or SMART Recovery can help support and sustain recovery-oriented journeys for people with problem alcohol use before, during and after treatment.

Keyworkers should be familiar with the peer-delivered and peer-led organisations and mutual aid meetings in their area and hold information on each of these. They should inform a person

about peer support options as part of the treatment and recovery planning process and help them to access this.

Effective peer support can:

- promote hope and optimism that change is desirable and possible
- enhance motivation
- help members to develop a positive identity
- improve coping mechanisms and social skills
- provide benefits for both the person delivering the support and the person receiving it

There are now a range of peer-delivered and peer-led support services and organisations. Their structures and activities vary widely across the different parts of the UK. The most common peer support organisations in the UK fall broadly into the following 3 groups.

1. Peer-delivered support that is linked to a particular treatment and recovery service.
2. Lived experience recovery organisations (LEROs), which are autonomous organisations led by people with lived experience.
3. Mutual aid groups such as AA and SMART Recovery, which are independent organisations offering a specific recovery programme that people follow together.

The activity of peer support varies from offering a specific kind of support, like making recovery visible and welcoming new people into an alcohol treatment service, to peer-led LEROs that offer a full range of non-clinical services.

Chapter 6 on recovery support services describes several kinds of peer support.

Keyworkers should encourage and support people to engage with peer support and mutual aid in a reflective and collaborative way. Simply providing information or leaving people to make contact themselves increases the risk that they will drop out or not attend (Humphreys, 1999). A motivational interviewing approach will be useful in this process.

Facilitating access to mutual aid

'Facilitating access to mutual aid' (FAMA) is a short, simple and effective method for increasing mutual aid participation. Alcohol treatment services should make sure keyworkers are trained to facilitate access to mutual aid.

The most common national mutual aid groups in the UK are:

- AA
- Narcotics Anonymous
- Cocaine Anonymous
- Families Anonymous

- Al-Anon and Alateen
- SMART Recovery

There are also additional emerging mutual aid groups and peer support options available in local areas and remotely.

FAMA involves 3 stages:

- introducing mutual aid
- encouraging the person to engage with mutual aid
- taking an interest in the person's involvement with the mutual aid group

1. Introducing mutual aid

Keyworkers should discuss the value of mutual aid groups for the person's individual recovery goals. They should supportively explore the person's experiences or views about mutual aid and provide accessible information about local groups. Information should include any meetings in languages other than English and for particular groups, for example LGBTQ+ people, women or people from particular minority ethnic groups.

Where the person agrees, the keyworker should also help the person to set goals to engage with mutual aid as part of their treatment and recovery plan (Timko and others, 2006).

2. Encouraging the person to engage with a mutual aid group

In the second stage, the keyworker discusses the information given in the previous session with the person and helps the person to talk through any concerns and find solutions to any barriers to attendance. The keyworker should aim to agree with the person which group they will try and when. It is often very helpful if a group member can accompany the person to their first group meeting and wherever possible, the keyworker should discuss this option with the person and organise it.

3. Taking an interest in the person's experience of mutual aid

In the following sessions, the keyworker takes an active interest in the person's attendance and engagement with mutual aid, helping them to overcome any difficulties they experience as they continue to attend meetings. Like most volunteer-led organisations, mutual aid groups do not have the same governance structures as public services. If for any reason the person does not feel comfortable in one group, the keyworker can encourage them to try other local groups or ask peers for recommendations. Once the person has attended a group for a while, the keyworker can encourage the person to become more involved with the activities of the group and eventually take on an active role.

For more detailed guidance and resources, see the Mutual aid toolkit for alcohol and drug misuse treatment.

The 3 stages set out above are based on an approach originally developed in the USA for referring people to 12-step groups (Timko, 2006) and adapted for a UK context in the

'Facilitating access to mutual aid (FAMA)' guidance in the toolkit. Current evidence for FAMA is based on facilitating access to AA and other 12-step fellowships (Kelly and others, 2020) but the guidance may also be useful for practitioners who are facilitating access to other forms of peer support.

Some people, particularly those with harmful drinking or mild dependence, may be less willing to engage in mutual aid groups like AA. But practitioners should still help them evaluate and find positive social and support networks. There are also emerging mutual aid groups and peer support options available in local areas and remotely, some of which may include support for people aiming at lower risk drinking.

Examples of interventions a keyworker can provide include:

- mapping a person's social network to identify people who could be supportive of recovery and making a plan to increase contact with these people
- helping a person to identify other social, cultural or faith- based resources that could be supportive of recovery
- facilitating access to mutual aid or peer support activities and groups
- helping the person to get a peer mentor
- helping the person to consider being a peer mentor themselves when they are ready

5.5.5 Self-efficacy and coping skills

Self-efficacy describes the person's confidence in their ability to make or maintain changes to their alcohol use. Self-efficacy develops as people implement and observe change (McKellar and others, 2008).

Throughout treatment, keyworkers should emphasise any improvements and associated gains in confidence. Keyworkers can use techniques from several treatment approaches that build self-efficacy, such as motivational interviewing which identifies strengths and resources for change (McKellar and others, 2008).

Some treatment approaches more specifically target and develop self-efficacy (Kadden and Litt, 2011). For example, cognitive behavioural therapy (CBT) approaches to alcohol use focus on developing skills to increase a person's ability to cope with high risk drinking situations and life stressors, to help increase their self-efficacy to avoid or control alcohol use.

CBT-based relapse prevention is a comprehensive package of interventions. Keyworkers can integrate elements of this formal psychological treatment within structured support.

Examples of interventions a keyworker can provide include:

- promoting the use of drink diaries to identify high risk situations and to make proactive plans to cope with them
- looking together at life stressors and working out how these can be reduced
- teaching craving management strategies

- teaching drink refusal skills
- helping the person to manage low mood by encouraging good sleep hygiene and daily activity
- helping the person to learn to manage anxiety by teaching relaxation techniques
- developing an emergency plan to ensure an unintended drinking episode does not escalate to regular uncontrolled drinking
- ensuring the person has a robust plan in place to support recovery when they are discharged from structured treatment, which anticipates future challenges and has a clear route back to getting professional support

5.5.6 Structured support and motivational interventions

Motivational interviewing (MI) and motivational enhancement therapy (MET, a form of MI) are evidence-based approaches to alcohol treatment. MI can be valuable in developing a strong therapeutic alliance and throughout treatment. But MI could be particularly important at a person's initial assessment to build engagement and it can be combined with other effective interventions (Moyers and others, 2005). When practitioners provide structured support, they should use MI principles and techniques. MI also supports effective brief interventions (see chapter 3 on alcohol brief interventions) and can be used alongside psychological treatments including those listed in section 5.6.

Motivational interventions need a non-judgmental approach from the practitioner to help the person recognise the problems associated with their alcohol use and support their motivation to change their behaviour.

MI techniques focus on exploring why the person might be unsure or hesitant about changing their drinking or other behaviour that might be preventing recovery. The practitioner should elicit the person's own reasons for change, to motivate them to make or strengthen their commitment to behaviour change. When using MI techniques, practitioners should use non-judgmental tone and language (Miller and Rolnick, 2023). Other MI specific skills include:

- asking open questions
- providing affirmations that support the change process
- reflective listening to highlight the person's desire and ability to change their behaviour (change talk)
- summarising the ideas the person has expressed

MET is a structured approach that combines MI techniques with elements such as feedback on assessments or test results (normative feedback, for example highlighting discrepancy between typical alcohol use and the person's use). MET can be used as a stand-alone treatment, or along with other psychosocial or pharmacological treatment modalities.

Developing MI skills can be difficult because they may go against the practitioner's instincts to offer advice without considering whether the person is ready to act upon it. Keyworkers

(usually alcohol workers) can deliver MI but it requires quality professional training and ongoing reflective practice supported by supervision in MI.

5.5.7 Structured support and support after treatment ends

An important part of structured support is preparing the person for the end of structured treatment and agreeing support after they leave. It is important that the end date leaves time and space to prepare the person for the end of their treatment and the next stage of their recovery journey. People can be at increased risk of relapse at transition or ending points without appropriate preparation and support.

Alcohol treatment services should work together with local recovery support services to help people sustain recovery after they leave treatment. Recovery support services can provide emotional and practical support for continuing abstinence (or low risk drinking where that is appropriate), daily structure and rewarding activities after the person has finished structured treatment.

The keyworker and the person can agree a recovery support plan for after they leave treatment that is proportionate to their level of recovery resources and need. Based on individual assessment, a recovery support plan for after treatment might include:

- recovery goals for after treatment
- recovery-oriented activities and recovery services they will engage with
- appropriate support people
- relapse prevention strategies following the end of structured treatment
- arrangements for prescribing and collecting relapse prevention medication
- arrangements for recovery check ups
- a re-engagement plan

Monitoring people after they leave treatment can help them to manage early recovery. Recovery check-ups are an agreed series of scheduled in-person, online or phone appointments with the person after they leave a treatment service, generally carried out by the keyworker. Through recovery check-ups, the service can:

- provide relapse prevention interventions
- identify any extra support the person might need
- where necessary, help the person to access the service again without delay

There is evidence to support recovery check-ups. You can find a summary in ‘Part 2: recovery support services - evidence and current provision’ in the guidance Recovery support services and lived experience initiatives.

You can read more about recovery check-ups in section 4.10.6 in chapter 4 on assessment and treatment and recovery planning.

5.6 Psychological treatments: selection and delivery

This section details several psychological treatments for people with problem alcohol use that are recommended by NICE in the guidelines Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) or are interventions with an emerging evidence-base that are supported by clinical consensus of the alcohol guidelines development group.

5.6.1 Selecting and using psychological treatments

Practitioners can use these psychological treatments in different settings, such as in community and residential settings.

You can find guidance on psychological therapies for people with co-occurring mental health conditions in chapter 18 on people with co-occurring mental health and alcohol use conditions.

Selecting a specific psychological treatment depends on:

- assessment and formulation
- the availability of suitably qualified staff
- a supporting clinical supervision and governance structure for the treatment
- use of relevant standardised outcome measurement tools

Practitioners can deliver these interventions one-to-one, and most can be adapted to be delivered to a group. Practitioners can also deliver some of these interventions using digital technologies like online video.

Elements of these interventions may be integrated into structured support under the oversight of a practitioner trained in the approach and with supporting supervision.

The psychological treatments below would normally be delivered by practitioners who have had specific training in the treatment. Services should provide clinical supervision by a professional clinical supervisor with training in the relevant treatment and appropriate clinical governance structures.

5.6.2 Using motivational interviewing alongside psychological treatments

You can use MI alongside the psychological treatments described in section 5.6.3 to 5.6.6 as they can be helpful in building the therapeutic alliance and engagement with treatment (Miller and Rollnick, 2023).

See section 5.5.6 for guidance on MI.

5.6.3 Behavioural approaches

Practitioners delivering behavioural treatments described in this section should be trained to deliver the specific treatment. Services should ensure that a clinical supervisor trained in the specific approach provides supervision for practitioners providing these treatments.

Behavioural approaches focus on changing the environmental or social circumstances to support a person to change their drinking. Based on the psychological concept of conditioning, behavioural approaches such as management aim to modify learned behaviours such as alcohol use.

Behavioural approaches include interventions that aim to unlearn (or 'extinguish') conditioned cues to drink alcohol. For example, 'extinction-focused approaches' include behavioural self-control training to reduce cravings to drink. Other behavioural interventions may help people develop recovery-supporting behaviours through support from others or specific rewards for positive behaviour. For example, a community reinforcement approach (CRA) or contingency management (CM) aim to reinforce abstinence and non-drinking behaviours.

CRA is based on the principle that addictive behaviours involve reinforcers (for example, learned environmental cues) that maintain the behaviour. Building motivation and engaging in alternative, rewarding activities shifts the person's reinforcement cues towards recovery-oriented behaviours. Positive social activities are important reinforcement goals, and engaging in peer support, therapies or other suitable activities may also be valuable (Meyers and others, 2011).

Behavioural self-control training (or behavioural self-management training) involves developing strategies, including managing high-risk drinking situations. Examples of strategies include learning drink-refusal skills or setting clear drinking limits. Behavioural self-control training can be used for people who have a low risk drinking goal (Marlatt and Witkiewitz, 2002).

CM provides incentives such as monetary rewards for specific behaviours. This can include rewards for staying abstinent, attending treatment or other recovery-supporting activities. CM is typically used alongside other interventions and has some supporting evidence for alcohol specific outcomes (Petry and others, 2014; McDonell and others, 2020). CM requires well defined behaviour targets (for example, attendance at the service) and a clear monitoring system to ensure it is delivered consistently and ethically.

There is evidence that CM is effective and cost effective in improving adherence to acamprosate (Donaghue and others, 2023), so CM can be considered for people whose treatment and recovery plan includes acamprosate.

5.6.4 Cognitive behavioural therapy

Practitioners delivering cognitive behavioural treatments described in this section should be trained to deliver the specific treatment. Services should ensure that a clinical supervisor trained in the specific approach provides supervision for practitioners providing these treatments.

Cognitive behavioural therapy (CBT) approaches aim to change addictive behaviours by changing unhelpful cognitions (alcohol related thoughts and images) and behaviours that maintain or contribute to drinking. CBT enables people to recognise these thoughts and

change the way they think and behave to support their recovery (Mitcheson and others, 2010; Liese and Tripp, 2018; Magill and others, 2019).

Relapse prevention

CBT-based relapse prevention, developed from Marlatt and Gordon's model, is a widely delivered intervention for harmful drinking and dependence (Marlatt and Donovan, 2005). The approach identifies the main contributors to a return to problematic drinking (or relapse) and interventions, which include:

- identifying high-risk drinking situations and learning how to manage them
- coping with urges and cravings, and challenging expected positive outcomes from drinking
- identifying and challenging personal permissions and justifications to drink, for example when a person says, "I deserve a treat" or "other people are drinking, why can't I?"
- drink-refusal skills training
- identifying lifestyle factors such as stress and social networks that encourage drinking and seeking to manage these better
- setting up self-reward systems for not drinking

Relapse prevention should be integral to treatment. Relapse prevention interventions are an important part of structured support (see section 5.5.5), enabling people to understand how to maintain changes in their behaviour and make progress in their recovery. Relapse prevention considers any returns to problematic alcohol use as a process rather than a stand-alone event. It focuses on developing strategies to reduce the likelihood of drinking, for example through coping skills or building self-efficacy and by attending to longer-term lifestyle stressors.

Relapse prevention also identifies how a 'slip' (a temporary or short return to problematic use) can be seen as a manageable event or even learning opportunity, rather than as a trigger for a full-blown relapse. It also helps people to change their thinking on how they see a slip.

Interventions for low risk drinking goals

NICE CG115 recommends that psychological interventions for abstinence broadly apply to low risk drinking goals. A formulation-based package of behavioural and cognitive interventions should form the basis of the approach.

Low risk drinking may be an appropriate goal for most people with mild dependence and people drinking at harmful (higher risk) levels who:

- do not have significant physical or mental health conditions
- have adequate social support

If the person meets the above criteria, a low risk drinking goal may be appropriate unless they prefer a goal of abstinence, or there is some other reason for abstinence.

The alcohol clinical guidelines development group recommend abstinence as the appropriate goal for most people with moderate or severe alcohol dependence. The guidelines development group also recommend abstinence as the appropriate goal for most people with mild dependence and for people drinking at harmful levels who have significant physical health or mental health conditions that can be made worse by alcohol use (for example, alcohol-related liver disease or clinical depression). Any person choosing a goal of abstinence should be supported to work towards that.

However, if the person makes an informed choice to opt for a low risk drinking goal, they should be supported in that goal. If there are considerable risks involved, the assessor should advise that abstinence is most appropriate and should support a negotiated approach where the person can consider abstinence if they do not achieve low risk drinking. People initially preferring a low risk drinking goal can switch to an abstinence treatment goal at a later point.

Low risk drinking in this guideline is defined in line with the UK chief medical officers' low risk drinking guidelines. The guidelines recommend it is safest not to drink more than 14 units a week on a regular basis and if a person drinks as much as 14 units per week, it is best to spread drinking evenly over 3 or more days. For women who are pregnant or think they could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to the baby to a minimum.

This definition of low risk applies to the general population. For some people, drinking any alcohol at all is a risk. For example, abstinence is crucial for the health of people with advanced liver disease, including cirrhosis.

A goal of low risk drinking is commonly known as controlled drinking (see definition of controlled drinking in the glossary). There is some evidence that tools such as the Impaired Control Scale may be appropriate for helping to identify the suitability of a controlled drinking goal (Heather and Dawe 2005). Low drinking goals should be regularly reviewed.

An initial period of abstinence may be valuable (where the person does not need medically assisted withdrawal) before beginning low risk drinking. A period of abstinence can allow the person to adjust a range of factors to support a low risk drinking goal. For example, recognising situations or feelings that lead to drinking, developing skills to manage these and adapting social behaviours and other daily habits to support low risk drinking.

People with mild dependence without additional complex needs and who have supportive social networks may only need a relatively brief period of treatment. However, this should be based on the individual assessment and formulation.

Several psychosocial approaches are particularly suited to low risk drinking goals. For example, exploring past and future motivations for a person's drinking and evaluating these as part of a low risk drinking plan is likely to be important.

CBT and CBT-based relapse prevention interventions are suitable to support low risk drinking goals (Marlatt and Gordon, 1985). Additional strategies to support low risk drinking goals include:

- setting clear limits for drinking
- self-monitoring of alcohol consumption, for example keeping a drinks diary
- methods to control the rate of drinking, for example alternating alcoholic drinks with soft drinks and not participating in buying rounds
- analysing triggers for excessive drinking, for example the role of stress or anxiety

5.6.5 Third wave approaches and mindfulness

Practitioners providing the interventions in this section should be trained and certified in the specific treatment. Services should ensure that a clinical supervisor trained in the specific approach provides supervision for practitioners providing these treatments.

More recent developments of CBT (sometimes referred to as 'third-wave CBT' or 'contextual CBT') are based on mindfulness-oriented approaches and include:

- acceptance and commitment therapy
- mindfulness-based relapse prevention
- dialectical behavioural therapy

Third wave approaches differ from traditional CBT as they focus on helping the person change their relationship to unhelpful thinking patterns (for example, believing "I cannot cope without a drink") and emotions rather than changing thoughts directly. This is done using mindfulness and acceptance strategies to increase awareness of these unhelpful thoughts and feelings and to enable more flexible responses that support recovery.

Mindfulness encourages people to focus on their sensations (for example, cravings), thoughts and emotions in the present moment without judgement or reaction. Then, people can accept negative thoughts or feelings that they experience, rather than seeing them as something that needs to be fixed.

Research on the relationship between mindfulness and substance use behaviours (Karyadi and others, 2014) found that:

- these practices were associated with a range of positive wellbeing measures
- greater ability to be mindful was associated with better managing cravings among people with alcohol-related problems

Mindfulness-based relapse prevention brings together the practice of mindfulness within the relapse prevention model. There is emerging evidence that mindfulness-based relapse prevention leads to reduced negative emotions, stress and other potential internal triggers (Byrne and others, 2019; Bowen and others, 2014).

There is some evidence that mindfulness can reduce cravings and support abstinence (Karyadi and others, 2014; Korecki and others, 2020) and that acceptance and commitment therapy may be effective as a treatment for substance dependence (Byrne and others, 2019).

There is also evidence that dialectical behavioural therapy, which incorporates mindfulness techniques, is effective for people with emotional regulation difficulties who use substances (Maffei and others, 2018). As this intervention is for people with a mental health condition, it is included in chapter 18 on people with co-occurring mental health conditions.

5.6.6 Interventions supported by family or social networks

Involving family, friends and social networks in treatment

The nature and extent of a person's social network can influence their recovery outcomes and is an important part of structured support (see section 5.3.4).

Social network interventions are based on the principle that harmful drinking and alcohol dependence occur in a social context that can enhance or undermine behaviour change. These interventions aim to improve the quality of relationships and reduce stress by:

- improving communication and problem-solving
- reinforcing behaviour consistent with changing drinking and recovery
- reducing unhelpful behaviours that may undermine efforts to change drinking

Improving how a person functions in a social network (family, friends, community) that supports abstinence or low risk drinking is an important recovery asset. NICE CG115 recommends involving families, partners and friends in treatment as long as the person in treatment has given consent.

It is important to review the support networks of any person with alcohol dependence as part of their assessment. The practitioner should ask what they think about each network member's attitude to supporting them in their treatment and how willing they might be to be more formally involved. The keyworker can use mapping to help to review social networks (see also section 5.5.2 on support, structure and goal direction and 5.5.4 on social support and recovery-oriented networks).

Some people do not wish to involve their family members because they are unsupportive, or in some cases abusive. In these situations, it is particularly important to help the person to draw on or build alternative support networks. However, at the point of assessment, some people can be anxious about involving their family members, even if they think they are supportive. In these situations, it is helpful for practitioners to ask again at review whether the person would like to involve their family in their treatment as they may feel differently when they have started to engage in treatment.

Talking about social networks and the benefits of involving others in treatment provides an opportunity to ask the person if they think their family members or significant others are affected and might want support (see section 5.8 on interventions for adult family members, partners and friends).

Practitioners should establish the boundaries of confidentiality and consent to contact family members or significant others at an early stage of treatment. This can be helpful if the person in treatment drops out of contact with the service. This can be formalised as part of a re-engagement plan.

Effective family-focused interventions

There is evidence that several family-focused interventions are effective for treating problem alcohol use and can indirectly support and protect children affected by parental alcohol use (Templeton, 2010). These can broadly be grouped into 3 approaches:

1. Work with adult family members and significant others to help the person with problem alcohol use to enter and engage with treatment.
2. Involve both the person with problem alcohol use and their adult family members and significant others in the treatment intervention.
3. Interventions responding to the needs of the adult family members and significant others without the person drinking involved. This support should be available regardless of whether the person with problem alcohol use is engaged in treatment or not (Copello and others, 2005; Orford and others, 2013) (see section 5.8).

The following 2 sections focus on the first 2 approaches and describe the main interventions that involve the wider social network to support behaviour change in adults with problem alcohol use. Section 5.9 outlines an approach to supporting adult family members and significant others without the person with problem alcohol use being involved.

You can find details of interventions that involve the family to prevent or reduce substance use by children and young people in chapter 23 on young people.

Social behaviour and network therapy

Practitioners providing social behaviour and network therapy (SBNT) should be trained in this treatment. Services should ensure that a clinical supervisor trained in the specific approach provides supervision for practitioners providing these treatments.

NICE CG115 recommends social network and environment-based therapies that focus on alcohol related problems. SBNT is an example of these. It directly engages a person's wider social network in the treatment process. The practitioner uses SBNT to support the person to explore and build social network support for changing their alcohol use and other problematic behaviour (Copello and others, 2002).

SBNT encourages a person to:

- be open about their goals
- be clear about their plans to cope if they return to problematic drinking at any stage
- improve communication within their social network

These interventions aim to support the person with problem alcohol use through the treatment journey, and, where necessary, back into treatment. SBNT brings together elements of network therapy, social aspects of the community reinforcement approach, relapse prevention and approaches involving families and concerned others.

Practitioners can use SBNT to help the person pursue a goal of abstinence or low risk drinking. The coping strategies developed through SBNT are useful during and after completing treatment.

Behavioural couples therapy

Practitioners providing behavioural couples therapy (BCT) should be trained in this treatment. Services should ensure that a clinical supervisor trained in the specific approach provides supervision for practitioners providing these treatments.

NICE CG115 recommends using BCT for people who have a partner who is willing to participate in supporting the person to change their drinking. It is not recommended if the partner is also drinking problematically or the person is currently experiencing, or is a current perpetrator, of domestic abuse.

BCT is a structured approach that focuses on improving the quality of the relationship through improved communication and planned structured activities. It also includes aspects of CBT-based relapse prevention. BCT may be appropriate for either abstinence or low risk drinking goals, determined by assessment and formulation.

5.7 Modes of delivery

This section describes ways that you can deliver psychosocial interventions other than through individual (in-person) sessions.

You can find information on mutual aid groups and groups run by peer networks or LEROs in chapter 6 on recovery support services.

5.7.1 Psychosocial interventions delivered in groups

This section includes psychosocial interventions delivered in groups by trained alcohol practitioners.

There is evidence that several interventions for substance use disorders delivered on a one-to-one basis can also be effectively delivered in groups (Weiss and others, 2004).

Facilitating any group requires a high level of skill. Meeting the needs of multiple group members is more complex than one-to-one work. Services should ensure that therapeutic approaches to groupwork are evidence-based and that group facilitators are trained in groupwork and the specific group intervention they deliver. Facilitators should also receive clinical supervision by a supervisor trained in supervision and in groupwork and in the specific intervention they supervise, so that groups are safe and viable and achieve positive outcomes (Hill and Harris, 2011).

Group interventions can offer therapeutic opportunities that are not available in one-to-one sessions (Yalom and Leszcz, 2020). For example, groups can help people realise they are not alone in their experiences. This can reduce feelings of shame and create a sense of belonging. Support and challenges from peers in a safe environment can be powerful in motivating people to change, and group members can learn from one another's experience. Groups can also help people learn to interact with others.

However, there are significant risks of attrition from groups in community treatment settings, so it's important to have competent facilitation and a focus on maintaining engagement throughout.

Groups can be highly structured (for example, a mindfulness-based relapse prevention group). Alternatively, they could be less structured support groups where members share their experience of working towards their treatment and recovery goals.

The choice of specific group offered should be based on the setting, practitioner and supervisor competences, and the identified needs of the participants. Groups may aim to address the needs of any person in treatment assessed as appropriate or the needs of a particular group (for example, women or LGBTQ+ people).

Groups may include:

- CBT groups such as relapse prevention (Wenzel and others, 2012) including coping skills training (see section 5.6.4 above) and mindfulness-based groups (see section 5.6.5 above)
- interactional (also called interpersonal) groups
- psychoeducational groups providing information on harmful drinking and alcohol dependence, health behaviours and recovery resources

There is little evidence on psychoeducational groups, but NICE CG115 recommends them as part of an intensive community programme and they provide practical help to reduce harm and build recovery resources.

Some services run groups focused on engagement and social or recreational activities. These can be an important part of supporting recovery, as identified in section 5.5.3 on rewarding activities and 5.5.4 on social support and recovery-oriented networks.

The parameters of a group intervention will vary according to its purpose and clinical leads will need to advise on:

- therapeutic approach and target group membership
- threshold of access (a closed group for one cohort only, cohorts joining at agreed points in a rolling schedule, or an open group that people can join at any time)
- attendance at all sessions expected or optional drop ins
- the length of time each group runs for and number of group sessions

- ground rules describing boundaries and acceptable behaviour
- adaptations for accessibility for individual members

The decision to offer a person a group intervention should be based on their assessment and formulation, and mutually agreed with the keyworker. There should be an explicit connection in the treatment and recovery plan between their goals and how the group can help to meet them.

Group interventions can be a valuable part of a person's treatment. However, groups should not replace the offer of one-to-one interventions. These should always be available for people who do not want to engage in groups. The practitioner should assess any mental health conditions (for example, social phobia) and assess any risks the person might pose to others, and their suitability for a group intervention.

People are often anxious about groups and practitioners should address their concerns. Services offering group interventions should describe how groups can support recovery and have an induction process for newcomers to ensure they feel welcomed and supported.

The practitioner will need to share information on the purpose of the group, how it will run, and the ground rules. They should communicate information accessibly, considering group members' language, literacy, sensory disability, cognitive disability and neurodiversity. It may be appropriate to introduce the new person to a peer who has experienced the group intervention and can share their experience of it, to help support engagement.

5.7.2 Intensive community and residential programmes

Intensive programmes consist of a range of groups and recovery-oriented activities to support people achieving their alcohol use goals (Orchowski and Johnson, 2012; Coco and others, 2019). These programmes provide support in the early weeks or months of abstinence, promote recovery, and strengthen social functioning.

Intensive programmes:

- are usually delivered in residential settings
- are generally abstinence based
- include a focus on participation in communal activities

Intensive programmes can be delivered in community settings with sufficient capacity and staff competence. NICE CG115 recommends an intensive community programme after medically assisted withdrawal for people with complex needs who are mildly or moderately dependent, and for those who are severely dependent. It recommends that an intensive community programme should contain:

- a drug regimen supported by psychological interventions including individual treatments
- group treatments

- psychoeducational interventions
- help to attend self-help (peer support) groups
- family and carer support and involvement
- case management

Intensive community programmes usually require the person to attend for 4 to 5 days per week, and residential programmes require attendance for at least 5 days per week, with some requirements during weekends for a fixed period of time. There is no clear evidence about the best length of the programme. In the UK, intensive community programmes generally last between 4 and 12 weeks. The length of a programme should ideally be tailored to the individual's needs. NICE CG115 recommends that a residential programme lasts up to 12 weeks.

You can find more guidance on intensive community and residential programmes in chapter 14 on residential and intensive structured day treatment.

Practitioners in community alcohol treatment services may have the opportunity to make referrals to an intensive community or residential based programme. Assessing whether such a referral is appropriate is a skilled job and there should be input from the MDT or a senior clinician. Intensive group programmes will usually be suitable for people who have engaged with standard treatment, but not appeared to benefit from it. However, there will be some people assessed as appropriate to move directly into an intensive programme.

Programmes are usually tailored to people with more severe dependence and with complex needs. These are usually orientated around the needs of people who need a high level of support to establish the foundations of their recovery and may require help in structuring their time and activities. However, some people with complex needs will require a more flexible, less intensive approach. Residential support may be most useful for people with little social support, including those experiencing homelessness.

There is wide variation in therapeutic approaches and programme requirements. It is important that the service and the practitioner are familiar with the approach and the requirements of the programme or programmes they are considering. The keyworker should communicate all relevant information to the person in an accessible way and should help the person to think through whether or not they want to engage in the treatment. If they do want to engage in the treatment, the keyworker should arrange visits.

The keyworker should ensure they have fully informed consent before making a referral. Where the referral is for residential treatment, the keyworker should find the results of the most recent inspection report (from the relevant inspection body) and only refer to services that are rated good quality or higher. They should share this information with the person so the person can make an informed decision. It's important to prepare the person before they start the residential programme because it can help to reduce the risk of disengagement.

The keyworker should maintain contact with the person and with the staff of the structured group programme. The keyworker should arrange for early re-engagement with community

treatment services for people who do not complete residential treatment and for those who need ongoing treatment and support after completing the programme.

5.7.3 Digital interventions

Definition of digital interventions

Services may offer digital and other remote interventions alongside in-person treatment to increase choice and accessibility for people with problem alcohol use. The term 'digital interventions' in alcohol treatment services covers a broad range of applications that enable remote support, which may combine both digital and in-person approaches as part of a person's treatment and recovery plan. Or it could mean fully remote treatment provided using video or phone.

In these guidelines, 'digital interventions' refers to any interactive digital programme where there is contact between a practitioner and a person with problem alcohol use, to support them to change their behaviour. This can involve real time contact on video platforms like Microsoft Teams or Zoom, in place of in-person support. It can also involve contact using email or text chat, or phone-based support, where treatment is offered by a practitioner by phone to complement other methods, or for the entirety of the treatment.

This definition of digital interventions does not include digitally delivered information or screening tools that are offered in isolation, without any involvement from a practitioner.

Evidence of effectiveness

There is limited (but growing) evidence of the effectiveness of digital interventions in alcohol treatment and recovery (Kaner and others, 2017). There is emerging evidence to support the use of digital interventions to reduce alcohol health risk. For example, screening and alcohol brief interventions to reduce consumption. These interventions are appropriate for people drinking at increasing risk and at harmful levels (see glossary) who do not need specialist assessment or additional healthcare support.

There is currently less evidence for treatment of people with alcohol dependence, or people drinking at harmful levels who need specialist treatment. There is some evidence that online AUDIT based tools can support engagement in alcohol treatment interventions. Online tools such as the Alcohol Change UK's Check your drinking quiz or TryDry app can be used to help people to reduce their drinking and can be considered as additional support alongside in-person structured treatment.

A systematic review of the effectiveness of remote and digital interventions in alcohol and drug treatment and recovery support found that remote interventions that supplement in-person alcohol and drug treatment appear to reduce relapse and the number of days people use drugs and alcohol (Kwan and others, 2025). The evidence is less conclusive for remote interventions that replace or partially replace in-person care due to a smaller body of evidence and uncertainty about how these interventions affect the number of days people use alcohol or drugs. The researchers noted that a high risk of bias means the findings should be interpreted with caution.

As more evidence on digital interventions emerges, these guidelines will be updated.

Offering digital interventions

Services can offer digital interventions to people seeking help for problem alcohol use if:

- digital interventions are available
- digital interventions are appropriate for the person after assessment and review
- the person wants to use digital interventions

Services should continue to offer in-person support where the person prefers it, and especially where it will encourage ongoing engagement with treatment. Digital interventions should not replace the option of in-person treatment. Some people will not have access to digital technology or may not have digital skills, so services should ensure that these people can access all interventions in person.

For more information, see guidance on providing remote and in-person interventions for alcohol and drug treatment services.

Potential benefits and limitations

Digital interventions offer some potential benefits to services and to people who need treatment, including:

- addressing geographical barriers, especially for people in rural communities or with limited transport options due to a lack of driving licence or public transport
- providing flexibility, as well as cost and time efficiency, especially for people with caring responsibilities
- enabling people with mobility issues to engage with treatment more easily
- addressing stigma-related barriers, including those experienced by some faith groups

However, digital interventions also involve potential limitations and risks, including identifying:

- alcohol and drug use by the person during the session
- signs of urgent health crisis
- undiagnosed physical and mental health conditions
- poor self-care
- general health issues

These limitations should be acknowledged in the assessment and in treatment planning. And from the start of treatment, practitioners should be aware of the need to manage risk in light of these.

Services can deliver in-person interventions in a way that minimises distractions and makes them more likely to be effective. But it's difficult to guarantee that digital interventions will take place in a distraction-free environment, and this might reduce their effectiveness. Practitioners should take steps to reduce distractions. For example, they can encourage people to complete the intervention in a quiet room free of distractions, where this is possible.

Policies to support delivery of digital interventions

Practitioners can gather initial information for assessment remotely, but there should normally be an in-person assessment. This enables the practitioner to complete a comprehensive assessment, including:

- the need for medically assisted withdrawal
- physical and mental health
- medical tests to be carried out, where indicated

Services using digital interventions should make sure that practitioners receive appropriate training so they are digitally competent. This includes understanding the ways that the therapeutic relationship can be established and maintained using digital interventions, as well being technically competent.

Services should maintain policies, and practitioners should receive training, in managing safeguarding and confidentiality when working remotely. For example, practitioners should always check whether the person is alone in the room. This will be particularly important where there are risks of domestic abuse. Services should also undertake a data protection impact assessment and maintain policies and procedures to protect confidentiality during remote interventions. And this should be discussed with the person.

Co-production, evaluation and sharing best practice are likely to be valuable in the future development of digital interventions to support alcohol treatment delivery. As services develop their digital interventions, they should seek feedback from people receiving and completing treatment to inform future developments.

5.8 Interventions for adult family members, partners and friends

Problem alcohol use can affect not only the person with the problem use, but also their partner, family and friends.

Members of the person's family and social network can contribute to the treatment and recovery process, but they may also have support needs of their own. This section focuses specifically on providing support for adult family members, partners and friends. Services should offer support to partners, family and friends of a person with problem alcohol use even when the person with problem alcohol use is not in treatment.

For when and how to involve adult family members, partners or friends in psychosocial treatment interventions for the person with problem alcohol use, see section 5.6.6 of this chapter.

For guidance on considering adult family members, partners and friends as part of assessment for the person with problem alcohol use, see section 4.9.15 in chapter 4 on assessment and treatment and recovery planning.

For guidance on interventions to support children affected by problem parental alcohol use, see chapter 26.

Many family members, partners and friends experience stress as a result of living with a person with problem alcohol use. This stress can cause physical and psychological symptoms, affect their ability to cope, and affect the amount and quality of the social support they receive.

Services should offer families, partners and friends:

- information on harmful drinking and alcohol dependence and how families, partners and friends can be affected
- an appointment to provide support
- an initial assessment of any urgent needs, where indicated

They should have clear, agreed arrangements covering confidentiality for both the person in treatment and the family member. Where a person does not agree to their personal information being shared with their family, partner or friends, the practitioner should provide general information about harmful drinking and alcohol dependence and how families can be affected, as well as information on treatment interventions. The service should still offer the family member a support intervention even if they are not involved in the person's treatment.

The 'stress-strain-coping-support model' has been shown to reduce family members' signs of strain (physical and psychological symptoms) and improve their coping mechanisms (Copello and others, 2000). This involves a 5-step approach:

1. Give the family member the opportunity to talk about the problem.
2. Provide them with relevant information.
3. Explore how the family member responds to and copes with their relative's problem substance use.
4. Explore and enhance social support for the family member.
5. Discuss the possibilities of being referred for further support.

Practitioners should assess risks such as domestic abuse, suicidality and safeguarding concerns. Where these risks are indicated, they should produce an initial safety plan and refer to appropriate services.

Practitioners delivering the 5-step approach need to be trained in the approach and regularly supervised by suitably qualified supervisors.

Providing this support to a family member can also help the person in treatment to recognise the extent of their problem alcohol use, while enhancing engagement and treatment

outcomes. However, this is an indirect secondary effect of the intervention and not its primary objective.

Family members or friends who spend a significant amount of time caring for a person with problem alcohol use are entitled to a formal carer's assessment to see if they are eligible for social care and support services. Each of the UK nations has legislation and guidance covering carer's support entitlement. You can find the relevant laws and guidance in annex 1.

Practitioners should discuss the carer's assessment with adult family members and carers and have established pathways with local services responsible for providing carers' assessments so they can make referrals as appropriate.

There are self-help groups which provide support for families, including:

- Al-Anon
- Families Anonymous
- SMART Family and Friends
- NACOA

Evidence has shown these groups to be beneficial (Miller and others, 1999). Practitioners should encourage family members to use local resources that support affected family members and carers.

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6. Recovery support services and lived experience initiatives

Recovery support services and lived experience initiatives provide practical and emotional support and help people build long-term recovery. They have an essential role in a recovery-oriented system of care and include peer support, mutual aid groups and other resources.

6.1 Main points

Recovery support services and lived experience initiatives are community services and interventions that can provide emotional and practical support for a person to work towards ongoing recovery.

Most recovery support services are run by a combination of staff with learnt experience and people with lived experience. Some peer support services are run entirely by people with lived experience.

Recovery support is important throughout a person's treatment and recovery journey and is vital when the person has finished structured treatment. Some people never attend treatment but use peer support and other recovery support services to achieve their recovery goals.

It is important that keyworkers know what services and support are available in their local area and help a person access their preferred service or support as part of their treatment and recovery plan.

Alcohol treatment services should have active working relationships and agreed pathways with all the recovery support services and lived experience initiatives in their local area.

6.2 Overview

You should read this chapter alongside section 5 on structured support in chapter 5 on psychosocial interventions.

Alcohol treatment services and recovery support services should work closely together, both contributing to a recovery-oriented system of care. You can read more about a recovery-oriented system of care in section 2.6 in chapter 2 on principles of care.

6.2.1 What recovery support services and lived experience initiatives are

Recovery support services are community services and interventions that can provide emotional and practical support for ongoing recovery from alcohol dependence and harmful drinking. These services and interventions help people build on their strengths to develop recovery resources.

Recovery resources (sometimes called recovery capital') are the healthy life resources that people can use to begin to recover and maintain recovery, including:

- housing
- education
- employment

- supportive family and social networks
- community and cultural resources and networks
- improved health and wellbeing

Recovery support services include health and care services, community services and lived experience initiatives.

In this guidance, any service and support which people with lived and living experience are involved in delivering or leading is described as a lived experience initiative. Where a treatment (or other service) provider employs peer workers or volunteers, we describe the services or support they offer as peer-delivered. We describe the services and support provided by a lived experience recovery organisation (LERO) as peer-led.

A 2017 systematic review on recovery support services in the USA found evidence that recovery support services help people to begin and maintain recovery and improve their quality of life.

6.2.2 Supporting treatment and recovery

Recovery support is important throughout a person's treatment and recovery journey and is vital when the person has finished structured treatment. Some people never attend treatment but use peer support and other recovery support services to achieve their recovery goals. Recovery support services can also be a first point of access to support for people and can later introduce people to structured treatment.

Recovery support services can contribute to a person's recovery journey by:

- engaging the person in treatment and supporting their engagement
- complementing treatment as part of the person's treatment and recovery plan
- offering continuous recovery support after the person finishes formal treatment
- helping the person re-enter treatment if they need to
- increasing opportunities for the person to volunteer or seek employment
- offering harm reduction advice and information to people outside treatment
- offering peer support services for family members

Recovery support services offer a wide range of interventions, but they all have a sense of social connection and community. They can help people and their families make links with wider communities of people in recovery, which help to sustain recovery in the long term.

It is important that keyworkers know what services and support are available in their local area and help people access their preferred service or interventions as part of their treatment and recovery plan. Alcohol treatment services should have active working relationships and agreed pathways with all the recovery support services and organisations in their local area.

You can read more about co-ordination between treatment services and recovery support services in section in section 2.6 in chapter 2 on principles of care.

The 2017 review found evidence of effectiveness for the recovery support services described in this chapter.

Most of these services are run by a combination of staff with learnt experience and people with lived experience. However, some peer support services are run entirely by people with lived experience.

These services and interventions are organised in different ways across different areas and are known by various names, so these might be called something slightly different in your area. They include:

- peer support services
- mutual aid
- recovery community centres
- recovery housing
- recovery support services in educational settings
- recovery management check-ups

6.3 Peer support services

6.3.1 Groups and organisations

Peers are people who share an experience. In the context of recovery support, peers with lived experience of alcohol dependence and of recovery use this experience to offer non-clinical support to others who are working towards recovery.

Peer support services include a broad range of peer-delivered interventions and organisations that support people to develop their recovery resources and take part in a recovery community. These services offer a positive culture that can help to reinforce recovery-oriented norms. A peer support service extends beyond representing people attending the treatment service (often known as service user involvement) and provides a range of support for people who are currently attending, who are no longer attending, or who have never attended structured treatment.

Peer-delivered recovery services are often provided by people who are volunteering or employed by an alcohol treatment service. The peer-delivered service may be distinct from but supported by the rest of the alcohol treatment service and have a dedicated co-ordinator who might be a volunteer peer or a member of staff. The support they offer ranges from a specific intervention, such as individual peer support to introduce a person to the service, to a full programme of individual and group peer support and activities.

A LERO may also provide peer support services. These are autonomous organisations led by people with lived experience of alcohol dependence and recovery. LEROs also differ in the

interventions they offer and often have a focus on promoting and developing recovery support services. Their activities include:

- offering physical space for recovery-related activities and service delivery
- offering peer-based recovery support services
- organising and engaging in advocacy efforts to improve policy and increase the availability of recovery resources and services
- educating the local community on alcohol dependence and the recovery process and potentially reducing stigma

In many areas, there are also peer support services specifically for families, partners and friends. Some peer support activities for people in recovery are also open to family and friends.

In some areas there are peer support groups or activities led by and tailored to the needs of particular groups of people, including minority ethnic groups, faith groups, women, LGBTQ+ people and older people. You can find some examples of tailoring services to particular groups in section 25.11 in chapter 25 on developing inclusive services.

The 2017 review found evidence that peer-based recovery support can help reduce alcohol use, reduce relapse and support and maintain treatment engagement.

6.3.2 Individual peer support

Peer support organisations often offer support to individuals as well as offering group activities. Local areas vary in the range of individual peer support that is available. As people gain experience and stability in recovery, they can volunteer to offer peer support, which can be beneficial to both the person offering the support and the person receiving it. Individual peer support can be thought of in 3 broad categories, which may overlap.

Peer support in treatment

A person may offer peer support to others while they are still in treatment. They can represent the views and concerns of individuals or groups of people in treatment to the treatment service staff and commissioners. They may also be active in organising community events involving people in treatment and their families. They could also be involved in commissioning, designing and monitoring the service. Role titles for this kind of peer support include:

- lived experience advocate
- service user representative

Peer support while in recovery

A person who is in recovery (often in early recovery just out of treatment) may take on a peer support role (often as a volunteer) drawing on their own lived experience. They show that recovery is possible. They also help others:

- into treatment
- to progress in treatment
- to establish themselves in early recovery

People in this role can offer practical and emotional support such as:

- introducing people to a service
- accompanying people to mutual aid or other recovery support groups (‘buddying’)
- accompanying people to healthcare and other appointments
- representing their wishes (‘peer advocacy’)

Role titles for this kind of peer support include:

- peer supporter
- peer volunteer
- recovery champion

Mentoring or coaching

A person who has been in stable recovery for some time may choose to supplement their lived experience by gaining some formal training and certification in a mentoring or coaching role. People in this peer support role are trained to offer informational, emotional, social and practical support to people with problem alcohol use. They may offer this as a volunteer or in a paid role. They show that recovery is possible and help people to build on their recovery resources. They will often work with people in early recovery after they have left treatment but may work with people at different stages of the recovery journey. Role titles for this kind of peer support include:

- recovery coach
- peer mentor

6.4 Mutual aid

Mutual aid groups offer a specific programme to support recovery that people follow together. Groups such as Alcoholics Anonymous (AA) or SMART Recovery provide a recovery-oriented support network with a focus on abstinence.

There is evidence that where practitioners in alcohol treatment services actively facilitate access to mutual aid for people in treatment, their treatment outcomes are better (Kelly and others, 2020). There is more detailed guidance on facilitating access to mutual aid in section 5.5.4 in chapter 5 on psychosocial interventions.

6.4.1 Alcoholics Anonymous

AA is the most widely established form of mutual aid with active groups all over the UK, online and internationally. They describe the organisation as “a fellowship of men and women who

share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism".

The Alcoholics Anonymous website provides information on local in-person and online groups. Groups are organised based on the principles of 12 steps to build recovery and on supporting each other. People can use groups at any stage of their recovery journey and some people achieve recovery through AA without ever entering treatment. People may drop into groups on an occasional basis according to need or follow the 12-step programme in a structured way with the support of a sponsor (another member of AA who is further on in recovery). Some AA groups are open to family members or professionals who are interested in understanding more about AA.

A 2020 review of the effectiveness of AA and 12-step programmes for alcohol use disorder (Kelly and others, 2020) found evidence for the effectiveness of AA and facilitating access to mutual aid in supporting abstinence and other alcohol related outcomes.

While AA is the most studied mutual aid model, researchers have argued that, since mutual aid models are similar, it is likely that participating in other mutual aid models is similarly beneficial to people's recovery (Kelly and Yeterian, 2012).

Other 12-step fellowships based on the same principles as AA include Narcotics Anonymous, Cocaine Anonymous and Al-Anon (for families and friends of alcoholics).

Twelve-step fellowships maintain independence from professional bodies and make sure they remain led by people in recovery in a volunteer capacity. They do not accept funding from external sources. However, many fellowships have links with alcohol treatment services and some AA groups take place in treatment services or in LEROs.

6.4.2 SMART Recovery

Self-management and recovery training (SMART) Recovery groups are alternative mutual aid groups informed by rational emotive behaviour therapy principles. Their approach is based on group discussion and support and learning practical skills and using tools to manage various addictive behaviours and lead fulfilling lives. SMART Recovery groups are usually run by a combination of staff with learnt experience and people with lived experience. The availability of SMART Recovery meetings has grown over recent decades and there are many groups in the UK.

The SMART Recovery website provides information on local in-person and online groups and training materials. SMART Recovery groups are open to anyone considering or aiming to achieve abstinence and people can join directly. SMART Recovery also works in partnership with treatment services, including residential and prison services which often host meetings. SMART Recovery champions work with people in treatment to develop peer-led SMART Recovery groups. There is a SMART veterans programme in the UK.

6.5 Recovery community centres

A recovery community centre is a physical base or hub that provides space for a recovery-oriented community and a wide range of individual and group peer support. Recovery

community centres may offer recovery focused groups and relapse prevention support groups. They can also offer a structure and a programme of meaningful activities such as:

- sports
- recreational activities
- activities in green spaces
- alcohol and drug free social activities
- education
- employment support

They might also host mutual aid groups. The centres may have links with local community activities and groups such as community gardening projects, local food banks and community kitchens. They may also offer individual peer support, often called peer mentoring or recovery coaching.

Recovery community centres are usually run by LEROs but may also be run by treatment providers. They usually have a mix of employed staff with learnt experience (often peers) and peer volunteers. Some community centres are open to the public, such as recovery cafes. Recovery community centres support people in recovery and help to build local recovery communities. They also promote recovery communities as contributors to wider local communities.

6.6 Recovery housing

Recovery housing is stable accommodation that provides an alcohol and drug free environment. This can be a vital element of recovery support for people who have previously experienced homelessness, inadequate housing or who were living in an environment where heavy drinking was the norm. Recovery housing usually involves sharing accommodation and so provides a recovery-focused community. People may live in recovery housing while in treatment or after the end of structured treatment. Treatment staff in prisons should consider the option of recovery housing for people leaving prison.

Most (though not all) recovery housing has some level of staffing, but the level of available support varies widely across different schemes, as do standards of care. Some recovery housing is registered with the Care Quality Commission or equivalent national regulator. It is important for the keyworker and the person to understand the level of available support and regulation so they can consider whether the project meets the person's needs.

6.7 Recovery support in educational settings

Recovery support services in educational settings are well established in the USA, but there are currently very few in the UK. These provide an alcohol and drug free social network and activities in a university or college setting. This is an important support in an environment where regular alcohol and drug use is normal. These programmes can provide:

- peer support

- advocacy
- support to access alcohol treatment
- help with problems affecting people's studies

Recovery housing may also be available on campus.

6.8 Recovery check-ups

Recovery check-ups are an agreed series of scheduled in-person, phone or online appointments with the person after they leave a treatment service. Recovery check-ups provide encouragement, identify and address any problems and help people to rapidly return to treatment if they have relapsed.

Keyworkers from alcohol treatment services should provide recovery check-ups. You can find guidance on recovery check-ups in section 4.10.6 in chapter 4 on assessment and treatment and recovery planning.

Some peer support services provide recovery check-ups later in the person's recovery journey or where the person has never attended a treatment service.

6.9 Resources

Recovery support services and lived experience initiatives provides detailed guidance on supporting lived experience initiatives and recovery support services to help people start and sustain recovery from problem drug and alcohol use.

6.10 References

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7. Employment support

Employment support is an important part of recovery planning. Good links between treatment providers and employment services can help people navigate complex systems and make informed decisions about employment opportunities.

7.1 Main points

Dame Carol Black's 2016 independent review into the effects on employment outcomes of drug or alcohol addiction (England) highlighted the mutually reinforcing benefits of employment and recovery.

Employment and accessing employment support can and should be part of the recovery planning process. Autonomy is central to this, although treatment providers should be aware that some people accessing alcohol treatment may be subject to welfare benefit conditionality and be required by Jobcentre Plus (or Jobs and Benefits office in Northern Ireland) to look for work.

Good links between treatment providers and employment support providers can help people in alcohol treatment navigate potentially complex systems and rules. Providers include Jobcentre Plus and, where available, Individual Placement and Support (IPS) services. A case management approach can help with this.

Access to welfare benefits advice can help people to make informed decisions about employment and particular roles.

7.2 Overview

This chapter outlines things that services can do to improve employment opportunities for people with problem alcohol use. There is strong evidence that being in good quality employment supports a person's health and wellbeing. Alcohol treatment staff should ensure that people in treatment can make informed choices about employment and accessing employment support.

7.3 Accessing employment support

7.3.1 Engaging people in alcohol treatment to support employment

Alcohol treatment services should develop and sustain links to employment support. Dame Carol Black's 2016 independent review recommended that employment should be addressed at the same time as treatment and recovery support, rather than at the end of structured treatment. This could include IPS, which is integrated in community drug and alcohol treatment across most of England and in some areas in Wales, or targeted employment services in Scotland, Wales and Northern Ireland (see section 7.3.4).

As well as being a barrier to employment, problem alcohol use can cause and be a consequence of:

- workplace stress
- difficulties at work

- job loss

Alcohol treatment staff should discuss the person's attitudes towards and expectations about employment as part of comprehensive assessment when they first access the service. They should also discuss this at each review, in a non-directive way. If alcohol treatment staff discuss employment and access to employment support early in the person's treatment, and review it regularly, this will enable the person to make an informed decision about their options. Practitioners should also discuss job insecurity and retention with people who are currently employed, and they should know where to refer people who are at risk of losing their job.

The period around starting a job can be stressful, as can transitioning to a new environment and adopting workplace routines. The treatment provider or an employment support provider should make extra support available to people starting work particularly those who have not worked before or not worked for some time. If possible, they should offer to contact them more often, as well as offering to go with the person to work on the first days and offering to support them with managing their first wages and any changes to their benefit claims.

7.3.2 Respecting the person's autonomy in employment support

For people who are not already in employment, or receiving employment support, or have not been referred to a mandatory programme, it is important that they decide when (or if) they are referred to employment support.

There are some circumstances where a person may be the subject of conditions where this may not be possible. For example, where a person:

- is on job-ready social security benefits and is expected to undertake particular activities to remain eligible for those benefits (conditionality)
- has been the subject of a mandatory referral to a Department for Work and Pensions (DWP) commissioned or co-commissioned programme, or a programme commissioned by a devolved government

Services should ensure that there is a single point of contact (SPOC) and regular, effective communication between the local Jobcentre Plus or Jobs and Benefits office. This will ensure that employment support and benefit conditionality supports treatment and recovery rather than working separately to it (see section 7.3.5 on benefit conditionality and support options below).

Jobcentre Plus work coaches and managers have access to the Flexible Support Fund. This is a discretionary fund that they can use for costs related to a person starting work, such as buying clothing or tools, or covering travel expenses. The Flexible Support Fund is also sometimes used by DWP to commission specialist services to meet local priorities and unmet local need. This could include specialist employment support for people accessing alcohol or drug community treatment. You can find more information on available national and local employment services and schemes, including the Flexible Support Fund, on the Getting into work page on the Turn2Us website (UK-wide).

7.3.3 Understanding the role of employment

Services should promote access to employment and employment support to all who attend their service. This should take place at or shortly after comprehensive assessment, and then regularly throughout treatment.

While employment is generally associated with recovery and wellbeing, not all employment will help with this. A review on the relationship between work, health and wellbeing found that sometimes employment does not result in improved health and wellbeing. For example, the beneficial health effects depend on the nature and quality of work a person does.

The jobs that are often the most accessible to people with limited experience include jobs that are low paid, insecure and with limited autonomy and routes for progression.

Where services provide or help people access employment support, they should try to support them into stable and secure work that matches what the person wants to do, while being realistic about the sorts of jobs that might be initially available to them. An entry-level job can provide a direct or indirect route to a better one following the ABC path: any job, better job, career.

7.3.4 Expansion of access to Individual Placement and Support and targeted employment support schemes

Commissioners and alcohol treatment providers should consider making IPS available. IPS is a highly personalised form of employment support with evidence that it is effective for people experiencing alcohol dependence, mental health conditions and related conditions. There are several important differences between IPS and conventional employment support. For example, IPS employment specialists engage employers directly to explore opportunities for their clients. IPS also provides in-work support, including supporting the person in their new workplace while they adjust to their new role.

The IPS programme is now integrated in alcohol and drug treatment and is available in most areas in England and in some areas in Wales. This mirrors a significant expansion of IPS in mental health services backed by NHS England. You can find a range of IPS resources at the Centre for Mental Health and at IPS Grow, a website funded by NHS England and DWP to support the national roll-out of IPS in mental health services.

The following employment support schemes are tailored to the needs of people experiencing problem alcohol or drug use, or the needs of several groups with specific needs including people with problem alcohol use:

- No One Left Behind from Employability in Scotland
- Out of Work Service offers support from peer mentors in Wales
- Community Family Support Programme in Northern Ireland

7.3.5 Benefit conditionality and support options

Jobcentre Plus requires people who are on out-of-work benefits (such as Jobseeker's Allowance or the Universal Credit all work-related requirements) to fulfil the requirements of their Claimant Commitment or face a sanction (a temporary reduction or suspension of

payments). People on these benefits who are accessing structured alcohol (or drug) treatment can have their Claimant Commitment temporarily suspended under current legislation. This is to allow the person to focus on engaging in treatment and recovery for a period of up to 6 months.

People in treatment who are receiving other benefits (for example, Employment and Support Allowance or Universal Credit no work-related requirements, work-focused interview requirement or work preparation requirement groups) may have little or no contact with Jobcentre Plus or the Jobs and Benefits office. However, they may still be able to access some Jobcentre Plus or Jobs and Benefits office services and can also ask to discuss referral to specialist employment support programmes. Specialist programmes can be national in scope, although many local or combined authorities also design and commission their own employment programmes.

7.3.6 Facilitating access to welfare benefits advice

The welfare benefits system is complex, and keyworkers, clinicians and claimants themselves are unlikely to fully understand it. In-work benefits are among the most complex aspects of the system. Alcohol treatment services should ensure that people have access to high-quality welfare benefits advice throughout treatment, including about benefit conditionality and financial planning, to help them make informed decisions about work.

Citizens Advice offers welfare benefits advice among other services. There are several charities that provide information and support for people wanting to access welfare benefits, including Turn2Us.

Ensuring that people in treatment have access to welfare benefits advice can help them to maximise their income, avoid problems and make informed decisions about the financial implications of taking a particular job. This includes whether they will be financially better off in work, and if so, by how much. As well as mainstream DWP benefits (and legacy tax credits administered by HM Revenue and Customs), services should be able to signpost people to local authority schemes, including:

- local welfare assistance schemes
- Council Tax Reduction
- Discretionary Housing Payments

7.4 Establishing joint working to support employment

7.4.1 Employment support agency links

Treatment services should develop links with Jobcentre Plus, or Jobs and Benefits offices in Northern Ireland, and other relevant local employment support providers. This is made easier with designated, named points of contact at each service.

Good and regular communication between the treatment service and the local Jobcentre Plus or Jobs and Benefits office should mean that:

- there is an effective referral pathway between Jobcentre Plus or the Jobs and Benefits office and alcohol treatment services and lines of communication from treatment to employment services to support effective co-ordination
- people feel that they can disclose problem alcohol or drug use to employment services and that the response of those services will be appropriately supportive
- Jobcentre Plus or Jobs and Benefits office can apply conditionality easements when needed
- services can better co-ordinate treatment and employment support around the person and adjust these to take account of changing circumstances (including referral to specialist employment support programmes)

In areas where IPS employment support is available, the IPS team should work closely with Jobcentre Plus staff and managers. They should work to ensure that:

- support is aligned and co-ordinated
- expectations of people receiving employment support are reasonable, realistic and support health and treatment goals
- there are stronger working relationships between treatment services and Jobcentre Plus

Co-locating Jobcentre Plus or Jobs and Benefits office work coaches in treatment services may be an effective way of providing employment support and resolving welfare benefits queries. Peer mentors or other staff from treatment services based in Jobcentre Plus or Jobs and Benefits offices may help people to navigate sometimes complex and potentially intimidating Jobcentre Plus processes.

While it is appropriate for staff at treatment services and Jobcentre Plus or Jobs and Benefits offices to work together, a SPOC approach can be an effective way of ensuring continuity. The points of contact at either end could be a service manager, team leader or IPS team leader on the treatment side, and a partnership manager or disability employment adviser on the Jobcentre Plus side, and equivalent positions in Jobs and Benefits offices in Northern Ireland. Individual services and Jobcentre Plus offices or Jobs and Benefits offices could establish a simple service level agreement, although this is not essential.

7.4.2 Case management approach

A case management approach means that there is co-ordination between the alcohol treatment service and the person's Jobcentre Plus or Jobs and Benefits office work coach (or their adviser if they have been referred to an external specialist programme). This approach can ensure that people can access conditionality easements (reducing or removing work-related requirements) when appropriate and their progress with treatment and recovery can inform any referrals to further employment support.

When an alcohol treatment service refers someone to employment support, or they are already accessing employment support, the keyworker and employment support provider

should adopt a case management approach to help co-ordinate treatment and other support. It is important to avoid a situation where treatment support and employment support have conflicting requirements. For example, a person in alcohol treatment may find it difficult to manage a claimant commitment requiring a large part of each week be spent on work search activities alongside attending a structured day programme.

7.4.3 Engagement with primary care

Many people accessing treatment for alcohol use experience poor health and often comorbidities. Treatment services should work with local GPs to ensure that they are aware of local employment support options, and that support is co-ordinated, including access to employment support.

Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. This is based on their knowledge of their patients' health status and, where applicable, treatment need. The fit note is intended to be a positive process that looks at people's strengths as well as their health conditions.

GPs will be aware that patients may have different priorities at different stages in their treatment and recovery when requesting a fit note. For example, people often need access to health-related benefits and may be too unwell to work early in their treatment journey but are likely to benefit from appropriate work or employment support as they progress, including support to make work part of their recovery journey. GPs need to know where to signpost patients for appropriate employment advice and support.

7.4.4 Recognising other health and wellbeing needs

People in treatment for problem alcohol use are likely to experience poor overall health and may have accumulated health harms because of their alcohol use. Ongoing support and access to treatment and medical care, including flexibility around appointment times, is essential to support employment and wellbeing. Treatment services offering flexible opening times, or at least flexible appointments, can be a good way of ensuring that working people in treatment can continue to access support.

7.5 Engaging employers

The workplace is a setting where alcohol (and drug) related harms can be identified, and steps initiated to meet needs. So, treatment providers should engage with employers in their local community. The primary aim of engaging with employers should be to reach people with treatment needs and to support employers to be more informed about alcohol use, harms, treatment, recovery and employment.

Engaging with employers can:

- help to support people in treatment to remain in work
- help reach under-served parts of the community
- build relationships that could support future employment opportunities for people in treatment

- offer a way to contact employees who might need advice or treatment but feel reluctant to engage with alcohol treatment services
- offer an opportunity to help employers improve their workplace alcohol policies

7.6 Safeguarding and risk management

Treatment services should have policies to guide responses to concerns about people in treatment working in safety-critical roles. Some safety-critical roles are defined in legislation, but more broadly this means any role where health and safety would be unacceptably compromised by someone being impaired due to alcohol (or drug) use. Risk assessment processes and any safeguarding matters relating to work should be:

- comprehensive
- transparent
- involve the person at the earliest stage

Services will be aware that ongoing alcohol (and drug) use may pose risks in safety-critical occupations, and that this could pose a range of issues depending on the circumstances, including ethical, legal and reputational. Risk assessments should take employment into consideration and should always be done with the person. Where a workplace risk is identified, services will need to carefully consider the details of each case.

8. Harm reduction

How to deliver interventions to reduce health and social harms associated with a person's alcohol use. This includes assessing, planning and monitoring gradual alcohol reduction, and providing alcohol harm reduction advice across healthcare settings.

8.1 Main points

A harm reduction approach or philosophy frames the aim of alcohol treatment as reducing harms associated with a person's alcohol use. Harm reduction can be understood as a continuum, with small changes at one end of the continuum and complete abstinence at the other.

A goal of abstinence is generally recommended for people with moderate or severe dependence.

If a person understands the recommendation but is not ready or chooses not to aim for abstinence or where appropriate, low-risk drinking, this should not be a reason to deny them support from the alcohol treatment service. The practitioner can agree a harm reduction approach with the person that focuses on reducing health and social harms associated with harmful drinking and alcohol dependence.

Working with a person to reduce harm can:

- build therapeutic rapport
- help people with more complex needs to engage in treatment
- provide an opportunity for motivational interventions

Assessment, including risk assessment, and treatment and recovery (support) planning are central to care for people working on harm reduction goals. These processes need to be tailored to the needs of each individual and provided flexibly.

Keyworkers should regularly review harm reduction goals with the person and discuss any barriers that prevent them working towards abstinence or where appropriate, low-risk drinking.

Clinicians should review the health of people who continue to drink at harmful or dependent levels.

A harm reduction approach may (although will not always) involve the person reducing their alcohol use. Any safe reduction in alcohol use, even while a person continues to experience alcohol dependence, can reduce alcohol related harm.

For people with alcohol dependence who experience withdrawal symptoms, the recommended intervention is medically assisted withdrawal and the clinician should inform people of this and discuss risks and benefits of the intervention.

If a person with moderate alcohol dependence is recommended medically assisted withdrawal but still wants to reduce their alcohol use rather than abstain, a clinician should

assess whether there are any safety considerations that indicate this approach is not appropriate. The clinician should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms.

If the person is assessed as appropriate, the clinician can develop and monitor a plan for gradual reduction with the person and work with the keyworker (if the clinician is not the keyworker) to support the person through the planned reduction.

If a person with severe dependence or high-risk factors for severe complications in withdrawal does not opt for the recommended medically assisted withdrawal but wishes to reduce their alcohol use, this requires a complex clinical decision. An experienced specialist clinician should assess the risks and benefits for the person and there may be some circumstances in which they agree to monitor and support the person in a planned alcohol reduction.

If a clinician assesses that the risks of serious complications in withdrawal cannot be effectively managed, they can advise the person to continue drinking at a steady rate, avoiding sudden reductions or binges, to reduce the risk of serious withdrawal complications. The clinician should continue to encourage the person to consider medically assisted withdrawal.

Clinicians should prescribe oral or intramuscularly administered thiamine (depending on risk levels) to people who continue to drink at harmful or dependent levels to reduce their risk of developing Wernicke-Korsakoff syndrome and other neurological consequences.

Services should help people access screening for alcohol related liver disease using a test that can detect fibrosis or cirrhosis.

Staff in alcohol treatment services and staff working in relevant health and care services should be trained to provide alcohol harm reduction information and advice.

Every person attending an alcohol treatment service should be offered harm reduction information and advice.

Alcohol harm reduction information and advice includes telling people about:

- the risks of stopping drinking suddenly or reducing too fast for people with alcohol dependence
- the decrease in tolerance after a period of abstinence and the risks of drinking at pre-abstinence levels
- risks related to intoxication including alcohol poisoning and risks to safety
- the increased risk of overdose and other harms when drugs (including prescription and over the counter medication) and alcohol are taken together
- stop smoking advice
- specific advice for older people, young people, and women and those who are pregnant or may become pregnant

8.2 A harm reduction approach

8.2.1 Overview

A harm reduction approach or philosophy frames the aim of alcohol treatment as reducing the harms associated with a person's alcohol use. Abstinence and harm reduction approaches can be seen in an unhelpfully polarised way that makes their goals seem mutually exclusive. Instead, it can be helpful to understand harm reduction on a continuum, with small changes at one end of the continuum and complete abstinence at the other.

People with alcohol dependence or drinking at harmful levels generally experience physical health, mental health or social harms associated with their alcohol use. Assessment, treatment and support to address those harms is vital to effective alcohol treatment and recovery. So, a harm reduction approach is relevant to everyone who engages in alcohol treatment, whatever their alcohol use goal.

In the context of a harm reduction approach to alcohol treatment, there are particular considerations for people with alcohol dependence who are not ready or do not choose a goal of abstinence or where appropriate, low-risk drinking. For this group of people, the main focus of the work is reducing harms related to their alcohol use, although practitioners should review their alcohol use goal with them regularly.

8.2.2 Recommending medically assisted withdrawal

For people with moderate or severe alcohol dependence, the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) recommend assessment for and delivery of medically assisted withdrawal to achieve abstinence.

If the person has a goal of low-risk drinking rather than abstinence, this is often best achieved following a period of abstinence. So, medically assisted withdrawal can also be an appropriate intervention if a person with alcohol dependence is aiming at low-risk drinking.

Based on individual assessment, the clinician assessing the person should generally recommend and offer medically assisted withdrawal for people with moderate or severe dependence. They should discuss the risks and benefits of this intervention for the person, providing accessible (written and verbal) information in a way the person can easily understand.

However, this chapter contains guidance for other approaches that clinicians can consider to achieve harm reduction goals, including planned alcohol reduction without medication.

8.2.3 Assessment and treatment and recovery planning

Assessment and treatment and recovery (support) planning processes, including risk assessment and risk management, are central to the care of a person who is working towards harm reduction goals. A choice of harm reduction as a goal should not mean the person misses

out on these essential processes, which should be tailored to their individual needs and may have to be delivered very flexibly.

You should read chapter 4 on assessment and treatment and recovery planning.

Treatment and recovery planning may include agreeing a contingency plan with the person. This would include actions the keyworker will take if the person disengages from treatment, such as making follow up phone calls or contacting a family member and relevant services.

8.2.4 A flexible service approach

Services may need to be flexible in how they provide assessment and treatment and recovery planning and harm reduction interventions. People experiencing multiple disadvantage and other groups of people for example, those who have poor health or are frail, often find it very difficult to attend a service for regular appointments.

Assertive outreach and co-ordinating a multi-agency team around the person are ways to flexibly deliver harm reduction approaches tailored to the needs of those who find it difficult to use structured alcohol treatment services without targeted support. Services may offer flexibility in other ways. For example, they may need to keep cases open even where the person misses several appointments.

You can find guidance on assertive outreach and a multi-agency team around the person in chapter 9.

8.3 Harm reduction goals

8.3.1 Alcohol harm reduction goals

A treatment and recovery plan should include harm reduction goals that address immediate and longer terms harms and risks the person may be experiencing. Chapter 4 describes assessment and treatment and recovery planning for a wide range of needs including physical health, mental health and social factors. A harm reduction plan generally involves actions to reduce harms in some or all those areas tailored to the person's individual needs.

Even if the person does not reduce their alcohol use at first, if the practitioner and the person can agree a plan that helps reduce the harms and risks related to their alcohol use, and build on their strengths, this is a positive outcome. It can even help to prevent premature death.

Working towards goals that address physical health and mental health, social harms and longer-term recovery (for example, stable housing) can help to build motivation, self-efficacy and engagement with services.

If the person continues to drink at harmful or dependent levels, assessing and reviewing the person's physical and mental health on an ongoing basis and responding to any indicators of increased risks is an important part of a harm reduction approach.

Goals can include a reduction of risks and harms related to:

- alcohol related brain damage, including Wernicke's encephalopathy and other neurological consequences of harmful drinking

- alcohol related liver disease
- unplanned acute withdrawal
- reduced tolerance after a period of abstinence
- intoxication, including alcohol poisoning and safety risks related to intoxication
- concurrent alcohol and drug use, including over the counter and prescribed medications
- smoking

See chapter 24 for reducing risk and harm resulting from alcohol exposed pregnancies.

8.3.2 Agreeing alcohol use goals in the context of harm reduction

You can read about agreeing alcohol use goals in section 4.7 in chapter 4 on assessment and treatment and recovery planning.

A goal of abstinence is generally recommended for people with moderate or severe dependence and people with complex needs. However, goals should always be collaboratively agreed with and based on the individual. If a person is not ready or does not opt for a goal of abstinence or where appropriate a goal of low-risk drinking, the practitioner can consider a harm reduction strategy and discuss this option with the person. The discussion should include information tailored to the person's individual needs, on any significant risks involved with the person's continued alcohol use, for example risks to their physical or mental health.

A harm reduction strategy involves developing a practical and personalised plan with the person that will include advice and interventions to reduce harm to a person's safety, and their physical and mental health. It may (although will not necessarily) include a limited reduction in alcohol use as a specific goal. Evidence shows a reduction in health harms when people reduce consumption, even though they may still be drinking at harmful or dependent levels (Witkiewitz and others, 2020).

Establishing a therapeutic alliance and achieving outcomes valued by the person can help to enhance their motivation and they may go on to choose a goal of reduced drinking or abstinence at a later stage.

8.3.3 Reviewing alcohol use goals

While a harm reduction approach may be the most useful way to work with a person initially, practitioners should never assume that a person is unable to achieve abstinence or make significant reductions in their alcohol use.

The practitioner should review alcohol use goals with the person at frequent defined intervals and adjust the plan as appropriate. At an appropriate time based on the person's individual circumstances, the clinician should encourage the person to consider the benefits and any risks of a goal of abstinence as this will generally have the greatest effect in reducing risks to the person and supporting long term outcomes (Mann and others, 2017).

8.3.4 Motivation

A person's unwillingness to consider a goal of abstinence or significant reductions in their drinking should not prevent them accessing support from an alcohol treatment service. An individual harm reduction plan is based on tailoring treatment to the person's level of motivation at the time they are assessed and then is reviewed regularly with the person. A harm reduction approach can be helpful in building therapeutic rapport and engagement with the service. This approach should make use of the principles, processes and communication skills of motivational interviewing. You can find more information on motivational interviewing in section 5.5.6 in chapter 5 on psychosocial interventions.

Training and supervision in motivational interventions and in a trauma-informed approach should help practitioners to understand ambivalence as a natural part of any decision about behaviour change. It will also help practitioners consider how the experience of trauma might contribute to the person's ambivalence towards making changes in their alcohol use. You can find more information on trauma-informed care in section 2.2.8 in chapter 2 on principles of care.

The person's life circumstances also affect how achievable changes in alcohol use are. For example, if a person with alcohol dependence is experiencing rough sleeping, it is unlikely they can achieve and maintain abstinence without accessing safe and secure accommodation. A harm reduction approach is likely to be the most beneficial approach while people are experiencing rough sleeping.

Addressing potential barriers to engagement can positively affect the person's motivation. For example, this can include flexible engagement interventions and support to address practical barriers including:

- housing needs
- financial and debt problems
- support needs around domestic abuse or sexual assault or exploitation

8.4 Reducing alcohol when a person is experiencing alcohol dependence

8.4.1 Risks and benefits of reducing alcohol use when a person is experiencing alcohol dependence

For people who are alcohol dependent, there are benefits and risks involved in cutting down their alcohol use. Any safe reduction in alcohol use can reduce both short and longer harm to health (Witkiewitz and others, 2021). But reducing alcohol use without medication when someone is alcohol dependent, especially when the reduction is sudden, can result in acute withdrawal symptoms and there is a risk of serious complications, including:

- seizures
- delirium tremens

- Wernicke's encephalopathy (sometimes leading to long term alcohol related brain damage)

For guidance on complications in withdrawal, read section 10.4 in chapter 10 on pharmacological interventions.

8.4.2 Supporting people to reduce alcohol use: overview

If a person with alcohol dependence wishes to reduce their alcohol use, a clinician competent in diagnosis and assessment of alcohol dependence and withdrawal should assess whether the person is suitable for a gradual planned alcohol reduction.

Once the person has been assessed as suitable, the clinician and keyworker (if the clinician is not the keyworker) can arrange to support the person to do this. They should agree the role each will have in monitoring and supporting the person as they reduce their alcohol use (see sections 8.4.3 and 8.4.4 below for an overview of the roles of specialist clinicians and non-clinical keyworkers). They can then help the person make a plan to reduce their alcohol use safely, regularly reviewing progress, recognising achievement, and offering ongoing motivational support.

For further guidance on supporting people to reduce their alcohol use, see section 8.7 on developing and monitoring a gradual alcohol reduction plan and section 8.8 for a step-by-step approach to reducing alcohol consumption below.

8.4.3 The role of the specialist clinician or multidisciplinary team

A clinician competent in diagnosing and assessing alcohol dependence and withdrawal symptoms or a specialist multidisciplinary team (MDT), should be responsible for:

- assessing the suitability of the person for reducing alcohol use without medication
- developing a personalised alcohol reduction plan
- monitoring the impact of the alcohol reduction on the person

8.4.4 The role of the keyworker

In addition to the input from the MDT or specialist clinician, the keyworker (who might not be the clinician) should offer psychosocial support to the person throughout their planned reduction. Keyworkers who support people during a planned alcohol reduction should be trained to do this.

The specialist clinician should continue to monitor the person during the planned reduction to assess whether the person is experiencing withdrawal symptoms or there are any concerns about their health.

The service should have an escalation process so the keyworker can receive advice and supervision from the lead clinician or MDT if they observe any signs of risk to the person's health while they are offering psychosocial support. Keyworkers should be trained to recognise withdrawal symptoms (shaking, sweating, anxiety, nausea), and particularly

symptoms of withdrawal complications that mean the person should be referred to hospital as an emergency. See step 3 in section 8.8 below for a list of these symptoms.

8.5 Assessing the suitability and safety of a gradual reduction in alcohol use

When the clinician assesses the appropriateness of a gradual alcohol reduction plan they should take account of the person's needs, risks and strengths as outlined in their comprehensive assessment including all relevant health factors.

The clinician should consider indications that it would not be safe for the person to reduce alcohol without medication, due to the high risk of serious complications in withdrawal.

The alcohol guidelines development group recommends that the person should generally be recommended medically assisted withdrawal rather than alcohol reduction if they:

- are assessed as severely alcohol dependent
- have experienced serious complications in withdrawal in the past (such as seizures (fits), hallucinations or delirium tremens, or Wernicke-Korsakoff syndrome)
- have epilepsy
- have significant unstable physical health or mental health

If the clinician has informed the person of the risks involved with a planned reduction in their care and they still want to reduce their alcohol use rather than engage with the recommended medically assisted withdrawal, the clinician has a complex clinical assessment to make. There is guidance on this in section 8.6.2 below.

8.6 Supporting people with different severity of dependence levels

8.6.1 People with moderate alcohol dependence

If a person with moderate dependence is assessed by a competent clinician as appropriate for a planned reduction, the clinician should provide them with accessible information on the risks and benefits of planned alcohol reduction tailored to their individual needs. Information should include advice against stopping or cutting down alcohol too suddenly, information on withdrawal symptoms and the risk of complications in withdrawal.

For information on what a unit of alcohol is, see the NHS page Alcohol units.

Most people need help to understand and calculate units. You can use a unit calculator such as the Alcohol Change UK's unit calculator to help the person work out how many units they are drinking on a typical day. You can also find information about units for various alcoholic drinks on the 'Alcohol units page' on the Alcohol Change UK website. For more information on other harm reduction resources, including drink diaries and apps, see section 8.15.

You can use the step-by-step approach in section 8.8 below to support people with moderate dependence to reduce their alcohol use where there are no safety considerations as outlined in section 8.5 above.

8.6.2 People with severe alcohol dependence or higher risks

Assessing risks and benefits of reducing alcohol use for people with severe dependence or other risks

This is a more finely balanced and complex clinical decision to make if a person has severe alcohol dependence, a history of complications in withdrawal or other risks as set out in section 8.5.

The alcohol guidelines development group recommend that people with severe alcohol dependence access medically assisted withdrawal, which is the evidenced based intervention, as there is a higher risk of developing serious complications in withdrawal.

However, there may be circumstances where a person with severe dependence or high risks opts not to follow the medical advice to access medically assisted withdrawal but wishes to make some reduction in their alcohol use. In this circumstance, the clinician should check the person understands their recommendation for medically assisted withdrawal and personalised advice on the risks of cutting down (see section 8.5) and check that the person has mental capacity to make the decision in question.

The clinician needs to weigh the short-term risks of serious complications in withdrawal against the long-term health risks if the person continues to drink at their current level, taking all health factors into account.

Based on an individual assessment of risks and benefits, if the clinician assesses the risk of inducing withdrawal symptoms can be effectively managed, then a gradual limited reduction to an agreed level can be undertaken. Such a reduction would require:

- regular in-person reviews with the clinician
- recording alcohol use in daily drink diaries or using apps
- a suitable support person aware of the reduction and staying with the person

The clinician can return to the recommendation for medically assisted withdrawal at a later stage.

The clinician and the person can agree an individual plan for reduction and how often this should be reviewed. The clinician can follow all the advice given in sections 8.7 and 8.8 for people with moderate dependence. But people with severe dependence should cut down at a slower rate and be very aware of any withdrawal symptoms.

As there are higher risks for people with severe dependence, the specialist clinician or MDT should closely monitor the person as they reduce their alcohol use. If they start to experience uncomfortable withdrawal symptoms (such as sweating, shaking, anxiety and nausea), this means they are cutting down too quickly. In that case, they need to drink a steady amount for a week, then cut down by smaller amounts over a longer period of time.

As the risks are higher for people with severe dependence, it is particularly important to advise the person to have somebody to support them as they cut down. The clinician should make sure the person and the person supporting them understand they should call an ambulance

or go immediately to the hospital emergency department if they see signs of serious complications (see step 3 in section 8.8 below on serious complications in withdrawal).

If risks are assessed as too high to manage effectively

Based on an individual assessment of risks and benefits, if the clinician assesses the risk of inducing withdrawal symptoms cannot be effectively managed, they can advise the person to continue to drink at a steady rate, without sudden reductions or heavy drinking episodes. This will reduce the risk of withdrawal symptoms and serious withdrawal complications. They can support the person to work towards drinking at a steady rate and avoid binges using drink diaries or apps and regular meetings to review progress.

The clinician should continue to:

- monitor the person's health
- encourage the person to consider medically assisted withdrawal
- address any barriers the person may experience in opting for medically assisted withdrawal

8.7 Developing and monitoring a gradual alcohol reduction plan

8.7.1 Developing a plan

The clinician should develop a plan for gradual alcohol reduction with the person. The plan will include:

- monitoring the person's current level of alcohol use
- the agreed initial level of reduction (how may units they aim to reduce by) and pace of reduction (how many days they aim to remain at each level of consumption)
- arrangements for the clinician to monitor the impact of the reduction
- arrangements for psychosocial support (keyworker)
- arrangements for an appropriate family member or person to offer support
- arrangements for prescribing thiamine (see section 8.9 below)
- when working with parents or carers, arrangements for supporting children or vulnerable adults where appropriate
- planning activities to help distract the person from cravings
- plan for further interventions or support once the person has reduced their alcohol use

8.7.2 Working with parents and carers who are cutting down on drinking

When developing a plan with a parent or carer, you should help them to consider the support that their family or children might need during the period when they are cutting down their alcohol use. For example, where appropriate, whether the children (or any adult the person

is caring for) could stay with supportive relatives or friends, or whether professionals can offer support if necessary.

The practitioner should work with professionals involved with the family to co-ordinate care for the person and their family if this is needed. As always, practitioners should work in line with safeguarding legislation and organisational procedures. You can find information on child and adult safeguarding legislation and guidance in annex 1.

Family members and friends may also want to access support through organisations such as Al Anon UK and Adfam. Alcohol treatment services should provide advice and information for family members who are supporting the person.

8.8 The step-by-step approach to reducing alcohol consumption

The guidance on gradually reducing alcohol use in this section is based on clinical consensus of the alcohol guidelines development group.

This step-by-step approach is for people with moderate dependence on alcohol and have been assessed as suitable for gradual alcohol reduction by a specialist clinician.

If a specialist clinician or MDT has decided to offer planned alcohol reduction to a person with severe alcohol dependence or at higher risk of serious complications, the person should reduce at a slower rate than shown in the plan below and be very aware of any withdrawal symptoms.

Step 1: work out how much the person drinks

Work out how much the person drinks in a day. A drink diary or app can be useful to record this (see section 8.15 for examples of drink diaries and apps). You should ask them to be accurate and explain that minimising their own use can increase risk when deciding on the reduction rate.

Ask the person to write down each drink they have, when they have it and help them to find out how many units the drink has in it. They can work it out with an online or printed unit calculator (see section 8.15 for an example of a unit calculator). Alternatively, the percentage of alcohol on the side of the bottle or can represents the number of units in a litre. If the person agrees, a family member or friend could help with this.

Step 2: make a plan

Once the person knows how much they have been drinking, suggest they keep their drinking at that level for at least 3 days (and up to 7 days), before starting to cut down.

Agree with the person what level of consumption they are aiming to achieve.

Suggest they try to space out their drinks, particularly in the middle of the day. They should measure drinks using the same glass, measuring cup or can, or ask a family member to do this for them. Suggest they record how much they drink each day in a drink diary or on an app.

Offer your support as they cut down and arrange regular meetings and phone calls with the person to monitor their wellbeing and enhance their motivation (see step 5 on cutting down at their own pace below).

Suggest they ask an appropriate family member or friend to support them and encourage them to arrange regular in-person and phone contact with them. Remind them they can use organisations that offer online and telephone support. For example, the Alcoholics Anonymous helpline or national alcohol helplines (see section 8.15 below for more details on these resources).

With the person's consent, speak to the family member or friend and provide them with information about the process.

You should also tell the person and the family member that they should call an ambulance if the person seems to be experiencing serious withdrawal complications (see step 3 below).

If the person is a parent or carer, discuss the support needs of their family members (see section 8.7.2 on working with parents and carers above).

Step 3: tell them about serious complications in withdrawal

Advise them to watch out for serious complications, including:

- symptoms worsening to the point of severe shaking and very heavy sweating
- seizures (fits)
- seeing, hearing or feeling things that are not there (hallucinations or delirium tremens)
- feeling confused about where they are, what time it is, who they are with (symptoms of Wernicke's encephalopathy which can cause brain damage)
- poor co-ordination and unsteadiness on their feet or impaired eye movements (symptoms of Wernicke's encephalopathy)

If any of these serious complications occur, they or the person providing support should call an ambulance immediately.

Inform them and the person supporting them that changes in mood and volatility can sometimes occur during a reduction programme.

You should provide this information verbally and also in a written format that is easy for the person and their family member or appropriate support person to understand, taking into account their communication, literacy and language needs.

Step 4: provide advice on health and wellbeing during gradual alcohol reduction

Reassure them that although people often describe feeling frightened and alone when they are reducing or stopping drinking, it can help if they let their keyworker, friends and family know how they feel. Tell them they should try to distract themselves with things that they enjoy.

Tell them that sleep may remain a problem for a while, but that they should keep to a routine and be patient.

Prescribe oral thiamine or prescribe and administer thiamine intramuscularly (see section 8.9). If the person is prescribed thiamine orally, remind them to make sure they take it. Advise them to try and eat foods high in thiamine (B1), such as meat, fish, brown bread and rice. You can also suggest they keep well-hydrated by drinking plenty of water.

Advise them on relapse prevention strategies including managing urges and cravings and taking part in distracting and meaningful activities.

Provide advice sheets for the person and their family member or friend. For example, this could include information on:

- serious complications in withdrawal and actions to take if the person experiences these
- diet
- sleep
- cravings
- concentration and mood
- coping strategies

You should include contact numbers for the alcohol treatment service and for other support, such as helplines. Advice sheets should be easy for the person (and the person supporting them) to understand and take into account the person's language, literacy and communication needs.

Step 5: cut down gradually at their own pace

It's important to cut down gradually at a pace that suits the person but aim at cutting down by no more than 10% a day. If they are drinking more than 25 units a day, are aged 65 years and over or their general health is not good, they may need to cut down more slowly. For example, this could be no more than 10% every 4 days.

It is important that the person cuts down at a pace that suits them. They may want to reduce by 10% or less and stay at that level for several weeks or months. Help the person, and where relevant the family member or support person, to work out what 10% of their intake is in units and how much of their usual alcoholic drink that would be.

If they start to experience uncomfortable withdrawal symptoms (sweating, shaking, anxiety, nausea), this means they are cutting down too quickly. In that case, they need to drink a steady amount for several days again, then cut down by smaller amounts over a longer period of time.

Step 6: arrange regular and frequent review

Arrange regular and frequent review supported by a clinician to identify any withdrawal symptoms (see step 4 above) or worsening physical or mental health.

How often you review the person should be agreed with the senior clinician or MDT overseeing the reduction and providing the clinical monitoring.

Ask about withdrawal symptoms, any health problems and changes in their mood and volatility.

Escalate to the lead clinician and refer and support the person to access medical help if their physical or mental health worsens.

Offer motivational support and recognise the person's progress.

If the person is not managing to reduce their drinking, review the plan and amend if appropriate. Offer motivational support and help the person to address barriers to progress.

8.9 Prescribing thiamine to prevent Wernicke's encephalopathy and other neurological consequences

In people who drink at harmful or dependent levels over a period of time, there is a risk of both short and long term alcohol related brain damage, most often caused by Wernicke's encephalopathy.

Prescribing oral or intramuscularly administered thiamine can prevent or reduce the risk of Wernicke's encephalopathy and other neurological consequences, such as peripheral neuropathy.

Thiamine can be prescribed orally or intramuscularly in the community. You should prescribe thiamine based on individual assessment and the type of healthcare setting you are treating the person in. For intramuscular administration, staff should have the appropriate competencies, and the setting should be equipped to respond appropriately in the event of anaphylaxis.

Thiamine is recommended for people undergoing medically assisted withdrawal and also for people who continue to drink at harmful and dependent levels. You should read guidance on risk levels for Wernicke's encephalopathy and prescribing and administering thiamine in section 10.4.3 in chapter 10 on pharmacological interventions.

Chapter 20 provides comprehensive guidance on alcohol related brain damage.

8.10 Referral for liver screening test

The Office for National Statistics data set Alcohol-specific deaths in the UK shows the majority of deaths from conditions caused solely by alcohol are deaths from alcohol related liver disease. Symptoms of liver disease do not usually appear until the disease is at an advanced stage. Arranging referral for liver screening with a test that can detect fibrosis or cirrhosis can inform people at an earlier stage of the disease when further damage can be prevented. Abstinence is strongly recommended for people with liver disease.

NICE guideline Cirrhosis in over 16s: assessment and management recommends that anyone drinking at harmful (high-risk) levels (35 units or more per week for women, 50 units or more per week for men) for 3 months or more should be referred for transient elastography. Some areas use alternative tests for detecting cirrhosis.

Screening for alcohol related liver disease should include a measure of liver fibrosis (such as transient elastography), in addition to liver function blood tests, because normal liver blood tests do not exclude advanced fibrosis.

There is more detailed guidance on liver screening tests in section 19.5.2 of chapter 19 on co-occurring physical health conditions.

8.11 Managed alcohol programmes

Managed alcohol programmes are comprehensive harm reduction programmes of care that aim to support people with alcohol dependence or drinking at harmful levels to manage their alcohol use and its associated harms. These programmes involve alcohol treatment practitioners distributing an agreed amount of alcohol each day to support people to drink at a steady pace, alongside other forms of support. Drinking at a steady pace is less harmful than very heavy episodic drinking and periods of unplanned withdrawal.

These guidelines do not include guidance on managed alcohol programmes as there is currently little high-quality evidence on their effectiveness to base guidance on (Magwood and others, 2020). There are also few formal managed alcohol programmes in the UK, so few UK clinicians have gained clinical expertise in this area. The alcohol guidelines development group recommend that more research in this area would be useful.

8.12 Driving while under the influence of alcohol

The Driver and Vehicle Licensing Agency (DVLA) has published general information for medical professionals about assessing fitness to drive to help healthcare professionals and doctors understand their roles and responsibilities for assessing fitness to drive.

DVLA guidance states that 'persistent alcohol misuse and dependence' are conditions that can affect a person's fitness to drive safely so these should be reported to the DVLA in Great Britain or to the Driver and Vehicle Agency (DVA) in Northern Ireland.

The guidance says that applicants and licence holders have a legal duty to:

- notify DVLA (or DVA) of any injury or illness that would have a likely impact on safe driving ability
- respond fully and accurately to any requests for information from either DVLA (or DVA) or healthcare professionals
- comply with the requirements of the issued licence, including any periodic medical reviews indicated by DVLA (or DVA)

It also says that doctors and other healthcare professionals should:

- advise the person on the impact of their medical condition for safe driving ability

- advise the person on their legal requirement to notify DVLA (or DVA) of any relevant condition
- treat, manage and monitor the person's condition with ongoing consideration of their fitness to drive
- notify DVLA (or DVA) when fitness to drive requires notification but an individual cannot or will not notify DVLA (or DVA) themselves

The DVLA guidance acknowledges the challenge for healthcare professionals on issues of consent and to the relationship with their patient when notifying DVLA (or DVA) if a person cannot or will not notify DVLA themselves. It directs healthcare professionals to General Medical Council (GMC) guidance Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA.

Healthcare professionals considering notifying the DVLA (or DVA) of the person's condition should read the GMC guidance before taking this action.

The GMC guidance sets out the steps a doctor should take to inform decisions about disclosing relevant medical information directly to the DVLA or DVA when a person's failure or refusal to stop driving exposes others to a risk of death or serious harm. The guidance recognises the duty of confidentiality doctors owe to their patients, but also acknowledges their wider duty to protect and promote the health of patients and the public.

The DVLA has also produced specific guidance on assessing fitness to drive in people with drug or alcohol misuse or dependence.

This guidance will help clinicians to give appropriate advice to people with alcohol dependence or drinking at harmful levels.

People who drink heavily and daily may not appear or feel intoxicated because they will have developed tolerance to alcohol. Tolerance is the need to drink more alcohol to get the same or desired effect, and it develops in people who drink heavily and regularly. They are likely to be over the legal driving limit on a daily basis and should be advised not to drive and to notify the DVLA (or DVA) of their condition. The practitioner should explain that although they may not feel intoxicated, their functioning and judgment will still be affected.

8.13 Safety and security

Intoxication is associated with several risks to the safety and security of the person and those around them. There is a summary of harm reduction information and advice for reducing risks of intoxication in section 18.4.5.

Some people with complex needs, including older people who are frail, may require more than information. For example, they may require home visits from an outreach team or staff member, or a referral to adult social care so that their care needs and risks in the home can be assessed and a risk reduction plan put in place. If the assessment is carried out by another service like adult social care, the alcohol treatment service may need to advocate for the person and contribute their expertise on risks related to intoxication.

8.14 Harm reduction information and advice

This section on harm reduction information and advice is relevant for practitioners in alcohol treatment services and primary care settings. It is also relevant for staff in a range of other health and social care settings, such as homelessness services, who work with people with problem alcohol use.

8.14.1 How to provide harm reduction information and advice

Wherever possible, services should make available simple, clear, written alcohol harm reduction information and practitioners should understand this information and be able to provide advice verbally. Information should be available in other formats (such as graphic, video or audio) and in translation for people whose first language is not English. You should make this information and advice available so it can be provided at a one-off occasion to support a Making Every Contact Count approach. Services should provide harm reduction advice to everyone who comes into treatment for alcohol or for drugs, or for both alcohol and other drugs.

Alcohol treatment practitioners can also provide information and advice over several sessions (either individual or group) using a psychoeducational approach. A psychoeducational approach involves the practitioner providing information and support to the person so they can better understand and make changes in their alcohol use and associated problems. The information may be new to the person, and it can prompt conversation about risks and benefits associated with their alcohol use. This can help the person to make informed choices about ways to manage harms and risks as part of their personalised harm reduction plan.

You should offer to provide harm reduction information to family members or friends supporting the person. Some of the advice, such as actions to take in a medical emergency, will be addressed specifically to family members and friends.

8.14.2 Providing harm reduction information and advice on specific areas

When providing harm reduction information and advice, it is useful to include:

- information and advice for people with alcohol dependence not to stop or reduce drinking suddenly
- information and advice about tolerance and the risks of reduced tolerance following a period of abstinence or low risk drinking
- information and advice about intoxication and related risks
- information and advice about alcohol poisoning
- information and advice about concurrent alcohol use and prescribed medications or illicit drug use
- harm reduction information and advice for specific populations

8.14.3 Advising people with alcohol dependence not to stop drinking or reduce suddenly

People who are moderately or severely alcohol dependent will experience withdrawal symptoms after stopping drinking (as early as between 6 to 8 hours).

If they suddenly stop or substantially reduce their alcohol use, they will experience acute alcohol withdrawal syndrome, which can lead to severe complications and can even be fatal.

There is a comprehensive list of alcohol withdrawal symptoms and complications in annex 3.

When advising people with alcohol dependence not to stop drinking or reduce their alcohol use too quickly, the practitioner should:

- describe withdrawal symptoms and explain they are a sign of alcohol dependence
- advise them that they should not suddenly stop drinking or substantially reduce their alcohol use too quickly
- advise them that stopping suddenly or reducing their alcohol use too quickly can lead to severe complications and can even be fatal
- briefly describe severe complications and how to recognise them
- advise them and anyone who supports them to call an ambulance if the person experiences severe withdrawal complications
- inform them that the safest way to stop drinking and the best treatment advice is to have a medically assisted withdrawal (detox)
- inform them you can offer or refer the person for an assessment by an alcohol specialist clinician for medically assisted withdrawal

If the person with alcohol dependence does not want to stop or reduce their drinking, the practitioner should advise them to maintain their drinking at a steady level and space out drinks evenly to help reduce the occurrence of withdrawal symptoms and risk of serious complications in withdrawal.

If the person does not want a medically assisted withdrawal, but they plan to reduce their drinking, see section 8.5 for guidance on assessment for planned gradual reduction.

8.14.4 Reduced tolerance and risks of intoxication including alcohol poisoning

Tolerance is the need to drink more alcohol to get the same or desired effect, and it develops in people who drink heavily and regularly. The effect of blood alcohol content on a person will decrease as tolerance develops. Although, even in people who have developed tolerance, a high level of alcohol use will still impair functioning and judgement. NICE CG115 (full guideline) found that people with very high alcohol tolerance are able to tolerate a high blood alcohol content that would be fatal to a person without tolerance to alcohol.

After a period of abstinence, tolerance is greatly reduced. If a person returns to drinking at their pre-abstinence level, the effects of blood alcohol content will be much greater than they were before they became abstinent. They will experience increased risks related to intoxication and they may even experience fatal alcohol poisoning. People who have had an

unplanned period of abstinence, for example during time in custody or in hospital, can be particularly at risk of returning to drinking at pre-abstinence levels.

The practitioner should provide information and advice to the person on tolerance and alcohol poisoning, including:

- what tolerance is and how it develops
- how tolerance is reduced after a period of abstinence
- how the risks of intoxication, including alcohol poisoning, increase after a period of abstinence (see section 8.14.5 below on intoxication and related risks)
- the increased risk of taking other drugs in addition to drinking after a period of abstinence (see section 8.14.7 on concurrent use of prescribed medications or illicit drugs)

8.14.5 Intoxication and related risks

Intoxication from drinking too much and too quickly may involve significant impairments in:

- motor co-ordination
- reaction time
- judgement and decision-making
- impulse control

It can also involve:

- drowsiness
- digestive problems
- dehydration

At higher levels of blood alcohol content there is a risk of alcohol poisoning.

The level of consumption that leads to significant impairment will vary according to factors such as:

- body size
- whether the person has eaten
- tolerance
- health, including liver function

Intoxication can be associated with several risky behaviours and expose people to risks from others (see section on mitigating risky behaviour while intoxicated below).

Intoxication: information and advice

The practitioner should provide information and advice about intoxication that includes:

- a summary of the UK chief medical officers' alcohol guidelines on lower risk, increasing risk, high risk drinking levels and single occasion drinking
- a summary of common short-term risks, such as injuries (including head injuries), falls, road traffic accidents, accidents with machinery, drownings and burns
- a summary of common increased risky behaviours, such as unsafe sex which can result in unplanned pregnancies or sexually transmitted diseases
- information about a person's increased risk of violence (as a perpetrator), including domestic violence
- information about a person's increased vulnerability to domestic abuse (as a victim) and to sexual assault
- information about a person's increased risk of self-harm (including suicide)
- information about the increased risk of problems at work including absence

Managing alcohol use: information and advice

Information and advice on managing alcohol use can include:

- drinking at a slower pace, including avoiding drinking in a round where there can be pressure to drink at a faster pace
- alternating between alcoholic drinks with soft drinks or water
- drinking lower strength drinks
- eating before drinking
- start drinking later or finishing earlier
- avoiding areas or activities associated with heavy drinking or heavy drinking social networks
- drinking with people who drink at lower risk levels, where possible
- avoiding taking alcohol and drugs together

Mitigating risky behaviour while intoxicated

Information and advice on mitigating risky behaviour while intoxicated should be individually tailored and can form part of a treatment and recovery plan. Examples include advice on:

- avoiding drink driving or operating machinery (see section 8.12 for responsibilities of staff relating to drink driving)
- arranging with a supportive friend or family member to stay together during the evening, and travel home together
- installing smoke detectors and removing trip hazards in the home (for people who are frequently very intoxicated and for older people who are at greater risk of falls)

- information about local sexual health services and what they provide
- discussing contraception and the risks of alcohol exposed pregnancies (see section 8.14.9 on women who are pregnant or could become pregnant)
- specific advice for people who are at risk of domestic abuse (see chapter 22 on domestic abuse)
- specific advice and support on self-harm including suicidal ideation (for guidance on providing information and support for people who self-harm, see the NICE guideline Self-harm: assessment, management and preventing recurrence)

8.14.6 Alcohol poisoning

Alcohol poisoning (sometimes known as alcohol overdose) can result when a person drinks a toxic amount of alcohol, particularly if this takes place over a short space of time. This leads to high blood alcohol levels which the liver cannot process. The level of consumption that leads to alcohol poisoning will vary according to factors such as:

- body size
- health, including liver function
- tolerance

However, drinking above 12 units, especially during a short space of time, is a broad indicator of risk of alcohol poisoning.

Alcohol poisoning may be experienced by people who are relatively inexperienced with alcohol use and unaware of its toxic effects. However, people with alcohol dependence can also experience alcohol poisoning and there is an increased risk of this if they drink heavily following a period of abstinence where their tolerance to alcohol has decreased (see section 8.14.4 on reduced tolerance and risks of intoxication including alcohol poisoning).

Alcohol poisoning affects the automatic functions of the body, including breathing, heart rate and gag reflex (which prevents choking), so it puts the person at risk of a coma and of death.

Signs and symptoms of alcohol poisoning

Signs and symptoms of alcohol poisoning may not all be present at the same time. They include:

- confusion
- vomiting
- seizures (fits)
- slow breathing
- pale or bluish skin
- cold and clammy skin

- unconsciousness

Alcohol poisoning: information and advice

As well as describing the signs and symptoms of alcohol poisoning, practitioners should provide information and advice on alcohol poisoning including telling people that:

- they can experience alcohol poisoning if they drink a large amount in a short space of time and that they should pace their alcohol use (see section 8.14.5 on intoxication and related risks)
- a person with suspected alcohol poisoning is a medical emergency and whoever is with them should call an ambulance immediately
- a person with suspected alcohol poisoning should not be left alone
- a person with suspected alcohol poisoning should be helped to stay upright and awake if possible and helped to drink water if possible
- if a person with suspected alcohol poisoning is unconscious, they should be placed on their side with their ear to the ground with a cushion under their head (the recovery position)
- a person with suspected alcohol poisoning should not be made to vomit as there will be a risk of choking (as the gag reflex is not functioning)
- symptoms of alcohol poisoning may worsen even after the person has stopped drinking and is unconscious

8.14.7 Concurrent use of alcohol and prescribed medications or illicit drugs

Identifying a person's concurrent alcohol and substance use

Advice on concurrent use of alcohol and prescribed medications or illicit drugs (drinking and taking drugs together) will usually be provided by qualified staff at specialist alcohol and drug treatment services. In these services, identifying a person's concurrent alcohol and substance use should take place at initial assessment and subsequent treatment reviews. There are many different interactions between prescribed medication and illicit drugs, so a clinician should make an individual assessment of the risks to the person and provide them with tailored advice. The British National Formulary provides information on interactions between alcohol and prescribed medicines.

The alcohol or drug treatment practitioner should support the person to reduce risks related to concurrent use of alcohol and prescribed medications and illicit drugs. They may need to agree additional treatment plans focused specifically on drug use. Section 10.6.1 in chapter 10 on pharmacological interventions provides guidance on pharmacological interventions for concurrent alcohol and illicit drugs or prescribed medications. Drug misuse and dependence: UK guidelines on clinical management provides guidance on drug use, including alcohol in drug treatment, in section 6.5.

Staff in other health and social care services should inform a person suspected of concurrent use that taking alcohol and drugs together can increase risks of overdose and other serious health risks. They should also offer the person referral to an alcohol and drug treatment service.

Concurrent use of alcohol and prescribed medications or illicit drugs: information and advice

Information and advice on concurrent use of alcohol and prescribed medications or illicit drugs should include the:

- increased risk of overdose due to reduced tolerance following a break in regular or dependent use of alcohol or an illicit substance or prescribed medication
- risks related to concurrent use of alcohol and specific illicit drugs and prescribed medication
- additional risks when both alcohol and drugs are used together

You can read guidance on risks related to specific illicit drugs and prescribed medications in 'Drug misuse and dependence: UK guidelines on clinical management'.

Information and advice on additional risks of using alcohol and illicit drugs or prescribed medications should include:

- risk of overdose from using sedative medications and depressant drugs with alcohol (this includes both prescribed drugs and those obtained illicitly, for example pregabalin, gabapentin, benzodiazepines and opioids, including opioid substitute medications methadone and buprenorphine)
- using illicit drugs such as heroin, or drugs sold as having the look of genuine prescribed medications have an additional risk as their strength and effects can vary
- alcohol and opioids (including methadone or buprenorphine) taken together increase the risk of slowing your rate of breathing, which can lead to death
- physical health harms of stimulant drugs, especially cocaine when it is taken with alcohol

Cocaethylene is formed by the liver when cocaine and ethanol coexist in the blood. Some evidence shows that cocaethylene is more cardiotoxic than the sum of the risks associated with cocaine and the risks associated with alcohol if they are used separately. Concurrent cocaine and alcohol use can increase euphoria, increase the heart rate and increase risk of overdose. Long term concurrent cocaine and alcohol use can increase the risk of heart attacks and strokes.

8.14.8 Smoking

There are high rates of smoking among people with problem alcohol use. The combined impact of smoking and drinking to excess increases various health risks. Practitioners in alcohol treatment services should be competent to provide or to support referral to stop smoking interventions.

You can find advice on smoking in section 19.6 in chapter 19 on people with co-occurring physical health conditions.

8.14.9 Specific populations

Practitioners can also provide harm reduction information tailored to specific populations.

Older people

The ageing process makes people more susceptible and at risk of the physical and mental health harms caused by alcohol (RCPsych, 2018).

In addition to general harm reduction information, there are harms that older people are more likely to experience. These harms are described in section 25.8 of chapter 25 on developing inclusive services. Services should have written information tailored to older people and practitioners should be trained to provide this information verbally to older people.

Women and those who are pregnant or think they could become pregnant

The UK chief medical officers' low-risk drinking guidelines is that it is safest for women who are pregnant or think they could become pregnant to completely avoid alcohol to keep risks to the fetus to a minimum.

Practitioners should provide information on the risks of alcohol use in pregnancy and advise women and those who are pregnant or think they could become pregnant to avoid alcohol. However, midwives, alcohol treatment practitioners and other healthcare professionals should advise women and those who are (or who could be) alcohol dependent not to stop drinking suddenly. This is because withdrawal complications risk harm to the fetus and the mother. They should rapidly refer the woman to specialist alcohol treatment to be assessed for medically assisted withdrawal (so they can stop drinking safely) and to specialist antenatal care if they are not already engaged with this. They will also need to make a safeguarding referral if the unborn child is at risk of significant harm.

You should read section 24.5.2 in chapter 24 on pregnancy and perinatal care on providing advice on avoiding alcohol use in pregnancy.

Young people

Young people and practitioners can find harm reduction information tailored to young people on the FRANK website.

See also chapter 23 on alcohol treatment and support for young people for more information on harm reduction.

8.15 Harm reduction resources

8.15.1 Helplines and meetings

Alcoholics Anonymous a free confidential helpline and website with information on local mutual aid meetings for people who need help with their drinking.

Drinkline, a free, confidential helpline for people who are concerned about their drinking, or someone else's. Call 0300 123 1110 (weekdays 9am to 8pm, weekends 11am to 4pm).

If you are in Scotland, you can contact Drinkline Scotland for free on 0800 7314 314 (weekdays 9am to 9pm, weekends 10am to 4pm).

Wales DAN 24/7 is a bilingual drug and alcohol helpline. Call free on 0808 808 2234 or text DAN to 81066. DAN 24/7 calls will not appear on home itemised call lists.

SMART Recovery holds both face-to-face and online meetings that support people in managing harmful drinking and other behaviours. You can find out about meetings on the SMART Recovery website.

8.15.2 Alcohol unit calculator

There are several interactive tools to help people check how much they're drinking. This includes Alcohol Change UK's unit calculator, which allows people to find out how many units are in a particular drink or to check out how much they're drinking on a weekly basis.

8.15.3 Drink diaries and apps

Encouraging people to self-monitor and record their alcohol use is a useful intervention. It can help with assessment, and it can also help people to have more self-awareness around drinking situations and to understand the consequences of their drinking.

People can record information on paper diary sheets or using digital apps. The diaries can be individually tailored to the person's treatment needs and the interventions they are receiving, but would typically include:

- the date and time
- a description of the drinking circumstances
- the amount they drank in units or drinks
- the person's thoughts and feelings
- the consequences of drinking

Alcohol Change UK's free Try Dry app is for people who want to cut down their drinking or who want to work towards abstinence. It helps people to track the units they drink, as well as calories consumed and money saved when they cut down. It helps people see their drinking patterns and provides a space to monitor thoughts, moods and cravings as well as sleep.

8.15 References

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Witkiewitz K, Kranzler HR, Hallgren KA and others. Stability of drinking reductions and long-term functioning among patients with alcohol use disorder. Journal of General Internal Medicine 2021: volume 36, pages 404 to 412.

9. Alcohol assertive outreach and a multi-agency team around the person

How alcohol assertive outreach can engage and support vulnerable people with alcohol dependence who experience multiple disadvantage. This includes co-ordinating care through multi-agency teams to address complex needs and reduce health inequalities.

9.1 Main points

Assertive outreach involves a service making proactive and persistent attempts to contact a person and build a relationship with them, using a trauma-informed approach.

Assertive outreach removes some of the barriers to treatment by bringing the service to the person in settings where they feel comfortable and that they can access easily.

Commissioners and services developing assertive outreach should identify vulnerable people in their local area with alcohol dependence with high levels of need and risk and agree referral pathways into the outreach service with partner agencies. Very vulnerable people with problem alcohol use who experience multiple disadvantage are often known to several local services. They may have repeated contacts with acute and emergency services but are often not engaged in planned treatment. They are also unlikely to engage with alcohol treatment services without targeted support.

Vulnerable people with problem alcohol use who experience multiple disadvantage need integrated care that addresses their various needs in a co-ordinated way.

Assertive outreach combined with a multi-agency team around the person are ways to engage and provide care tailored to the needs of vulnerable people with problem alcohol use who experience multiple disadvantage.

This approach can also be used to engage and provide care for specific groups of people with high levels of need who are unable or unlikely to attend a service base, including:

- people who attend hospital frequently for alcohol related conditions
- people with severe alcohol related illness
- groups of people who experience marginalisation and have very poor health outcomes, such gypsies, Roma and travellers

A multi-agency team around the person involves agencies working together to share information and co-ordinate integrated care for vulnerable people with high levels of complex need. You can read more about what a multi-agency team around the person means in section 9.7.

Many local areas co-ordinate care and manage risks for vulnerable people (including those with alcohol dependence or who drink harmfully) through multi-agency forums that meet regularly.

A multi-agency team around the person should provide joint assessment and management of risk and share information based on agreed information sharing arrangements.

Assertive outreach practitioners and services should tailor interventions to the needs of vulnerable people with alcohol dependence who experience multiple disadvantage. They can do this using a harm reduction approach if the person is not ready to change their alcohol use.

9.2 Introduction

This chapter offers guidance on providing alcohol assertive outreach as part of a multi-agency team to support vulnerable people with problem alcohol use and high levels of unmet need and reduce the health inequalities they experience.

An assertive outreach approach is a way of working where practitioners offer support and deliver interventions wherever it is most appropriate, rather than asking a person to engage with treatment in a particular service or place. After a person has been referred to the assertive outreach service, practitioners make proactive and persistent ('assertive') attempts to contact them to help them to engage with support (see section 9.6).

A multi-agency team around the person is a way of working that involves services and organisations working together to share information and co-ordinate integrated care for vulnerable people with high levels of complex need (see section 9.7).

You should read this chapter with chapter 21 on people experiencing homelessness, which provides more extensive guidance on providing appropriate care for that group of people.

9.3 Evidence

There is evidence from a systematic review that assertive outreach for people with severe mental illness is effective (Dieterich and others, 2010).

There is also evidence that a combination of assertive outreach and a multi-agency team around the person can be effective in helping vulnerable people with alcohol dependence with harmful patterns of drinking achieve a range of positive outcomes. This evidence includes:

- a limited number of peer reviewed studies
- large scale programme evaluations
- small scale service evaluations

The studies identify positive outcomes (Drummond and others, 2017; CFE Research and the University of Sheffield, 2022; Bailey and others, 2020; Mohan and others 2022). These include:

- an increase in treatment engagement
- reduced alcohol use
- increased wellbeing
- reduced emergency service use
- fewer hospital admissions

9.4 Who assertive outreach and a team around the person can support

An assertive outreach approach combined with a multi-agency team around the person can help very vulnerable people with problem alcohol use who experience multiple disadvantage or have particularly high levels of unmet need.

In these guidelines, multiple disadvantage is defined as the co-occurrence and interaction of adverse circumstances leading to social exclusion, marginalisation and extreme inequality.

Complex, intersecting issues that can contribute to compounded disadvantage include:

- health inequalities
- poverty
- housing instability
- systemic discrimination
- family and individual history, including adverse (traumatic) childhood experiences

As well as problem alcohol use, people can experience a range of other problems, for example:

- other substance use
- mental or physical health conditions
- domestic abuse
- sexual exploitation and violence
- interaction with the criminal justice system

An approach that combines alcohol assertive outreach and a multi-agency team around the person supports people who:

- experience alcohol dependence or harmful drinking
- have very high levels of unmet need (physical and mental health, social care, safeguarding, or housing and material resources)
- have not engaged or have not benefited from alcohol treatment services
- may be at a high level of risk or pose risk to others
- lack or may lack mental capacity to make the 'decision in question' (see glossary), or need support to make decisions about their care

In each local area there will be a relatively low number of very vulnerable people with alcohol dependence who experience multiple disadvantage and are not engaged in ongoing treatment and support but may be known to acute and emergency services. Numbers of people will vary across regions and local areas, and are likely to be higher in areas with high levels of deprivation.

Based on local need, commissioners and services can use assertive outreach to engage local groups of people who experience marginalisation and poor health outcomes and who are

underrepresented in alcohol treatment services. Groups can include, for example, sex workers, vulnerable migrants, or gypsies, Roma and travellers.

Local areas can focus on people living in areas of socioeconomic deprivation who experience health inequalities. For example, the Primary Care Alcohol Nurse Outreach Service targets people in selected GP practices that serve the 100 most deprived communities across Scotland.

Hospital based assertive outreach teams can target people who attend hospital frequently for alcohol related reasons. Community teams with medical or nursing staff can also target people with severe alcohol related health conditions, particularly alcohol related liver disease, who are too unwell to access the treatment service easily.

9.5 Developing targeted referral pathways

Commissioners and services need to identify vulnerable people experiencing multiple disadvantage with high levels of need, who are not engaging in alcohol treatment services. They should then develop targeted referral pathways into the assertive outreach service in agreement with partner agencies.

Identifying people who might benefit from assertive outreach and agreeing referral pathways will often involve emergency and acute services or the police and community safety services. This group of people is more likely to have contact with acute and emergency services than planned care. Other relevant services include:

- services for people experiencing homelessness
- primary care
- community mental health services
- criminal justice services
- services for domestic abuse or sexual violence or exploitation
- third sector community services and organisations for particular groups of people
- peer support services and organisations

Some areas have established multi-agency forums for managing care for vulnerable people with alcohol dependence or other groups of people with high levels of risk. They can use these forums to identify people who are known to member agencies but not in contact with alcohol treatment services (see section 9.7.2 on setting up multi-agency forums).

There is also evidence to suggest that community alcohol treatment services can identify people who may currently benefit from assertive outreach by looking at people with previous unsuccessful alcohol treatment episodes (Passetti and others, 2008).

You can find guidance on developing targeted pathways for groups of people who are under-represented in services in chapter 25 on developing inclusive services.

9.6 Assertive outreach

9.6.1 Making it easier to access treatment

Vulnerable people experiencing multiple disadvantage or very high levels of need often find it extremely difficult to access or remain in treatment. For example, they might fear treatment services based on previous negative experiences or have difficulty forming trusting relationships because of past trauma. They might also experience barriers that are service-related, such as stigmatising services with inflexible opening times or procedures for missed appointments.

An assertive outreach approach helps to remove these barriers by meeting people in settings that are familiar to them. This could be at their home, in a community venue or in services they already attend, such as services for people experiencing homelessness.

9.6.2 How assertive outreach works

After a person has been referred to the assertive outreach service, practitioners make proactive and persistent ('assertive') attempts to contact them to help them to engage with support. With the person's consent, practitioners can contact the person at least once a week And they should continue to make supportive contact even if the person does not attend agreed meetings.

Practitioners should be flexible in the way they make contact and communicate about appointments. They can use whatever method the person prefers, including text, phone, email, letter and in-person visits, in a setting the person finds comfortable. In-person meetings are important to build a therapeutic relationship, but practitioners can use other methods to make initial contact and to support in-person meetings. Services can also support engagement in practical ways, such as providing transport costs or phone data.

Large scale service evaluations and qualitive research show that a supportive relationship between the assertive outreach practitioner and the person is central to this approach (CFE Research and others, 2021; Ward and Holmes, 2016). Hard Edges: mapping severe and multiple disadvantage in England found many people experiencing multiple disadvantage have experienced trauma as children. This often means that as adults they find it difficult to form trusting relationships. It is important that practitioners take an empathic, trauma-informed approach and focus on developing a relationship with the person at the person's pace, which is likely to take some months, and in some cases, years.

You can read more about using a trauma-informed approach in the Office for Health Improvement and Disparities Working definition of trauma-informed practice (for England) and A roadmap for creating trauma-informed and responsive change: guidance for organisations, systems and workforces in Scotland.

9.6.3 Role of assertive outreach practitioners

The role of the assertive outreach practitioner providing in-person support is central to the assertive outreach approach, but they do not work alone. The practitioner should always be part of a multidisciplinary team or supervised by a member of a multidisciplinary team. Examples include a multidisciplinary team:

- in the alcohol treatment service
- in another relevant service, like a homelessness service, a hospital 'frequent attenders' service or a primary care nurse outreach service
- working specifically with people with multiple disadvantage or with specific groups of people experiencing marginalisation

Assertive outreach practitioners should also be working in a co-ordinated way with other services and systems in contact with the person, through the multi-agency team around the person.

9.6.4 Aims of assertive outreach

The aims of assertive outreach are to:

- engage people who experience barriers to accessing or completing treatment
- support the person's motivation to make changes in their alcohol use and other areas of their life
- encourage the person's belief in their ability to change
- reduce harm and manage risk
- support people to build on strengths and protective factors in their lives, including reconnecting with family members where appropriate
- tailor components of care and specific interventions to meet the person's needs
- help people to access other services they need
- co-ordinate care and contribute to a co-ordinated multi-agency approach
- work with family members or friends where appropriate and with the person's consent
- support people to access peer support
- prepare people for structured treatment and recovery where appropriate

9.6.5 Different models of assertive outreach

There are different models of alcohol assertive outreach. For example, it could be provided by:

- a community alcohol treatment service
- a hospital alcohol care team or hospital 'frequent attenders' service
- a multidisciplinary homeless health service that includes specialist alcohol treatment practitioners
- a primary care nurse outreach service

- an outreach service for people experiencing multiple disadvantage that includes specialist alcohol treatment practitioners

These services may be public or third sector services and some include peer led or peer-delivered outreach interventions.

This chapter does not consider specific models but provides guidance relevant to most alcohol assertive outreach services, which have several components in common.

9.6.6 Essential components of alcohol assertive outreach

A national survey of alcohol assertive outreach teams proposes the following 6 essential components of alcohol assertive outreach (Fincham-Campbell and others, 2018):

- a maximum caseload of between 10 and 20 patients per practitioner
- input from a multidisciplinary team in form of input from at least 3 different professions including nurses, medical and psychology or community support and drug workers
- regular contact between patient and practitioner (at least once a week)
- at least 50% of contacts occurring outside of the service settings, either in patients' homes or local community settings
- a focus on both health and social care needs, including accommodation, finance, leisure, occupation, and physical and mental health
- extended care provided for a prolonged period of 12 months

Programme evaluations of projects working with people experiencing multiple disadvantage have identified that caseloads as low as 6 to 10 may be needed when working with people who experience the most severe and multiple disadvantage (CFE Research and others, 2021). Practitioners may need to contact people mostly in their homes or in the community (at least 50% of the time as noted above) for a prolonged period of time (Drummond and others, 2017).

9.7 A multi-agency team around the person

9.7.1 What a multi-agency team around the person does

Vulnerable people with problem alcohol who experience multiple disadvantage and have high levels of need are usually known to local services, but they are often not engaged in ongoing treatment and support. They are more likely to use acute or emergency services than planned health and social care. And where they are engaged with acute and emergency services, these may be only responding to one of their problems.

Vulnerable people with problem alcohol use who experience multiple disadvantage need co-ordinated and integrated care that addresses all their needs and risks. Section 21.4 in chapter 21 on people experiencing homelessness provides more guidance on integrated care (for people experiencing homelessness, but also relevant to other vulnerable people). Developing

and maintaining a multi-agency team around the person is a way of providing integrated care for vulnerable people with high levels of need and risk.

A multi-agency team around the person:

- shares and records information about the person between services based on local information sharing agreements
- jointly assesses the person's needs and risks
- co-ordinates and jointly plans the management of the person's care and involves the person wherever possible in the planning
- co-ordinates and jointly manages risks to the person or risks they pose to others and involves the person in risk management (safety) planning wherever possible
- agrees who is the main care co-ordinator for the person
- allocates and reviews tasks to member agencies and reviews progress
- meets regularly to jointly review the person's care
- co-ordinates, so the person can access all the care they need from the minimum number of services possible

9.7.2 Setting up multi-agency forums

A multi-agency team around the person that carries out the functions listed above can be organised in different structures.

Commissioners and service providers can work together across local systems to set up multi-agency forums that can receive referrals and co-ordinate integrated care for the most vulnerable people with problem alcohol use and high levels of unmet need. Involving clinical and strategic leadership is important to maximise the effectiveness of multi-agency forums.

Multi-agency forums bring together services that come into contact with this group of people and meet regularly to co-ordinate care for each person referred to the forum. The forums share information and professional expertise. Forum member services that are relevant to each person's needs will form a team around the person and agree a co-ordinator for the team. They will then work together to provide care for the person outside of the regular meetings of the forum and report back to the forum regularly.

Multi-agency forums regularly review care for individuals so they will identify problems with pathways between services. They will also identify policies and procedures that make it difficult for vulnerable people with problem alcohol use and high levels of need to access appropriate care. Forum members can then work together to remove some of these barriers.

Local areas may choose to establish multi-agency forums that are solely for integrating care for vulnerable people with problem alcohol use and high needs and risks. An example of this is the Blue Light model designed by Alcohol Change UK.

Some local areas may have established multi-agency forums to co-ordinate care for vulnerable adults. This might be, for example, a multi-agency adult safeguarding hub or forum to co-ordinate care for people experiencing multiple disadvantage. An example of the latter are forums established by some of the Fulfilling Lives project partnerships (CFE Research and others, 2021) and the Changing Futures partnerships, outlined in the Ministry of Housing, Communities and Local Government's Evaluation of the Changing Futures programme.

Commissioners of alcohol treatment services can propose that these types of forums include referrals and multi-agency care co-ordination for vulnerable people with problem alcohol use and high levels of need and risks.

In areas with no appropriate multi-agency forum, services in contact with very vulnerable people with high needs and high risks should have an alternative system in place. This is so the practitioner who is co-ordinating care can quickly arrange a multi-agency risk management meeting about a particular person. Services should then agree ongoing joint working arrangements that include regular multi-agency review meetings.

Various things need to be made clear when setting up a multi-agency forum, including:

- terms of reference
- membership
- referral procedures
- task allocation
- procedures for members to report information to the forum
- information sharing agreements
- escalation process if disagreements among members cannot be resolved

9.7.3 Information sharing

Information sharing is crucial to co-ordinating care and managing risk for vulnerable people with problem alcohol use experiencing multiple disadvantage. They may only have sporadic contact with several agencies and without effective information sharing, each agency might be unaware of information that another agency is holding. An analysis of adult safeguarding reviews has shown that lack of information sharing is often a factor when serious incidents occur.

There should be formal information sharing agreements and mechanisms between all organisations involved in the multi-agency forum and with any organisation the person is referred to. The agreement should make clear how information will be shared at regular reviews and between regular reviews if the person's situation or risks change. Where possible, it is helpful for partner agencies to have access to a shared electronic case record.

9.8 Care for vulnerable people experiencing multiple disadvantage

9.8.1 Overview

Alcohol services and assertive outreach practitioners should offer the same components of care that the service offers to people attending standard community alcohol treatment. But they will need to do this in a way and at a pace that is tailored to the complex needs of vulnerable people experiencing multiple disadvantage or with very high levels of need. They will need to be flexible in their approach so they can engage people effectively in support and treatment.

The following sections give some examples of tailoring care to meet the individual needs of very vulnerable people experiencing multiple disadvantage.

9.8.2 Assessing the person's needs

The assertive outreach practitioner should aim to follow the guidance in chapter 4 on specialist assessment but will need to work very flexibly to carry out the assessment, using an informal approach.

Assertive outreach practitioners (or designated lead professional if this is someone else) should gather information from other agencies in the multi-agency team around the person as part of a joint assessment of need and risk to provide a comprehensive picture. Wherever possible, they should do this with the person's consent. But in some situations where the person is at risk or poses risks to others, they can share information without the person's consent.

Gathering information from partner agencies can help to reduce the number of questions about sensitive personal issues that the practitioner needs to ask the person when they first meet. This can help to reduce stress for the person.

The assertive outreach practitioner should:

- carry out the assessment in an informal and conversational way
- keep paperwork to a minimum during the appointment (although they should record their notes after the meeting)
- tailor the duration of each appointment to the needs of the person and not expect the person to engage for a full hour if this is difficult for them

Once they have gathered information on urgent needs and risks, the practitioner may need to carry out the rest of the assessment very gradually and informally over several meetings. This will allow time to build trust and help the person to feel safe before discussing sensitive personal issues.

It is important that the practitioner shows they believe in the person's ability to make changes from the beginning and throughout their contact.

9.8.3 Assessing and managing risk

While tailoring their approach to the person, the assertive outreach practitioner should aim to follow guidance in chapter 4 on assessment and treatment and recovery planning in:

- section 4.8 on initial assessment of risks and urgent treatment or support needs

- section 4.10.4 on multidisciplinary and multi-agency treatment and recovery plans

Very vulnerable people with problem alcohol use experiencing multiple disadvantage often pose high levels of risk to themselves and sometimes pose high levels of risk to others. This means assessing and managing risk is vital. One of the main functions of the team around the person is to carry out a multi-agency risk assessment and agree a multi-agency risk management (safety) plan, involving the person in this process wherever possible. Where appropriate they should also involve family members who can offer an additional perspective and information. Services should inform partner agencies whenever there is a change in risk, in line with their local information sharing agreement and they should review the risk management plan regularly.

9.8.4 Understanding and using adult safeguarding and legislative frameworks

Assertive outreach practitioners working with vulnerable people experiencing multiple disadvantage should understand and act in line with the relevant national legal frameworks.

Practitioners should follow their organisational procedures on:

- adult safeguarding
- child safeguarding
- mental capacity
- mental health
- domestic abuse

All of these can often apply with this group of people. There is information on these frameworks in annex 1 on legislation and guidance across the UK.

Information sharing is vital where there are risks to the person or to others. While it is good practice to ask for the person's consent to share information, practitioners can share information without consent in certain cases where:

- there are adult or child safeguarding concerns
- the person lacks mental capacity to make decisions about information sharing
- the person is in a mental health crisis and is at risk or posing risk to others

Services should have organisational procedures for managing these situations, including procedures for sharing information without consent.

9.8.5 A harm reduction approach

Taking a harm reduction approach

The alcohol practitioner and the person should consider setting alcohol use goals as part of the person's treatment and recovery plan (sometimes called support plan). This should be based on a comprehensive multidisciplinary assessment and tailored to the person's current situation.

A harm reduction approach will often be appropriate for very vulnerable people with problem alcohol use and experiencing multiple disadvantage who may not be ready to make changes in their alcohol use.

You can read guidance on alcohol use goals, including a harm reduction strategy, in section 4.7 in chapter 4 on assessment and treatment and recovery planning.

A harm reduction approach aims to reduce immediate and longer-term harms, risks and health inequalities that the person is experiencing. It involves actions to address a person's:

- physical health
- mental health
- social care needs, including housing needs

The person may not be ready to reduce or stop their alcohol use initially, but meeting these needs is a positive outcome. This can encourage the person and increase their motivation to engage in alcohol treatment at a later stage.

You should read chapter 8 on a harm reduction approach for people with alcohol dependence.

Making changes in alcohol use

A focus on reducing harms may be the most useful way to work with a vulnerable person experiencing severe multiple disadvantage. But practitioners should never assume that the person is unable to make significant reductions in their alcohol use or achieve abstinence. Practitioners should regularly review a person's goals with this in mind and adjust the goals as appropriate.

Some people may not opt for a medically assisted withdrawal but may want to make a limited reduction in their alcohol use. If the person is (or may be) alcohol dependent and they want to make a limited reduction in their alcohol use, a clinician should assess the person to assess the risks of serious complications in withdrawal. They should also advise on an appropriate plan before the person is encouraged to reduce. You should follow the detailed guidance on this in chapter 8 on:

- assessing the suitability and safety of a gradual reduction in alcohol use (section 8.5)
- supporting people with different severity of dependence levels (section 8.6)

Where the person continues to drink at harmful or dependent levels, the service should regularly review their health and take action to address any deterioration.

9.8.6 Linking people to other services

Linking people to relevant services and helping them to navigate complicated systems is often a vital part of the role of an assertive outreach practitioner.

Practitioners should be aware of local support pathways and, where relevant, assertively link the person to:

- primary and secondary healthcare services, including mental health
- social care
- the criminal justice system
- housing support
- domestic abuse services
- peer support services and mutual aid
- local community organisations

Assertively linking the person to these other services means that the practitioner:

- provides the person with information on the service tailored to their individual needs
- helps the person to talk through their anxieties
- helps the person to complete any forms required by services, or completes the forms on their behalf
- helps the person to make an appointment or makes the appointment for them
- introduces the person to the professional they will see by phone or in person
- sends text or phone reminders
- accompanies the person to the appointment
- arranges with a peer to accompany the person to the appointment where possible
- provides transport tickets where needed

Practitioners may need to advocate for the person, providing the other services with information on what might help the person to engage. They may also need to ask the services for some flexibility, for example around referral criteria or missed appointments.

9.8.7 Supporting the person over time

Vulnerable people experiencing multiple disadvantage will usually need to be in contact with alcohol treatment services for longer than average and may be in contact for more than a year.

Wherever possible, they should have a continuous relationship with one keyworker (usually the assertive outreach practitioner) to help with building a trusting relationship.

Transitions (significant changes in the person's circumstances) are often stressful and associated with an increased risk that vulnerable people return to harmful behaviours, including more harmful alcohol use. This can be the case even if there is a positive transition, like moving into stable accommodation or leaving prison. The multi-agency team around the person should consider increasing support at times of transition. A consistent keyworker who the person trusts can help the person manage the stress involved with transitions.

Well before the assertive outreach relationship ends, practitioners should gradually introduce people to other services to help them build a support network. These might include peer support services and organisations and mutual aid.

There is guidance on facilitating access to mutual aid and peer support in section 5.5.4 in chapter 5 on psychosocial interventions.

There may be other recovery support services that are relevant for the person. There is guidance on recovery support services in chapter 6.

9.8.8 Supporting the person to engage with structured alcohol treatment

If the person's motivation increases, the assertive outreach practitioner can help prepare them for structured treatment and accompany them to the service base.

If the person is already attending a peer support organisation, a peer could accompany them to the service. Or the assertive outreach practitioner could introduce the person to a peer supporter who had joined the treatment service after initially engaging with an assertive outreach practitioner. That peer supporter can then share their experience of the process.

Services may need to make small changes to their procedures to become accessible to vulnerable people with multiple disadvantage. This might include allowing for more missed appointments and longer periods of engagement. They will also need to allow for staff time to contribute to meetings of the multi-agency team around the person.

Assertive outreach can continue while the person engages with the treatment service to help the person make the transition to structured treatment at the service base. For example, the assertive outreach practitioner might schedule some meetings with the person away from the service base and some at the service base for a period to support their transition. It is important that the person has adequate support during this time.

9.9 Staff competencies and governance

9.9.1 Staff competencies

Assertive outreach and multi-agency working is highly skilled work and practitioners need to have a range of advanced competencies and specialist knowledge.

You can find information on staff competencies in manuals and programme evaluations in the resources section at the end of the chapter.

Important skills that practitioners should have include:

- building and maintaining relationships with very vulnerable people
- communicating with vulnerable people and with professionals
- trauma-informed practice
- assessment of vulnerable people
- risk assessment and risk management

- advocacy
- multi-agency working
- using a friendly, informal approach while maintaining professional boundaries
- crisis management and conflict resolution
- management of challenging behaviour
- resilience under pressure

Important knowledge that practitioners should have for assertive outreach includes:

- alcohol dependence and associated health harms
- flexible engagement processes
- harm reduction approaches and information
- strengths based approaches
- evidence-based alcohol interventions
- mental health conditions
- the impact of trauma
- adult safeguarding legislation and procedures
- mental capacity and mental health legislation and procedures

9.9.2 Staff support and governance

Assertive outreach practitioners should receive regular input from a multidisciplinary team, including medical, nursing and alcohol and drug treatment specialists.

There should be clear lines of accountability in their organisation for:

- reporting and escalating risks and clinical concerns
- regular clinical supervision
- training

Caseloads for assertive outreach need to be much smaller than the average caseload in alcohol services. This is because people experiencing multiple disadvantage who are not engaged with services usually have high levels of need and risk and require more intensive interventions. Caseload size will depend on how the caseload is made up but can range between a maximum of 6 and 20 (see section 9.6.6 for more information).

Risks can be higher when staff are working away from the service base. This means services should have comprehensive policies and procedures for assessing and managing risks to staff.

Services should provide appropriate support to outreach staff to help them manage the impact of their work on their wellbeing. Outreach staff are normally working closely with

people with the highest levels of need, who can be in distressing circumstances. People on their caseload experience high risks and are often more likely to die than people in the general service, so support and supervision for these staff are essential.

9.10 Resources

9.10.1 Alcohol Change UK

Alcohol Change UK 's Blue Light Project develops alternative approaches and pathways for people with problem alcohol use who are not in contact with treatment services but have complex needs. Resources include a manual and evaluations of services using a Blue Light model.

Alcohol Change UK has also published a manual on assertive outreach.

9.10.2 Changing Futures (and Fulfilling Lives) programme

Changing Futures is a £91.8 million initiative between the UK government and the National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage, including:

- homelessness
- drug and alcohol problems
- mental ill health
- domestic abuse
- contact with the criminal justice system

The funding builds on the Fulfilling Lives programme. It is running in 15 areas, covering 34 council areas across England from 2021 to 2026.

The Evaluation of the Changing Futures programme evaluated the impact of the Changing Futures programme on people experiencing multiple disadvantage. It also looked at how changes at a wider system level affected the way services were delivered.

9.10.3 Making Every Adult Matter

The Making Every Adult Matter (MEAM) approach network helps local areas design and deliver better co-ordinated services for people experiencing multiple disadvantage. The MEAM website describes their approach and includes a 5-year (2017 to 2022) evaluation of the programme.

9.10.4 Primary Care Alcohol Nurse Outreach Service

In 2019, the Primary Care Alcohol Nurse Outreach Service (PCANOS) was implemented in selected 'deep end' GP practices in Glasgow. These are the practices that serve the 100 most deprived communities across Scotland. This involved specialist addiction nurses working closely with GP practices to help engage and provide care for patients with alcohol problems

who had not previously engaged, or had not engaged well, with community alcohol services. They also aimed to eventually link patients to mainstream services after discharge.

The report Alcohol management in deep end practices presents the findings of a qualitative study to gather stakeholders' experiences and perspectives on PCANOS and the wider community alcohol services.

A qualitative study of the views of alcohol frequent attenders at Royal Alexandra Hospital, Renfrewshire was conducted in the West of Scotland where the impact of alcohol consumption and the level of health inequalities is significant and the population is distinct compared to other similar studies.

9.11 References

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10. Pharmacological interventions

How to provide pharmacological interventions for alcohol dependence, covering specific medications such as benzodiazepines for withdrawal management, acamprosate and

naltrexone for preventing relapse and thiamine supplementation to prevent neurological complications.

10.1 Main points

Pharmacological interventions are used:

- for medically assisted withdrawal from alcohol
- to prevent and manage specific complications of withdrawal from alcohol
- to prevent and treat the consequences of thiamine deficiency, including Wernicke's encephalopathy, in people at high-risk who continue to drink alcohol, as well as those undergoing withdrawal
- to reduce craving, prevent relapse and promote abstinence
- to reduce alcohol consumption in specific groups of people who have a high drinking risk level

Pharmacological interventions can be provided in a range of settings. Clinicians will need to plan the setting and regimens for interventions, based on a full assessment of the patient, considering a range of factors including:

- severity of dependence
- complexity of need including co-occurring physical and mental health conditions
- skills and resources needed to provide the intervention effectively and safely

The main purpose of medication in medically assisted withdrawal is to help people with alcohol dependence to stop drinking without experiencing withdrawal complications. These can include seizures, delirium tremens and Wernicke's encephalopathy.

Benzodiazepine reducing regimens are the standard pharmacological treatment to manage withdrawal from alcohol. Regimens can be fixed-dose or symptom-triggered.

If a person experiences any severe withdrawal complications during medically assisted withdrawal in the community, it should be treated as an emergency. You should provide appropriate emergency care (as available) and call an ambulance.

The choice of relapse prevention medication will need to be based on full assessment of the patient, their preference and ability to adhere to the regimen.

Clinicians should provide thiamine supplementation to all people about to undergo or undergoing medically assisted withdrawal. However, it's important to offer thiamine prophylaxis to all people who drink harmfully and dependently, whether or not they intend to undergo medically assisted withdrawal.

Where possible, clinicians should explore options for medication to support relapse prevention and promote abstinence with the person before they start making plans for medically assisted withdrawal.

Particular considerations apply when using pharmacological interventions for people from specific groups or with co-occurring conditions (see section 10.6 for guidance on this).

10.2 Context

10.2.1 General principles

When pharmacological interventions are used, they should be as part of a broad treatment plan where a person's goals have been agreed.

You should choose the pharmacological intervention based on a thorough assessment and be clear about the goals and purpose for prescribing medication, considering the patient's views and preferences.

When using medication, you will need to monitor for effectiveness and for any unwanted effects in the patient. People who are particularly unwell will need specifically skilled nursing and medical care, for example, if they are in severe acute withdrawal.

Where there is a choice of recommended medications or regimens that are equally effective, it is usually better for clinical teams to work with the option with which they are most experienced. For example, although you can use a range of benzodiazepine drugs (most commonly, chlordiazepoxide or diazepam in the UK) to manage acute alcohol withdrawal, skilled care and monitoring are more important than the choice of medication.

Medication regimens will vary, depending on the setting where they are administered. Each organisation or service should have written policies and procedures on administering pharmacological interventions that are appropriate to the setting and level of competence of the staff.

Prescribers should adhere to the:

- General Medical Council (GMC) guidance Good practice in prescribing and managing medicines and devices
- Royal Pharmaceutical Society's prescribing competency framework
- British National Formulary (BNF) guidance on non-medical prescribing, where appropriate

Clinicians should administer medication in line with Royal Pharmaceutical Society guidance Professional guidance on the administration of medicines in healthcare settings (PDF, 319KB).

You should also be aware of potential interactions between alcohol and prescribed drugs. You can view this information on the BNF website.

You should provide information about medication in a way that is accessible to the person, considering:

- their preferred language
- their level of literacy

- any sensory disability
- any cognitive impairment
- any neurodiversity

In some cases, you may need to determine whether the patient has the mental capacity to consent to medical treatment. You can find information on mental capacity in annex 1 on relevant legislation and guidance.

10.2.2 Off-label or unlicensed use of medicines: prescribers' responsibilities

There are situations when clinicians might decide that using unlicensed medicines or using medicines outside the terms of the licence (known as off-label use) is in the best interest of the patient, based on available evidence.

When prescribing unlicensed or off-label medications, prescribers should be aware of their responsibilities under:

- GMC guidance
- local organisational policies
- the Medicines and Healthcare products Regulatory Agency (MHRA) guidance Off-label or unlicensed use of medicines: prescribers' responsibilities

10.2.3 The importance of setting and staff skills

Pharmacological interventions take place in a variety of settings, including:

- primary care
- community alcohol treatment services
- specialist inpatient units
- acute (general) hospitals
- mental health inpatient units
- prisons

It is important that the setting in which you deliver a pharmacological intervention is the appropriate place for the intervention. For example, some community alcohol treatment services are well set up to administer oral or intramuscular thiamine on-site for patients who continue to drink and are at high risk of Wernicke's encephalopathy (WE). Other alcohol services may need to make alternative arrangements. Most specialist inpatient units will need to transfer people to acute general hospital settings to manage severe medical complications, such as delirium tremens or WE. Other specialist inpatient units that are closely aligned to general hospitals may be able to manage these complications without transfer.

This chapter goes on to describe the approaches a service can take, depending on the setting and skill-set of the staff. It is important that:

- staff responsible for assessing and managing should be clinicians competent in diagnosing and assessing alcohol dependence and withdrawal symptoms
- the setting in which the intervention is taking place is appropriate for the intervention and for the patient's needs
- the service provider has clinical governance, supervision and assurance systems in place to ensure staff are appropriately skilled and settings are appropriate

10.2.4 Setting for medically assisted withdrawal based on severity of dependence and complexity of need

Planning the setting and regimens

Clinicians will need to plan the setting and regimens for medically assisted withdrawal based on:

- the patient's severity of dependence
- withdrawal history
- all assessed patient risk factors including co-occurring physical and mental health conditions
- the patient's needs and circumstances

You can find guidance on assessing someone for medically assisted withdrawal in section 11.5 in chapter 11 on community based medically assisted withdrawal and chapter 12 on specialist inpatient medically assisted withdrawal.

People with moderate alcohol dependence (who typically drink 15 to 30 units per day and score between 15 and 30 on the Severity of Alcohol Dependence Questionnaire (SADQ)) should be offered an assessment for community medically assisted withdrawal.

Criteria for specialist inpatient medically assisted withdrawal

Clinicians should base decisions on whether to refer people for specialist inpatient medically assisted withdrawal on individual clinical assessment. But they should consider specialist inpatient withdrawal weighing up the risks and benefits of that setting for people who meet one of more of the criteria below.

These criteria are based on the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) and clinical consensus from the guidelines development group.

They drink over 30 units of alcohol per day or have a score of more than 30 on SADQ (indicating severe dependence). Clinicians should normally consider inpatient medically assisted withdrawal for people who experience severe dependence. But if the

person does not have any complex needs or significant comorbidities, it can be appropriate to offer them a community-based medically assisted withdrawal. A decision to do this should be based on individual assessment by a clinician with appropriate training and expertise in managing withdrawal for people with severe alcohol dependence and comorbidities.

They have a history of seizures, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes.

They are assessed as at high risk of WE. Based on individual assessment, it may be possible to offer them medically assisted withdrawal in the community if intramuscular thiamine is available on site and there is a sufficiently skilled, trained and resourced team to administer it. Clinicians should follow guidance in section 10.4.3 on WE and medically assisted withdrawal.

They have a co-occurring substance use problem, including harmful or dependent use of illicit drugs, prescribed, or over the counter medication, which requires management, or concurrent medically assisted withdrawal from alcohol and one or more substances.

They have a severe mental health condition (for example, untreated psychosis, severe depression or suicidal ideation) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

They have a significant physical health condition (for example, chronic liver disease, malnutrition, congestive cardiac failure ,or unstable angina or chronic lung disease) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

They have a significant learning disability or cognitive impairment.

They are pregnant.

There is guidance on delivering medically assisted withdrawal in inpatient settings in chapter 12 on specialist inpatient medically assisted withdrawal and chapter 16 on acute hospital settings.

Lower threshold referrals

Clinicians should consider a lower threshold for referring vulnerable groups and people who are frail to specialist inpatient medically assisted withdrawal. This includes:

- people experiencing homelessness
- older people
- children and young people
- people with established liver disease

People in each of these groups are very likely to require closer monitoring (for safety reasons) than can be provided in a community medically assisted withdrawal. Additionally,

people experiencing homelessness are unlikely to have a sufficiently safe and stable home environment to manage community-based medically assisted withdrawal.

Support for community medically assisted withdrawal

During community medically assisted withdrawal, an appropriate family member or other support person should normally stay with the person, for support and to call an ambulance in an emergency. Where an appropriate family member or support person is not available, the person should normally be offered medically assisted withdrawal in a residential setting. However, the clinician can work with the person to assess their relative risks and benefits of a community-based medically assisted withdrawal, considering:

- severity of alcohol dependence
- history of withdrawal symptoms
- co-occurring physical and mental health conditions
- other risk factors

If the person experiences severe complications in the community, they should be immediately admitted to hospital.

Chapter 11 on community-based medically assisted withdrawal gives detailed guidance on delivering community-based medically assisted withdrawal.

10.2.5 Specific groups

Specific considerations apply when using pharmacological interventions for:

- young people
- older adults
- women and those who are pregnant
- people with co-occurring physical or mental health problems or other complexities

You can read more about considerations for specific groups in section 10.6, which you should read along with the guidance on specific pharmacological interventions below.

10.3 Prescribing medication for management of withdrawal from alcohol

It is important to read this section along with section 10.4 on preventing complications of withdrawal. Depending on your setting, you should also read:

- chapter 11 on medically assisted withdrawal in the community
- chapter 12 on specialist inpatient medically assisted withdrawal units
- section 16.8 on medically assisted alcohol withdrawal and section 16.9 on withdrawal complications in chapter 16 on alcohol care in acute hospitals

10.3.1 Main purpose of medication in medically assisted withdrawal

The main purpose of medication in medically assisted withdrawal is to enable people with alcohol dependence to stop drinking without experiencing complications of withdrawal, which include:

- seizure
- delirium tremens
- WE

Medication also eases discomfort and distress associated with withdrawal and so helps the person to plan with confidence to prevent future relapses.

10.3.2 Planned and unplanned withdrawal

This section provides guidance on planned medically assisted withdrawal following assessment and preparation. Section 16.7.7 in chapter 16 on acute hospital settings provides guidance on unplanned medically assisted withdrawal in hospital.

If a patient has stopped drinking in an unplanned way and is beginning to experience withdrawal symptoms, which are not yet acute, you should tell them about the risks of stopping drinking suddenly, which can lead to withdrawal complications. Withdrawal symptoms can include:

- sweating
- shaking
- palpitations
- headache
- nausea or vomiting
- anxiety or agitation
- insomnia or disturbed sleep

you should tell them about the risks of stopping drinking suddenly (which can lead to withdrawal complications). You should also consider offering an assessment for a planned medically assisted withdrawal.

If the person is severely alcohol dependent, it may be appropriate for them to continue to drink at a steady pace (to avoid potential complications), avoiding episodes of increased heavy alcohol use or periods without alcohol until they can access medically assisted withdrawal. In this situation, you should arrange access to medically assisted withdrawal as quickly as possible.

If the person is mildly or moderately alcohol dependent and does not have any risk factors for complications in withdrawal, you can advise them to cut down gradually while they are waiting for medically assisted withdrawal if they want to do this, with the support of the alcohol service.

There is guidance on assessing for suitability and safety when stopping drinking gradually in sections 8.5 and 8.6 in chapter 8 on harm reduction.

Sometimes, a patient might present to a community treatment service when they are already in complicated acute withdrawal. Symptoms of complicated acute withdrawal include intense shaking and may include:

- seizures
- delirium tremens
- suspected WE

In this situation, you should arrange for the patient to be transferred to an appropriate setting immediately. Patients in the community who experience severe withdrawal complications should be transferred to an acute hospital setting.

You can find guidance on dealing with acute alcohol withdrawal in section 16.7.7 in chapter 16 on acute hospital settings.

10.3.3 Benzodiazepine withdrawal regimens

Benzodiazepine reducing regimens are the standard pharmacological treatment of choice to manage withdrawal from alcohol. The choice of specific regimen will depend on the individual and the setting. In all settings, regular skilled monitoring of symptoms and of the effects of medication is an essential component of care.

For planned medically assisted withdrawal, selecting an appropriate setting for the person is an important consideration. See section 10.2.4 for guidance on setting.

10.3.4 Choice of regimen

Fixed dose regimens (with a specified schedule of reducing daily dose, subject to daily review) are suitable for medically assisted withdrawal in the community.

The initial dose of medication should be titrated to the severity of a person's alcohol dependence or their regular daily level of alcohol consumption. There are example regimens provided in section 10.7 on benzodiazepine withdrawal regimens.

Fixed-dose regimens should include some flexibility:

- to give additional 'top-up' doses in case the person's symptoms are not adequately controlled
- to reduce the dose to avoid over-sedation before the next daily review

This flexibility is supported by clinical consensus of the guidelines development group.

The prescribing regimen can include additional doses and the person supporting the patient can be advised on the situations in which this should be given. For instance, if there are breakthrough withdrawal symptoms present in the morning before the reviewing team are able to attend. If the additional dose is used, the monitoring team should review whether

the prescribed doses are adequate or whether the regimen should be reviewed by the prescriber.

In inpatient settings, you can use either fixed dose regimens or symptom-triggered regimens. In contrast to fixed dose regimens, the symptom-triggered approach does not follow a pre-planned reduction schedule but has a flexible dosing system in response to careful monitoring of the person's withdrawal symptoms. A symptom-triggered approach only continues as long as the patient shows withdrawal symptoms. This is a specialist approach that requires all team members to be trained to ensure that it can be applied consistently and safely.

Hospitals intending to use symptom-triggered regimens should consider investing in additional training and competency assessment to ensure that this can be done safely. One of the roles of a specialist alcohol care team (ACT) can be to support safe and consistent use of this approach. However, in hospitals where there is no ACT or suitably trained staff, it is more appropriate to use fixed-dose regimens with daily review.

The quality of monitoring of the person's response to medication is important with both fixed dose and symptom-triggered regimens.

10.3.5 Choice of medication

Chlordiazepoxide, diazepam and other benzodiazepines

Chlordiazepoxide or diazepam are the most commonly used benzodiazepines. There are example regimens for both of these in section 10.7.

You can choose benzodiazepines with a shorter half-life, such as oxazepam, for people who potentially metabolise medication more slowly, such as those with extensive liver disease or older patients. This is to avoid patients gradually becoming over-sedated. However, you can also use chlordiazepoxide successfully for these patients, and the quality, level and skill of monitoring is more important than the choice of benzodiazepine.

Chlordiazepoxide and diazepam are recommended by NICE CG115 and are licensed for use in medically assisted withdrawal. Other recommended benzodiazepines do not have a specific license but may be used for this purpose (see section 10.2.2 on off-label and unlicensed prescribing).

You should be aware of the MHRA safety alert for the use of benzodiazepines and opioids.

Chlordiazepoxide and possible risk of genotoxicity (damage to genetic information)

Chlordiazepoxide should not be used during pregnancy, especially during the first and last trimesters unless the clinical condition of the woman requires treatment with chlordiazepoxide. You can find the available evidence on the safety of chlordiazepoxide in the summary of product characteristics for Librium 5mg capsules.

The European Medicines Agency (EMA) safety working party and non-clinical working party issued guidance in 2022, revised in March 2023, outlining recommendations on the duration of contraception following the end of treatment with a genotoxic drug (PDF, 1.07MB).

Following this, the summary of product characteristics for Librium and some generic chlordiazepoxide varied their licence to implement the guidance.

The change is the result of new EMA guidance, rather than new evidence for the genotoxicity of chlordiazepoxide.

MHRA is reviewing the evidence available on chlordiazepoxide to ensure that appropriate and proportional warnings are implemented as required. MHRA advises that healthcare professionals should continue to use current clinical guidelines while this evaluation takes place.

The risks from continued excessive alcohol consumption and complications from alcohol withdrawal, such as seizures and delirium tremens, are likely to significantly outweigh any potential risk of genotoxic effects from the duration and doses of chlordiazepoxide used for medically assisted withdrawal. When prescribing chlordiazepoxide, the clinician should consider the proportionate balance of risk and discuss this with the patient. Both men and women should be advised about contraception following the end of treatment.

10.3.6 Using carbamazepine as an alternative to a benzodiazepine for managing withdrawal

Carbamazepine is an effective alternative medication for medically assisted withdrawal from alcohol. There are specific (though uncommon) circumstances in which it is a helpful alternative to benzodiazepines. These include situations where the patient has a:

- history of adverse reaction or allergy to benzodiazepine drugs (although uncommon, this can be fatal)
- preference for carbamazepine (for example, people who have a history of harmful use or dependence on benzodiazepine drugs and who do not want to take them in this context)

You can use carbamazepine in inpatient settings for managing concurrent withdrawal from alcohol and benzodiazepine drugs.

You can find more information on concurrent withdrawal from alcohol and benzodiazepines in section 10.6.1.

Carbamazepine is not licenced for management of withdrawal. See section 10.2.2 on unlicensed or off-label prescribing.

Also, for patients who are pregnant, you should be aware of the MHRA safety review on using antiepileptic drugs in pregnancy.

10.3.7 Using clomethiazole

Clomethiazole was used historically to manage alcohol withdrawal but has been replaced by benzodiazepine drugs, which are safer. NICE CG115 recommends that you should not use clomethiazole for medically assisted withdrawal in the community, where the preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam).

In inpatient settings, clomethiazole has no advantages over benzodiazepines in managing withdrawal.

10.4 Prescribing medication to prevent and to manage specific complications of withdrawal

Depending on your setting, you should read this section along with:

- chapter 11 on community-based medically assisted withdrawal
- chapter 12 on specialist inpatient medically assisted withdrawal
- chapter 16 on acute hospital settings

There is detailed guidance on alcohol-related brain damage in chapter 20.

10.4.1 Preventing and managing withdrawal seizures

Withdrawal seizures

Withdrawal seizures are grand mal epileptiform seizures (a seizure causing loss of consciousness and violent muscle contractions) occurring usually 12 to 48 hours after stopping or significantly reducing alcohol consumption. It is important to note that seizures can occur with a breathalyser reading greater than zero in people with severe alcohol dependence. Several seizures may occur, but status epilepticus (a seizure that lasts longer than 5 minutes, or more than one seizure in a 5-minute period, without returning to a normal level of consciousness between episodes) is rare.

If a person has a seizure during medically assisted withdrawal in the community, this should be treated as an emergency. Provide appropriate emergency care as available and call an ambulance.

Preventing withdrawal seizures

Preventing withdrawal seizures is one of the main aims of medically assisted withdrawal. Identifying people at risk will enable you to effectively plan their care, to reduce the likelihood of this complication.

Initial assessment should identify the following risk factors in as much detail as possible, including any history of:

- seizures, including withdrawal seizures
- epilepsy

Other factors such as electrolyte disturbance can contribute to seizure risk in severe alcohol dependence with comorbid malnutrition, though this is a matter of debate, you should consider detecting and correcting this before planned withdrawal, where this is possible.

People at risk of severe withdrawal should generally undergo medically assisted withdrawal in a specialist inpatient withdrawal unit or in general hospital. Those at high risk are likely to need a higher dose regimen of long-acting benzodiazepine.

There is no evidence to support prophylactic use of additional anticonvulsant medication to prevent seizures in people who are at high-risk, and you should not initiate additional anticonvulsant medication. Your focus should be on adequate dosing with the chosen benzodiazepine, in line with the British Association for Psychopharmacology (BAP) updated guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity (PDF, 1.13MB).

For people who are already on established anticonvulsant medication to treat epilepsy, you should continue the antiepileptic treatment dose along with the medically assisted withdrawal medication. You should then monitor their medication levels to ensure they stay within the therapeutic range.

10.4.2 Preventing and managing delirium tremens

Identifying delirium tremens

Delirium tremens usually emerges between day 2 and 3 (occasionally up to day 5) of alcohol withdrawal in a person with severe alcohol dependence. This is a medical emergency and requires immediate transfer to an inpatient setting with 24 hour medical and nursing care. It is crucial that you are alert to the possibility of delirium tremens developing in people undergoing alcohol withdrawal. One of the main aims of medically assisted withdrawal is to prevent the onset of delirium tremens.

Delirium tremens is a toxic confusional state, characterised by:

- disorientation
- agitation
- tachycardia (heart rate of more than 120 beats per minute)
- hypertension (20mmHg (millimetre of mercury) rise in systolic blood pressure)
- fever
- hallucinations (auditory, olfactory, and visual)
- marked tremor
- sleeplessness
- paranoid ideation

These symptoms may not always all be present at the same time.

Preventing delirium tremens in medically assisted withdrawal

Many potential cases of delirium tremens can be prevented by quickly starting appropriate treatment for withdrawal as set out in section 10.3 and thiamine prophylaxis as set out in 10.4.3 of this chapter.

Risk factors for delirium tremens include:

- previous seizures or delirium
- many co-occurring physical health problems
- low potassium
- thiamine deficiency
- systemic disease
- low magnesium

Under-treated withdrawal is also a significant factor.

If there is high risk of delirium tremens, planned medically assisted withdrawal should take place in a specialist inpatient withdrawal unit with appropriate staffing and facilities, or in an acute hospital setting with alcohol specialist input.

Evidence on the role of magnesium deficiency as a risk factor for delirium tremens is inconclusive and an area of ongoing debate. However, in people with severe alcohol dependence and comorbid malnutrition, consider checking and rectifying magnesium levels as quickly as possible, though this should not delay other treatment. Where magnesium deficiency is identified, you should be mindful of risk and monitor for any signs of the onset of delirium tremens.

Managing established delirium tremens

If the person develops delirium tremens despite preventative efforts as outlined above, you should treat it as a medical emergency. If delirium tremens emerges during medically assisted withdrawal in the community, you must transfer the person to an acute hospital as an emergency.

If the person is being managed in a specialist inpatient medically assisted withdrawal unit that is not in an acute hospital, you should consider transferring the patient to an acute medical setting, depending on resources and staff expertise available to the unit.

NICE clinical guideline Alcohol-use disorders: diagnosis and management of physical complications (CG100) recommends using lorazepam for treatment of delirium tremens and haloperidol as an option where oral lorazepam is declined or symptoms persist. However, the consensus of the alcohol clinical guidelines development group (and clinical guidelines from other countries) is that neuroleptics such as haloperidol should:

- not be given as first line treatment or monotherapy for delirium tremens
- only be used as an adjunct to benzodiazepine treatment where adequate doses have failed to manage the behavioural disturbance
- not replace adequate doses of benzodiazepines

The treatment should be different from that for delirium arising from other causes, and larger doses of benzodiazepines are required (ASAM, 2020; Schuckit, 2014; Mayo-Smith and others, 2004). Haloperidol can lower the threshold for seizures.

There is guidance on the medical and nursing management of delirium tremens in section 16.9.3 on identifying risk and managing delirium tremens in chapter 16 on alcohol care in acute hospitals.

10.4.3 Preventing and managing Wernicke's encephalopathy

WE is a serious complication of deficiency of thiamine (vitamin B1), for which the most common cause is alcohol dependence. This can result in lasting brain injury, so preventing this complication is vital. See chapter 20 for more detailed guidance on alcohol-related brain damage.

Thiamine is used to:

- prevent WE in people at risk (in community or inpatient settings)
- treat WE (in an inpatient setting)

WE is a potential complication of alcohol withdrawal and thiamine should be prescribed as part of medically assisted withdrawal to prevent WE from developing. However, WE does not occur only when people stop drinking, and people who are malnourished or have decompensated liver disease remain at risk while they continue to drink alcohol.

People with any degree of risk of WE, who choose not to have parenteral (intramuscular or intravenous) thiamine, should be offered oral thiamine.

This section deals with prophylactic administration of thiamine You can find guidance on treatment of suspected or established WE in section16.9.4 and in section 16.9.3 on identifying risk and managing delirium tremens in chapter 16 on acute hospital settings.

All local areas should have an agreed pathway for provision of preventive intramuscular (IM) or intravenous (IV) thiamine, which ensures that the setting in which it is provided is equipped to respond appropriately in the event of anaphylaxis.

Thiamine prophylaxis to prevent WE

Many people with alcohol dependence are at risk of developing WE due to thiamine deficiency. They may also have deficiencies in other vitamins. You should provide thiamine supplementation as part of any medically assisted withdrawal. However, you should also consider offering thiamine prophylaxis in all people who drink harmfully and dependently, whether or not they intend to undergo medically assisted withdrawal.

The risk of anaphylactic reaction from parenteral (IM or IV) vitamins has sometimes deterred clinicians from using them, but the risks of failing to correct thiamine deficiency are significant. You should consider the following points.

Absorption of oral thiamine from the intestine is saturated at 5 to 10 milligrams (mg) per dose in healthy people and can be reduced to negligible amounts in people with alcohol dependence, especially those with malnutrition. So, the oral route will not be adequate to replace depleted thiamine in a significant proportion of these people (Tallaksen and others, 1993; Weber and Kewitz, 1985).

Thiamine stores need to be replaced as quickly as possible and high circulating levels of thiamine are needed for passive diffusion into the central nervous system (based on clinical consensus of the guidelines development group).

For people who need parenteral thiamine, the risk of anaphylaxis is very low: less than 1 in 5,000,000 for IV infusion and lower still for the IM route (Cook and others, 1998; Thomson and Marshall, 2006).

MHRA has published a drug safety update on allergic reactions to parenteral Pabrinex (thiamine and other vitamins).

Pharmacological regimen for thiamine prophylaxis

The appropriate regimen for thiamine prophylaxis will depend on whether the person:

- is considered to be at lower-risk
- has no signs of WE but is at high risk of it developing
- is showing signs of WE

Thiamine should be given orally or parenterally as described below.

The lower-risk group comprises people who drink harmfully or dependently but who do not have any of the conditions that put them at high-risk. In practice, all people presenting for treatment in community alcohol treatment services, who do not meet criteria for the high-risk regimen, should be given thiamine 50mg oral 4 times daily.

People in the high-risk group can have a range of conditions, including:

- significant weight loss
- poor diet
- low body mass index (BMI) (a BMI score of less than 18)
- other signs of malnutrition
- memory disturbance
- peripheral neuropathy
- previous history of complicated withdrawal including WE
- decompensated liver disease
- long history of harmful drinking and alcohol dependence

In community settings, consider offering prophylactic IM thiamine to people at high risk of WE, following the dosing below.

Give IM thiamine 200mg to 300mg once daily for at least 3 days with daily review and monitoring for signs of WE.

Injections should be given by appropriately skilled, trained and resourced staff.

If the person is significantly underweight with limited tissue for IM injection, has a clotting problem or prefers IV rather than IM thiamine, you should transfer them to an inpatient setting.

IM thiamine should be followed by a course of oral thiamine until holistic review of overall recovery indicates it is no longer necessary.

If you have well-founded nutritional concerns, you can also prescribe a suitable nutritional supplement.

For administration of prophylactic IM or IV thiamine in hospital settings, see section 16.9.4 in chapter 16 on alcohol care in acute hospitals.

Treatment for incipient Wernicke's encephalopathy

Incipient WE is characterised in most cases by confusion, in some cases with classical symptoms of ataxia (unsteady walking), memory disturbance and ophthalmoplegia (impaired eye movements). People with suspected WE should immediately be transferred to an inpatient setting with 24 hour medical and nursing staffing.

You can find guidance on managing and prescribing for treatment of WE in section 16.9.4 in chapter 16 on alcohol care in acute hospitals.

Preventing Wernicke's encephalopathy in people who continue to drink alcohol

There are opportunities, in alcohol treatment services, primary care and other community settings, to provide thiamine to people:

- in the lower risk group for WE who continue to drink alcohol
- at high risk of developing WE even if they intend to continue to drink

In community settings, consider offering:

- preventive oral thiamine to people in the lower-risk group
- IM thiamine followed by oral thiamine to people at high risk of WE (as described above in this section)

Appropriately skilled and resourced services should assess and consider offering parenteral thiamine to people at high risk when they present to services, even if they do not imminently plan to undergo medically assisted withdrawal. The benefits of this outweigh the low risk of anaphylaxis (see above and chapter 16 on acute hospital settings and chapter 20 on alcohol-related brain damage).

10.5 Pharmacological interventions for preventing relapse and promoting abstinence

10.5.1 Principles for prescribing for relapse prevention and promoting abstinence

Planning medication to support relapse prevention

Medication can be an important addition to psychosocial treatment and recovery plans, yet clinicians often under-use evidence-based pharmacological treatments. This could be because both clinicians and people seeking help are unaware of all the options.

Where possible, you should explore options for medication to support relapse prevention and promote abstinence with the person before you start making plans for medically assisted withdrawal. This allows you to carry out baseline assessments, so you are ready to prescribe in a seamless plan after the end of the patient's withdrawal. This also allows (off-label) acamprosate treatment to begin before withdrawal. If you need to carry out medically assisted withdrawal without prior planning, you should consider relapse prevention medication before the patient completes withdrawal.

For people with harmful patterns of drinking or with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, you should consider offering acamprosate or oral naltrexone along with a psychosocial intervention. There is less evidence for acamprosate in the treatment of these groups than that for naltrexone and this would be an off-label use of acamprosate.

Integrating pharmacological and psychosocial interventions in community alcohol treatment services or primary care

Whether through community alcohol treatment or primary care, there should be an agreed local pathway for prescribing relapse prevention medications and partners should share information so they are familiar with a person's prescribing history. You should prescribe medication for relapse prevention in the context of a psychosocial treatment and recovery plan. This does not mean that you need to provide complex formal psychological treatments, and the lack of specialised approaches should not stop someone accessing relapse prevention medication.

If the person has not received treatment from a specialist alcohol treatment service, their GP should offer them a referral and encourage them to attend the specialist service. If they decline referral, or if they have completed their treatment at a specialist alcohol service, regular monitoring and review by the GP along with supportive contact in primary care will help them to benefit from medication.

If a GP prescribes relapse prevention medication, they should provide information about:

- alcohol use disorders
- the purpose of the medication
- how to manage safe adherence to a medication regimen

The GP can support the person's treatment by encouraging them to engage with mutual aid groups and peer support organisations. To support treatment effectiveness, it helps to return to the offer of a referral to a specialist alcohol treatment service where appropriate and encourage the person to attend.

10.5.2 First-line pharmacological interventions

Acamprosate and naltrexone are first-line options for pharmacological treatment to support relapse prevention, following successful withdrawal from alcohol for people with moderate to severe dependence.

Acamprosate

This section on acamprosate covers:

- indications
- baseline investigations and monitoring
- dose schedule
- suggested dose schedule in renal impairment
- prescribing arrangements

Indications

Acamprosate is usually well-tolerated, and mild gastrointestinal disturbance is the most commonly reported side effect (see section on acamprosate in the BAP guidelines (PDF, 1.13MB)). It is a first-line treatment for relapse prevention and you should consider it as an option for all people who are undergoing or have completed a medically assisted withdrawal, as well as for people with alcohol dependence who have managed to withdraw without medication but still need help with relapse prevention.

Acamprosate can be started before or during medically assisted withdrawal. Acamprosate is thought to have the potential to reduce toxicity and neuronal impairment during the withdrawal process, although this is not clearly established (Kalk and Lingford-Hughes, 2014). Prescribing acamprosate before completing withdrawal ensures that the person can benefit in the vulnerable period when medication to manage withdrawal symptoms has finished. This prescribing is outside the summary of product characteristics (SPC), but it is common practice and it is supported by clinical consensus of the alcohol guidelines development group. The Royal Pharmaceutical Society provides an overview of SPC.

Baseline investigations and monitoring

You should determine the person's body weight before prescribing, because a lower dose schedule is used for adults who weigh under 60kg.

Baseline blood tests should include hepatic and renal function. Acamprosate is predominantly excreted by the kidneys. The manufacturers recommend it should not be prescribed in "cases of renal insufficiency" and state this is indicated with a serum creatinine level of more than 120 micromoles per litre, based on a 1994 report. Clinical judgement may also be supported by measuring a person's estimated glomerular filtration rate (eGFR) (see dose schedule below).

The safety of acamprosate has not been established in patients with severe liver insufficiency. So, the manufacturers recommend caution in its use for this group. You should not give acamprosate to people with severe hepatic impairment, but you can give it to people with mild to moderate hepatic impairment if there is ongoing monitoring.

For people with acceptable baseline blood test results, repeated blood test monitoring is not essential. Although it may be helpful in treatment generally to provide feedback on a person's improvement (for example, if liver enzymes were elevated at baseline but have since come down).

Dose schedule

Appropriate doses are 666mg (2 tablets), 3 times daily, for adults whose weight is 60kg and over. Adults under 60kg are advised to take a total of 1,332mg daily in divided doses (for example, 2 tablets (666mg) in the morning, one tablet (333mg) in the afternoon and one (333mg) more in the evening).

You should prescribe for people with mild to moderate renal impairment with caution (Ashley and Dunleavy, 2019) and in consultation with the BNF guidance on prescribing in renal impairment.

Suggested dose schedule in renal impairment

Guidance from the renal drug handbook (Ashley and Dunleavy, 2019) recommends that acamprosate can be considered for prescribing in renal impairment at the following doses:

- eGFR 30 to 50 millilitres per minute - 333mg 3 times a day
- eGFR 10 to 30 millilitres per minute - 333mg twice daily
- eGFR below 10 millilitres per minute - 333mg once daily

Prescribing in renal impairment should be a shared decision with the patient and other professionals, such as the specialist renal team if applicable. Prescribing in patients with a creatinine level greater than 120 micromoles per litre, remains a contraindication based on the SPC. Naltrexone is an alternative option.

Prescribing arrangements

You can prescribe acamprosate in community alcohol treatment services, primary care, or hospital. When a person starts being prescribed acamprosate in community alcohol treatment services or hospital, it is generally in their best interests that prescribing is transferred to primary care when possible. This allows them to move on from specialist services while continuing to benefit from the medication.

There is no specific time limit on prescribing acamprosate, but a common approach is to prescribe for 6 months, with an extension to 12 months for people who experience ongoing benefit.

You should consider stopping prescribing acamprosate after 4 to 6 weeks if the person is continuing to drink alcohol and has experienced no reduction in drinking days and alcohol consumption.

Naltrexone

This section on naltrexone covers:

- indications
- baseline investigations and monitoring
- dose schedule
- prescribing arrangements

Indications

Naltrexone is a non-selective opioid antagonist that reduces the rewarding effect of alcohol and therefore the motivation to drink alcohol. Several meta-analyses and systematic reviews have concluded that naltrexone reduces a person's return to heavy drinking, by reducing the risk that a lapse progresses to a full relapse (NICE, 2011).

Naltrexone is a first-line treatment for relapse prevention and you should consider it as an option for people who are undergoing or have completed a medically assisted withdrawal. You should also consider it for people with alcohol dependence who have managed to withdraw without medication but who need help with relapse prevention.

Specific considerations

Naltrexone is an opioid-receptor antagonist, so you should not prescribe it for people who:

- are prescribed opioid medication
- use non-prescribed opioids regularly or intermittently
- are likely to need opioid medication

Naltrexone administered to opioid-dependent people can cause life-threatening withdrawal symptoms. If you suspect a patient of using or being dependent on opioids, you should establish that they have not taken any opioids for 7 to 10 days before starting naltrexone treatment.

Baseline investigations and monitoring

Baseline blood tests should include hepatic and renal function. Repeat blood tests are not needed for everyone but are advised for:

- older people
- people with co-occurring health conditions, including obesity
- feedback on improvement of physical health, where that would be useful

You should not prescribe naltrexone for people with severe or acute hepatic impairment, acute hepatitis, or liver failure.

You can prescribe naltrexone for people with mild to moderate hepatic impairment with ongoing monitoring.

Dose schedule

The typical dose is 25mg as an initial dose increasing to 50mg daily. The 25mg dose is off-label. You should refer to MHRA guidance 'Off-label or unlicensed use of medicines: prescribers' responsibilities' (see section 1.2). Prescribers should also refer to the SPC.

Prescribing arrangements

You can prescribe naltrexone in community alcohol treatment services, primary care or hospitals. When a person starts being prescribed naltrexone in community alcohol treatment services or hospitals, it is generally in their best interest that prescribing is transferred to primary care when possible because this allows them to move on from specialist services while continuing to benefit from the medication.

There is no specific time limit on prescribing naltrexone, but a common approach is to prescribe for 6 months, with an extension to 12 months for people who experience ongoing benefit.

You should stop prescribing naltrexone after 4 to 6 weeks if the person is continuing to drink alcohol and has experienced no benefit.

Choosing between acamprosate or naltrexone as first-line treatment

There are currently no clear indicators of which people respond best to which first-line treatments. Some studies (including Mann and others, 2018) have been based on the proposed mechanisms of action of the 2 drugs.

Based on these studies, acamprosate is likely to be of more benefit for people motivated by the 'relief' effects of alcohol (such as easing anxiety) by operating on the upregulated glutamatergic system (brain functions) found in alcohol dependence.

Naltrexone is more likely to benefit people whose alcohol use is mainly motivated by seeking the 'positive reward' effects of alcohol (since naltrexone blunts these effects) and so, a person who has a history of recurrent lapses (unrelated to anxiety) may be more likely to benefit from naltrexone.

Precision in choice of medication remains an area for further investigation to identify clear predictors of effectiveness.

In practice, the choice between acamprosate and naltrexone as first-line treatment is likely to be shaped by factors such as:

- the person's previous experience and preference
- medical factors, such as the person's renal or liver function or concurrent opioid use

- practical details, such as the person's preference for 3 times daily or once daily dosing

10.5.3 Second-line pharmacological interventions

Disulfiram

This section on disulfiram covers:

- indications
- baseline investigations and monitoring
- dose schedule
- prescribing arrangements

Indications

Disulfiram is usually a second-line treatment for people with moderate or severe alcohol dependence who have successfully completed withdrawal and want to maintain abstinence. NICE CG115 recommends that it should be considered for people who:

- have a goal of abstinence but for whom acamprosate and naltrexone are not suitable
- prefer disulfiram and understand the rationale and relative risks of taking the drug

Disulfiram acts by blocking aldehyde dehydrogenase (an enzyme), causing accumulation of aldehyde if a person drinks alcohol. This results in adverse effects including nausea, flushing and palpitations. So, it acts as a deterrent to alcohol use. The patient must not start disulfiram until 24 hours after they consumed their last alcoholic drink. Patients (and where relevant their families) must be warned that a disulfiram-alcohol reaction is potentially dangerous.

It's very important that you inform the patient about the adverse consequences from disulfiram of taking even small amounts of alcohol. This involves informing them about the effects and about what food, drink and other products to avoid, including ingesting alcohol accidentally in food products or even from absorbing alcohol on the skin from cosmetic products. You should also inform the person that there is a potential for a reaction with alcohol up to 14 days after stopping disulfiram.

You should warn patients, and their families and carers, about the rare complication of liver damage, which can have rapid onset and be unpredictable. You should also advise patients that if they feel unwell or develop a fever or jaundice, they should stop taking disulfiram and seek urgent medical attention.

There are several medical conditions for which disulfiram should be prescribed with caution or is even contraindicated. These include:

- hypertension
- ischaemic heart disease

- stroke

Disulfiram is contraindicated in psychosis and severe personality disorder and where there is risk of suicide (see SPC and BNF).

Prescribers should ensure they have access to the patient's full medical history, and they should check on drug interactions, cautions and contraindications to prescribing in the SPC.

Where possible, clinicians should advise that a supportive family member or appropriate support person witnesses the doses. This has been shown to enhance the medication's effectiveness by helping the patient adhere to the regimen.

Baseline investigations and monitoring

Baseline blood tests should include hepatic and renal function. Ongoing blood test monitoring should be guided by the results of baseline tests and the medical history.

Dose schedules

In the UK, the usual dose of disulfiram is 200mg daily, though higher doses are sometimes used for people who do not experience adverse effects with alcohol at this dose.

In the SPC, there is an example of an initial loading dose regimen with higher doses being given in the first few days. However, it is common and acceptable to start on 200mg daily without an initial loading regimen.

Prescribing arrangements

You can prescribe disulfiram in community alcohol treatment services, primary care, or hospitals. It is usual for disulfiram to be started and initially monitored by specialist alcohol treatment services. When a person starts being prescribed disulfiram in community alcohol treatment services or in hospital, they should be transferred to primary care prescribing, when possible, because this allows them to move on from specialist services while continuing to benefit from the medication.

Prescribers should review the person at least every 2 weeks for the first 2 months, then monthly for the following 4 months.

There is no specific time limit on prescribing but for subsequent, longer term prescription, monitoring at least 6-monthly is recommended by the guidelines development group.

Baclofen

This section on baclofen covers:

- indications
- baseline investigations and monitoring
- dose schedule
- prescribing arrangements

Use of baclofen in the UK

Baclofen is a GABA-B agonist that is licensed for other uses in the UK. It is not included in NICE CG115.

Several studies have evaluated its use to support abstinence from alcohol since the NICE clinical guideline was published and there has been an international consensus statement on its use (Agabio and others, 2019).

Baclofen is included in this guideline, although you should be clear that its use in the UK for the treatment of alcohol use disorders would be off-label. You should refer to MHRA guidance 'Off-label or unlicensed use of medicines: prescribers' responsibilities' (see section 1.2). Prescribers should also refer to the SPC.

Indications

You should not use baclofen for patients who are still drinking alcohol or for managing alcohol withdrawal.

You should also avoid using baclofen where there is a risk of:

- psychotic disorders
- significant mood disorders, including hypomanic and manic episodes
- current or past suicidal ideation or attempts (see SPC and BNF) (Sinclair and others, 2016; Agabio and others, 2018)

You can consider baclofen as a second line treatment for relapse prevention following successful withdrawal from alcohol for people who have:

- not responded to first-line treatments (acamprosate or naltrexone)
- contraindications to prescribing first-line medications, for example those who have advanced liver disease

The SPC also states that cases of misuse, abuse and dependence have been reported with baclofen. You should exercise caution when prescribing baclofen to patients with a history of substance use and they should be monitored for symptoms of baclofen misuse, abuse, or dependence. For example, this includes cases of dose escalation, drug-seeking behaviour or a development of tolerance.

You should prescribe baclofen with caution in people with co-occurring health conditions, particularly:

- epilepsy (effect on seizure threshold)
- mood disorder (risk of manic or hypomanic episodes)
- current suicidal ideation or a history of suicide attempts (risk of intentional overdose)

Baseline investigations and monitoring

Baseline blood tests should include hepatic and renal function. Clinicians should refer to the SPC. However, you can prescribe baclofen with caution for people with hepatic or renal impairment.

You do not need to repeat blood test monitoring for everyone, but you should be guided by the patient's medical history.

You must monitor liver enzymes in patients with hepatic impairment. You may need to adjust dosing for people with renal impairment.

Dose schedules

Research shows very wide variations in the size of the dose of baclofen, but we do not recommend using high doses. Clinical consensus of the guidelines development group is that baclofen should:

- be started at a low dose and slowly titrated, with a typical maximum of 60mg daily
- not be stopped abruptly, but slowly reduced (for example, reduce the total daily dose by 5mg each week) to avoid withdrawal symptoms

Prescribing arrangements

Baclofen should only be prescribed by a specialist clinician who takes responsibility for the ongoing monitoring of the patient.

10.5.4 Other drugs used for relapse prevention

Other drugs that are used for relapse prevention in alcohol use disorders include:

- topiramate
- gabapentin
- sodium oxybate

While these drugs are used elsewhere in the world, they are not routinely used in the UK due to the lack of evidence.

10.5.5 Drugs that should not be used for relapse prevention

Antidepressant medication

Many people seeking help for alcohol use disorders have already been prescribed antidepressant medication. This may be appropriate if you are clear that the purpose of the prescription is to treat a pre-existing or co-occurring depressive disorder, but there is no role for antidepressant medication specifically to treat an alcohol use disorder. You should not prescribe antidepressant drugs (including selective serotonin reuptake inhibitors) with the purpose of preventing relapse in alcohol use disorders.

Benzodiazepines and z-drugs

You should not start prescribing benzodiazepines or z-drugs (sleeping tablets with effects similar to benzodiazepines, such as zopiclone or zolpidem) or continue them after managing withdrawal, with the goal of relapse prevention or promoting abstinence from alcohol.

For some people, it may still be appropriate to use these drugs for their standard recommended uses, such as for the short-term management of anxiety or insomnia.

10.5.6 Pharmacological intervention to reduce alcohol use: nalmefene

Use of nalmefene in the UK

Nalmefene is an opioid receptor antagonist at mu and delta subtypes and partial agonist at kappa subtype. In 2014, NICE published a technology appraisal on nalmefene.

Nalmefene is indicated for the reduction of alcohol consumption in adult patients with alcohol dependence who are likely to continue to drink, who do not experience physical withdrawal symptoms and who would not require detoxification.

You should only start prescribing nalmefene for patients who continue to have a high drinking risk level 2 weeks after initial assessment and it should be prescribed alongside psychosocial interventions.

Indications

Nalmefene is not suitable for people with moderate or severe alcohol dependence or who are non-dependent drinkers.

The target group for this pharmacological intervention is people with mild dependence, without complications, whose aim is to continue to drink alcohol at a reduced level and who are prepared to engage in concurrent psychosocial interventions.

Psychosocial interventions are the mainstay of treatment for this defined group, and most people will not require a pharmacological intervention. However, you can consider prescribing nalmefene for people in this group for whom a psychosocial intervention alone is not proving adequate. You should ask the patient to record their alcohol consumption for at least 2 weeks before deciding to start nalmefene.

If you do prescribe nalmefene, you should only do so alongside psychosocial interventions in specialist alcohol treatment services or a primary care setting.

Specific considerations

As nalmefene is an antagonist and partial agonist, you should not prescribe it for people who take opioid medication, use non-prescribed opioids either regularly or intermittently, or for those who are likely to need opioid medication. You should not prescribe nalmefene for people who:

- have a current or recent opioid dependence
- are in opioid withdrawal
- have a recent history of acute alcohol withdrawal syndrome

Baseline investigations and monitoring

Baseline blood tests should include hepatic and renal function. You should avoid prescribing nalmefene to people with severe hepatic or renal impairment and prescribe it with caution to people with mild to moderate hepatic impairment.

Repeated blood test monitoring is not essential though it may be helpful in treatment overall, for feedback to the person on improvement in their health.

10.6 Pharmacological interventions for specific groups of people

This section provides guidance for specific groups. You should read this guidance along with:

- general information on prescribing for withdrawal (in sections 10.3.1 to 10.3.7 in this chapter)
- thiamine supplementation (in sections 10.4.2 and 10.4.3 in this chapter)
- relapse prevention (section 10.5 in this chapter)

10.6.1 Pharmacological treatments for people using alcohol and other drugs or medications

People who use drugs and who are dependent on alcohol should be offered alcohol treatment interventions, including support for alcohol reduction and cessation either in the community or as an inpatient. You should follow this up with psychological and pharmacological interventions to prevent relapse.

You can find detailed guidance on addressing problem alcohol use with people who are in treatment for drug dependence in section 6.5 of Drug misuse and dependence: UK guidelines on clinical management.

Co-occurring alcohol and opioid dependence

Alcohol dependence is a common co-occurring condition in people with opioid dependence, and people with this combination of conditions are at high risk of death from the combined sedative effects of opioids and alcohol in overdose, as explained in NICE CG115. Treatment for both conditions should be integrated so they are managed together.

The UK drug treatment clinical guidelines are clear that optimising medication for opioid dependence is important. Some people will wish to undergo medically assisted withdrawal from alcohol while maintaining stable opioid substitution treatment (OST). This may be because they want to stop drinking alcohol but also want to continue to benefit from ongoing OST. Or they may want to withdraw from both alcohol and opioid drugs in due course but want to deal with alcohol first.

Management of withdrawal from alcohol for people with opioid dependence

When planning medically assisted withdrawal, clinicians should consider the degree of supervision required for its safe management alongside OST. Some people will need inpatient services or intensive community support such as day-patient supervision. This

decision needs to be based on the factors that are considered for all people undergoing medically assisted withdrawal from alcohol, together with any additional factors related to their opioid use.

The UK drug treatment clinical guidelines recommend that when a person wants to withdraw from both alcohol and opioid drugs, you should aim to stabilise them on OST and then plan assisted withdrawal from alcohol, particularly if they are going to be managed in a community setting. Simultaneous withdrawal from both alcohol and opioid drugs is challenging and is best managed in an inpatient setting.

There is MHRA safety information on concurrent use of benzodiazepines and opioids.

Medication for relapse prevention

You should not prescribe naltrexone for people with ongoing opioid dependence or those who use opioid drugs intermittently. Because naltrexone is an opioid antagonist, you can prescribe it to support a patient to maintain their abstinence from opioid drugs (after their abstinence is clearly established), as recommended by the NICE technology appraisal guidance Naltrexone for the management of opioid dependence.

For people who have achieved abstinence from both alcohol and opioid drugs, and want to maintain this, you can prescribe naltrexone as long as there are no other contraindications, with the aim of supporting abstinence from both.

There is a lack of studies looking at the effectiveness of acamprosate in people who are also dependent on opioids. However, given its safety and tolerability, there is no reason acamprosate should not be used to support abstinence from alcohol, following medical assessment and the guidance on prescribing acamprosate (see section 10.5.2 on acamprosate above).

There is also a lack of studies of the use of disulfiram to support abstinence from alcohol in people dependent on opioids. If you are considering using disulfiram, you need to carry out a medical assessment and follow the guidance on prescribing disulfiram (see section 10.5.3 on disulfiram above).

Baclofen has potential to cause sedation if it is given alongside opioid medication such as methadone or buprenorphine, so should be used with caution.

Nalmefene is an opioid antagonist and should not be prescribed for people who are using prescribed or unprescribed opioid drugs (see section 10.5.6 on nalmefene above).

Co-occurring alcohol and cocaine use

This section covers management of alcohol withdrawal and relapse prevention for people who also use cocaine.

Management of withdrawal from alcohol

If a person takes cocaine with alcohol, some effects (including euphoria and increased heart rate) may be enhanced compared to using either substance alone. Long term concurrent

cocaine and alcohol use can increase the risk of heart attacks and strokes. You should offer support and treatment to people with alcohol dependence who also use cocaine, to help them achieve abstinence from alcohol, whether or not they intend to stop using cocaine. When planning medically assisted withdrawal, you must consider the degree of supervision required for its safe management. If a person is unlikely to be able to stop using cocaine during the period of withdrawal from alcohol, there is a potential for problematic increases in blood pressure and heart rate during withdrawal. This means some people will need inpatient services or intensive community support.

Medication for relapse prevention

There have been a small number of studies of the potential effect of acamprosate to support abstinence from cocaine, and while the findings are inconclusive, acamprosate has been well-tolerated (Kampman and others, 2011). It is appropriate to offer acamprosate to support abstinence from alcohol in people who use cocaine (see the considerations described in section 10.5.2 on acamprosate above).

There have been several trials of naltrexone and disulfiram in people with co-occurring problem alcohol and cocaine use. For naltrexone, it is so far unclear whether this is effective, but there is a possible association between disulfiram and abstinence from both alcohol and cocaine (Pettinati and others, 2008).

You can offer either naltrexone or disulfiram to support abstinence from alcohol in people who also use cocaine, based on their medical history and current health, as well as their choice (see section 10.5.2 on naltrexone and section 10.5.3 on disulfiram for cautions and contraindications).

Co-occurring alcohol and benzodiazepine dependence

This section covers management of withdrawal and relapse prevention medication for people with co-occurring benzodiazepine dependence.

Management of withdrawal

Concurrent use of a prescribed benzodiazepine or z-drug (such as zopiclone or zolpidem) is common in patients with alcohol dependence. These drugs are often prescribed in primary care or initiated by mental health services.

If you need to plan concurrent withdrawal from both alcohol and benzodiazepines, you should consider managing the person in an inpatient setting. This is because the dose of benzodiazepine medication used for withdrawal will need to be higher. You should base their initial daily dose on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine. When the person has been using unprescribed benzodiazepines, this is difficult to assess and they are likely to need an inpatient setting.

Withdrawal is best managed with one benzodiazepine (chlordiazepoxide or diazepam) rather than multiple benzodiazepines. Concurrent withdrawal from alcohol and benzodiazepines will take longer than withdrawal from alcohol alone, so you should plan inpatient admissions

for 2 to 3 weeks or longer, depending on the severity of co-occurring benzodiazepine dependence.

Concurrent withdrawal from alcohol and benzodiazepines is best managed in an inpatient setting. If withdrawal is managed in the community, the regimen may need to last for several weeks, depending on the person's symptoms and discomfort, as recommended by NICE CG115. It will also be necessary to involve specialist clinicians with knowledge and competencies in managing withdrawal for people with co-occurring alcohol and benzodiazepine dependence.

Some people requiring medically assisted withdrawal from alcohol are already receiving a prescription for a stable regular daily dose of a benzodiazepine or z-drug, possibly for another indication. They may not want any change to this prescribed medication while they undertake alcohol withdrawal. In these circumstances, the regular medication can be maintained as a baseline while they undergo withdrawal from alcohol, with a planned reducing regimen of chlordiazepoxide or diazepam. The person may then decide (at a later date) on a plan to reduce and stop the regularly prescribed medication.

As for all medically assisted withdrawal from alcohol, you should consider the degree of supervision required for its safe management alongside use of current medication.

Medication for relapse prevention

You can offer pharmacological interventions for preventing relapse to alcohol use to people who have benzodiazepine dependence. If you do this, the same considerations as for all people will apply. However, you should note that for people who continue to take benzodiazepine medication, increased sedation can occur if they take baclofen, which should be considered when prescribing baclofen.

10.6.2 Prescribing for older people

You should read this section with section 25.8 on older people in chapter 25 on developing inclusive services.

Screening older people

There is an increasing prevalence of problem alcohol use in older populations (people aged 65 years and over). Routine screening for alcohol use risk among older people should be part of any ongoing comprehensive assessment in any health or social setting (RCPsych, 2018).

Issues to consider when prescribing for older people

Older adults are more likely to:

- have other mental health conditions
- have other physical health conditions
- be taking other medication

You will therefore need to make appropriate dose adjustments for age-related pharmacokinetic and pharmacodynamic changes and carry out regular monitoring (Butt and others, 2020; Lingford-Hughes and others, 2012; Haber and others, 2009). But this should not be a deterrent to using medication, as it can play a crucial role in treatment and recovery and you should always consider using it. Refer to BNF guidance on prescribing in the elderly.

Pharmacological management of withdrawal for older people

NICE CG115 recommends that benzodiazepines remain the treatment of choice for managing withdrawal in older people, alongside nutritional supplements. See section 10.3 in this chapter on prescribing medication for managing withdrawal from alcohol. However, you can consider prescribing a shorter-acting benzodiazepine, such as oxazepam (off-label), where you have concerns about accumulation and subsequent over-sedation.

Clinicians are less likely to be familiar with such shorter-acting benzodiazepines compared with other benzodiazepines that are more commonly used, such as chlordiazepoxide or diazepam. So, it may be preferable to use familiar benzodiazepines with careful titration and choice of dose. Given the patient is likely to have co-occurring physical health conditions and be at risk of nutritional deficiencies, it is essential to assess them for potential complications, and for Wernicke's encephalopathy, as well as continuing to monitor them during withdrawal. So, you need to consider whether a community or inpatient setting is most suitable for withdrawal. See section 10.4.3 on preventing and managing Wernicke's encephalopathy.

Pharmacological management of relapse prevention for older people

There is limited evidence about the efficacy and safety of prescribing relapse prevention medication in this population. If we assume that treating older people with relapse prevention medication has similar results to the working age adult population, you can consider using it for older people with moderate to severe alcohol dependence if you think that the benefits outweigh the risks for an individual (Butt and others, 2020; Lingford-Hughes and others, 2012; NICE, 2011).

When using naltrexone in older people, you should monitor their liver function tests before and during medically assisted withdrawal and at 3 months and 6 months afterwards.

Acamprosate may require dose adjustment due to age-related kidney disease. Using acamprosate in people aged 65 and over is off-label due to lack of evidence on its use in that age group (see SPC and baseline blood tests and monitoring for acamprosate in section 10.5.2 in this chapter).

Disulfiram is less likely to be appropriate to use, due to the number of contraindications and cautions that apply to older adults.

10.6.3 Prescribing for young people

There are specific considerations when prescribing for young people. You should read this section along with section 23.14 in chapter 23 on specialist alcohol interventions and support for children and young people, and the British National Formulary for Children.

NICE CG115 covers young people aged 10 years and older and includes a specific pathway for 10 to17 year-olds. For those young people who require medically assisted withdrawal, you can use benzodiazepines (chlordiazepoxide or diazepam) with doses adjusted based on their:

- age
- height
- weight

Consider inpatient admission in an age-appropriate setting with access to specialist alcohol treatment expertise. Children and young people should not be treated in an adult setting.

There is limited evidence from trials investigating the efficacy or use of relapse prevention medications in young people. Also, relapse prevention medications are not licensed for use in people aged 17 and under because of the lack of evidence to guide their use and safety in younger people. There are some pilot placebo-controlled or open-label randomised control trials of acamprosate, naltrexone or disulfiram in young people (mainly 15 to 19 years old). But all the studies are based on small groups and their results should be interpreted very cautiously (Clark, 2012).

NICE CG115 recommends that after a careful review of the risks and benefits, specialist clinicians can consider offering acamprosate or oral naltrexone, along with cognitive behavioural therapy, to young people over 16 who have not benefited from or engaged with a multicomponent treatment programme.

This would be an off-label use of oral naltrexone and acamprosate. See section 10.2.2 on unlicensed or off-label prescribing.

10.6.4 Women and those who are pregnant or breastfeeding

Alcohol use during pregnancy

This section focuses on alcohol treatment prescribing interventions for women and those who are pregnant or breastfeeding. There is guidance on other aspects of treatment and support during pregnancy and the perinatal period, and on fetal alcohol spectrum disorder in chapter 24 on pregnancy and perinatal care.

Psychosocial interventions are the mainstay of managing problem alcohol use during pregnancy, though evidence comes primarily from experience rather than clinical trials.

Many patients who continue to drink excessively in pregnancy are likely to have several co-occurring conditions including mental health disorders. Some will also smoke tobacco or use other substances, so comprehensive assessment for alcohol treatment by an experienced clinician is crucial (McAllister-Williams and others, 2017).

It is essential that all services involved with the patient during pregnancy and in the perinatal period work together to co-ordinate care and share information appropriately. This will include joint multidisciplinary and multi-agency assessment, and care-planning, including

safeguarding, maternity services and other relevant services such as mental health or domestic abuse services (NICE, 2010).

If a patient is undergoing medically assisted withdrawal while pregnant or in the perinatal period, child safeguarding services should normally be involved. The clinicians and staff involved with the patient must follow national guidance (see annex 1 on legislation and statutory guidance) and their service procedures on child safeguarding.

See section 24.7.4 in chapter 24 on pregnancy and perinatal care for further guidance on safeguarding in pregnancy. And see section 24.9.1 in chapter 24 on pregnancy and perinatal care for further guidance on multi-agency assessment and multi-agency care-planning.

Pharmacological management of withdrawal in pregnancy

For patients who require medically assisted withdrawal during pregnancy, you can use chlordiazepoxide. You should consider if it's best to do this as an inpatient with the antenatal team, so that they can appropriately monitor the patient and the fetus.

Risks and benefits of treatment should be discussed with the patient.

Chlordiazepoxide and possible risk of genotoxicity (damage to genetic information)

Chlordiazepoxide should not be used during pregnancy, especially during the first and last trimester unless the clinical condition of the woman requires treatment with chlordiazepoxide. You can find the available evidence on the safety of chlordiazepoxide in the summary of product characteristics for Librium 5mg capsules.

The European Medicines Agency (EMA) safety working party and non-clinical working party issued guidance in 2022, revised in March 2023, outlining recommendations on the duration of contraception following the end of treatment with a genotoxic drug (PDF, 1.07MB). Following this, the summary of product characteristics for Librium and some generic chlordiazepoxide varied their licence to implement the guidance.

The change is the result of new EMA guidance, rather than new evidence for the genotoxicity of chlordiazepoxide.

MHRA is reviewing the evidence available on chlordiazepoxide to ensure that appropriate and proportional warnings are implemented as required. MHRA advises that healthcare professionals should continue to use current clinical guidelines while this evaluation takes place.

The risks from continued excessive alcohol consumption and complications from alcohol withdrawal, such as seizures and delirium tremens, are likely to significantly outweigh any potential risk of genotoxic effects from the duration and doses of chlordiazepoxide used for medically assisted withdrawal. When prescribing chlordiazepoxide, the clinician should consider the proportionate balance of risk and discuss this with the patient. Both men and women should be advised about contraception following the end of treatment.

You should not use carbamazepine in pregnancy for safety reasons.

There is an MHRA drug safety update about using antiepileptic drugs in pregnancy.

Patients undergoing medically assisted withdrawal during pregnancy will need thiamine supplementation as described in section 10.4.3 on preventing and managing WE. Pregnant patients should also take folic acid supplements as advised in the NICE public health guideline Maternal and child nutrition. Patients should follow advice from the GP and specialist midwife on other aspects of nutritional support.

You can undertake medically assisted withdrawal with patients in any trimester, though if it's close to their delivery, you must consider the impact of withdrawal from alcohol or benzodiazepines on the baby. The baby will need specialist paediatric monitoring if it is born during the medically assisted withdrawal. Any enduring alcohol withdrawal in the parent should be appropriately treated. The baby should be assessed and then assessed again regularly throughout infancy for fetal alcohol spectrum disorder.

Section 24.8.3 in chapter 24 on pregnancy and perinatal care provides more guidance on caring for the new-born baby with prenatal alcohol exposure.

Relapse prevention during pregnancy

Abstinence from alcohol is strongly recommended in pregnancy. The UK chief medical officers' low-risk drinking guidelines advise that the safest approach is to avoid drinking any alcohol during pregnancy. Due to lack of safety data, relapse prevention medication cannot be routinely recommended.

The BNF advises that acamprosate and naltrexone should be avoided during pregnancy unless the potential benefit outweighs risk. But alcohol is a known human teratogen and treatment may be considered in individual cases, based on the balance of risk and discussion with the patient. Women and those who become pregnant while taking acamprosate or naltrexone will generally be advised to stop taking these.

You should avoid using disulfiram during pregnancy due to potential teratogenic effects of acetaldehyde.

The BNF for baclofen states that the manufacturer advises using it in pregnancy only if the potential benefit outweighs risk (as it was found to produce toxicity in animal studies).

The BNF for nalmefene states that the manufacturer advises to avoid its use during pregnancy (as it was found to produce toxicity in animal studies).

For up-to-date information on medication in pregnancy, you can visit the UK teratology information service.

Pharmacological management of withdrawal for patients who are breastfeeding

In general, the health benefits of breastfeeding mean that it should be encouraged whenever possible. When a breastfeeding woman consumes alcohol, it is readily transferred into breast milk. The amount received by the baby will depend on the timing of feeding related to when the alcohol was consumed. Alcohol is likely to cause lethargy, drowsiness

and poor feeding in babies. It also presents a risk of hypoglycaemia. So, you should strongly recommend that breastfeeding patients do not consume alcohol.

Alcohol treatment services should prioritise women and those with alcohol dependence and have babies, including those who are breastfeeding, for rapid assessment for and provision of medically assisted withdrawal.

There is a lack of well-conducted studies to guide how you provide advice about breastfeeding in the context of prescribed medication. You should get specialist advice when planning and providing individually tailored pharmacological interventions for women who are breastfeeding. Useful sources of specialist advice include the Breastfeeding network and the Specialist Pharmacy Service safety in breastfeeding guidance.

Clinicians should discuss the risks and benefits of medically assisted withdrawal when breastfeeding with the patient so a shared decision about treatment can be made. However, clinicians should recommend that the patient stop breastfeeding while taking the medication to avoid adverse effects in the baby if the medication is transferred in the breast milk. This may be particularly relevant if large doses of benzodiazepines are used during the medically assisted withdrawal.

There should be a multidisciplinary approach to supporting the mother and baby and this should include input from neonatal paediatricians and specialist breastfeeding advice and support for the mother. The mother can be supported to express milk during the medically assisted withdrawal, to increase the chance that she can continue to lactate and resume breastfeeding after the medically assisted withdrawal has finished.

Patients may vary in their approach to risk. If the patient makes a fully informed choice not to stop breastfeeding, the clinician should seek specialist advice on the relative risks and benefits and any actions they can take to mitigate risks associated with breastfeeding during medically assisted withdrawal.

Relapse prevention during breastfeeding

Psychological approaches and social support are the mainstay of relapse prevention for women who want to start or continue breastfeeding.

You should discuss the risks and benefits of relapse prevention medication with the patient so a shared decision can be made. However, due to the lack of comprehensive evidence available, you should routinely recommend that women and those who are breastfeeding should avoid pharmacological treatment to prevent relapse using medications such as acamprosate, naltrexone and disulfiram.

The lack of studies looking at long-term outcomes after taking relapse prevention medication during breastfeeding introduces a degree of uncertainty and patients may vary in their approach to risk. In exceptional circumstances you might want to consider prescribing relapse prevention medication, if the patient has requested this based on a fully informed understanding of risks and benefits.

If you are considering treatment, you should undertake comprehensive assessment of risk for each individual patient who is breastfeeding. You should also get individualised specialist advice on prescribing relapse prevention medication for the patient who is breastfeeding (see section above on pharmacological management of withdrawal for useful sources of specialist advice on prescribing and breastfeeding). Pharmacological principles suggest using the lowest possible effective dose, for the shortest time. For example, this might only be during periods of a particularly high risk of relapse. You should not consider pharmacological treatment as a single option without accompanying psychological support or interventions to help reduce risk of relapse.

Due to the lack of information on safety, you should avoid prescribing disulfiram. If considering prescribing relapse prevention medication in exceptional circumstances, you should consider alternatives (acamprosate or naltrexone).

10.6.5 Prescribing for people with co-occurring mental health conditions

Many people with problem alcohol use have co-occurring mental health conditions or their symptoms. When you are considering treatment with medication you should do a comprehensive assessment with the patient to understand the relationship between their alcohol use and any other mental health symptoms or conditions.

Evidence shows that you should treat both their problem alcohol use and their mental health condition in their own right as treating one does not necessarily lead to resolution of the other (Lingford-Hughes and others, 2012; Haber and others, 2009). There is no evidence that a treatment for a mental health condition is less effective when it is co-occurring with problem alcohol use, so treatment should follow usual clinical guidelines, for example NICE guidelines.

There is more guidance on other aspects of working with co-occurring mental health conditions in chapter 18 on co-occurring mental health conditions.

Pharmacological management of withdrawal for people with co-occurring mental health conditions

This section should be read with section 10.2.4 on setting for medically assisted withdrawal based on severity of dependence and complexity of need in this chapter.

When choosing a benzodiazepine in people with a co-occurring mental health condition, you can follow guidelines outlined in this chapter. However, you will need to check the BNF and SPC for interactions of medicines used for medically assisted withdrawal against an individual patient's current medication.

Pharmacological management of relapse prevention for people with co-occurring mental health conditions

Abstinence, or at least a reduction in a person's alcohol consumption, is important to improving their mental health symptoms and conditions. You should consider prescribing relapse prevention medication for people with moderate or severe alcohol dependence alongside psychosocial or psychological interventions (Lingford-Hughes and others,

2012; NICE, 2011; Barnes and others, 2020; Goodwin and others, 2016; Cleare and others, 2015).

Disulfiram is contraindicated in psychosis and severe personality disorder and where there is risk of suicide (see SPC and BNF).

You should also avoid using baclofen where there is a risk of:

- psychotic disorders
- significant mood disorders, including hypomanic and manic episodes
- current or past suicidal ideation or attempts (see SPC and BNF) (Sinclair and others, 2016; Agabio and others, 2018)

Naltrexone has been the most studied and reviewed medication with evidence to support it improving alcohol dependence when co-occurring with a range of mental health conditions (Lingford-Hughes and others, 2012). This includes for:

- depression
- post-traumatic stress disorder
- bipolar disorder

There is an association between problem alcohol use and depression, and antidepressant use among people with problem alcohol use is common. However, reviews of the evidence show that the effectiveness of antidepressant medication is reduced while people are drinking heavily. Study of the relationship between selective serotonin reuptake inhibitors (SSRIs) and alcohol use is an emerging field and, when prescribing these medications for patients with problem alcohol use, it is important to be aware of the most up to date evidence and carefully consider the risks and benefits. It remains important to offer medication such as acamprosate or naltrexone and monitor for efficacy (Agabio and others, 2018; Foulds and others, 2015; Iovenio and others, 2011; Nunes and Levin, 2004; Torrens and others, 2005).

See section 10.5.1 to 10.5.5 for guidance on prescribing for relapse prevention.

10.6.6 Prescribing for people with liver disease

Pharmacological management of withdrawal in people with alcohol-related liver disease

There is no specific evidence on which to base the management of alcohol withdrawal in people with advanced alcohol-related liver disease (ARLD). People with decompensated cirrhosis (complicated by jaundice, ascites, variceal bleeding, renal impairment, sepsis or hepatic encephalopathy) and alcohol withdrawal can be challenging to manage. In these cases, you should seek advice from a healthcare professional with experience in the management of liver disease, hepatic encephalopathy and withdrawal, as recommended by NICE CG100.

Specific treatment considerations will depend on the severity of liver disease and the severity of withdrawal risk. People with advanced ARLD should be admitted to hospital for withdrawal.

In general, you can consider using a shorter-acting benzodiazepine in people with significantly compromised liver function, such as oxazepam or lorazepam. This includes jaundice (bilirubin of more than 80 micromoles per litre), coagulopathy (international normalised ratio (INR) of more than 1.5) and in particular, the presence of hepatic encephalopathy. You can use longer-acting benzodiazepines (for example chlordiazepoxide and diazepam) with the knowledge that people with compromised liver function will:

- need less
- metabolise slower
- have greater accumulation (NICE, 2011)

Expertise available in the service, guidance and the quality and skill of monitoring is more important than the choice of benzodiazepine. You should take care not to over-sedate the person. If hepatic encephalopathy worsens, you should stop the benzodiazepine, and if it is needed later, you should prescribe it at a lower dose.

Pharmacological management of relapse prevention in people with alcohol-related liver disease

Abstinence from alcohol is a vital goal for people with ARLD since abstinence improves outcomes in all stages of the disease. There should be established care pathways between specialist liver services and alcohol treatment services. You can find examples of guidance on developing care pathways in guidance on alcohol treatment pathways and Scottish Health Action on Alcohol Problems good practice guidance for people with ARLD.

You should consider pharmacotherapy for relapse prevention for people with ARLD. However, many of the drugs available have not specifically been tested in people with advanced ARLD.

Of the relapse prevention drugs recommended by NICE CG115, disulfiram and naltrexone are metabolised in the liver, whereas acamprosate is not. You should avoid using disulfiram for people with advanced ARLD because of potential hepatotoxicity (Forns and others, 1994; EASL, 2018; Crabb and others, 2020). Naltrexone has not been studied systematically in people with advanced ARLD.

Acamprosate has a generally good safety profile and is not metabolised in the liver. While there is preliminary data suggesting safety in people with Childs' A and B cirrhosis, there are no trials of repeatedly administering acamprosate in people with cirrhosis.

For people with advanced ARLD, using either disulfiram or naltrexone is not recommended (EASL, 2018; Crabb and others, 2020). Based on limited data, acamprosate is probably safe and may be used (Crabb and others, 2020).

In clinical practice, it is important to make the distinction between people with advanced ARLD and those with less severe liver disease. For the latter group, relapse prevention medication could be safely used with appropriate monitoring. People with advanced ARLD will have at least one of:

- significant synthetic dysfunction (impaired ability to synthesise proteins), indicated by jaundice (bilirubin of more than 80 micromoles per litre)
- coagulopathy (INR of more than 1.5)
- hepatic encephalopathy (decline in brain function that occurs as a result of severe liver disease)

You should involve specialist hepatology services in diagnosis.

Baclofen is currently the only pharmacotherapy for alcohol use disorder for which there is randomised controlled trial data in people with cirrhosis (including those with decompensated cirrhosis but excluding hepatic encephalopathy) (Addolorato and others, 2007). Further confirmatory studies are required and there are still questions on optimal dosing and duration of treatment. However, it does appear that baclofen may be useful in people with ARLD cirrhosis and alcohol use disorder. Prescribing baclofen in such cases should be in consultation with a hepatology specialist.

Pharmacological interventions to reduce alcohol use in liver disease

As described earlier in this chapter, NICE recommends using nalmefene to reduce alcohol consumption in a defined group of people who have mild alcohol dependence with a high drinking risk level without physiological withdrawal symptoms. Nalmefene has not been tested in people who have ARLD cirrhosis, and for these people the goal should be abstinence rather than reduction. However, you can use nalmefene for people with earlier stage liver disease who can benefit from a reduction goal if abstinence is not feasible, provided they meet the criteria described in section 10.5.6 on nalmefene above.

10.7 Benzodiazepine withdrawal regimens

10.7.1 Overview

Individual needs, circumstances and setting

The following benzodiazepine withdrawal regimens are examples only, based on the clinical consensus of the alcohol guidelines development group. They are not protocols that must be followed.

Clinicians should make prescribing decisions based on individual needs, circumstances and setting.

The regimens suggested in this section are suitable for people with moderate dependence (15 to 30 units of alcohol per day and a SADQ score of 15 to 30) who undergo medically assisted withdrawal in the community or, where indicated, in inpatient settings. There are 3 suggested tiers of dosage for each drug. You should select the dosage based on the number

of units the person drinks per day, the SADQ score within the range, and other clinical factors.

Adapting regimens

Although such regimens often work with no need for change, community staff will need experienced prescribers for support if regimens require adaptation (if doses need to be reduced or withheld). For people who show objective alcohol withdrawal symptoms and score high on alcohol withdrawal scales such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version), the doses may need to be increased. These regimens include the option to provide an additional daily dose to be used PRN (if needed) based on telephone advice or in-person advice from the clinician monitoring the medically assisted withdrawal. This can be useful as it helps control symptoms, while allowing clinicians the time to adapt the regimen and supply the additional medication that the person will need.

Severe dependence

The example regimens in section 10.7.2 below are for treating people with moderate dependence. For people with severe dependence, they will likely need higher doses than are shown in these regimens to adequately control withdrawal, prescribed according to the SPC for the chosen medication. This should usually be managed in an inpatient setting with careful titration of dose and ongoing evaluation of the severity of withdrawal and appropriate interventions. In some circumstances, it may be possible to provide community medically assisted withdrawal in the community (see section 10.2.4).

Make sure the patient is adequately supervised if high doses are administered and gradually reduce the dose over 7 to 10 days to avoid alcohol withdrawal recurring. If you are considering offering community medically assisted withdrawal to someone with severe dependence, you should follow the guidance on individual assessment of benefits and risks of the setting for the person in sections 11.5.5 and 11.7.2 in chapter 11 on community medically assisted withdrawal.

The BNF contains a safety alert from the MHRA about prescribing benzodiazepines along with opioids.

10.7.2 Example regimens for planned, fixed-dose alcohol withdrawal (moderate dependence)

Chlordiazepoxide

Table 1: alcohol withdrawal regimen (moderate dependence) for chlordiazepoxide 5mg capsules

Start dose chlordiazepoxide 15mg QDS (4 times daily).

Day	8am (number of capsules to take)	12:30pm (number of capsules to take)	5pm (number of capsules to take)	10pm (number of capsules to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of capsules to take per day (without PRN)	Total number of capsules to take per day (with PRN)
1	15mg (3)	15mg (3)	15mg (3)	15mg (3)	15mg (3)	12	15
2	10mg (2)	10mg (2)	10mg (2)	10mg (2)	10mg (2)	8	10
3	10mg (2)	Stop	10mg (2)	10mg (2)	10mg (2)	6	8
4	5mg (1)		5mg (1)	5mg (1)	5mg (1)	3	4
5	5mg (1)		Stop	5mg (1)	5mg (1)	2	3
6	Stop			5mg (1)	Stop	1	1
7				Stop		Stop	Stop

Table 2: alcohol withdrawal regimen (moderate dependence) for chlordiazepoxide 5mg capsules

Start dose chlordiazepoxide 20mg QDS (4 times daily).

Day	8am (number of capsules to take)	12:30pm (number of capsules to take)	5pm (number of capsules to take)	10pm (number of capsules to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of capsules to take per day (without PRN)	Total number of capsules to take per day (with PRN)
1	20mg (4)	20mg (4)	20mg (4)	20mg (4)	20mg (4)	16	20

Day	8am (number of capsules to take)	12:30pm (number of capsules to take)	5pm (number of capsules to take)	10pm (number of capsules to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of capsules to take per day (without PRN)	Total number of capsules to take per day (with PRN)
2	15mg (3)	15mg (3)	15mg (3)	15mg (3)	15mg (3)	12	15
3	10mg (2)	10mg (2)	10mg (2)	10mg (2)	10mg (2)	8	10
4	10mg (2)	Stop	10mg (2)	10mg (2)	10mg (2)	6	8
5	5mg (1)		5mg (1)	5mg (1)	5mg (1)	3	4
6	5mg (1)		Stop	5mg (1)	5mg (1)	2	3
7	Stop			5mg (1)	Stop	1	1
8				Stop		Stop	Stop

Table 3: alcohol withdrawal regimen (moderate dependence) for chlordiazepoxide 5mg capsules

Start dose chlordiazepoxide 25mg QDS (4 times daily).

Day	8am (number of capsules to take)	12:30pm (number of capsules to take)	5pm (number of capsules to take)	10pm (number of capsules to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of capsules to take per day (without PRN)	Total number of capsules to take per day (with PRN)
1	25mg (5)	25mg (5)	25mg (5)	25mg (5)	25mg (5)	20	25

Day	8am (number of capsules to take)	12:30pm (number of capsules to take)	5pm (number of capsules to take)	10pm (number of capsules to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of capsules to take per day (without PRN)	Total number of capsules to take per day (with PRN)
2	20mg (4)	20mg (4)	20mg (4)	20mg (4)	20mg (4)	16	20
3	15mg (3)	15mg (3)	15mg (3)	15mg (3)	15mg (3)	12	15
4	10mg (2)	10mg (2)	10mg (2)	10mg (2)	10mg (2)	8	10
5	10mg (2)	Stop	10mg (2)	10mg (2)	10mg (2)	6	8
6	5mg (1)		5mg (1)	5mg (1)	5mg (1)	3	4
7	5mg (1)		Stop	5mg (1)	5mg (1)	2	3
8	Stop			5mg (1)	Stop	1	1
9				Stop		Stop	Stop

Diazepam

Table 4: alcohol withdrawal regimen (moderate dependence) for diazepam 2mg tablets

Start dose diazepam 6mg QDS (4 times daily).

Day	8am (number of tablets to take)	12:30pm (number of tablets to take)	5pm (number of tablets to take)	10pm (number of tablets to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of tablets to take per day (without PRN)	Total number of tablets to take per day (with PRN)
1	6mg (3)	6mg (3)	6mg (3)	6mg (3)	6mg (3)	12	15
2	4mg (2)	4mg (2)	4mg (2)	4mg (2)	4mg (2)	8	10
3	4mg (2)	Stop	4mg (2)	4mg (2)	4mg (2)	6	8
4	2mg (1)		2mg (1)	2mg (1)	2mg (1)	3	4
5	2mg (1)		Stop	2mg (1)	2mg (1)	2	3
6	Stop			2mg (1)	Stop	1	1
7				Stop		Stop	Stop

Table 5: alcohol withdrawal regimen (moderate dependence) for diazepam 2mg tablets

Start dose diazepam 8mg QDS (4 times daily).

Day	8am (number of tablets to take)	12:30pm (number of tablets to take)	5pm (number of tablets to take)	10pm (number of tablets to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of tablets to take per day (without PRN)	Total number of tablets to take per day (with PRN)
1	8mg (4)	8mg (4)	8mg (4)	8mg (4)	8mg (4)	16	20
2	6mg (3)	6mg (3)	6mg (3)	6mg (3)	6mg (3)	12	15

Day	8am (number of tablets to take)	12:30pm (number of tablets to take)	5pm (number of tablets to take)	10pm (number of tablets to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of tablets to take per day (without PRN)	Total number of tablets to take per day (with PRN)
3	4mg (2)	4mg (2)	4mg (2)	4mg (2)	4mg (2)	8	10
4	4mg (2)	Stop	4mg (2)	4mg (2)	4mg (2)	6	8
5	2mg (1)		2mg (1)	2mg (1)	2mg (1)	3	4
6	2mg (1)		Stop	2mg (1)	2mg (1)	2	3
7	Stop			2mg (1)	Stop	1	1
8				Stop		Stop	Stop

Table 6: alcohol withdrawal regimen (moderate dependence) for diazepam 2mg tablets

Start dose diazepam 10mg QDS (4 times daily).

Day	8am (number of tablets to take)	12:30pm (number of tablets to take)	5pm (number of tablets to take)	10pm (number of tablets to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of tablets to take per day (without PRN)	Total number of tablets to take per day (with PRN)
1	10mg (5)	10mg (5)	10mg (5)	10mg (5)	10mg (5)	20	25
2	8mg (4)	8mg (4)	8mg (4)	8mg (4)	8mg (4)	16	20
3	6mg (3)	6mg (3)	6mg (3)	6mg (3)	6mg (3)	12	15

Day	8am (number of tablets to take)	12:30pm (number of tablets to take)	5pm (number of tablets to take)	10pm (number of tablets to take)	PRN (only to be taken if recommended by a doctor or nurse)	Total number of tablets to take per day (without PRN)	Total number of tablets to take per day (with PRN)
4	4mg (2)	4mg (2)	4mg (2)	4mg (2)	4mg (2)	8	10
5	4mg (2)	Stop	4mg (2)	4mg (2)	4mg (2)	6	8
6	2mg (1)		2mg (1)	2mg (1)	2mg (1)	3	4
7	2mg (1)		Stop	2mg (1)	2mg (1)	2	3
8	Stop			2mg (1)	Stop	1	1

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11. Community based medically assisted withdrawal

How to provide medically assisted alcohol withdrawal in community settings for people with moderate or, in some cases, severe alcohol dependence. It outlines when this approach is appropriate, covering assessment criteria, safety considerations, preparation and monitoring.

11.1 Main points

Community based medically assisted withdrawal should be available within every local treatment system. People should be able to access it easily and promptly.

People with moderate alcohol dependence (who typically drink 15 to 30 units per day and score between 15 and 30 on the Severity of Alcohol Dependence Questionnaire (SADQ) should be offered an assessment for community medically assisted withdrawal.

People with severe alcohol dependence (who typically drink 30 units or more per day and score 30 or more on SADQ) should normally be considered for a specialist inpatient withdrawal. However, where the person does not have complex needs or significant comorbidities, an appropriately competent clinician can assess the individual risks and benefits of a community based medically assisted withdrawal with them.

Staff responsible for assessing and managing community medically assisted withdrawal should be clinicians who are competent in diagnosing and assessing alcohol dependence and withdrawal symptoms. They should also be competent using recommended drug regimens appropriate for a community setting and trained in the use of a validated tool for measuring withdrawal symptoms.

Clinicians responsible for assessing and managing medically assisted withdrawal should have access to regular clinical supervision and where necessary, consultation with a senior clinician or a multidisciplinary team (MDT).

Specialist assessment for medically assisted withdrawal should include assessing the appropriateness of a community setting against criteria based on specific safety considerations. This includes:

- severity of alcohol dependence
- history of withdrawal symptoms
- co-occurring physical and mental health conditions
- other risk factors

Where the person has experienced medically assisted withdrawal in recent months, the clinician should carefully assess the risk-benefit ratio of offering the intervention.

There should normally be someone (for example, a family member or friend) to stay with the person during the medically assisted withdrawal process, to support the person and call an ambulance in an emergency. Where the person meets the criteria for a community medically assisted withdrawal but appropriate support is not available, the person should

normally be offered it in a residential setting where staff can support them. However, the clinician can assess individual relative risks and benefits of a community based medically assisted withdrawal for the person.

The clinician or keyworker and the person should agree a plan for organising their support and their time during the medically assisted withdrawal, and the ongoing treatment they will move on to immediately after completion.

The clinician should discuss and provide accessible verbal and written information on the medically assisted withdrawal process and on severe complications that should trigger a call for an ambulance, including:

- symptoms worsening to the point of severe shaking and very heavy sweating
- seizures
- delirium tremens
- incipient Wernicke's encephalopathy

The clinician should prescribe prophylactic oral thiamine or consider administering parenteral (intramuscular) thiamine to reduce the risk of Wernicke's encephalopathy based on individual assessment or risk level.

Clinicians should follow guidance on prescribing and managing alcohol withdrawal in sections 10.3 and 10.4 of chapter 10 on pharmacological interventions.

For people with mild or moderate alcohol dependence without complex needs, the clinician should be in daily contact with the person during the first 3 days of the medically assisted withdrawal and should see the person face to face at least every other day during the first week. On the days when the clinician does not see the person, they should monitor the person's condition remotely. The frequency of in- person monitoring should be increased in some cases, based on individual assessment.

Clinical monitoring should include using a breathalyser, assessing withdrawal symptoms using a validated measure of withdrawal symptoms, such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) and monitoring the effects of medication.

If a person has complex needs or is severely dependent and is assessed as suitable for community based medically assisted withdrawal, there is likely to be increased risk to them. Assessment, prescribing and monitoring should be carried out by clinicians who have appropriate training and expertise in managing medically assisted alcohol withdrawal for people with severe dependence and comorbidities. The clinician will need to monitor the person closely.

People with severe alcohol dependence will require higher doses of benzodiazepines to adequately control withdrawal and increased supervision. The doctor with clinical responsibility for the intervention should determine the programme, including the drug regimen, on a case-by-case basis.

Clinicians should normally prescribe for short dispensing intervals, with no more than 2 days medication supplied per prescription. This will help to prevent overdose or diversion (the drug being taken by someone other than the person it was prescribed for).

If the person drinks alcohol, the medically assisted withdrawal should generally be discontinued. If this happens, the alcohol treatment service should offer the person alternative psychosocial support within the service and collaboratively re-assess their needs for medically assisted withdrawal.

After completing a successful community based medically assisted withdrawal, the treatment service should offer the person:

- psychosocial interventions
- relapse prevention medication, unless otherwise indicated

See section 10.5 in chapter 10 on pharmacological interventions for guidance on prescribing for relapse prevention.

11.2 Introduction

This chapter describes the broader context of care in which community medically assisted withdrawal is provided.

You should read this chapter with chapter 10 on pharmacological interventions, which provides detailed guidance on prescribing for the management of withdrawal from alcohol, including for preventing and managing specific complications.

11.3 Settings and the treatment pathway

11.3.1 Overview

Most people with moderate dependence on alcohol (who typically drink 15 to 30 units per day and score between 15 to 30 on the SADQ) and some people with mild dependence (who typically drink less than 15 units per day with some signs of dependence) will need medically assisted withdrawal to prevent significant withdrawal symptoms when stopping drinking. It will be appropriate to carry this out in the community unless there are safety concerns that indicate that the person needs more specialised medical and nursing care, or the more intensive monitoring provided in an inpatient setting.

You can find more information on the indications for providing medically assisted withdrawal in an inpatient or residential setting rather than a community setting in section 11.5.5 below.

11.3.2 A range of clinical teams and different settings

A range of clinical teams may provide community based medically assisted withdrawal in several different settings, including:

- specialist community alcohol (and drug) treatment services delivering the intervention at the service or in the person’s home

- primary care where GPs have the appropriate specialist competencies, or where GPs work with specialist community alcohol treatment services (see chapter 15 on primary care and community health services)
- some hospital-based alcohol care teams offer planned community based medically assisted withdrawal

11.3.3 Home based medically assisted withdrawal

Some local alcohol (and drug) treatment systems provide community based medically assisted withdrawal in the home to people who are assessed as eligible. In other areas, services usually deliver the intervention from a service base. Services have a duty to ensure their activities offered to people without protected characteristics are equally accessible to people with protected characteristics (see information and guidance on the Equality Act 2010). So, the treatment system should be able to provide medically assisted withdrawal in the home for people who cannot attend the service base because of a disability, including a long-term mental health condition.

Home based medically assisted withdrawal can help reduce barriers to accessing medically assisted withdrawal, such as cost and difficulties in travel.

It may be appropriate in rural areas where travel to the service base several days a week may be impossible or difficult enough to deter people from attending.

Home-based medically assessed withdrawal also allows the clinician to make an assessment of risks in the home environment.

The service procedure for delivering home based medically assisted withdrawal should be aligned with its home-based working and lone working procedures.

11.3.4 The treatment pathway

People should be able to easily access community based medically assisted withdrawal wherever they are in the treatment and recovery system and at the stage in their treatment journey when they need it. A suitably qualified and experienced clinician should assess the person's suitability for medically assisted withdrawal and deliver this intervention.

If there are no exclusionary factors (see section 11.5.5 for a summary of criteria for considering inpatient or residential medically assisted withdrawal), a person may be offered planned community based medically assisted withdrawal at any of the stages below. So, this could be after:

- initial assessment
- comprehensive assessment
- a period of engagement with harm reduction interventions
- a relapse into dependent drinking during a treatment episode

The referral pathways between different parts of the treatment and recovery system should be effective and clear to everyone who works within it and to the referring agencies.

The clinician who delivers community based medically assisted withdrawal is often not the person's keyworker and may be based in a different part of the alcohol treatment system. It is essential to have good communication and joint planning between staff, and to involve the person (and family member or support person where appropriate), before, during and after community based medically assisted withdrawal. There should be a seamless transition to ongoing treatment and support following community based medically assisted withdrawal, because gaps in treatment can increase the risk of returning to problematic drinking.

Occasionally it may be possible to continue a medically assisted withdrawal in the community that has been started in a hospital. In this situation, both the hospital and community should agree that this is suitable and appropriate to the clinical needs of the person. Both services should also agree the plan for transition to the community. And with the person's consent, hospital clinicians should share relevant clinical information with community clinicians before they discharge the person from hospital.

11.4 Principles for delivering community based medically assisted withdrawal

11.4.1 Staff competence

Staff responsible for assessing and managing community based medically assisted withdrawal should be suitably qualified clinicians. They should be specialist and competent in diagnosing and assessing alcohol dependence and withdrawal symptoms and using recommended drug regimens appropriate for a community setting. They should also be trained in the use of a validated measure of withdrawal symptoms, such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar). Staff should have access to regular clinical supervision and when necessary, consultation from a senior clinician or MDT.

11.4.2 Written procedure

Service providers should have a written procedure that covers all elements of delivering and supervising community based medically assisted withdrawal within their service.

11.4.3 Access to medically assisted withdrawal

Services should offer assessment for community based medically assisted withdrawal as quickly as possible as there is evidence that a prompt offer of treatment at a point when the person is open to changing their drinking can increase the likelihood that they will engage in treatment (Passetti and others, 2008). There is also a risk that the person's health could deteriorate if access to the intervention is delayed.

Services should provide medically assisted withdrawal as soon as a competent clinician has assessed a person as needing it, the person consents, and adequate preparations are in place. In cases where the person has had repeated episodes of medically assisted withdrawal, the clinician will need to assess relative risks and benefits of proceeding. This is discussed in section 11.5.6 below.

Services should minimise any barriers to accessing medically assisted withdrawal. These barriers might include:

- lack of staff capacity within the service, including lack of specialist clinicians
- long waiting times for assessment and referral for the intervention
- excessive requirements for people to show they are motivated, such as a requirement to attend a series of groups or appointments

Excessive requirements that people need to attend a fixed number of appointments or groups can put people at risk, because their condition may deteriorate while they attempt to meet these requirements.

11.4.4 Integrating pharmacological and psychosocial interventions

Community based medically assisted withdrawal is centred around a pharmacological intervention, but psychosocial interventions should be an integral part of the treatment programme. Both these elements are important and can reinforce one another. The psychosocial element may be particularly important to maximise chances of maintaining abstinence for people who have undergone several previous episodes of community based medically assisted withdrawal.

People will often be anxious about stopping drinking. Taking an empathic, supportive, and collaborative approach will help to engage and encourage the person, as well as family members supporting them. Preparation, assessment and monitoring of medically assisted withdrawal should always involve motivational interventions.

You can find more information on motivational interventions in section 5.5.6 in chapter 5 on psychosocial interventions.

The medically assisted withdrawal process also presents an opportunity for brief psychosocial interventions, like providing information on physical and mental health harms and considering how the person might reduce or manage some of the harms they experience.

Giving the person feedback on tests can be helpful in showing care and activating behaviour change. This might include:

- breathalyser readings
- blood test results
- liver testing results
- blood pressure readings
- cognitive tests

11.5 Assessment for community based medically assisted withdrawal

You should read this section along with chapter 10 on pharmacological interventions.

The following recommendations on assessment for community based medically assisted withdrawal draw on the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) and on the clinical consensus of the alcohol guidelines development group.

11.5.1 Assessing severity of dependence

Initial assessment should include assessing the severity of the person's dependence and their need for medically assisted alcohol withdrawal. You can find guidance on assessing severity of dependence in section 4.8.3 and 4.9.5 in chapter 4 on assessment and treatment and recovery planning. Services should offer an assessment for medically assisted alcohol withdrawal to people with a goal of abstinence who typically drink:

- over 15 units of alcohol per day or score over 20 on the 'Alcohol use disorders identification test' (AUDIT), available in the guidance Alcohol use screening tests
- under 15 units a day but have a previous history of significant withdrawal symptoms (for example, people with a low body weight)

Community based medically assisted withdrawal will usually be suitable for people who are moderately dependent (typically drink 15 to 30 units daily or score between 15 and 30 on SADQ) and do not have complex needs that require the intensive monitoring provided in an inpatient setting. It may also be suitable for people drinking less than 15 units per day with a previous history of significant withdrawal symptoms. You can find a summary of criteria for inpatient or residential medically assisted withdrawal in section 11.5.5 below.

A breathalyser reading of breath alcohol provides additional information at assessment for medically assisted withdrawal. Breath alcohol is used to estimate blood alcohol concentration. A breathalyser reading correlated with the level of intoxication can indicate the likely severity of withdrawal symptoms. For example, if the person has a high blood alcohol concentration reading and does not appear intoxicated, this may indicate tolerance to alcohol and an increased risk of severe withdrawal.

When assessing the severity of alcohol dependence and the need for assisted withdrawal, clinicians should adjust the criteria for:

- women
- pregnant women and other people who are pregnant
- older people
- children and young people
- people with advanced alcohol related liver disease who may have problems with the metabolism of alcohol

You should seek specialist advice from an experienced senior specialist clinician or MDT when assessing pregnant women and other people who are pregnant, young

people, older people, people with liver disease, people with concurrent drug use and people with concurrent mental health conditions for medically assisted withdrawal.

You should read the guidance on prescribing and managing withdrawal for these groups in section 10. 6 in chapter 10 on pharmacological interventions.

For children and young people aged between 10 and 17 years old, NICE CG115 recommends inpatient medically assisted withdrawal in an age-appropriate setting with access to staff with specialist expertise.

You can find guidance on medically assisted withdrawal for young people in section 23.14.1 of chapter 23 on specialist alcohol interventions and support for children and young people.

The clinician should ask about previous periods of abstinence or low risk drinking. If the person has managed periods of abstinence or low risk drinking in the past, this can add additional information about the person's potential suitability for community medically assisted withdrawal.

11.5.2 Assessing risk that severe medical complications will occur in withdrawal

You should read this section along with sections 10.3.1 to 10.3.7 and 10.4.1 to 10.4.3 in chapter 10 on pharmacological interventions. These sections provide detailed guidance on assessing severity of risk of complications in withdrawal, as well as prescribing and managing withdrawal.

The main complications in withdrawal that can occur are:

- seizures
- delirium tremens
- Wernicke-Korsakoff syndrome

You should assess the risk that these complications may occur during medically assisted withdrawal. Factors that contribute to the level of risk include:

- severity of dependence
- history of severe withdrawals
- the above complications during previous medically assisted withdrawal
- individual health factors

If there are factors that indicate the risk is high, the service should offer the person a referral for medically assisted withdrawal in an inpatient setting instead of a community based intervention. You can find a summary of criteria for considering medically assisted withdrawal in an inpatient or residential setting in section 11.5.5 below.

11.5.3 General medical history and current health

The clinician should take a general medical history and assess the person's current physical and mental health. There is more detailed guidance on assessing physical and mental health

in chapter 4 on assessment. The potential impact of medically assisted withdrawal on any physical or mental health condition will inform decisions about prescribing and managing withdrawal, including the setting. Section 10.6 in chapter 10 on pharmacological interventions provides guidance on prescribing medically assisted withdrawal for specific groups of people.

The clinician should assess whether the person will need oral thiamine or parenteral intramuscular thiamine. They should also assess what setting is best to administer this. You should follow the guidance on prescribing and administering thiamine to reduce the risk of Wernicke's encephalopathy and Wernicke-Korsakoff syndrome in section 10.4.3 of chapter 10 on pharmacological interventions.

The clinician should arrange for blood tests to be carried out before starting the intervention to help identify any clinical issues. Blood tests usually include (but do not have to be limited to):

- full blood count (FBC)
- liver function test (LFT)
- urea, creatinine and electrolytes (U&E)
- international normalised ratio (INR)
- total protein and albumin

These blood tests should be taken no more than 3 months before the start of the medically assisted withdrawal.

The clinician should consider carrying out a baseline assessment of cognitive function using a validated tool, such as the mini-Addenbrooke's cognitive examination III (mini-ACE) assessment tool (PDF, 65.1KB) or the Montreal Cognitive Assessment (MoCA). This baseline cognitive assessment, along with other elements of the assessment and the clinician's observations, can show any difficulties the person has retaining information in the short term. This might affect their ability to consent to treatment, even if their cognitive function will improve in the longer term.

The clinician will need to consider the impact of a person's substance use on prescribing and managing withdrawal, including:

- illicit drug use
- prescribed medication
- misusing prescribed or over the counter medication

The impact will depend on the substance and pattern of use. If the person has a drug dependence as well as an alcohol dependence, the clinician should consider an inpatient setting. Community medically assisted withdrawal should only be offered after a thorough assessment of risks and benefits for the person, and only where the staff are sufficiently skilled, trained and resourced to manage the complexity of concurrent drug use. You should

follow the guidance on medically assisted withdrawal where there is concurrent drug use or dependence in section 10.6.1 of chapter 10 on pharmacological interventions.

Where the person requires medically assisted withdrawal from benzodiazepines in addition to alcohol, services should normally offer this in an inpatient setting. A clinician with competencies in managing withdrawal for people with co-occurring alcohol and benzodiazepine dependence may decide to offer withdrawal management in the community after carrying out a careful assessment of risk and benefit. In this case, they should follow the guidance in section 10.6.1 of chapter 10 on pharmacological interventions.

With consent, the clinician should inform the person's GP that they plan to deliver a community based medically assisted withdrawal and obtain information on any medication the GP is prescribing and any relevant health information.

11.5.4 Level of support and identifying barriers

Services should generally only offer community based medically assisted withdrawal where there is someone (for example, a family member or friend) available to supervise the process and to call an ambulance if the person experiences severe complications. It is preferable if a family member, friend or another support person supervises the medication. However, if the clinician is considering offering community based medically assisted withdrawal where this support is not available, they should follow the guidance in section 11.5.5.

The clinician should establish what level of support is available to the person. Comprehensive assessment of the person should include an assessment of the strengths and any risks (such as intimate partner violence) they face within the family and their support network. If the clinician is not the practitioner who carried out that assessment, they should refer to it, to ensure that the family member is appropriate to provide support to the person during medically assisted withdrawal. The clinician should also consider any potential risks to the family member or support person from the person undergoing the medically assisted withdrawal that could make it inappropriate to involve them. You can find more information about involving a person's partners, family and friends in section 5.6.6 in chapter 5 on psychosocial interventions.

The clinician should consider how any individual barriers to maximising the person's chances of completing the process can be addressed. Barriers might include personal issues such as needing to assertively set boundaries with friends drinking at harmful levels who may want to visit, or practical issues such as pressure not to be absent from work or caring responsibilities.

11.5.5 Summary of criteria for offering medically assisted withdrawal in a specialist inpatient or residential setting and not in the community

It is important to determine whether medically assisted withdrawal can be carried out safely in the community or whether they should be offered specialist inpatient medically assisted withdrawal or residential withdrawal. This will depend on a person's:

- severity of dependence
- withdrawal history, including any complications in withdrawal
- assessed risk factors, including co-occurring physical and mental health conditions
- needs and circumstances

Specialist inpatient medically assisted withdrawal: criteria

Clinicians should base decisions on whether to refer people for specialist inpatient medically assisted withdrawal on individual clinical assessment. But they should consider specialist inpatient withdrawal, weighing up the risks and benefits of that setting for people who meet one or more of the following criteria.

The person drinks over 30 units of alcohol per day or has a score of more than 30 on SADQ (indicating severe dependence). People with severe dependence should normally be considered for inpatient medically assisted withdrawal. But if the person does not have any complex needs or significant comorbidities, it can be appropriate to offer them a community based medically assisted withdrawal. Any decision to do this should be based on individual assessment by a clinician with appropriate training and expertise in managing withdrawal for people with severe dependence and comorbidities.

The person has a history of seizures, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes.

The person is assessed as being at high risk of Wernicke's encephalopathy. Based on individual assessment, it may be possible to offer them medically assisted withdrawal in the community if parenteral (intramuscular) thiamine is available on site and there is a sufficiently skilled, trained, and resourced team to administer it. Clinicians should follow guidance in section 10.4.3 on Wernicke's encephalopathy and medically assisted withdrawal in chapter 10 on pharmacological interventions.

The person is experiencing co-occurring harmful or dependent substance use (including prescribed and over the counter medication) which requires management, or concurrent medically assisted withdrawal from alcohol and one or more substances.

The person has a severe mental health condition (for example, psychosis, severe depression or suicidal ideation) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

The person has a significant physical health condition (for example, chronic liver disease, malnutrition, congestive cardiac failure, unstable angina or chronic lung disease) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

The person has a significant learning disability or cognitive impairment.

They are pregnant (see more information on pregnancy and medically assisted withdrawal in section 10.6.4 of chapter 10 on pharmacological interventions).

Specialist inpatient medically assisted withdrawal: vulnerable groups

Clinicians should consider a lower threshold for referring vulnerable groups and people who are frail to specialist inpatient medically assisted withdrawal. This includes:

- people experiencing homelessness
- older people
- children and young people
- people with established liver disease

People in each of these groups are very likely to require closer monitoring (for safety reasons) than can be provided in a community medically assisted withdrawal. Also, people experiencing homelessness are unlikely to have a sufficiently safe and stable home environment to manage community based medically assisted withdrawal.

Medically assisted withdrawal in a residential setting

People who meet the criteria for community based medically assisted withdrawal but do not have a family member or other support person to stay with them during it, should normally be offered medically assisted withdrawal in a residential setting and not a community based setting (see section 12.6 in chapter 12 on specialist inpatient medically assisted withdrawal for a description of residential medically assisted withdrawal and the distinction between specialist inpatient withdrawal and residential medically assisted withdrawal).

Where a family member or other support person is not available, but the person meets all other criteria for community based withdrawal, the clinician can consider a community based medically assisted withdrawal in some circumstances. The clinician can assess the individual relative risks and benefits of a community based medically assisted withdrawal with the person (see the 'individual assessment of risks and benefits of the setting for the person' section below). Increased monitoring is likely to be required.

There are other reasons that people should be considered for residential medically assisted withdrawal when they would otherwise meet the criteria for community medically assisted withdrawal. For example, people should be considered for residential medically assisted withdrawal if they are:

- at risk of domestic abuse, or their home environment is not safe
- caring for children or vulnerable adults, so they do not have to carry out caring responsibilities while going through medically assisted withdrawal

Individual assessment of risks and benefits of the setting for the person

In some circumstances, clinicians with appropriate training and expertise in managing medically assisted withdrawal for people with severe dependence and significant comorbidities can offer community based medically assisted withdrawal to people who meet one of the criteria listed above for inpatient or residential medically assisted withdrawal. They should base this decision on a careful assessment of the risks and benefits of providing this intervention taking into account:

- severity of dependence
- withdrawal history
- co-occurring physical and mental health conditions
- other risk factors

They should also consider what the person wants.

For more guidance on managing community based medically assisted withdrawal for people with severe dependence or significant co-occurring physical or mental health conditions, see section 11.7.1.

11.5.6 Repeated episodes of medically assisted withdrawal

During the assessment, the clinician should consider the number of previous medically assisted withdrawal episodes (either community based or inpatient) the person has experienced. There is evidence that repeated withdrawal episodes at relatively short intervals can cause damage to cognitive functioning and is associated with more severe withdrawal symptoms (Booth and Blow, 1993; Becker, 1998; Ooms and others, 2021). This process is sometimes referred as 'kindling'. Repeated episodes of both untreated withdrawal and medically assisted withdrawal pose risks. But careful planning so the right psychosocial support is in place, and well managed medically assisted withdrawal (with appropriate dosing), can help to reduce those risks.

Where the person has experienced medically assisted withdrawal in recent months, the clinician should carefully assess the risk-benefit ratio of offering the intervention. There are risks involved with frequent periods of withdrawal at short intervals, but there are also risks involved if the person cannot access medically assisted withdrawal and continues to drink. The clinician should discuss relative risks and benefits with the person and inform them of the increasing risks. This includes seizures and cognitive impairment associated with repeated episodes of both untreated withdrawal and medically assisted withdrawal.

11.6 Preparing for community based medically assisted withdrawal

11.6.1 Preparing a person for medically assisted withdrawal

Preparing a person for medically assisted withdrawal should take place during assessment or shortly after the assessment in a follow up appointment.

The clinician should prescribe prophylactic oral thiamine or consider administering parenteral (intramuscular) thiamine to reduce risk of Wernicke's encephalopathy, based on the guidance in section 10.4.3 of chapter 10 on pharmacological interventions.

Where possible, clinicians should explore options for medication to support relapse prevention and promote abstinence with the person before making plans for medically assisted withdrawal. This allows clinicians to carry out baseline assessments, so they are ready to prescribe in a seamless plan after the end of the person's community medically assisted withdrawal. This also allows (off-label) acamprosate treatment to begin before

withdrawal. If a clinician needs to carry out medically assisted withdrawal without prior planning, they should consider relapse prevention medication before the patient completes withdrawal.

Community based medically assisted withdrawal is a significant undertaking. People (including family members or others supporting the person) will need information and a chance to ask questions and discuss anxieties. They will also need to make practical arrangements such as organising support and cancelling commitments for the duration of the medically assisted withdrawal.

Preparation for community based medically assisted withdrawal should include:

- identifying an appropriate family member or support person to stay with the person during the process for support, and to call an ambulance if the person experiences complications
- discussing results of blood tests with the person
- psychosocial support including motivational interventions
- meeting with the person and family member or support person so they can ask questions and raise concerns
- a mutually agreed plan detailing how the person will organise their support and manage their time during the medically assisted withdrawal
- a mutually agreed plan for ongoing treatment and support immediately after completing medically assisted withdrawal
- an offer of peer support as this may be useful to reduce anxiety and support motivation

Clinicians should also communicate verbal and written information to the person who will go through medically assisted withdrawal and to the person supporting them on:

- the medically assisted withdrawal process and arrangements for monitoring meetings
- any support they will need from a family member or support person
- managing their medication
- advice to avoid activities that could be dangerous if the person has a seizure, such as swimming or driving
- severe complications that should trigger a call for an ambulance (see section 10.4 on prescribing medication to prevent and to manage specific complications of withdrawal in chapter 10 on pharmacological interventions)

Clinicians should make the information fully accessible for the person. For example, they should consider the person's:

- preferred language
- literacy
- sensory disability
- cognitive impairment
- neurodiversity

11.6.2 Additional preparation on a case-by-case basis

Some people may need additional preparation between assessment and receiving community medically assisted withdrawal for practical reasons, due to complex needs, or because they are ambivalent about starting. Clinicians should only delay the start of medically assisted withdrawal if an assessment of the person's individual needs shows it is in their interest to do this.

Commissioners and services should work to reduce any barriers that prevent people having rapid access to community based medically assisted withdrawal, such as prolonged assessments or standard requirements. Clinicians should determine the urgency of each person's need for rapid access.

There is little evidence to suggest that people always need to attend a series of preparation groups or appointments before accessing medically assisted withdrawal. This may be very difficult for some people who are physically dependent or have complex needs. Having a requirement like this risks excluding some people who could and should benefit from medically assisted withdrawal. It also puts people at risk as their health can deteriorate.

Preparation groups can be helpful for people who are not sure if they are ready for medically assisted withdrawal. For people in this situation, the groups can provide support in thinking through pros and cons and discussing any fears. Support from members of peer-based support services may also be helpful so the person can hear from others who have experienced community based medically assisted withdrawal and are now in recovery.

If a waiting list is unavoidable, the service should offer the person individual support and some services offer the option of additional group support while waiting. Services should make it clear to people on waiting lists that the wait is due to limited resources and any offer of group support is optional. They do not have to attend groups to access medically assisted withdrawal.

Clinicians should review the assessments of people on a waiting list regularly in an in-person meeting. This is because:

- a person's level of risk may change
- community based medically assisted withdrawal might no longer be suitable
- a person may require urgent treatment

They should review the assessment as close as possible to the start of medically assisted withdrawal.

11.6.3 Safeguarding children and vulnerable adults

Where the person is caring for children or a vulnerable adult, preparation for medically assisted withdrawal should include arrangements for a trusted and responsible person to care for the children or vulnerable adult where necessary. Where children's social care or adult safeguarding services are working with the family, the clinician should involve them in these arrangements. Clinicians must work within statutory guidance and their organisational safeguarding procedures for children and vulnerable adults.

With consent, clinicians should support the person who will undergo medically assisted withdrawal to discuss the plans for this with their children and other family members in an appropriate way.

Children and adult family members, including vulnerable adults, may also benefit from support outside of the medically assisted withdrawal process. Staff should offer support to family members or provide phone and online contact details for relevant support organisations. There is guidance on support for families in section 5.8 in chapter 5 on psychosocial interventions.

11.7 Community based medically assisted withdrawal programmes

A community based medically assisted withdrawal programme should vary in intensity according to a person's:

- severity of dependence
- available social support
- co-occurring conditions, such as physical or mental health conditions

11.7.1 Monitoring medically assisted withdrawal and severity of dependence

People with mild or moderate dependence (without complex needs)

The clinician delivering the medically assisted withdrawal to people with mild or moderate dependence (without complex needs) should be in daily contact with them during the first 3 days when risks are likely to be highest and should then monitor every other day during the medically assisted withdrawal. Where possible, monitoring meetings should be in-person for the first 3 days. If this is not possible, clinicians should have an in-person monitoring meeting at least every other day during the first 5 days. On the days when the clinician does not offer an in-person monitoring meeting, they should monitor the person's condition remotely.

Severe dependence or mild or moderate dependence with complex needs

If a person has complex needs or has a severe dependence and is assessed as suitable for community based medically assisted withdrawal, there is likely to be increased risk to them and they should be closely monitored.

Assessment, prescribing and monitoring should be carried out by specialist clinicians with appropriate training and expertise in managing medically assisted alcohol withdrawal for people with severe dependence and significant co-occurring physical health or mental health conditions. Where the clinician is not a doctor, then a doctor with appropriate training and expertise should have overall clinical responsibility for managing the intervention and prescribing. Clinicians should provide an increased level of monitoring. This can include, for example, daily in-person monitoring checks or treatment within a day programme.

People with severe alcohol dependence will normally require higher doses of benzodiazepines than those set out in the drug regimens in section 10.7 in chapter 10 on pharmacological interventions. This is so the clinician can adequately control withdrawal. Benzodiazepines should be prescribed according to the summary of product characteristics for the chosen medication. Clinicians should make sure the person receives adequate supervision if the person is administered high doses, and gradually reduce the dose over 7 to 10 days to avoid alcohol withdrawal recurring. A specialist doctor with appropriate training and expertise should have clinical responsibility for determining the drug regimen, on a case-by-case basis. Clinicians should provide an increased level of monitoring, for example, daily in-person monitoring checks or treatment within a day programme.

Immediately after medically assisted withdrawal, NICE CG115 recommends that people with complex needs or severe dependence should have access to a day programme for 4 to 7 days a week over a 3-week period. This day programme should include:

- keywork (case management) support
- individual psychosocial interventions
- group support
- psychoeducational interventions
- facilitated access to peer support and mutual aid where appropriate
- family and carer support and involvement where appropriate

11.7.2 Monitoring meetings

Monitoring meetings should include:

- an assessment of withdrawal symptoms using a validated measure of withdrawal symptoms, such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) and of the effects of medication
- being very alert for signs of incipient Wernicke's encephalopathy and for delirium tremens
- using a breathalyser to confirm the person is alcohol free
- monitoring blood pressure, respiration rate and heart rate

- a chance for the person to share their experience and ask any questions
- a chance for the family member or support person to share observations and ask questions (with consent from the person)
- psychosocial support such as motivational interventions and cravings management
- issuing of prescriptions (where there are no safety concerns)
- discussion with the clinical supervisor or MDT if there are any other concerns

The clinician should call an ambulance immediately if the person is experiencing complications such as:

- symptoms worsening to the point of severe shaking and very heavy sweating
- seizures
- delirium tremens
- incipient Wernicke's encephalopathy

See section 10.4.1 to 10.4.3 in chapter 10 on pharmacological interventions for detailed guidance on prescribing for and managing these serious complications.

If the person reports drinking or the breathalyser shows that they have been drinking alcohol, the medically assisted withdrawal should generally be discontinued. If this happens, the service should offer the person alternative psychosocial support (see chapter 5 on psychosocial interventions) and appropriate harm reduction advice (see chapter 8 on harm reduction).

People with alcohol dependence may need several attempts to become abstinent but they may feel a sense of failure or shame at not completing a medically assisted withdrawal. The clinician or keyworker should offer encouragement and using a non-judgemental approach, review with the person what additional or alternative support they might need for a future attempt at stopping drinking. They should also determine whether or when it might be appropriate to assess the person for another medically assisted withdrawal.

If the medically assisted withdrawal is stopped, the clinician should make sure the person returns any medication prescribed for managing withdrawal.

If the person continues to drink, the clinician should consider continuing to prescribe oral thiamine and, where appropriate, parenteral (intramuscular) thiamine to prevent Wernicke's encephalopathy. They should follow the guidance on preventing and managing Wernicke-Korsakoff syndrome in section 10.4.3 of chapter 10 on pharmacological interventions. The clinician should regularly review the person's health as it can deteriorate.

If the person manages to remain alcohol free throughout the medically assisted withdrawal and they feel well enough, encourage them to access additional support between monitoring appointments, such as a keywork session, support groups, peer support or mutual aid (see section 11.7.1).

After completing a successful community based medically assisted withdrawal, the treatment service should offer the person psychosocial interventions. You can find guidance on psychosocial interventions in chapter 5.

Services should also offer relapse prevention medication unless there are concerns about the safety of prescribing this for the person. You can find guidance on prescribing relapse prevention medication, including contraindications in sections 10.5.1 to 10.5.5 in chapter 10 on pharmacological interventions.

11.8 Drug regimens for assisted withdrawal

You should follow guidance on prescribing and managing alcohol withdrawal in sections 10.3.1 to 10.3.7 and 10.4.1 to 10.4.3 in chapter 10 on pharmacological interventions.

When managing alcohol withdrawal in the community, avoid giving people large quantities of medication to take home. This will help to prevent overdose or diversion (the drug being taken by someone other than the person it was prescribed for). Prescribe for short dispensing intervals, with no more than 2 days' medication supplied per prescription.

The clinician who prescribes the medication should discuss whether short interval prescribing could pose difficulties for the person. This includes weighing up the risk that the person may not complete the treatment programme if there are reasons like cost or difficulty travelling to a pharmacy that could prevent them receiving their medication. If this is the case, the team should find an alternative where possible, such as a staff member delivering the medication.

11.9 References

Becker H. Kindling in alcohol withdrawal. Alcohol Health and Research World 1998: volume 22, issue 1, pages 25 to 33.

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12. Specialist inpatient medically assisted withdrawal

The core specialist competencies and systems needed to provide specialist inpatient medically assisted withdrawal for people with severe dependence or complex needs. The chapter distinguishes between specialist inpatient withdrawal units and residential withdrawal settings.

12.1 Main points

Specialist inpatient medically assisted withdrawal units provide medically assisted withdrawal to people with severe dependence or complex needs. They require specific specialist competencies and systems to do this.

Every local treatment system should have a pathway so that people with the highest levels of need can access specialist inpatient medically assisted withdrawal. People should be able to access it easily and without any unnecessary delays.

Specialist inpatient medically assisted withdrawal units should have a thorough admissions process to assess whether the unit can safely manage the withdrawal process for each patient.

Each patient should have a multi-agency treatment and recovery plan that includes plans for ongoing treatment and recovery support after discharge.

Core elements of specialist inpatient withdrawal include specialist competencies and systems including:

- a skilled multidisciplinary team led by an addiction specialist, normally a consultant addiction psychiatrist
- medical and nursing staff with a range of specialist competencies
- ability to identify and manage severe withdrawal complications including seizures, delirium tremens and Wernicke's encephalopathy
- ability to assess and manage complex co-occurring physical health, mental health, additional drug use conditions, alcohol related brain damage and other complexities
- ability to implement relevant legislation and statutory guidance for safeguarding, mental capacity and mental health
- tailored psychosocial interventions and pharmacological interventions
- staffing arrangements that offer out of hours cover that are adequate for the safe running of the unit and the number of patients they treat
- an extensive range of referral pathways, including a rapid pathway to acute hospital care
- multi-agency working partnerships with community alcohol treatment services, health, social care, criminal justice and community agencies

Residential settings providing medically assisted withdrawal that do not have the core elements in place (as outlined in this chapter) do not have the appropriate capacity to manage people with more severe withdrawal complications or complex co-occurring conditions. These settings are suitable for people with alcohol dependence who would otherwise meet the criteria for community based medically assisted withdrawal but are lacking adequate social support.

12.2 Introduction

This chapter describes the core elements of specialist inpatient medically assisted withdrawal, usually referred to as specialist inpatient detoxification units. You should read this chapter alongside:

- chapter 10 on pharmacological interventions
- chapter 11 on community based medically assisted withdrawal
- chapter 16 on alcohol care in acute hospitals

12.3 Medically assisted withdrawal in different settings

Medically assisted withdrawal occurs in several different inpatient, community healthcare and other residential settings, in both a planned way and as part of unscheduled care. Settings include the following.

12.3.1 Community-based medically assisted withdrawal

Community-based medically assisted withdrawal is usually provided by the community alcohol treatment service but may be provided in other community settings, such as primary care or by a community mental health team.

You can read about community based medically assisted withdrawal in chapter 11.

12.3.2 Residential settings

Medically assisted withdrawal is provided by some residential treatment services and in some supported housing settings. See section 12.6 below for further definition and distinction between residential medically assisted withdrawal settings and specialist inpatient medically assisted withdrawal units.

12.3.3 Specialist inpatient medically assisted withdrawal units

Specialist inpatient medically assisted withdrawal units are set up to provide medically assisted withdrawal to people with severe dependence or complex co-occurring conditions, including physical health, mental health, additional drug comorbidities and other complexities. These services require specialist competencies and systems tailored to manage people with complex needs. They are the subject of this chapter and described in detail below.

12.3.4 Acute hospital settings

People may be provided with medically assisted withdrawal in an acute general hospital setting following an admission for acute alcohol withdrawal, or admission for other reasons. In some areas, planned specialist inpatient medically assisted withdrawal is provided within an acute hospital as part of a planned local pathway. Hospital alcohol care teams provide additional specialist expertise where these exist.

You can read about medically assisted withdrawal in acute hospital settings in chapter 16.

12.3.5 Mental health hospital settings

People may be provided with medically assisted withdrawal in an inpatient mental health hospital setting following admission.

You can read about medically assisted withdrawal in inpatient mental health settings in chapter 18 on people with co-occurring mental health conditions.

12.3.6 Prison settings

People may be provided with medically assisted withdrawal if they enter the prison system while experiencing alcohol dependence.

You can read about medically assisted withdrawal in criminal justice settings in chapter 17.

12.4 Criteria for referring people for specialist inpatient medically assisted withdrawal

Clinicians should base decisions on whether to refer people for specialist inpatient medically assisted withdrawal on individual clinical assessment. But they should normally consider specialist inpatient withdrawal for people who meet one or more of the criteria below, weighing up the risks and benefits of that setting for the person.

These criteria are based on the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) and clinical consensus from the guidelines development group.

12.4.1 Criteria for considering inpatient medically assisted withdrawal

You should consider inpatient medically assisted withdrawal for people who meet one of more of the following criteria.

People who drink over 30 units of alcohol per day or have a score of more than 30 on the Severity of Alcohol Dependence Questionnaire (indicating severe dependence). People with severe dependence should normally be considered for inpatient medically assisted withdrawal, but if they do not have any complex needs or significant comorbidities, it can be appropriate to offer them a community based medically assisted withdrawal. Any decision to do this should be based on individual assessment by a clinician with appropriate training and expertise in managing withdrawal for people with severe alcohol dependence and comorbidities.

People who have a history of seizures, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes.

People who are assessed as at high risk of Wernicke's encephalopathy (WE). Based on individual assessment, it may be possible to offer them medically assisted withdrawal in the community if intramuscular thiamine is available on site and there is a sufficiently skilled, trained and resourced team to administer it. Clinicians should follow guidance in section 10.4.3 on WE and medically assisted withdrawal.

People who have a co-occurring substance use problem. This includes harmful or dependent use of drugs (illicit, prescribed, or over the counter medication) which requires management. They may need concurrent medically assisted withdrawal from alcohol and one or more substances.

People who have a severe mental health condition (for example, untreated psychosis, severe depression, or suicidal ideation) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

People who have a significant physical health condition (for example, chronic liver disease, malnutrition, congestive cardiac failure, unstable angina or chronic lung disease) that makes medically assisted withdrawal in a community or residential setting potentially unsafe.

People who have a significant learning disability or cognitive impairment.

Pregnant women and other people who are pregnant.

12.4.2 Considerations for vulnerable groups

Clinicians should consider a lower threshold for referring vulnerable groups and people who are frail to specialist inpatient medically assisted withdrawal. This includes:

- people experiencing homelessness
- older people
- children and young people
- people with established liver disease

People in each of these groups are very likely to require closer monitoring (for safety reasons) than can be provided in a community medically assisted withdrawal.

Also, people experiencing homelessness are unlikely to have a sufficiently safe and stable home environment to manage community-based medically assisted withdrawal.

12.5 Pathways for accessing specialist inpatient medically assisted withdrawal

Access to specialist inpatient medically assisted withdrawal is an essential part of any local alcohol treatment system. Every local area should have a pathway so that people with the highest levels of need can access appropriate treatment, including accessing specialist inpatient services.

If a local area does not have access to specialist inpatient medically assisted withdrawal unit as described in this chapter, there should be an alternative pathway so people with complex physical and mental health conditions can access the care they need. For example, a local

agreement between commissioners and services that people with high risks spend at least 48 hours on a medical ward or medical assessment unit to stabilise their condition, before going on to complete medically assisted withdrawal in an appropriate specialist setting.

Commissioners and services should work to reduce any barriers that prevent people having rapid access to specialist inpatient medically assisted withdrawal such as prolonged funding processes or standard requirements. Clinicians should determine the urgency of need for rapid access for each individual.

Practitioners in community alcohol treatment services (and other referrers) should consider a person's need for specialist inpatient medically assisted withdrawal at their first assessment. Where clinical assessment identifies a need for specialist inpatient medically assisted withdrawal, they should refer the person without any unnecessary delays.

A period of preparation work before a person enters specialist inpatient medically assisted withdrawal may be useful. However, it is not helpful to have a standard requirement that people should attend a fixed number of groups or sessions to prepare them for specialist inpatient medically assisted withdrawal. This is because it could exclude people whose lives are particularly complex and who often face the highest risk. People with the highest levels of need may not be able to comply with requirements to attend a fixed number of meetings.

It is important that people being referred to specialist inpatient medically assisted withdrawal know what to expect from this treatment. Practitioners also need to make sure that the person already has in place an aftercare and contingency plan for after they are discharged. But these processes should not cause unnecessary delays in referring them to treatment.

12.6 Distinguishing between specialist inpatient and residential medically assisted withdrawal

12.6.1 Background

In 2006, the Specialist Clinical Addiction Network consensus project published 'Inpatient treatment of drug and alcohol misusers in the National Health Service'. This report distinguished between different levels of clinical input and supervision offered by inpatient or residential units providing medically assisted withdrawal. It introduced the terms 'medically managed' and 'medically monitored' to describe these different kinds of provision, which are still used in the treatment sector.

However, there is now some confusion and a lack of shared understanding about the kind of units that the 2 terms 'medically managed' and 'medically monitored' refer to. For this reason, the alcohol guidelines development group has not used these terms. Instead, this chapter introduces the terms 'specialist inpatient medically assisted withdrawal' and 'residential medically assisted withdrawal'. The chapter goes on to distinguish between these different settings and gives a detailed description of the core elements that units need to provide 'specialist inpatient medically assisted withdrawal' from alcohol. These units were formerly referred to as 'medically managed' inpatient settings. The core elements of

specialist medically assisted withdrawal units described below are based on clinical consensus of the alcohol guidelines development group.

12.6.2 Residential medically assisted withdrawal settings

Residential settings providing medically assisted withdrawal that do not have the core elements in place (as outlined in section 12.7 below) do not have the appropriate capacity to manage people with more severe withdrawal complications or complex co-morbidities. These guidelines refer to those services as residential medically assisted withdrawal settings.

Residential medically assisted withdrawal settings are suitable for people with alcohol dependence who would otherwise meet the criteria for undergoing a community based medically assisted withdrawal but are lacking adequate social support. Residential medically assisted withdrawal settings are important and provide a supportive environment for managing people with limited psychosocial support. They also support people who would benefit from an environment free from alcohol or drug using networks while going through medically assisted withdrawal.

Residential medically assisted withdrawal settings were formerly referred to as 'medically monitored' settings. These settings need to ensure that they meet the criteria and follow the guidance for a community medically assisted withdrawal set out in chapter 11 on community medically assisted withdrawal. There is no further information about residential medically assisted withdrawal settings in this chapter.

12.6.3 Defining specialist inpatient medically assisted withdrawal units

Specialist inpatient medically assisted withdrawal units are services that are staffed with appropriately trained specialist medical and nursing staff. These appropriately trained staff are able to manage people with more severe withdrawals and the associated complex physical and mental health conditions they can experience. The provision can be in the NHS, non-statutory or the private sector and may be in specialist units, which also provide stabilisation and management of withdrawal from other substances.

Within this group of specialist inpatient medically assisted withdrawal units there is wide variability in the workforce and the complexity of medically assisted withdrawal that they can manage. The guidance in section 12.7 below describes core elements of service provision for all specialist inpatient medically assisted withdrawal units. Specialist inpatient units can provide additional elements beyond these core elements if suitably staffed and equipped. Examples of additional elements that could enhance service provision are also included below.

All units should operate with a comprehensive quality assurance framework. They should assure themselves that staff have the appropriate competencies, and the unit has the appropriate facilities, systems, and protocols to meet the needs of their patients. All units need to have pathways to acute or mental health hospitals to meet the needs of patients if required.

12.7 Core elements needed in a specialist inpatient medically assisted withdrawal unit

12.7.1 A skilled and competent workforce

Core elements

All specialist inpatient medically assisted withdrawal units should have a workforce with relevant skills and competence. Core elements of a skilled and competent workforce include the following.

An addiction specialist leading the service. In most cases, this will be a consultant addiction psychiatrist or a specialist with a similar standard of training and expertise and acknowledged on the appropriate specialist register of the General Medical Council. The role of addiction specialist doctors in drug and alcohol services provides guidance on required competencies.

Registered nurses and doctors with different competencies, including registered mental health nurses, registered general nurses and doctors on the specialist register.

Staff with competencies in assessment for inpatient specialist medically assisted withdrawal and in comprehensive assessment of patient needs.

All clinical staff are competent in providing evidence-based medically assisted withdrawal, including identifying and managing severe complications. This should be in line with NICE CG115 and NICE clinical guideline Alcohol-use disorders: diagnosis and management of physical complications (CG100).

A team with several specific physical health and mental health competencies. This should include competencies to assess and manage a patient's complex physical health, mental health, concurrent drug use, and other complexities described in section 12.7.2 below.

Competence in the team to manage alcohol medically assisted withdrawal for pregnant patients, except where they have complex co-occurring conditions (see section 10.6.4 in chapter 10, for guidance on medically assisted withdrawal during pregnancy). In Scotland, pregnant patients are generally admitted to the maternity hospital for medically assisted withdrawal, under the care of multidisciplinary specialist antenatal substance use teams.

Competence in the team to provide a therapeutic environment and psychosocial interventions appropriate to the patients' stage of their treatment journey.

All staff undertake regular supervision and training to develop and maintain their competencies in line with clinical governance requirements. There should be mechanisms in place to monitor and ensure revalidation takes place for staff who are required to do so.

Access to or support from additional specialist staff including from:

- pharmacy
- psychotherapy or psychology
- other specialist services, for example physiotherapy and occupational therapy

People with lived experience of alcohol dependence are involved in service provision. This could include paid employees, volunteers or peer mentors. People with lived experience should also receive appropriate training, supervision and support.

Nursing competencies

All units should assure themselves that there are adequate numbers of nursing staff at a suitable grade to manage the service safely. All units require specific nursing competencies, which include the following.

On every shift, the team should include at least one registered mental health nurse (RMN) or one registered general nurse with appropriate additional skills in the management of complex alcohol withdrawals. These nurses should have a minimum of 6 months' experience in a specialist inpatient medically assisted withdrawal unit. Larger services will require more staff in their teams and possibly more than one RMN, depending on need.

An adequate number of registered nurses and healthcare assistants to staff the unit safely, depending on its size. Staff should be competent to use evidence-based assessment tools, risk management formulation and care plans.

Registered nurses with enhanced skills and experience of assessing and managing complex medically assisted withdrawal, complex physical health, mental health and drug use conditions and other complexities as described in section 12.7.2 below.

Registered nurses who are competent in using patient group directions.

Registered nurses who are competent in undertaking electrocardiograms (ECGs).

Registered nurses who are competent in undertaking relevant nursing tasks such as:

- administering parenteral thiamine
- dressing wounds
- performing venepuncture
- giving advice on blood-borne virus testing and vaccination
- managing medications such as possible side effects, concordance (reaching an agreement with the patient about prescribing and administering their medicines), and interactions

Additional elements that can enhance service provision

Some units have staff with relevant additional skills and competencies who can enhance service provision. Examples include:

- nurses trained in administering intravenous (IV) medication
- nurses trained to cannulate
- nurses trained as non-medical prescribers

- staff are able to manage patients with neurocognitive deficits, such as patients with alcohol related brain damage (ARBD) who need regular medication reviews to avoid over medication, falls and confusion
- specialist psychology provision, including neuropsychology for patients with ARBD dedicated to the unit
- a social worker dedicated to the unit
- specialist pharmacy provision dedicated to the unit
- allied health professionals dedicated to the unit, such as physiotherapists, dieticians, occupational therapists and speech and language therapists

12.7.2 Managing patients with complex needs

Core elements of managing complex needs that all specialist inpatient medically assisted withdrawal units should provide are set out below.

Admission and assessment

All specialist inpatient units should have a thorough admissions process where referrers are required to provide clinical information, including medical history and the results of physical examinations and tests, for each person they refer. An appropriately trained clinician from the specialist inpatient unit should screen the information on each new referral to assess whether the unit can safely manage the withdrawal process.

On accepting the patient into the unit, the team should further assess their physical, psychological, forensic and social needs, including any experience of domestic abuse. The clinicians responsible for screening and assessment should ask the referrer and the patient's GP for any additional relevant information on their needs and any risks. They should also develop a personalised care plan, which includes post-discharge planning. In specific cases, a member of the team may need to meet the referrer and the patient before their admission to the unit to discuss expectations of treatment and work together on a care plan.

Multi-agency working and pathways

All specialist inpatient medically assisted withdrawal units should have working relationships with other relevant health, social care and criminal justice services to support people with complex or multiple support needs. All units should work with the relevant community alcohol treatment service (or other referrer) and the patient's GP before and during treatment. Referrers and other relevant services should contribute to care planning, including discharge and contingency planning where appropriate. Patients will sometimes come from different local areas to the specialist inpatient unit and the community alcohol treatment services can offer relationships with and referrals to local services.

Identifying and managing severe alcohol withdrawal complications

All specialist inpatient medically assisted withdrawal units should identify and immediately manage severe alcohol withdrawal complications. These complications can include delirium tremens and seizures.

Core elements

Core elements of identifying and managing severe alcohol withdrawal complications include the following.

Staff competent to use recognised alcohol withdrawal scales to inform prescribing, for example the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar), and recognised early warning scales, for example the Royal College of Physicians' National Early Warning Score 2 (NEWS 2).

Staff competent in assessing and identifying the onset of severe withdrawal complications and intervening to prevent their escalation.

Skilled nurses competent in managing severe withdrawal complications, including delirium tremens, seizures and overdose.

The unit has procedures for escalating medication regimens when severe withdrawal complications occur.

The unit has developed treatment protocols and guidelines for recognising and immediately managing severe alcohol withdrawal complications.

The unit has an agreed pathway to acute physical and mental health hospital care where needed.

Additional elements that can enhance service provision

Some units with suitably trained and experienced medical and nursing staff and appropriate facilities may be able to treat acute and severe complications of withdrawal without transferring patients to an acute setting. Those units should have clear criteria for escalating care to safely manage and treat severe withdrawal complications. Where units are able to offer this, the person can receive tailored care in a specialist setting throughout the process of medically assisted withdrawal.

You can read more about identifying and treating severe withdrawal complications in sections 10.4.1 to 10.4.3 of chapter 10 on pharmacological interventions and in section 16.9 in chapter 16 on alcohol care in acute hospitals.

Assessing and managing Wernicke's encephalopathy

All specialist inpatient units should be able to assess patients at risk of WE and those with incipient WE and manage this appropriately.

Core elements

Core elements of assessing and managing Wernicke's encephalopathy include the following.

Staff competent to identify patients at risk of developing WE

Staff competent to treat patients at risk of WE with intramuscular thiamine.

The unit has an established pathway for patients with incipient WE so that they can access treatment immediately. There is also an established pathway to an acute hospital.

The unit has an agreed treatment pathway for patients with established Wernicke-Korsakoff syndrome.

Additional elements that can enhance service provision

Some units have specialist clinical competencies and facilities to provide high dose intravenous thiamine in patients with suspected or confirmed WE. This is so patients can be treated in the unit and not transferred to an acute setting.

You can read more guidance on WE in section 10.4.3 of chapter 10 on pharmacological interventions and in section 16.9.4 in chapter 16 on alcohol care in acute hospitals.

Assessing and managing complex physical health conditions

All specialist inpatient medically assisted withdrawal units should be able to assess and manage a patient's complex physical health conditions. This includes alcohol-related conditions, such as liver disease, as well as more common physical health conditions unrelated to alcohol.

Core elements

Core elements of assessing and managing complex physical health conditions include team competencies and arrangements in the following areas.

Staff are able to assess patients using early warning scales such as the NEWS 2. As a minimum this needs to be completed 6 times during the first 72 hours of admission. There should also be procedures in place for escalating any concerns about the patient's condition and managing them if they start deteriorating.

Staff are able to assess and manage pregnant patients for specialist inpatient alcohol treatment. In Scotland, pregnant patients are generally admitted to the maternity hospital for medically assisted withdrawal, under the care of multidisciplinary specialist antenatal substance use teams.

Staff are able to assess and manage patients for medical emergencies. The team should include nurses qualified to provide immediate life support (ILS) and basic life support (BLS). Other competencies include assessing and managing patients for anaphylaxis, overdose and naloxone prescribing.

Staff are able to assess and manage patients for common medical conditions, for example diabetes, myopathy, balance, falls and mobility issues.

Staff are able to undertake investigations, such as blood tests, ECGs, venous thromboembolism risk, and can understand the laboratory results and act on those results.

Staff are able to assess and manage malnourished patients.

Staff are able to identify and manage patients with alcohol-related liver disease.

Staff are able to provide smoking cessation interventions and manage chronic obstructive pulmonary disease.

The unit has pathways into relevant local primary and secondary care services, and social care services, and staff are aware of these pathways.

The unit has an agreed pathway for transferring patients to an acute hospital in an emergency.

It's important to note that the list above contains a combination of competencies that the team needs to have (as a team, not necessarily for every staff member in the team) and relevant arrangements they need to have in place, such as appropriate procedures and equipment. This applies to the core elements set out in the following sections as well.

Additional elements that can enhance service provision

Some units have additional staff competencies and facilities for assessing and managing complex physical health conditions. These could include the following.

Appropriately trained staff with higher level physical health skills, including GPs and physicians, able to assess and provide initial treatment for a range of alcohol-related physical health conditions.

Staff with experience in using vitamin K for clotting disorders.

Staff who are able to assess and manage specialist alcohol treatment for pregnant women and other people who are pregnant and have other complex co-occurring conditions, such as severe mental health conditions.

Some units have access to urgent laboratory results and integrated record systems.

Some units can offer virtual ward rounds with primary and secondary care services as an expansion of multidisciplinary team working.

Assessing and managing mental health conditions

All specialist inpatient medically assisted withdrawal units should be able to provide assessment and management of mental health conditions. Mental health problems may manifest during medically assisted withdrawal or may be part of an ongoing co-occurring mental health condition. These could include common mental health conditions, such as depression and anxiety, and severe mental health conditions, such as psychosis.

Core elements

Core elements of assessing and managing mental health conditions include team competencies and arrangements in the following areas.

Staff are able to carry out a mental health assessment, risk formulation and assessment and manage mental health conditions.

Staff are able to apply the appropriate legal framework to assess mental capacity and manage issues where people lack the relevant capacity (see annex 1 for relevant national legislation and guidance).

Staff have knowledge and experience of the Mental Health Act, Mental Capacity Act (including the Deprivation of Liberty Safeguards), or equivalent legislation in the devolved nations. They should also understand how these apply to patients undergoing medically assisted withdrawal (see annex 1 for relevant national legislation and guidance).

The unit has robust risk management plans and safeguarding procedures in place to either implement these legal frameworks or urgently transfer the patient to the appropriate facility.

The unit has clearly established pathways to inpatient and community mental health services.

The team provides trauma-informed care, recognising that many patients will have experienced trauma. The unit has developed pathways for ongoing management of trauma-related mental health difficulties both during and after medically assisted withdrawal.

You can read more about trauma-informed care in section 2.2.8 of chapter 2 on the principles of care.

Additional elements that can enhance service provision

Where units have the appropriate quality governance frameworks, facilities and staff competencies they may be able to provide one or both of the following elements.

Staff manage severe acute behavioural disturbances associated with imminent risk to self and others, for example through using the Mental Health Act or equivalent national legislation, rapid tranquillisation and seclusion, as appropriate (see annex 1 for information on national legislation and guidance).

Staff with appropriate approval in the team are able to assess and apply the Mental Health Act and manage patients detained under the act or other equivalent national legislation.

Medically assisted withdrawal in patients with co-occurring substance use

All units should have competencies to manage medically assisted withdrawal from alcohol in patients who are using a range of licit and illicit drugs, including opiates, stimulants or sedatives, in addition to alcohol. Some patients will continue to be prescribed medication (for example, methadone or benzodiazepines) during the medically assisted withdrawal, while some patients will require medically assisted withdrawal from additional substances as well as alcohol.

Core elements

Core elements of managing patients with co-occurring drug use include the following.

Staff competence within the team to understand and assess the importance of co-occurring substance use and how this may affect the medically assisted withdrawal from alcohol.

The unit has appropriate protocols and procedures for managing a range of complex medically assisted withdrawal often required in this group. For example, this could include patients who are also using benzodiazepines, GBL, new psychoactive substances, crack cocaine or methadone.

Additional elements that can enhance service provision

Some units will have the necessary staff competence and arrangements in place to manage more complex medically assisted withdrawal from alcohol and one or more substances at the same time.

You can read more about medically assisted withdrawal from alcohol for people who have co-occurring drug use, including co-occurring benzodiazepine dependence, in section 10.6.1 of chapter 10 on pharmacological interventions. You can read guidance on drug use and dependence, including medically assisted withdrawal, in Drug misuse and dependence: UK guidelines on clinical management.

Alcohol related brain damage

All specialist medically assisted withdrawal units should have competencies and procedures to identify possible ARBD and develop assessment and referral protocols for ongoing management.

Core elements

Core elements of managing patients with alcohol related brain damage include the following.

Competence within the team and procedures to complete routine psychometric screening for possible ARBD using a validated tool, such as the Addenbrooke's Cognitive Examination - III (available through the NHS Scotland Addenbrookes Cognitive Examination page). The team may also use the 'Montreal Cognitive Assessment', available on the MoCA Cognition website (the test is copyrighted and requires registration and payment).

The unit has established pathways for referring patients for a specialist neurological assessment and treatment where ARBD is suspected or indicated following screening.

Staff have knowledge and expertise in applying the Mental Capacity Act or equivalent national legislation in relation to patients with ARBD.

Staff tailor communication and psychosocial interventions to the needs of people with ARBD (see chapter 20 on alcohol related brain damage for guidance on tailoring communication and interventions).

The unit has a multidisciplinary approach to discharge planning.

Additional elements that can enhance service provision

Some units have access to a full multidisciplinary team during the admission to assess the ongoing treatment requirements for patients with ARBD and help refer them into

appropriate therapeutic settings. The team can include input from neuropsychology, social work, physiotherapy and occupational therapy.

You can find guidance on ARBD in chapter 20.

12.7.3 Safeguarding

Core elements

All specialist inpatient medically assisted withdrawal units should comply with national safeguarding legislation and statutory guidance. You can find information on safeguarding legislation and statutory guidance for each of the UK nations in annex 1.

Core elements of this provision include the following.

The unit has organisational safeguarding procedures and governance structures in place. It complies with relevant national legislation on child and adult safeguarding.

All staff trained in child and adult safeguarding and able to make a safeguarding referral.

The unit has mechanisms to involve patients' family, partner or appropriate friends in safeguarding risk assessment, care planning and treatment decisions.

All staff trained to make routine enquires on domestic abuse and respond appropriately to current risks.

Additional elements that can enhance service provision

Additional elements that can enhance service provision include some units having access to dedicated social workers.

12.7.4 Psychosocial interventions

Core elements

All specialist inpatient medically assisted withdrawal units should provide therapeutic support based on the principles of care set out in chapter 2. Core elements of therapeutic support include the following.

The unit's ethos and approach of staff towards patients is non-judgmental, empathic and non-stigmatising.

Staff provide culturally competent care.

The service and staff provide a trauma-informed approach to care. This includes helping people to manage distressing thoughts and feelings that might become apparent during the medically assisted withdrawal process. And where appropriate, assessing the person for any ongoing trauma-focused treatment they may need.

Individual and group psychosocial interventions are available, and staff are proactive in encouraging patients to engage in psychosocial support based on individual assessment.

The service offers psychosocial interventions including:

- motivational interventions
- psychoeducational interventions providing information on alcohol dependence and basic harm reduction advice (see chapter 8 on harm reduction)
- relapse prevention support and recovery planning for patients after discharge

Staff help patients to access mutual aid groups (such as Alcoholics Anonymous and SMART Recovery programmes) or peer support groups that may run in the unit and promote their value as part of a recovery support plan (see chapter section 5.5.4 of chapter 5 on facilitating access to mutual aid and peer support and chapter 6 on recovery support services).

Staff identify mental health conditions and provide support and information for ongoing management of these conditions through national and local pathways to psychological therapy services, and bereavement services.

Staff provide information and support for families, partners or supporting friends.

Additional elements that can enhance service provision could include

Additional elements that can enhance service provision could include some units having:

- 7-day availability of a therapeutic support service
- initial psychological support based on evidence-based approaches, such as cognitive behavioural therapy for common mental health conditions, including post-traumatic stress disorder
- mindfulness-based relapse prevention
- family interventions delivered by a family therapist, such as initial assessment and referral for ongoing support
- couples-based interventions delivered by a couples or family therapist, such as initial assessment and referral for ongoing support

You can find detailed guidance on psychosocial interventions in chapter 5.

12.7.5 Pharmacological interventions for relapse prevention

Core elements

All clinicians in specialist inpatient medically assisted withdrawal units should be competent to provide pharmacological interventions for relapse prevention, including prescribing acamprosate, naltrexone and disulfiram.

Additional elements that can enhance service provision

Experienced specialist clinicians may also prescribe baclofen and other novel medications based on clinical assessment. This should be done in consultation and with agreement of clinicians continuing the care plan after discharge.

You can find guidance on pharmacological interventions for relapse prevention in section 10.5 of chapter 10 on pharmacological interventions.

12.7.6 Out of hours cover

Core elements

All specialist inpatient medically assisted withdrawal units should have arrangements for out of hours cover and make sure that these are adequate for the safe running of the unit and the number of patients they treat. Core elements of this provision will include:

- at least one registered ILS trained nurse and one other appropriately trained member of staff (larger units require additional staff)
- 24-hour in-person clinical cover for acute assessment and management of withdrawals
- out of hours on call cover arrangements that can:
- provide access to medications
- arrange for replacement staff to respond to any staff shortages
- respond to medical emergencies and overall be able to manage acute withdrawals
- respond to safeguarding concerns and incidents affecting the safe running of the unit
- have a duty doctor, consultant psychiatrist or senior clinical manager available on call to support these arrangements

Additional elements that can enhance service provision

Additional elements that can enhance service provision include some units having access to on-call pharmacist provision.

12.7.7 Referral pathways

Services have two-way referral pathways, and they communicate effectively with these other relevant services to provide comprehensive assessment, care and discharge planning for their patients. All units should be able to confidentially share patient information appropriately across systems. Pathways should include:

- GP and wider primary care, including community pharmacy
- secondary care and acute hospitals
- primary, secondary and crisis mental health services
- safeguarding and social care services
- community alcohol treatment services and residential treatment services
- psychological services
- neuropsychology services and memory clinics

- housing and homelessness services
- criminal justice services
- community services, such as domestic abuse services
- lived experience recovery organisations and mutual aid groups
- support organisations for family members and carers

13. Community alcohol treatment and recovery services

How community alcohol treatment and recovery services can provide accessible, trauma-informed, inclusive care. This includes how they work with health, care and recovery services to develop personalised treatment plans and deliver evidence-based interventions.

13.1 Main points

Community alcohol treatment services should:

- provide a positive experience of care for people who are stigmatised and disadvantaged
- promote a trauma-informed therapeutic environment that can help engage and involve people in their treatment and recovery
- make sure the service is accessible to anyone who needs alcohol treatment
- promote equitable access and personalised treatment that meets the diverse needs of the local population, including people with protected characteristics, socially excluded groups and those with specific needs such as very poor health
- implement a quality governance framework informed by strong clinical leadership to help deliver safe, appropriate care and evidence-based treatment
- make sure that integrated drug and alcohol treatment services are inclusive for people whose main or only substance problem is alcohol
- be part of a recovery-oriented system of care which offers alcohol treatment integrated with longer-term recovery support
- involve peer support networks and organisations in service feedback, design, monitoring and in delivering recovery support
- work in partnership with the wider health and social care system, criminal justice system and community services at a strategic and a service level
- develop service level agreements and information sharing arrangements with partner services to provide integrated care to people with multiple needs and support transitions from one service to another
- have competent, caring staff who are well-trained and supervised and have appropriate caseloads
- provide quick and easy access to initial assessment, urgent treatment and risk management, and comprehensive assessment
- offer a named keyworker, personalised, collaborative treatment and recovery planning and structured support for each person in treatment
- offer evidence-based alcohol focused psychosocial, recovery support, pharmacological and harm reduction interventions

13.2 Introduction

In every local area there should be community alcohol treatment and recovery services for adults and for young people. These services should:

- provide a positive experience of care
- be designed to meet the alcohol treatment needs of the local community
- be easy to access
- provide evidence-based interventions

Most people access alcohol treatment in community services and those who need planned inpatient or residential treatment can access this through referral from community services.

Most of these clinical guidelines are relevant for community alcohol treatment and recovery services. So, this chapter summarises the main elements of adult community alcohol treatment and recovery services and directs you to other sections in the guidelines that provide more detailed guidance on each element.

Chapter 23 provides guidance on community alcohol treatment and support for young people.

You should also read this chapter together with chapter 25, which provides guidance on developing inclusive alcohol treatment services.

13.3 Core elements of community alcohol treatment

13.3.1 Principles of care

You should read guidance on principles of care in chapter 2.

These principles should form the foundation of a community alcohol treatment and recovery service.

They include service and system arrangements and clinical practice that contribute to:

- a positive experience of care
- equality, diversity and inclusion
- quality governance
- recovery-oriented care and systems of care
- local strategic partnerships

13.3.2 Designing services to meet the alcohol treatment needs of the local community

Community alcohol treatment services should be based on the unique needs of the local area they serve.

While the form of local strategic partnerships vary across the UK, there should be a local strategic partnership that commissions and plans alcohol and drug treatment for their area.

Each local strategic partnership should co-produce an assessment of local need involving local people and communities in the process, including those with lived and living experience of alcohol problems. If community services are combined alcohol and drug treatment services, the distinct needs of people with problem alcohol use, people with problem drug use and people with both alcohol and drug problem use should be identified. The community alcohol treatment and recovery service should be aware of the local needs assessment and of any changing local needs.

Service providers should design services so that they are accessible to everyone in their local area. They should work with people with protected characteristics and socially excluded groups to identify their needs and co-produce plans to target and tailor services to those groups.

You can read more about targeting and tailoring services in:

- chapter 25 on developing inclusive services
- chapter 9 on alcohol assertive outreach and a multi-agency team around the person
- chapters 18 to 24, 26 and 27 on specific populations

13.3.3 Service ethos

Creating a positive service ethos

Service ethos describes the culture and feel of a service. There are a number of things that a service can do to make sure they have a positive ethos, including having:

- strong clinical leadership
- engaged staff
- clear and supportive management direction
- a service framework based on the principles of care outlined in chapter 2

Making good first impressions

First impressions of a treatment service can have a lasting impact on a person. These impressions can affect their experience of assessment, how they engage with the treatment process and ultimately affect their treatment outcomes.

Services can avoid or limit stigmatising and stereotyping people with problem alcohol use by paying attention to:

- how staff interact with people on the phone or online
- how staff interact with people face-to-face at reception or in clinical interactions
- how the service ethos is portrayed in its information about itself
- the environment in which assessment and treatment take place

This applies to people who need alcohol treatment, as well as their family or carers.

13.3.4 Meeting the needs of people with primary problem alcohol use in integrated drug and alcohol treatment services

Integrated drug and alcohol services should be organised so that people whose main substance problem is alcohol:

- feel they are in the right place to seek help
- get a treatment offer that is tailored to their alcohol treatment needs
- feel safe and supported

To make integrated drug and alcohol services more inclusive to people with problem alcohol use, the services should make sure that:

- the service name is inclusive (not called a drug treatment service)
- there is visible information on site specifically for people with problem alcohol use
- the service is promoted to people whose main substance problem is alcohol, using targeted service information
- they offer evidence-based alcohol-focused interventions
- they have a dedicated alcohol team or staff with alcohol specific competences
- they have information about alcohol and alcohol treatment options available and staff are competent to discuss these options with people
- it's clear that people can make their own choices about treatment options
- they offer to host peer support organisations and mutual aid groups such as Alcoholics Anonymous on the service site

13.4 Partnership working

Community alcohol treatment and recovery services provide specialist alcohol treatment and recovery support, but they cannot meet all the needs of people with problem alcohol use or their families. So, it's essential that they work in partnership with other local services and with peer support organisations to meet those needs. Community alcohol treatment and recovery services have a vital role to play in the wider partnership approach. Local strategic partnerships should support local services to develop and maintain effective partnerships and play a role in addressing any difficulties in partnership working at service level.

13.4.1 Working with peer support organisations

In some areas, peer support networks are closely linked to the community alcohol treatment service and in others they are independent lived experience recovery organisations. Community alcohol treatment services should involve peer support organisations or networks in the service.

You can read more about working with peer support organisations in section 2.6.5 in chapter 2 on principles of care.

You can read more keyworkers helping people to access peer support organisations and mutual aid as part of the structured support they offer in section 5.5.4 in chapter 5 on psychosocial interventions.

You can read guidance on recovery support services, including more on peer support organisations, in chapter 6.

13.4.2 Integrated care pathways with partner services

Local strategic partnerships should agree how local systems will work together to meet the needs of people with problem alcohol use. The community alcohol treatment and recovery service has an important role in making and maintaining service level agreements to support integrated care pathways.

With each partner service, community alcohol services should agree:

- clear referral pathways into the community alcohol treatment and recovery service
- how the alcohol service can refer people to the partner service
- joint working arrangements, setting out who is responsible for what
- information sharing agreements and mechanisms
- to attend and contribute to multi-agency case conferences and care planning reviews

Effective partnership working at service level requires support from local strategic partnerships. So, commissioners and leaders in local strategic partnerships should support local services to:

- develop and maintain effective partnerships
- address any difficulties they have integrating pathways with partner services

Commissioners and service managers need to allocate time and provide training for staff to work in partnership with other services. Where possible it is helpful for a named staff member in the community alcohol service and in each partner service to lead on partnership working.

Services should make sure that all their staff are aware of and updated on the pathways and related information sharing arrangements.

13.4.3 Co-ordinating care with partner services

Service level agreements with partner systems and services should include agreements between the community alcohol treatment and recovery services and a wide range of other services, including:

- GPs and local primary care networks, including pharmacy teams

- liver screening and liver departments in hospitals
- alcohol care teams in local acute hospitals
- community, inpatient and crisis mental health services
- neuropsychology and services for cognitive impairment (for alcohol related brain damage)
- occupational therapy services
- antenatal and maternity services
- early help and child safeguarding services
- adult social care and safeguarding services
- criminal justice services including police custody suites, courts and prisons
- homelessness and housing services
- domestic abuse services
- community services working with people with protected characteristics or socially excluded groups, including people experiencing severe and multiple disadvantage

You can read more guidance on partnership working with these services in the relevant chapters on specific settings and specific populations in part 2 of the guidelines.

13.4.4 Continuity of care and transitions

Transitions from one service to another, or one setting to another, are often vulnerable times for people, even when transitions are about making progress in recovery. Services need to work in partnership so that people:

- stay engaged with services throughout the transition and settle into the new service
- get the level of support they need to manage the transition (which can mean a temporary increase in support)

Adult community alcohol treatment services should have ongoing agreed continuity of care arrangements with several services. These services include:

- young people's community alcohol treatment service
- specialist inpatient medically assisted withdrawal
- residential rehabilitation
- liver departments in acute hospitals, including liver transplant specialists
- hospital alcohol care teams
- prison substance use or healthcare services and probation services

When a person makes one of these transitions, both (or all) services involved and the person should agree an individually tailored transition plan. This should be agreed well ahead of the transition, so the person is appropriately supported at a vulnerable time.

You can read more guidance on these transitions in other parts of the guidelines, including:

- sections 9.8.7 and 9.8.8 in chapter 9 on alcohol assertive outreach and a team around the person
- section 12.7.2 in chapter 12 on specialist inpatient medically assisted withdrawal
- section 14.4 in chapter 14 on residential treatment and intensive structured day treatment
- section 16.10 in chapter 16 on discharging patients from acute hospitals to ongoing treatment and care
- sections 17.5.6 and 17.6 in chapter 17 on alcohol treatment in criminal justice settings
- section 18.7.3 in chapter 18 on people with co-occurring mental health conditions
- sections 23.8 in chapter 23 on alcohol treatment and support for young people

13.5 Caring and competent staff

Community alcohol treatment and recovery services should be staffed with a multidisciplinary team that includes:

- doctors
- nurses
- psychologists
- social workers
- family support workers
- peer support workers
- other practitioners

Caring and competent staff are vital to an effective community alcohol treatment and recovery service. Staff should be able to form therapeutic alliances with people who are stigmatised, often marginalised and with high levels of trauma. This requires care and skill.

Staff also need alcohol specific competences. In integrated drug and alcohol services there should be enough staff with alcohol specific competences and specialist expertise to meet alcohol treatment need.

You can read guidance on staff competences in section 2.5 on a skilled and competence workforce.

13.6 Assessment

The community alcohol service should provide quick and easy access to:

- initial assessment
- urgent treatment and risk management
- comprehensive assessment including risk assessment

Assessment involves the person choosing an alcohol use goal. Severity of dependence and complexity of need provide broad indicators for appropriate alcohol use goals, but these should always be mutually agreed between the person and the assessor.

You can find detailed guidance on assessment in chapter 4 on assessment and treatment and recovery planning.

13.7 Personalised treatment and recovery planning

Based on assessment, formulation (see the glossary) and discussion of available treatment and recovery support interventions, the assessor or allocated keyworker should agree a treatment and recovery plan with each person.

Care should always be personalised and plans should be regularly reviewed. Personalised care should take into account important aspects of a person's identity and experience, including any protected characteristics.

Each person should also have a risk management (safety) plan that is regularly reviewed.

You can find guidance on treatment and recovery planning, including risk management (safety) planning in section 4.10 in chapter 4 on assessment and treatment and recovery planning.

You can find guidance on formulation in section 5.4 in chapter 5 on psychosocial interventions.

13.8 Evidence-based alcohol interventions

Community alcohol treatment and recovery services should offer evidence-based alcohol interventions. These should include:

- psychosocial interventions
- access to recovery support interventions
- pharmacological interventions
- harm reduction interventions

The choice of treatment options (in-house or through referral) should be clear to the person when they enter treatment and during their assessment.

Clinicians and other practitioners should provide accessible information on the risks, benefits for the person and on known outcomes of interventions, so the person can make informed decisions about their choice of treatment.

13.8.1 Psychosocial interventions

Psychosocial interventions are an essential part of treatment for everyone. They should always take place in the context of a broader personalised treatment and recovery plan.

The service should offer everyone in treatment a named keyworker who provides structured support. Structured support involves using specific psychosocial interventions that are common to evidence-based psychological treatments for alcohol and drug use.

Services should also offer formal psychological treatments focused specifically on alcohol-related problems according to individual need. These treatments are generally provided by a specialist member of the multidisciplinary team alongside a keyworker who provides structured support.

You can find guidance on structured support in section 5.5 and formal psychological treatments in section 5. 7 in chapter 5 on psychosocial interventions.

13.8.2 Recovery support interventions

Keyworkers should help people to set recovery goals in their treatment and recovery plan and help them to access appropriate recovery support interventions. Recovery support is important from the beginning and throughout treatment and especially after the person has left structured treatment.

Recovery support interventions can include:

- involvement in recovery-oriented peer support activities and mutual aid
- employment support
- education, training and volunteering
- involvement in supportive family and social networks
- involvement in cultural and community networks
- support for health and wellbeing
- recovery check-ups after the person has left structured alcohol treatment and re-engagement plans

Alcohol treatment and recovery services should have pathways and joint working arrangements with recovery support services including peer support organisations so they can help people access emotional and practical support for their ongoing recovery from alcohol dependence.

You can read about the keyworker's role in providing recovery interventions as part of the structured support they offer in section 5.5 3 and 5.5.4 in structured support in chapter 5 on psychosocial interventions.

You can read more about recovery support services in chapter 6 on recovery support services and in chapter 7 on employment support.

13.8.3 Pharmacological interventions

Pharmacological interventions are used:

- for medically assisted withdrawal from alcohol
- to prevent and manage specific complications of withdrawal from alcohol
- to prevent Wernicke-Korsakoff syndrome in people at high-risk who continue to drink alcohol, as well as those undergoing withdrawal
- to reduce craving, prevent relapse and promote abstinence
- to reduce alcohol consumption in specific groups of people who have a high drinking risk level

You can read more guidance in:

- chapter 10 on pharmacological interventions
- chapter 11 on community based medically assisted withdrawal

13.8.4 Harm reduction interventions

A goal of abstinence is usually recommended for people with moderate or severe dependence and practitioners should give people information about the risk of harm associated with their level of alcohol use. If a person understands the recommendation but is not ready or chooses not to consider abstinence or, where appropriate, low risk drinking, this should not be a reason to deny them support from the alcohol treatment service. The practitioner can agree an initial goal of harm reduction with the person and they can regularly review this. For people with severe dependence or complex co-occurring physical and mental health conditions, the practitioner should ultimately encourage a goal of abstinence.

You can read guidance on alcohol use goals in section 4.7 of chapter 4 on assessment and treatment and recovery planning.

You can read guidance on harm reduction in chapter 8.

13.9 Commissioning and contracting community alcohol treatment services

Commissioning and contracting arrangements vary across the UK. These processes play an important role in shaping community alcohol treatment and recovery services.

Where services are integrated alcohol and drug services, service specifications should set out distinct requirements for alcohol treatment and for drug treatment and monitor

effectiveness of their delivery. These guidelines focus on service delivery rather than commissioning and contracting but the Office for Health Improvement and Disparities' Commissioning quality standard provides guidance on commissioning drug and alcohol treatment services. The standard applies to England but some of the content may be useful for other UK nations.

14. Residential treatment and intensive structured day programmes

Residential treatment and intensive structured day programmes for alcohol dependence aim to help people achieve abstinence and begin recovery through evidence-based interventions. This includes group work, individual support and planning for continuity of care in the community.

14.1 Main points

Residential and intensive day programmes are an important part of a recovery-oriented system of care.

Services should be trauma-informed and have clear clinical governance structures and policies including for staff supervision.

Programmes may be based on different therapeutic approaches and these should be explicit to enable service user choice.

Residential treatment focused on abstinence should be available for people with the most complex needs, particularly people experiencing homelessness.

Structured day programmes can provide intensive support to people in their communities and are a useful addition for people living in supported accommodation.

There should be as seamless transition as possible into residential and intensive day programmes for people completing medically assisted withdrawal.

It is important to prepare people for residential and intensive programmes but not at the expense of making it hard for them to access.

Multi-agency planning involving the person should take place to help the person integrate back into community treatment and recovery support in their local community before they leave residential treatment.

14.2 Introduction

This section provides guidance on residential treatment and structured day treatment.

Intensive structured treatment programmes can be provided in either a residential treatment setting or a community treatment service or a day hospital. These programmes are designed to meet the needs of people who need a higher level of support to achieve their treatment and recovery goals than they could receive through standard community alcohol treatment (Orchowski and Johnson, 2012; Coco and others, 2019).

Residential treatment programmes are one of the longest established forms of treatment for alcohol and drug dependence. A recent systematic review of research published between 2013 and 2018 found moderate quality evidence for the effectiveness of residential treatment in improving outcomes across a number of substance use and life domains (de Andrade and others, 2019).

The National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) recommends residential treatment for people who are experiencing homelessness.

The NICE clinical guideline Drug misuse in over 16s: psychosocial interventions (CG51) recommends considering residential treatment for people who are seeking abstinence and who have significant co-occurring physical health, mental health or social (for example, housing) conditions and have not benefited from previous community treatment. The clinical consensus of the alcohol guidelines development group is that these criteria are also applicable to people with alcohol dependence.

There are mixed findings on the effectiveness of residential treatment compared with structured day treatment of a similar intensity and duration. NICE CG115 recommends more research in this area because studies are limited, and no recent comparative studies have been reviewed.

14.3 Intensive structured treatment programmes

14.3.1 Types of intensive structured treatment programmes

Intensive structured treatment programmes, whether in a residential or day setting, support people to achieve abstinence and encourage their recovery. Intensive programmes usually provide daily structure and a focus on health, personal and social functioning, as well as treatment and recovery goals.

The programmes are varied because they are based on different therapeutic approaches and use a range of different treatment components. Programmes are usually abstinence based and include:

- individual sessions
- structured group work and participating as a member of a community
- social and recovery-oriented activities
- encouragement to join mutual aid groups, peer networks and peer support services
- family support and involvement where appropriate

There is no clear evidence about optimal treatment length, although several studies have found that longer programmes (lasting 3 months or more) are associated with better treatment outcomes (Eastwood and others, 2018; Helena Kennedy Centre for International Justice, 2017).

The length of time somebody should be in an intensive treatment programme should be tailored to their needs but should also allow enough time for them to:

- engage with the programme
- build trust with the staff

- commit to the treatment community
- work on individual change
- get ready for reintegration to their community after treatment

The time needed for all of this will vary from person to person.

14.3.2 Residential treatment

Residential treatment services are an important part of a recovery-oriented system of care. Every local area should provide access to this treatment option for the minority of people who require intensive support to achieve abstinence and begin their recovery.

Residential treatment services are facilities where residents stay overnight, usually for several months. They are run by voluntary and private sector organisations and in Scotland there is also some statutory provision.

Residential treatment provides a daily structure and safe place for people who may have come from unsafe circumstances, including rough sleeping or living in an abusive situation. It provides a complete break from current social networks that revolve around alcohol use or from high-risk situations in the community. People who are susceptible to returning to drinking or who have vulnerable mental health may need the 24-hour support that these services can provide, beyond the formal programme interventions. A placement in residential treatment can give people the space to build their recovery resources and develop the skills they need to sustain longer-term recovery and reintegration into the community.

Entering residential treatment and returning to the community can both be challenging transitions. Both these transitions require preparation and planning to minimise people's risk of leaving treatment unplanned or returning to problematic drinking after they leave (see section 14.4).

Some residential services provide medically assisted withdrawal before the person moves on to the main part of the intensive structured programme.

You can find guidance on medically assisted withdrawal in chapter 10 on pharmacological interventions, chapter 11 on community medically assisted withdrawal and chapter 12 on inpatient medically assisted withdrawal.

14.3.3 Intensive structured day treatment

A structured day programme may be a more accessible treatment option for people who do not want or need residential treatment, such as those who have a good local support system and stable and secure accommodation.

In the UK, intensive structured day treatment programmes generally require the person to attend for 4 or 5 days each week and normally last between 4 and 12 weeks. Ideally the length of treatment should be tailored to the needs of the person.

Intensive day treatment provides a high level of structure and support, while allowing the person to maintain day to day contact with their support networks and remain in their accommodation. People usually attend intensive day treatment while living at home, but some programmes are designed for people living in supported accommodation for the duration of their treatment, which can offer additional stability to support recovery.

Intensive day programme participants typically return home each evening and have to manage weekends without access to treatment activities. Real world exposure to everyday issues or drinking cues during the treatment programme may help them to practice their new skills and techniques and link in with local recovery support networks as these challenges arise (Leighton 2016).

14.3.4 Core elements of intensive structured treatment programmes

All intensive structured treatment programmes (day or residential) should have:

- a coherent treatment programme with a clear rationale and therapeutic framework
- a consistent risk assessment process, both for medically assisted withdrawal (if the service provides this) and the psychosocial programme
- a comprehensive assessment process that fully involves the person with alcohol dependence, and leads to a personalised treatment and recovery plan
- clear links between the assessed needs of a person and the interventions they receive
- evidence-based group interventions delivered by trained staff who receive clinical supervision for a groupwork approach and for the specific interventions
- individual key working support with a named keyworker that runs alongside the group programme
- a focus on community reintegration throughout the programme, encouraging people to build recovery resources by getting involved in mutual aid groups or peer support networks or services
- individually agreed plans for ongoing treatment and recovery support after the person has left the programme (sessional, day or extended residential depending on assessed need)
- strong links with community alcohol treatment services who should contribute to planning for ongoing treatment and recovery support after the person leaves the programme

14.3.5 Therapeutic approach

Intensive structured treatment programmes use a range of therapeutic, recovery-focused approaches. These include programmes where the central focus is therapeutic community, the 12-step model, and programmes based on cognitive behavioural therapy. Other approaches used in UK settings have included faith-based programmes, or personal and

skills development-based models. Most residential treatment programmes are now fairly eclectic and draw on a range of interventions. There is no strong evidence to support one evidence-based approach over another.

The perceived quality of the programme is an important indicator of outcome. For example, one study reported that people who saw their residential treatment programme as more involving, cohesive, well-organised, and oriented toward independence and self-understanding had better drinking-related outcomes (Moos and Finney, 1983).

In both residential and community settings, evidence suggests that an effective programme has a welcoming, accepting ethos and a highly structured and predictable programme. These factors are likely to be more important than the theoretical basis or exact content of the programme because they provide the context for building trust, commitment, and starting to make significant change (Leighton, 2017).

Intensive structured treatment programmes tend to be based on the therapeutic value of being part of a community. This can include formal structured activities in which staff and residents are expected to participate (such as community meetings), and peers offering support to each other. Peers can support one another as part of formal group therapy. Peers who are further on in the treatment programme can also act as role models as they interact with newer participants during daily shared activities. Participating in the community helps people to gain social skills in an alcohol-free, recovery-oriented environment.

14.3.6 Trauma-informed care and cultural competence in intensive structured treatment programmes

Services and practitioners should apply all of the core principles of care outlined in chapter 2 to intensive structured treatment programmes.

Services should recognise the importance of trauma-informed care and related staff competencies. Intensive structured treatment programmes have the potential to trigger traumatic memories because of their intensity and their focus on groupwork. And, in the worst case, can seriously retraumatise participants. This may be particularly relevant in residential settings where shared living arrangements mean that people are always near one another when they are feeling vulnerable. Providers of intensive structured treatment programmes should develop and maintain a trauma-informed treatment environment. All staff should be trained in trauma-informed care.

Cultural competence is essential for all services and practitioners. Given the intensity of day and residential structured programmes, services should make extra effort to make sure they are inclusive, safe and effective, taking into account differences in:

- culture
- ethnicity
- religion
- sex

- gender identity
- sexual orientation
- age
- physical ability

Services should provide training in cultural competence and regularly review their staff's cultural competence.

14.3.7 Quality governance

There should be a strong focus on the overall service quality and on quality governance for intensive structured treatment programmes.

You can find guidance on quality governance in section 2.4 in chapter 2 on principles of care.

Residential treatment services should be registered with national regulatory bodies and comply with their standards.

The national regulatory bodies are:

- Care Quality Commission (England)
- Healthcare Improvement Scotland and the Care Inspectorate (Scotland)
- Healthcare Inspectorate Wales
- Regulation and Quality Improvement Authority (Northern Ireland)

Intensive structured treatment programmes are complex to deliver. Staff should have training and competencies in:

- counselling, psychotherapy or psychology
- groupwork
- the therapeutic approach the service uses

The service should provide regular clinical supervision by a professional trained in supervision and also trained and experienced in the interventions being supervised.

Where residential treatment services offer medically assisted withdrawal, it is vital they have the appropriate facilities and staff competence to work with the people they offer this intervention to.

There is guidance on medically assisted withdrawal in chapter 10 on pharmacological interventions, chapter 11 on community-based medically assisted withdrawal and chapter 12 on specialist inpatient medically assisted withdrawal.

Residential services offering medically assisted withdrawal should be aware of the guidance on distinguishing specialist inpatient medically assisted withdrawal and residential medically assisted withdrawal in section 12.6 in chapter 12.

14.4 The journey through an intensive treatment programme

14.4.1 Assessment for an intensive treatment programme in community alcohol treatment services

Comprehensive assessment and treatment and recovery planning

Community alcohol treatment services should consider intensive structured day treatment programmes as a treatment option during comprehensive assessment, and during treatment and recovery plan reviews.

Most people who would benefit from residential or intensive day treatment programmes will have previously engaged in standard treatment interventions in the community. Some people, such as those experiencing homelessness or multiple disadvantage, might not be able to respond to less intensive interventions. So, intensive structured treatment may be appropriate for them from the start of their treatment journey.

It is complex to assess whether a person should be referred to an intensive treatment programme. There should be input from the multidisciplinary team or a clinician with experience of assessing people for residential treatment. The decision to refer should be reached collaboratively with the person, based on clinical assessment and discussion about their preference.

Co-occurring mental and physical health conditions

You should invite other services involved in the person's care and their family members to contribute to the assessment, with the person's consent. In cases where a person has a co-occurring severe mental health or physical health condition, practitioners need to work closely with the community mental health team or the physical health treatment team to make decisions about the suitability of a placement.

A person may be assessed as suitable for residential treatment who is also receiving treatment for their physical health or mental health. In these cases, involved professionals from those services will need to agree who will lead on communicating with the residential treatment service. This is to make sure that appropriate physical health and mental health care can be provided for the person in the local area of the residential service.

There is some evidence that outcomes are improved when residential settings offer treatment for both mental health conditions and substance use conditions (Brunette and others, 2004).

For more information about working with co-occurring conditions, see chapter 18 on co-occurring mental health conditions and chapter 19 on co-occurring physical health conditions.

Medically assisted withdrawal

Intensive structured treatment usually follows medically assisted withdrawal, which can be provided in a community, residential, specialist inpatient setting, depending on the person's assessed need. If medically assisted withdrawal is not provided in the residential treatment

setting, or if the person requires specialist inpatient medically assisted withdrawal, the referrer and the person will need to plan for the medically assisted withdrawal. And where possible they need to arrange for an immediate transfer to the intensive structured programme after the medically assisted withdrawal.

Section 10.2.4 in chapter 10 on pharmacological interventions provides guidance on criteria for considering specialist inpatient medically assisted withdrawal.

Section 12.6 in chapter 12 on specialist inpatient medically assisted withdrawal provides guidance on differentiating specialist inpatient medically assisted withdrawal and residential medically assisted withdrawal.

No unnecessary delays

It is important to prepare with the person for both medically assisted withdrawal and for a residential or intensive day programme, but you should also consider the urgency of the person's need, based on their physical and mental health and social circumstances. The preparation should be based on the person's assessed needs. There should be no standard requirements that everyone attends a set number of groups or appointments before accessing intensive structured treatment, because these requirements can create barriers to accessing treatment.

Once the person has made a fully informed decision to undertake medically assisted withdrawal followed by residential treatment or intensive structured day treatment, services should work together to make sure there are no unnecessary delays. People who are assessed as needing intensive structured treatment are likely to be vulnerable and have the highest levels of need and risk. So, it's important that they can access residential and intensive structured day programmes as easily as possible. Delays can be demotivating to a person with severe dependence or with complex needs and risk people changing their minds about joining an intensive programme. Commissioners and services should make sure that processes for agreeing funding and related arrangements are as streamlined as possible.

People referred to intensive structured treatment programmes often have poor health. If there are any unavoidable delays before admission, a clinician in the referring service should regularly review the person's physical and mental health. If their needs and risks change, the service should consider different interventions. The keyworker should continue to provide support to the person throughout this time, to keep them engaged in the treatment journey and monitor any risks.

14.4.2 Preparation in community treatment services

It is good practice to prepare people for intensive treatment. Effective preparation can help improve people's retention, engagement and their awareness of the benefits of the programme they are going to enter. You should do this by:

- giving them up to date, accessible information (verbal and written or video) about available options
- arranging visits to the programme where possible

- discussing relevant concerns or questions about the programme

If a person is assessed as needing an intensive treatment programme, the keyworker should help them think carefully about whether or not they want to engage in it. They should consider:

- the intensity of the groupwork experience
- how the staff delivering the programme help people to manage the pressures of participating
- how the person might respond to this experience

For people considering a residential placement, keyworkers should help them think about the potential impact of leaving their home community and living close to other people with complex needs. If they have specific cultural needs, they will need to consider how these can be met within the programme.

Arranging visits can help people to make a decision and the keyworker should encourage them to visit the service before accepting a place. It may also help the person to talk with someone who has been through the programme.

The keyworker should ensure they have the person's fully informed consent before making a referral.

Services should only refer people to residential treatment services that are registered with national regulatory bodies and comply with their standards (see section 14.3.7).

14.4.3 Assessment in residential or community intensive programmes

Staff who deliver intensive programmes also have an important role to play in assessing people's suitability and preparing them for admission to their programme. These staff should help people prepare by giving them pre-admission advice about:

- behaviour boundaries and how to interact with others on the programme
- the kind of emotional experiences that joining the programme can evoke and how the staff can support people to manage these
- how the programme is balanced to offer formal therapeutic activities, social activities and activities that contribute to recovery
- how group therapy works, including rules for confidentiality and acceptable behaviour and how a new participant will be inducted into the group
- how groups can be run in a safe way
- how a person's family or wider community can be involved in the programme

Research shows that if a person stays in the treatment programme and completes it, this is associated with improved treatment outcomes (Eastwood and others, 2018). There is

emerging evidence that particular practices can help enhance engagement and retention in a residential setting. These include:

- motivational interviewing (Carroll and others, 2006)
- using senior staff to induct new residents into treatment (De Leon, 2000)
- increasing the focus on the therapeutic relationship in staff training and supervision (Meier and others, 2006)

14.4.4 Personalised treatment and recovery planning

It is important that anybody taking part in an intensive structured programme sets and agrees their own personal treatment goals and timelines for the programme in consultation with their keyworker. They should also get to regularly review their own progress against their goals. This allows the treatment and recovery plan to be personalised to meet their own needs in the context of the overall goals of the programme.

You can read guidance on treatment and recovery planning in section 4.10 in chapter 4 on assessment and treatment and recovery planning.

When a person is in an intensive structured programme, it is good practice that they keep in regular communication with a named keyworker in their home community alcohol treatment service about their progress, priorities for action and next steps.

There are a number of issues that might affect the success of the person's eventual re-integration into the community, and you should consider these when developing their treatment and recovery plan during their time on the intensive structured programme. These issues can include:

- finding accommodation for people without housing
- encouraging them to develop new skills, such as helping them access education, training and employment opportunities
- engaging with recovery support services including peer support networks and services and mutual aid groups
- re-establishing or maintaining family links (where appropriate) so they have family support when they leave the programme

14.4.5 Preparing for discharge from community or residential intensive programmes

Inter-agency communication is vital during the treatment programme and when the person leaves, whether in a planned or unplanned way. It is good practice to agree confidentiality, boundaries and information sharing arrangements with the person at the start of their treatment, so you can discuss arrangements for ongoing treatment and support and put these in place, regardless of how the placement ends. You need to plan with the person for their ongoing treatment and recovery support in good time to enable a smooth transition to a reduced level of support.

All intensive programme providers should develop policies to reduce the risk of negative outcomes for people who do not complete the treatment programme.

14.4.6 Considerations specific to discharge planning in residential programmes

Successful outcomes after residential treatment

There is good evidence for the importance of ongoing treatment and support, as well having a job and stable housing, as factors that predict successful outcomes after residential rehabilitation (Helena Kennedy Centre for International Justice, 2017). There is also evidence of positive outcomes for people who engage with 12-step support when they leave residential rehabilitation (de Andrade and others, 2019).

There is often a high risk of the person returning to problematic alcohol use in the period immediately after residential treatment. So, it is very important that there is a plan in place for continuous care between the residential and community alcohol treatment services. The plan should also include arrangements for other support, including:

- housing
- welfare benefits
- mental healthcare
- physical healthcare

People should be actively supported to access peer support and mutual aid in their home community.

Re-engaging with community-based alcohol treatment services

At the start of a person's residential treatment, you should agree pathways for them to re-engage with community-based treatment services as soon as possible after they leave the programme. This includes agreeing relevant pathways and agreed actions keyworkers will take if people leave the programme before completing treatment.

Planning for continuity of care may include arrangements for transporting the person back to their home, or how local treatment and recovery support services will be notified when they are about to be discharged. It will be useful to have an agreement so residential staff can quickly contact the community treatment keyworker to let them know when somebody is being discharged. Verbal communications at the point of discharge should be followed up in writing. The residential service and the community based keyworker should also agree who will contact the person's GP and other services such as mental health services, with current health information including details of any medication they are taking. They should provide information in writing to the GP immediately following discharge.

Contact and support after residential treatment

If people have complex needs and less social stability, you should be clear with them about what contact and support they can access after the formal end of residential treatment. You

should make every effort not to discharge anybody from the programme if they have no secure accommodation to return to.

Resource

The Scottish Government published the good practice guide Pathways into, through and out of residential rehabilitation in Scotland to help improve residential rehabilitation pathways. Although it was developed for Scotland, it sets out principles of good practice for pathways that are useful to all 4 nations.

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15. Primary care and community health services

How primary and community health services can routinely identify health risk from alcohol use and respond appropriately. GPs and their teams identify and manage alcohol related health conditions, provide harm reduction interventions and work with specialist alcohol services.

15.1 Main points

A significant proportion of patients in primary care and community health services are drinking at levels that risk harm to their health.

Alcohol harms are highest in people experiencing the highest levels of social and economic deprivation.

Primary care and community health services can reduce risk of alcohol related harm by:

- routinely identifying people with alcohol use disorders using a validated screening tool and providing brief interventions
- referring patients who are or who may be alcohol dependent, and those with alcohol related health conditions to specialist alcohol treatment services

GPs and their teams can help to reduce alcohol-related harm by:

- opportunistically identifying alcohol use disorders in the context of potential alcohol-related health conditions and advising on risks of alcohol use to prevent harm in people with relevant conditions
- identifying, managing and arranging further investigations for patients with alcohol-related physical and mental health conditions
- providing advice on alcohol use in pre-conception, pregnancy and the perinatal period and referring pregnant women who are drinking harmfully to specialist antenatal care and alcohol treatment services
- identifying child and adult safeguarding concerns and contributing to multi-agency safeguarding plans
- offering harm reduction advice and interventions to patients who continue to drink at harmful or dependent levels
- working with specialist alcohol treatment services and sharing information with the patient's consent
- contributing to multidisciplinary, multi-agency care planning, risk management and safeguarding for patients with multiple and complex needs
- helping family members to access support where they need it
- reducing barriers to accessing primary healthcare and considering the needs of all people with problem alcohol use, including people who experiencing the highest

levels of social and economic deprivation and communities experiencing the worst health outcomes

Some primary care teams include GPs or nurses with appropriate competencies to provide specialist alcohol treatment interventions (for example, medically assisted withdrawal), and they may be commissioned to offer these.

There should be strong strategic leadership and senior level commitment to support primary care and community health services to carry out their role in preventing, reducing and managing alcohol related harm in their patients. An appointed alcohol lead can help to prioritise effective interventions and pathways for the full range of alcohol use disorders.

15.2 Introduction

The chapter describes the crucial role that primary care services and community health services can play in:

- preventing, identifying and managing alcohol-related harms
- contributing to their patients' treatment and recovery

15.3 Primary care services and community health services

Guidance in sections 15.3 to 15.5 is for staff in any primary care or community health services.

Primary care services include GPs and their teams, community pharmacists and opticians. GPs may be supported by wider multidisciplinary teams or networks.

Community health services cover a wide range of services and provide care for people of all ages. Some community health teams support people with complex health and care needs. Examples include:

- district nurses
- specialist nurses for long term conditions
- falls prevention services
- community occupational therapy

Community health services also include health promotion services such as health visiting services or sexual health services. These services can be run by the NHS, local authorities or third sector organisations.

National and local arrangements vary, but in many areas community services work across health and social care and include a wide range of professionals such as:

- GPs
- community nurses
- community pharmacists

- social workers
- mental health nurses

15.4 Routine identification of alcohol health risk

Guidance in section 15.4 is for staff in any primary care or community health services.

The UK chief medical officers' low risk drinking guidelines recommend that to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.

Severity of alcohol health risk is related to levels of consumption. Initial identification of alcohol-related health risk is categorised as:

- hazardous (also called increasing risk) drinking
- harmful drinking (also called higher risk) drinking
- alcohol dependence

The appendix at the end of this chapter explains these different types of alcohol-related health risk and alcohol use disorder and recommends appropriate interventions.

Almost a quarter of the UK population drink in a way that increases lifetime risk to their health.

People drinking at hazardous (increasing risk) levels and most people drinking at harmful levels do not need specialist alcohol treatment but may benefit from identification and brief intervention, sometimes known as screening and brief interventions. Alcohol brief intervention (ABI) is a general term used to describe a short, structured intervention that supports people drinking at hazardous or harmful levels to reduce their consumption towards lower risk levels.

In England, the term 'identification and brief advice' (IBA) is commonly used to describe alcohol risk screening and brief intervention.

Any trained health or social care practitioner can offer alcohol identification using a validated tool and structured brief advice in about 10 minutes.

15.5 Identification of alcohol use disorders and brief interventions

Guidance in section 15.5 is for staff in any primary care or community health services.

15.5.1 The importance of identification and brief interventions

In this guideline, we use the term alcohol use disorder (AUD) to describe harmful (higher risk) drinking including alcohol dependence. People drinking at hazardous levels do not have an alcohol use disorder but their pattern of alcohol use increases lifetime risks to their health.

People with AUD or drinking at hazardous levels use many different health and social care services, including primary care services and community healthcare services. This provides a

crucial opportunity for health and care staff to identify them and offer a brief intervention or referral to specialist alcohol treatment where required. Offering brief interventions for people who are drinking at hazardous or harmful levels can help prevent further health harms. Primary care services are in a unique position to identify alcohol-related health risks and act early so potentially improve a patient's prognosis.

Chapter 3 sets out guidance on providing identification and brief interventions. It includes guidance on several validated AUD identification tests and on appropriate interventions based on the patient's level of alcohol related health risk. Best practice is that identification and brief advice are embedded within standard assessment processes.
Where AUD identification tools are not included in standard assessments healthcare staff can offer brief opportunistic interventions in line with the Making every contact count approach. Healthcare practitioners should be trained and supported to ask the appropriate questions about alcohol use and provide simple brief interventions.

15.5.2 Frameworks and requirements for identification and alcohol brief interventions across the UK

There is guidance and support for delivering ABI in each of the UK nations but frameworks and requirements for primary care providers to carry out identification and alcohol brief interventions vary.

In England, the General Medical Services contract requires primary care providers to offer all adults an alcohol risk assessment (identification) when they register with a GP. The NHS Health Check, provided in some areas from primary care services, also includes the requirement that people receiving it are offered an alcohol risk assessment.

The National Institute for Health and Care Excellence (NICE) public health guideline Alcohol use disorders: prevention (PH24) recommends that people whose alcohol risk assessment shows that they are above low risk should be offered brief advice. Or, if their alcohol risk assessment shows they are potentially dependent, they should be referred for specialist assessment.

Large scale provision of ABI is part of Scotland's national Alcohol Framework 2018. In October 2024, Public Health Scotland published its review of the ABI programme, which included recommendations to refresh the programme so that it better meets the needs of individuals in Scotland.

15.5.3 Training and skills for identification and brief intervention

NICE PH24 says that managers of NHS-commissioned services must ensure staff are trained to provide alcohol identification (alcohol risk assessment) and structured brief advice.

Identification and brief advice can be offered by any health or social care practitioner who has been trained. Training can be provided in a session lasting about 40 minutes. NHS England provides a module on alcohol identification and brief advice with pathways for primary care services, community pharmacists, dental teams and hospitals.

Training should ensure that health and social care staff have sufficient knowledge and skills to:

- routinely initiate appropriate identification (screening) questions
- understand AUD categories and appropriate responses
- use an empathic, non-judgmental approach
- use non-stigmatising AUD terminology that is person centred and does not label people
- provide effective person-centred brief interventions
- make referrals to specialist alcohol treatment services where appropriate

Clinicians involved in delivering specialist alcohol treatment interventions (for example medically assisted withdrawal) require additional competencies. The Royal College of Psychiatrists and Royal College of GPs' Delivering quality care for drug and alcohol users: the roles and competencies of doctors (PDF, 404KB) provides guidance on appropriate competencies for clinicians who provide specialist alcohol treatment interventions.

15.6 The role of GPs and their teams

The guidance in this section 15.6 is for GPs and their wider primary care teams.

Alcohol interventions and support offered by GPs and their teams vary depending on national and local commissioning arrangements, clinical competencies within the wider primary care team and local partnership arrangements. However, all GPs and their teams will provide interventions to:

- prevent, identify and manage alcohol-related harms in their patients
- work with specialist alcohol treatment services to support patients in their treatment and recovery

15.6.1 Expectations of GPs and their teams

All GPs and their teams should:

- routinely identify patients with AUDs at any stage in their alcohol use and offer brief interventions or referral to specialist alcohol treatment as indicated
- with their consent, refer patients who are alcohol dependent, possibly dependent, or have alcohol related health conditions, to specialist community alcohol treatment services
- opportunistically identify AUDs in the context of potential alcohol-related health conditions and advise on risks of alcohol use to prevent harm in people with relevant conditions including:
    - liver disease

    - hypertension
    - cardiovascular disease
    - obesity
    - specific cancers
    - anxiety disorders
    - depressive disorders
- identify possible alcohol-related physical and mental health conditions and (with patient consent) make or arrange for further investigations
- manage alcohol related physical and mental health conditions in their patients or refer to relevant specialist secondary healthcare care services and work with them to manage the condition
- provide advice on alcohol use in pre-conception, pregnancy and the perinatal period
- refer pregnant women who are drinking harmfully to specialist antenatal care and specialist alcohol treatment services
- identify and act on risks to the person and to others such as child safeguarding and adult safeguarding (see annex 1 on relevant legislation and statutory guidance for more information)
- help family members to access support for their own needs
- offer alcohol harm reduction advice and interventions to people who are drinking harmfully or experiencing alcohol dependence, based on the 'Making every contact count' approach
- encourage people with alcohol use disorders to take up the routine screening and vaccinations that are offered to the general population
- ask about social circumstances and offer social prescribing and support (for example, from a link worker or peer support worker) for people who need social support and care
- work with alcohol treatment services (where patients are in specialist alcohol treatment) to support patients to achieve their recovery goals and share information appropriately
- contribute to a multidisciplinary and multi-agency care plans to support recovery and manage risks where patients have complex needs in addition to alcohol problems
- consider the needs of people who drink harmfully and have alcohol dependence who experience health inequalities due to social and economic deprivation
- consider the needs of specific inclusion health groups (see section 15.6.11 below for more information)

Some GPs and their teams who have appropriate competences can also offer specialist alcohol treatment interventions, for example medically assisted withdrawal. There is guidance on specialist alcohol treatment interventions in primary care in section 15.6.10 below.

15.6.2 Identifying alcohol use disorders in the context of potential alcohol-related conditions and advising on alcohol-related health risk

Alcohol use disorders, particularly when alcohol use is non-dependent, can often go undetected. As well as offering routine identification as outlined in section 15.5, GPs and their teams are in a unique position to identify AUDs by asking about the person's alcohol use in the context of common health conditions that alcohol can cause or contribute to. Common conditions where alcohol can be a causal or contributing factor include hypertension, dyspepsia, and low mood or depressive disorder and liver disease.

People are often wary of sharing accurate information about their alcohol use because harmful drinking and alcohol dependence are stigmatised conditions. Where the GP or practice nurse can have a non-judgemental, supportive conversation about alcohol use in the context of managing the patient's health condition, this may help to reduce the difficulty that some people have in talking about their problem alcohol use. Where it seems likely the patient is drinking at harmful levels, the GP or nurse can then take a fuller alcohol history. They should offer a brief intervention to support the patient to reduce or stop their alcohol use, or offer a referral to alcohol treatment services if the person is alcohol dependent, possibly alcohol dependent, or their health condition could be alcohol-related.

The GP or team member should also provide the patient with information on how alcohol use can cause or contribute to their health condition and outline the risks involved in the context of their specific condition. For some patients, general advice on health risks at different levels of consumption based on the UK chief medical officers' low risk drinking guidelines needs to be adjusted based on their specific health condition and level of severity.

15.6.3 Identifying and managing alcohol-related health conditions

Evidence on alcohol-related health conditions

The public health burden of alcohol: evidence review found that there are over 60 health conditions associated with harmful drinking and alcohol dependence. Common alcohol related health conditions include:

- alcohol-related liver disease
- cardiovascular disease
- cancers including oral cavity, pharynx, oesophagus, larynx, breast, colorectum
- alcohol related brain damage including Wernicke-Korsakoff syndrome
- mental health conditions including anxiety and depression
- increased risk of self-harm including suicide

The role of the GP and their team in identifying and managing alcohol-related health conditions

GPs and their teams are in a position to identify probable alcohol-related health conditions, and to carry out or refer the patient for investigations. GPs, practice nurses and the wider team can play a vital role in identifying alcohol-related health conditions at an early stage by asking about a person's alcohol use and by screening for alcohol-related conditions in those people at risk. For example, see liver disease in the section below.

People who drink at harmful and dependent levels often have poor health and may also have poor self-care. So, the GP has a vital role in identifying health conditions and helping the patient to manage alcohol-related health conditions.

Liver disease

Liver disease is responsible for most (about 80%) deaths that are caused wholly by alcohol in the UK.

It is important to screen for liver disease as it often does not show outward symptoms until it is at an advanced stage and the patient is severely ill. GPs, practice nurses and the wider primary care team have a vital role in identifying liver disease at an earlier stage, which can reduce the risk of severe illness and deaths.

The NICE guideline Cirrhosis in over 16s: assessment and management (NG50) recommends that anyone drinking at harmful (high risk) levels for 3 months or more should be referred for transient elastography, such as a fibroscan (harmful levels is 35 units or more per week for women and 50 units or more per week for men).

In some areas where transient elastography is not currently available, the pathways involve alternative tests for detecting cirrhosis including the enhanced liver fibrosis (ELF) test and intelligent liver function test (i-LFT). Screening for alcohol-related liver disease should include a measure of liver fibrosis, in addition to liver function blood tests. This is because normal liver function tests and gamma-glutamyl transferase (GGT) tests do not exclude cirrhosis.

There is more detailed guidance on liver screening tests in section 19.5.2 of chapter 19 on co-occurring physical health conditions.

Primary care services should make or refer people for further investigations or specialist management of liver disease where this is indicated by screening.

Cardiovascular disease

There is a close relationship between drinking alcohol and hypertension (high blood pressure). Risk of high blood pressure starts at lower levels of alcohol use for women (from about 2 units per day) than for men. High blood pressure accounts for most alcohol-related hospital admissions for cardiovascular disease. In England, about half of all hospital admissions where alcohol is a primary or secondary cause, are for cardiovascular disease.

Screening and management of high blood pressure among people with AUDs can play a vital role in reducing their risk and hospital admissions.

You can find more information on alcohol and cardiovascular disease in section 19.5.3 in chapter 19 on co-occurring physical health conditions.

Cancers

There is strong evidence for an association between alcohol use and cancer, including cancers of the:

- lip, oral cavity and pharynx
- oesophagus
- larynx
- colon
- rectum
- liver and intrahepatic bile ducts
- breast

The risk is increased in men who also smoke. However, for women who have never smoked, the risk of alcohol-related cancers, mainly breast cancer, increases even when drinking up to about 2 units per day.

You can find more information in section 19.5.1 in chapter 19 on co-occurring physical health conditions.

Patients who drink harmfully and dependently may miss screening appointments. Primary care services can support patients who drink harmfully or dependently by prompting them to take up regular screening and by considering whether proactive screening (for example for breast cancer) might be appropriate.

Alcohol related brain damage including Wernicke-Korsakoff syndrome

Alcohol related brain damage describes various psychoneurological or cognitive conditions that are associated with long term, heavy alcohol use and related vitamin deficiencies (particularly thiamine deficiency).

Wernicke-Korsakoff syndrome is a serious complication of deficiency of thiamine (vitamin B1), for which the most common cause is alcohol dependence. This can result in lasting brain injury, so preventing this complication is vital. Many people with alcohol dependence are at risk of developing Wernicke-Korsakoff syndrome due to thiamine deficiency. They may also have deficiencies in other vitamins.

People with alcohol dependence should be prescribed thiamine supplementation before undergoing medically assisted withdrawal. However, it’s important to offer vitamin

prophylaxis to all people who drink harmfully and dependently, whether or not they intend to undergo medically assisted withdrawal.

You can find:

- guidance on prescribing and administering thiamine in section 10.4.3 in chapter 10 on pharmacological interventions
- more detailed guidance on people with alcohol related brain damage in chapter 20

Mental health conditions

GPs and their teams play a vital role in identifying and managing the mental health of their patients. Mental health conditions and AUDs commonly occur together. Research on depression, anxiety and substance use found 70% of people in a sample from community substance use treatment also met the criteria for common mental health problems (Delgadillo and others, 2012). Harmful drinking and alcohol dependence can result from an attempt to manage mental health symptoms or can cause or contribute to mental health conditions, in particular anxiety and depression.

The National Confidential Inquiry into Suicide and Safety in Mental Health Annual report 2024: UK patient and general population data found that 47% of people in contact with UK mental health services who died by suicide between 2011 and 2021 used alcohol problematically.

There is also evidence that intoxication is a risk factor for suicide (Kaplan and others, 2013; Ledden and others, 2022).

People with co-occurring mental health and alcohol use conditions often have treatment or support needs in other areas too. In every local area, commissioners, strategic managers and senior service providers should work together to commission and plan services for people with co-occurring mental health and alcohol conditions. They should also work with other services including primary care to establish treatment pathways for this group of people who frequently do not receive the care they need.

GPs and their teams contribute to reducing harm and risk in people with co-occurring mental health conditions and alcohol use disorders by:

- identifying and managing both conditions
- referring patients (with their consent) to specialist alcohol treatment or mental health services (or both)
- contributing to multi-agency care planning and safeguarding
- sharing information with specialist mental health services, alcohol treatment services and other relevant services
- contributing to crisis support, for example when a patient is at risk of self-harm or suicide

Managing suicide risk

People with mental health conditions and co-occurring AUDs are at increased risk of suicide. Both alcohol dependence and intoxication can increase risk of suicide in people with co-occurring mental health and alcohol use conditions.

When working to reduce the risk of suicide, primary care services should work in line with clinical guidelines, including NICE guideline:

- Self-harm: assessment, management and preventing re-occurrence (NG225)
- Coexisting severe mental illness and substance misuse: community health and social care services (NG58)

Collaborative care plans for ongoing care should include arrangements for immediate information sharing with the identified lead professional and quick follow-up if a person at risk of suicide loses contact with a service.

Managing mental health crisis and episodes of intoxication safely

People in a mental health crisis can resort to alcohol to manage their distress. Their alcohol use can also lead to an escalation in symptoms of mental ill-health including:

- psychosis
- self-harm
- suicidal intent

They might present to primary care services in a state of acute intoxication. The underlying alcohol use disorder may reflect episodic binge drinking or a severe dependence that requires rapid medical management. Whatever the case, the immediate priority is to make sure any acutely intoxicated person is safe and not a risk to themselves or others.

People presenting in a mental health crisis, self-harming or with suicidal intent should never be turned away from services, because this could increase risks to themselves or others. Staff should support them to access suitable care, including a place of safety where necessary, and monitor their safety.

There is guidance on treating people with problem alcohol use and co-occurring mental health conditions in chapter 18.

15.6.4 Health promotion and non-alcohol related health conditions

People who drink harmfully or dependently often have poor health and may have health conditions unrelated to their problem alcohol use. They can neglect their health or be wary of taking up routine screening and vaccinations for various reasons, including difficulty in trusting services due to a history of trauma or bad experiences of services.

Healthcare professionals can also miss non-alcohol related health conditions, assuming symptoms are related to a patient's alcohol use. Primary care staff can help to reduce harm

by encouraging their patients with alcohol problems to take up routine screening and vaccinations and by checking they have done this.

15.6.5 Pre-conception, pregnancy and the perinatal period

Alcohol use during pregnancy can affect fetal development throughout pregnancy and cause birth defects and perinatal complications. It can result in fetal alcohol spectrum disorder, a term that describes the wide range of outcomes that can result from prenatal alcohol exposure, including lifelong physical, cognitive, behavioural and mental health difficulties.

The UK chief medical officers' advice on low risk drinking is that women who are pregnant or think they could become pregnant should completely avoid alcohol. GPs and their teams, alongside midwives, have a vital role to play in preventing harm by providing this information to women who are considering pregnancy or who are pregnant. Women who are or could be alcohol dependent should be advised not to stop drinking suddenly because this can increase risk to the fetus and the mother. Instead, they should be rapidly referred to specialist alcohol treatment for an assessment for medically assisted withdrawal. They should also be referred to a specialist or substance misuse midwife if they are not engaged in antenatal care.

Women who drink heavily during pregnancy and the perinatal period will require a multidisciplinary, multi-agency approach to care planning and safeguarding. Primary care services will have an important role to play as part of this approach, contributing to monitoring their patient's health during pregnancy and the health of the mother and baby after birth. The primary care team will contribute to safeguarding, and midwives and health visitors will have a particular role in this.

Chapter 24 provides guidance on working with women during pregnancy and the perinatal period.

15.6.6 Providing harm reduction information, advice and interventions

Working on the principle of Making every contact count, primary healthcare practitioners can help to prevent short term alcohol-related harm by providing harm reduction information and advice on the acute risks of intoxication and for people with alcohol dependence.

Intoxication leads to increased risk:

- of sexually transmitted diseases and unplanned pregnancies
- to safety (for example fire, falls and accidents, violence)
- of alcohol poisoning

Combined alcohol and drug use increases risk of:

- overdose and death, when someone takes drugs and alcohol together
- other harms related to mixing drugs, for example cocaine and alcohol are more toxic when taken together

People with alcohol dependence, particularly people with severe alcohol dependence, should be given information on:

- the risks of stopping suddenly (complications of withdrawal) and how they can access medically assisted withdrawal or reduce their drinking safely
- a decrease in tolerance after a period of abstinence and the risks of drinking at pre-abstinence levels

You can find more guidance on harm reduction advice and interventions in chapter 8.

15.6.7 Identifying and responding to risks and safeguarding

Harmful drinking and alcohol dependence is associated with an increased risk of:

- domestic abuse (both as a victim and as a perpetrator)
- sexual violence
- child safeguarding concerns
- adult safeguarding concerns

Being aware of these will help primary care staff to identify any risks to the safety of the patient and people they are in contact with, and to respond to these in line with statutory guidance and organisational procedures. The GP and their team are in a unique position as they have a continuous relationship with the patient and with their family. So, this can help them to identify risks. Primary care teams also play a vital role in a multidisciplinary, multi-agency response to safety planning and safeguarding.

There is information on statutory guidance on safeguarding in annex 1 on legislation and guidance across the UK.

15.6.8 Identifying support needs of family members

A person's problem alcohol use can put considerable strain on their family members. As well as identifying safeguarding risks (both child and adult), primary care staff can support family members by asking about their own support needs and referring them for a carer's assessment where appropriate. You can find information on legislation and guidance on support for carers in annex 1.

Primary care staff can support family members by providing information on:

- problem alcohol use
- how problem alcohol use can affect family members
- local or national support services for family members

Local specialist alcohol treatment services often provide information and support for family members and they can signpost people for additional support.

15.6.9 Working with specialist alcohol treatment services

A GP and their team will need to work with specialist alcohol treatment services. This can include:

- referring patients to alcohol treatment services
- sharing information with alcohol treatment services
- contributing to multidisciplinary, multi-agency care planning and risk management

Referring patients to alcohol treatment services

After screening with a validated tool, healthcare practitioners should offer referral for specialist alcohol assessment and treatment to people:

- identified as probably alcohol dependent
- drinking at harmful levels who have an alcohol-related physical health condition (for example liver disease) or mental health condition (for example depression)
- drinking at harmful levels who have not responded to brief interventions

It's common for people who drink harmfully or dependently to be anxious or ambivalent about approaching an alcohol treatment service. Reasons for this can include:

- stigma and fear of being judged
- difficulties in trusting services due to a history of trauma
- poor past experiences of alcohol treatment
- lack of understanding about what alcohol treatment involves

Most people need some support to approach and engage with an alcohol treatment service.

Primary care staff can help their patients to engage with alcohol treatment by having a conversation with them about what it will involve and acknowledging their anxieties. They could use an approach based on the principles of motivational interventions. There is guidance on motivational interventions in section 5.5.6 in chapter 5 on psychosocial interventions.

The primary care service should have information provided by the local community alcohol treatment service (or at least their website address) to share with the patient. They should also have information on local mutual aid groups (for example Alcoholics Anonymous or SMART Recovery) and local peer-based recovery services. There is more information on mutual aid and peer-based support in chapter 6 on recovery support services.

Some people who are not ready to access specialist alcohol treatment may be happy to access mutual aid or peer-based recovery groups for support. If the person does not want treatment, it's helpful to raise the option at a later appointment. If the GP or primary healthcare worker already has a relationship with the patient, they may be in the best position to encourage them to attend an alcohol treatment service.

Wherever possible, with the patient's consent, primary care staff should make a referral by contacting the alcohol treatment service, rather than expecting the person to refer themselves. This allows the alcohol treatment service to contact the person and encourage them to attend and follow up if the person misses the appointment. This approach is associated with increased engagement in alcohol treatment services (Passetti and others, 2008). A referral can also provide the alcohol treatment service with information on the person's health and on any risks. Since people are often ambivalent about alcohol treatment, it is helpful for the referrer to follow up the outcome of a referral or a planned self-referral.

Ongoing collaboration with alcohol treatment services

With the patient's informed consent, GPs and their teams and specialist alcohol treatment services should share relevant information about the patient including:

- significant information on health status
- changes in prescribing
- information on risks to the patient and to others
- child and adult safeguarding risks (in line with national safeguarding statutory guidance and organisational procedures)

Where possible, community alcohol treatment services should have access to relevant electronic health records so that so they can access summary health information effectively and quickly.

In England, essential health information is shared electronically through the summary care record held by National Care Records Service.

In Scotland, NHS services share health information electronically through the Key Information Summary (part of the Emergency Care Summary (unless the patient has opted out))

These electronic health records are put in place by the GP team after discussing them with the patient.

In Wales, some clinicians have access to patients' digital health records through the Welsh Clinical Portal.

In Northern Ireland, Encompass is being rolled out so that health and social care trusts will have access to digital health and care records.

However, some alcohol treatment services may not be able to access these electronic records. In those circumstances, alcohol treatment services and GPs and their teams should make other arrangements to share relevant summary information of patients.

Even where alcohol treatment services can access health care summaries electronically, there may be additional information that needs to be shared between community alcohol

treatment services and GPs and their teams. For example, sharing information relevant to the person's alcohol treatment and recovery plan.

The GP will sometimes contribute to the treatment provided by the specialist alcohol treatment service, for example by contributing information to the comprehensive assessment carried out by the alcohol treatment service.

Depending on commissioning arrangements, GPs can also continue to prescribe relapse prevention medication after a patient has been discharged from the alcohol treatment service. If the patient has completed their specialist alcohol treatment episode and is ready to move on in their recovery journey, they can continue to benefit from medication with regular monitoring and review, along with supportive contact in primary care. Section10.5 in chapter 10 on pharmacological interventions provides guidance on prescribing relapse prevention medication.

Contributing to multidisciplinary, multi-agency care planning and risk management

Some patients with alcohol dependence have multiple and complex needs, such as:

- co-occurring mental health conditions
- history of trauma
- multiple physical health conditions
- alcohol related brain damage
- domestic abuse (as a victim or a perpetrator)
- child safeguarding risks
- adult safeguarding, including extreme self-neglect

Working effectively with people with multiple and complex needs requires a multidisciplinary, multi-agency approach. The GP and their team will have important contributions to make to multidisciplinary care planning and review, and to ongoing risk management, including safeguarding. Members of the team that may contribute to supporting people with multiple and complex needs and their families include:

- practice nurses
- pharmacists
- social prescribing staff
- welfare support workers
- link workers
- peer support workers
- health visitors

15.6.10 Offering specialist alcohol treatment interventions in primary care

Some primary care services are commissioned to provide specialist alcohol treatment interventions for people with alcohol dependence or drinking at harmful levels. Models vary across local areas and include commissioning a:

- primary care team that has members with specialist alcohol treatment competences
- partnership or other local arrangements where specialist nurses from specialist alcohol treatment services provide regular surgeries in primary care settings and share the care of the patient with the GP team

In some areas, there are innovative primary care models aimed at reducing health inequalities. An example is the primary care alcohol nurse outreach service, which involves specialist addiction nurses working closely with selected GP practices in the most deprived communities in Scotland. The service helps to engage and provide care for patients who had not previously engaged or had not engaged well with community alcohol services.

For more information on reducing health inequalities, see section 15.6.11 below.

Primary care settings with staff with specialist alcohol treatment competencies can provide an important opportunity to treat people who drink harmfully or experience alcohol dependence who may not be willing or able to engage with specialist alcohol treatment services. Specialist practitioners can provide treatment tailored to the individual patient and co-ordinate their care. They can also raise awareness about the needs of patients with alcohol dependence among the primary care team.

Primary care practitioners with alcohol specialist competencies should follow the guidance in chapters 1 to 12 of these guidelines. This includes guidance on:

- assessment in chapter 4
- pharmacological interventions in chapter 10
- community based medically assisted withdrawal in chapter 11
- psychosocial interventions in chapter 5

Where formally commissioned treatment models are in place, commissioners and primary care services should ensure patients have access to the full range of options in the local recovery-oriented system of care.

15.6.11 Addressing health inequalities

People who experience economic and social deprivation are disproportionately affected by the harm caused by alcohol dependence and harmful drinking. For example, the National Records of Scotland report Alcohol-specific deaths 2023 showed that the mortality rate for deaths caused solely by alcohol was 4.5 times higher in the most deprived fifth of the population than in the least deprived. And in England in 2023, the Fingertips alcohol profile showed the mortality rate was twice as high in the most deprived tenth of the population than in the least deprived.

By preventing, identifying and managing alcohol-related health conditions and working with specialist alcohol treatment services, GPs and their teams, particularly those serving socially and economically deprived communities, play an important role in reducing health inequalities. They should work to understand the needs of people experiencing socioeconomic deprivation and reduce any barriers to engaging with their services. For example, link workers or peer support workers on primary care teams can support patients to access:

- welfare benefits and debt advice
- social prescribing
- housing support
- employment support
- peer networks

People with alcohol dependence can be considered an 'inclusion health group'. An inclusion health group is a term used to describe people who experience:

- social exclusion
- poor access to healthcare
- multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma)
- stigma and discrimination
- poor health outcomes

The guidance Inclusion health: applying All Our Health provides more information on the needs of inclusion health groups.

15.6.12 The needs of specific health inclusion health groups

Within the wider group of people with alcohol dependence, and the wider group of people experiencing high levels of socioeconomic deprivation, there are groups that experience particularly poor access to healthcare and the worst health outcomes. Their life expectancy and the number of years they live in good health are much lower than the general population because of social factors affecting them, including stigma and discrimination.

These groups include:

- people experiencing homelessness
- vulnerable migrants
- Gypsy, Roma and Traveller groups
- sex workers
- people in contact with the criminal justice system, especially prisoners

- victims of modern slavery

Primary care services can help to reduce the extreme health inequalities that these groups of people experience by:

- understanding the needs of people with alcohol dependence, particularly those who experience extreme social exclusion and the poorest health outcomes
- removing some of the access barriers to their services
- tailoring interventions to meet the needs of specific inclusion health groups

The approach of the service and its healthcare staff to people from these groups can help to make the service more inclusive. People with alcohol dependence or who drink harmfully experience stigma in some healthcare services, and research consistently identifies stigma as a major barrier to them seeking help and engaging with treatment (Kilian and others, 2021). So, a non-stigmatising, non-judgemental and trauma-informed approach is vital. You can find more information on a trauma-informed approach in the working definition of trauma-informed practice.

Primary care managers and practitioners should all understand who is entitled to access their services and avoid mistakenly excluding the most vulnerable people. People in England, Scotland and Wales are entitled to register with GPs even if they cannot provide proof of address or identification, and regardless of their immigration status.

There is guidance on this issue for the UK nations in the:

- Primary medical care policy and guidance manual (pages 154 to 155), which provides guidance for England on registering at a GP practice without ID or a permanent address
- Access to healthcare in the Health Literacy Place toolkit, which provides information for Scotland
- Access and entitlement to NHS services and first time registration web page, which provides guidance for Northern Ireland

There are many other actions that primary care staff, managers and strategic leaders can take to reduce the health inequalities these groups of people experience and to improve their health outcomes. The resource list below (section 15.8) includes guidance on health inclusion. Some of the guidance is for England, but much of the content is relevant for primary care services in other UK nations.

15.7 Strategic leadership

There should be strong strategic leadership and senior level commitment to support primary care and community health services to carry out their role in preventing, identifying and managing alcohol-related harm in their patients.

An appointed alcohol lead can help to prioritise effective interventions and pathways for the full range of alcohol use disorders.

Organisational structures for primary care and community health systems vary across UK nations. So, there will be different ways that alcohol harm reduction interventions can be delivered in these. In England, primary care networks and integrated care systems provide important opportunities to address alcohol harm at a whole system level and to reduce the health inequalities experienced by people with alcohol dependence or who drink at harmful (higher risk) levels.

Commissioners, strategic managers and lead clinicians in primary and community healthcare should consider the needs of people with alcohol dependence as an inclusion health group. They should also consider whether they should commission specific services to reduce barriers to access to primary care and to improve health outcomes for people with alcohol dependence, particularly in areas of high social and economic deprivation, for those experiencing multiple disadvantage or specific health inclusion groups. Examples might include:

- targeted outreach services in areas of high social and economic deprivation or for specific socially excluded local communities
- collaboration with homelessness health teams
- interpreting services

15.8 Inclusion health resources

The list of resources below provides information and support for healthcare professionals, including primary care services, on addressing the needs of inclusion health groups.

Inclusion health self-assessment tool for primary care networks helps primary care networks to assess their engagement with inclusion health groups. It takes about 10 minutes to complete. After completion, the tool provides a guide to tailored actions the primary care network can take to address health inequalities into its everyday activities.

The Migrant health guide can support primary care practitioners in caring for patients who have come to the UK from overseas. It includes:

- information on migrants' entitlement to the NHS
- guidance for assessing new patients
- tailored health information for over 100 countries
- guidance on a range of communicable and non-communicable diseases and health issues

The Doctors of the World Safe Surgeries initiative supports GP practices that commit to taking steps to tackle the barriers faced by excluded groups in accessing primary healthcare. The initiative provides a range of support, including:

- resources to support practice staff
- simple guides to NHS entitlement

- translated posters for patients
- training for clinical and non-clinical staff on migrants' entitlement to NHS care

For specific resources on homelessness and health see chapter 21 on people experiencing homelessness.

Improving Roma health: a guide for health and care professionals supports health and care professionals to improve services by better understanding the health outcomes that some people in the Roma community face.

How to tackle health inequalities in Gypsy, Roma and Traveller communities: a guide for health and care services was developed by Friends, Families and Travellers. The guide includes actions to reduce health inequalities in the Gypsy, Roma and Traveller communities and to increase access to primary care.

The UK modern slavery and exploitation helpline and resource centre provides access to information and support for victims, the public, statutory agencies, and businesses.

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Appendix: identifying levels of alcohol-related health risk and appropriate interventions

1. Low risk drinking

Definition

The terms low risk drinking describes a pattern of drinking at a level that does not significantly increase lifetime risk of alcohol-related ill health.

Drinking levels and AUDIT scores

Drinking levels and alcohol use disorders identification test (AUDIT) scores are used to indicate low risk drinking.

Drinking level: less than 14 units per week (men and women).

AUDIT score: 0 to 7: low-risk - no current AUD (see section 3.3.2 in chapter 3 on identification and alcohol brief interventions for guidance on using AUDIT).

2. Hazardous drinking

Definition

The term hazardous drinking (also called increasing risk drinking) describes a pattern of alcohol use that increases the lifetime risk of harm to the physical or mental health of the person drinking or to others. Hazardous drinking has not yet reached the level of having caused harm and is not an alcohol use disorder but represents a risk.

Drinking levels and AUDIT scores

Drinking levels and AUDIT scores are used to indicate hazardous drinking.

Drinking level: 14 to 34 units a week for women and 14 to 49 units a week for men.

AUDIT score: 8 to 15 in (see section 3.3.2 in chapter 3 on for guidance on using AUDIT).

Effective interventions

Offer identification and brief advice (IBA) (sometimes called screening and brief intervention). This involves assessing alcohol related health risks with the person using a validated tool (such as AUDIT) and offering brief structured advice on cutting down. You can read more about identifying and alcohol related health risk and brief interventions in section 15.5 and in chapter 3 on identification and brief interventions.

3. Harmful drinking

Definition

A pattern of alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of alcohol use is evident over a period of at least 12 months if substance use is episodic, or at least one month if use is continuous. Drinking levels and AUDIT scores

Drinking levels and AUDIT scores are used to indicate harmful drinking.

Drinking level: 35 units and above per week for women and 50 units and above per week for men.

AUDIT score: 16 to 19 (see section 3.3.2 in chapter 3 on for guidance on using AUDIT).

Effective interventions

Offer IBA (as described in 'Hazardous drinking' above). You can read more about identifying alcohol use disorders and brief interventions in section 15.5 and in chapter 3 on identification and brief interventions.

A minority of higher risk drinkers may need referral for specialist alcohol treatment if they have:

- not benefited from alcohol brief interventions
- an alcohol related health condition

4. Alcohol dependence

Definition

This guideline uses the definition of alcohol dependence in International Statistical Classification of Diseases and Related Health Problems 11th revision.

You can find a summary of this definition of alcohol dependence in the glossary.

What this means

Alcohol dependence involves people continuing to drink despite the consequences. They experience psychological dependence, and with more severe dependence, physical withdrawal symptoms when they stop drinking. Drinking in this way is likely to be causing psychological, physical, and social harms.

Effective interventions

If an alcohol risk assessment with a validated tool (identification) indicates that a person has possible alcohol dependence, you should refer them to specialist alcohol treatment. Alcohol dependence is a clinical diagnosis and a specialist assessment is required to confirm that the person is experiencing alcohol dependence.

In specialist alcohol treatment services, they will receive:

- a specialist alcohol assessment
- psychosocial and pharmacological interventions in the community for most people
- specialist inpatient detoxification or residential rehabilitation for a minority of people with severe dependence or complex needs

The alcohol risk categories described above are general indicators not diagnoses and the scores should not override clinical judgement or your knowledge of the person in individual cases. Some people can experience alcohol dependence even if their alcohol use is lower than the amounts described for hazardous or harmful drinking. If you are concerned about a patient's alcohol use or health, you should offer to refer them for a specialist assessment, whatever their score is.

16. Alcohol care in acute hospitals

How to care for people with alcohol-use disorders in acute hospitals, covering assessment, providing a multidisciplinary approach, managing withdrawal, treating complications and planning discharge to ensure continuity of care with community alcohol treatment services.

16.1 Main points

People with alcohol-use disorder present to acute hospitals with a wide range of primary diagnoses. The presence of alcohol-use disorder may not always be obvious to the patient or to clinical staff. There will need to be a system in place for alcohol risk screening and assessing the severity of alcohol-use disorder among all inpatients throughout the hospital.

Acute hospitals will need to have resources and staff with the skills to assess patients with alcohol-use disorders and plan care in relation to their alcohol-use disorders and any co-occurring physical and mental health conditions.

Patients admitted to hospital, who are assessed as drinking in a dependent way, may need medically assisted withdrawal during their inpatient stay. Care plans will need to include appropriate pharmacological interventions for medically assisted withdrawal, including:

- baseline testing
- medication regimens
- ongoing monitoring
- psychosocial support

Hospitals will need protocols or guidelines in place for assessing and managing withdrawal treatment.

In most cases, an acute hospital is the most appropriate setting for patients experiencing complications of alcohol withdrawal, and patients may present to emergency care or be referred from community services because they are experiencing or at significant risk of:

- acute alcohol withdrawal
- complications of alcohol withdrawal, such as:
    - seizures
    - delirium tremens
    - Wernicke’s encephalopathy (WE)

These complications can be very serious and require immediate, skilled management to avoid escalation and potentially life-threatening or life-changing outcomes.

Patients with alcohol dependence and co-occurring physical and mental health conditions, and those whose health is deteriorating, will also be referred to acute hospitals, sometimes in crisis. These patients should not be denied care because they are intoxicated. If they are not able to participate in an assessment, they should be regularly reviewed to manage

clinical risks until a more detailed psychosocial assessment is possible. These patients require specialist multidisciplinary assessment and care planning.

On discharge from hospital, all patients with alcohol dependence should be offered referral for ongoing treatment and support in mental health, alcohol treatment and other community services as appropriate and, where indicated, specialist secondary care for co-occurring health conditions.

16.2 Introduction

This chapter is about managing alcohol-use disorders and complications of alcohol use in acute hospital settings. It focuses on:

- assessing need and risk
- decisions about admission to hospital
- pharmacotherapy for managing alcohol withdrawal, relapse prevention and the most severe complications of alcohol withdrawal

Alcohol-use disorder (AUD) has a disproportionate impact on emergency department attendances and hospital admissions. Research has estimated that 1 in 5 adults admitted to hospital in England drinks alcohol at harmful levels. As many as 1 in 10 adults admitted to hospital are alcohol dependent (Roberts and others, 2019).

All levels of AUD increase the lifetime risk of alcohol-related conditions, and risk increases with severity of the AUD. There are over 20 wholly alcohol-attributable or 'alcohol-specific' conditions in the International Classification of Diseases 11th Revision. These are conditions that are specifically caused by alcohol, for example alcohol poisoning or alcohol-related liver disease (ARLD). There are over 200 partially alcohol-attributable or 'alcohol-related conditions', which include all alcohol-specific conditions. They also include conditions where alcohol use is a known cause in some but not all cases, for example high blood pressure, various cancers and falls (Jones and Bellis, 2014; Rehm and others, 2010).

Patients with AUD can present to any team in the hospital, either through the elective route or the emergency route. Patients can arrive at the emergency department with a range of conditions that can lead to alcohol-related emergency admissions. As well as acute alcohol withdrawal, research (Phillips and others, 2019) has shown that these may include (but are not limited to):

- mental health conditions
- poisonings (including overdoses)
- incidents such as near drowning
- head injury
- laceration
- central nervous system conditions

- cardiovascular conditions
- diabetic conditions
- gastrointestinal conditions
- haematological conditions

A sustainable and well-organised hospital-wide system needs to be in place to ensure hospitals can identify and care for patients with AUD.

For detailed guidance on pharmacological interventions used in the treatment of alcohol dependence and complications of alcohol withdrawal, see chapter 10 on pharmacological interventions.

People with alcohol dependence often have complex needs or experience multiple disadvantage and some people will need more flexible approaches to engagement and delivering these interventions. They will also require integrated ongoing care and support on discharge. For example, see chapter 21 on people experiencing homelessness.

16.3 Main elements of alcohol care in acute settings

The main elements of alcohol care in acute hospitals are as follows. Hospitals should:

- screen all inpatients for AUD (see chapter 3 on identification and brief interventions)
- assess the severity of AUD to inform the appropriate intervention (see chapter 4 on assessment and treatment and recovery planning)
- identify need and manage medically assisted withdrawal from alcohol during admission to hospital
- screen for important comorbidities such as ARLD or mental health conditions and arrange access to appropriate treatment
- provide meaningful psychoeducation (learning about their condition and ways to manage it) and support for people being admitted to hospital with alcohol-related conditions
- organise access to community alcohol treatment services, peer support organisations and mutual aid groups
- collaborate with other local commissioning and provider agencies to ensure they have integrated pathways across primary care, secondary care and community care

16.4 Secondary care alcohol specialist teams can improve care

In some hospitals, specialist staff are organised as alcohol specialist teams. There are various terms used to describe secondary care specialist alcohol services in the UK. For example, alcohol liaison services or alcohol care teams (ACTs). There is also variation in how these services are configured.

This guideline uses the term ACTs, meaning multidisciplinary secondary care specialist alcohol services that are broadly in line with the consensus-based 'core service descriptor', available on NHS England's Alcohol care teams in district general hospitals: resources page. This includes having the appropriate numbers of specialist staff for the size of the hospital site it covers.

Services that provide only in-reach from community alcohol services are a valuable accompaniment to ACTs, but these work best with an optimally staffed ACT within the hospital. Hospitals with no ACT or specialist alcohol provision as part of mental health liaison services should still try to implement the requirements for managing alcohol dependence in the sections below, within their resources and in line with local need.

16.5 Identifying alcohol-use disorders and alcohol health risk

Patients with AUD often do not recognise the extent of their alcohol use, or that it may be causing them harm, so admission to hospital is an opportunity for intervention for all patients with AUD.

Staff throughout the hospital should be able to:

- routinely screen inpatients for alcohol health risk
- provide brief advice for people who drink at increasing-risk and harmful (higher-risk) levels
- refer people with possible dependence for specialist assessment

Patients who have not approached community alcohol treatment services before may be having their AUD identified for the first time when they present to an acute hospital. Any alcohol use can carry a significant stigma for people across different social groups, cultures and religions. So, hospitals need to work with them sensitively and confidentially to help them recognise risk or ongoing problems, which is vital to help them change behaviour.

Hospitals should promote a culture that destigmatises AUD. They should also provide education and training to medical, nursing and other colleagues across the trust, and work strategically with stakeholders in the hospital system and wider community to monitor the effectiveness of treatment pathways.

The National Institute for Health and Care Excellence (NICE) public health guideline Alcohol-use disorders: prevention (PH24) recommends the 'alcohol use disorders identification test' (AUDIT), available on the Alcohol use screening tests page, to identify risk levels from alcohol use. There are short forms of AUDIT (which were originally developed as pre-screens) if time is limited. Using AUDIT tools is covered in detail in chapter 3 on identification and brief interventions.

When assessing alcohol risk in people aged 17 and under, you should assess their ability to consent to alcohol-related interventions and treatment. Some will require parental or carer involvement. You can find more about assessing alcohol risk in people aged 17 and under in section 23.4.4 of chapter 23 on alcohol treatment and support for young people.

16.6 Managing alcohol dependence in acute hospitals

Acute hospitals can effectively manage the care of patients with alcohol dependence by making sure that:

- they have a strategy and operational systems in place to identify and manage alcohol-use disorders and alcohol-related harms
- they work with commissioners and partner organisations to build effective care pathways throughout the alcohol treatment system
- they have clear alcohol-related policies and procedures, make staff aware of them and provide staff training to apply them
- they have governance structures to monitor hospital data, audit clinical practice and encourage quality improvement
- staff throughout the hospital are trained to identify and manage AUD

Hospitals should also make sure that there are specialist staff with the appropriate competencies (Philips and others, 2020).

If staff have these competencies, they will be able to:

- undertake a comprehensive alcohol assessment and monitor the patient's progress
- provide the specialist advice and care to enable evidence-based, high-quality treatment across the hospital system
- oversee the identification and management of all aspects of medically assisted withdrawal, and its complications, across a range of clinical presentations
- deliver psychosocial interventions (such as motivational interviewing) to engage patients to address their AUD (see chapter 5 on psychosocial interventions)
- safely discharge the patient, or transfer their care to the community
- oversee training to deliver alcohol brief interventions in the hospital

16.7 Alcohol assessment

You can find detailed guidance on specialist alcohol assessment in chapter 4 of this guideline. In this section, we focus on aspects of assessment that should occur in an acute hospital setting. You will often have to do an initial assessment with patients in emergency care.

There should be clinicians competent to carry out an assessment of:

- immediate alcohol-related risk as well as a specialist diagnosis of alcohol dependence
- severity of dependence
- the potential impact of dependence on a patient's treatment and recovery

- risk of complications of withdrawal

Research has shown that delirium tremens and WE are under-recognised conditions (Schuckit, 2014; Harper, 1983; Naidoo and others, 1996). Education and awareness of these conditions will help with early recognition, prevention and poor patient outcomes.

Patients should not be refused assessment because they are intoxicated. Clinicians will need to assess the patient's degree of intoxication and immediate risk. A series of assessments of risk and temporary inpatient admission may be necessary for people who are intoxicated. Where there is a proper reason to think that the patient may lack capacity to make decisions about alcohol consumption, a capacity assessment should be carried out.

16.7.1 Assessment considerations

If a patient's initial clinical assessment indicates immediate risk or an AUDIT indicates potential alcohol dependence, they should receive further assessment. At all stages, assessment should consider risk from:

- alcohol withdrawal
- alcohol withdrawal seizures (see section 16.9.1 on risk of complicated withdrawal)
- delirium tremens (see section 16.9.3 on identifying risk and managing delirium tremens)
- WE (see 16.9.4 on WE and chapter 20 on people with alcohol-related brain damage (ARBD))
- mental health crisis, self-harm and suicide risk (see section 16.16 on co-occurring mental health crisis)
- co-occurring physical and mental health conditions (see section 16.15 on co-occurring physical health conditions)

16.7.2 Risk of self-harm or abuse

NICE guideline Self-harm: assessment, management and preventing recurrence (NG225) recommends that all healthcare professionals and social care practitioners "consider admission to a general hospital after an episode of self-harm if:

- there are concerns about the safety of the person (for example, the person is at risk of violence, abuse or exploitation) and psychiatric admission is not indicated
- safeguarding planning needs to be completed and psychiatric admission is not indicated
- the person is unable to engage in a psychosocial assessment (for example, because they are too distressed or intoxicated)"

16.7.3 Initial assessment for people who may have alcohol dependence

Initial assessment should focus on assessing a patient's immediate needs and risks from:

- alcohol withdrawal
- complications of withdrawal
- current mental health crisis, self-harm and suicide risk
- complexities from co-occurring physical and mental health conditions
- other people, such as domestic abuse

Based on the initial assessment, for patients in an emergency setting, clinicians will need to decide whether to admit the patient because of identified risks, or not to admit them. For people who are alcohol dependent but not admitted to hospital, clinicians should tell the patient to avoid a sudden reduction in alcohol intake and refer them to community alcohol treatment. This is because a sudden reduction in alcohol intake can result in severe withdrawal in dependent drinkers.

16.7.4 Further alcohol assessment and monitoring

Patients with alcohol dependence may be admitted by an elective or emergency route for an alcohol-related condition, or for a condition not related to alcohol. They may require medically assisted withdrawal while they are treated for that condition. Patients whose initial assessment or AUDIT indicates potential alcohol dependence should have further assessment for:

- diagnosis of alcohol dependence
- the severity of their dependence
- risk of complications of withdrawal
- co-occurring complexities and social circumstances
- potential impact of their dependence on their ongoing physical and pharmacological treatment and recovery

Staff responsible for assessing and managing medically assisted withdrawal should be clinicians who are competent in diagnosing and assessing alcohol dependence and withdrawal symptoms. They should also be competent in using recommended drug regimens appropriate for a community setting and trained in the use of a validated tool for measuring withdrawal symptoms.

To assess presence or severity of dependence (mild, moderate or severe), you can use structured self-evaluation questionnaires like the severity of alcohol dependence questionnaire (SADQ) or the Leeds dependence questionnaire (LDQ) to support clinical judgement. Structured tools should never take the place of a clinical interview. There is more information on assessment tools in chapter 4 on assessment and treatment and recovery planning.

16.7.5 Assessing intoxicated patients

You should not refuse a patient an assessment because they are intoxicated. You may need to do a series of assessments of risk, for example every 45 minutes.

Severe intoxication can affect breathing and staff should be able to assess patients using early warning scales such as the Royal College of Physicians' national early warning score (NEWS) 2. There should also be procedures in place for escalating any concerns about the patient's condition and managing them if they start deteriorating.

There are several issues to consider when assessing intoxicated patients.

You should undertake a clinical assessment of intoxication. If there is a proper reason to think that the patient lacks capacity to make the 'decision in question' (see glossary), you should carry out a capacity assessment. For example, you may need to assess the patient's capacity to make decisions about alcohol consumption.

You should not delay psychiatric assessment. However, there is still dynamic risk (risk that changes with time and circumstance) related to intoxication, which means that you should wait until the patient is not clinically intoxicated to undertake a re-assessment to inform onward care. You may need to consider temporary inpatient admission if you feel that the level of risk is too great.

Part of the assessment should involve checking if the patient has an underlying alcohol use-disorder, and if they do, how severe it is.

16.7.6 Assessing the relevant mental capacity

Some patients with severe alcohol dependence can present to acute services with cognitive or behavioural disturbance, due to a confusional state, such as alcohol withdrawal delirium tremens or WE. In some cases, there may be a proper reason to consider that a patient may lack mental capacity to make the decision in question (see glossary) either temporarily or permanently. For example, it may be necessary to assess the patient's capacity to consent to medical treatment. This can make clinical assessment or managing behaviour more difficult.

Healthcare professionals should treat patients with empathy, dignity and respect, including recognising that withdrawal states and craving can involve significant suffering. A clinician with experience of complex capacity assessment should assess mental capacity to make the decisions in question. This will often be carried out by staff from the ACT in hospitals where they exist.

You can find guidance on assessment of mental capacity on specific decisions for people with ARBD in chapter 20.

You can find information on national legislation and statutory guidance on assessing mental capacity and ability to consent to treatment in annex 1.

You can find further guidance on managing challenging behaviour during treatment in section 16.13 below.

16.7.7 Dealing with acute alcohol withdrawal

Acute hospital emergency departments should have protocols for people presenting in acute withdrawal. Hospitals should admit anyone presenting with acute alcohol withdrawal or who is assessed to be at high risk of developing:

- withdrawal seizures (see section 16.9.1 on risk of complicated withdrawal)
- delirium tremens (see section 16.9.3 on identifying risk and managing delirium tremens)
- WE (see section 16.9.4 on WE)

Patients in acute withdrawal need immediate assessment after admission by a healthcare professional skilled in assessing and managing alcohol withdrawal.

Emergency departments should not indiscriminately admit patients to general hospitals for unplanned medically assisted withdrawal, but they should not refuse managed withdrawal because it is unplanned. Clinicians should assess the need for admission for medically assisted withdrawal based on:

- assessment of risk of withdrawal complications
- co-existing physical or mental health conditions
- social support available to them
- vulnerability or frailty or risk of self-harm

You should consider a lower threshold for admitting people:

- who are lacking in social support, for example people experiencing homelessness
- with significant physical or mental health comorbidities, cognitive impairment or learning disabilities
- who are frail or vulnerable in other ways

Children and young people aged 10 to 17 who need medically assisted withdrawal should be admitted to an age-appropriate inpatient setting with access to specialist expertise for physical and psychosocial assessment.

Patients who are treated for acute withdrawal should be offered a referral to specialist services for ongoing treatment of alcohol dependence after they are discharged from hospital and informed of peer support organisations and mutual aid groups.

People with potential or diagnosed alcohol dependence who are not admitted to hospital should be advised not to stop drinking suddenly as this can lead to dangerous acute withdrawal. It may be appropriate for them to continue to drink at a steady pace (to avoid potential complications), avoiding episodes of increased heavy alcohol use or periods without alcohol, until they can access medically assisted withdrawal.

16.8 Medically assisted alcohol withdrawal

16.8.1 Risk of alcohol withdrawal

Alcohol withdrawal symptoms generally start within 6 to 24 hours after stopping drinking and can last around a week. Patients with a history of alcohol dependence who present to services after weeks of abstinence will not suffer withdrawal symptoms. You should bear in mind that patients self-reporting their drinking may not be accurate, so it will be important to use clinical judgement. They should be asked about withdrawal symptoms after stopping drinking, which include (but are not limited to):

- sweating
- shaking
- palpitations
- headache
- nausea or vomiting
- anxiety or agitation
- insomnia or disturbed sleep

Patients might also have withdrawal complications, such as seizures, delirium tremens and WE.

Hospital staff should look for signs of WE and assess patients where necessary.

The NICE clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) recommends the clinical institute withdrawal assessment alcohol - revised (CIWA-Ar) to assess withdrawal risks for patients in general hospital settings. The alcohol guidelines development group also recommend using the alcohol withdrawal scale (AWS) or the Glasgow modified alcohol withdrawal scale (GMAWS). The GMAWS is designed specifically for inpatient use.

16.8.2 Managing withdrawal

You should read guidance on medically assisted withdrawal in section 10.3 in chapter 10 alongside this section when prescribing and managing medically assisted withdrawal.

Staff responsible for assessing and managing medically assisted withdrawal should be clinicians who are competent in diagnosing and assessing alcohol dependence and withdrawal symptoms.

It's very important to discuss patients' drinking goals, such as low-risk drinking or abstinence, and securing appropriate support after discharge from hospital. ACTs can play an important role in supporting medically assisted withdrawal in hospital, and where they exist, they should be involved as early as possible.

Benzodiazepine reducing regimens are the standard pharmacological treatment of choice to manage withdrawal from alcohol. In all settings, regular skilled monitoring of symptoms and of the effects of medication is an essential component of care (see sections 10.3.3, 10.3.4 and 10.3.5 of chapter 10).

NICE clinical guideline Alcohol-use disorders: diagnosis and management of physical complications (CG100) gives guidance on symptom-triggered medically assisted withdrawal in inpatient settings, which has been associated with lower benzodiazepine requirements and a shorter length of stay. A symptom-triggered approach requires sufficient numbers of appropriately trained staff. In some settings with fewer appropriately trained staff, a fixed dose regimen may be safer, particularly for patients at high risk of severe withdrawal and complexities.

Clinicians responsible for the clinical governance of medically assisted withdrawal provision (such as ACTs), or those responsible for acute clinical team leadership, should assess the nursing staffing levels and the capability and training of nursing and allied staff. This is to decide which approach would be appropriate and safe to use for people at high risk of severe withdrawal. The options are a:

- symptom-triggered medically assisted withdrawal
- fixed dose medically assisted withdrawal
- hybrid approach

Staff across acute wards should receive training to familiarise them with:

- structured withdrawal assessment tools
- the possible consequences of under-treatment
- the need for adequate monitoring of respiratory rate and oxygen saturations

In hospitals where ACTs exist, they should provide this training.

Where high doses of benzodiazepines have affected patients' balance, they may require mobility assistance.

16.8.3 Using carbamazepine as an alternative to a benzodiazepine to manage withdrawal

Benzodiazepine reducing regimens are the standard pharmacological treatment of choice to manage withdrawal from alcohol.

NICE CG100 recommends carbamazepine as an effective alternative medication for medically assisted withdrawal from alcohol. There are specific (though uncommon) circumstances in which it is a helpful alternative to benzodiazepines. These include using carbamazepine for patients with a:

- history of adverse reaction or allergy to benzodiazepine drugs (although uncommon, this can be fatal)
- respiratory compromise
- preference for carbamazepine (for example, people who have a history of harmful use or dependence on benzodiazepine drugs and who do not want to take them in this context)

Carbamazepine can also be used in inpatient settings to manage concurrent withdrawal from alcohol and benzodiazepine drugs. You can find more information on concurrent withdrawal from alcohol and benzodiazepines in section 10.6.1 of chapter 10 on pharmacological interventions.

Carbamazepine is not licenced for the management of withdrawal. See section 10.2.2 on unlicensed or off-label prescribing in chapter 10 on pharmacological interventions. Also, you should note the Medicines and Healthcare products Regulatory Agency (MHRA) drug safety update about using anti-epileptic drugs in pregnancy and section 10.6.4 on medically assisted withdrawal in pregnancy in chapter 10 on pharmacological interventions.

16.8.4 Medically assisted withdrawal admission for children and young people

You should admit children and young people aged 10 to 17 who need assisted withdrawal to an age-appropriate setting with access to specialist expertise for physical and psychosocial assessment, as well as medically assisted withdrawal. Children and young people should not be treated in an adult setting.

Many medications for alcohol dependence will be off-label for children and young people aged 17 and under.

Prescribers should be aware of their responsibilities when prescribing unlicensed or off-label medications, outlined in the MHRA guidance Off-label or unlicensed use of medicines: prescribers' responsibilities.

Children and young people respond differently to medications than adults and younger children respond differently than older children. So, clinicians need to show detailed care and attention when making prescribing decisions for children and young people.

For those children and young people who require medically assisted withdrawal, clinicians can use benzodiazepines (chlordiazepoxide or diazepam) with doses adjusted based on their:

- age
- height
- weight
- stage of development

Clinicians should consult the British National Formulary for Children and the product specification.

It is important that any child or young person offered medically assisted withdrawal is closely monitored by competent specialist staff. What this looks like in practice will be based on clinical judgement determined on a case by case basis, but prescribing should be regularly reviewed.

There is more guidance in section 23.14 on pharmacological interventions for children and young people in chapter 23 on specialist alcohol interventions for children and young people.

16.8.5 Managing alcohol withdrawal in people with alcohol-related liver disease

You should read guidance on medically assisted withdrawal for people with ARLD in section 10.6.6 in chapter 10 on pharmacological interventions and the section on liver disease under co-occurring physical health conditions in section 16.15.1 of this chapter.

16.8.6 Continuing medically assisted withdrawal outside of acute hospitals

Where people have good support networks and no significant physical or mental health complications, it may be beneficial for them to continue and complete medically assisted withdrawal outside the hospital in the community. People with more complex needs might require an alternative setting, such as a specialist inpatient medically assisted withdrawal unit.

Assessing the patient's suitability to complete medically assisted withdrawal in an alternative setting should only be done by a competent alcohol specialist, after a detailed assessment of the patient's needs. The assessing specialist must ensure the receiving service can provide appropriate withdrawal management, support and maintain intramuscular thiamine and other nutrition according to the patient's needs. Transferring the patient should only be done in line with a mutually agreed care pathway with a clear discharge plan agreed between the hospital, the receiving service and the patient.

16.9 Withdrawal complications

Complications of alcohol withdrawal include seizures, delirium tremens and Wernicke's encephalopathy. These conditions can be very serious and require urgent treatment.

16.9.1. Risk of complicated withdrawal

You should assess patients with alcohol dependence for risk of complicated withdrawal because this will affect decisions about admitting them to hospital, and it will inform treatment for people admitted for other reasons.

You should offer admission to people who:

- have complicated withdrawal
- are at risk of developing complicated withdrawal
- have signs of WE

Refer to section 10.4 of chapter 10 on pharmacological interventions to prevent and manage specific complications of withdrawal.

16.9.2 Managing seizures

The risk of withdrawal seizures should be minimised by effective medically assisted withdrawal. Where seizures occur, they should be managed using adequate doses of benzodiazepines.

NICE CG100 advocates administering a short-acting benzodiazepine, such as lorazepam, while acknowledging that this is not a licensed indication for the drug. The British National

Formulary page on lorazepam suggests a dose for treating seizures (although alcohol is not specified as a cause) of 4 milligrams (mg) intravenously into a large vein, followed by another dose of 4mg after 10 minutes, if necessary.

NICE CG100 also states that the anti-epileptic drug phenytoin should not be used to treat alcohol withdrawal seizures. Benzodiazepines are generally favoured (Amato, 2010) over anti-epileptic drugs, and this is also the case with newer anti-epileptic drugs.

Following an alcohol withdrawal seizure, you should monitor patients 1 to 2 hourly for 6 to 14 hours. They should be closely monitored for delirium and the need for intravenous (IV) fluids as electrolyte abnormalities may contribute (as outlined in the American Society of Addiction Medicine (ASAM) alcohol withdrawal management guideline).

NICE CG100 recommends that if a patient has an alcohol withdrawal seizure during medically assisted withdrawal, their withdrawal treatment regimen should be reviewed. This is because seizures occurring during medically assisted withdrawal reflect suboptimal dosing.

16.9.3 Identifying risk and managing delirium tremens

Delirium tremens is a severe complication of withdrawal and is preventable by appropriate pharmacological withdrawal management. Patients with delirium tremens should be immediately admitted to a suitably equipped and staffed acute hospital unit.

This section provides guidance on managing delirium tremens in the acute general hospital rather than a specialist detoxification setting with the competence to manage delirium tremens.

Symptoms and risk factors of delirium tremens

Delirium tremens is a preventable complication that research has found to occur in around 3% to 5% of people admitted to hospital for alcohol withdrawal (Schuckit, 2014). It is an agitated delirium that causes:

- disorientation
- agitation
- tachycardia (heart rate of more than 120 beats per minute)
- hypertension (20mmHg (millimetre of mercury) rise in systolic blood pressure)
- fever
- hallucinations (auditory, olfactory and visual)
- marked tremor
- sleeplessness
- paranoid ideation

These symptoms may not always all be present at the same time.

Delirium tremens usually emerges between day 2 and 3 (occasionally up to day 5) of alcohol withdrawal in a person with severe alcohol dependence. Risk factors for delirium tremens can include:

- previous seizures or delirium
- many co-occurring physical health problems
- low potassium
- thiamine deficiency
- systemic disease
- low magnesium

Evidence on the role of magnesium deficiency as a risk factor for delirium tremens is inconclusive and an area of ongoing debate. However, in people with severe alcohol dependence and comorbid malnutrition, consider checking and rectifying magnesium levels as quickly as possible, though this should not delay other treatment. Where magnesium deficiency is identified, you should be mindful of risk and monitor for any signs of the onset of delirium tremens.

As managing delirium tremens differs in important respects from managing other types of delirium, hospitals should have a specific protocol in place for treating delirium tremens as part of their alcohol treatment guidelines.

Guidelines for treating delirium tremens

NICE CG100 covers recommendations on managing and treating delirium tremens. Since the publication of NICE CG100, guidelines have been published in the USA and Australia. These are the:

- ASAM alcohol withdrawal management guideline
- Australian guidelines for the treatment of alcohol problems

While these more recent guidelines largely reflect expert consensus rather than new evidence, they provide further detail about managing delirium tremens, which clinicians may find helpful.

Managing delirium tremens

The sections below outline the recommendations of the alcohol guidelines development group drawing on the UK, USA and Australian guidelines.

A patient with delirium tremens should:

- be treated in a suitability equipped and staffed acute hospital unit or suitably equipped specialist medically assisted withdrawal unit
- receive one to one nursing care

- receive frequent measurement of their vital signs, respiratory rate and oxygen saturations

The patient should receive a thorough examination and a set of suitable investigations to detect alternative causes of delirium, which you should treat if present. Other causes of delirium can include:

- subdural haematoma
- WE (see section below on the importance of vitamin treatment for potential WE in delirium tremens)
- hepatic encephalopathy
- hypoxia
- sepsis
- metabolic disturbance
- intoxication or withdrawal from drugs

Patients will benefit from a multidisciplinary approach to the management of delirium tremens, with input from:

- an acute medical team
- clinicians with specialist expertise in alcohol dependence and withdrawal complications
- an ACT in hospitals that have them
- a liaison psychiatry team and intensive care unit outreach team, if necessary

Delirium tremens is a disturbance of mind or brain and can in some cases mean that that the person cannot make the decision in question (see glossary). If there is a proper reason to consider that the patient may lack the relevant capacity, the decision-maker should undertake a formal assessment of the patient's mental capacity to consent to medical treatment. If the patient lacks capacity to consent, the team will need to make a 'best interests' decision regarding the treatment. A best interests decision must consider all the relevant circumstances, including having regard to the patient's wishes and feelings. There should also be consultation with family and carers where practicable and appropriate. You can find more information in the NICE guideline Decision-making and mental capacity (NG108).

Pharmacological intervention for delirium tremens

The goal of pharmacological treatment of delirium tremens is to produce a rousable but sedated state in the patient, similar to a light sleep.

Pharmacological management of delirium tremens is different from other forms of behavioural disturbance because benzodiazepines should be a first-line treatment. You

should use adequate doses of benzodiazepines to manage severe alcohol withdrawal before you consider using neuroleptics (antipsychotic medication - see section on neuroleptics below). You should not use neuroleptics as monotherapy (treating the condition with a single drug), other than in exceptional circumstances.

You should review the patient's withdrawal regimen if they develop delirium tremens (NICE CG100). This is because cases of delirium tremens may arise through untreated, or under-treated withdrawal. To prevent delirium tremens from developing, it is important to:

- identify patients early who are at risk of severe withdrawal
- monitor patients frequently with a validated withdrawal tool
- prescribe patients an appropriate amount of a suitable benzodiazepine, based on their assessed score

Benzodiazepines for treatment of delirium tremens

Benzodiazepines are the mainstay of treatment for delirium tremens (Mayo-Smith and others, 2004).

Benzodiazepines used as a first-line treatment may include:

- oral or intramuscular (IM) lorazepam (NICE recommends oral lorazepam as first-line treatment)
- oral diazepam, as recommended in the Australian guidelines
- oral chlordiazepoxide, which the alcohol guidelines development group agree is appropriate, based on clinical experience

Other benzodiazepines without specific license for treatment of withdrawal are used off-label for this purpose (see section 10.2.2 on off-label and unlicensed prescribing in chapter 10 on pharmacological interventions).

In some circumstances it may be appropriate to give diazepam, which is specifically licensed for alcohol withdrawal (or, if appropriate, another benzodiazepine) parenterally. However, absorption from IM injection of diazepam may be variable, particularly for the gluteal muscles, and so, the IM route of administration of diazepam should only be used if IV administration is not possible.

You should be aware of the MHRA safety alert for the use of benzodiazepines and opioids.

Chlordiazepoxide and possible risk of genotoxicity (damage to genetic information)

Chlordiazepoxide should not be used during pregnancy, especially during the first and last trimester unless the clinical condition of the woman requires treatment with chlordiazepoxide. Evidence on the safety of chlordiazepoxide is available on the Electronic Medicines Compendium summary of product characteristics for Librium 5mg capsules.

Issued in 2020 (and revised in 2023), the European Medicines Agency (EMA) safety working party and non-clinical working party published recommendations on the duration of

contraception following the end of treatment with a genotoxic drug (PDF, 1.07MB). Following this advice, the summary of product characteristics for Librium and some generic chlordiazepoxide varied their licence to implement the guidance.

The change is the result of new EMA guidance, rather than new evidence for the genotoxicity of chlordiazepoxide.

MHRA is reviewing the evidence available on chlordiazepoxide to ensure that appropriate and proportional warnings are implemented as required. MHRA advises that healthcare professionals should continue to use current clinical guidelines while this evaluation takes place.

The risks from continued excessive alcohol consumption and complications from alcohol withdrawal, such as seizures and delirium tremens, are likely to significantly outweigh any potential risk of genotoxic effects from the duration and doses of chlordiazepoxide used for medically assisted withdrawal. When prescribing chlordiazepoxide, the clinician should consider the proportionate balance of risk and discuss this with the patient. Both men and women should be advised about contraception following the end of treatment.

Dosage and regimen for benzodiazepines when treating delirium tremens

You should tailor the benzodiazepine dose to the person based on a specific hospital protocol for delirium tremens and specialist advice from clinicians experienced in the treatment of alcohol withdrawal and complications, for example the hospital's alcohol care team or liaison psychiatry team. While NICE CG100 does not specify a dose for oral or parenteral lorazepam for the treatment of delirium tremens, it is the consensus of the alcohol guideline development group that high doses of whichever benzodiazepine is used may be required to treat delirium tremens adequately. High dose benzodiazepines carry a risk of respiratory depression and so it is essential to frequently monitor the patient, including oxygen saturations and respiratory rate.

When giving benzodiazepines, use either a symptom-triggered regimen (see section 10.3.4 on choice of regimen in chapter 10 on pharmacological interventions) or loading (as recommended by USA and Australian guidance).

Loading is a regimen where specific doses of benzodiazepine are given frequently until light sedation is achieved and then no more given until the following day. As an example of a benzodiazepine loading regimen, the Australian guidelines recommend loading with 20mg diazepam orally given hourly up to 80mg in total over 24 hours (in some cases this may need to be exceeded). Both symptom-triggered and loading regimens aim to achieve rapid control of symptoms and neither of them is a conventional fixed-dose regimen where benzodiazepines are administered 4 times a day.

The choice of regimen will depend on available expertise and resources. Both symptom-triggered and loading approaches require all team members to be trained to ensure that it can be applied consistently and safely.

Managing IV benzodiazepines safely

If a patient is unable to take oral benzodiazepines, you should use parenteral benzodiazepines (NICE CG100). You should not give IV benzodiazepines outside emergency department resuscitation or high dependency settings. This is because of the risk of respiratory depression and the required skills profile of staff. In other settings, you should use an IM route of administration. If you give repeated boluses of IV benzodiazepines to patients, you should be aware of the potential complication of hyponatraemia (low levels of sodium in the blood) and acidosis (high levels of acid in the body).

Neuroleptics

NICE CG100 recommends haloperidol for treatment of delirium tremens as an option where oral lorazepam is declined or symptoms persist. However, the consensus of the alcohol clinical guidelines development group (and clinical guidelines from other countries) is that neuroleptics such as haloperidol should:

- not be given as first-line treatment or monotherapy for delirium tremens
- only be used as an adjunct to benzodiazepine treatment where adequate doses have failed to manage the behavioural disturbance
- not replace adequate doses of benzodiazepines

Risk of Wernicke's encephalopathy in delirium tremens

Any change in mental status including delirium can be a sign of WE if accompanied by one of the other criteria, which research (Caine and others, 1997) shows are:

- a history of poor nutrition
- ataxia (disorders that affect co-ordination, balance and speech)
- any eye movement abnormality

Clinicians should be aware that WE can be a contributing factor to the delirium and treat as necessary. You can find information on administering thiamine (vitamin B1) to treat WE in section 16.9.4 below.

16.9.4 Wernicke's encephalopathy

You can find detailed guidance on WE in chapter 20 on people with ARBD.

This section deals with administration of thiamine to prevent and treat WE.

Treatment of WE should take place in a hospital setting. Thiamine should be administered parenterally. IV is preferable as the IM route is painful.

Preventing and treating Wernicke's encephalopathy

WE is a serious complication caused by deficiency of thiamine (vitamin B1), for which the most common cause is alcohol dependence. This can result in lasting brain injury, so preventing this complication is vital.

WE is a potential complication of alcohol withdrawal and thiamine should be prescribed as part of medically assisted withdrawal to prevent WE from developing. However, WE does not occur only when people stop drinking, and people who are malnourished or have decompensated liver disease remain at risk while they continue to drink alcohol.

People with any degree of risk of WE, who choose not to have parenteral (intramuscular or intravenous) thiamine, should be offered oral thiamine.

Vitamin prophylaxis to prevent WE

Many people with alcohol dependence are at risk of developing WE due to thiamine deficiency. They may also have deficiencies in other vitamins. You should provide thiamine supplementation as part of any medically assisted withdrawal. However, it's essential to offer vitamin prophylaxis in all people who drink harmfully and dependently, whether or not they intend to undergo medically assisted withdrawal.

The risk of anaphylactic reaction from parenteral vitamins has sometimes deterred clinicians from using them, but the risks of failing to correct thiamine deficiency are significant. You should consider the following points.

Absorption of oral thiamine from the intestine is saturated at 5mg to 10mg per dose in healthy people and can be reduced to negligible amounts in people with alcohol dependence, especially those with malnutrition. Oral thiamine will not be adequate to replace depleted thiamine in a significant proportion of these people (Tallaksen and others, 1993; Weber and Kewitz, 1985).

Thiamine stores need to be replaced as quickly as possible and high circulating levels of thiamine are needed for passive diffusion into the central nervous system (based on clinical consensus of the guidelines development group).

For people who need parenteral thiamine, the risk of anaphylaxis is very low: less than 1 in 5,000,000 for IV infusion and lower still for the IM route (Cook and others, 1998; Thomson and Marshall, 2006).

MHRA has published a drug safety update on allergic reactions to parenteral Pabrinex (thiamine and other vitamins).

Pharmacological regimen for vitamin prophylaxis

The appropriate regimen for vitamin prophylaxis will depend on whether the person:

- is considered to be at lower risk
- has no signs of WE but is at high risk of it developing
- is showing signs of WE

Thiamine should be given orally or parenterally as described below.

The lower-risk group comprises people who drink harmfully or dependently but who do not have any of the conditions that put them at high risk. In practice, all people admitted to

hospital who drink harmfully or dependently, who do not meet criteria for the high-risk regimen, should be given thiamine 50mg oral 4 times daily.

People in the high-risk group can have a range of conditions, including:

- significant weight loss
- poor diet
- low body mass index (BMI) (less than 18)
- other signs of malnutrition
- memory disturbance
- peripheral neuropathy
- previous history complicated withdrawal including WE
- decompensated liver disease
- long history of harmful drinking and alcohol dependence
- admission to hospital with an acute injury or illness

For people in the high-risk group, offer thiamine 200mg to 300mg IM or IV once per day for 3 to 5 days with daily review and monitoring for signs of WE.

Injections should be given by appropriately skilled, trained and resourced staff.

IM or IV thiamine should be followed by a course of oral thiamine until holistic review of overall recovery indicates it is no longer necessary.

If you have well-founded nutritional concerns, you can also prescribe a suitable nutritional supplement.

Treatment for incipient Wernicke's encephalopathy

People will require inpatient treatment for WE if they have any of the following additional symptoms:

- impaired eye movements (ophthalmoplegia)
- unsteady walking (ataxia)
- confusion

Pharmacological regimen for treating suspected or established Wernicke's encephalopathy

If you suspect or diagnose WE, the patient will need the following treatment and monitoring. You should:

- give IV thiamine 300mg to 500mg 3 times a day for 3 to 5 days with daily review

- give IV thiamine 300mg to 500mg once daily for a further 3 to 5 days if the patient is still symptomatic after the first 5 days of treatment - then for as long as clinical improvement continues
- explore other causes for a patient's confusion
- take appropriate steps to manage the small risk of anaphylaxis by administering thiamine in a setting with facilities for treating anaphylaxis and with appropriately trained staff available during the infusion
- continue to give the full dose of IV thiamine (as set out above) if the patient subsequently develops WE
- follow a course of parenteral thiamine with a course of oral thiamine
- consider checking and re-checking magnesium in all patients with incipient WE and correct it if it's low

Magnesium is a co-factor for converting thiamine to the active form in the liver (hypomagnesaemia (magnesium deficiency) is a documented cause of WE that does not respond to treatment)

Magnesium deficiency (hypomagnesaemia) can prevent thiamine from working properly in the body (McLean and Manchip, 1999). This means patients may not respond to standard treatment for WE while their magnesium levels are deficient.

Preventing Wernicke's encephalopathy in people who continue to drink alcohol

For people with a harmful or dependent pattern of drinking, with a lower risk of WE, offer prophylactic oral thiamine, as described above in this section, even if they are likely to continue to drink alcohol.

For people at high risk of WE, offer prophylactic IM or IV thiamine followed by oral thiamine, as described above in this section, even if there are no plans for them to undergo medically assisted withdrawal.

16.10 Psychosocial interventions to support medically assisted withdrawal and ongoing abstinence

During medically assisted withdrawal, all staff should actively listen to and support the patient and give them information on how to manage withdrawal symptoms and where to access help and support. Patients need to understand that they have had a medically assisted withdrawal if they leave hospital after completing one, because they may not realise this.

Trained staff should help the patient explore any ambivalence they have towards treatment of their alcohol dependence and encourage them to access ongoing support to maintain abstinence. The staff can also discuss with the patient about how:

- important they think it is to change their drinking behaviour after they leave hospital

- confident they feel about being able to change their behaviour

If the patient understands the risks and harms from alcohol, especially using their current health problems as a focus, it can help to:

- build motivation for change
- identify goals
- agree initial plans that can be started when they are discharged from hospital

You can find out more about exploring readiness to change and encouraging engagement with further support in chapter 4 on assessment and treatment and recovery planning in section 4.9.3 on motivation, readiness and belief in the ability to change.

16.11 Relapse prevention treatment

Pharmacological interventions for relapse prevention are covered in detail in section 10.5 of chapter 10 on pharmacological interventions.

NICE CG115 recommends initiating relapse prevention medication in hospital following or concurrently with medically assisted withdrawal. It also recommends making appropriate arrangements for psychosocial support and follow-up with repeat prescription.

You should make sure there are clear follow-up procedures, so that the patient is prescribed relapse prevention medications for the appropriate timescale. You should continue to monitor the relapse prevention medication, and ask questions about:

- concordance (interaction and co-operation between patients and healthcare professionals, which addresses patients' needs)
- concordance strategies
- access to a range of psychosocial interventions, if people want it (you can find more comprehensive guidance on psychosocial interventions in chapter 5)

16.12 Managing deteriorating alcohol dependent patients

As outlined above, alcohol dependent patients may be suffering several concurrent problems, including:

- dehydration
- malnutrition
- electrolyte derangement (or imbalance)
- sepsis
- traumatic injury

Alcohol dependence is associated with needing intensive care for lower respiratory infections and a higher risk of adult respiratory distress syndrome following trauma (Gupta and others, 2019; Kózka and others, 2020; Tignanelli and others, 2019). It is beyond the

scope of this guideline to consider treatment for alcohol dependence in intensive care settings, where management is based on physiological principles. However, healthcare professionals who care for patients with alcohol dependence in acute hospital settings should be aware that patients can quickly deteriorate.

Where you identify multimorbidity (2 or more chronic conditions co-occurring), patients are likely to benefit from increased nursing observations and frequent review by the junior medical team. We recommend that there is clear communication between people directly managing the patient, such as emergency department staff, ACT and medical and nursing staff. There should also be early contact between these staff and intensive care outreach or on-call intensive care unit doctors to inform them about the patient and seek advice.

16.13 Managing challenging behaviour

Staff in acute hospitals often have to deal with challenging behaviour from patients admitted for withdrawal or complicated withdrawal. The guidance in this section is based on clinical consensus of the guideline development group.

16.13.1 Reasons for challenging behaviour

Patients with AUD may exhibit challenging behaviour. It is important to understand the reasons why this might occur. Challenging behaviour from patients may be a response to their unmet needs, including compulsion to drink, and may need you to:

- review the patient's medication and dosages
- understand their priorities
- review the arrangements for them receiving visitors
- address nicotine replacement
- encourage carers' and families' involvement to help mitigate against difficult behaviours

Assessing a patient's capacity to consent to treatment and/or their capacity to make discharge decisions, can be a vital part of managing behavioural challenges. Capacity to make such decisions can fluctuate throughout medically assisted withdrawal, particularly if they are in severe withdrawal, so clinicians need to be aware that that behavioural disturbance can emerge from a confusional state.

16.13.2 Behavioural contracts

If the patient has capacity to consent to medical treatment but has been behaving in a way that makes continued treatment too dangerous (for example, drinking alcohol while being prescribed benzodiazepines for medically assisted withdrawal), you can consider having a behavioural contract with clear expectations and consequences. You should not use a behavioural contract where the patient is incapacitated.

Making decisions about behavioural contracts requires a careful balance of risks and benefits to the patient. Ideally, you should follow a multidisciplinary approach, fully involving the patient.

16.14 Co-occurring physical and mental health conditions

AUD is often accompanied by physical and mental health conditions that may influence the choice of treatment for alcohol dependence and the treatment for physical health conditions in acute hospitals.

When assessing patients, clinicians should understand that it's possible that the patient might have a co-occurring condition, including:

- a mental health crisis
- alcohol-related liver disease
- alcohol-related hepatitis
- refeeding syndrome if they are malnourished
- experiencing multiple disadvantage

Where you identify 2 or more chronic conditions co-occurring, patients are likely to benefit from increased nursing observations and frequent review by the junior medical team.

This section covers co-occurring physical and mental health conditions. The next 2 sections cover co-occurring physical health conditions, and co-occurring mental health crisis, respectively.

16.15 Co-occurring physical health conditions

16.15.1 Liver disease

Detecting liver disease early

Signs and symptoms of ARLD develop late in the progression of the disease and a high proportion of people with ARLD will have no clinical symptoms nor significant blood test abnormalities.

Eventually, their liver may fail to function sufficiently and will decompensate. This is the stage at which ARLD becomes clinically apparent. The risk of developing liver disease and subsequent decompensation decreases with abstinence (or reduced alcohol consumption). So, it's important to detect liver disease early and begin interventions.

Screening for liver disease

NICE guideline Cirrhosis in over 16s: assessment and management (NG50) recommends that women drinking more than 35 units per week or men drinking more than 50 units per week for 3 months or more should have their liver stiffness measured by transient elastography (TE, also known as fibroscan) to determine the stage of progression of liver disease.

There are other non-invasive screening methods for liver fibrosis in development, which include the following.

Ultrasound based screening includes:

- acoustic radiation force impulse
- shear wave

Serum fibrosis markers include:

- enhanced liver fibrosis (ELF)
- liver traffic light test
- intelligent liver function test (iLFT)

However, research shows that these tests are currently less well validated for ARLD than TE is (Moreno and others, 2019).

Healthcare professionals who perform and interpret non-invasive fibrosis tests should be trained to do so.

Any screening test should be part of a clear pathway, to make sure the tests are reviewed and acted on.

Scottish Health Action on Alcohol Problems published Alcohol-related liver disease: guidance for good practice for healthcare staff in primary and secondary health services and in alcohol treatment services. The content may also be useful for healthcare staff in other UK nations.

Care for people with liver disease

People diagnosed with significant fibrosis or cirrhosis should be followed up by a specialist in liver disease.

Alcohol abstinence is a vital goal for people with ARLD, since abstinence improves outcomes in all stages of ARLD. However, the patient should not be excluded from treatment if they do not accept this goal initially.

There should be effective care pathways between specialist liver services and alcohol treatment services in the hospital and in the community.

Cirrhosis

The European Association for the Study of the Liver (EASL) clinical practice guidelines recommends that if you suspect that a patient has cirrhosis, you should evaluate their liver function and the presence of portal hypertension by measuring:

- serum bilirubin
- albumin
- prothrombin time (PT) or international normalised ratio (INR)

- platelet count

Other liver blood tests may indicate alcohol excess (gamma glutamyl transferase (GGT) and raised aspartate aminotransferase (AST) to alanine aminotransferase (ALT) ratio). They may also suggest alcohol as the cause of liver disease. But the EASL clinical practice guidelines points out that these tests cannot be used to determine the severity of fibrosis or cirrhosis and test results can be entirely normal, even in people with cirrhosis.

Other causes of liver disease

NICE CG100 recommends evaluating alternative causes of liver disease in people who drink at higher-risk levels with abnormal liver blood test results. In particular, risk factors for the other common liver diseases in the UK (non-alcoholic fatty liver disease and hepatitis C infection) include the metabolic syndrome (obesity and type 2 diabetes mellitus) or injecting drug use.

Ultrasonography helps to exclude other causes of liver disease and may help you to assess advanced disease (for example, splenomegaly and irregular hepatic contour) and its complications (for example, ascites and hepatocellular carcinoma), whatever the causes. However, ultrasonography cannot establish alcohol as the specific cause of a person's liver disease nor reliably assess hepatic fibrosis.

Decompensated liver disease

Clinical signs of decompensated liver disease include:

- jaundice, shown by yellow discolouration of the skin and sclera (whites of the eyes)
- spider naevi, shown by red star-shaped markings on the face and upper body which blanch when pressed
- easy bruising
- swollen abdomen, caused by ascites (fluid in the abdomen), which patients often mistake for weight gain
- swollen legs
- confusion, such as reversal of day-night waking pattern, drowsiness and poor memory

The patient may also complain of fatigue, itching, abdominal pain and nausea.

The National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report Alcohol related liver disease: measuring the units recommends that people with decompensated cirrhosis should be managed by a specialist with experience in managing patients with liver disease.

Decompensated cirrhosis is a medical emergency with a high mortality. In particular, heavy drinkers presenting with new-onset jaundice, who have suspected alcohol-related hepatitis, can progress rapidly to liver failure and have a significant short-term mortality (30% at 90

days and 56% at one year) (Thursz and others, 2015). Effective early intervention improves outcomes. When you are assessing people who have presented with decompensated cirrhosis, you should determine the precipitating causes and treat the patient appropriately.

A decompensated cirrhosis care bundle, as recommended by NCEPOD, can help to standardise and optimise the patient's management in the first 24 hours, when specialist input might not be available. Patients should be reviewed by the gastroenterology or liver team at the earliest opportunity (ideally within 24 hours). You should quickly escalate care for patients with ARLD, who deteriorate acutely and whose background functional status is good. The medical and critical care teams should work closely when making escalation decisions.

Referral for liver transplantation

The UK liver advisory group has produced updated guidelines on liver transplantation for alcohol-related liver disease in the UK, published by the British Society of Gastroenterology.

Alcohol-related pancreatitis

For guidance on diagnosis and management of alcohol related pancreatitis, see NICE CG100.

Further information and resources

The British Liver Trust has developed information guides for liver disease and liver cancer patients and carers.

16.15.2 Nutrition support

Nutritional support for alcohol-related hepatitis

NICE CG100 recommends assessing the nutritional requirements of people with acute alcohol-related hepatitis. This includes offering nutritional support if needed and considering using nasogastric tube feeding (see NICE clinical guideline Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (CG32)).

Assessing nutritional status

Many alcohol-dependent patients have poor nutritional status. When you suspect that they do, refer them to a dietician.

NICE CG32 recommends that all patients admitted to hospital should be:

- assessed to determine their BMI
- screened for unintentional weight loss
- asked if they have eaten little or nothing for the last 5 days

NICE CG32 highlights that patients with decompensated cirrhosis secondary to alcohol, and patients with alcohol dependence who often drink alcohol instead of eating, are at particular risk of malnourishment.

Nutritional assessment is especially important with particular conditions such as alcoholic ketoacidosis, which is associated with periods of complete lack of food. Alcoholic ketoacidosis is a clinical syndrome seen mostly in patients with chronic AUD and often seen in patients who have a pattern of heavy episodic drinking. Typical patients are usually chronic drinkers who are unable to tolerate oral nutrition for a 1 to 3 day period (Howard and Bokhari, 2022).

NICE CG32 recommends providing nutritional assessment and support for people who have:

- a BMI of lower than 18.5
- a BMI of lower than 20 and greater than 5% weight loss in the past 3 to 6 months
- had little food or nutritional supplements in the past 5 days

Poor nutrition is a risk factor for WE, which can cause temporary or permanent brain damage. You should follow the guidance on screening for risk of WE .Guidance on managing WE in acute hospital settings is covered in section 16.6.4 of this chapter.

It's important to be aware that the metabolic demand produced by acute physical illness in general hospitals will increase the risk of WE.

The NCEPOD report on ARLD also recommends that in the care bundle for decompensated cirrhosis, people who are actively drinking are treated with a treatment regimen of parenteral thiamine and other B vitamins.

Refeeding syndrome

Refeeding is a metabolic disturbance that can occur when nutrition is restored in people who are starved or significantly malnourished. It can happen to people who are admitted to hospital for treatment of alcohol-use disorders, so it's important to screen people for risk of refeeding syndrome, specifically those who:

- are very underweight (BMI of less than 16) or have lost more than 15% body weight over 3 to 6 months
- have not been eating for the preceding 10 days or more before admission
- have low levels of serum magnesium, phosphate or potassium
- have had severe vomiting or diarrhoea

After identifying people at high risk of refeeding syndrome, you should check their electrolytes, particularly:

- sodium
- potassium
- calcium
- phosphate

- magnesium

Refeeding syndrome should always be managed in an acute hospital setting. Research has shown that alcohol dependent patients are considered at high risk of refeeding syndrome (Mehanna and others, 2008), particularly those with cirrhosis and those with a history of poor nutrition. Refeeding syndrome is characterised by potentially fatal shifts in electrolyte and fluid balance that occur when malnourished patients begin to take in food again. Patients at risk of refeeding syndrome should be reviewed by a dietician within 48 hours. NICE CG32 advises an initial rate of 10 calories per kilogram of body weight per day (kcal/kg/day) in high risk or 5 kcal/kg/day in extreme risk.

Patients should receive regular blood test monitoring of phosphate, magnesium, calcium and potassium, with careful correction of abnormalities. You should not use 5% glucose as a rehydration fluid because it is likely to worsen both WE and electrolyte disturbances.

There are cardiac complications of electrolyte deficiencies, particularly arrhythmias, so the alcohol guidelines development group advise electrocardiogram (ECG) monitoring or telemetry to record severe low electrolyte levels. Electrolytes should be monitored daily for 5 days and then 3 times weekly until stable. You should quickly replace electrolytes when required.

Management of refeeding should be accompanied in all cases by a multivitamin preparation and thiamine replacement immediately before and during the first 10 days of refeeding. This will help prevent neurological complications such as WE.

16.16 Co-occurring mental health crisis

16.16.1 Evidence for co-occurring alcohol and mental health problems

Research shows that people presenting to emergency departments following self-harm and suicidal acts (such as overdose) or acute psychiatric symptoms is associated with intoxication and chronic alcohol-use disorder (Phillips and others, 2019).

Alcohol dependence increases risk of death by suicide by 9.8 times (Ferrari, 2014). Both alcohol dependence and alcohol use at harmful levels are associated with repeated suicidal acts and increased mortality after attending an emergency department (Hawton and others, 2013).

The National Confidential Inquiry into Suicide and Safety in Mental Health Annual report 2024: UK patient and general population data 2011 to 2021 found that 47% of people in contact with mental health services who died by suicide used alcohol problematically. However, patients who are intoxicated when they present to hospital following a suicide attempt are more likely to be discharged home than those who are not (Urban and others, 2018; Robins and others, 2021).

Patients who use substances are reported to be stigmatised by health workers because of the perception that they are “violent, manipulative and unmotivated” (Van Boekel, 2013). Qualitative research suggests that alcohol use remains a major barrier to accessing crisis

care (Suicide Prevention Consortium, 2022). Stigma like this can create barriers to people accessing mental health services.

16.16.2 Working with people who have co-occurring conditions

The 2 main principles for working with people who have co-occurring mental health conditions and problem alcohol use are:

1. Everyone's job: providers of mental health and alcohol and drug services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
2. No wrong door: providers of alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

There should also be an agreed and understood care pathway to ensure patients' needs can be met appropriately.

Patients presenting to emergency departments following a suicidal act, or in suicidal crisis, should receive care in line with NICE guideline Self-harm: assessment, management and preventing recurrence (NG225). The following guidance is taken from NICE NG225 and clinical consensus of the alcohol guidelines development group.

When a person attends the emergency department following an episode of self-harm including a suicide attempt or is at risk of suicide, offer referral to age-appropriate liaison psychiatry services as soon as possible after arrival. For children and young people, this might be a crisis response service (or an equivalent specialist mental health service or a suitably skilled mental health professional). These services will do a psychosocial assessment and provide support alongside any physical healthcare.

After a person attends an emergency department for an episode of self-harm, an age-appropriate liaison psychiatry professional or a suitably skilled mental health professional should see and speak to them.

Do not use breath or blood alcohol concentration to delay assessment.

If the person who has self-harmed, attempted suicide or is in suicidal crisis is intoxicated with alcohol, agree with the person and colleagues what immediate assistance is needed. For example, this could include support and advice about medical assessment and treatment.

Patients presenting with self-harm or suicidal acts should be offered psychosocial assessment at triage. Assessment should include structured and well-documented assessment of the existence and severity of the AUD. In addition, clinicians should do a thorough psychiatric assessment, including:

- taking a psychiatric history

- assessing the relationship between psychiatric symptoms and alcohol use
- performing a mental state examination

Consider admission to the acute hospital after an episode of self-harm including suicidal act or ideation if the person is unable to engage in a psychosocial assessment (for example, because they are too distressed or intoxicated).

If the person is not able to participate in the psychosocial assessment, review their condition frequently in line with local protocols for monitoring people at risk of self-harm or suicide. Complete a psychosocial assessment as soon as possible.

Focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety.

Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

If a person has self-harmed and presents to services but wants to leave before a full psychosocial assessment has taken place, assess the person's safety and any mental health problems before they leave. Some people may require an assessment of their capacity to make the decision about discharge or an assessment under the Mental Health Act.

Mental health professionals should discuss with the person harm minimisation strategies that could help to avoid, delay or reduce further episodes of self-harm or suicidal crisis and reduce complications. For example, the impact of alcohol and recreational drugs on the urge to self-harm.

Where possible, the patient and assessor should both agree whether the person is referred for further assessment and treatment or whether they are discharged. A decision to discharge a person without follow-up after an act of self-harm or suicidal ideation should include an assessment of their social and personal problems. These problems may increase risk and the person may respond to therapeutic or social interventions. So, a decision to discharge a person should not be based solely on apparent low risk of repeating self-harm and the absence of a mental illness.

Clinicians should assess how long a person has had suicidal thoughts and whether these are continuous or have reached a crisis. The goal of this kind of assessment should be to provide a risk formulation including a risk management plan (see glossary) and guide onward care, which may include both community alcohol and drug services and primary or secondary mental health services.

When prescribing medicines to someone who has previously self-harmed or who may self-harm in the future, healthcare professionals should take into account factors including the:

- patient's recreational drug and alcohol use
- risk of harmful alcohol or drug use
- possible interaction with prescribed medicines

16.16.3 Understanding the severity of both alcohol and mental health conditions

It is important to understand the relative severity of both a patient's AUD and co-occurring mental health disorder to know where the clinical concern should focus. Someone who has recently begun to drink at harmful levels to manage depression will require a different pathway from someone with severe alcohol dependence and depression. You should do a full risk assessment and document it clearly.

16.16.4 Do not exclude people from mental health services because of alcohol use

You should not exclude patients from mental health interventions because of their drinking status. Alcohol and mental health services need to work together to be most beneficial.

NICE NG225 recommends a cognitive behavioural therapy-based approach to prevent repeated self-harm, suicidal thoughts or acts. It states that professionals should not use "substance use or coexisting conditions as reasons to withhold psychological interventions for self-harm".

All professionals should be aware that repeated episodes of self-harm increase the risk of self-injury death. They should also be aware that self-harm linked to alcohol intoxication is associated with recurring self-harm (Hawton and others, 2013), particularly in patients with alcohol dependence (Robins and others, 2021).

Where ACTs exist, their make-up and skillset varies, but all staff members should be trained in commonly occurring mental disorders and suicide risk assessment. However, patients should not be excluded from formal psychiatric assessment because they are under the care of an ACT.

16.17 People with alcohol use disorders who frequently attend hospital

A study based on 2 London hospitals found that 9% of patients who had 3 or more alcohol-specific admissions accounted for 29% of all alcohol-specific admissions. (Health Innovation Network, South London, 2017).

People experiencing multiple disadvantage including AUD often have multiple admissions or emergency department attendances related to alcohol during a relatively short period (Drummond, 2016; Blackwood and others, 2017; Blackwood and others, 2020; Blackwood and others, 2021).

Patients with AUD with high individual use of secondary care services are more likely to:

- be men
- be aged in their 50s
- live in income deprived areas
- have mental and physical health comorbidities (Blackwood and others, 2017)

While they are likely to attend the emergency department with an alcohol-related condition (Blackwood and others, 2017), they may not think that alcohol dependence is their main

problem (Parkman and others, 2017) and say that medical attention for physical injuries and pain is their main reason for attendance. These people require additional attention because a larger proportion of this group is diagnosed with alcohol-related cirrhosis in the following 5 years than those who do not attend frequently (Blackwood thesis, 2019).

Community-based services for people experiencing multiple disadvantage are covered in detail in chapter 9 on alcohol assertive outreach and a multi-agency team around the person.

16.18 Discharge from hospital

16.18.1 Safe discharge and wrap-around support in the community

Patients should be discharged in a planned, safe way with a seamless transition to care in the community that meets all their needs (wrap-around care), including ongoing specialist alcohol treatment. This means that these services need to be planned in an integrated way at a local strategic planning and commissioning level.

Research has shown that alcohol-related readmissions to hospital happen when the patient:

- was discharged against medical advice
- had incomplete withdrawal treatment programmes and clinical complexity (Yedlapati and Stewart, 2018; Blackwood and others, 2020)
- was discharged to live on the streets (Phillips and others, 2025)

Wherever possible, patients should complete medically assisted withdrawal once they have started, either in the hospital or in the community. Decisions about when to discharge people and what care package they need should be based entirely on multidisciplinary assessment and the plan of action that's most likely to be successful for the patient. You can find guidance on comprehensive, multidisciplinary assessment in chapter 4 on assessment and treatment and recovery planning.

It is essential that discharge planning considers the risks of complicated withdrawal and the patient's physical or mental health possibly deteriorating in the community, especially for people who are experiencing rough sleeping.

With the patient's consent, clinicians should support continued abstinence from alcohol after discharge by:

- making direct referral for engagement with community alcohol treatment services and other relevant support services, where agreed with the patient
- encouraging the sharing of goals and plans with carers and relatives
- providing information on mutual aid, peer-support services, care services and helplines

16.18.2 Transfer to specialist mental health services

Patients may require transfer to specialist mental health services. The mental health team should assess all patients who need this transfer. The mental health team should identify and agree the clinical needs of the patient before transfer, in collaboration with the alcohol specialist and the patient. They should write a plan with arrangements for joint working, specifying which service is 'lead service' and what strategies they will use if the patient disengages from either service.

16.18.3 Referral to alcohol treatment services

The managing multidisciplinary team or ACT should be responsible for referring patients to the alcohol treatment provider and other providers of their ongoing care package. This means that the ACT or multidisciplinary team will need to understand providers' capacity, protocols, and inclusion and exclusion criteria. They will also need to share accurate information about the patient and their treatment with the service providers.

When the patient is discharged from hospital, there should be a clear handover of responsibility for the care package to the provider, for example to a community alcohol treatment service keyworker and prescriber.

It is not usually appropriate to discharge patients who need ongoing treatment for their alcohol dependence and expect them to self-refer to a community alcohol treatment service. The guidelines development group's clinical consensus is that this can introduce an unnecessary barrier to the patient's continued care, and it's also inefficient, because of the need to duplicate assessments.

Clinicians should take responsibility for liaising with community alcohol treatment services and handing over important information, including the patient's risk to self and others. They should also make plans, as necessary, for:

- continuing medically assisted withdrawal in the community
- arranging aftercare following unplanned medically assisted withdrawal
- continuing relapse prevention treatment

Where ACTs exist, they may take responsibility for planning and contacting services to arrange a patient's ongoing treatment and care. Whether ACTs are in place or not, in-reach provision from community alcohol treatment services is valuable. Where this provision exists, the in-reach worker should meet with the patient before discharge to provide information and orientation about their ongoing care.

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17. Alcohol treatment in the criminal justice system

How to deliver alcohol treatment interventions in police custody suites, prisons and other secure settings and for people with community sentences or on licence.

17.1 Main points

People with alcohol use disorders in the criminal justice system are entitled to care that is safe and effective at a standard that is equivalent to care in the community. Care should be delivered by staff with appropriate competencies.

To address the needs of people with alcohol use disorders, healthcare staff should take opportunities at all points in the criminal justice system to identify, assess and treat people, as well as make appropriate referrals.

Healthcare staff should be competent to manage:

- alcohol use disorders
- drug use disorders
- complex co-occurring physical and mental health disorders
- risks in custody suites and secure settings

Effective communication and co-ordination between alcohol treatment staff, other healthcare services and criminal justice services is essential to provide integrated and continuous care for people throughout the criminal justice system.

Healthcare staff should re-assess, plan support and share clinical information when people move from one criminal justice setting (including court) to another so there is no interruption in medication and treatment can continue.

Alcohol intoxication and withdrawal:

- put the person at risk of medical or mental health complications
- are associated with deaths in police custody and in prison

The clinical safety of people in those settings is the highest priority.

A suitably competent clinician should comprehensively assess anyone identified as potentially alcohol dependent or intoxicated on arrival in a police custody suite or prison, and start medically assisted withdrawal where needed.

Where the clinician assesses that clinical risks (severity of dependence and complexity of co-occurring conditions) are too high for a person to be treated for alcohol withdrawal in the custody suite or prison, they should be transferred and admitted to an acute hospital.

It is essential to monitor anyone who is intoxicated or in withdrawal in police custody suites or in prison. Healthcare staff may also need to monitor other clinical risks.

Healthcare staff with appropriate competencies in alcohol and drug dependence are responsible for clinical monitoring, and people should be placed where healthcare staff can access them to provide this.

Non-clinical custodial staff in police custody and in some prisons carry out welfare observations. There should be standard protocols and staff training for carrying out these observations.

Healthcare staff and non-clinical custodial staff both have a role in managing risk. Communication between healthcare staff and non-clinical custodial staff about the person's condition and any change in risk levels should be accurate and up to date because risks can change quite rapidly.

People should be offered care-planned and evidence-based psychosocial interventions and recovery support from when they enter prison and throughout their stay (see chapter 5 on psychosocial interventions).

Prison-based services and community services should have systems for sharing clinical information and arranging a smooth transition to community alcohol treatment following release to support continuity of care.

Probation (criminal justice social work in Scotland) and community alcohol treatment services should have clear partnership arrangements and information sharing agreements to support people to engage in alcohol treatment as part of a community sentence or licence condition.

17.2 Introduction

This chapter provides guidance on safe and effective alcohol treatment and care for people in contact with the criminal justice system in the community and in secure settings.

Criminal justice systems vary across England and Wales, Scotland and Northern Ireland. This chapter summarises important principles for people working in those systems to consider.

Commissioners and managers of health and criminal justice systems should have local protocols and operating procedures for delivering alcohol treatment in criminal justice community and secure settings. These protocols and procedures should be based on the most recent evidence and national guidelines, including these guidelines.

17.3 Providing healthcare in criminal justice settings

There is a high proportion of people with alcohol and drug use disorders among those in contact with the criminal justice system (Bebbington and others, 2017; Perkins and others, 2022). So, healthcare providers can intervene at several points in the system, in different settings, to address their needs. These settings include:

- police custody suites
- diversion to mental health services where this is available
- courts

- prisons
- probation services
- community alcohol treatment services

Effective communication and co-ordination between healthcare providers in these settings, and with non-clinical justice staff, is essential to ensure integrated and continuous care for people throughout the system and after they return to the community.

Treatment in the criminal justice system should be based on the principles of care in chapter 2 including taking a trauma-informed and a non-stigmatising approach. See the Working definition of trauma-informed practice for more information.

17.4 Alcohol treatment in police custody suites

Guidance in section 17.4 is for:

- clinicians working in police custody suites
- non-clinical police custody staff
- liaison and diversion workers
- drug arrest referrals workers

17.4.1 Overview

In this section, we summarise the main considerations for working with people with alcohol use disorders in police custody. The Faculty of Forensic and Legal Medicine of the Royal College of Psychiatrists' clinical guidelines Detainees with substance use disorders in police custody (also known as 'the blue guidelines') provide detailed guidance for healthcare professionals and custodial staff across the UK.

People who have been arrested are normally detained in police custody suites while police decide whether to charge them with a crime. Police custody suites are usually based in large police stations. The person detained will have contact with staff including:

- custody sergeants who manage the custody suite, including the care and welfare of detained people
- custody detention officers whose main role is to ensure the dignity and welfare of the people detained in custody suites
- healthcare professionals with clinical and forensic competencies to work in a custodial environment
- liaison and diversion workers or drug arrest referral workers who assess and refer detainees with mental health or alcohol or drug use disorders (liaison and diversion services are available in all custody suites in England but not in all areas of the UK)

A review of deaths in police custody in England and Wales between 2004 to 2005 and 2014 to 2015 found that alcohol or drugs featured as causes in nearly half of deaths (49%) and as

associated factors in 82% of deaths (Home Office, 2017). Managing intoxication and treating alcohol withdrawal in police custody is essential to prevent physical and mental health complications and deaths (Independent Police Complaints Commission, 2011).

17.4.2 Competencies for clinicians working in police custody

Several different healthcare professionals work in criminal justice settings and there are multidisciplinary teams in many large police custody suites. It is essential that all clinicians working in police custody have specific training, competencies and clinical support to assess and manage people with alcohol use and drug use disorders. These professionals also need to be able to manage complicated co-occurring physical and mental health conditions in the police custody setting.

You can find the necessary competencies for clinicians working in police custody in appendix A of the blue guidelines.

17.4.3 Considerations for working in police custody suites

The clinical safety needs of people detained in police custody suites is the highest priority, given the distress experienced by them and the need for urgent assessments.

Alcohol intoxication and withdrawal both put the person at risk of medical or mental health complications and are associated with deaths in police custody. Clinical staff must be competent to assess and manage alcohol intoxication and withdrawal.

Healthcare staff should be competent to screen, assess and manage all urgent needs and risks in police custody, including the risks of self-harm and suicide and any urgent physical and mental health conditions.

Healthcare staff should be able and competent to arrange urgent transfers to hospital if required. For example, if the person is experiencing severe complications of alcohol withdrawal.

Where it is indicated in the assessment, healthcare staff should arrange for people with co-occurring mental health conditions to be assessed for compulsory admission to hospital by suitably qualified mental health professionals under the:

- Mental Health Act 1983 (England and Wales)
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health (Northern Ireland) Order 1986

In appropriate cases, healthcare staff should be able to assess whether the person has mental capacity to make the decision in question (see glossary), including consenting to their medical treatment. Healthcare staff are responsible for clinical monitoring and should be able to access the person to monitor their condition.

Non-clinical custodial staff carry out observations to help manage risk. There should be standard protocols and staff training for carrying out these observations.

Communication between healthcare staff and non-clinical custodial staff about the person's health and current risks should be accurate and continuous because the person's condition may change rapidly. Information should be recorded in line with local protocols.

All healthcare staff and non-clinical custodial staff should be trained to make simple assessments of whether a person can be roused and what actions to take if there are any difficulties in rousing them.

Healthcare staff should:

- be aware of the person's right to:
    - equivalent standard of care to any member of public
    - have prescribed medication continued while in custody, as long as it is clinically safe to do so
    - be informed of the outcome of an assessment and the consequent clinical decisions
- pay close attention to the issue of informed consent by a person to any examination
- understand their role in providing an opinion on the person's fitness to be interviewed if custodial staff request this

17.4.4 Assessment in police custody

Comprehensive assessment

In police custody suites, a comprehensive assessment, appropriate monitoring and re-assessments are crucial.

In addition to a full assessment of alcohol intoxication and dependence, clinicians should:

- assess the person for intoxication and dependence on drugs in addition to alcohol
- assess the person for co-occurring physical or mental health conditions
- assess the person for any urgent social care and safeguarding needs
- make a comprehensive risk assessment including for risks of self-harm and suicide

Following an initial comprehensive assessment, clinicians or healthcare staff trained and competent in monitoring people who are intoxicated or in withdrawal should continue to monitor and re-assess people who are detained. This is essential to manage alcohol intoxication and withdrawal and to monitor any other risks, since a person's condition can change quite rapidly. There should be a place in the custody suite where varied levels of monitoring and re-assessment can take place.

There is guidance on comprehensive assessment, including risk assessment, in chapter 4 on assessment and treatment and recovery planning.

Information gathering

Clinicians should consult custody staff at an early stage in assessment because they can provide information on when the person was arrested. This can help the clinician assess when someone last used alcohol. Information about the person's presentation and behaviour from custody staff and the police risk assessment can also support the clinicians' risk assessment.

Clinicians should gather as much clinical information as possible about the person from primary or secondary health services, or community alcohol treatment services. However, they may not always be able to obtain this information within the required timescale.

Mental capacity and fitness for interview

If there is a proper reason to believe that the person may lack capacity to make the decision in question, a capacity assessment should be carried out. For example, the clinician may need to assess the person's mental capacity to consent to their medical treatment. For the purposes of the Mental Capacity Act 2005, an inability to make the decision in question can arise - for example, because of severe intoxication. There is information on legislation and guidance on mental capacity in annex 1.

Clinicians may also be asked by custody staff for their opinion on whether the person is fit to be interviewed by the police. There is guidance on fitness for interview in chapter 4 of the blue guidelines.

Sharing assessments and plans with custody staff

Clinicians should communicate relevant information about a person's assessed alcohol use disorder and health needs and their risk assessment with custody staff. They should share the risk management plan so custody staff are aware of the person's needs. Sharing information also enables custody staff to make better decisions about charging and disposals, and to pass on information to courts to inform sentencing.

Referral for further alcohol treatment and other health and social needs

Even if people do not need medically assisted withdrawal, they may still benefit from psychosocial alcohol treatment in the community or in prison. By accurately assessing a person and referring them to treatment and further support, clinicians can effectively address healthcare problems to improve their health outcomes and reduce re-offending.

Police custody healthcare services are responsible for responding to people in need of immediate clinical intervention. Where liaison and diversion services are available, it is their role to provide supported referrals into local treatment services for those not in immediate need of intervention.

Dedicated liaison and diversion practitioners identify people who have vulnerabilities, including alcohol and drug use disorders, when they first come into contact with the criminal justice system in police custody suites or courts. They can then:

- support them through the early stages of the criminal justice system pathway
- refer them to appropriate health or social care services

- enable them to be diverted away from the criminal justice system into a more appropriate setting, such as a mental health setting if required

17.4.5 Intoxication in police custody

Managing intoxication in police custody is vital to reduce risks to the person, including risk of death.

Assessing and managing a person who is intoxicated

Clinicians assessing the person should note their symptoms and signs of intoxication.

For clinicians to diagnose alcohol intoxication, the person should have:

- recently drunk alcohol
- behavioural or psychological changes associated with drinking alcohol
- the necessary physical signs of being intoxicated
- no other medical conditions that explain the symptoms

There is a full list of signs of intoxication and of severe intoxication (which can be fatal) in section 3.3 of the blue guidelines - Detainees with substance use disorders in police custody.

The clinician should take baseline observations of the (potentially) intoxicated person's:

- pulse
- blood pressure
- temperature
- respiratory rate
- oxygen saturation
- pupils, which should be checked for response to light and symmetry
- blood glucose level as low blood sugar mimics alcohol intoxication (potentially fatal)
- consciousness levels

Clinicians should not manage people who are severely intoxicated in custody suites, in particular those who are unable to walk unaided or speak to provide a coherent history. The person should be transferred to hospital for observation and treatment.

Symptoms of intoxication and alcohol poisoning can continue to worsen for a while after the person has stopped drinking. Alcohol poisoning (overdose) can lead to coma and death.

Clinicians should consider the possibility of illnesses, injury or mental conditions other than intoxication. A person who is drowsy and smells of alcohol may also have concurrent medical problems, including but not limited to:

- drug intoxication or overdose

- epilepsy or seizures
- head injuries
- hypoglycaemia (low blood sugar)
- infections
- metabolic causes (for example, diabetes mellitus)
- encephalopathy (either Wernicke's encephalopathy or caused by infections), which causes damage or disease to the brain

There is detailed guidance on making a differential diagnosis in section 3.3 of the blue guidelines.

A breath test may be useful to confirm alcohol use, but this should never be a substitute for a full assessment. Clinicians and non-clinical staff should be aware that, even when a person has a breath test reading of a low blood alcohol level, they can still be alcohol dependent or at risk. They should not assume that certain breath test levels can be defined as safe without further assessment.

Monitoring and observing a person who is intoxicated in police custody

A person who is intoxicated in police custody is at risk of experiencing health complications and, in some cases, their behaviour can pose a risk to others. The person should be monitored regularly because their condition can change quite rapidly.

The clinician and healthcare staff who are trained and competent in monitoring intoxication and alcohol dependence are responsible for carrying out all clinical monitoring in line with local protocols.

In addition, custody staff are usually responsible for carrying out regular observations in line with the guidance on observation levels in appendix C of the blue guidelines. Staff carrying out observations should be trained to do so.

The clinician or healthcare practitioner should inform the custody sergeant of the risk management plan and can advise on observation levels.

All clinical monitoring by healthcare staff and regular observations by non-clinical custodial staff should be documented, so any changes in the person's condition can be detected.

Urgent medical attention when a person cannot be easily roused

Intoxication can lead to over-sedation, which in some cases can lead to fatal respiratory depression.

All healthcare and custodial staff involved with people detained in custody should be trained to carry out simple assessments of whether someone can be roused.

They should also remember that a person who smells of alcohol and seems drowsy may have other serious and urgent physical problems that are making it difficult to rouse them.

You can find guidance on actions to rouse people and how to respond in appendix B of the blue guidelines - Detainees with substance use disorders in police custody.

Non-clinical custodial staff should immediately inform a healthcare professional or urgently call an ambulance if they have difficulty rousing a person or there is significant deterioration of the person's condition.

A healthcare professional undertaking an assessment when a person cannot be roused should be trained to undertake these assessments through a suitably accredited course. In Northern Ireland, clinicians should know the Northern Ireland alcohol use disorders care pathway – management in the acute hospital setting.

Clinical staff should use a standardised system to monitor for early warning signs of deterioration in condition or loss of consciousness. For example, they can use the Royal College of Physicians' National early warning score (NEWS) 2 guidance.

The clinician or healthcare professional should arrange for the person to be transferred to an external hospital if there are concerns about their level of consciousness or their condition following their assessment.

17.4.6 Managing alcohol withdrawal in police custody

Withdrawal symptoms and severe withdrawal complications

People with alcohol dependence might only be in police custody a short while, but they may begin to experience alcohol withdrawal, which puts them at risk. It is essential that:

- clinicians assess and diagnose alcohol dependence and its severity
- start early treatment to manage withdrawal symptoms and avoid the severe complications that can occur in withdrawal - which, in some cases, can be fatal

You can find a list of withdrawal symptoms and severe withdrawal complications in annex 3.

Severe withdrawal complications include:

- seizures (fits)
- auditory and visual hallucinations
- delirium tremens (severe shaking, agitation, fever, tachycardia, profound confusion, delusions and hallucinations)
- Wernicke-Korsakoff syndrome (confusion, impaired eye movements or unsteady walking)
- course tremor (very severe shaking)

Anyone experiencing these complications should be transferred to hospital immediately.

All healthcare staff and non-clinical custodial staff should be aware of the signs of severe withdrawal complications and understand that they are a medical emergency.

For guidance on preventing and managing severe withdrawal complications, see section 10.4 of chapter 10 on pharmacological interventions.

Treating alcohol withdrawal

There is guidance in section 17.5.5 on treating alcohol withdrawal in prisons, which is also relevant for treating withdrawal in police custody suites, and the clinician and healthcare staff should follow this.

The clinician should assess whether it is safe for a medically assisted withdrawal to be managed in the custody suite. People with a history of severe complications in withdrawal should be transferred to hospital. The clinician should review any past records for the person that show complications in withdrawal in police custody suites. People with severe dependence and complex co-occurring physical and mental health conditions, co-occurring drug dependence, or other vulnerabilities such as pregnancy may also need to be transferred to hospital.

When the clinician provides a person with medically assisted alcohol withdrawal in police custody, they should provide clinical monitoring of the person's symptoms and overall condition. All clinical monitoring should be carried out by a specialist clinician or healthcare staff trained and competent in monitoring alcohol and drug withdrawal.

They should use a validated tool such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) scale or a similar validated tool. Frequency of monitoring should be based on individual assessment and in line with their local protocol on alcohol withdrawal.

Monitoring after providing treatment for alcohol withdrawal is particularly important for people with co-occurring medical conditions or drug dependence. If a person does not respond to treatment as expected, the clinician should reassess the person and consider other clinical conditions that can mimic alcohol withdrawal as a possible cause.

In addition to clinical monitoring, the person should be observed regularly. Non- clinical custodial staff should follow guidance on structured observation levels in appendix C of the blue guidelines. The clinician can advise the custody sergeant on the level of observation based on their clinical assessment.

People being treated for alcohol withdrawal can become over-sedated or have other urgent health complications. The guidance in section 17.4.5 on urgent medical attention when a person cannot be roused should be followed.

If a person being treated for alcohol withdrawal is transferred to court, the clinician should consider providing a limited supply of medicine used for this treatment to avoid the person experiencing withdrawal while at court. See section 17.5.5 on medicines continuity for more information.

With the person's consent, the clinician should share information from the patient record, including full and accurate information on medicines, with the person's GP and, where the

person has agreed to a referral, with the community alcohol treatment service. Wherever possible, the person should be seen by a clinician in the community on release.

17.5 Alcohol treatment in prisons

Guidance in sections 17.5 and 17.6 is for clinicians that provide alcohol treatment interventions in prisons, and for other healthcare staff and non-clinical prison staff who have a role in supporting people with alcohol use disorders in prisons.

Guidance in these sections focuses on alcohol treatment in prisons, but much of it can be applied to other secure settings, including immigration removal centres (IRCs) (see section 17.7) and secure hospitals.

This guidance provides a summary of healthcare for people with alcohol use disorders in prison. Clinicians and practitioners should also follow national guidelines on care for people in prison including:

- National Institute for Health and Care Excellence (NICE) guideline Physical health of people in prison (NG57)
- NICE guideline Mental health of adults in contact with the criminal justice system (NG66)
- Royal Pharmaceutical Society (RPS) guidance Professional standards for optimising medicines for people in secure environments
- Royal College of General Practitioners (RCGP) guidance Safer prescribing in prisons

17.5.1 The prison population

As of March 2024, UK prison population statistics reported a total prison population of about 97,700 people, comprising:

- 87,900 in England and Wales
- 8,000 in Scotland
- 1,900 in Northern Ireland

Many more people than this pass through prison in a year. Some people have short stays in prison while others are there for many years.

Evidence (Bebbington and others, 2017; Wright and others, 2019) shows that compared with the general population, people in prison experience high levels of:

- alcohol and drug use and dependence
- mental health conditions
- some physical health conditions
- social support needs

Many people have a history of trauma. There are also very low levels of literacy and some prisoners do not speak English.

Healthcare teams often need to work with prisoners moving through a system where there is pressure on availability of prison places. Prison systems need access to healthcare staff who can competently assess, treat and monitor people with alcohol dependence, especially during the early days in prison and, increasingly, across all categories of prison.

17.5.2 Equivalence of treatment and care in secure settings

The principle of equivalence of care - as set out in RCGP Secure Environments Group position statement Equivalence of care in secure environments in the UK - is particularly important for people in prisons and similar secure settings.

Equivalent care does not mean that care is exactly the same in community and secure settings, and some interventions recommended in part 1 of these guidelines may need to be adapted for secure settings. There are situations where healthcare provision affects security decision making (for example, the need for frequent access to monitor a patient). Healthcare providers need to understand the potential impact of their actions and work with their non-clinical prison colleagues to find appropriate solutions so people can receive the care to which they are entitled.

17.5.3 Governance for alcohol treatment in prisons

Commissioners and providers of health and justice services should develop a clinical and quality governance strategy to ensure safe and effective treatment and care for people with alcohol and drug disorders in secure settings.

Local protocols should be in place that adequately reflect:

- the current evidence base
- these clinical guidelines
- any other authoritative guidance on implementing alcohol treatment and care in secure settings, for example Drug misuse and dependence: UK guidelines on clinical management
- national guidelines (as listed in section 17.5 above)

Protocols should include guidance on collaborative working between healthcare and non-clinical prison staff to manage risk.

RPS guidance ‘Professional standards for optimising medicines for people in secure environments’ provides a framework to support the commissioning and provision of safe, high-quality services in secure settings, including prisons, IRCs and other places of residential detention. These standards are for anyone working in or with secure settings in England, but they may also be useful in Wales and Scotland.

Each prison should have a HM Prison and Probation Service site-specific drugs (or substance use) strategy, or an equivalent strategy in each UK administration. This strategy should include the management of people with alcohol dependence or problem alcohol use.

It is the responsibility of any commissioners and managers to ensure healthcare staff in prisons are adequately resourced and supported in their roles to meet service demand.

Commissioners and managers of health and justice services should make sure there are sufficient competent staff and medical facilities to provide appropriate treatment and care for people with alcohol dependence.

17.5.4 Staff competencies

Competencies needed by staff for working in prisons include the following.

Competencies for doctors working with alcohol and drug use

The Royal College of Psychiatrists and RCGP report Delivering quality care for drug and alcohol users: the roles and competencies of doctors (PDF, 404KB) lists competencies for doctors. These are not specific to secure settings but identify competencies for working with alcohol and drug use at generalist, intermediate and specialist levels.

Providing safe and effective care

Providing safe and effective alcohol treatment and care in a prison setting is complex and skilled work due to the high levels of need and risk in the prison population, and the operational constraints of the setting.

Care should be delivered by clinicians and allied staff who are:

- suitably competent
- well led
- properly supervised
- operating within a clear quality and clinical governance framework that supports safe and effective service delivery

Healthcare staff, including alcohol treatment staff, should have a thorough understanding of the needs and risks of the prison population and should be able to confidently assess and manage individual clinical risk in the prison environment. This will involve regular re-assessments as risk can change quite rapidly for people in a prison setting.

Clinicians responsible for assessing and managing medically assisted alcohol withdrawal should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and in using recommended drug regimens appropriate to the prison setting.

As people with alcohol dependence often have complex co-occurring needs, clinicians should be competent in procedures for clinical monitoring for both alcohol and drug withdrawal or stabilisation, and other systems for monitoring clinical risk. For example, this

could include NEWS 2 for assessing and responding to acute illness and risk management systems for preventing suicide such as Assessment, Care in Custody and Teamwork (ACCT) assessments.

Training and supervision

Commissioners and providers of health and justice services should make sure that healthcare staff and prison officers are appropriately trained and supervised, and are competent to carry out their roles when working with people with alcohol dependence.

Healthcare staff providing psychosocial interventions to people with alcohol dependence should be trained and supervised by a supervisor with experience of working in secure environments.

All healthcare staff and prison officers in contact with prisoners should have essential first aid training, including training for the person first on the scene in an emergency.

Working together

Clinical and healthcare staff and prison officers should be competent in working together to provide integrated care and manage risk.

Healthcare staff responsible for alcohol treatment should be competent to work collaboratively with other healthcare teams in the prison, including the mental health care team and with community alcohol treatment services, to provide integrated care.

17.5.5 Considerations for delivering alcohol treatment and care in prisons

Opportunities to access treatment and recovery support

Prison is an opportunity for people with alcohol dependence who have not effectively engaged with community services to access:

- alcohol treatment and support for longer-term recovery
- treatment and care for co-occurring drug use disorders, and mental health and physical health conditions
- health promotion and related social prescribing
- peer networks and peer mentoring

Alcohol withdrawal or intoxication

When a person is admitted to prison and identified as intoxicated or potentially alcohol dependent, a suitably trained and competent clinician should provide a comprehensive assessment and manage the risks of alcohol intoxication and withdrawal at reception.

The clinician should treat alcohol withdrawal in line with:

- local evidence-based protocols or operating procedures
- these clinical guidelines for alcohol treatment

- other relevant national guidelines as set out in section 17.5

Consumption of medication for alcohol withdrawal should always be supervised in prison.

People who are intoxicated or at risk of acute alcohol withdrawal should only be placed in a prison:

- with 24-hour healthcare provision
- where appropriately trained staff can carry out clinical monitoring and enhanced, regular observations based on local protocols

If a person being treated for alcohol withdrawal is transferred to court or another part of the prison system, a clinician should provide them with a limited supply of medicines being used for this treatment. This will help to prevent withdrawal symptoms from recurring and the risk of complications in withdrawal while they are in court or, if they are moving to another prison, until a clinician in the receiving prison can take over the person's care. See the guidance on medicines continuity in section 17.5.5.

Managing self-harm and suicide risks

All staff (healthcare and prison officers) should understand the increased risks of self-harm and suicide for people on their first night in prison and the early weeks after. They should also understand that people with alcohol dependence or who are intoxicated are at particularly high risk of suicide.

Local risk management protocols and procedures should support an integrated approach to providing safe care for people with alcohol dependence. Clinicians and healthcare staff and non-clinical prison staff should work together to reduce harm and manage risk, particularly the risk of fatalities.

Prescribing decisions

Clinicians need to make prescribing decisions, including about polypharmacy (where the patient has been prescribed several different medicines for different conditions), in line with national guidance that identifies factors for safer prescribing. This includes all those listed in section 17.5 above.

Care planning and integrated care

The clinician or alcohol treatment staff should develop a care plan with the person and with staff from other relevant teams (for example, mental health) that:

- links initial treatment with ongoing treatment and recovery support in prison
- when they are released, links them to community treatment

Staff from different teams should work together to provide integrated care.

Continuity of care

The alcohol treatment or healthcare team should work with colleagues to plan and manage continuity of care from prison entry, through to court appearances, changes in prison setting and preparing for prison release. They should share clinical information (with the person's consent) to minimise interruption in treatment and reduce risks.

All staff should understand the increased risks the person faces after release, including the risk of relapse and death from alcohol poisoning or drug overdose. Pre-release planning should take these risks into account.

Medicines continuity

RPS guidance 'Professional standards for optimising medicines for people in secure environments' describes how people should continue to access their medicines safely and promptly as they move within (including during transit for critical doses of medicines) or leave different criminal justice settings.

Partnership working is essential to provide a seamless and safe transition of medicines optimisation. This includes partnership working between:

- clinicians in sending and receiving care settings
- custodial teams
- healthcare teams
- pharmacy teams

Relevant patient information and full and accurate information on all medications should be provided.

Where people undergoing treatment for alcohol withdrawal are transferred to court or another part of the prison system, a clinician should arrange for a supply of the medicines used for this treatment for the person. This is to prevent withdrawal symptoms from recurring and the risk of complications in withdrawal.

The member of staff escorting the person to the next setting should hold the medication and hand it to a member of the healthcare or court staff in the receiving setting. The management of the medicines and access to the next and following doses will follow the usual arrangements and standards for the specific type of setting.

All staff involved in prescribing and handling medicines for people being transferred from one part of the criminal justice system to another should follow national guidelines on continuity of medicines as set out in NICE NG57 and RPS's 'Professional standards for optimising medicines for people in secure environments'.

17.5.6 The patient pathway in prisons

Screening

Screening for patterns of harmful drinking and alcohol dependence should take place at the first-stage health assessment on the day the person is admitted to the prison, at reception, before they go to a cell.

NICE NG57 provides guidance and a template for first-stage assessment which includes questions on alcohol use.

The screening assessment should include questions and actions on:

- alcohol use
- substance use
- physical health
- mental health
- self-harm and suicide risk

There are high levels of domestic abuse, assault and sexual violence among women who enter the prison system, and men also experience this. Screening should include sensitive questions on these topics in a private setting. There is guidance on routine questions on domestic abuse in chapter 22.

If screening identifies harmful drinking or alcohol dependence, or other substance use or dependence, the person should be referred to the substance misuse team or to a clinician with competencies in assessing and treating alcohol dependence and alcohol withdrawal and drug dependence and withdrawal. The clinician should then carry out a specialist assessment in reception before the person goes to the cell.

Comprehensive assessment

The clinician should comprehensively assess the person's needs and risks. They should use validated tools to identify dependence and severity of dependence, but these tools should be used to support a clinical interview with the person, not to replace it.

You should read guidance on initial and comprehensive assessment in chapter 4 on assessment and treatment and recovery planning.

The increased isolation people experience from being in custody can amplify feelings of hopelessness and make mental and physical health symptoms worse. So, clinicians should take care to treat patients holistically by involving other appropriate services in assessment and care planning.

Many people with alcohol dependence or who drink at harmful levels have co-occurring mental health conditions. If the person appears to have possible symptoms of a mental health disorder, the prison mental health team should assess their mental health and contribute to the comprehensive assessment.

In line with NICE NG57, at screening assessment, healthcare staff should refer people for a mental health assessment if they have:

- previously seen a mental health professional in any service setting
- ever been admitted to a psychiatric hospital
- taken medicine for mental health problems

If the clinician identifies drug dependence (including dependence on prescribed or over-the-counter medication) in addition to alcohol dependence, the person will need concurrent treatment for their drug dependence. Medically assisted alcohol withdrawal will be more complex and requires specialist skills. See section 17.5.7 on co-occurring dependence on alcohol, illicit drugs or prescribed medication below.

Continuity of care on entry into prison

The clinician carrying out the assessment should obtain information from other services on the person's:

- health (including any allergies)
- prescribed medication
- planned medical appointments
- community alcohol treatment

There are a range of other services and staff that could have important clinical information about the person, including:

- primary care
- community pharmacists
- secondary care physical and mental health services
- criminal justice healthcare services inside and outside the prison
- prison staff records and observation
- community alcohol treatment services
- adult social care

The clinician might not be able to contact all relevant services immediately (for example, if the person enters prison in the late evening), but they should try to make contact as soon as possible so they can make a full assessment.

It is vital that there are agreed partnership arrangements between community alcohol treatment services and prison substance misuse teams or healthcare services. Community alcohol treatment services that have been working with a person can support continuity of care by getting their consent to share their clinical information with a prison substance misuse team if the person is due to attend court and could be sentenced to prison. The community service should share information quickly to help prison substance misuse treatment services with their first assessment of need and risk.

Individual support

The first night and weeks in prison can be extremely stressful for people who are often already vulnerable. Assessment is a chance for the person to speak to someone on an individual basis.

The principles of care set out in chapter 2 apply in secure settings as well as the community.

People with alcohol use disorders in the prison population have often experienced high levels of trauma and disadvantage. A trauma-informed approach and a non-stigmatising attitude from staff can help the person to feel less isolated and distressed on entry into prison and help them go on to engage in alcohol treatment.

17.5.7 Managing urgent clinical needs and risks

Starting treatment and agreeing a plan

In reception, the clinician should start treatment to address all immediate clinical needs, including alcohol intoxication or withdrawal, and agree a risk management plan for all risks.

The clinician should make sure there is a clear, recorded plan for managing clinical needs and risks. The plan should be based on the person's individual needs and include information from other healthcare teams and actions for these teams. This might include the mental health team and any relevant community services. The plan should take into account the person's sentence and sentence planning.

The clinician should arrange for risk management plans to be regularly reviewed, particularly in the early days, as risks can change quite rapidly. Plans should also be reviewed when a person's condition changes and at transition points during their stay in prison when they may need increased monitoring or observation.

The clinician should follow local protocols for recording and sharing information on risk with healthcare colleagues and non-clinical prison staff. Keeping a person's record up to date and accurate is essential.

Staff from different teams should work together to provide integrated care in line with the care plan. Healthcare staff and prison officers should contribute to multidisciplinary prison risk management systems - for example, the ACCT process used in prisons in England and Wales.

Assessing and managing alcohol intoxication in prison

Clinicians should assess people in prison for symptoms and signs of alcohol intoxication. It is a vital step in the primary and secondary assessment for people who are received into a reception prison and on transfer between prison sites in the early days in custody.

While people cannot access alcohol in prison, it can be illicitly brewed from a variety of sources, such as fruit and bread, and is known as 'hooch'. There are reports of prisoners becoming acutely intoxicated as a result of drinking illicit 'hooch'.

Section 17.4.5 provides guidance on assessing and managing intoxication in police custody and clinicians can apply this to the prison setting. Alcohol intoxication can also be complicated by polydrug use or prescribed medications.

People who are intoxicated at reception or at another time during their prison stay need to be in an area of the prison where competent healthcare staff can monitor their condition. Clinicians should agree arrangements with prison officers so that healthcare staff can access the person to monitor their condition and make repeated observations at a sufficient level to manage risks to the person.

The clinician, in discussion with a multidisciplinary team when appropriate, should decide on the frequency of observation based on personalised risk assessment. Risk assessment should include intoxication and other risks, such as self-harm. In cases of self-harm or suicidal thoughts and behaviour, the clinician should begin their integrated risk management procedure if it has not already been started. For example, in England and Wales, an ACCT document should be opened. The clinician should be guided by local protocols that specify standard minimum observation levels related to level of risk, including in reception and overnight. They should also have the option to increase the level of observation if there are changes in the person's condition that indicate increased risk.

All clinical monitoring should be carried out by clinicians and healthcare practitioners skilled in monitoring harmful and dependent alcohol and drug use and intoxication.

In addition, non-clinical prison officers may carry out welfare observations in some circumstances. There are variations in prison systems across the UK in the role of non-clinical prison staff in carrying out observations. Each prison should have a standardised protocol or local operating procedure that sets out guidance on standard minimum observation levels in relation to:

- levels of risk
- respective roles of healthcare staff and non-clinical staff

Clinicians should advise on level of observation based on the protocol and on their clinical assessment of the person. All staff carrying out observations should be trained to do so.

As an example of a standardised protocol for observation levels, prisons could consider the guidance set out in appendix C of the blue guidelines.

Clinicians, healthcare staff and non-clinical prison officers should work closely together, and clinicians should make sure prison officers are clear about when and how they should escalate any concerns about the person's condition.

Assessing and managing medically assisted withdrawal

This section provides guidance specific to assessing and managing medically assisted withdrawal in prisons or other secure settings.

You should read it alongside the detailed guidance on assessment and pharmacological interventions for medically assisted withdrawal in chapter 10 on pharmacological interventions.

You should also read chapter 11 on community-based medically assisted withdrawal. Although this chapter provides guidance on community-based withdrawal, it describes the appropriate context of care when providing medically assisted withdrawal and much of this is relevant to secure settings.

Chapter 12 provides guidance on specialist inpatient medically assisted withdrawal.

The importance of effectively managing medically assisted withdrawal

Alcohol withdrawal is associated with significant mortality if it is undiagnosed or undertreated. About 15% of people entering custody report a history of alcohol withdrawal, although this figure is possibly an over-estimate due to an exaggeration of symptoms (Wright and others, 2019).

There should be local evidence-based protocols for carrying out medically assisted alcohol withdrawal drawn up on the advice of a specialist clinician and in line with national guidance.

It is essential that appropriately competent clinicians assess and diagnose alcohol dependence including severity of dependence. Once dependence has been confirmed, the clinician should start early treatment in reception to manage withdrawal symptoms and avoid the severe complications that can occur in withdrawal.

Severe complications include:

- seizures (fits)
- auditory and visual hallucinations
- delirium tremens (severe shaking, agitation, fever, tachycardia, profound confusion, delusions and hallucinations)
- Wernicke-Korsakoff syndrome (confusion, impaired eye movements or unsteady walking)

Clinicians should remember that not everyone will disclose their alcohol dependence and that alcohol withdrawal symptoms can look like or complicate symptoms of withdrawal from other substances. Alcohol withdrawal can also complicate agitated mental health presentations, because the 2 conditions together can cause distress and it can be difficult to know which condition is causing the symptoms.

If the person has been treated for alcohol withdrawal in a police custody suite before entry into prison, treatment for alcohol withdrawal should be continued (see section 17.5.5 on medicines continuity).

Preventing and managing severe complications

Severe complications of alcohol withdrawal can pose a serious threat to a person's health. Both treated and untreated delirium tremens are related to increased mortality. There is also risk of alcohol related brain damage if Wernicke's encephalopathy develops. A patient's history of severe complications is a factor in deciding how and where the medically assisted withdrawal should be managed in the prison setting.

If there are signs of delirium tremens, Wernicke's encephalopathy, auditory or visual hallucinations or withdrawal related seizures, the person should be immediately transferred to an external hospital with 24-hour medical and nursing care so they can receive parenteral treatment, constant observations or intensive care management if required.

See section 10.4 in chapter 10 on pharmacological interventions for more guidance on preventing and managing severe complications.

If a person's alcohol dependence has not been identified at reception, they might present to healthcare staff or prison officers with acute withdrawal symptoms. All healthcare staff and prison officers involved in the care of people undergoing medically assisted withdrawal should be trained to recognise signs and symptoms of severe withdrawal complications as a medical emergency.

Deciding on the appropriate setting for medically assisted withdrawal

The clinician, and where appropriate the multidisciplinary team, will need to assess how and whether the medically assisted withdrawal can be managed in prison. This will be based on an individual assessment of:

- severity of dependence
- co-occurring drug use or dependence
- history and current risk of severe withdrawals
- complexity of co-occurring physical and mental health conditions

There is more detailed guidance on deciding on setting in section 10.2.4 in chapter 10 on pharmacological interventions. Although that section refers to community medically assisted withdrawal, it provides some guidance on criteria used to determine levels of monitoring and care required.

People undergoing medically assisted withdrawal should be placed in a prison (or held at reception) where 24-hour healthcare is available and in an area where competent healthcare staff can monitor and observe them to manage risk. Healthcare staff should work with prison officers to arrange appropriate access to the person.

People with the highest level of need, including severe alcohol dependence or complex co-occurring conditions, can require 24-hour monitoring from a healthcare team during the medically assisted withdrawal. These people will need constant monitoring from a healthcare team and should be treated in a prison hospital (or enhanced healthcare) unit which can offer nursing and clinical support and intensive clinical monitoring.

Local procedures for managing medically assisted withdrawal should set out the need for repeated risk assessment and monitoring, so that if the person's clinical risk increases, they can be transferred to a setting with increased clinical care and monitoring. This should be a specific part of any local protocol or operating procedure for managing alcohol withdrawal in a prison setting.

In the most complex cases with the highest risks, or rapidly deteriorating conditions, patients may need to be transferred to an external acute hospital.

Clinical monitoring and observation during medically assisted withdrawal

People who are treated for withdrawal should be monitored regularly to check for:

- withdrawal symptoms
- any signs of severe complications
- over-sedation

Over-sedation can lead to respiratory depression. Depending on the complexity of the person's needs, they may have other monitoring requirements, for example for drug withdrawals or for mental health symptoms or self-harm.

Clinicians should have access to their patients so they can carry out monitoring as often as required for safe care.

The quality, level and skill of clinical monitoring is an important factor in successfully managing medically assisted alcohol withdrawal. Clinical monitoring should include:

- assessing withdrawal symptoms using a validated measure of withdrawal symptoms, such as the Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) or a similar validated tool
- monitoring the effects of medication

The level of monitoring required will depend on several factors including:

- severity of alcohol dependence (assessed with a validated tool)
- risks of severe withdrawal complications
- co-occurring substance use or dependence
- co-occurring physical health and mental health conditions
- risk of self-harm or suicide

The clinician, in discussion with the multidisciplinary team where appropriate, should determine how often the person should be clinically monitored and observed, based on individual assessment guided by local protocols for medically assisted withdrawal. Local protocols should specify minimum levels of monitoring and observation required in relation to level of risk, with an option to increase these according to individual need. All staff carrying out observations should be trained to do so.

Care and support levels can be increased based on outcomes of clinical monitoring and ongoing repeated assessment of other risks.

Clinicians are responsible for carrying out all clinical monitoring during medically assisted withdrawal. In addition, non-clinical prison officers may carry out welfare observations in some circumstances. There are variations in prison systems across the UK in the role of non-clinical prison staff in carrying out observations. Clinicians should advise on level of observation based on their local protocol and their clinical assessment of the person's risk. Local protocols should set out the respective roles of healthcare staff and non-clinical prison staff.

Prescribing for medically assisted withdrawal

When clinicians prescribe for medically assisted withdrawal in the community, they should normally arrange for blood tests to be carried out before starting the intervention to help identify any clinical issues. In prison, it is not necessary to wait for blood tests to be carried out before prescribing but blood tests should be carried out as soon as it is feasible. If the patient is very unwell, they may need to go to an external hospital for medically assisted withdrawal.

Blood tests usually include (but do not have to be limited to):

- full blood count (FBC)
- liver function test (LFT)
- urea, creatinine and electrolytes (U&E)
- international normalised ratio (INR)
- total protein and albumin

Medicines to treat alcohol and drug withdrawal and dependence are usually controlled drugs covered by The Misuse of Drugs Regulations 2001. Due to the risks of abuse and diversion (being used by other people) of these medicines, there are national standards in secure environments including in:

- NICE NG57
- RPS guidance 'Professional standards for optimising medicines for people in secure environments'
- Royal College of GPs' guidance Safer prescribing in prisons (PDF, 769KB)

The consumption of medication for alcohol misuse and drug misuse should always be directly supervised in prison and this should be done in line with local protocols. Clinicians should work with non-clinical prison staff to arrange timings of medicine doses, so they are in line with the prescribed dose regimen to manage the withdrawal safely.

Benzodiazepines (for example, chlordiazepoxide or diazepam) are the recommended pharmacological treatments for alcohol withdrawal. In the rare situation where the person

cannot take oral medication, the clinician should arrange for them to be transferred to a general hospital where they can receive parenteral treatment.

The clinician should be aware that prisoners might falsely claim to be alcohol dependent to obtain benzodiazepines. If there is no clinical information to confirm the person is alcohol dependent, the clinician should immediately start to observe the person regularly. Then they should normally only prescribe benzodiazepines if they observe withdrawal symptoms beginning to develop.

A fixed and adequate dose regimen of a long-acting benzodiazepine is likely to be the most suitable regimen for medically assisted alcohol withdrawal in prison. A symptom triggered regimen will not normally be suitable because this requires a team trained in the approach and enough clinical staff to carry out careful hourly monitoring. You can read guidance on fixed dose and symptom triggered regimens in section 10.3.4 in chapter 10 on pharmacological interventions.

You can read guidance on benzodiazepine regimens in section 10.3 in chapter 10 on pharmacological interventions.

In line with local protocols, arrangements should be in place so that the clinician can adjust the dose of benzodiazepines promptly if they find the fixed dose has led to over-sedation or has not been enough to manage withdrawal symptoms adequately. If necessary, this could include providing an extra dose of medication under supervision.

For people being transferred to court or another part of the prison system medicines while they are being treated for alcohol withdrawal continuity isa priority. See section 17.5.5 on medicines continuity.

Polypharmacy

People in the prison population often have several long-term health conditions and the clinician should consider the risks of polypharmacy (prescribing several medicines for several different conditions at the same time). The person may also have been using illicit drugs or abusing prescribed or over-the-counter medication.

The person may have already been prescribed benzodiazepines (a sedative) for alcohol withdrawal (for example, in the police custody suite). NICE NG57 recommends that medication for alcohol withdrawal should not be stopped until medically assisted withdrawal has been completed.

Clinicians should consider contraindications for prescribing other medicines when prescribing benzodiazepines for medically assisted withdrawal.

National guidance recommends that clinicians should carry out a reconciliation of medicines so there is a complete and accurate list of the person’s medicines recorded. This includes:

- identifying an accurate list of the person’s current medicines
- noting any discrepancies with current medicines in use

- documenting any changes

It may not always be possible to obtain information on the person's health or medication on the first day. RPS guidance 'Professional standards for optimising medicines for people in secure environments' is that a clinician should carry out a medicines reconciliation within 72 hours of the person being received in prison. The clinician needs to be aware that the person may be falsely claiming that they are prescribed medicines or high doses of medicines.

Polypharmacy in people with alcohol or drug dependence can be problematic, particularly other medications with sedative potential. The clinician needs to decide whether to continue some or all of the medications, taking into account the risks of stopping any medication and the risk of diversion. These are complex prescribing decisions requiring a high level of skill. When making decisions, the clinician should consult other healthcare teams where relevant - for example, the mental health team or pharmacists. The clinician should aim to simplify the prescription and make it as safe as possible. They need to be particularly careful in managing medicines in the first few days when risks of suicide are high and they might not have all the relevant information about a person.

Co-occurring dependence on alcohol, illicit drugs or sedating prescribed medication

The process is more complex if the person who needs medically assisted alcohol withdrawal has a co-occurring dependence on illicit drugs or prescribed medication that causes sedation. It will require more care and increased monitoring from a multidisciplinary team with specialist input.

Concurrent alcohol dependence and opioid dependence

There is guidance on treatment in prison for misuse or dependence on several illicit substances and on benzodiazepines in chapter 5 of 'Drug misuse and dependence: UK guidelines on clinical management'. It includes guidance that clinicians should follow on opiate substitute prescribing, including guidance on concurrent alcohol and opioid dependence.

Clinicians need to take particular care when they are assessing and prescribing for people with concurrent opioid use (or other analgesics with habit-forming potential) and alcohol dependence. This is because there is a high risk of over-sedation and fatal respiratory depression when benzodiazepines and opioids are taken together. See important safety information from the Medicines and Healthcare products Regulatory Agency on Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression. Clinicians should also consider the risk of over-sedation in patients who have been prescribed anti-depressants.

Concurrent benzodiazepine dependence

If the patient has concurrent alcohol and benzodiazepine dependence, the clinician should treat the alcohol withdrawal before any withdrawal from benzodiazepines, as benzodiazepines are used to manage alcohol withdrawal. You should follow guidance in

section 10.6.1 on medically assisted alcohol withdrawal when a person is also dependent on benzodiazepines in chapter 10 on pharmacological interventions.

Close observation and clinical monitoring are required when a patient with concurrent alcohol and benzodiazepine dependence is undergoing medically assisted alcohol withdrawal. They may need to be treated in the hospital (enhanced care) unit in the prison or, where clinical risks are very high, in an external hospital.

There is further guidance on benzodiazepine withdrawal, including where there is concurrent alcohol dependence, in section 5.4.6.7 in chapter 5 of 'Drug misuse and dependence: UK guidelines on clinical management'.

Concurrent alcohol, opioid and benzodiazepine dependence

The management of polydrug and alcohol dependence requires specialist skills. Clinicians should take great care if the person has concurrent dependence on alcohol, opiates and benzodiazepines, and treatment will require input from a specialist clinician and a multidisciplinary team.

Chapter 5 of 'Drug misuse and dependence: UK guidelines on clinical management' includes guidance on managing medications in prison. It recommends that clinicians avoid prescribing people more than 2 drugs with sedative potential on the first night or for the first few days unless they confirm that:

- a clear medicines reconciliation has been carried out
- the person has fully adhered to their current prescriptions

Clinicians must use careful clinical judgement on what prescribed medications with sedative potential should be withheld from people in the early days in prison, before a full medicines reconciliation process led by pharmacists has taken place.

Concurrent alcohol dependence and cocaine use

Healthcare staff should intensively monitor a patient with alcohol dependence who has been using or is also dependent on cocaine. Normally, they should be in the prison hospital (enhanced healthcare) unit where there is 24-hour healthcare. There are risks of problematic increases in blood pressure and increased heart rate during alcohol withdrawal and there can be a risk of sudden death.

Management of stimulant withdrawal is associated with several risks and requires input from specialist addiction clinicians and often mental health teams.

You should read the guidance on managing stimulant withdrawal in the first week in section 5.4.6.8 in chapter 5 of 'Drug misuse and dependence: UK guidelines on clinical management'.

Monitoring when there is concurrent alcohol dependence and drug dependence

When carrying out medically assisted withdrawal from alcohol in people with a concurrent drug dependence, close clinical monitoring and regular observation is required for the safety of the patient. This is because, in some cases (as outlined above), there is a risk of death.

The clinician, in discussion with the multidisciplinary team, should carry out a careful assessment and decide on the appropriate setting for medically assisted withdrawal.

Medically assisted withdrawal for people with concurrent alcohol and drug dependence will usually require monitoring in the prison hospital (enhanced care) unit where there is 24-hour care. In the most complex cases, patients may need to be admitted to an external hospital.

Assessing and monitoring for risk of self-harm and suicide

There is an increased risk of self-harm and suicide on the first night and weeks in prison among the prison population. Both alcohol intoxication and alcohol dependence are associated with increased risk of suicide (Kaplan and others, 2013; Ledden and others, 2022). A systematic review shows that alcohol misuse in the year before entry into prison is a risk factor for suicide in prison (Zhong and others, 2021).

Evidence suggests that the distress caused by withdrawal in an already highly stressful situation may be a factor in the high levels of suicide among people with alcohol dependence entering prison (Backet, 1987).

It is essential that the clinician assesses the risk of self-harm and suicide, and involves the mental health team if there are signs that the person is at current risk or specialist assessment is needed.

Where a patient is assessed as at risk of self-harm or suicide with suicidal ideation and intent, the clinician, healthcare staff and prison officers should follow the local prison suicide prevention protocol. They should observe the patient based on this protocol until the mental health team can assess the patient. Close clinical monitoring and intensive observation is required for the safety of the patient.

If a patient is assessed as at risk of self-harm or suicide, this should trigger the prison's multidisciplinary risk management process - for example, the ACCT process in England and Wales. Clinicians and allied healthcare staff should make sure risks are recorded clearly and promptly in the patient's record. They should also make sure that all relevant staff, including prison officers, are:

- informed of the risks and the risk management plan
- understand the rationale for the plan
- understand the agreed level of observation and clinical monitoring

Managing deteriorating health and emergencies

Prisons should have local protocols that set out how healthcare staff and prison officers should respond to situations in which a person's health quickly deteriorates or is in a health emergency.

NICE NG57 provides guidance on what these protocols should include.

All secure environments need close working relationships between prison officers and healthcare providers, including mental health teams, and local hospital emergency departments to manage emergencies.

With the patient's consent, clinicians should tell all healthcare staff and prison officers if someone has a chronic health condition that could deteriorate or has allergies. In emergencies, healthcare staff should share relevant confidential clinical information in line with their duty to do so.

If there is a concern about the patient's condition, the clinician or multidisciplinary team should develop a clear plan for managing their condition that is shared with all relevant healthcare and prison staff. The clinician should carry out regular clinical assessments to identify signs that the person's condition is deteriorating or there is an emergency, using a standardised early warning system, such as NEWS 2. They should escalate the patient's care to include increased monitoring or transfer them to an external hospital, where this is indicated.

Staff need to know how to respond if they are concerned that someone may not be conscious. Prisons should have local protocols for checking if a person can be roused. As an example, appendix B in the blue guidelines provides guidance on these checks - see Detainees with substance use disorders in police custody.

All healthcare staff and prison officers should know how to carry out simple checks to see if a person can be roused.

If an officer finds that they cannot wake up a prisoner by either speech or light touch, they should follow their local protocol and immediately inform the on-call clinical staff member or call an ambulance.

All healthcare staff and prison officers in contact with prisoners should have essential first aid training, including training for the person first on the scene in an emergency.

17.5.8 Care planning

Developing the care plan

The clinician or a member of the substance misuse team should develop a care plan (also called a treatment and recovery plan) for anyone needing alcohol treatment in prison or another secure setting. To meet the principle of equivalent care to the community, they should offer personalised care-planned treatment and recovery support to people:

- with alcohol dependence

- who drink at harmful levels and have co-occurring physical health or mental health conditions

Where more than one clinician is providing care for the person, the clinicians should agree who is the lead professional who will be responsible for developing and reviewing the care plan. Even where the alcohol treatment clinician is not the lead professional, they should contribute to the care plan and care plan reviews.

The care plan should:

- be started at reception
- be linked with plans for further assessments and care planning throughout the person's time in prison and at pre-release
- extend to treatment and support in the community

The plan should take account of the person's sentence and sentence planning and be reviewed regularly and when there is a change in the person's circumstances.

There is guidance on care planning (referred to as treatment and recovery planning) in section 4.10 in chapter 4 on assessment and treatment and recovery planning.

Planning for continuity of care

Plans should include actions to provide continuity of care if the person attends court appearances or moves to a different setting. Alcohol treatment staff (or the lead professional where people have complex needs) should make sure all relevant clinical information is passed on to the next setting with the person's consent. This should include information about:

- their alcohol problem
- current alcohol treatment they are receiving
- any medication they are taking
- co-occurring drug use or dependence
- co-occurring physical health and mental health conditions
- any allergies

Medications, including for alcohol withdrawal and ongoing management of alcohol dependence, should also be transferred to the next setting including to courts. For more information on continuity of care leading up to release see section 17.6 below.

Multidisciplinary integrated care

It is likely that several teams will be involved in the care of prisoners with alcohol dependence, including from:

- healthcare (for example, mental health or substance misuse teams)

- prison officers
- community services

Assessment, care planning and risk management needs to be multidisciplinary and integrated. Good communication between community alcohol treatment services, prison healthcare teams and prison officers is essential from when the person enters prison through to transfer or release back into the community.

For people with the most complex needs, a multidisciplinary team should be involved in developing and monitoring their care plan and there should be an identified lead professional.

Psychosocial interventions and recovery support

Everyone requiring alcohol treatment should be offered psychosocial interventions. Chapter 5 provides guidance on psychosocial interventions.

Staff providing psychosocial interventions should be trained in the interventions they offer and have the appropriate competencies. They should also receive supervision from a qualified clinical supervisor. Providing psychosocial interventions in a prison setting requires advanced skills. Mental health symptoms can be intensified and there are heightened risks of:

- self-harm
- suicide
- violence

NICE NG66 provides guidance on considerations when offering mental health interventions in prisons.

Prison provides an opportunity for alcohol treatment practitioners to support the person with alcohol dependence to identify and work toward their recovery goals and help them to build recovery resources. There is guidance on structured support, which includes building recovery resources, in section 5.5 in chapter 5 on psychosocial interventions and chapter 6 on recovery support services.

There may be opportunities for the person to develop skills and activities that can help them towards employment or education on their release. These may include:

- literacy skills
- education classes
- occupational skills
- physical exercise

There may also be opportunities for them to join mutual aid groups, for example Alcoholics Anonymous, or meet with peer support workers, and so begin to build recovery-oriented support networks. Alcohol treatment staff should help people to engage with these groups.

Harm reduction and health promotion

People with alcohol dependence are often not aware of the health risks of harmful drinking and alcohol dependence. Alcohol treatment practitioners should provide them with information on health risks and offer harm reduction information and advice. There is guidance on harm reduction information and advice in chapter 8.

Information specific to the prison setting includes the health risks of alcohol brewed in prison ('hooch') and increased vulnerability caused by intoxication within in a prison setting.

Care plans should also include relevant health promotion interventions. For example, these could include interventions to:

- stop smoking
- lose weight
- increase exercise levels

Prison is also an opportunity to help people access routine vaccinations and scans they have missed. You can find guidance on physical health assessment in section 4.9.11 in chapter 4 on assessment and treatment and recovery planning.

17.6 Continuity of care: release, resettlement and recovery

Section 17.6 provides guidance on continuity of care on release from prison. This guidance is for staff in:

- prison substance misuse teams
- prison healthcare teams
- community alcohol treatment services

17.6.1 The importance of continuity of care

A significant proportion of people in prison serve short sentences, often a few months or less. This means people with problem alcohol use have less time to develop a stable recovery and any progress they make in prison can be difficult to maintain when they are released.

People who have served long sentences will be making a significant transition when they leave prison. This is likely to be a stressful experience for them and it can increase their risk of relapse, even if they have been abstinent for a long time.

Prison substance misuse services, wider prison healthcare services and community treatment providers are all responsible for making sure that people transferring from prison to the community have good continuity of care. There should be effective communication

systems and pathways between substance misuse teams in prisons and community alcohol treatment services.

Joint planning between prison healthcare and community services should aim to:

- help the person engage in community alcohol treatment and recovery support services after release
- ensure the person is referred to relevant support for health and social needs
- reduce re-offending
- reduce homelessness
- reduce alcohol related harm
- make sure prescribing arrangements are in place for medication

If a prisoner on remand has a planned court date, it's best practice for the prison-based alcohol treatment provider to:

- inform community alcohol treatment services about the date
- tell them the outcome of the court appearance

If this has not happened, the prison treatment service providers may need to check that anybody released in an unplanned way from court has information about and a referral to specialist alcohol treatment in the community.

17.6.2 Pre-release care planning

Care planning for release is essential and should begin about 6 weeks before release. For prisoners with very short sentences, planning for release should begin at the comprehensive assessment in the first week in prison.

A clinician should carry out a health assessment with the person and summarise information on their health and treatment needs and the risks to the person and others. If a multidisciplinary team has been involved with the person's care, they should be involved in the pre-release health assessment and care plan.

NICE NG57 provides guidance on pre-release health assessments. The assessment should include information on:

- the person's alcohol dependence
- the alcohol treatment and recovery support they received in prison
- any relapse prevention medication they have been prescribed before release

The pre-release care plan should be based on this assessment and the substance misuse team's assessment of the person's ongoing needs for alcohol treatment and recovery support.

The pre-release care plan should be written and should include:

- prison-based pharmacological, psychosocial and recovery support interventions, and ongoing treatment requirements from community alcohol treatment services
- details of planned appointments with community alcohol treatment services and recovery support networks
- details of planned appointments with relevant health, social care and prisoner resettlement services
- ongoing health and social support needs as outlined in the pre-release health assessment
- planned actions to reduce or manage risks to the person or to others
- details on provision of harm reduction advice (alcohol and drugs)
- details of any medication, including relapse prevention medication prescribed before release

If the person has problem with opioids or might possibly take opioids on release, the pre-release care plan should also include plans for provision of naloxone and harm reduction advice from appropriately trained staff in line with protocols.

When a person leaves prison, they should receive a copy of their pre-release assessment and care plan.

If the person is not registered with a GP, prison healthcare services should help them to register before release.

17.6.3 Information sharing between prison and community alcohol treatment services

There needs to be effective communication and information sharing between substance misuse services in the prison and the local alcohol treatment service before the person is released.

With the person's consent, prison substance misuse services should share appropriate information, using a standard referral form, with community alcohol treatment services. This should include the information in the pre-release assessment and care plan.

Community alcohol treatment services should continue the specific treatment interventions offered in prison.

17.6.4 Arranging an appointment with community alcohol treatment services

People being released from prison normally have complex health and social care needs. They should receive a rapid assessment from the community alcohol treatment service to avoid their situation deteriorating.

The community alcohol treatment service should offer an assessment appointment before or immediately after release. Where alcohol treatment services can provide in-reach into prisons, this can help to engage people and strengthen continuity of care. Where in-reach is

not an option, video appointments (telemedicine) is an alternative way for prisoners to engage with community treatment providers.

17.6.5 Medicines continuity and release into the community after a brief period on remand

Some people are on remand for a few days only. It is possible that they start treatment for alcohol withdrawal in police custody or on entry into prison and the course of treatment has not been completed when they are released into the community.

If a person being treated for alcohol withdrawal is released into the community, the clinician can consider providing them with a short-term supply of the medicine being used for their treatment. This will help to prevent withdrawal symptoms from recurring and the risk of complications from withdrawal. The clinician should carry out an individual assessment of the risks and benefits to the person of continuing and discontinuing the medication.

With the person's consent, the clinician should share information from the patient record with the person's GP and community alcohol treatment service (where the person has agreed to a referral) as soon as possible. This includes full and accurate information on medicine. Wherever possible, the person should be seen by a clinician in the community when they are released, so they can monitor the person if they complete the treatment for alcohol withdrawal.

17.6.6 Prescribing to prevent relapse

You should read section 10.5 on relapse prevention and section 10.6 on the needs of specific groups in chapter 10 on pharmacological interventions.

Some patients can remain abstinent from alcohol in prison without difficulty. But some may ask to start relapse prevention medication before being released from prison due to the risk of relapsing after release.

Clinicians should consider prescribing medication that supports relapse prevention. They will need to take account of the unique clinical risks in a prison setting when making decisions about prescribing before release.

Clinicians should not prescribe naltrexone (or nalmefene) for people using or possibly using prescribed or unprescribed opioid drugs, because these medications are opioid antagonists.

17.6.7 Pre-release harm reduction advice and interventions

When a person is released from prison, clinical staff should give them harm reduction advice to ensure that they keep themselves as safe as possible when they are released.

A person should receive harm reduction advice before release, including information on:

- how ending the sentence and a wish to celebrate can represent a risky situation for relapse
- their decreased tolerance to alcohol after a period of abstinence, including the risk of alcohol poisoning

- the increased risk of overdose and death if they use alcohol with illicit drugs or prescribed or over the counter medications, particularly those with sedative potential
- the medication they are currently taking and risks of using it with alcohol
- the risk of acute reactions and death from combining alcohol with specific substances, such as the increased toxicity of combined alcohol and cocaine

Appropriately trained prison substance misuse services staff should make sure naloxone is available to people who they think might also use opioids, in line with local protocols.

For people who have been exploited (for example, through county lines or sex work), all services should take extra care to ensure they have safe transport and somewhere safe to go, and are not being picked up by people who are likely to abuse them.

Staff should make sure there is a safety plan in place for people who are at risk of domestic abuse on their release. There is guidance on domestic abuse in chapter 22.

17.6.8 Improving continuity of care at a system level

Systems vary across the UK. Work to strengthen joint working between healthcare and substance misuse teams in prison and community alcohol and drug treatment providers at a system level can help to improve continuity of care. This is vital for people with problem alcohol use who often have co-occurring physical and mental health conditions.

Specialist services to support continuity of care

In England, the RECONNECT service aims to improve the continuity of care of people leaving prison or an IRC with an identified health need. This involves working with them before they leave to support their transition to community-based services, and so safeguarding the health gains they made while in prison or an IRC. People can also be referred to the service up to 28 days after their release.

Guidance on continuity of care

Continuity of care for prisoners who need substance misuse treatment is an audit toolkit and guidance on data recording for prison and community treatment providers and commissioners, to help improve continuity of care between prison and the community.

The main recommendations are as follows.

Prison healthcare services should consider developing a standard referral form to community treatment services.

Local alcohol and drug treatment systems should agree a referral protocol with their main feeder prisons.

Local commissioners and providers should consider establishing or expanding in-reach provision in prisons from community alcohol and drug treatment services.

Community alcohol treatment providers should review what they offer to people leaving prison to make sure it meets their needs and communicate this offer to their main feeder prisons.

Prison treatment services should review their links with resettlement services and jointly co-ordinate appointments and referrals arranged for the community (for example, to avoid appointments clashing).

Local community alcohol and drug treatment and recovery support services in England and Wales should ensure that their main feeder prisons are aware of the community single point of contact (SPOC).

Prison healthcare services and community alcohol treatment services should only communicate personal information through a secure method, such as secure email.

Treatment providers in prisons should record their data in line with data guidelines so that their post-release engagement rates accurately reflect the true picture of continuity of care.

There is more detail on all of these recommendations in the guidance.

To help effective referral and communication, the Office for Health Improvement and Disparities (OHID) SPOC criminal justice directory (England and Wales) lists the contact details of all:

- prison healthcare teams
- community-based treatment providers
- probation teams

If you want to be included on the distribution list for updates, email spoc-ohid@dhsc.gov.uk.

17.7 Immigration removal centres

The guidance on alcohol treatment in prisons is relevant to IRCs. There are also some specific considerations when working in this context.

Migrants may have been exposed to trauma, before, during and after their migration journey, and prevalence of mental health conditions, such as post-traumatic stress disorder (PTSD), is high among people in IRCs. The Royal College of Psychiatrists' report Detention of people with mental disorders in immigration removal centres (PDF, 338KB) suggests that a high proportion of immigration detainees show clinically significant levels of depression, PTSD and anxiety. They also show intense fear, sleep disturbances, profound hopelessness, self-harm and suicidal ideation.

Services should follow trauma-informed principles and practice to help remove the barriers to access that people affected by trauma can experience.

Staff should routinely provide interpretation services to make sure they do not miss signs and symptoms of dependence and withdrawal when people do not speak English. OHID's migrant health guide has guidance on language interpreting and translation.

The IRC treatment service should share appropriate information about the pharmacological and psychological treatment that the person has received, as well as suicide and self-harm risks and any other risks with community alcohol treatment services. This will help reduce risks as people transfer from custody.

Healthcare staff in IRCs should carefully consider people's language and cultural needs to make sure that their alcohol treatment and support does not suffer.

17.8 Probation services and criminal justice social work

Section 17.8 provides guidance for probation services (criminal justice social work in Scotland) and community alcohol treatment services.

There are several ways in which probation services (criminal justice social work services in Scotland) and alcohol treatment services work together to help people on community sentences to engage in alcohol treatment. Arrangements vary in different UK nations, and even within nations, because some initiatives operate in a limited number of areas.

17.8.1 Community treatment requirements

In general, initiatives aim to reduce re-offending and divert people from short-term custodial sentences by addressing people's alcohol dependence through community treatment requirements. If an area has good working between agencies, it's more likely that courts will use treatment requirements. Community alcohol treatment services can contribute important information about the person's alcohol problem and their treatment needs that can be included in the pre-sentencing report.

Examples of community treatment requirements include:

- alcohol treatment requirements as part of community orders or suspended sentence orders in England and Wales
- alcohol treatment requirements that can run jointly with mental health treatment requirements where the person also has mental health needs
- alcohol treatment as part of community payback orders mandated through problem-solving courts in Scotland
- access to alcohol treatment before sentencing, with levels of engagement acknowledged in subsequent sentencing in substance misuse problem-solving courts in Northern Ireland

17.8.2 Licence conditions

People can also be mandated to engage in alcohol treatment as part of a licence condition. Licence conditions are the rules that people must abide by when they are released from prison, if there is still part of their sentence to serve in the community.

Probation officers (social workers in Scotland) should discuss treatment plans with the community treatment provider before licence conditions are proposed. They should also discuss the plan with the person concerned.

Effective partnership working between alcohol treatment services and probation and other criminal justice services is essential to help people engage in treatment and recovery support and stay engaged.

17.8.3 Working relationships

Alcohol treatment services and criminal justice services should have working agreements that specify the responsibilities of each service:

- in relation to treatment requirements imposed through courts
- as part of licence conditions

Arrangements should include details of the information that each service is required to share with the other and the system for sharing this confidential information. The services should clearly explain these arrangements to the person.

Alcohol treatment and probation staff need to work to form positive, trusting relationships with people who are supervised so they feel they have an active role in their own treatment. The principles of care set out in chapter 2 are vital to engaging people who may be ambivalent or anxious about treatment.

17.8.4 Alcohol abstinence monitoring requirements

In England and Wales, the alcohol abstinence and monitoring requirement (AAMR) can be used as part of a community order or suspended sentence order for alcohol-related criminal behaviour. The AAMR imposes a total ban on drinking alcohol for up to 120 days.

A person's compliance with the AAMR is monitored electronically using a tag that continuously monitors their sweat for the presence of alcohol. A 2021 Ministry of Justice alcohol monitoring statistics report shows evidence of high levels of compliance during the AAMR period. But there is currently no evidence of how AAMRs affect abstinence or controlled drinking outcomes when they are no longer in place.

Courts cannot impose an AAMR on someone who is alcohol dependent or has an alcohol treatment requirement imposed or recommended as part of a community sentence.

Given the significant health risks of rapid alcohol withdrawal, sentencers should carefully consider self-reported alcohol use (which is often under-reported) before imposing an AAMR. Any decision to impose an AAMR should be supported by a thorough alcohol assessment, conducted by staff with alcohol treatment competencies, at the pre-sentence stage.

Through their normal contact with offenders, probation staff must be alert to physical signs of worsening health and be aware of what action to take and where to refer the person.

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18. People with co-occurring mental health conditions

How to support people with co-occurring mental health conditions and problem alcohol use, emphasising the 'everyone's job' and 'no wrong door' principles while outlining co-ordinated care across mental health and alcohol treatment services and evidence-based interventions.

18.1 Main points

Main principles: everyone's job and no wrong door

Co-occurring mental health conditions and problem alcohol use are common among people attending mental health services and alcohol treatment services. But there is evidence that people with co-occurring conditions are often excluded from services and cannot access the care they need.

The 2 main principles for working with people who have co-occurring problem alcohol use and mental health conditions are 'everyone's job' and 'no wrong door'.

'Everyone's job' means that commissioners and providers of mental health and alcohol treatment services should share responsibility and work together to commission and plan services for people with co-occurring conditions. They should:

- fully involve senior clinicians, people with lived experience and carers
- agree local treatment pathways and information sharing agreements

'No wrong door' does not mean that everyone should receive ongoing care at the service they first attend, but it does mean that all services and practitioners should be:

- proactive, flexible, compassionate and non-discriminatory in their response
- able to offer an initial assessment as soon as possible, refer the person onto a specialist service if needed and support their urgent physical and mental health needs
- active in planning longer term care with other services

Assessing people with co-occurring mental health conditions and problem alcohol use

When assessing a person, alcohol treatment practitioners and mental health practitioners should consider:

- the interrelationship of their mental health condition and problem alcohol use
- how this affects the choice or timing of interventions
- how it affects risk and risk management and safeguarding plans

Agreeing a care plan

When alcohol treatment services and mental health services are both working with a person, practitioners from both services and the person should agree and review a care plan that identifies:

- the treatment interventions for each condition
- who will deliver the interventions
- whether the interventions will be delivered at the same time or in sequence

The plan should also address other support needs, such as physical healthcare and social support.

Co-ordinating care

A named lead professional should co-ordinate care and act as the first point of contact for the person, their family or carer and other services. When the person has a severe mental health condition, they should be allocated a lead professional from the mental health service.

Where one service has appropriate expertise to provide treatment for both conditions, this provides consistency and continuity for the person.

Expertise across services varies. Alcohol treatment services should be able to work with people with non-severe common mental health conditions, but they can refer people to psychological therapies or mental health services to treat specific conditions if they do not have the expertise in their service.

Community mental health services will usually provide mental health care and alcohol treatment for people with severe mental health conditions but clinicians in alcohol treatment services can provide specialist input where necessary.

Training for staff in mental health settings

Staff across all mental health settings should be trained to:

- offer screening (identification) for alcohol use disorders (problem alcohol use) and offer brief advice
- arrange a rapid alcohol assessment if the person may be alcohol dependent or is drinking at harmful levels

Inpatient services: admission and discharge

When people with alcohol dependence are admitted to inpatient mental health services, it is vital that they are rapidly assessed for medically assisted withdrawal by someone with specialist alcohol treatment competence. As soon as possible, the clinician should provide the person with medically assisted withdrawal or where necessary refer them to a specialist inpatient medically assisted withdrawal unit or acute hospital.

Discharge planning from mental health crisis and inpatient settings should involve preparation and planning for alcohol treatment in community mental health teams. Where a person needs more specialist alcohol treatment input, then their discharge planning should also involve community alcohol treatment services.

Intoxication and exclusion

Intoxication increases a person's risk of harm to themself and to others. It is often implicated in self-harm, including suicide. However, there is evidence some people in mental health crisis who are intoxicated are excluded from appropriate care. Practitioners in mental health services and alcohol treatment services should be able to manage episodes of intoxication and mental health crisis safely, making referrals to crisis or emergency care where necessary. See chapter 16 on acute hospital settings for guidance on managing a person in mental health crisis who is intoxicated.

Access to evidence-based interventions

People with co-occurring conditions should have access to evidence-based psychosocial and pharmacological interventions. There are several National Institute for Health and Care Excellence (NICE) evidence-based guidelines recommending interventions for:

- harmful or high risk drinking and alcohol dependence
- mental health conditions
- co-occurring mental health and problem substance use

18.2 Introduction

This chapter describes principles and approaches to treatment and support for people who experience both problem alcohol use and mental health conditions.

18.2.1 Prevalence

Mental health conditions and problem alcohol use commonly occur together. Research on substance use and mental illness (Weaver and others, 2003) showed that up to:

- 85% of people in alcohol treatment had a psychiatric disorder in the past year
- 25.5% of patients in community mental health teams reported harmful alcohol use
- 9.2% of patients in community mental health teams reported severe alcohol use problems

More recently, research on depression, anxiety and substance use (Delgadillo and others, 2012) found 70% of a sample from community substance use treatment also met criteria for common mental health conditions.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual report 2024: UK patient and general population data found that 47% of people in contact with UK mental health services who died by suicide between 2011 and 2021 used alcohol problematically. There is also evidence that intoxication is a risk factor for suicide (Kaplan and others, 2013; Ledden and others, 2022).

In addition, people with co-occurring mental health and problem alcohol or drug use as a group experience poor health and earlier death than the general population (Hayes and others, 2011).

18.2.2 Exclusion from services

Although co-occurring mental health conditions and problem alcohol use are common, those people are often excluded from services.

Some mental health services and psychological therapies services might exclude people because of their problem alcohol use and some alcohol treatment services might exclude people because of their mental health condition. People in mental health crisis are sometimes excluded from mental health crisis and emergency services because they are intoxicated. This should not happen because it is likely to make the crisis worse and increase risks to themself and others.

Commissioners and providers of mental health services and alcohol treatment services should work together to make sure that people with co-occurring mental health conditions and problem alcohol use are not excluded from services and can access the care they need when they need it.

18.3 Principles

The guidance in this section is for staff in mental health services and alcohol treatment services.

18.3.1 Main principles

The 2 main principles of care for working with people with co-occurring mental health conditions and problem alcohol use are:

1. Everyone's job: providers and commissioners of services have a joint responsibility to meet the needs of people with co-occurring conditions by working together to reach shared solutions.
2. No wrong door: alcohol treatment services, mental health services and other care services should have an open-door policy for people with co-occurring conditions and make every contact count (see section 18.3.3 on no wrong door: initial response and planning). Treatment for the co-occurring conditions should be available no matter which service they first contact.

18.3.2 Everyone's job: partnership working

The way mental health services and alcohol treatment services are commissioned and planned varies across the UK, but the principle of partnership working applies to all areas.

Commissioners and providers of mental health and alcohol treatment services share responsibility for making sure that people with co-occurring conditions can access the help they need, when they need it, in an appropriate setting.

Commissioners, system leaders and senior service providers should work together to commission and plan services for people with co-occurring conditions, involving senior clinicians and people with lived experience and carers. They will also need to work closely with commissioners and providers of other relevant services, including:

- primary care

- acute physical health care
- social care and safeguarding
- criminal justice services

They could use existing partnership forums or create a specific forum to develop and monitor care for people with co-occurring mental health and problem alcohol use.

Commissioners and local health and social care system leaders should agree treatment pathways that enable people with co-occurring mental health conditions and problem alcohol use to access appropriate treatment and support for both conditions. All staff working in mental health services and alcohol treatment services should be aware of these treatment pathways. Commissioners and system leaders should make sure that services publicise the treatment pathways across health, social care, and community services and to the local population so that people know how to access the help they need. The partnership should monitor the effectiveness of agreed treatment pathways and address any problems.

People with co-occurring mental health conditions and problem alcohol use often have other needs including:

- other substance use needs
- physical health needs
- safeguarding needs
- social support needs
- housing needs
- criminal justice involvement needs

Treatment pathways should specify how people can access support from these services when they need it.

The partnership should develop local information-sharing agreements and (where possible) shared access to electronic patient records. This will involve agreements between NHS and third sector organisations in some local areas.

Developing and monitoring treatment pathways and information-sharing agreements, with strong and visible support from senior leaders, will encourage services and practitioners to work together to provide co-ordinated and integrated care tailored to individual need. There should be a mechanism for resolving any disagreements between services about their respective roles in providing appropriate care to individuals.

Healthcare Improvement Scotland's National mental health and substance use protocol is an example protocol setting out how services should work together to provide more integrated care for people with co-occurring conditions. Some of the content will be relevant for other UK nations.

You can find more information on working together in section 18.5 on collaborative care planning.

18.3.3 No wrong door: initial response and planning

'No wrong door' does not mean that people must receive care at the first service they attend, but that all services should:

- be proactive, flexible, compassionate and non-discriminatory in their response
- offer an initial assessment as soon as possible and refer the person onto an appropriate specialist service if needed
- offer a person support for their urgent physical and mental health and social care needs, while also making plans for longer term care and support
- have a named lead professional who can co-ordinate care and comprehensive support from multiple services effectively, underpinned by clear communication reflected in case notes
- explore with people why they may have stopped using services in the past and agree a plan to help them stay engaged

When someone with a co-occurring severe mental health condition is accepted by secondary care mental health services, the person should be allocated a lead professional from within the mental health service. You can find more guidance on working with co-occurring conditions in secondary care mental health services in NICE guideline Coexisting severe mental illness and substance misuse: community health and social care services (NG58).

Practitioners in both alcohol treatment services and mental health services should be competent and supported to provide initial assessment and support for both conditions and work together to provide appropriate treatment.

An important part of the 'no wrong door' principle is that providers should be using the Making every contact count (MECC) approach. MECC helps promote health and healthy lifestyles by taking every opportunity to reduce health harms by offering advice and support to:

- stop smoking
- eat healthily
- maintain a healthy weight
- undertake the recommended amount of physical activity
- improve mental health and wellbeing

18.3.4 Broader principles of care

People with co-occurring mental health conditions and problem alcohol use, are stigmatised in society and sometimes within healthcare services. They have historically often been excluded from services or have had negative experiences of care. Chapter 2 on principles of care sets out principles that should underpin all treatment and help to provide a better experience of care for people who have been excluded and marginalised. These principles include prioritising:

- the therapeutic relationship
- reducing stigma
- trauma-informed care
- cultural competence

18.4 Assessment

The guidance in this section is for staff in mental health services and alcohol treatment services.

Practitioners in both alcohol treatment and mental health services should be able to:

- identify mental health conditions and problem alcohol use
- offer initial assessment as soon as possible and initial support for urgent needs
- work together to plan and provide treatment for both conditions

Services should provide training, supervision, and procedures for escalating concerns about people with co-occurring conditions for immediate advice from the multidisciplinary team or senior clinicians so that practitioners are competent and supported to do this.

If the person is already attending a mental health service or an alcohol treatment service when they present at the other service, the assessor should involve the keyworker from the other service (with the person's consent) in assessing and planning for the person's needs.

Initial assessment should include consideration of the interrelationship between the person's alcohol use and their mental health conditions, how they impact on one another and on risk formulation and risk management (safety) planning.

In some services there will be clinicians with the expertise to carry out a more comprehensive assessment and formulation of the person's needs and offer interventions that address both conditions. Where this is possible, it offers the person more consistency and continuity. However, expertise varies across services and this will not always be possible.

Chapter 4 provides guidance on initial and comprehensive assessment, including risk assessment, for people with problem alcohol use. Section 4.9.9 of that chapter provides guidance on assessing mental health as part of that assessment.

18.5 Collaborative muti-agency care planning

The guidance in this section is for staff in mental health services and alcohol treatment services.

People with co-occurring conditions should be able to access the care they need, when they need it, provided in the setting most suitable to their needs.

Mental health services and alcohol treatment services should have an agreed protocol or written agreement to support practitioners in developing and reviewing collaborative care plans. The agreement should set out how organisations will collaborate, share responsibilities and ensure regular communication. It is helpful to have a mechanism for resolving disagreements about roles in collaborative care planning. The written agreement can also include other relevant services such as:

- primary care and secondary healthcare services
- social care and support services
- child and adult safeguarding
- criminal justice services
- other organisations like housing and employment services
- voluntary and community sector support services such as domestic abuse services

18.5.1 Agreeing a co-ordinated care plan

Practitioners from mental health services, alcohol treatment services and other relevant services should agree with the person how collaborative care will be provided based on the person's individual needs and on locally agreed treatment pathways. The availability of suitably trained and competent staff will also determine what is available locally.

For each individual person, it may be appropriate to deliver interventions:

- addressing both conditions in one service
- from both services at the same time
- in sequence where one service leads to address a specific issue and then refers to the other for an additional unmet need

Where the mental health service and the alcohol treatment service will both provide care, they should agree a care plan (treatment and recovery plan). This will identify the treatment interventions for each condition, who will deliver them and whether they will be delivered at the same time or in sequence. The plan should address other support needs including physical healthcare, social support and safeguarding.

Personalised risk management (safety) planning should include strategies to manage risks related to mental health and to alcohol use. Services should share information and expertise on managing these risks. Where the person may be at risk or pose a risk to others, there should also be contingency and crisis plans for managing loss of contact or a deterioration in the person's mental health (including increased suicide risk) or a relapse in their alcohol use.

Mental health and alcohol treatment services should work to one overall co-ordinated care plan. In some cases, they may have their own more detailed plans, which are aligned with the overall plan. The person should be fully involved in developing their care plan. This includes, as far as reasonably practicable, if they lack capacity to make the 'decision in question' (see glossary). Services should also ask family members or carers to be involved where this is appropriate and the person consents.

A named lead professional should co-ordinate care and act as the first point of contact for the person, their family or carer, and other services.

Practitioners from both services and the person should jointly regularly review the co-ordinated care plan including risk management (safety) plans and amend as appropriate. They should also agree arrangements for ongoing information sharing. The practitioners should communicate regularly and update one another if there are changes in the person's situation or changes in risk to themselves or others. This should include sharing information on changes in the person's pattern of alcohol use.

Services should work together to develop a shared plan for ongoing care with the person and where appropriate with family members before:

- a transition from one service to another (for example, between a young person's service and an adult service)
- discharge from a service (for example, an inpatient service)

There are increased risks at both those times. You can find more guidance on this in NICE NG58.

There is further guidance on multi-agency treatment and recovery planning in section 4.10.4 of chapter 4 on assessment and treatment and recovery planning.

18.5.2 Safeguarding

Not all children of parents or carers with co-occurring mental health and problem alcohol use will experience harm, but they are at a greater risk of doing so. Both parental problem alcohol use and parental mental health conditions are common factors in child abuse, neglect and deaths.

There may also be adult safeguarding risks for people with co-occurring conditions or members of the family.

The safeguarding needs of all members of the family, both children and adults, should be considered as part of assessment. Any safeguarding needs should be built into the collaborative care plan and multi-agency working arrangements.

Practitioners in mental health services and alcohol treatment services must follow their national safeguarding guidance and local organisational procedures.

You can read guidance on working with parents in chapter 26 and guidance on pregnancy and perinatal care in chapter 24.

18.5.3 Collaborative care for people with severe mental health conditions

Mental health services should take the lead on delivering interventions to people with more severe mental health conditions and generally should address both conditions. Specialist clinicians from alcohol treatment services can provide input if the mental health service needs more specialist alcohol treatment expertise.

When alcohol treatment services are working with mental health services to provide treatment and support for people with co-occurring severe mental health and problem alcohol use, the mental health service should lead and co-ordinate care in line with national and local practice. The named lead professional should be from the mental health service.

Guidance for working with people with co-occurring drug and alcohol use and severe mental illness is set out in NICE NG58 and in NICE clinical guideline Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120).

18.5.4 Collaborative care planning for people with common less severe mental health conditions

Alcohol treatment services should be able to work with people with non-severe common mental health conditions, but they can refer people to psychological therapies services or mental health services to treat specific conditions if they do not have the expertise within their service.

Where people have a less severe mental health condition (non-severe anxiety or depression), alcohol treatment services should start treatment for the problem alcohol use as this may reduce the person's psychological distress. However, once the person has reinstated control over their drinking or achieved abstinence and the mental health condition remains, the psychological therapies service or mental health service should treat the mental health condition if the alcohol treatment service does not have staff with appropriate expertise. The 2 services can then work together with the person to address both conditions. There is no evidence that delaying mental health treatment to monitor abstinence from alcohol for weeks or months is effective in helping people.

People with problem alcohol use with non-severe mental health conditions (anxiety and depression) can benefit from psychological therapies for those conditions, even while they are drinking problematically (see section 18.8.5) and care planning should take account for this.

18.5.5 Co-ordinating medically assisted withdrawal (detoxification)

Where mental health services and alcohol treatment services are both working with a person, medically assisted withdrawal (detoxification) should be carefully co-ordinated.

Some people may need medically assisted withdrawal but have longstanding or severe mental health conditions or have unstable mental health. They should have a mental health support package in place before they start withdrawal. Mental health services and alcohol treatment services should work together to arrange this support package to help the person

through the process of medically assisted withdrawal and reduce their risk of relapse. A clinician with specialist alcohol treatment expertise should assess the person for medically assisted withdrawal and recommend whether a specialist inpatient setting would be the appropriate setting due to safety considerations.

Sections 10.3 and 10.4 of chapter 10 on pharmacological interventions provides guidance on medically assisted withdrawal. Section 10.6.5 in chapter 10 provides brief guidance on pharmacological interventions for people with co-occurring mental health conditions.

Section 10.2.4 of chapter 10 on pharmacological interventions provides guidance on criteria for deciding on the appropriate setting for medically assisted withdrawal based on safety considerations. Decisions about appropriate setting for medically assisted withdrawal should be based on individual assessment but where people have unstable mental health, specialist inpatient withdrawal is usually the appropriate setting.

18.5.6 When the person does not want to engage in alcohol treatment

If the person does not want to engage with specialist alcohol treatment, depending on the severity of the mental health condition and the risk assessment and formulation for the person, the mental health service will still need to remain engaged. In these circumstances, the care plan should include:

- ongoing monitoring of alcohol use
- ongoing monitoring of physical health, including access to liver screening (see NICE guideline Cirrhosis in over 16s: assessment and management (NG50) and section 19.5.2 of chapter 19 on liver disease screening and management)
- motivational work
- provision of harm reduction interventions, advice and information (see guidance on harm reduction in chapter 8)

The mental health service may need to work with primary care to manage the person's problem alcohol use. There should be some staff in mental health services with alcohol specialist expertise. Specialist clinicians in alcohol treatment services can also share expertise with staff in mental health services if required.

18.6 Managing suicide risk

The guidance in this section is for staff in mental health services and alcohol treatment services.

18.6.1 Risk factors for suicide and self-harm

Both problem alcohol use and mental health conditions put people at greater risk of suicide than the general population.

Research has shown that alcohol, both through intoxication and dependence, is a factor in a significant proportion of deaths by suicide (Kaplan and others, 2013; Ledden and others, 2022).

A NCISH national study on suicide by people in contact with drug and alcohol services found that between October 2021 and September 2022, 8% of all people who had died by suicide in England and Wales were people who had been in contact with drug and alcohol services within 12 months of their death. The study found that 48% of those people had been in contact with drug and alcohol treatment services for alcohol as the primary substance.

Since 2013, men aged 40 to 54 have had the highest suicide rate in the UK. According to the Office for National Statistics report Suicides in England and Wales: 2023 registrations, men are about 3 times more likely than women to die by suicide.

England, Scotland, Wales and Northern Ireland have national suicide prevention strategies, which are:

- Suicide prevention strategy for England: 2023 to 2028
- Scotland's Creating hope together: suicide prevention strategy 2022 to 2032
- Wales' Suicide prevention and self-harm: strategy and delivery plan
- Northern Ireland's Protect life 2 - suicide prevention strategy

Services should be aligned with their national suicide prevention strategies which include information on risk factors for suicide.

People with mental health conditions and co-occurring problem alcohol use generally experience one or more additional risk factors for suicide which include but are not limited to:

- socioeconomic deprivation, financial difficulty and economic adversity
- a history of self-harm or suicide attempts
- long term physical health conditions
- gambling harm
- drug use
- domestic abuse
- social isolation and loneliness
- bereavement
- interpersonal difficulties

18.6.2 Identifying and responding to people with co-occurring conditions at risk of suicide

Having a policy for working with people with co-occurring mental health conditions and problem alcohol use can help to reduce suicide risk. A 2013 national inquiry into suicide and homicide by people with mental illness (PDF, 310KB) found that in England, there was a 25% fall in rates of suicide by patients in NHS trusts that had a policy on managing patients with

co-morbid problem alcohol and drug use. When working to reduce the risk of suicide, mental health services and alcohol treatment services should work in line with:

- NICE guideline Self-harm: assessment, management and preventing re-occurrence (NG225)
- NICE NG58

Staff in mental health services and alcohol treatment services should:

- understand that both alcohol dependence and intoxication can increase risk of suicide
- understand that self-harm, suicidal thoughts, intentions or behaviour should always be taken seriously, regardless of whether the person is or was intoxicated at the time
- understand other risk factors for suicide
- be trained and supported by a multidisciplinary team to identify and respond to risk of self-harm and suicide, in line with organisational protocols and procedures

Mental health staff assessing risks should be trained to assess harmful drinking and alcohol dependence.

You can find guidance on assessing risk of self-harm and suicide in alcohol treatment services in section 4.9.9 of chapter 4 on assessment and treatment and recovery planning.

Services and practitioners should always personalise risk management (safety) plans and tailor them to the specific needs and risks of the person. NICE NG225 states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment or who should be discharged. The guidelines recommend that risk assessment should focus on the person's needs and how to support their immediate and long-term psychological and physical safety.

Risk assessment should include significant dates and anniversaries and online suicide-related activity which may then form part of safety planning.

18.6.3 Responding to immediate risk of suicide or self-harm

People presenting in a mental health crisis, self-harming or with suicidal intent should never be turned away from services, because this could increase risks to themselves or others. There is further guidance on this in section 18.7.

Services should have agreed pathways and procedures for managing people who are assessed as at immediate risk of suicide or self-harm. Staff should follow these procedures and seek support from the appropriate experienced clinician or clinical team. Where necessary, practitioners should arrange an assessment from an age-appropriate specialist mental health professional as soon as possible through local urgent and emergency mental health care pathways.

The practitioner should identify whether the person has access to the means of self-harm (for example, tablets) and discuss removing this or reducing other forms of immediate risk with the person.

Where appropriate, the practitioner should ask the person for consent to involve family members. If the person does not consent, the practitioner and multidisciplinary team (MDT) should follow organisational procedures on information-sharing and suicide prevention.

The assessor should also tell the person and if relevant their family member about local support that they can access in an emergency.

18.6.4 Ongoing support

Collaborative care plans for ongoing care should include arrangements for immediate information sharing with the lead professional and quick follow-up if a person at risk of suicide loses contact with a service.

Self-harm may indicate that the person has difficulty managing their emotions and they may need specialist treatment from a mental health service, such as dialectical behaviour therapy (a type of talking therapy). For people with ongoing problems with self-harm, suicide risk or a severe or significant mental health condition, the lead professional should be the mental health professional.

18.7 Managing mental health crisis and episodes of intoxication safely

The guidance in this section is for staff in mental health services and for staff in alcohol treatment services.

People who are in mental health crisis, whether or not they are intoxicated or have problem alcohol use, should be managed by mental health crisis or emergency services. Alcohol treatment services are not equipped to manage mental health crises.

People in a mental health crisis can resort to alcohol to manage their distress. Their alcohol use can also lead to an escalation in symptoms of mental ill-health including psychosis, self-harm, suicidal intent or suicide attempts. They might present to emergency services, crisis services, inpatient mental health services or community services in a state of acute intoxication. The underlying problem alcohol use may reflect heavy episodic drinking or a severe dependence that requires rapid medical management.

Whatever the case, the immediate priority is to make sure any acutely intoxicated person is safe and not a risk to themselves or others. People presenting in a mental health crisis, self-harming or with suicidal intent should not be turned away from services, because this could increase risks to themselves or others. Staff should support them to access suitable care, including a place of safety where necessary, and monitor their safety.

There is guidance on managing and monitoring people who are intoxicated and in mental health crisis in an acute setting in section 16.7 of chapter 16 on alcohol care in acute hospital settings.

Staff in mental health services and alcohol treatment services should be able to identify the signs of intoxication and respond appropriately to the associated risks. In particular, these risks include:

- the person not being able to maintain their own safety (for example, being disorientated or losing motor co-ordination)
- physical risks (for example, accidents or alcohol poisoning)
- disinhibition (possibly enhancing feelings of distress, anger, self- harm or suicidal intent)

You can find guidance on intoxication and related risks in section 8.14.5 in chapter 8 on harm reduction.

If someone is at risk of self-harm, including suicide, or presents after an act of self-harm, services should work in line with NICE NG225. This provides detailed guidance on self-harm. NICE NG225 states that assessment should not be denied because the person is intoxicated or has been drinking.

Once the person is less intoxicated, a suitably competent clinician should reassess the severity of their alcohol dependence and their mental health. Staff responsible for treating or monitoring the person should provide harm reduction information relating to alcohol use and mental health. They should also refer the person to specialist alcohol treatment and the appropriate mental health service based on their assessment and follow up the referral to make sure they have engaged with the service.

18.8 Working with people with co-occurring problem alcohol use in mental health services

The guidance in this section is for staff in mental health services.

18.8.1 Strategic leadership

There should be senior level commitment from mental health services to deliver appropriate interventions for people with co-occurring mental health and problem alcohol use. This could require a cultural shift in the organisation to understand that working with people with problem alcohol use is a core part of their role.

Mental health systems should work with primary care, community healthcare and secondary care to be part of a whole system approach to improve local outcomes for mental health and problem alcohol use.

Commissioners, system leaders and providers of mental health services should work with commissioners and providers of alcohol treatment to plan services and agree treatment pathways between mental health services and alcohol treatment services. Section 18.3.2 on partnership working provides guidance on this.

Senior mental health clinicians and senior alcohol treatment clinicians should be involved in the planning and commissioning of pathways between mental health and alcohol treatment services. A designated alcohol lead in the local partnership can help to make sure that

mental health services offer effective interventions and pathways for the full range of problem alcohol use.

18.8.2 Identification (screening) of people with alcohol use disorders

Alcohol use disorders (problem alcohol use) are common among people with mental health conditions, so mental health services (community based, crisis and inpatient) should provide routine identification (screening) for alcohol use disorders. Staff should be trained to carry out identification using a simple validated tool such as the Alcohol use disorders identification test (AUDIT), the Alcohol use disorders identification test for consumption (AUDIT-C) or the adapted Alcohol, smoking and substance involvement screening tool (ASSIST-lite), and to offer brief advice. You can find guidance on identification (screening) and brief interventions in chapter 3 on alcohol brief interventions.

18.8.3 Specialist alcohol assessment and formulation in mental health services

Where people are identified as possibly alcohol dependent, their alcohol use is likely to be affecting their mental health condition or increasing risks to themselves and others. Staff should refer the person for a specialist alcohol assessment. This assessment can be carried out in the mental health service where there are trained staff with appropriate alcohol specialist competencies. Where practitioners with these competencies are not available, the mental health practitioner responsible for the person's treatment should make a referral to the local specialist community alcohol treatment service.

Psychological therapists working in mental health services should have the competence to provide a psychological formulation that integrates the function of the alcohol use with an understanding of the presenting mental health need. You can find guidance on formulation in section 5.4 of chapter 5 on psychosocial interventions. Agreeing a formulation with the person will show that the clinician wants to understand them. It can also help the person to recognise their problems and enhance their motivation to seek specialist help.

18.8.4 Referral to alcohol treatment services and collaborative care planning

If staff in mental health services do not have the appropriate competencies to provide specialist alcohol treatment interventions, they can refer people to alcohol treatment services.

Section 18.3.2 on partnership working provides guidance on developing treatment pathways between mental health services and alcohol treatment services. Mental health services should make sure that staff are aware of local treatment pathways and that these pathways are clear, simple and clearly communicated to people identified as suitable for referral. Services should have information-sharing agreements and systems in place so that practitioners can share information about the person (with their consent), including information on risks. This also helps them to avoid having to tell their story repeatedly to different services. In some areas this will involve sharing information between NHS services and commissioned third sector alcohol treatment services.

Wherever possible, mental health practitioners should refer people for alcohol treatment by contacting alcohol treatment services. Relying on a person to self-refer is unlikely to be successful because many people find it difficult to approach alcohol treatment services. This may be because of stigma, the effects of trauma, previous poor experiences of services or their daily routine. If the alcohol treatment service receives a referral, they can contact the person and encourage them to come and attend another appointment if they miss the first one. The referrer should routinely follow up with the person and with the alcohol treatment service, so they know if the person is engaging with the service.

Following the referral to specialist alcohol treatment, the practitioners from the mental health service and alcohol treatment service will need to agree whether the person's care will be handed over to the alcohol treatment service or whether the services will work together to provide care. You should follow the guidance in section 18.5 on collaborative care planning.

18.8.5 Working with people with problem alcohol use in psychological therapies services

People should not be excluded from psychological therapies based on problem alcohol use. There is evidence (Buckman and others, 2018) that people drinking at harmful levels can have equivalent psychological treatment outcomes to people who do not drink at harmful levels. But some people drinking at harmful levels may find accessing psychological therapies more difficult as they are more likely to drop out. The evidence suggests that the confidence and competence of staff to engage and work with people drinking at harmful levels may affect outcomes.

In England, the NHS talking therapies manual (formerly known as improving access to psychological therapies) includes a 'bite-size positive practice guide' for psychological therapists on working with people who use drugs and alcohol and a link to the full drug and alcohol positive practice guide (PDF, 406KB). Some of the guidance will also be useful to mental health and psychological therapies services across the UK.

18.8.6 Working with people with problem alcohol use in inpatient mental health services

The guidance in this chapter is relevant to all mental health services, but there are some additional considerations for inpatient settings.

Medically assisted withdrawal

When people who may be alcohol dependent are admitted to inpatient mental health services, it is vital that they are quickly assessed for medically assisted withdrawal by someone with specialist alcohol treatment competence. This is important because untreated withdrawal symptoms can lead to serious complications and can even be life threatening.

Staff involved in admissions and assessment processes should be able to identify that someone may be alcohol dependent and in need of medically assisted withdrawal. All inpatient mental health services should have local guidelines on delivering or providing access to medical assisted alcohol withdrawal. Staff involved in admissions and assessment processes should be able to arrange for the person to have a medically assisted withdrawal

according to local guidelines, with support from specialist clinicians. The specialist clinician should provide the person with medically assisted withdrawal, or where necessary refer them to a specialist inpatient medically assisted withdrawal unit or acute hospital.

There is guidance on medically assisted withdrawal in sections 10.3 and 10.4 of chapter 10 on pharmacological interventions and guidance on appropriate settings for medically assisted withdrawal in section 10.2.4. There is guidance on prescribing for people with mental health conditions in section 10.6.5 of chapter 10 on pharmacological interventions.

Managing intoxication on the ward

Inpatient settings should have local protocols or guidelines for managing intoxication safely on the ward and should not exclude people who are intoxicated. Staff should be aware that intoxication increases a person's risk of harm to themself and to others. See section 18.7 on managing episodes of intoxication safely.

Planning for discharge

Discharge planning from mental health crisis and inpatient services should involve preparation and planning for alcohol treatment with community mental health teams. Where specialist input is needed, the discharge planning should involve community alcohol treatment services. The transition from inpatient care to the community can be a vulnerable time when people are at increased risk of a return to problematic alcohol use. If the community mental health team has appropriate expertise, they should plan alcohol treatment interventions alongside mental health interventions before discharge. This is so the person has support during that high-risk transition.

If the plan needs input from community alcohol treatment services, the practitioner co-ordinating discharge planning should involve the alcohol treatment service in planning before discharge. This is so they can offer an appointment before or just after discharge and have the information they need to provide appropriate care. Visits from people with lived experience of co-occurring mental health conditions and problem alcohol use can also encourage people to engage with the alcohol treatment service.

The NICE guideline Transition between inpatient mental health settings and community or care home settings (NG53) provides more guidance on planning for discharge.

18.8.7 Training and skills for staff working in mental health

All practitioners working in mental health care settings should be trained and supported to:

- carry out routine identification (screening) and brief interventions
- make an initial assessment of alcohol and drug use and respond to urgent physical and mental health needs
- identify and make effective referrals to alcohol treatment services
- participate in collaborative care planning and co-ordination

- provide alcohol harm reduction advice and interventions (see chapter 8 on harm reduction)
- understand and identify additional risks or referrals (for example, a safeguarding referral or a housing referral)
- assess alcohol and drug use as factors for suicide risk and include actions to reduce or manage use as part of risk management (safety) planning
- safely manage episodes of intoxication

Additional skills and training will be necessary for staff working in crisis services and inpatient services. They should be able to:

- ensure a person who is acutely intoxicated and in mental health crisis is safely managed and monitored
- identify when a person requires medical management and medically assisted withdrawal
- safely provide a medically assisted withdrawal, according to local policy and procedures and these alcohol clinical guidelines (alcohol specialist members of the team only)

NICE clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) recommends that staff responsible for assessing and managing medically assisted alcohol withdrawal should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and the use of drug regimens appropriate to the setting (for example, inpatient or community) where the withdrawal is managed. This is important so staff can manage the process safely.

Mental health services are responsible for ensuring practitioners are suitably trained and supported. Mental health and alcohol treatment commissioners should support services to make sure the above alcohol-related skills become part of their standard workforce competencies.

18.9 Working with people with co-occurring mental health conditions in alcohol treatment services

The guidance in this section is for staff in alcohol treatment services.

For more on assessment and collaborative care planning, see section 18.5 on collaborative care planning.

You should also read section 4.9.9 of chapter 4 on assessment and treatment and recovery planning. This provides guidance on assessing mental health as part of a comprehensive alcohol assessment.

Alcohol treatment services should support people with common mental health conditions such as non-severe depression and anxiety if they are not accessing community mental

health services. Practitioners should include any goals the person has around managing their mental health within their treatment and recovery plan.

Where alcohol treatment practitioners deliver psychosocial interventions to address common, less severe mental health conditions there should be a clinical governance structure, clinical supervision and input from a trained psychological therapist.

Alcohol treatment services should provide access to self-help resources (print or online) to address common mental health conditions and practitioners can also support people to work through these resources if they need help to do this.

Practitioners can provide psychoeducation on the mental health condition including the role of alcohol in maintaining this condition or making it worse. For example, while people may use alcohol as an attempt to manage depression, harmful or dependent alcohol use is likely to increase depression. Cognitive behavioural approaches to relapse prevention often include this kind of psychoeducation and coping strategies for managing anxiety and depression. See section 5.6.4 in chapter 5 on psychosocial interventions for more information on cognitive behavioural interventions.

If there are staff trained and supervised to deliver recommended evidence-based psychological treatments for specific mental health conditions, then these could be provided in the alcohol treatment setting. These interventions should follow the relevant NICE guideline (or equivalent national clinical guideline) for the condition (see section 18.10 below). If the alcohol treatment service does not have staff with appropriate training and supervision, they should refer the person to a psychological therapies service or a community mental health service for treatment for the condition.

Some psychological therapies services may wish to exclude people because of their problem alcohol use. In these situations, alcohol treatment staff and service commissioners may need to advocate for people with problem alcohol use and support people to engage.

18.10 Psychological treatments for co-occurring mental health and problem alcohol use

The guidance in section is for staff in mental health services and alcohol treatment services who have the relevant competencies.

People with co-occurring mental health and problem alcohol use should have access to evidence-based interventions for both problem alcohol use and mental health conditions. You can find guidance on pharmacological interventions for problem alcohol use (harmful drinking and alcohol dependence) in chapter 10 and psychosocial interventions for people with problem alcohol use in chapter 5.

This section details several specific mental health conditions that commonly co-occur with problem alcohol use, although other mental health conditions not included here may also co-occur with problem alcohol use. Suitably trained and competent practitioners can provide evidence-based psychological treatments to address these conditions. Services should provide clinical supervision and oversight by psychological therapists trained in the relevant approach.

18.10.1 Assessment and formulation, and different approaches to psychological treatment

As with all psychological treatments, assessment and formulation are essential to understand the relationship between alcohol use and any mental health condition and to develop treatment that addresses both. There is guidance on formulation in section 5.4 in chapter 5 on psychosocial interventions.

There are different approaches to delivering effective treatments for people with co-occurring mental health conditions and problem alcohol use and the evidence for the best approach is still emerging.

Where more than one service is involved, they can agree one overarching care plan (treatment and recovery plan) together and each service may have their own more detailed care plan (treatment and recovery plan) that sets out the interventions they will provide. Best practice includes good communication between professionals about the care plans (treatment and recovery plans). The person should be fully involved in choosing the goals and interventions that are included in treatment and recovery plans.

Where there are suitably trained staff, it may be possible to treat both conditions as part of a single intervention. This is described as a dual-focused approach.

While research in this area is still limited, evidence shows that a dual-focused approach with a combination of psychological treatments can be effective for:

- depressive disorder (Delgadillo and others, 2015)
- bipolar disorder (Farren and McElroy, 2008; Weiss and others, 2009)
- post-traumatic stress disorder (Najavits, 2007)

A dual-focused approach could mean adapting a single treatment approach (for example, cognitive behavioural therapy) to address both conditions at the same time or blending 2 different evidenced-based treatments (such as cognitive behavioural therapy and motivational interviewing). A dual-focused approach may help to better engage people in treatment, because many people will not believe their alcohol use and mental health condition are easily separable. So, they might find addressing both issues in one setting makes more sense and is more convenient.

18.10.2 Depression

Primary mild or moderate depressive disorder is very common in alcohol treatment populations. Alcohol treatment services should use basic approaches to identify people who may have depressive disorder. For example, the NICE clinical guideline Common mental health problems: identification and pathways to care (CG123) suggests asking the following 2 questions.

1. During the last month, have you often been bothered by feeling down, depressed or hopeless?

2. During the last month, have you often been bothered by having little interest or pleasure in doing things?

Answering yes to either question indicates possible depressive disorder, so you should follow this with an assessment by an appropriately trained mental health practitioner, as set out in NICE CG123. However, practitioners should also be aware that people might experience depressed mood if they have recently used alcohol, been intoxicated or they are experiencing withdrawal. Their depressed mood may improve after reducing alcohol use or after a period of abstinence, although this will not always be the case.

Practitioners should provide guided self-help based on cognitive behavioural approaches as part of routine clinical care (for example during keyworking) for mild or moderate depressive disorders (one or two sessions).

Dual-focus treatments that combine cognitive (for example identifying and changing unhelpful patterns of thinking), behavioural (for example behavioural activation) and motivational (for example motivational interviewing) components generally have better outcomes at follow-up than offering separate treatments in different services. If there are staff in alcohol treatment services with appropriate competencies and trained in a psychological treatment for non-severe depression, the service could consider offering treatment for non-severe depression at the same time as alcohol treatment so the person can receive treatment in one place. You should only offer the treatment for depression in the alcohol treatment service if there are qualified practitioners trained in the approach and with the relevant governance structures, including clinical supervision.

To treat depression in adults, trained staff should use NICE guidelines on:

- Depression in adults (NG222)
- Depression in adults with a chronic physical health problem (CG91)

18.10.3 Anxiety disorders

Primary mild or moderate anxiety disorders (panic disorder, social anxiety, generalised anxiety disorder) are very common in alcohol treatment populations. Alcohol treatment services should identify people who may have anxiety disorders.

NICE CG123 suggests using the 2-item Generalised Anxiety Disorder scale (GAD-2) to ask the person about feelings of anxiety and their ability to stop or control worry.

For more information and the full GAD-2 scale see NICE CG123.

Sometimes, the person needs to be stable in their alcohol treatment before a healthcare professional can diagnose an anxiety disorder and plan treatment. Practitioners should give people advice on managing anxiety if it is indicated during assessment.

Specialist mental health services or alcohol treatment services (where staff are suitably trained and supervised) should use the standard interventions for treating and managing anxiety disorders when appropriate.

To treat anxiety disorders, trained staff with the necessary competences should use NICE guidelines on:

- Social anxiety disorder: recognition, assessment and treatment (CG159)
- Generalised anxiety disorder and panic disorder in adults: management (CG113)

18.10.4 Post-traumatic stress disorder and complex post-traumatic stress disorder

People in alcohol treatment have high rates of post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD), so services should be trauma-informed. Trauma-informed care requires services and practitioners to use an approach based on its core principles, which are set out in the Office for Health Improvement and Disparities guidance Working definition of trauma-informed practice. They should also be able to understand the impact of trauma and recognise the signs and symptoms of PTSD or CPTSD. This is different to providing specialist treatment for PTSD or CPTSD.

It is essential that all services can identify possible PTSD or CPTSD and can confirm the diagnosis or refer to a specialist team for assessment. The PTSD or CPTSD services and the alcohol service may need to work together to deliver treatment interventions.

Treatment for PTSD requires qualified staff with specialist training and supervision. An alcohol treatment service should only provide it where staff trained and supervised in the approach are available. In most circumstances, a high intensity psychological therapies service or a specialist mental health team will provide treatment.

Trauma-focused treatments with an exposure component, combined with interventions for substance misuse, have been shown to reduce PTSD severity (Roberts and others, 2022). Some people may need stabilisation interventions (for example, to reduce risky behaviours and increase emotional regulation skills) before they start trauma-focused treatment, to help prepare them and minimise the risk they drop out.

Treatment for PTSD requires a phase-based approach consisting of:

- an initial phase focusing on safety and stabilising symptoms (present-focused)
- a second phase focusing on processing traumatic memories (past-focused)
- a reintegration phase (future-focused)

Stabilising a person's alcohol use can support this phased approach, although the specific role for alcohol treatment services in trauma treatment should be determined locally and will be dependent on the training and competencies of staff.

Where alcohol treatment services agree to provide the first phase focusing on safety and stabilising symptoms, this should be based on a recognised, evaluated manual. This work should be carried out by staff trained in the approach and supervised by psychological professionals. It is important that there is a clear local pathway through which people can access phase 2 work if they need it.

Trained staff should use NICE guideline Post-traumatic stress disorder (NG116).

18.10.5 Eating disorders

Eating disorders are common in alcohol treatment populations, although there is limited research in this area.

When identifying people with eating disorders, alcohol treatment practitioners should be aware of the range of indicators set out in the NICE guideline Eating disorders: recognition and treatment (NG69).

Mental health services should provide treatment for the co-occurring eating disorder with support from a specialist alcohol treatment service if required. Common components of treatment for both conditions can include psychoeducation, cognitive restructuring (identifying and changing unhelpful patterns of thinking) and teaching coping skills. Targeting psychological processes that are common to both conditions (for example, learning to manage emotions better) may be helpful for each condition.

You can find further information about treating eating disorders in NICE NG69.

18.10.6 Severe mental illness: psychosis and bipolar disorder

People with a severe mental illness need a care package co-ordinated by mental health services or a GP.

At present, there is not enough evidence to recommend dual-focused treatment to manage co-occurring psychosis and problem alcohol use. Services should offer patients specific interventions for each disorder as outlined in existing NICE guidance identified below.

For bipolar disorder, services (usually mental health services) should offer dual-focused treatments based on cognitive behavioural principles that are focused on bipolar disorder and alcohol use disorder (problem alcohol use) interactions. Evidence shows that these treatments are more effective for depressive, manic and substance use symptoms, compared to single treatment approaches (Farren and McElroy, 2008; Weiss and others, 2009).

Motivational interviewing (MI) offers a non-confrontational and person-centred approach to talk about alcohol use with people who have serious mental illness and co-occurring problem alcohol use. MI can be delivered as a brief intervention but can also be deployed over a longer period of time. MI could also help people with severe mental illness to engage with treatment. You can read more about MI in section 5.5.6 of chapter 5 on psychosocial interventions.

Services should provide harm reduction advice as well as information about how alcohol negatively affects mood, sleep and managing emotions. There is guidance on harm reduction information and advice in chapter 8.

To treat severe mental illness, trained staff should use the NICE guidelines on:

- Coexisting severe mental illness and substance misuse: community health and social care services (NG58)

- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120)
- Psychosis and schizophrenia in adults: prevention and management (CG178)
- Bipolar disorder: assessment and management (CG185)

18.10.7 Personality disorder

Mental health specialists will usually treat people with personality disorders, in line with current NICE guidelines, because this is a complex condition that requires specific training and supervision.

For people with co-occurring alcohol use disorders, their mental health treatment should include helping them gain insight and control over their alcohol use. Mental health services may work with alcohol treatment services where they do not have the relevant specialist expertise to provide alcohol treatment interventions in mental health services. Staff in alcohol treatment services will need support and supervision from the MDT or wider clinical team when working with people with personality disorders.

Systems and pathways for emergency psychiatric care should be available to assess and manage people with co-occurring personality disorder and alcohol or drug use who are experiencing a mental health crisis.

To treat personality disorders, trained staff should use NICE guidelines on:

- Borderline personality disorder: recognition and management (CG78)
- Antisocial personality disorder: prevention and management (CG77)

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19. People with co-occurring physical health conditions

Healthcare assessments, treatment and recovery planning and referral pathways for primary or secondary healthcare for people with alcohol related physical health conditions including liver disease, cardiovascular disease, specific cancers, and smoking and lung health issues.

19.1 Main points

Alcohol increases the risk of many health conditions including some cancers, liver disease, cardiovascular disease, and diseases of the central nervous system.

Smoking and drinking in combination increases the risk of some alcohol-related diseases.

Everyone starting alcohol treatment should receive an initial assessment of their health as part of comprehensive assessment. The assessor can then refer the person (with their consent) to their GP or a clinician (a doctor or nurse) in the alcohol treatment service for a further assessment of any symptoms or unmet healthcare needs.

If a physical health assessment suggests concerns, the person should be quickly referred for further investigation and supported to access and complete any necessary treatment.

Commissioners and strategic managers of local alcohol treatment services and primary and secondary healthcare services should develop and support care pathways for people with alcohol-related illnesses, such as liver disease.

There should be ongoing communication between clinicians or keyworkers in alcohol treatment services and clinicians in primary and secondary care about the person's physical healthcare needs.

When developing a treatment and recovery plan with the person, alcohol treatment practitioners should include goals and actions related to the person's physical health where relevant.

Alcohol treatment services should ensure their teams are aware of the latest guidance on supporting people to stop smoking and provide opportunities for them to support smokers to quit.

Alcohol treatment services should make sure there are clear local referral and care pathways to stop smoking support.

19.2 Alcohol and health risks

People who drink alcohol, especially people who drink at harmful or dependent levels, have an increased risk of a range of health problems, including:

- some cancers
- liver disease
- cardiovascular disease
- diseases of the central nervous system, such as alcohol-related brain damage

Alcohol-related health risks vary according to the volume and frequency of alcohol consumed, as well as several other factors including:

- age
- sex
- body mass index (BMI)
- length of time someone has been using alcohol

In general, the more that someone drinks, the greater their risk of alcohol-related health harms.

Alcohol treatment services and other health professionals should provide people with simple, accessible information on alcohol-related health risks, and personalise advice on reducing health harms.

19.3 Assessing and managing physical health in alcohol treatment services

Everyone starting alcohol treatment should receive an initial assessment of their health as part of comprehensive assessment. The assessor, who might not be a clinician, can then refer the person (with their consent) to their GP or a clinician (a doctor or nurse) in the alcohol treatment service for further assessment of any symptoms or unmet healthcare needs.

The clinician prescribing in the alcohol treatment service needs to be satisfied that an adequate health assessment is being provided for each person they prescribe to, or whether further assessment is needed from primary care or secondary care specialist services.

It is good practice for the clinician assessing a person for alcohol treatment to complete a general health assessment that they are competent to carry out. Following this, they can decide whether the person needs a further assessment (or other intervention), and whether it is urgent or not. It is important for services to achieve a balance that focuses on the needs of the person, while not attempting to replace the role of primary care.

Clinicians should assess for health conditions that are alcohol-related and conditions that are unrelated. You should read guidance on providing a physical health assessment in alcohol treatment services in section 4.9.11 of chapter 4 on assessment and treatment and recovery planning.

If a physical health assessment suggests concerns, people should be quickly referred for further investigation and supported to access and complete any necessary treatment.

The alcohol treatment clinician or the person's keyworker should work with the person's GP and relevant secondary care clinicians to make sure that the person's healthcare needs are addressed.

19.4 Including physical health conditions in the treatment and recovery plan

When developing a treatment and recovery plan with the person, alcohol treatment practitioners should include goals and actions related to the person's physical health where relevant.

For example, a treatment and recovery plan might include:

- personal goals and actions in relation to physical health such as stopping smoking
- actions around attending healthcare appointments and reviewing outcomes
- attendance at health and wellbeing activities such as support groups for people with long term conditions and appropriate physical activities
- discussion of harm reduction and health information

You can find guidance on treatment and recovery planning in chapter 4 on assessment and treatment and recovery planning.

19.5 Alcohol-related health risks

An evidence review on the public health burden of alcohol found that risks for the following diseases were increased by drinking.

19.5.1 Cancers

There is strong evidence for an association between alcohol use and cancer, including cancers of the:

- lip, oral cavity and pharynx
- oesophagus
- larynx
- colon
- rectum
- liver and intrahepatic bile ducts
- breast

Smoking and drinking alcohol increases several health risks.

There is evidence that for men who have never smoked, the risk of alcohol-related cancers is not much higher than for those drinking less than 3.75 units per day (Cao and others, 2015). However, for women who have never smoked, the risk of alcohol-related cancers, mainly breast cancer, increases even within the range of up to around 2 units per day.

A large scale longitudinal study found that compared to men who have never smoked and do not drink, men who smoke and drink more than 15 units a week have the highest mortality from smoking-related cancers (Hart and others, 2010a). Either drinking alcohol or smoking increases the risk of getting cancer but doing both increases the risk to a greater extent than either behaviour alone.

Healthcare professionals treating people with these cancers should ask about their alcohol use and, where possible, use a screening tool such as the alcohol use disorders identification test (AUDIT or AUDIT-C) to do this.

You can find screening tools at Alcohol use screening tests and guidance on identification of alcohol use disorders in chapter 3 on alcohol brief interventions.

19.5.2 Alcohol-related liver disease

Overview

Alcohol-related liver disease is a type of damage or disease to the liver caused by heavy alcohol use, including fatty liver disease, alcoholic hepatitis and cirrhosis.

In 2023, 76% of alcohol-specific deaths in the UK were from alcohol-related liver disease (Office for National Statistics, 2025).

There is evidence that obesity-induced fatty liver can progress to cirrhosis and liver failure, but obesity can also increase the harm to the liver caused by alcohol use (Hart and others, 2010b). In simple terms, for a person with a BMI of over 35, the liver risk doubles at any given volume of alcohol use.

Hepatitis C (or B) can increase the harm to the liver caused by alcohol-related liver disease.

There is evidence (Williams and others, 2014) that people with alcohol-related liver disease experience stigma, including from healthcare professionals. Stigma can deter people from seeking help and can lead to poor healthcare experiences. A non-judgemental, non-stigmatising approach is vital to help people engage with treatment as early as possible in the development of the disease. Alcohol treatment staff may need to advocate for people with alcohol-related liver disease with other healthcare services, so they can access the care they need.

You can find guidance on delivering pharmacological interventions for medically assisted withdrawal and relapse prevention for people with liver disease in section 10.6.6 in chapter 10 on pharmacological interventions.

Detecting liver disease early

Signs and symptoms of alcohol-related liver disease (ARLD) develop late in the progression of the disease and a high proportion of people with ARLD will have no clinical symptoms nor significant blood test abnormalities.

Eventually, their liver may fail to function sufficiently and will decompensate. This is the stage at which ARLD becomes clinically apparent. The risk of developing liver disease and subsequent decompensation decreases with abstinence (or reduced alcohol consumption). So, it's important to detect liver disease early and begin interventions.

Screening for liver disease

National Institute for Health and Care Excellence guideline Cirrhosis in over 16s: assessment and management (NG50) recommends that women drinking more than 35 units per week,

or men drinking more than 50 units per week, for 3 months or more should have their liver stiffness measured by transient elastography (TE, also known as Fibroscan) to determine the stage of progression of liver disease.

There are other non-invasive screening methods for liver fibrosis in development, which include the following.

Ultrasound based screening includes:

- acoustic radiation force impulse
- shear-wave

Serum fibrosis markers include:

- enhanced liver fibrosis (ELF)
- liver traffic light test
- intelligent liver function test (iLFT)

However, research shows that these tests are currently less well validated for ARLD than TE is (Moreno and others, 2019).

Healthcare professionals who perform and interpret non-invasive fibrosis tests should be trained to do so.

Any screening test should be part of a specified pathway, to make sure the tests are reviewed and acted on.

Care for people with liver disease

People diagnosed with significant fibrosis or cirrhosis should be followed up by a specialist in liver disease.

Alcohol abstinence is a vital goal for people with ARLD, since abstinence improves outcomes in all stages of ARLD. However, the patient should not be excluded from treatment if they do not accept this goal initially. Guidance on developing pathways for alcohol treatment is clear that it is better to engage the person, rather than alienate them if they fail to agree to or achieve abstinence.

Commissioners and system leaders should develop and support effective care pathways between specialist liver services and alcohol treatment services in the hospital and in the community.

You can find guidance on treating cirrhosis in chapter 16 on acute hospital settings.

Scottish Health Action on Alcohol Problems published Alcohol-related liver disease: guidance for good practice for healthcare staff in primary and secondary health services and in alcohol treatment services. The content may also be useful for healthcare staff in other UK nations.

19.5.3 Cardiovascular disease

Hypertension

There is a close relationship between drinking alcohol and hypertension (high blood pressure). Risk of high blood pressure starts at lower levels of alcohol use for women (from about 2 units per day) than for men. High blood pressure accounts for most alcohol-related hospital admissions for cardiovascular disease.

Alcohol treatment services and other health professionals should screen people with alcohol dependence or harmful patterns of drinking for high blood pressure. Healthcare professionals treating people with high blood pressure should ask people about their alcohol use and where possible should use a screening tool such as AUDIT or AUDIT-C to do this.

Stroke

There is evidence (Ronksley and others, 2011) that people who drink more than 7.5 units a day are at increased risk of incident stroke (bleeding in or around the brain or blocked artery to the brain) compared with people who do not drink at all.

Either drinking alcohol or smoking increase the risk of stroke, but smoking and drinking together increases the risk to a greater extent than either behaviour alone.

There is evidence (Hart and others, 2010a) that men who smoke and drink more than 15 units per week have the highest risk of death from stroke.

Heart disease

Heavy drinking and episodic (binge) drinking increases the risk of heart disease (angina, heart attack, heart failure) and death from heart disease.

Men who smoke and drink more than 15 units per week have the highest risk of death from heart disease.

Atrial fibrillation

Binge drinking is a risk factor for atrial fibrillation (severe irregular heartbeat). However, the risk of atrial fibrillation increases with the amount the person drinks from 1.5 units per day upwards.

19.5.4 Central nervous system

Brain damage

Alcohol-related brain damage describes various psychoneurological or cognitive conditions that are associated with long-term, heavy alcohol use and related vitamin deficiencies (particularly thiamine deficiency).

Wernicke's encephalopathy is an acute medical emergency where alcohol withdrawal and lack of vitamin B1 causes inflammation of the brain. It has a high risk of death and if untreated, may lead to Wernicke-Korsakoff syndrome which involves irreversible memory loss. However, if caught early enough and treated with thiamine supplementation, long term brain damage is preventable.

You can find guidance on prescribing thiamine for prevention of Wernicke's encephalopathy in section 10.4.3 of chapter 10 on pharmacological interventions.

You should read guidance on alcohol-related brain damage in chapter 20.

Peripheral neuropathy

Peripheral neuropathy is damage to the nerves that results from excessive drinking. It causes symptoms that include numbness in the arms and legs and abnormal sensations such as pins and needles.

Epilepsy

There is a relationship between heavier levels of drinking and the risk of epilepsy. People with alcohol dependence can also experience withdrawal seizures.

You can find guidance on seizures in withdrawal in section 10.4.1 in chapter 10 on pharmacological interventions.

19.5.5 Acute health risks

In addition to the disease risks associated with alcohol use, there are acute (short term) health risks including injuries.

The risk of unintentional and intentional injuries resulting from drinking alcohol increases with the amount of alcohol people drink. Health risks associated with intoxication and alcohol dependence include risks arising from:

- road traffic accidents
- alcohol poisoning
- overdose or increased harms when alcohol and other substances (illicit, prescribed or over the counter) are taken together
- falls
- fires
- drowning and water transport incidents
- air or transport incidents
- work or machine incidents
- firearms incidents
- inhalation and ingestion of gastric contents
- exposure to excessive cold (from passing out while outside)
- intentional self-harm or suicide
- increased risk of sexual diseases and unplanned pregnancies resulting from unprotected sex

- increased risk of being a victim or perpetrator of violence

Alcohol treatment services should provide harm reduction information and advice on the risks associated with intoxication and alcohol dependence. You can read guidance on harm reduction information and advice for several of those risks in section 8.14 of chapter 8 on harm reduction.

Alcohol, both intoxication and dependence, increase the risk of self-harm and suicide.

You can find guidance on self-harm and suicide in section 4.9.9 of chapter 4 on assessment and treatment and recovery planning. and section 18.6 of chapter 18 on co-occurring mental health conditions.

19.5.6 Complications of alcohol withdrawal

For people with alcohol dependence, unplanned withdrawal and in some cases, medically assisted withdrawal can be associated with complications that have health consequences. In some people, these can be severe and can even lead to death.

You should read guidance on preventing and managing complications in withdrawal in section 10.4 in chapter 10 on pharmacological interventions.

19.6 Smoking-related diseases and lung health

Smoking harms every organ in the body and causes several diseases including lung cancer. Smoking and drinking combined increases the risk of several alcohol-related conditions.

Alcohol treatment staff are in an ideal position to help reduce smoking-related harm in people in treatment.

19.6.1 Asking a person about their smoking and related problems

Alcohol treatment services need to:

- identify a person’s history of smoking tobacco and other drugs
- provide information on the stop smoking support available locally
- help the person engage with local smoking cessation interventions or provide smoking cessation support directly
- support the person to engage with services to treat respiratory problems, including their GP or specialist respiratory health services

Clinicians should ask questions to explore potential respiratory disease, including asking about:

- current or recent history of cough, shortness of breath and symptoms of asthma, and any impairment caused by activities like walking
- previous respiratory diagnoses and any treatment for existing lung disease

Clinicians should also ask questions to explore the person's smoking history and intentions to quit, including their:

- recent and previous levels of smoking and current quit status (for tobacco and other smoked drugs)
- desire, now or in the future, to quit tobacco smoking
- experience of previous quit attempts
- willingness to consider smoking cessation (including pharmacotherapy)
- use of e-cigarettes

19.6.2 Physical examinations and exploring respiratory disease

Physical examination and investigations for smoking and exploring respiratory disease are normally undertaken by the GP or respiratory team, but they can be carried out by in some alcohol or drug treatment services where clinical staff have the appropriate competencies.

Examinations and investigations include:

- checking for signs of breathlessness, cough, wheeze, and other signs of respiratory (or cardiovascular) disease
- pulse oximetry, a simple test that can show unrecognised impaired lung function (this may be useful if the person is using opioids and other respiratory depressants or has had a recent opioid overdose)
- spirometry (including handheld spirometry, which may be more easily used in non-specialist clinics) can quantify impairment that could have been caused by tobacco or other drug use

19.6.3 Accessing interventions for respiratory problems

Clinicians can support people to access appropriate interventions for respiratory problems by:

- clearly documenting smoking and respiratory health in the patient record
- noting any observed deterioration in apparent respiratory health over time
- referring the person to their GP for investigation and treatment, if necessary (which may include full lung function tests and chest X-ray)
- supporting referral (usually by the GP) to the local specialist respiratory service or chest clinic, which may be required for people with established respiratory disease if there are health concerns (such as evidence of low oxygen levels)
- making an urgent referral to the GP or local rapid access chest clinic for any person with respiratory disease who has 'red flag' symptoms of chest malignancy (such as patients who report haemoptysis and weight loss)

- making an urgent referral to an emergency department for people presenting with imminently dangerous conditions such as unstable or deteriorating asthma

19.6.4 Providing or supporting smoking cessation interventions

Staff in alcohol treatment settings also need to be competent to provide or support smoking cessation interventions.

Alcohol treatment services should:

- provide feedback to commissioners about where local stop smoking services are working well and where there are problems for people accessing support
- ensure their teams are aware of the latest guidance and interventions to help people to stop smoking
- provide learning and development opportunities for team members on how to support smokers to quit and to provide very brief advice
- make sure there are clear local referral and care pathways to stop smoking support

19.6.5 Very brief advice

Very brief advice has 3 components: ask, advise and act.

Ask and record smoking status: is the patient a smoker, ex-smoker or non-smoker?

Advise on the best way of quitting: a combination of stop smoking aids and specialist support.

Act on the patient response: build confidence, give information, refer and prescribe.

Staff can access free online training from the National Centre for Smoking Cessation and Training. They can also make the most of existing opportunities like the NHS Health Check to include smoking cessation support in routine clinical care.

19.6.6 Providing different options to stop smoking

Different approaches suit different people, so if the first thing a smoker tries does not help, they should try another way to quit. Clinicians should be confident to talk to people about the different options available for stopping smoking and how effective they are. There is guidance to support conversations between clinicians and people who want to quit smoking, which will help them with what method to choose.

19.6.7 Vaccinations

Alcohol dependence by itself is not an indication for either influenza (flu) or pneumococcal vaccination. However, if there are other underlying health issues, for example chronic liver disease or respiratory disease, this would place the person in a clinical risk group and the Green Book recommends vaccination. The Green Book provides guidance on which vaccines should be administered to people with at-risk comorbidities including comorbidities that

may be attributable to alcohol. For flu and pneumococcal disease, see 19.4 Influenza: the green book, chapter 19 and table 25.3 Pneumococcal: the green book, chapter 25.

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20. People with alcohol related brain damage

How to prevent, identify, assess and treat alcohol related brain damage (ARBD) using brief cognitive assessment, harm reduction, multidisciplinary pathways for comprehensive assessment and treatment planning, adapted interventions for cognitive impairments and long term support.

20.1 Main points

Alcohol related brain damage (ARBD) describes various psychoneurological or cognitive conditions that are associated with long term, heavy alcohol use and related vitamin deficiencies (particularly thiamine deficiency).

Local health and care partnerships (for example integrated care boards, health and care boards or health boards) should develop joined up, multidisciplinary, person-centred pathways. This is so people have access to appropriate interventions for the full spectrum of ARBD.

Local health and care partnerships including strategic managers, lead clinicians and commissioners should act to reduce barriers that people with ARBD can experience when trying to access local pathways for neurological disorders or cognitive impairment.

Alcohol treatment services should intervene to prevent the onset of ARBD by:

- raising awareness of the harm it causes and offering harm reduction advice
- prescribing thiamine supplementation
- providing well managed medically assisted withdrawal to reduce the risk of withdrawal complications

Alcohol treatment services, primary, community and secondary health care services should include a brief cognitive assessment as part of the routine assessment of people drinking at harmful levels and people experiencing alcohol dependence.

Where the brief cognitive assessment indicates the person may have some cognitive impairment, clinicians should refer them for a comprehensive multidisciplinary assessment. This should include a measure of functional ability.

Services that do not have access to staff with specialist competences in ARBD should refer people for specialist multidisciplinary assessment and diagnosis through the local pathway for ARBD. Where no specialist ARBD pathway exists, services should use the standard pathway for neurological conditions. Diagnosing people with ARBD early increases their chances of cognitive improvement.

Services should work together to:

- develop a comprehensive multidisciplinary management plan for people diagnosed with ARBD

- allocate a keyworker with expertise in ARBD (or cognitive impairment where no ARBD specialist is available)

Involve family members where appropriate.

Abstinence is crucial to support cognitive improvement. So, services should re-assess the person with ARBD regularly over 3 years and adjust their plan accordingly.

If a person with ARBD continues to drink, services should continue to offer multidisciplinary psychosocial support and prescribe thiamine.

Services should offer multidisciplinary support and rehabilitation tailored to the stage of the person's recovery from ARBD. Adapt psychosocial interventions and neurological rehabilitation strategies to take account of the level of a person's cognitive impairment.

Once the person has reached their optimum level of cognitive function, services should arrange access to appropriate long term support or care for people with permanent ARBD. This should be tailored to their level of need.

There are specific considerations for assessing mental capacity to make a decision in people with ARBD who have 'executive functioning' difficulties. Executive functions are a range of cognitive processes that include planning, organising, prioritising, working memory and self-regulation. People with executive functioning difficulties may be able to describe how they would carry out tasks but not be able to carry them out in practice. So, it's important to gather information from family or carers. One assessment may not be enough.

20.2 Overview

20.2.1 Definition of ARBD used in these guidelines

Alcohol related brain damage as an umbrella term

Alcohol related brain damage (ARBD) describes various psychoneurological or cognitive conditions that are associated with long term, heavy alcohol use and related vitamin deficiencies (particularly thiamine deficiency). ARBD describes a spectrum of disorders of varying degrees of severity. Severe ARBD can affect a person's life to such an extent that independent living is no longer possible but many people with ARBD can live in the community with appropriate support.

Psychoneurological or cognitive conditions described as ARBD include:

- Wernicke-Korsakoff syndrome
- alcohol related traumatic brain injury
- cognitive impairment resulting from multiple episodes of withdrawal
- vascular brain injury

These different causes can all result in ARBD and there will be similarities in how the person presents regardless of the cause of ARBD. There are also some differences in presentation

that a full specialist neuropsychological assessment would be able to pick up, including a measure of the person's day-to-day functioning.

ARBD is not a progressive condition like dementia. If clinicians can identify it at an early stage and the person can stay abstinent, then the prognosis can be good. So, it is very important to prevent, identify and treat ARBD. This requires establishing joined up, multidisciplinary, person-centred pathways that take account of the complex range of factors involved in preventing and managing ARBD.

The modified Oslin criteria

The modified Oslin criteria (Oslin and Carey, 2003) provides a useful framework for identifying possible ARBD as a set of conditions based on:

- evidence of cognitive impairment (confirmed by clinical examination or using appropriate tools, for example the mini-Addenbrooke's cognitive examination III (mini-ACE) assessment tool (PDF, 65.1KB)
- significant alcohol use, defined by the minimum average of 35 standard drinks (or 50 units) per week for men and 28 standard drinks (or 35 units) for women for more than 5 years - the period of significant alcohol use must be within 3 years of the cognitive deficits' clinical onset

Although the use of brief cognitive assessment tools can alert the clinician to the possibility of ARBD in a person at risk, they cannot confirm this. A thorough multidisciplinary assessment led by a neuropsychologist or other suitably trained clinician is needed to confirm a diagnosis of ARBD (see section 20.6 below).

20.2.2 Wernicke-Korsakoff syndrome

Wernicke-Korsakoff syndrome is a form of ARBD that comprises:

- an acute brain syndrome (Wernicke's encephalopathy)
- a more chronic condition, Korsakoff's syndrome (previously known as Korsakoff's psychosis)

Wernicke's encephalopathy is an acute medical emergency where alcohol withdrawal and lack of vitamin B1 causes inflammation of the brain. It has a high mortality rate and may lead to Wernicke-Korsakoff syndrome if it is not treated with intravenous vitamin B1. You can find guidance on managing Wernicke's encephalopathy in section 16.9.4 in chapter 16 on acute settings.

The 3 main symptoms of Wernicke's encephalopathy are not always present. These are:

- unusual eye movements
- confusion
- ataxia (unsteady walking)

So, clinicians must be very aware that all people with a history of alcohol use disorder who have even one of these symptoms could have Wernicke's encephalopathy.

Korsakoff's syndrome refers to a chronic amnesic disorder with a pattern of:

- severe short-term memory impairment
- varying impact on longer term memories
- possible presence of confabulation (false memories arising from the action of the amnesic brain to make sense of current circumstances)

20.2.3 Managing ARBD

People with ARBD need to remain abstinent from alcohol for their cognition to improve as a result of not being exposed to the direct toxic effects of alcohol. Cognition can begin to improve as soon as the person stops drinking and can continue to improve substantially for 3 to 6 months if they remain abstinent. During this time, someone who lacked mental capacity to make decisions about various aspects of their care due to ARBD may regain capacity.

While people usually experience most cognitive improvement in the first 3 months of abstinence, people who remain abstinent can continue to experience varying degrees of improvement for up to 3 years.

The Royal College of Psychiatrists (RCPsych) college report Alcohol and brain damage in adults (PDF, 1.95MB) (CR185) recommends improving a person's cognition through:

- progressive socialisation
- training in daily living activities like cooking
- alcohol education

When the person achieves what is likely to be their optimal level of cognitive function, based on ongoing clinical assessment, practitioners should support them to access an appropriate setting (for example, independent living, supported living or residential care). About 50% to 70% of patients who are actively and appropriately managed and remain alcohol-free will show improvement in their psychosocial functioning.

22.2.4 Evidence for preventing and treating ARBD

Most of the literature about preventing and treating ARBD is made up of case reports, correlation studies and case control studies. So, most recommendations in these guidelines are made using evidence from:

- evidence summaries developed from systematic reviews
- guidelines developed from systematic reviews

22.2.5 Care pathways

In many parts of the UK, care pathways for people with ARBD are not well established and this can lead to people not receiving the care they need when they need it.

There are a few specialist services for ARBD and some areas have staff with ARBD specialist expertise. However, where this is not available, it's important that local health and care partnerships (for example integrated care boards, health and care boards, health boards) collaborate and agree pathways so that relevant services can identify people with potential ARBD. They can then refer them for:

- comprehensive specialist assessment
- appropriate treatment
- rehabilitation
- social care and housing support

There should be an identified service for leading on a specialist comprehensive assessment of their neurological or cognitive conditions and on multi-agency management plans. This would need to be a service with specialist expertise in neurological conditions or cognitive impairment. While alcohol treatment services will have a role, they do not usually have expertise in neurological and cognitive conditions. Alcohol treatment commissioners, and commissioners, strategic managers and lead clinicians for the local healthcare system can help to identify the need for appropriate pathways within their local partnerships.

There is emerging good practice in some areas. The Welsh Government guidance Substance misuse: prevention, diagnosis, treatment and support for alcohol-related brain damage incudes recommendations for establishing dedicated ARBD services. It also provides examples of how health and care systems can work together to meet the needs of people with ARBD.

20.3 Brief assessment of cognitive function in people drinking at harmful levels and people with alcohol dependence

20.3.1 People at higher risk of ARBD

Health and care staff, including staff in alcohol treatment services should take high risk groups into account when targeting brief cognitive assessments, raising awareness and referring for specialist multidisciplinary comprehensive assessment.

Higher risk groups include people:

- drinking at high-risk levels
- with a low body mass index (BMI)
- who regularly miss meals
- who have had multiple episodes of withdrawal (both treated and untreated)
- with previous episodes of complicated withdrawal
- with a long history of harmful drinking or alcohol dependence

- with other conditions associated with thiamine deficiency such as peripheral neuropathy and cerebellar disease (Thomson and others, 2009)

20.3.2 Identification and assessment in community health and care settings

People with ARBD can present at a wide range of health and care settings including alcohol treatment services. Staff in health and care settings should consider the possibility of ARBD in any person who is drinking at harmful levels or has done so previously.

Staff in community alcohol treatment services should routinely carry out a brief cognitive assessment as part of comprehensive assessment. They should then refer people needing more specialist neuropsychological assessment through locally agreed pathways to services for neurological disorders or cognitive impairment.

Healthcare staff should carry out a brief cognitive assessment during the initial assessment period and repeat it at appropriate intervals to review progress.

There are several formal assessment tools that staff can use to identify the possibility of cognitive impairment. Healthcare staff (including alcohol treatment staff) who are trained to do so can routinely use the mini-ACE tool to identify possible ARBD across all settings. The longer Addenbrooke's cognitive examination III (ACE III) is also available for suitably trained clinicians. It is important that brief cognitive assessments include tests of frontal lobe function. These assessments can alert staff to the possibility of cognitive impairment that can then be further investigated by specialists.

The Oslin criteria recommend that people should be abstinent for 3 months before having brief cognitive assessments. However, clinicians should take a pragmatic approach to cognitive testing and should be clear on the distinction between using it as a diagnostic instrument as opposed to using it as a screening tool. Brief cognitive assessment in a person who is acutely intoxicated is of no value. But clinicians can test a person who is currently drinking if they recognise that there will be some acute effects of alcohol, such as acute memory impairment, that should resolve when the person stops drinking.

Thorough, holistic and multidisciplinary assessment is required to confirm the presence or absence of ARBD. Where the brief cognitive assessment indicates the person may have some cognitive impairment, healthcare staff should refer them for a full comprehensive assessment that is led by a neuropsychologist or other suitably trained professional. It is important that the assessment incorporates some measure of functional ability through formalised assessments involving specialists such as occupational therapists and information from the person, family members and professionals. Speech and language therapists can also provide input to a multidisciplinary assessment.

20.3.3 Brief cognitive assessment in acute hospital settings

Treating people with alcohol dependence admitted to acute hospitals is often complex. Comorbidities that can confuse the picture include:

- infection

- hepatic encephalopathy
- pain
- mental health issues (such as depression)

Alcohol related cognitive impairment can easily be missed by acute hospital teams. So, it is important to have broad criteria to alert clinicians to the possibility of ARBD so they can carry out further assessment. Suitable criteria include:

- probable history of heavy, long-standing alcohol consumption (see Oslin criteria in 20.2.1 above)
- confusion, memory problems, doubt about mental capacity to make decisions about aspects of their care and concerns about risk on discharge, after withdrawal or physical stabilisation
- 3 or more admissions into hospital or the emergency department in one year, either directly (withdrawal, unconscious) or indirectly (trauma, organ diseases) associated with drinking alcohol

20.4 Preventing ARBD

ARBD is preventable. There are several ways in which specialist alcohol treatment services and broader healthcare services can contribute to prevention.

20.4.1 Raising awareness about the effects of alcohol on the brain

Research has found that knowledge of the damaging effects of alcohol on the brain is poor among people with ARBD and some healthcare professionals (Heirene and others, 2018; Wilson, 2011). Raising awareness of ARBD at a population level ensures that people at risk can make informed choices about their drinking. The Royal College of Psychiatrists has produced 'Alcohol related brain damage patient and public information leaflet' (in RCPsych college report CR185, page 73) and Alcohol Change UK has several ARBD factsheets.

20.4.2 Thiamine and advice on diet

Wernicke-Korsakoff syndrome is caused by thiamine deficiency. Once a clinician identifies harmful or dependent drinking in a patient, they should:

- give them advice on diet
- prescribe thiamine supplementation
- screen them for cognitive impairment
- be alert to any signs of Wernicke's encephalopathy

Section 10.4.3 in Chapter 10 on pharmacological interventions has detailed guidance on prescribing thiamine to prevent Wernicke-Korsakoff syndrome and assessing patients for potential Wernicke's encephalopathy.

20.4.3 Advice against suddenly stopping drinking for people with alcohol dependence

For physically dependent drinkers, clinicians should outline the dangers of precipitated withdrawal after stopping drinking suddenly. Research suggests that the more withdrawal episodes a person experiences, the more likely they are to have cognitive impairment (Wagner Glenn and others, 1988; Loeber and others, 2010). Clinicians should advise patients against stopping drinking suddenly and offer an assessment for medically assisted withdrawal.

You can find guidance on prescribing for medically assisted withdrawal in sections 10.3 and 10.4 in chapter 10 on pharmacological interventions.

20.5 Preventing withdrawal related ARBD

20.5.1 Anticipate withdrawal and identify early withdrawal

Unmedicated or poorly medicated alcohol withdrawal can progress to complicated forms of withdrawal associated with ARBD. Wernicke's encephalopathy is directly linked to ARBD, and delirium tremens and seizures can also be risk factors for this. So, clinicians should identify and treat withdrawal as soon as possible.

Clinicians should closely monitor people with a higher risk of developing ARBD.

See section 20.3.1 for a list of people at higher risk.

20.5.2 Use evidence-based protocols for medical management of withdrawal

Clinicians should use evidence-based protocols for routine and more complicated withdrawals. There is detailed guidance in sections 10.3 and 10.4 in chapter 10 on pharmacological interventions for medically assisted withdrawal, including prescribing prophylactic oral or parenteral thiamine to reduce the risk of developing withdrawal complications leading to ARBD.

20.5.3 Identify and treat co-occurring illness

A patient is more likely to progress to complicated withdrawal if they have a co-occurring illness, such as an infection or gastrointestinal bleed. Early diagnosis and treatment will reduce this risk.

20.5.4 Identify and treat Wernicke's encephalopathy

Wernicke's encephalopathy is a complication that can occur in withdrawal. Clinicians should treat Wernicke's encephalopathy as an emergency and manage the person in an acute medical setting. Clinicians who identify cases in the community should transfer the patient to the emergency department of an acute hospital setting immediately.

When a clinician has identified a patient with Wernicke's encephalopathy, they should be given immediate treatment with intravenous thiamine. Section 16.9.4 in Chapter 16 on alcohol care in acute hospital settings provides detailed guidance on prescribing and administering intravenous thiamine.

20.6 Diagnosis and treatment of ARBD

20.6.1 Early diagnosis of ARBD and referral into appropriate service

People with ARBD can present to:

- healthcare services with an acute condition such as Wernicke's encephalopathy
- services in the community following a gradual decline in cognitive abilities

By diagnosing ARBD early, clinicians with expertise in neurological and cognitive conditions can deliver appropriate interventions to increase the person's chances of cognitive improvement.

Early diagnosis also enables healthcare staff to make prompt referrals to appropriate supported accommodation and social care if necessary. Supported accommodation can help some people with ARBD to improve their day-to-day function and reduce their likelihood of returning to harmful drinking. However, ARBD is consistently underdiagnosed because of a lack of awareness among clinicians (Wilson and others, 2012) and many people are not identified until their cognitive impairment becomes severe. It is important that clinicians investigate the main cause of any cognitive impairment and distinguish ARBD from other conditions.

People at risk of ARBD often have additional intracranial pathology affecting their cognitive and other functional abilities, for example:

- traumatic brain injury
- vascular brain injury (damaged blood vessels causing intracranial bleeding)
- dementia
- acute conditions, such as hepatic encephalopathy (liver-related brain dysfunction)

So, comprehensive assessments should ideally include:

- neurocognitive testing (carried out by appropriately qualified professionals)
- brain scans
- appropriate blood tests
- functional assessments by occupational therapists and speech and language therapists

All patients with ARBD should have a comprehensive management plan drawn up when they are first diagnosed. RCPsych college report CR185 recommends that every patient has a designated keyworker who has expertise in assessing and treating adults with cognitive deficits.

20.6.2 Regular follow-up and re-evaluation

After diagnosing a person with ARBD it is important that clinicians review them on a regular basis. This is so they can assess any improvements in cognition and functioning and make appropriate changes to the management plan. The Royal College of Psychiatrists recommends reassessing a patient's cognitive function 3 months after the initial assessment. Clinicians should then repeat this every 6 months for 3 years.

It is also important to reassess a person's cognitive function so that if it deteriorates despite not drinking alcohol, clinicians can investigate other potential causes of cognitive impairment.

20.6.3 Maintaining abstinence from alcohol

Maintaining abstinence from alcohol is crucial to support cognitive improvement. For people with established ARBD (when their cognitive function has reached optimal level) who have stopped drinking, it is important that clinicians (including alcohol treatment workers) provide ongoing support to maintain this.

Clinicians will need to adapt standard psychosocial interventions and neurorehabilitation strategies for people with cognitive impairment (see section 20.7.6 in this chapter). Clinicians should also consider prescribing relapse prevention medication. There is guidance on prescribing relapse prevention medication in section 10.5 in chapter 10 on pharmacological interventions.

20.6.4 People who continue to drink alcohol

For people who continue to drink alcohol (and have mental capacity to make decisions to do so), alcohol treatment staff should try to keep them attending services. They should do this by using approaches such as motivational interviewing (appropriately adapted for people with cognitive impairment) and helping them to access peer support. Flexible engagement approaches such as assertive outreach can help to support people who are unlikely to attend service bases (see chapter 9 on assertive outreach).

Practitioners should also provide people with information on what services can offer in a way that they can understand. For people not currently engaged in treatment, practitioners should try to maintain contact and be alert for signs of:

- increased motivation to engage
- the loss of mental capacity to make decisions to consume alcohol or make other decisions about aspects of their care and support

Other health and care staff should also be alert for these signs so they can make appropriate referrals.

People with alcohol dependence who continue to drink often experience unplanned episodes of withdrawal. Some of these episodes occur outside of clinical settings so the person remains at risk of repeated episodes of complicated withdrawal. Recurrent periods of thiamine deficiency cause cumulative brain damage (Crowe and El-Hadj, 2002; Price and others, 1988; Ciccia and Langlais, 2000). So, clinicians should give prophylactic thiamine

routinely to people with alcohol dependence who continue to drink, whenever they present to medical services (Thomson and others, 2012). See section 10.4.3 in chapter 10 on pharmacological interventions for guidance on prescribing and administering oral and parenteral (intramuscular) thiamine.

20.7 Recovering from ARBD

Broadly speaking, people with ARBD may present to health services in one of two ways:

- an acute presentation
- a more chronic presentation

An acute presentation is often as part of a hospital admission, where comorbid physical health issues (such as encephalopathy, delirium tremens or pancreatitis) will be the initial focus for treatment. This is also often complicated by the presence of multiple comorbidities including features such as a head injury and vascular trauma.

A more chronic presentation is where there is a gradual cognitive decline in the community which may be recognised by the person, family members or as a result of routine cognitive screening in community services. Some of these people will be abstinent from alcohol but most will still be alcohol dependent.

Of course, the picture is rarely that simplistic and the 2 will often overlap.

20.7.1 An acute framework

Research (Wilson and others, 2012) has described a framework for understanding the natural history of ARBD in people who present with acute problems. This framework is split into 5 stages, which was developed from retrospective clinical studies, clinical consensus statements and studies on the rehabilitation of patients presenting with acquired, traumatic brain injury. The 5 stages are:

- physical stabilisation
- psychosocial assessment
- therapeutic rehabilitation
- adaptive rehabilitation
- social integration and relapse prevention

Not all people with ARBD present with acute problems. Those presenting to community services with more gradual cognitive decline may need to initially focus on becoming abstinent from alcohol (in the most appropriate setting) and then engage in interventions relevant to their stage of recovery. Although it may not be appropriate for them to move through the 5 stages above in sequence, clinicians can take relevant elements from the stages to form a comprehensive treatment plan for the person based on their presenting need. It is possible that some people regain near normal cognitive function in the earlier

stages of the process. So, it is extremely important to maintain a flexible and dynamic care plan that can adapt to the changes in a person's function.

20.7.2 Phase 1: physical stabilisation

Physical stabilisation is concerned with preventing or treating withdrawal and ensuring that any comorbid acute medical conditions are treated. Sections 10.3 and 10.4 in chapter 10 on pharmacological interventions provides guidance on medically assisted withdrawal and section 10.5 in chapter 10 provides guidance on prescribing for relapse prevention.

20.7.3 Phase 2: psychosocial assessment

If a person can maintain abstinence from alcohol following the treatment of acute conditions, their cognitive and functional abilities usually improve over the next 3 to 4 months. So, support to maintain abstinence is of vital importance, but clinicians may need to adapt standard treatment approaches to take into account any cognitive impairment (MacRae and Cox, 2003). Advice for adapting psychosocial interventions is provided later in this section.

There are a number of principles and interventions that should be considered during the psychosocial assessment phase. These include:

- developing a therapeutic relationship and offering psychosocial support (MacRae and Cox, 2003; North and others, 2010; Wilson and others, 2012)
- promoting 'normalisation', such as establishing daily routines and recommending appropriate nutritional intake (planning and providing a timetable and structure may help)
- arranging help for practical needs, such as debt and welfare benefits and introducing them to a support worker or advocate
- involving family and other carers where appropriate
- planning for orientation and memory support
- providing alcohol harm reduction information (see chapter 8 for guidance on harm reduction)

At this point it may also be helpful to encourage people to start a personal journal. This may be a useful thing for them to do because it can:

- help with recent memories (could include photographs of recent events)
- introduce the concept of routine by providing a memory of recent events
- build a relationship between the person and keyworker
- provide an introduction to planning

20.7.4 Phase 3: therapeutic rehabilitation

A therapeutic rehabilitation programme aims to gradually improve a person's skills for daily living as their cognition improves. There are a number of targets for interventions in this phase, which include the following.

Developing autonomy

You can help a person to develop autonomy by helping them to become more independent and improve their ability to self-manage where cognitive or functional deficits remain (Wilson and others, 2021).

Promoting functional recovery

You can promote functional recovery through maintaining a journal, planning activities and learning skills. Occupational therapists or other healthcare staff with expertise in neurorehabilitation can support people in re-learning everyday tasks and establishing routines that are important for regaining skills, confidence and orientation.

Supporting memory

You can support a person's memory with strategies such as:

- using a journal to provide an opportunity for regular review of progress and to help the person remember recent and past events
- using a whiteboard to keep a continuous and easy-to-see record of the date, day and location of recent events
- keeping lists of things to do and remember
- using visual signs and memory aids

Managing executive dysfunction

Some people with ARBD have problems with executive function. Executive function describes a set of skills needed to:

- plan ahead and meet goals
- display self-control
- follow multiple-step directions even when interrupted

People with problems with executive function are likely to need a lot of help to use strategies. For example, staff may need to prompt and help people to make use of their journal. It is helpful to give people simple repeated instructions about carrying out tasks and avoid giving them unnecessary information.

Managing apathy and motivation

For some people, ARBD can result in apathy and problems with motivation. Staff need to take a persistent and consistent approach to encouraging people to carry out tasks and participate in activities. They need to explore approaches and activities that can support the person's motivation. Establishing a motivating environment is important. For example,

routines can be helpful and these should be obvious in the setting, such as through information on a noticeboard.

Managing alcohol use

You can help the person manage alcohol by using adapted psychosocial interventions and considering the appropriateness of relapse prevention medication. As with all medication, the clinician needs to obtain the person's informed consent before they start the medication, and they will need to get their consent on a regular basis. Cognitive impairment can affect a person's capacity to consent to medication and their ability to observe a regular dosing schedule. So, clinicians may need to carry out a mental capacity assessment to assess the person's capacity to consent to that treatment.

Developing relationships

Developing relationships is important to support the person to build relationships with their keyworkers and to improve relationships with people who care about them, such as family and carers. This will strengthen their informal community support structure for times when professionals are not so closely involved.

20.7.5 Phase 4: adaptive rehabilitation

Adaptive rehabilitation is a transitional phase that takes place when clinicians consider that the person has reached their optimal level of cognitive and behavioural improvement. It is important to reassess their functional ability and the amount of support they will need, encouraging autonomy but ensuring safety.

A full assessment of activities of daily living should take place. This should include a review of the person's environment and care package to see if anything needs to be adapted. Phase 4 often involves transferring care from a setting with a high level of support to a less dependent environment or reducing carer support.

During this phase, the person is at increased risk of returning to problem alcohol use, particularly if they are returning to their previous environment (where they may be exposed to previous triggers for drinking). So, any transfers of care must occur in a managed, planned way, involving all relevant health and social care agencies as well as the person and their family or carers. An identified person should co-ordinate the care plan and ensure that regular reviews are undertaken.

20.7.6 Phase 5: social integration and relapse prevention

The main therapeutic principles of social integration and relapse prevention are to maintain abstinence from alcohol and an optimum level of independence and quality of life moving forward.

Staff can reduce and manage a person's exposure to drinking triggers by supporting them to engage in non-drinking social networks, including peer support networks and finding new, more suitable accommodation. Ongoing training and education to develop employment and life skills as well as support to manage their own finances may be appropriate. It is also

important to support people to make healthy lifestyle choices, such as eating healthy diets and engaging in positive activities and hobbies.

20.7.7 Adapting psychosocial interventions

Standard psychosocial interventions rely on a degree of cognitive flexibility and abstract thinking which may be impaired in people with ARBD. This does not exclude their use for people with ARBD but means that standard approaches need to be adapted and tailored to the needs of the person. Adaptations could include:

- proactively engaging people with cognitive dysfunction, with more frequent and assertive attempts to make contact
- limiting the number of subjects discussed at each appointment to allow for reduced levels of concentration and difficulties in swapping from topic to topic
- providing rewards for appropriate behaviour, which may include psychological rewards such as praise, or social rewards such as attending enjoyable social activities - but all rewards should be tailored to the person and may help recall by positively reinforcing the behaviour
- increasing the length of appointments
- adapting sessions to accommodate problems in remembering new information, for example having the person repeat information as soon as it is given
- offering information in various ways, including verbal, written and using diagrams
- using memory cues and reminders such as diaries, electronic reminders to complete tasks, notices, colour coding to identify the person's room and having cupboards with transparent doors
- having simple rules to apply when making decisions and dealing with problems, for example to ask a support worker or a family member if they are not sure what action they should be taking
- keeping relapse prevention strategies very simple

You can find more information on psychosocial interventions in chapter 5 on psychosocial interventions. Section 5.5 on structured support can be adapted for people with ARBD.

20.7.8 The location for cognitive rehabilitation for people with ARBD

Dependent on social needs, people with ARBD may access rehabilitation interventions in a variety of settings and it is important for their recovery that they receive an appropriate level of support. Support settings and interventions should reduce risk while enhancing autonomy and independence.

People living in residential environments on the basis of care needs may receive psychosocial interventions as part of an ARBD rehabilitation package. However, this is not the same as engaging in a dedicated ARBD residential rehabilitation programme. There are a

small number of dedicated ARBD residential programmes in the UK. A recent evaluation of a 12-week dedicated ARBD residential programme in Scotland showed significant reductions in attendances at emergency departments and the use of inpatient beds, as well as significant improvements in cognitive function (Smith and Willenborg, 2024).

Receiving cognitive rehabilitation in a residential setting should usually have advantages over similar programmes in the community, as the person with ARBD would be shielded from their specific triggers for drinking within their own environment. To date, there is no evidence-base to confirm this. However, the alcohol guidelines development group recommends that access to residential and community forms of cognitive rehabilitation should be available, so that people with ARBD can be placed in the most appropriate treatment setting based on their individual needs.

20.8 Multidisciplinary, multi-agency community support in the longer term

It is important to provide long-term psychosocial support for people with residual cognitive deficits from ARBD who seem to have reached their optimal level of cognitive and behavioural improvement. Multi-agency long-term support that addresses the person's physical health, mental health, day-to-day functioning and social care needs, including help to establish a personalised support network, can reduce the likelihood of someone returning to harmful alcohol use (Wilson and others, 2012).

Dedicated ARBD services are rare in the UK, so people with ARBD will often have their health and social care provided by a variety of different services. People with ARBD often have additional mental health conditions, so it is important that mental health services are part of the team supporting the person where relevant. It is vital that the person has a single, comprehensive care plan that all services work to. The person should also have an identified lead professional who has expertise in managing ARBD, or where this is not possible, expertise in managing cognitive impairment.

Part of the role of the lead professional is to update the different services involved in a person's care about the care plan. As well as sharing this information with the person and their family or carers, lead professionals need to communicate with:

- alcohol treatment services
- community mental health teams (both adult and older adult)
- adult social care
- specialist services including occupational therapy
- primary care
- secondary care services (for example hepatology)
- housing organisations
- independent mental capacity advocates
- other advocates supporting the person on issues such as attending appointments

- peer support

Appropriate accommodation is often the most important factor in maintaining a person's abstinence. It is vital that various levels of support are available to match the person's needs. This can range from nursing home care to independent living with minimal support.

Some people may return to harmful alcohol use. If clinicians think that the person has the capacity to make decisions about drinking, the clinicians should normally encourage them to stop or limit their drinking and refer them to alcohol treatment services, if they consent.

If they do not have the capacity to make decisions about drinking, then following a 'best interests decision', they should usually be managed in services that are competent in managing people with severe cognitive impairment.

20.9 Assessing mental capacity in people with ARBD

20.9.1 Legislation and statutory guidance

ARBD can affect a person's memory and reasoning, which are important factors when assessing their mental capacity to make a specific decision. The assessment of capacity is governed by the relevant legal framework, such as that contained in sections 1 to 3 of the Mental Capacity Act 2005.

You can find information on the legislation and statutory guidance on mental capacity in annex 1. There are some differences in legislation relating to mental health, mental capacity, and safeguarding across the different nations of the UK.

Impairment or disturbance

To determine whether a person lacks capacity to make the decision in question, you must be able to show that the inability to make the decision in question has been directly caused by an impairment or disturbance in the functioning of the mind or brain. This could include the symptoms of alcohol use, and conditions associated with alcohol use. While a formal diagnosis may help to establish if the person has an impairment or disturbance, a formal diagnosis is not necessary for the purposes of the Mental Capacity Act.

Best interests

Once it has been established that the person lacks capacity to make the decision in question, any decision or act carried out on their behalf must be in that person's best interests. Section 4 of the Mental Capacity Act 2005 sets out a checklist of factors that decision makers must work through in deciding what is in a person's best interests. In particular, it sets out that decision makers should:

- consider the person's past and present wishes and feelings
- consider the person's beliefs and values that would influence the decision if the person had capacity, and any other factors they would have considered
- consult the views of other people, including friends and family members

Advocacy

You should also consider whether the person would benefit from support and representation from an independent advocate.

The Mental Capacity Act places a duty on the local authority or the NHS to appoint an independent mental capacity advocate whenever a decision is required about serious medical treatment or long-term change of accommodation. They need to do this where a person lacks the capacity to make the decision in question and there is no one appropriate to consult about the person's best interests, other than someone engaged in providing care for them in a professional or paid context.

There are also duties on local authorities to provide independent advocacy when undertaking certain functions under the Care Act 2014.

Deprivation of liberty

In some cases, it may be necessary and proportionate to put in place care and treatment arrangements that amount to a 'deprivation of liberty' under article 5 of the European Convention on Human Rights. In these cases, proper legal authorisation should be obtained before the deprivation of liberty is implemented. Depending on the circumstances, this authorisation can be provided under the Mental Health Act 1983 or the Mental Capacity Act.

In the Mental Capacity Act, the deprivation of liberty safeguards can be used to authorise the deprivation of liberty of an adult lacking the relevant capacity in a hospital or care home. A court or protection order can authorise deprivation of liberty in other settings and for 16 and 17 year olds.

20.9.2 Potential effects of memory deficits on capacity to make a decision

When assessing a person's capacity to make the decision in question, the assessor must follow the relevant legal framework. In doing so, the following practice considerations may be relevant.

Short-term memory

Short-term memory deficits are common among people with ARBD. Short-term memory involves the ability to register, retain and recall new information. During a conversation there may not be any obvious signs of short-term memory deficits. The person may be able follow a conversation and hold information long enough to weigh it up and make a decision, but might forget the content of the conversation (and the decision made) a few hours later.

Long-term memory

Long-term memory problems are common among people with Wernicke-Korsakoff syndrome. People with ARBD may have experienced up to 20 years of retrospective memory loss and may not have any significant understanding of their harmful drinking and that it has contributed to their current situation.

When assessing a person's capacity to make a specific decision, practitioners should not assume that they remember their own history, or are aware of:

- the amount they drink
- how long they have been drinking at this level
- the social and financial consequences of drinking

People often lose long-term memories, so practitioners must be aware the person will make decisions when they are not fully aware of what they have been through.

Combination of short-term and long-term memory problems

A person with Wernicke-Korsakoff syndrome may have a limited short-term memory of 2 to 30 minutes and long-term memory loss of some years. The person's current thoughts might relate only to the last few minutes or hours. Their most recent remembered events might have occurred years ago, possibly before they had alcohol problems. So, they might not be able to retain the relevant information long enough to use it to make a decision.

Although the Mental Capacity Act says that people who can retain information for a short while must not automatically be assumed to lack the relevant capacity, it depends on what is necessary for the decision in question. It can be important to provide support (such as voice notes and visual prompts) to help the person retain the information.

False memories

False memories (or confabulations) often occur in people with memory deficits who will commonly appear confused when presenting at services. People with short-term memory loss can unconsciously fill gaps in their memory with false memories to explain their current situation. A person who has memory loss and is creating false memories is vulnerable to suggestion from others. You should check anything the person says with information from a suitable professional, carer or relative about their cognitive and functional abilities.

20.9.3 Reasoning difficulties and potential effects on mental capacity

Reasoning problems are common in people with ARBD. Signs of reasoning difficulties may not be obvious and can often be missed when examining people for cognitive impairment. In people with more advanced ARBD these signs can include:

- problems in social awareness
- not understanding the consequences of actions
- not being able to estimate risk

People with ARBD can experience difficulties in processing and understanding information they are given. Some people with ARBD lack motivation and have problems in changing their behaviour and routine. They may find it difficult to resist situational cues, such as triggers to drinking in stressful situations. In structured settings, such as when being assessed by a

practitioner, a person may contain and regulate their behaviour. But in other, less structured circumstances, their impulsive and disinhibited behaviour may become more obvious.

20.9.4 Practical suggestions for assessing the mental capacity of a person with ARBD to make a decision

Standardised tools

Clinicians should establish evidence of cognitive impairment using a standardised tool such as ACE III. You should be aware that ACE III cut off scores provided with the tool have not been validated in people with ARBD. A comprehensive multidisciplinary assessment is required to confirm ARBD.

The relevant decision in question when assessing capacity

It is very important that you correctly identify what is the specific decision that needs to be made (this is known as 'the matter' under the Mental Capacity Act). For example, you may need to assess the person's capacity to make decisions about care in circumstances where you are proposing to change their care plan. Or you may need to assess capacity to make residence decisions if you are proposing a change in accommodation.

You will also need to think about the information relevant to the decision, which may include the impact of the person's drinking on their care or residence arrangements.

Considerations for assessing capacity to make decisions about alcohol consumption

In some cases, you may need to assess a person's capacity to make decisions about their alcohol consumption. For example, this might be because you are proposing a care plan to restrict alcohol consumption and there is a good reason to believe the person may lack capacity to consent. The following considerations and questions might also be useful in undertaking this assessment.

You must think about the relevant information for the decision that the person would need to be able to understand, retain, and use to make the decision. Normally this will include the:

- nature of the decision
- reason why the decision is needed
- likely effects of deciding one way or another or of making no decision at all

But there may be other relevant information, specific to the case, that will need to be added.

When assessing capacity to make decisions about alcohol consumption, you may need to ask the person if they:

- are aware of their alcohol consumption and associated risks
- are aware of other related problems they are potentially facing - for example, and depending on the facts of the case, fire risk, malnutrition, hospital admissions, financial or legal problems

- are aware of the degree and nature of any cognitive impairment
- know what will happen if they continue drinking

You should assess if the person can retain the relevant information for long enough to make the decision. In doing so you should also think about strategies to assist the person to retain the information, such as:

- reminding the person's carers to reinforce the information afterwards
- checking the person has personalised written information they can refer to

20.10 Frontal lobe paradox

'Frontal lobe paradox' describes where a person with frontal lobe impairment who shows difficulties with everyday tasks may still be able to explain quite clearly how to carry out these tasks. They may also perform well in tests of function carried out in clinical settings (George and Gilbert, 2018).

Even if they have no obvious frontal lobe damage, some people with ARBD may be able to describe how they would do things but not able to carry these actions out. This difference would have potential implications for clinicians, as people with frontal lobe impairment may perform well in clinic-based tasks such as cognitive testing due to the well-defined rules and requirements of the task. But the same people will struggle with poorly structured tasks in less ordered environments in everyday life (Burgess and others, 2009; Jackson and others, 2014).

Frontal lobe impairment is often an early sign of ARBD and may go unrecognised by both patients and professionals. So, the frontal lobe paradox may be a factor in the difference between formal assessments in clinical settings and behaviour in the community for people with ARBD. However, there is a current lack of research evidence to support this. For this reason, you must take care when making changes to assessment methodology based primarily on opinions, as opposed to an empirical research base (Newstead and others, 2022).

For now, it is important to highlight that the information obtained from structured assessments (such as the ACE-III) in people with ARBD must be supplemented with:

- general assessments
- collateral reports from clinicians and significant others
- general observation

The danger of basing functional evaluations on structured interviews or assessments alone is that effects such as the frontal lobe paradox may not be fully evident.

When assessing a person's capacity to make a decision, in respect of someone with executive functioning difficulties, it will be particularly important to consider their ability to use and weigh up the relevant information. People with executive functioning difficulties may appear to understand the relevant information during the assessment but may be

unable to put into effect their stated intentions. So, it is also useful in this context to get evidence from others, such as friends and family, to supplement information from the interview. A one-off assessment may be insufficient.

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21. People experiencing homelessness

How to provide tailored alcohol treatment for people experiencing homelessness. It covers strategies for improving access and engagement, highlighting the need for multi-agency integrated care to address alcohol use, housing and wider needs while reducing health inequalities.

21.1 Main points

People experiencing homelessness also experience multiple disadvantage that requires an integrated response across local systems and services.

Alcohol treatment commissioners and services should work with homelessness services, health, social care and community services to plan and provide integrated models of care such as co-located services, in-reach sessions, or multi-agency forums.

People experiencing homelessness should have a multi-agency assessment and care plan (treatment and recovery plan) that addresses alcohol treatment, housing and wider health and social care needs and is co-ordinated by a named keyworker.

People experiencing homelessness experience personal barriers (such as the impact of trauma) and service barriers (such as inflexible appointment systems) to accessing alcohol treatment services.

To reduce barriers to treatment, services need to offer flexible engagement arrangements tailored to the needs of people experiencing homelessness, such as assertive outreach or open access services.

Individual practitioners and services should work with a compassionate, non-stigmatising and trauma-informed approach to support ongoing engagement with people experiencing homelessness.

Services need to tailor treatment and recovery support to the needs of people experiencing homelessness such as offering long term support and increasing support before, during and after the move to independent housing.

A harm reduction approach is often appropriate for people experiencing homelessness. This could aim to reduce the physical and mental health and social harms associated with problem alcohol use and homelessness.

For people experiencing homelessness with alcohol dependence and who want to stop drinking, services should consider offering inpatient medically assisted withdrawal followed by planned treatment and access to appropriate housing and support.

People with lived and living experience of problem alcohol use and homelessness should be involved in commissioning and planning services and offering peer support to people in treatment and recovery.

Practitioners working with people with problem alcohol use who are experiencing homelessness should be trained and supported to identify adult safeguarding concerns.

They must act in line with statutory guidance as homelessness, particularly rough sleeping, is associated with increased safeguarding risks.

21.2 Introduction

The chapter provides guidance about support and treatment for people experiencing homelessness with alcohol dependence or who drink at harmful levels.

21.2.1 Alcohol treatment for people experiencing homelessness

Alcohol treatment services should provide inclusive, targeted and flexible support tailored to the needs of people experiencing homelessness, including rough sleeping. They should work together with homelessness and housing support, health, social care, and community services to make sure people experiencing homelessness can access integrated care.

Commissioners and services should be aware of and work in line with the National Institute for Health and Care Excellence (NICE) guideline Integrated health and social care for people experiencing homelessness (NG214).

21.2.2 Definition

Homelessness: applying All Our Health sets out a definition of homelessness, which is that a household has no home in the UK or anywhere else in the world available and reasonable to occupy.

The same guidance gives examples of homelessness, including:

- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary, in institutions or a shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as ‘sofa surfing’)
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)

People can move in and out of periods of homelessness. It can be temporary and some people experience repeated episodes of homelessness, moving in and out of short-term accommodation.

21.3 Addressing health inequalities

People experiencing homelessness experience some of the most extreme health inequalities. Office for National Statistics Deaths of homeless people in England and Wales: 2021 registrations shows that the average age at death for people experiencing homelessness was 45.4 years for men and 43.2 years for women. This is more than 30 years lower than the average age at death of the general population of England and Wales. National Records of Scotland data on homeless deaths in 2023 shows that half (50%) of homeless deaths in 2023 were people aged under 45.

People experiencing homelessness often find health and social care services (including alcohol treatment services) difficult or impossible to access. Commissioners and services often need to make more effort and target approaches to providing care to this group of people. They should aim to reduce the health inequalities affecting people experiencing homelessness by allocating resources and tailoring services to meet their specific needs. This is so alcohol treatment is available and accessible to people experiencing homelessness and provided to the same standards and quality as it is for the rest of the alcohol treatment population.

21.4 Integrated care

21.4.1 Integrated care for people experiencing homelessness and problem alcohol use

People experiencing homelessness and problem alcohol use often experience multiple disadvantage and their needs require an integrated response across local systems and services, including:

- alcohol and drug treatment services
- primary care
- acute health care
- community, inpatient and crisis support mental health care
- social care
- homelessness, housing and housing support services
- peer-support organisations
- domestic abuse services
- local community and voluntary sector services

All integrated care should be based on a trauma-informed approach and care environments should be psychologically informed (see section 21.5.2 on supporting and maintaining engagement below). There is guidance on trauma informed practice in section 2.2.8 in chapter 2 on principles of care.

21.4.2 Commissioning and planning integrated services

NICE NG214 recommends that commissioners and planners of services for people experiencing homelessness involve commissioners of other relevant health and social care services in their planning.

Alcohol treatment commissioners and services should be aware of:

- how alcohol treatment fits into the local model of integrated care aimed at addressing the needs of their local population experiencing homelessness
- the legal obligations on their local authority to provide housing support

Commissioners and planners of alcohol treatment and of services for people experiencing homelessness should work together to agree pathways between services and joint working arrangements. This will support effective joint working at a service delivery level.

21.4.3 Providing integrated care

Models of integrated care for people experiencing homelessness vary. In areas with high numbers of people experiencing homelessness, NICE NG214 recommends that multi-agency teams provide integrated care (including alcohol treatment) through one service. In areas where multi-agency teams do not exist, alcohol treatment services and practitioners should work with homelessness and housing services, and relevant health and social care services, to provide integrated treatment and support.

Models for providing integrated care can include:

- direct and rapid links between alcohol treatment services and local housing, street outreach and rough sleeping services
- practitioners from homelessness services providing regular sessions in alcohol treatment services, for advice and referral (known as in-reach)
- practitioners from alcohol treatment services providing regular sessions for street outreach teams, rough sleeping services and temporary accommodation
- peer- support and lived experience recovery organisations being involved in the design and delivery of the service
- a regular multi-agency forum that assesses, co-ordinates, plans and reviews support for vulnerable people experiencing multiple disadvantage, in an integrated way (see section 9.7 in chapter 9 on assertive outreach and a multi-agency team around the person for more guidance on multi-agency forums)
- a multidisciplinary, multi-agency team formed around one individual to assess, co-ordinate, plan and review support for a person experiencing multiple disadvantage in an integrated way (see chapter 4 for more guidance on assessment and treatment and recovery planning)
- alcohol treatment services, mental health services and services for people experiencing homelessness operating on the principle of ‘no wrong door’ for people with co-occurring problem alcohol use and mental health conditions, so they can access care from any point across any of these services (see section 2.3.4 in chapter 2 on principles of care for more guidance on a ‘no wrong door’ approach)

You can read more about care for people with co-occurring problem alcohol use and mental health conditions in chapter 18 on co-occurring mental health conditions.

‘Making Every Adult Matter’ outlines the benefits of integration. This may include:

- building skills
- exchanging knowledge, experiences and examples of good practice

- leading local innovation and systems change

21.4.4 Individual integrated treatment and support

Alcohol treatment services should make sure their staff know when a person needs to be referred to specialist homelessness support services, including specialist homeless health and social care (where these exist). Services should also have processes in place to make sure referrals are made without delay.

Staff from alcohol treatment services and staff from homelessness services should contribute to multi-agency assessment and person-centred, treatment and recovery planning, using local arrangements. There is guidance on multi-agency treatment and recovery planning in section 4.10.4 in chapter 4.

While it is often important to involve staff from several services in the person's care, careful planning is needed so the person does not feel overwhelmed by contact with several services. There should be a named lead worker who co-ordinates care and is the main person to communicate continuously with the person throughout their treatment and recovery journey.

Staff from alcohol treatment services and staff from homelessness services should give people accessible information about their rights to health and social care services and how to access them.

Staff from alcohol treatment services and homelessness services should be aware that people have the right to register with a GP without a permanent address. Part B, section 4 on 'GP patient registration standard operating principles for primary medical services' of the Primary medical services policy and guidance manual makes this clear for England, and the Health Literacy Place toolkit provides similar information for Scotland.

GP access cards are available in several languages that state that everyone in England, Scotland and Wales has a right to register with a GP without providing proof of address or identification. Staff should give people information on how to register with a GP, provide a GP access card where possible (see resources section below) and support them to register. Peer supporters or other advocates may accompany the person to help them with this process.

You can find guidance and resources for registering with a GP at the end of the chapter.

21.4.5 Training for staff in alcohol treatment services and in services for people experiencing homelessness

Staff in alcohol treatment services need basic training on:

- main support needs of people experiencing homelessness
- information about local pathways and services
- when and how to refer people experiencing homelessness to local services

Staff working in services for people experiencing homelessness need basic training on:

- main support needs of people with problem alcohol use
- how to recognise signs and symptoms that require emergency treatment in hospital including complications in withdrawal, such as seizures, delirium tremens and Wernicke's encephalopathy (WE) (see section 10.4 in chapter 4 on pharmacological interventions for guidance on complications in withdrawal)
- basic alcohol harm reduction advice (see section in chapter 8 on harm reduction)
- information about local pathways and services
- when and how to refer to local services for alcohol treatment

It may be helpful for staff with appropriate expertise from local alcohol treatment services and local services for people experiencing homelessness to provide training for each other.

21.5 Reaching people experiencing homelessness and tailoring treatment to meet their needs

People experiencing homelessness should have access to the full range of evidence-based interventions (described in chapters 1 to 12 of this guidance), based on individual assessed need. This section outlines additional considerations for reaching people experiencing homelessness and tailoring treatment to meet their needs.

21.5.1 Increasing access to alcohol treatment

People experiencing homelessness may not be able to access alcohol treatment services for reasons that relate to past trauma, such as a difficulty in forming trusting relationships. They might also experience barriers that are service-related such as stigmatising services with inflexible opening times or procedures for missed appointments.

Alcohol treatment services and staff need to reduce barriers that prevent people accessing and engaging in treatment.

One way to improve access is to bring the service to people who need it. This can include outreach on the street and in-reach in services for people experiencing homelessness, like day centres, hostels, and other forms of temporary accommodation. Outreach and in-reach both help to remove barriers to engagement. You can find guidance on assertive outreach in chapter 9 on assertive outreach and a multi-agency team around the person.

Other ways that services can improve access include:

- direct access services where people can drop in without an appointment on some days or any day of the week
- flexible opening times and appointments, including broad appointment times, like a whole morning rather than a fixed time
- co-locating alcohol treatment services with homelessness services or relevant health and social care services

- service bases that are close to where people are staying and easy to access by public transport
- providing practical help, for example with transport costs or data for phones.
- giving people the option of referral to the service either by self-referral or by a professional
- having peer support and advocates available when needed
- allowing people to contact the service and have some appointments by phone and online - but also recognising that some people will not have relevant skills or access to the internet or a phone and will need in-person contact
- providing professional interpreters and translation where needed.
- providing accessible information about alcohol treatment taking into account people's literacy, language, sensory disabilities, cognitive disabilities, and neurodiversity
- using a harm reduction approach (see section 21.7 below)

Alcohol treatment services and staff should realise there are many reasons why a person may not be able to provide proof of their identity or their address. If a person says that they live in the area covered by a service, but cannot produce proof, they should not be refused access.

Alcohol treatment services and practitioners in England should be aware of the Department of Health and Social Care Guidance on implementing the overseas visitor charging regulations (section 3 on 'Exempt and out of scope services', relevant case study 1). This explains that community drug and alcohol treatment services (which it calls "first point of contact services") are free of charge to overseas visitors, regardless of immigration status, if the providers consider the services provided are 'equivalent services' to primary medical services (if they do not then the services may be chargeable). This can include people who have a no recourse to public funds status. Services and staff in Scotland, Wales and Northern Ireland should be aware of charging regulations for overseas visitors in alcohol treatment services.

21.5.2 Supporting and maintaining engagement

Building a trusting relationship

Building and maintaining a trusting relationship is vital to help people stay engaged in treatment. Alcohol treatment services and staff should use a compassionate, non-judgmental, and non-stigmatising approach, treating people with dignity and respect. These principles should underpin all alcohol treatment, but they are particularly important for people experiencing homelessness because they are more likely to experience stigma and discrimination.

You can read more about principles of care that should underpin all alcohol treatment in chapter 2.

A longer period of contact is often required when working with people experiencing homelessness. For many people, this includes time to build relationships and remove barriers to engagement before they decide to make changes in their alcohol use.

Trauma-informed practice

Hard Edges: mapping severe and multiple disadvantage in England shows that many people who have experienced homelessness have also experienced significant trauma during their lives and may continue to experience traumatic events while in treatment or while experiencing homelessness.

A trauma-informed approach recognises that trauma can affect a person's ability to feel safe in services, develop trusting relationships with their staff or manage their emotions. Trauma-informed practice seeks to remove the barriers that people affected by trauma can experience when accessing care and services.

You can read about a trauma-informed practice in section 2.2.8 in chapter 2 on principles of care.

A trauma-informed approach includes the way staff communicate with people and support them. It also includes creating service environments that are psychologically informed. Psychologically informed environments are based on an understanding of the psychological needs of people with a history of complex trauma. They are organised to address these needs, and to support people to make changes. Community alcohol treatment services should be psychologically informed, and alcohol treatment staff can also contribute to psychologically informed environments in services where they provide in-reach (such as hostels and day centres).

See resources section below for more on psychologically informed environments.

Addressing diverse needs

Services and practitioners should provide inclusive person-centred care, to address the diverse range of needs of people experiencing homelessness and tailor treatment and support appropriately. For example, needs and risk vary across age, sex, ethnicity, sexual orientation and gender identity. And the issues that have led someone to become homeless also vary.

Proactive engagement approach

Practitioners should proactively try to engage people experiencing homelessness. This can include making repeated attempts to contact them and following up missed appointments in an encouraging way. Practitioners should be flexible in the way they make contact and communicate about appointments and use whatever method the person prefers and has access to, including text, phone, internet, letter and in-person visits.

Flexible delivery of interventions

Commissioners and services need to be flexible in the way they deliver alcohol treatment interventions to meet the needs of people experiencing homelessness.

The following recommendations are based on NICE NG214 and on clinical consensus of the alcohol guidelines development group.

If services have waiting lists for assessment or specific treatment interventions, they should consider giving priority to people experiencing homelessness. This is because their circumstances could mean they are at higher risk of their condition deteriorating and even premature death.

People who have experienced homelessness, especially rough sleeping, may need long term support to help them sustain recovery. Services should consider offering extended periods of treatment and support so the person can form trusting relationships with individual keyworkers. Longer term support can also help the person if their circumstances become stable enough for them to engage with structured alcohol treatment and achieve positive outcomes.

Wherever possible, each person should have one keyworker throughout their treatment to help develop a good therapeutic alliance. Services should consider reducing caseloads for practitioners working with people experiencing homelessness, so they can provide flexible and regular contact over an extended period.

People experiencing homelessness may find it difficult to attend appointments due to their life circumstances. So services should not have policies that require them to discharge people after a particular number of missed appointments.

Services and practitioners should be aware that the transition to independent living can be very stressful. The additional responsibilities may increase their risk of returning to previous behaviours, including problematic alcohol use. So, practitioners should consider increasing the support they offer before, during and after these transitions. End of treatment planning (including recovery check-ups and re-engagement plans) is particularly important for this group of people.

You can read guidance on end of treatment planning in section 4.10.6 in chapter 4 on assessment and treatment and recovery planning.

Assertive outreach is an approach that can be useful when working with people who experience multiple disadvantage, including those experiencing homelessness. There is guidance in chapter 9 on assertive outreach and a multi-agency team around the person.

21.6 Peer support and involving people with lived experience

21.6.1 Involving people in service provision

People with lived and living experience of homelessness can play a valuable role in service provision, by helping to improve the quality of targeted services. So wherever possible, alcohol treatment commissioners and services should include people with lived and living

experience of problem alcohol use and homelessness in all aspects of service provision including:

- needs assessment
- service design
- commissioning processes
- quality governance processes
- service promotion
- service delivery

21.6.2 Peer support

Peer support is a valuable component of treatment for people who are homeless or experiencing rough sleeping. For example, peers can:

- show that change and recovery are possible
- help someone to form good relationships with services and practitioners
- make sure the person attends their appointments
- act as an advocate for the person in different situations
- involve people in recovery-oriented activities organised by peers

People with lived experience of homelessness and problem alcohol use may be particularly welcomed by people experiencing homelessness.

Any peer support should be provided as a component of a personalised treatment and recovery plan and not instead of it. Commissioners of peer support initiatives should make sure that the peers involved have access to training, supervision and support from treatment services.

You can read more on the role of people with lived experience and peer support in chapter 6 on recovery support services and in sections 5.5.3 and 5.5.4 in chapter 5 on psychosocial interventions.

21.7 A harm reduction approach

21.7.1 Taking a harm reduction approach

The alcohol treatment practitioner and the person should consider alcohol use goals as part of the person's holistic treatment and recovery plan. This should be based on a comprehensive multidisciplinary assessment.

A harm reduction approach will often be appropriate for people experiencing homelessness, particularly those experiencing rough sleeping.

You can read guidance on agreeing alcohol use goals, including a harm reduction strategy, in section 4.7 in chapter 4 on assessment and treatment and recovery planning.

A harm reduction approach aims to reduce immediate and longer-term harms, risks and health inequalities that the person is experiencing. It involves actions to address a person's physical health, mental health and social care needs, including housing needs. The person may not be ready to reduce their alcohol use initially, but meeting these needs is a positive outcome. This can encourage the person and increase their motivation to engage in alcohol treatment at a later stage.

Service provision targeted at practical needs such as putting on breakfast clubs and serving hot food and drinks may help to reduce harm by providing nutrition, reducing isolation and beginning to build relationships.

People experiencing homelessness often have poor nutrition and may be at higher risk of WE due to a deficiency in thiamine. WE can lead to both short and long term brain damage. Advice and support for nutrition is an important harm reduction intervention. Alcohol treatment clinicians should follow the guidance on identifying risk of WE and administering oral or parenteral (intramuscular or intravenous) thiamine (see section 10.4.3 in chapter 10 on pharmacological interventions).

You should read chapter 8 on harm reduction which provides guidance on several harm reduction interventions appropriate for people experiencing homelessness, including rough sleeping.

21.7.2 Making changes in alcohol use

A focus on reducing harms may be the most useful way to work with a particular person experiencing homelessness. But practitioners should never assume that the person is incapable of making significant reductions in their alcohol use or achieving abstinence. Practitioners and the person should regularly review the person's goals with this in mind and adjust the goals as appropriate.

Where the person continues to drink harmfully or dependently, the service should regularly review their health or arrange for this to take place and take action to address any deterioration.

21.8 Access to medically assisted withdrawal and residential treatment

21.8.1 Medically assisted withdrawal

For people experiencing homelessness with alcohol dependence and who want to stop drinking, services should consider offering inpatient medically assisted withdrawal, including for people who are not severely alcohol dependent. People experiencing homelessness are likely to have several physical or mental healthcare needs and will require a safe, stable setting for medically assisted withdrawal where their health can be monitored.

For more information on the criteria for referring people for specialist inpatient medically assisted withdrawal, see section 12.4 in chapter 12.

The person, the alcohol practitioner and relevant members of the multidisciplinary team should jointly assess whether this treatment option would meet the person's needs. And if it would, the practitioners should make sure the person has adequate support before, during and after each stage of the treatment and recovery journey. This is important because transitions to and from inpatient or residential treatment can be very stressful times.

Staff in the specialist inpatient medically assisted withdrawal unit should make every attempt to build a rapport with the person early in their stay to help them engage. It will also be helpful if the community alcohol treatment practitioner (or trusted keyworker from another service, where appropriate) continues contact with the person throughout their time in inpatient or residential treatment.

21.8.2 Residential treatment and housing

There should be an agreed multidisciplinary plan so that the person has adequate support immediately after the medically assisted withdrawal and in the longer term. They will need ongoing support and treatment, such as a residential treatment or an intensive structured day programme, after medically assisted withdrawal. This is because they will be at risk of returning to problematic drinking and its associated risks to physical and mental health and potential threats to safety. So, the plan should include arrangements for ongoing treatment after medically assisted withdrawal and suitable accommodation when they leave treatment (either by completing it or dropping out).

Ongoing arrangements should include support for their physical health, mental health and social care needs alongside accommodation. There should also be support for building recovery resources such as supportive family and social networks, peer support, education volunteering, training and employment support. The housing and support offered should be based on their individual assessed recovery, health and social care needs. The identified keyworker should make sure care is co-ordinated and relevant information shared between all the services working with the person.

It is important that alcohol treatment services and their staff are aware of the different housing support options available to people in their local area, including any options tailored to the needs of people with problem alcohol use and those in recovery. Some local areas across the UK commission the 'Housing First' model (see resource section below) which provides housing and open-ended support tailored to the needs of people experiencing multiple disadvantage, including problem alcohol use. The person is offered personalised support, but the offer of housing is not dependent on their involvement in treatment and support.

Alcohol treatment services need good links with services that provide specialist homelessness and housing support and advice, so that the person benefits from appropriate specialist advice and support.

21.8.3 End of life care

People experiencing homelessness die 30 years earlier on average than the general population. Some people may require end of life care. Practitioners (in alcohol treatment

and homelessness services) working with people experiencing homelessness should be trained and supported to recognise signs of deteriorating health. Health services should provide end of life care and practitioners should also contribute to a multi-agency personalised end of life care plan, to provide appropriate and respectful care.

21.9 Safeguarding

Homelessness, and particularly rough sleeping, is associated with increased safeguarding risks. People experiencing homelessness are more likely to be a vulnerable adult at risk of abuse or neglect, including self-neglect. They may also be a safeguarding risk to others, including vulnerable adults or children. Alcohol treatment and homelessness commissioners and services should be aware of findings of adult safeguarding reviews relating to people with problem alcohol use experiencing homelessness and recommendations for practice (see resources section below).

Commissioners and services should support alcohol treatment practitioners to understand and apply laws and related statutory guidance that are relevant to people experiencing homelessness. Support from commissioners and services should include training for practitioners so that they can recognise signs of abuse and neglect (including self-neglect) and know how to make adult safeguarding and child safeguarding referrals. Practitioners should also know how to assess mental capacity to make a specific decision or should be aware of the organisational procedure for assessing mental capacity where there is a proper reason to believe that a person may lack capacity to make the decision in question. There should also be clear organisational procedures for practitioners to access support and supervision for safeguarding concerns.

Practitioners must make safeguarding referrals in line with legislation, statutory guidance and organisational procedures.

You can find information on adult safeguarding legislation and statutory guidance in annex 1.

21.10 Resources

The Revolving Doors report Evaluation of the impact of psychologically informed environments describes what psychologically informed environments are and evaluates the impact on staff and on services of introducing training on the topic. The evaluation took place in several services for vulnerable people with multiple needs.

The Homeless palliative care toolkit provides information and resources for frontline staff supporting people who are homeless and who have significant health needs.

The Local Government Association has published reports that provide good practice recommendations based on an analysis of adult safeguarding reviews and homelessness. They are:

- Second national analysis of Safeguarding Adult Reviews: April 2019 to March 2023
- Adult safeguarding and homelessness: a briefing on positive practice

- Adult safeguarding and homelessness: experience informed practice, which includes input from people with lived experience

The Doctors of the World GP access cards for England, Scotland and Wales provide information on the right to access a GP that people can show to GP surgeries. Practitioners can print them and use them to provide information to people experiencing homelessness and people with concerns about their immigration status. They should encourage people to use them and follow up on whether they were able to register.

For Northern Ireland, the Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015 covers GP access and information on charges for healthcare for people not ordinarily resident.

Housing First is a housing and support approach that:

- gives people who have experienced homelessness and long-term health and social care needs a stable home from which to rebuild their lives
- provides intensive, person-centred, holistic support which is open-ended
- places no conditions on individuals but they should want to have a tenancy

You can find more information about Housing First on the Homeless Link website or the Scottish Government's Housing First: monitoring reports

The Changing Futures programme is an initiative between the UK government and The National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage, including homelessness, drug and alcohol problems, mental ill health, domestic abuse and contact with the criminal justice system.

22. People experiencing or perpetrating domestic abuse

How to identify, assess and respond to domestic abuse among both victims and perpetrators in alcohol treatment services. It covers safety planning, staff training, multi-agency approaches and appropriate referral pathways and working with specialist domestic abuse services.

22.1 Main points

There is a high proportion of both victims and perpetrators of domestic abuse in the alcohol treatment population, compared to the general population.

Problem alcohol use alone does not directly cause domestic abuse, but it may increase the risk of domestic abuse occurring and increase the risk of more serious harm resulting from domestic abuse.

Alcohol treatment services should have domestic abuse policies and procedures that they regularly review.

Alcohol treatment services should be aligned with the multi-agency approach to domestic abuse and have pathways and working arrangements with specialist domestic abuse services.

Alcohol treatment services should make sure staff are trained to:

- ask about domestic abuse in a safe, trauma-informed and appropriate way
- respond to disclosure (by a victim or perpetrator) in an empathic way which prioritises the safety of the victim
- identify and assess immediate risks to safety
- refer to specialist domestic abuse services, and where appropriate sexual assault and abuse services and child safeguarding services
- contribute to a multi-agency approach to working with people experiencing or perpetrating domestic abuse

Alcohol treatment services should promote an environment that encourages disclosure of domestic abuse and helps victims, children and perpetrators to access appropriate support.

Asking about and responding to domestic abuse should be a routine part of the role of alcohol treatment staff.

Alcohol treatment staff should offer referral to specialist domestic abuse services for victims and for perpetrators, intervening at an early stage where possible. They should work with specialist domestic abuse services to reduce immediate risk and offer longer risk management and support.

When working with a perpetrator of domestic abuse, the safety of adult victims and children is the priority. Alcohol treatment staff also need to identify and respond to the needs of the person perpetrating the abuse.

Domestic abuse puts children at risk of significant harm, including where they see, hear or experience the effects of domestic abuse in their household. Practitioners must act in line with national child safeguarding legislation and organisational procedures. In England and Wales, the Domestic Abuse Act 2021 recognises affected children as victims of domestic abuse in their own right.

Where both partners in an abusive relationship have an alcohol problem (including where the partnership no longer exists), services should make arrangements so that the victim does not attend the same service as the perpetrator. If this is not possible, victims and perpetrators should be seen at different sites and confidentiality boundaries should be very carefully maintained.

The person (victim or perpetrator) and their family are likely to need help from several services. Alcohol treatment staff and domestic abuse staff should work together and with other relevant services so there is an integrated multi-agency approach to their care and support.

Alcohol treatment services should be part of local strategic multi-agency partnerships to reduce domestic abuse and follow protocols for multi-agency bodies that manage high risks for victims or perpetrators of domestic abuse, such as:

- multi-agency risk assessment conference (MARAC)
- multi-agency public protection arrangements (MAPPA)
- violence against women and girls strategic partnerships
- adult and child safeguarding referrals, assessments and conferences

22.2 Introduction

This chapter provides guidance on identifying and responding to domestic abuse in alcohol treatment services. This includes victims and perpetrators of domestic abuse and their children.

Addressing domestic abuse requires a co-ordinated multi-agency response and, alcohol treatment services should be part of this multi-agency response.

22.2.1 Definition of domestic abuse

England, Wales, Scotland and Northern Ireland each have national legislation that defines domestic abuse. The legislation is:

- England and Wales: Domestic Abuse Act 2021
- Wales: Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Northern Ireland: Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021
- Scotland: Domestic Abuse (Scotland) Act 2018

You can find more details in annex 1 on relevant legislation and guidance.

Alcohol treatment services should be aware of the definition in their relevant national legislation and associated guidance.

The term domestic abuse includes abuse between intimate partners or ex-partners, as well as abuse between adult family members. For example, sons or daughters abusing their parents. Other forms of abuse carried out by or at the request of family members include honour-based abuse (including forced marriage and female genital mutilation). Young people under 18 may also use abusive behaviour in their own intimate relationships or towards their parents.

Children may experience domestic abuse directly. Seeing, hearing of experiencing the effects of domestic abuse also puts children at risk of significant harm. National safeguarding legislation and related guidance in all 4 UK nations takes account of the harmful effects of domestic abuse for children. Practitioners must follow national child safeguarding legislation and guidance and organisational procedures.

Through the Domestic Abuse Act 2021, children and young people in England and Wales are recognised as victims of domestic abuse in their own right. This includes children who have seen, heard, or experienced the effects of domestic abuse, and are related to either the victim of the abusive behaviour, or the perpetrator.

The terms victim and survivor are used interchangeably in the research literature. In this chapter, we largely use the term victim, but many people go on to become survivors of domestic abuse.

22.2.2 Prevalence of domestic abuse victimisation

Women, men and non-binary people can be victims of abuse and violence in heterosexual and LGBTQ+ relationships.

Research suggests that around 1 in 20 women have experienced extensive physical and sexual violence during their life, compared with 1 in 100 men (Scott and McManus, 2016). Of these women:

- more than half have a common mental health problem
- 1 in 5 have experienced homelessness
- around a third have an alcohol problem

The Office for National Statistics report Domestic abuse in England and Wales overview using data from the Crime Survey for England and Wales, estimated that 2.3 million people aged 16 years and over (1.6 million women and 712,000 men) experienced domestic abuse in the year to March 2024.

Between 2019 and 2020, about 1 in 15 child

ren under the age of 17 lived in households where a parent is a victim of domestic abuse (Home Office, 2022).

22.3 Domestic abuse and alcohol

22.3.1 Alcohol as a risk factor for domestic abuse

The World Health Organization (WHO) guidance Preventing intimate partner and sexual violence against women: taking action and generating evidence identified alcohol as one of 50 risk factors that increase a person's likelihood of being a victim or a perpetrator of domestic abuse.

WHO suggests that problem alcohol use alone does not directly cause domestic abuse, but it may increase the risk of domestic abuse occurring and increase the risk of more serious harm resulting from domestic abuse. Domestic abuse is also more likely and more severe when both the perpetrator and victim have been drinking.

The Home Office report Analysis of domestic homicide reviews: October 2022 to September 2023 found that where vulnerabilities were recorded, problem alcohol use was a vulnerability for 24% of victims and for 26% of perpetrators. Other vulnerabilities for both victims and perpetrators include illicit drug use and mental health conditions.

Alcohol Change UK's Rapid evidence review: alcohol's contribution to violence in intimate partner relationships found:

- a strong association between alcohol use and intimate partner violence (IPV) perpetration and victimisation in heterosexual relationships
- women appear to be at a higher risk of having physical IPV perpetrated against them by a male partner who has been drinking than the other way around
- alcohol-related IPV occurring in lesbian, gay, bisexual or transgender relationships is understudied

One study found that around 60% of men in alcohol or drug treatment were violent to their intimate partners in the preceding year (O'Farrell and others, 2004).

22.3.2 Alcohol and abusive relationships

There are several ways in which alcohol can be involved in abusive relationships.

Victims of domestic may use alcohol as an attempt to self-medicate by drinking to relieve the symptoms of trauma resulting from the abuse. They may then develop problem alcohol use or pre-existing problem alcohol use may get worse.

Victims of domestic abuse are likely to be more vulnerable to abuse when they are intoxicated as they may not react as quickly as they would do when not intoxicated.

People who perpetrate domestic abuse can try to exploit a victim's problem alcohol (or drug) use. For example, they can try to sustain a victim's dependence or threaten to expose this to health and care professionals, family members or communities. This can be particularly threatening to victims with children, or those from cultural backgrounds where drinking alcohol is not considered acceptable.

Perpetrators may deny responsibility for their abuse and (wrongly) blame the victim for the abusive behaviour, citing the victim's problem alcohol use as the reason for their abusive behaviour. They may say that the person's (usually the woman's) problem alcohol use justifies abusive behaviour.

Where people who perpetrate domestic abuse have an alcohol problem, they may cite intoxication or a hangover as an excuse or to justify their abusive behaviour.

When there has been an incident where both partners have been violent to one another and alcohol is involved, responders can find it hard to understand who the victim is in the relationship, particularly where the life circumstances of both partners are challenging and disorganised.

It is helpful for staff in alcohol treatment services and domestic abuse services to be aware that these elements sometimes exist in abusive relationships where problem alcohol use is involved. Staff should be clear that while alcohol may be one risk factor, neither the alcohol use of the victim or the alcohol use of the perpetrator can justify or explain domestic abuse.

22.4 Working with victims of domestic abuse

22.4.1 Overview

This section summarises guidance, best practice principles and recommendations on addressing domestic abuse that is relevant to alcohol treatment and recovery services. They have been drawn from a range of guidance developed by national domestic abuse and substance use specialists, including:

- National Institute for Health and Care Excellence (NICE) public health guideline Domestic violence and abuse: multi-agency working (PH50)
- NICE quality standard Domestic violence and abuse (QS116)
- Statutory guidance for the Domestic Abuse Act 2021 (England and Wales)
- Alcohol Concern and AVA's Domestic abuse and change resistant drinkers: preventing and reducing harm (PDF, 770KB)

Given the prevalence of both victims and perpetrators of domestic abuse in alcohol treatment, treatment services and their staff have a vital role to play in:

- identifying victims and their children
- intervening at an early stage where possible
- helping victims and their children to access specialist support
- contributing to a multi-agency response

Alcohol treatment services and their staff also have an important role to play in:

- identifying perpetrators of domestic abuse
- identifying and responding to safety needs of their victims and children

- helping perpetrators to access specialist support

22.4.2 Domestic abuse policies and procedures in alcohol treatment services

Alcohol treatment services should have domestic abuse policies and procedures that they regularly review. These should include:

- lines of accountability for managing risks to adult victims and child safeguarding risks
- requirements and arrangements for staff training and supervision for work involving domestic abuse
- clinical processes for:
    - assessing immediate risk
    - escalating the risk internally
    - making referrals to domestic abuse services and other relevant services including child safeguarding services
    - collaborative safety planning
- involvement with local strategic approaches to domestic abuse and membership of multi-agency forums to address risk
- information-sharing arrangements and protocols
- supporting staff who have been affected by domestic abuse

22.4.3 Staff training

Working with domestic abuse is complex and sensitive, often linked to high risks to safety. Commissioners and services should make sure staff are trained to ask about and respond to domestic abuse in a way that prioritises the safety of adult victims and affected children. It is essential that staff receive appropriate training so they can safely ask about domestic abuse and respond appropriately.

Practitioners should be trained in both level 1 and level 2 on domestic abuse, as described in NICE PH50 and outlined below.

Level 1 is training to respond to a disclosure of domestic abuse (as a victim or a perpetrator) sensitively and in a way that ensures people's safety. Practitioners trained to level 1 should also be able to direct people to specialist domestic abuse services and help them to access these.

Level 2 is training to ask about domestic abuse (both as a victim and a perpetrator) in a way that makes it easier for people to disclose it. This includes:

- risk factors for domestic abuse
- understanding which groups of people are more likely to experience higher levels of domestic abuse

- how it affects people's lives
- their role and the role of other professionals in intervening safely
- responding with empathy and understanding
- assessing someone's immediate safety to help prevent further incidents
- referring to specialist domestic abuse services and other relevant services

Training should include an understanding of honour-based abuse (including forced marriage and female genital mutilation) and an understanding of equality and diversity issues.

Training should be provided by qualified trainers, use accredited materials where possible and include face-to-face contact, as well as online content. Training should be ongoing, and staff should have supervision and support for their work with domestic abuse.

It can be helpful if services appoint a named domestic abuse lead, with appropriate training and competence, to promote good practice and provide support and supervision to staff. In some services the safeguarding lead also leads on domestic abuse.

Services should regularly update staff on:

- local policy
- protocols for identifying and assessing risk
- information-sharing
- pathways to and from specialist domestic abuse services

22.4.4 Pathways with domestic abuse services

Increasing safety for victims of domestic abuse needs a multi-agency approach at a strategic and a service delivery level.

Commissioners and services should be aligned with the strategic multi-agency approach to domestic abuse in their local area. They should also agree pathways and working arrangements between alcohol treatment services and specialist domestic abuse services and with sexual assault and abuse services where domestic abuse has involved sexual assault or abuse. They should make sure that frontline practitioners from these services:

- are aware of the pathways
- know how to make referrals and support people to access appropriate services
- know and can explain what each service offers

Services and staff should be aware of and refer people to domestic abuse services or professionals for specialist needs where appropriate. For example, there may be specific pathways for:

- young people aged 17 years and under experiencing or perpetrating domestic abuse

- older people
- people from specific minority ethnic groups
- refugees and asylum seekers
- people with disabilities
- LGBTQ+ people
- male victims

See the resources section for GOV.UK links to specialist domestic abuse support including helplines.

Alcohol treatment services should be part of a muti-agency approach to supporting people experiencing or recovering from domestic abuse. They should work with the adult victim, domestic abuse services and other relevant services such as:

- sexual assault and abuse services
- child safeguarding services
- physical health services
- mental health services
- substance use services
- social care services
- housing support services

In some areas, alcohol treatment services and domestic abuse services provide regular in-reach sessions in each other's services to reduce barriers and support partnership working. People can then access support for domestic abuse or for problem alcohol use in whichever service they feel most comfortable.

Services should regularly update staff about pathways and working arrangements with domestic abuse services.

22.4.5 Information-sharing arrangements

Services should have information-sharing arrangements with all other agencies working with people experiencing domestic abuse. Confidentiality is important for everyone that comes to alcohol treatment services, but it is particularly vital for people experiencing domestic abuse. This is because any information that gets to a perpetrator can put the victim at increased risk of abuse. Some perpetrators of domestic abuse can be persistent in seeking out information about victims and their movements.

Alcohol treatment services should develop or adapt information-sharing agreements about people at risk of, experiencing and perpetrating domestic abuse within their service and between services. The information-sharing agreements should specify:

- the duty of confidentiality
- what information should and can be shared and with whom
- circumstances in which information can be shared without consent
- technical information-sharing systems, which must be secure

It is always best to have consent to share information, but information can be shared without consent for child safeguarding and if an adult is at serious risk. A practitioner should involve the accountable professional in the service or organisation (for example, domestic abuse lead or safeguarding lead) if they are making a decision about sharing information without consent.

Services should be aware of and comply with information-sharing protocols of local multi-agency risk assessment forums.

Services should make sure their staff are aware of the information-sharing arrangements and protocols and regularly review them with staff.

22.4.6 Promoting an environment that encourages disclosure

Alcohol treatment services should clearly display information in waiting areas and other suitable places about the support they offer for people affected by domestic abuse and about specialist domestic abuse services. They should also display the information in places that people can read it in private, like toilets. Information should include contact details of relevant local and national helplines. Services should display information in local community languages, in accessible formats and in simple language.

It is essential that any question or discussion about domestic abuse takes place in a private setting. Services should make sure these private spaces are available.

A perpetrator and victim should not be seen in the same service because this could put the victim at risk. If there is only one local service, the victim and perpetrator should be seen at different sites and great care should be taken to preserve confidentiality about the victim's attendance.

Domestic abuse is traumatic, and victims of domestic abuse may have multiple experiences of trauma. So, it's important that services and practitioners use a trauma-informed approach. You can read more about a trauma-informed approach in section 2.2.8 in chapter 2 on principles of care.

Offering a choice of either a male or female practitioner may help the person to feel safe enough to discuss their situation.

22.4.7 Alcohol treatment practitioners asking about and responding to domestic abuse

Alcohol treatment practitioners should ask about and respond to domestic abuse as a routine part of their work and require training to do this. Trained practitioners should know how to ask and respond sensitively and in a way that prioritises people's safety.

Services should make sure that questions about domestic abuse are routinely part of assessment, whether or not there are potential indicators of domestic abuse.

There is guidance on assessing domestic abuse in section 4.9.15 in chapter 4 on assessment and treatment and recovery planning.

A victim is unlikely to disclose abuse and can be put at greater risk if they are asked about their experience in the presence of the perpetrator or in some cases, other family members or members of their social network.

If a service is using interpreters, these should be independent from the person's family and social network so that victims can speak confidentially and avoid potential risks from family members.

The practitioner should:

- explain the service's duty of confidentiality
- reassure people that their attendance at the service and their treatment and support will never be discussed with the perpetrator
- explain the circumstances when information can be shared without consent

Victims of abuse may find it hard to disclose because they are afraid of the perpetrator finding out, being judged, or intervention from local children's services. They may also (wrongly) believe the abuse is their own fault or they may not recognise the perpetrator's behaviour as abusive. However, they may appreciate the chance to disclose. When alcohol treatment practitioners use a sensitive, empathic, trauma-informed approach and make efforts to build a trusting relationship, a victim is more likely to disclose their experience and consider accessing specialist support.

People often do not disclose abuse when they first contact services. So, if practitioners see indications that the person might be experiencing domestic abuse, they should ask them about it again as they build a relationship and review treatment and recovery plans. For example, a person may refer to their partner not allowing them to do something or appear fearful.

22.4.8 Helpful questions

Alcohol treatment practitioners need to be sensitive in the way they ask questions.

They can start with broad, generic questions, such as:

- how are things at home?
- how are things with your partner?
- how are you feeling?
- how are you managing at the moment?

Then, where appropriate, they can follow up with more direct questions that use non-judgemental language, for example:

- how do you and your partner work out arguments?
- do arguments ever result in you feeling put down or bad about yourself?
- do arguments ever result in hitting, kicking or pushing?
- has anyone ever made you feel frightened or scared at home?
- do you ever feel controlled by your partner?

You can also communicate that other people have similar experiences and explain why you are asking these questions and they are not alone.

If the person has an injury, rather than asking how it happened, they can ask “who hurt you?”.

Active listening helps establish rapport and build trust. It helps the person to disclose their feelings and helps to gather information. The practitioner could ask more questions to clarify the extent of abuse disclosed and to identify the level of risk that exists, such as:

- do you feel safe right now?
- do you feel safe leaving this appointment, or going home?
- what do you fear might happen in future? (to find out about what types of abuse could happen to them)
- what threats has the perpetrator made to you or your children?

22.4.9 Responding to a disclosure of domestic abuse or concern the person is at risk

Indications of domestic abuse

Alcohol treatment practitioners should be trained to recognise potential indicators of domestic abuse and to respond appropriately to a disclosure. If they have any concern that the person may be experiencing abuse, they should ask the person about it. They should ‘make every contact count’ and not delay asking about it until a later appointment, as the person could be in immediate danger or they might not return to the service. They should ask questions sensitively and in a completely private setting.

Referring to specialist domestic abuse services

When a victim discloses current or past experience of domestic abuse, practitioners should:

- respond with empathy and understanding
- identify whether the person and any children are likely to be at immediate risk
- complete the service risk assessment process for domestic abuse in a sensitive way

- offer referral to specialist domestic abuse services for managing immediate risks and for longer term specialist support
- discuss the situation, including the risk assessment and what to do next, with their manager and the accountable person in the organisation (for example, the domestic abuse lead, the safeguarding lead

Specialist support services can help to address the emotional, psychological, physical and sexual harms arising from domestic violence and abuse. They can offer advice, help to develop plans for the future and increase the safety of those affected.

People may be anxious about contacting domestic abuse services, so practitioners should offer to make the initial referral or support the person to make contact. The practitioner should be familiar with local domestic abuse services, so they can explain what they offer and how they can help the victim.

Risk assessment

Alcohol treatment staff should be trained to make an initial assessment of any immediate safety risks. Risk assessments and risk management (safety) plans should adequately reflect the seriousness of:

- the risk associated with problem alcohol use and domestic abuse
- other risk factors, such as a person's mental health
- the fact that risks can change rapidly

Alcohol treatment staff who are trained to do so can use tools to help identify the current level of risk to a person from domestic abuse. Services should train any staff who are expected to carry out an assessment of risk from domestic abuse and on the use of appropriate tools.

An example of a tool used in risk assessment is the SafeLives Dash (domestic abuse, stalking and honour-based abuse) risk checklist, which has versions adapted for use in each UK nation. The checklists are not definitive assessments of risk but help identify and assess risk based on structured professional judgment.

Professionals using checklists, or other risk assessment tools, should be alert to the risk to children as well as adults. It is essential to identify changes, such as escalation in severity and frequency of abuse. Statutory guidance for the Domestic Abuse Act 2021 highlights that:

risk assessments should holistically encompass specialist professional judgement, survivor perceptions of risk, along with additional indicators relevant to minority groups.

In England and Wales, there is a mandatory duty to report female genital mutilation. In addition to safeguarding legislation, the Scottish Government and Northern Ireland Assembly have published national multi-agency guidance on responding to female genital mutilation in their respective nations (see annex 1 on legislation and statutory guidance).

Current risk

If a victim and any children are currently at risk, their safety is the priority. Specialist domestic abuse services can intervene to help the person to create a safety plan, provide specialist advice and access to support. Services for victims at current risk include:

- local and national helplines
- safety planning
- advocacy
- access to refuges
- access to legal advice
- counselling
- MARAC for people at high risk

People at high risk will need a multi-agency response to reduce risk and to address health and care needs. In England and Wales, services should refer them to the local MARAC. In Scotland and Northern Ireland, they should refer people to equivalent multi-agency risk management structures.

A MARAC is a regular meeting where information is shared to provide a fuller picture of risk to adult and child victims, between representatives of:

- independent domestic violence advocate services
- housing services
- children's services
- the Probation Service
- primary care
- mental health
- alcohol and drug treatment services
- adult social care

Alcohol treatment services should follow local protocols for making referrals to MARAC or equivalent multi-agency structure. In some parts of the UK, services use the Dash risk checklist as a referral to MARAC.

After information-sharing, the MARAC agrees co-ordinated actions to reduce risk. Member organisations share information in between meetings to monitor risk and improve safety, observing the information-sharing protocol.

Alcohol treatment services should be members of their local MARAC and related multi-agency panels, for example MAPPA. These take a multi-agency approach to monitoring and managing people who pose a risk to others, including domestic abuse perpetrators.

No consent for referral to domestic abuse services

If the person does not agree to access specialist domestic abuse services or give consent to share information, the practitioner should inform their manager and the accountable professional (such as the domestic abuse lead and safeguarding lead) and discuss next steps.

It is always best if a person consents to their information being shared but in some cases, the practitioner or accountable person will need to share information without the person's consent. This includes situations where children are at risk, or an adult is at serious risk of harm.

The practitioner must follow:

- child and adult safeguarding legislation and organisational procedures
- organisational risk management procedures and information-sharing protocols
- multi-agency domestic abuse risk management procedures

They should inform the victim they will be sharing information and explain their reasons unless doing so would put children at further risk.

Ongoing support

Domestic abuse affects many aspects of a person's life. If the adult victims and their children are not currently at risk of harm but they have been affected by domestic abuse, specialist domestic abuse services can intervene to provide legal, emotional and social and housing support.

Services include:

- floating support and outreach
- legal advice and advocacy
- housing support
- support groups
- skills training
- access to talking therapies for adults and children and young people

22.5 Children and young people

22.5.1 Children experiencing or affected by domestic abuse experienced by a relative

Children may experience domestic abuse directly. Seeing, hearing or experiencing the effects of domestic abuse also puts children at risk of significant harm and are grounds for a child safeguarding referral. National safeguarding legislation and related guidance in all 4 UK nations takes account of the harmful effects of domestic abuse for children. Practitioners must follow national child safeguarding legislation and guidance and organisational procedures.

Through the Domestic Abuse Act 2021, children and young people in England and Wales are recognised as victims of domestic abuse in their own right. This includes children who have seen, heard or experienced the effects of domestic abuse, and are related to either the victim of the abusive behaviour or the perpetrator. This important recognition helps ensure locally commissioned services continue to carefully consider and address the needs of children.

Where one or both parents have problem alcohol use, children and young people will be affected and may be at risk of significant harm from both alcohol related behaviours and domestic abuse, compounding the harms they experience.

22.5.2 Young people experiencing or perpetrating domestic abuse in their own relationships

Young people experiencing or perpetrating abuse in their own relationships need to be supported in a way that is tailored to their needs, although they may often have to rely on specialist services designed for adult victims that are not always appropriate. It is vital that young people who experience domestic abuse in their own relationships are referred through a multi-agency risk assessment.

In responding to cases of abuse involving young people aged 17 and under, child safeguarding procedures should be followed as set out in national legislation and statutory guidance. Professionals should be mindful that young people may be reluctant to discuss relationships or their concerns around abuse with adults. Also, it may be particularly difficult for young people to deal with certain practical challenges, such as moving home to escape the abuse or managing their own finances.

Staff in young people's alcohol treatment services should be equipped to identify and respond to children and young people experiencing domestic abuse, drawing on the range of support available, including specialist domestic abuse professionals, from early intervention to crisis stage. Best practice responses involve an integrated response that combines child safeguarding and high-risk domestic abuse expertise, particularly in relation to risk assessment and safety planning.

22.5.3 Young people using abusive behaviour towards a parent

Statutory guidance for the Domestic Abuse Act 2021 (England and Wales) says:

It is important that a young person using abusive behaviour towards a parent or family member receives a safeguarding response, which should include referral to a Multi-Agency Safeguarding Hub or local equivalent in the first instance where a parent advocate may attend, followed by referral to MARAC if necessary, regardless of whether any police action is taken.

22.6 An integrated multi-agency approach

People experiencing or affected by domestic abuse often experience multiple disadvantage, including:

- alcohol and drug use
- mental health conditions
- physical health conditions or disability
- trauma
- homelessness or inadequate housing
- poverty
- contact with the criminal justice system

Several of these factors can increase vulnerability to domestic abuse.

People at risk of or affected by domestic abuse will not all meet the high risk threshold for MARAC (or the threshold set by an equivalent multi-agency structure) but they still need a multi-agency approach. Practitioners should work with multiple agencies including:

- domestic abuse services
- children's services
- adult social care
- the police
- probation
- healthcare
- mental health services
- housing and homelessness services

Services need flexible engagement approaches to make it easier for women and those with severe disadvantage to access the service. They also need to reach out to groups who might not usually approach services, including women from ethnic minority groups and other people with protected characteristics. There is guidance on developing inclusive services in chapter 25. There is information on specialist domestic abuse support in the resources section below.

Women coming to alcohol treatment who have experienced domestic abuse are likely to benefit from access to women-specific, trauma-informed services. Mixed gender alcohol services can feel intimidating and uncomfortable and can re-traumatise some women. Holding women's groups or sessions in an area where male clients cannot enter, see into or potentially harass women leaving, can help to create emotional safety for women.

While most victims of domestic abuse are women, a significant number of men and people who identify as non-binary also experience domestic abuse. Domestic abuse occurs in heterosexual relationships and in LGBTQ+ relationships. Services need to consider a person's

needs for physical and emotional safety and agree with the person how the service can best support them to feel safe and supported while they are in treatment.

22.7 Working with perpetrators of domestic abuse

22.7.1 General principles

Similar principles apply to services and staff working with perpetrators of domestic abuse as those set out in this chapter for working with victims of domestic abuse. This includes practitioners sensitively and non-judgementally asking about current and historic domestic abuse as part of standard practice and responding appropriately if a person discloses they have perpetrated domestic abuse. A trauma-informed approach and developing a trusting relationship are important to encourage disclosure and discussion about perpetrating domestic abuse.

Any interventions with the perpetrator must prioritise increasing the safety of the adult victim and affected children.

22.7.2 Acting on a disclosure of domestic abuse (person perpetrating abuse)

After a person discloses they have perpetrated domestic abuse, practitioners should respond non-judgementally, while not condoning the abuse in any way. Practitioners should discuss this as soon as possible with appropriate staff members and follow national legislation and guidance and their organisational domestic abuse procedures. They should discuss any disclosures with:

- their line manager
- the accountable person such as domestic abuse lead or child and adult safeguarding lead
- other relevant staff who need to know

The practitioner, appropriate lead and line manager should then agree on actions to take, prioritising the safety of the adult victim and children.

Practitioners should:

- follow protocols for MARAC, MAPPA and adult and child safeguarding referrals where relevant
- be aware of local resources and be confident about how to use local pathways to specialist domestic abuse services for victims and for perpetrators
- share information with relevant services according to local information sharing protocols and arrangements
- obtain consent to share information wherever possible but be clear with people about how and when they will need to break confidentiality without consent
- continue to support and work positively with the perpetrator and give them hope and optimism that it’s possible to change their behaviour

In England and Wales, there is a mandatory duty to report female genital mutilation. The Home Office and Department for Education has published guidance on the mandatory reporting of female genital mutilation. In addition to safeguarding legislation, Scotland and Northern Ireland have published national multi-agency guidance on responding to female genital mutilation in their respective nations (see annex 1 on legislation and statutory guidance).

People with problem alcohol use who perpetrate domestic abuse are likely to have complex needs, possibly including their own histories of abuse, neglect or mental health problems. This does not reduce responsibility for the abuse but may suggest they need to be referred to support services according to an individual assessment and formulation of their needs.

People should be offered referral to specialist evidence-based services for people who perpetrate domestic abuse. They may be able to access a Respect accredited perpetrator intervention. These interventions aim to keep victims and survivors safe and hold perpetrators accountable, while offering them meaningful opportunities to change. There are interventions for adults and for young people. See resources section 22.7 for more on the work of Respect.

Making changes in problem alcohol use and in abusive behaviour is not a linear process. Alcohol treatment practitioners, perpetrators and victims of domestic abuse should not assume that if the person makes changes in their alcohol use, or begins a perpetrator programme, the risk to victims no longer exists. Specialist staff on the perpetrator programme can advise on this. The safety of the adult victim of domestic abuse and children should continue to be monitored and managed.

22.7.3 A framework for alcohol and drug treatment services to work with perpetrators

There is a lack of evidence about the effectiveness of interventions in alcohol treatment to address domestic abuse perpetration and so these guidelines cannot make detailed recommendations at present.

King's College London has published A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings (PDF, 949KB). The framework is specific to drug and alcohol treatment services and clarifies the capabilities staff need for working with men who use drugs and alcohol and who perpetrate IPV. These capabilities include:

- knowledge
- attitude and values
- ethical practice
- skills and reflection
- professional development

22.8 Resources

Domestic abuse: how to get help

Domestic abuse: how to get help is aimed at people who are experiencing domestic abuse or know someone who is. It provides information on domestic abuse and on sources of support across all 4 UK nations including national helplines. Information translated into several languages is available.

Domestic abuse: specialist sources of support

Domestic abuse: specialist sources of support on the UK government website provides information on specialist sources of support. It includes information:

- about helplines and services for people from different groups with protected characteristics
- about help for children and young people
- about welfare benefits and housing advice
- for people who do not have settled status in the UK
- on specific types of abuse

Women's Aid

The Women's Aid website provides information and support for women who experience domestic abuse, including:

- the survivor's handbook, which provides advice and support for women experiencing domestic abuse
- a directory of domestic abuse support services across the UK

Respect

Respect is the UK charity stopping perpetrators of domestic abuse. It was established to focus on perpetrators of domestic abuse, as well as working with young people who cause harm and providing expert support to male victims of domestic abuse. They do this work by:

- conducting research
- engaging in practice and piloting new interventions
- accrediting services
- influencing policy

22.9 References

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treatment involvement and abstinence. Journal of Consulting and Clinical Psychology 2004: volume 72, issue 2, pages 202 to 217 (registration and subscription required for full article).

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23. Specialist alcohol interventions and support for children and young people

How to provide specialist alcohol interventions and support for children and young people. This includes assessment, care planning, multi-agency co-ordination, working with parents, safeguarding and the transition arrangements needed for young people moving to adult services.

23.1 Main points

Specialist alcohol interventions and the competencies for working effectively with children and young people are different to those for adults.

Children and young people's alcohol use does not happen in isolation. Their problem alcohol use generally exists in a complex interdependence of mental health, social and educational problems and can be associated with experience of abuse, neglect or exploitation.

Practitioners working in services for children and young people aged 17 and under should be trained so they can:

- routinely identify children and young people at risk from alcohol and drug use
- offer brief information and advice where appropriate
- refer children and young people with problem alcohol and drug use to specialist alcohol services for assessment

Specialist alcohol and drug treatment services for children and young people should be child and young people centred, non-stigmatising and easily accessible.

Specialist alcohol treatment services working with children and young people should be fully integrated and aligned with schools and local services for children and young people at risk of poor outcomes. Specialist alcohol interventions and support fit into a wider context of safeguarding children and young people from harm and promoting their wellbeing.

All specialist alcohol and drug treatment services for children and young people must have child safeguarding policies and procedures in place and a child safeguarding lead. They must make sure all staff are trained in child safeguarding and know how to work in line with safeguarding procedures.

The legal framework for getting informed consent to treat children and young people is different to the framework for adults. Staff in specialist alcohol and drug treatment services should have a thorough understanding of capacity, competence and consent issues when working with children and young people aged 17 and under (such as the role of parental consent).

Alcohol and drug treatment practitioners should undertake comprehensive assessment alongside specialists from other involved services and make new referrals to relevant services.

Alcohol and drug treatment practitioners should work with children and young people to develop and review individualised care plans. And they should work in partnership with parents wherever possible.

Care plans for children and young people should address the child or young person's problem alcohol use and their wider needs. This will usually involve working in partnership with other services.

For children with the most complex needs, including mental health problems or child protection concerns, there should be an integrated multi-agency approach across services. This includes having a named lead professional, such as a specialist mental health clinician or a child social worker. Alcohol and drug treatment practitioners should contribute to the multi-agency plan.

If a young person is moving from the children and young people's alcohol and drug treatment service to an adult service, there should be a transitional plan in place well before they are due to move. The plan should set out how the transition will be managed and how the young person's ongoing support needs will be met.

Alcohol and drug treatment practitioners should be able to engage and work effectively with children and young people of different ages.

Keyworkers should offer structured support. Structured support involves using specific psychosocial interventions which are common to evidence-based psychological treatments for alcohol and drug use. These common factors include:

- a strong therapeutic alliance
- structure and goal direction
- interventions to develop alternative rewards and activities to alcohol use
- engagement with supportive family and social networks and peer relationships
- building self-efficacy and coping skills

The evidence shows that age-appropriate cognitive behavioural and multi-component family therapies delivered by practitioners trained in these approaches can help children and young people to reduce alcohol use and related harms.

Although alcohol dependence is rare in children and young people aged 17 and under, medically assisted withdrawal must be available when they are diagnosed with alcohol dependence. There should be an agreed local pathway for age-appropriate inpatient medically assisted withdrawal for children and young people.

Medically assisted withdrawal is only one component of a child or young person's care plan. Specialist staff should deliver the intervention along with relevant psychological therapies and mental health interventions within a clinical governance framework. If a child or young person is alcohol dependent, child safeguarding services should be involved.

Practitioners delivering interventions to children and young people should:

- be trained and have the skills required for the specific intervention they offer
- have access to ongoing supervision from an appropriately qualified professional

23.2 Overview

This chapter provides evidence-based guidance on prevention and specialist alcohol interventions for children and young people aged 17 and under.

The overall proportion of children drinking alcohol has been declining over the last decade. However, of the children and young people that do drink alcohol, a small number drink heavily. Children and young people's alcohol use varies, but more typically involves experimenting or binge drinking. A small number of children and young people experience alcohol dependence.

Children and young people's alcohol use does not happen in isolation. Children and young people's problem alcohol use generally exists within a complex interdependence of mental health, social and educational problems and can be associated with experience of abuse, neglect or exploitation.

Guidance on the consumption of alcohol by children and young people from the chief medical officer for England in 2009 recommended that an alcohol-free childhood is the healthiest and best option. However, if children drink alcohol, it should not be until at least the age of 15 years. If 15 to 17 year olds do consume alcohol:

- they should do so infrequently and certainly on no more than one day a week
- they should never exceed recommended adult daily limits
- it should always be with the guidance of a parent or carer or in a supervised environment

Alcohol and drug treatment services for children and young people should ensure the support and specialist alcohol interventions they offer to children and young people aged 17 and under is focused on their needs, is age-appropriate and offered in spaces that are separate from adult treatment.

Some specialist children and young people's alcohol treatment services are commissioned for young adults up to the age of 25 as part of transitional arrangements to adult services.

Children and young people's services that provide support for young adults up to the age of 25 should offer support and interventions appropriate to their age and developmental stage. Thy should also put in place transition arrangements to adult services for young adults who have ongoing support needs.

Adult alcohol treatment services need to provide targeted, age-appropriate interventions and support for young adults between 18 and 25 years old.

Children and young people with problem alcohol use may also have problem drug use. In this chapter we refer at times to drug use but we do not provide guidance on specialist drug

interventions. Guidance on specialist drug interventions can be found in Drug misuse and dependence: UK guidelines on clinical management.

23.3 Vulnerabilities, protective factors, alcohol related risks and harms in children and young people

This section describes:

- vulnerabilities that increase the risk of children and young people developing problem alcohol use
- factors that can protect children and young people from developing risky behaviours including problem alcohol use
- alcohol related risks and harms for children and young people with problem alcohol use

The relationship between vulnerabilities and alcohol related harms can be complex and work in both directions. For example, children and young people might drink problematically to try and manage mental health problems or traumatic experiences. Problem alcohol use can also make mental health problems more severe or leave a child or young person more vulnerable to exploitation.

23.3.1 Vulnerabilities

As young people journey from childhood to adulthood, they go through a period of rapid developmental change. This is associated with a desire to experiment with adult behaviours, and with an increase in impulsive and risky behaviour. Some vulnerable children begin to drink before adolescence. Generally, the earlier children and young people drink, particularly heavily, the greater their risk of developing problem alcohol use and greater harm in later years (Bonomo and others, 2004; DeWit and others, 2000; Kuntsche and Gmel, 2013; Hingson and others, 2006).

Some vulnerabilities increase the likelihood of children and young people using alcohol, drugs or tobacco and developing problems with them.

Vulnerabilities include:

- experiencing abuse, neglect or exploitation
- being in care or a care leaver
- being affected by parent or carer issues including problem alcohol or drug use and mental health
- being affected by domestic abuse
- not being in education, or poor school attendance and engagement
- growing up in poverty or a marginalised community
- having a mental health problem, including an emotional or behavioural disorder

- having particular neurodevelopmental conditions such as attention deficit hyperactivity disorder (ADHD) or fetal alcohol spectrum disorder (FASD)
- having special educational needs
- being part of social norms and environments that encourage alcohol use
- involvement in anti-social behaviour or offending
- early sexual activity

23.3.2 Protective factors

Generally, the more risk factors a child or young person has, the more likely they are to use alcohol (or drugs). However, there is evidence that even when children have several vulnerabilities, there are some factors that can protect them from developing risky behaviours, including problem alcohol use. Keeping children and young people safe involves reducing and managing risks and also strengthening protective factors. Protective factors include strengths and skills that the child or young person has or can develop, as well as support from family, school and community.

The United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) International Standards on Drug Use Prevention (second updated edition) summarises important protective factors that help make young people less vulnerable to alcohol and drug use and other risky behaviours. These include:

- resilient mental and emotional health
- strong attachment to caring and effective parents
- strong attachment to supportive schools and communities
- personal and social competence

Other research (Velleman and Templeton, 2018) identifies additional protective factors including:

- a trusting relationship with a significant caring adult
- the child or young person's own temperament
- engagement with school and community activities
- positive peer relationships
- swift resolution to parents' problems

23.3.3 Alcohol related harms and risks to children and young people

Alcohol intoxication and problem alcohol use can have wide ranging health, social, educational and offending consequences for children and young people.

Physical and mental health alcohol related harms to children and young people

There is evidence that children and young people may be more vulnerable than adults to the negative effects of alcohol, particularly if they have a pattern of binge drinking (McCambridge and others, 2011). Children and young people are particularly vulnerable to alcohol related physical and mental health problems. Children and young people's problem alcohol use is a significant public health concern.

There are differences between boys and girls that affect their risk of binge drinking. There is evidence that girls are more vulnerable than boys to binge drinking in response to stress caused by trauma. Girls are also more likely to have anxiety and depressive disorders. In contrast, among boys it is conduct disorder that is associated with binge drinking (Foster and others, 2014; Kilpatrick and others, 2003).

Alcohol use may be particularly harmful to children and young people's developing brains. Alcohol use is associated with poorer cognitive functioning that can lead to educational and social problems (Toumbourou and Catalano, 2005; Lees and others, 2020).

Alcohol use is also associated with a range of mental health and neurodevelopmental conditions, particularly ADHD and behavioural difficulties in adolescence that leads to them being excluded from schools (Costello and others, 2000). If children and young people do not remain in education, it can affect their future opportunities. It also keeps them away from systems that can protect them from a range of risks and harms they might be experiencing.

Alcohol use is a risk factor for drug taking and is associated with an increased prevalence of smoking. Some children and young people experience problems with alcohol, drugs and smoking.

Alcohol related risks

Drinking alcohol can affect decision making, physical co-ordination, mood and impulse control. Intoxication and problem alcohol use, often combined with other risk factors (see section 23.3.1), can make it more likely that children and young people develop risky behaviours including:

- other substance use (which can increase harmful impact of both alcohol and drugs, including a risk of overdose)
- self-harm, including suicide
- accidents
- alcohol poisoning (which can be fatal)
- violence including domestic abuse
- risky sexual behaviours

Intoxication and problem alcohol use can increase vulnerability of children and young people to exploitation from adults or other young people who seek to harm them. They can be at increased risk of:

- exploitation, including criminal or sexual exploitation or modern slavery
- being a victim of violence, including sexual violence
- domestic abuse in their relationships

There is guidance on domestic abuse in young people's relationships in section 22.5 in chapter 22 on people experiencing or perpetrating domestic abuse.

23.4 Prevention

This section is about prevention, including universal alcohol education and screening and brief intervention. Prevention for children and young people includes interventions aimed at:

- avoiding or delaying the start of alcohol use by children and young people
- children or people who have already started drinking in a risky way, to reduce the risk of this developing into harmful or dependent use

Prevention interventions should be commissioned and be available in every local area.

23.4 .1 Universal alcohol education

All children and young people should be given information and advice about sexual heath, mental health and drugs and alcohol to support their resilience. These issues are inter-related and advice should address them in an integrated way and not as separate issues.

Schools have a role to play in delivering interventions that prevent and reduce alcohol use among children and young people. The National Institute for Health and Care Excellence (NICE) guideline Alcohol interventions in secondary and further education (NG135) recommends that schools should adopt a whole-school approach to alcohol education that includes universal and targeted interventions. As well as classroom-based curriculum activities and pastoral support, NICE encourages schools to provide preventative and educational activities involving parents, carers, families and communities. Schools should also develop strong connections and clear referral pathways with the children and young people's specialist alcohol and drug treatment service for the most vulnerable pupils who need assessment and further support.

Specialist alcohol and drug treatment services do not need to be involved in planning or providing classroom-based alcohol education. But they may have a role in training school staff and should develop referral pathways with their local schools. They could also offer targeted interventions for groups or individual children and young people who may be at increased risk of developing problem alcohol use.

See section 23.15 for resources to support schools in teaching about alcohol and drug use.

23.4.2 Screening children and young people to identify risk of alcohol and drug use

Practitioners working with children and young people aged 17 and under should be trained to routinely undertake screening to identify children and young people at risk of alcohol and drug use and related harms.

There is guidance on identification and brief interventions in chapter 3.

Practitioners need to obtain consent from the child or young person or their parent or carer, as appropriate. There is guidance on competence and consent in section 23.6.

Practitioners should:

- know how to explain the screening in an age-appropriate way
- know how to respond non- judgementally and supportively and provide information to a child or young person who is drinking at harmful levels
- be sensitive to a child or young person's beliefs and culture
- know when and how to refer a child or young person for a targeted prevention intervention or specialist comprehensive assessment
- know when and how to refer the child or young person to safeguarding services and other services to meet any other urgent needs

Practitioners need to work with all other services involved in the child or young person's care.

23.4.3 Screening tools

The NICE guideline Alcohol-use disorders: prevention (PH24) endorses several validated screening tools. The alcohol use disorders identification test for consumption (AUDIT-C) is the most commonly used tool. You can find guidance on alcohol screening tools in section 3.3 in chapter 3 on identification and brief interventions.

A study of screening 10 to 17 year olds in emergency departments (Coulton and others, 2018) found that AUDIT-C is more effective than the alcohol use disorders identification test (AUDIT) in screening adolescents for:

- at-risk alcohol use
- heavy episodic alcohol use
- alcohol abuse (harmful drinking)

AUDIT (which can be completed after AUDIT-C) is more effective than AUDIT-C for identifying alcohol dependence.

The thresholds for levels of risk when using AUDIT-C with a child or young person are different to the thresholds used for adults. When screening children and young people between 10 and 17 years old, an AUDIT-C score of 3 or more identifies high risk drinking. Young people who score 5 or more should be offered a comprehensive assessment to assess alcohol and drug use (Coulton and others, 2018) and their wider needs (see section 23.8.4).

Research among 14 to 17 years olds in hospital emergency departments found no benefits to delivering brief interventions over screening alone (Deluca and others, 2020). Screening alone potentially raises awareness of high-risk drinking and may be enough to start behaviour change (McCambridge and Day, 2008). However, where screening identifies a child or young person with problem alcohol use, staff should talk to them about their alcohol use and (with consent) refer them to a specialist service.

23.4.4 Focusing on children and young people at risk of developing problem alcohol use

Services should focus screening on groups of children and young people at increased risk of developing problematic forms of alcohol or drug use. Section 23.3.1 describes these groups of children and young people.

Services attended by children and young people who are at increased risk of problem drinking include:

- pupil referral units
- youth offending services
- children's social care services
- child and adolescent mental health services (CAMHS) and other mental health services
- GPs
- community and voluntary sector services for children and young people

Commissioners need to work with their contracted services to make sure there are comprehensive local arrangements across these services. This is to make sure children and young people who do not attend school, or who are excluded, are offered screening for problem alcohol and drug use, supported by appropriate referral and prevention interventions. An interactive approach is important when talking with children and young people about alcohol use.

23.5 Specialist alcohol and drug treatment services for children and young people

Commissioners, service providers and practitioners all play an important role in making sure that specialist alcohol and drug treatment services for children and young people are safe and welcoming.

Services should provide evidence-based specialist interventions for children and young people's problem alcohol use, and care planned support for their wider needs. This will often involve working closely with other services for children and young people.

23.5.1 Age-appropriate services

Services working with children and young people should be age-appropriate and reflect that there are differences not only between adults and children, but also between children of different ages.

Children and young people's specialist services work with 10 to 17 year olds. Some children and young people's services continue to work with 18 to 24 year olds as a transitional arrangement. There is guidance on managing transitions in section 23.10.

Adult services work with young adults aged 18 to 24 and need to ensure services are age-appropriate and adequately targeted to their needs.

Service providers should always ensure shared spaces, including drop-ins, waiting rooms, and group work sessions, are age-appropriate and safe. Contact between young people using the service, particularly between different age groups or those with differing needs, should be risk assessed. If young adults aged 18 and over are using the service as part of transitional arrangements, the service should ensure they do not negatively affect the safety and age-appropriateness of the service for children and young people aged 17 and under. Services should consider separate locations or spaces for young adults.

23.5.2 Services centred on children and young people's needs

Specialist alcohol treatment for children and young people is different to adult treatment. Specialist services need to be centred on the needs of children and young people and take into account:

- age and maturity
- developmental needs
- safeguarding duties
- issues of consent, competence and confidentiality (and the legal framework for this)
- patterns of problem alcohol (and drug) use and associated harms
- appropriate partnership working with parents or carers

The principles of quality governance apply to all alcohol and drug treatment services. But there are specific considerations and actions for services for children and young people aged 17 and under, including child safeguarding duties. These need to be incorporated into service policies and quality governance arrangements. You can find more information on quality governance in section 2.4 in chapter 2 on the principles of care.

A child safeguarding lead should contribute to designing and reviewing quality governance arrangements for children and young people's services.

23.5.3 Co-production or consultation with children and young people

Children and young people's voices should be at the heart of the care and support they receive.

Commissioners and service providers should actively support children and young people with lived and living experience of problem alcohol use to contribute to local needs assessment. These children and young people should also contribute to designing,

implementing, monitoring and evaluating specialist children and young people's alcohol treatment services.

Safeguarding processes should include children and young people's involvement in co-production and consultation about services.

23.5.4 Integrating with schools and other services for children and young people

Specialist alcohol treatment services working with children and young people should be fully integrated and aligned with schools and local services for children and young people at risk of poor outcomes. Specialist alcohol interventions and support fit into a wider context of safeguarding children and young people from harm and promoting their welfare.

There should be clear and comprehensive referral pathways and agreements that confirm joint working arrangements to address the multiple vulnerabilities and complex needs children and young people experience. Services should have policies and agreements that set out information-sharing arrangements with other children and young people' services, including children's social care, education and mental health services, and also with parents and carers.

The Department for Education has published information sharing advice for safeguarding practitioners in England that may also be useful across the UK.

Services for children and young people at risk of poor outcomes including problem alcohol use include:

- schools and pupil referral units
- children's social care services
- CAMHS and other mental health services
- youth offending services
- community and voluntary sector services for children and young people

23.5.5 Safeguarding

Children and young people's services for children and young people have a vital role to play in contributing to safeguarding children and young people and promoting their welfare.

Services must have child safeguarding policies and procedures in line with national legislation and statutory guidance and local protocols. These should be agreed locally with children's social care. There is information on national child safeguarding legislation in annex 1.

Each service must have a child safeguarding lead and all staff should be trained in child safeguarding and know how to follow organisational procedures.

Staff should know how and when to make child safeguarding referrals and share information appropriately.

Services must also have adult safeguarding policies and procedures and an adult safeguarding lead, in line with national legislation and statutory guidance. There is information on national legislation and guidance for adult safeguarding in annex 1.

Staff should be trained in adult safeguarding and know how and when to make adult safeguarding referrals for young adults or parents or carers.

23.5.6 The role of specialist alcohol and drug treatment service providers and commissioners

Commissioners and service providers should ensure that services:

- are non-stigmatising
- provide age-appropriate treatment in line with evidence-based guidance
- have staff that are competent to provide the interventions they offer and are supported and supervised to do so
- operate within local safeguarding frameworks for assessing children and young people's needs
- have strong referral pathways and working relationships with other children and young people's services, supported by active strategic partnerships
- are safe, accessible, welcoming and engaging for children and young people who should be able to self-refer
- are promoted in ways that will reach and feel relevant to children and young people
- target children and young people from groups at risk of problem alcohol use
- take account of diversity among children and young people including:
    - age
    - sex
    - gender identity
    - sexual orientation
    - race and ethnicity
    - religion
    - disability
    - socioeconomic position
- offer interventions in private settings at a service base and also at other organisations or places where children and young people feel safe and comfortable
- offer flexible appointments to fit with children and young people's school or college timetables, or appropriate other commitments

- provide age-appropriate service information in child and young person-friendly formats and media
- have a clinical care pathway in place for the small number of children and young people requiring a pharmacological intervention

23.5.7 Relevant clinical guidance and standards

The Royal College of Psychiatrists' College Centre for Quality Improvement Practice standards for young people with substance misuse problems sets out criteria for:

- comprehensive assessment
- integrated care planning
- delivering interventions
- transferring care after completing treatment

Services should also follow NICE guideline Transition from children's to adults' services for young people using health or social care services (NG43).

The Royal College of Paediatrics and Child Health's Healthcare standards for children and young people in secure settings has guidance on meeting the needs of young people with problem alcohol or substance use in secure settings in England.

23.5.8 Monitoring

Services should monitor the extent to which staff routinely follow locally agreed thresholds to identify children and young people at risk.

Where appropriate, services should record and monitor:

- how often these locally agreed risk thresholds are used as a prompt for further action
- the number of children and young people identified as being at risk of harm from their alcohol use
- the number of children and young people identified as needing a comprehensive assessment and treatment interventions

23.5.9 The role of practitioners

Practitioners in children and young people's treatment services should:

- work with children and young people based on an understanding of their individual age related and developmental needs
- engage and form a trusting therapeutic alliance with children and young people of different ages
- understand how trauma affects children and young people and use a trauma-informed approach to working with them

- understand child safeguarding and act on safeguarding concerns in line with national statutory guidance and organisational procedures
- work with a strengths-based approach (see section 2.2.7 in chapter 2 on principles of care) and therapeutic optimism
- work in partnership with parents or carers wherever possible and appropriate
- work with a child or young person, their parent or carer (where appropriate) and other relevant services to comprehensively assess the child or young person's needs and develop an individualised care plan and risk management (safety) plan
- consider protected characteristics including gender and gender identity differences and the impact of inequality in developing the care plan
- deliver evidence-based structured support and specialist interventions including targeted prevention, harm reduction, psychosocial interventions or pharmacological interventions
- co-ordinate the child or young person's care within the service and routinely work with other agencies and professionals including children and young people's mental health and child safeguarding services in the best interests of the child or young person
- contribute to multi-agency care plans and conferences such as child protection conferences
- be able to assess the competence of the child or young person to give consent for the appropriate interventions (competence)
- be able to assess capacity to make the decision in question (see glossary) for 16 to 17 year olds where they have any concerns
- understand parental responsibility, as defined by UK legislation in the Children Act 1989 for England and Wales, or the Children (Scotland) Act 1995, or the Children (Northern Ireland) Order 1995

23.6 Confidentiality and consent to treatment

Decisions about sharing confidential information and consent to treatment in children and young people's services are different from adult services.

23.6.1 Confidentiality and consent in children and young people's services

Practitioners should make confidentiality and consent policies clear to children and young people, and their parents or carers, when they first access the service. They should provide age-appropriate information that makes it clear that children and young people are entitled to confidentiality. They should also make clear any limitations to confidentiality due to safeguarding and managing risk.

Practitioners should let children and young people know who holds information about them, and when and how it can be shared.

Services should make sure all staff are trained and competent to act in line with their policies on confidentiality and consent.

All practitioners should understand the importance of confidentiality for children and young people. They should also know how and when it is appropriate to share information and with whom.

23.6.2 Competence to consent to treatment

Practitioners must obtain informed consent for a child or young person to begin treatment. The legal position on consent and refusal of treatment by children and young people aged 17 and under is different to that for adults. Practitioners should get voluntary consent from the child or young person, or the person with parental responsibility (as legally defined) as appropriate, before starting any intervention. They should make sure the child or young person and the parent or carer with parental responsibility has information about the service and interventions they are offering, including any risks and benefits.

Across the UK, there is no specific age when a child becomes competent to consent to treatment apart from Scotland where the Age of Legal Capacity (Scotland) Act 1991 draws the line between childhood and adulthood at a young person's 16th birthday. Usually, competence to consent to their own treatment will depend on the maturity of the child and the seriousness and complexity of the treatment being proposed.

In England, Wales and Northern Ireland, where the young person is assessed as competent to give their consent to treatment, this is known as 'Gillick competence'. Generally, young people aged 16 to 17 fall under the Mental Capacity Act and accordingly must be presumed to have capacity to consent to their own treatment. However, in very rare cases, the courts have overridden a young person's refusal of treatment even when they had capacity to make that decision.

Children under 16 are not necessarily considered legally competent to give consent to treatment. Practitioners need to assess Gillick competence if the child wants to go ahead with treatment without their parents' or carers' knowledge or consent. It would be very unusual for a child under 13 years old to be offered treatment without first getting parental consent.

In Scotland, the Age of Legal Capacity (Scotland) Act requires the medical practitioner attending a child under the age of 16 years to consider whether the child is capable of understanding the nature and possible consequences of the procedure or treatment. If the child is assessed as capable, the practitioner must seek the consent of the child rather than of the parent. In practical terms, practitioners should look for signs that the child can consent on this basis from when the child is about 12 years old.

It is important that all staff working with children and young people in specialist alcohol treatment services are trained and competent to assess a child or young person's

competence or capacity to understand all aspects of the proposed treatment intervention. This includes training to ensure understanding of the legal framework for obtaining valid consent. There is information about competence to consent in the resources section at the end of this chapter. Practitioners should also be trained and competent to understand the legal concept of parental responsibility and how it applies to their work. There is information on parental responsibility in the resources section at the end of this chapter.

Even when a child or young person is assessed as competent, it is good practice to involve their parent of carer in the decision-making process wherever possible, but only if the child consents to their information being shared. Practitioners should ask the child or young person their views, wishes and feelings so that they are involved in, understand and agree decisions about their treatment, regardless of their competence. Practitioners should always record the outcome of the assessment of competence to consent in the case notes.

23.7 Working in partnership with parents

Practitioners should work in partnership with parents and carers where this is possible. Some children and young people will not want their parent or carer involved in their support or treatment, but many will be happy for them to be involved.

The way in which parents or carers are involved in a child or young person's treatment will be based on:

- individual assessment
- the wishes of the child or young person
- their competence or capacity to consent to treatment

If the child or young person under 16 years is assessed as not competent, or a 16 to 17 year old is assessed as lacking capacity to give consent for treatment, the person with parental responsibility needs to give consent for treatment.

If the child or young person consents for the parent or carer to be involved in their treatment, the assessor or keyworker should agree with the child or young person what their involvement will be.

Involvement can include:

- contributing information and views to assessment, care planning and care plan reviews
- supporting the child or young person to meet their care plan goals which can include:
    - encouragement
    - rewards for achievements
    - practical actions like helping the child or young person take part in a supportive activity
- taking part in a treatment intervention such as family therapy

- sharing information if there are concerns about the safety or welfare of the child or young person

The service should have a confidentiality policy that sets out how staff will work with parents and carers while respecting the confidentiality of the child or young person.

When a parent or carer is involved with a child and young person's treatment, the practitioner should create opportunities for the parent and child or young person to discuss the situation together as well as ensuring the child or young person can discuss their concerns and give their perspective alone.

If the child or young person is competent to give consent to treatment and they do not want their parent or carer to be involved, the service should offer them the opportunity to attend on their own, with a trusted friend or a support person if they wish. This should be made clear in the service information.

Involving parents or carers and providing them with support and information on alcohol and other substances can help them to:

- understand the child or young person's problem alcohol use and how it is linked with their other needs
- support the child or young person to work towards their goals to stop or reduce their alcohol use
- contribute to promoting safety and managing risk for the child or young person
- manage stresses related to the child or young person's alcohol use
- support the child or young person to remain engaged with the service
- support the child or young person to work on other issues such as school engagement or involvement in anti-social or offending behaviour
- improve communication between the parent or carer and the child and young person and strengthen family relationships

Discussions with parents or carers can help to identify their own support needs.

For example, these can include:

- their own problem alcohol or drug use
- mental health problems
- physical health problems
- conflict between parents or carers
- domestic abuse
- social needs, including housing and financial problems

The practitioner should offer referral to services that can offer support for the parent or carer's needs. If the parent or carer is able to access support, this could also help to strengthen their parenting capacity and family functioning.

23.8 Assessment and engagement

There is guidance on assessment in chapter 4 on assessment and treatment and recovery planning. Much of chapter 4 is relevant to children and young people as well as adults and you should read chapter 4 for more guidance. This section summarises additional considerations when assessing children and young people.

23.8.1 Assessment and engagement: main points

Services should provide straightforward access to assessment which should start as soon as possible after referral.

Assessment should involve the assessor and the child or young person working together to reach a shared understanding of their alcohol use and their wider needs, strengths and goals. Where appropriate, a parent or carer should also contribute.

As children and young people with problem alcohol use have complex needs, assessment should involve other relevant children and young people's services including mental health services and children's social care where appropriate.

Services should use validated assessment tools to support assessment, but these should not take the place of a structured clinical interview with the child or young person.

Practitioners should actively try to engage the child or young person in an age-appropriate way from first contact and throughout the assessment process.

23.8.2 Referral and initial contact

The referral process for the service should be straightforward and accessible for children and young people. Services should actively reach out through organisations and social media most commonly used by children and young people to provide accessible information about how children and young people can refer themselves to the service and what help the service can offer. They should also provide information on the service website and circulate information to relevant services so parents or carers and professionals can refer a child or young person.

It is vital that children and young people are safe and feel comfortable accessing the service. Staff should consider whether access is safe and convenient for the child or young person. If the child or young person, or the professional supporting them, have any concerns, the service should offer a choice of location that is safer or has better transport links. This is so they can access the service independently, where appropriate. The service should also fit appointments around the child or young person's schooling and other activities that are important for them.

If the child or young person has been referred by a professional, the assessor should ask for relevant information about the child or young person from that professional (who should

gain the child or young person's consent, or their parent or carer's consent). This will help the assessor to have a better understanding of the child or young person's needs. It can also help to reduce the number of times that they are asked about difficult areas of their life by professionals when they are new to a service.

Staff should consider children and young people's preferences about the appointment. This includes who they prefer to be seen by, whether they can bring a friend, parent or carer and how many people will be present. Staff should work with the child or young person to manage their expectations and provide open and honest explanations if their preferences cannot be granted.

Staff should also ask a child or young person, or their parent, carer or support worker, if they need any reasonable adjustments for a disability or a mental health problem. The service should then make these adjustments.

Staff can encourage children and young people to attend the service by providing welcoming introductory communication before their first appointment. Providing clear age-appropriate information about the assessment process and confidentiality can also help. Friendly reminders about appointments (digitally if appropriate) can also encourage attendance. If the child or young person misses the appointment, non-judgemental follow-up with another appointment offer might make it easier for them to attend and can help them stay engaged. Staff should always communicate information in an age-appropriate way avoiding clinical language and in accessible formats considering:

- language
- literacy
- sensory disability
- cognitive disability
- neurodiversity
- digital literacy and access

Interpreters (including sign language) who are not known to the child or their family should be available to make sure there is equal access to assessment.

Initial contact is very important to help the child or young person feel welcome and to help them to begin their engagement with the service at this early stage.

23.8.3 First appointment

Staff who greet children and young people should do this with professionalism and a non-stigmatising, warm approach. It is vital that all staff, including reception staff and volunteers, treat children and young people with respect. Where children and young people are accompanied by a parent or carer, staff should also make them welcome.

The wating room and the room where the assessment takes place should be age-appropriate. The information displayed should show that it is a children and young people centred service.

Assessment should include a focus on engagement. The assessment appointment is often the first face-to-face contact the child or young person has with the service and it is an opportunity to begin building a therapeutic alliance.

To help the child or young person engage in treatment, the assessor should use a warm, empathic and non-judgmental approach and integrate the principles of motivational interventions into the assessment process (see section 5.5.6 on motivational interventions in chapter 5 on psychosocial interventions).

Since many children and young people with problem alcohol use experience trauma, staff should use a trauma-informed approach. Services should make sure staff are trained, supervised and supported to use a trauma-informed approach applied to children and young people. There is guidance on trauma informed practice in section 2.2.8 in chapter 2 on principles of care.

The assessment should take the form of a structured clinical interview (a conversation aimed at assessing the child or young person's treatment needs). The assessor will need to record information in a structured way, but a 'checklist' approach to assessment is not a good way to engage a child or young person.

It is very important to show an interest and listen to the child or young person's concerns, views, interests and hopes. If they are accompanied by their parent or carer, the assessor should also involve the parent or carer in the process and ask them for their views at appropriate points.

23.8.4 Initial assessment

This section sets out how to carry out an initial assessment with a child or young person during the first meeting. The assessor can then carry out a more comprehensive assessment, involving other clinicians over the following meetings.

Assessing protective factors and any immediate risks

It is important to ask about the child or young person's alcohol use and identify any immediate risks to the child or young person but wherever possible, the initial assessment should focus on the child or young person's strengths, interests, positive activities and supportive networks as well.

Assessors will need training and therapeutic competencies to ask the assessment questions and to respond sensitively to the answers.

At the first appointment the assessor should briefly assess the child or young person, focusing on:

- the duration, pattern and severity of their alcohol use

- the duration, pattern and severity of their other drug use
- their mental health and physical health problems
- their family situation
- any urgent treatment needs, including the potential need for assisted withdrawal
- any urgent social needs such as housing
- any immediate risks to the child or young person
- any immediate risks to others
- their strengths and other protective factors
- their ideas about the help they might need

Assessors should record if the child or young person:

- is in contact with other services
- has been prescribed any medication
- has any health needs, such as allergies

Assessing alcohol use

The assessor should make an initial assessment of the child or young person's alcohol use. They should use a screening tool such as AUDIT-C, but this should support a conversation about the child or young person's alcohol use, not replace it.

The thresholds for levels of risk when using AUDIT-C with a child or young person are different to thresholds used for adults. When screening children and young people between 10 and 17 years old, an AUDIT-C score of 3 or more identifies high risk (harmful) drinking.

The assessor should ask the child or young person about:

- their alcohol use (approximate number of units and pattern) over the last 1 to 4 weeks
- what age their drinking began and how long they have experienced problem alcohol use
- any symptoms of dependence (withdrawal symptoms or withdrawal complications)

Alcohol dependence among children and young people is rare but can happen. If the initial assessment suggests the child or young person may be alcohol dependent, based on whether the assessor has the appropriate competence, they should carry out or arrange an assessment of the child or young person's need for medically assisted withdrawal. Any doctors, nurses or pharmacists responsible for assessing and managing medically assisted alcohol withdrawal should be competent to diagnose and assess alcohol dependence and withdrawal symptoms in children and young people.

The assessor can also begin to explore with the child or young person how their experiences within their families and networks, including their friends and peer groups, interplay with their alcohol use.

Assessing urgent needs and risks

In the initial assessment, the assessor should aim to identify any immediate risks to the child or young person or to others. Areas to consider as part of the initial risk assessment are listed below in section 23.8.6 on risk assessment.

Assessing strengths and protective factors

It is helpful for the assessor to ask the child or young person about:

- supportive parents, carers or family members, safe adults in their broader network and supportive friends
- their strengths
- their interests
- their identity
- their culture
- any supportive groups or activities they take part in
- their hopes and aspirations
- their views on what changes they want to make to their alcohol use or in related areas of their life

Actions at the end of initial assessment

At the end of the initial assessment, the assessor, the child or young person and parent or carer should agree a simple plan about what will happen next.

The assessor should explain in an age-appropriate way what a comprehensive assessment involves and obtain consent from the child or young person or their parent or carer as appropriate to go ahead with this.

With consent, they should agree a date for the next appointment.

The assessor and the child or young person can also agree some actions, based on the readiness of the child or young person, that they can take towards changing their alcohol use before the next session. For example, they could record their alcohol use in a drink diary either on paper or digitally.

The assessor should begin to discuss with the parent or carer how to understand:

- their child or young person’s alcohol use
- their broader needs

- how they can best support their child

The assessor should provide the child or young person with age-appropriate information about:

- the nature of problem alcohol use and drug use
- available support and specialist alcohol interventions
- harm reduction information and advice (see information on harm reduction interventions in section 23.8.6)

If the child or young person is (or has recently been) in contact with other services, the assessor should ask for consent to contact those services so they can contribute to the assessment.

The assessor should also ask for consent from the child or young person or the parent or carer (as appropriate) to make referrals to other relevant specialist services so they can contribute to a comprehensive assessment. Depending on the child or young person and the urgency of need, this referral can be done at the end of the initial assessment or can wait until the next appointment.

Sharing information and consent

If the initial assessment or comprehensive assessment (see section 23.8.5) identifies any urgent needs or risks, including safeguarding concerns, the assessor should agree any actions they can take to manage the risks with the child or young person and their parent or carer. The assessor should get consent from the child or young person or their parent or carer to share information with relevant services.

If the child or young person or parent does not give consent, and the assessor thinks they need to share information without consent because of a safeguarding concern or to manage risk they should follow relevant national and organisational safeguarding procedures and organisational risk management procedures.

This will usually involve consulting their child safeguarding lead or a senior member of the clinical team.

The assessor should explain openly their reasons for sharing information without consent and what information will be shared and with whom. They should listen to the child or young person's and the parent or carer's concerns and explain they believe that sharing information is in the child's best interests.

The assessor should clearly document any decision to disclose information without consent, setting out:

- the reasons for disclosure
- details of who agreed the decision
- details of what needs to change before full confidentiality will be reinstated

You can find details of relevant child safeguarding legislation and statutory guidance in annex 1.

23.8.5 Multidisciplinary comprehensive assessment

This section sets out elements of a comprehensive assessment which practitioners can carry out over several sessions.

A multidisciplinary approach to comprehensive assessment

All children and young people with problem alcohol use should be offered a comprehensive assessment of their needs. Comprehensive assessment builds on the initial assessment.

For the assessment to be comprehensive it needs to be undertaken by a team of specialists who have the competence to assess the child or young person's wider developmental, mental health and safeguarding needs. This will involve working with specialists from other children and young people's services.

This might include working with:

- CAMHS and other mental health support services
- GPs
- children's social care
- youth justice services
- schools, pupil referral units and education support services
- services for children with special educational needs or disabilities
- community and third sector services for children, young people and families

The role of the assessor in the alcohol and drug treatment service is to assess the child or young person's problem alcohol use and related needs, which would include awareness of their mental health needs, and to co-ordinate information and assessments of their wider needs by other relevant specialists.

Many children with problem alcohol use also have a mental health problem. Services should ensure that a child or young person coming for support and treatment for problem alcohol use should have access to a specialist mental health clinician for children and young people. This clinician can carry out a comprehensive assessment of their needs if their problem alcohol use is associated with physical, psychological, educational and social problems and/or comorbid problem drug use. A child or young person being assessed in a mental health service should also have their alcohol and drug use assessed.

Alcohol and drug treatment services should make sure that specialist alcohol and drug practitioners responsible for alcohol assessments for children and young people are trained, supported and supervised to do this. This includes competencies in multidisciplinary and multi-agency working.

Aims for the comprehensive assessment

The aim of comprehensive assessment is to gather and consider information, so the assessor, the child or young person, the parent or carer (where appropriate) and professionals from relevant services can agree a personalised care plan and a risk management (safety) plan.

The assessor should explain the process of the comprehensive assessment to the child or young person and their parent or carer where appropriate. The child or young person should be at the centre and fully involved in this assessment process.

Comprehensive assessment process

A comprehensive assessment can take some time to do, but support and specialist alcohol interventions can begin before the comprehensive assessment is complete. The practitioner should make sure any immediate needs and risks are addressed.

The assessment is the beginning of an ongoing conversation with the child and young person about their alcohol use. The assessor's approach to this should be based on the principles of motivational interviewing. A confrontational approach is not effective or helpful. There is guidance on motivational interviewing in section 5.5.6 in chapter 5 on psychosocial interventions.

Through the assessment process, the assessor can help the child or young person consider their alcohol use and any changes they might want to make. Based on the readiness of the child or young person, the assessor can encourage them to monitor their own alcohol use and be curious about triggers for drinking and things that help them to avoid drinking or avoid drinking heavily.

Assessment tools

Assessors should carry out the assessment as a structured clinical conversation.

Validated clinical tools, such as the Teen Addiction Severity Index (T-ASI), can support this conversation but should not replace it. Assessment is a continuing process and the assessor should not attempt to cover all the areas below in one meeting. Children and young people, particularly those who have experienced trauma, often need time to develop trust in a new relationship with a practitioner and may need help to reflect on aspects of their lives for their needs to be identified.

Practitioners can get information from the child, young person, parents and carers and other professionals. Sometimes it is helpful to corroborate information gained from one source with another.

The assessment should review:

- alcohol use - patterns, frequency, how much they consume (see section 23.8.3 above initial assessment)
- any signs of alcohol dependence

- drug use - patterns, frequency, how much they consume
- any signs of drug dependence
- mental health including self-harm and suicidal thoughts, intentions or past suicide attempts
- neurodevelopmental conditions including autism, ADHD and FASD
- physical health problems
- sexual health and pregnancy
- family relationships and environment
- any parental issues including alcohol or drug use, mental health, domestic abuse
- developmental and cognitive needs, school attendance and engagement
- special educational needs
- physical disabilities and learning disabilities
- peer relationships, social functioning and community networks
- partner relationships
- past history of abuse of trauma (adverse childhood experiences)
- current risks and safeguarding concerns including abuse, neglect and exploitation (see section 23.8.6 on risk assessment)
- protective factors including supportive adults and peers and coping strategies
- aspirations, readiness to change and belief in ability to change

There is guidance on comprehensive assessment in chapter 4 on assessment and treatment and recovery planning and much of this guidance can be adapted for children and young people.

Professionals and services involved in a child or young person's care should share relevant information to support high quality care in line with multi-agency information sharing agreements.

23.8.6 Risk assessment

Assessing risks and protective factors

Assessing risk is an important part of any assessment. Risk assessment should inform the content of the care plan and should consider risks to the child or young person and any risks they might pose to others. Multiple risk factors can mean that the overall risk to the child or young person is higher.

When assessing risks to children and young people, service assessment frameworks and practitioners can draw on the assessment framework set out in Appendix 4: triangle chart

for the assessment of children in need and their families of the 'London Safeguarding Children Procedures'.

Although it is important to identify risks, it is also important to identify protective factors and to talk with the child or young person about these. It is important that the child or young person is supported to feel they have agency and can make choices and access support to reduce risks.

Multi-agency approach

For some children and young people, there is already a multi-agency plan in place such as a safeguarding plan led by children's social care or a risk management (safety) plan led by a child and adolescent mental health specialist. The multi-agency plan should inform the alcohol and drug treatment service risk management plan. And the alcohol and drug treatment practitioner should also contribute to the multi-agency plan and to a multi-agency approach to managing risk.

Risks to consider in a risk assessment

Risks to consider in a risk assessment for a child or young person include:

- abuse, neglect and exploitation (consider any risks related to parenting or family environment and also the wider social context they are in)
- domestic abuse within their family or within their own partner relationships (as a victim or a perpetrator)
- mental health related risks, including signs of severe mental illness (psychosis or bipolar disorder)
- self-harm and suicide risks
- any physical health risks
- if they are not in education or have poor school attendance
- if they are a victim or a perpetrator of violence
- their association with peer networks that increase risk of exploitation or offending
- homelessness
- online harms
- harmful gambling
- gaming addiction

Alcohol related risks to consider in a risk assessment for a child or young person include:

- high risks to health due to the quantity of alcohol use, including the risk of alcohol poisoning and risks to liver health or cognitive development

- risks associated with alcohol dependence in a child or young person such as withdrawal and withdrawal complications and longer-term health risks, and their need to fund alcohol use
- high risks related to intoxication including:
    - accidents
    - being at risk or being a victim of violence (including sexual violence)
    - alcohol (and drug) use and intoxication in risky contexts such as association with adults or other young people who seek to harm them including criminal or sexual exploitation
    - increased risk of being drawn into offending behaviour

Risks related to other substances to consider in a risk assessment for a child or young person include:

- increased risk of harm and of overdose if they are using both alcohol and other substances
- nicotine and smoking health related risks
- high risks to health and safety related to their use of other substances (illicit drugs, prescription or over the counter medication, complementary health medicines) including:
    - dose
    - which substances and route of administration
    - risk of substances being mislabelled or mis-sold

You can find guidance on assessing drug related risks in Drug misuse and dependence: UK guidelines on clinical management.

You can find details of relevant child safeguarding legislation and statutory guidance in annex 1.

Harm reduction information and advice

The assessment is an opportunity for the assessor to give the child or young person harm reduction information and advice based on their individual needs, as well as more general health and wellbeing information and advice. Based on the individual needs of the child or young person, the assessor should provide age-appropriate harm reduction information and advice. This can include:

- information and advice about intoxication and related risks
- information and advice about alcohol poisoning

- information and advice about concurrent alcohol use and prescribed medications or illicit drug use
- information on alcohol and health risks

If a child or young person is alcohol dependent, the assessor should give them information and advice:

- to help them not stop or reduce drinking suddenly
- about tolerance and the risks of reduced tolerance after a period of abstinence or low risk drinking

You can find harm reduction information in chapter 8 on harm reduction.

They should also provide details of information resources on alcohol and drugs for children and young people, such as FRANK.

23.9 Care planning

This section is about care planning. Section 23.11 provides guidance on selecting care packages and interventions.

23.9.1 Developing a care plan

The assessor should summarise the findings of the assessment in a broad written care plan. If the assessor does not continue to work with the child or young person, they will hand the care plan over to the keyworker or a clinician who will further develop the plan with the child or young person.

The keyworker is a single named practitioner who:

- meets regularly with the child or young person in treatment
- co-ordinates their care planning within the service
- leads on working with other services involved in their care
- provides structured support (see section 23.13.3 below)

The child or young person should have an active role in developing the care plan and their views and wishes should be considered. It is important that the child or young person feels they have choices about plans for their support and interventions. The parent or carer (where appropriate) and other relevant professionals should also contribute to developing the plan.

Every child or young person's care plan should:

- be based on and tailored to meet their individual needs
- summarise the findings of the assessment
- describe their agreed initial goals and preferred outcomes

- describe how their needs will be met, including the interventions the alcohol and drug treatment service will offer
- be multidisciplinary and outline arrangements agreed with other services and agencies to meet their wider needs, including any mental health needs
- include pharmacological interventions if these are assessed as needed
- have a named keyworker responsible for co-ordinating their care in the alcohol and drug treatment service and communicating with other services
- have one named lead professional responsible for co-ordinating care across all relevant agencies, where several services are providing care
- include names and contact details of other professionals and services involved

23.9.2 Risk management (safety planning)

The risk assessment is the basis for risk management (safety planning). Risk assessment (safety) plans will build on the initial assessment and are likely to be expanded following the comprehensive assessment and adjusted throughout the child or young person's treatment.

A risk management (safety) plan is usually a separate plan to the care plan, but agreed actions in the risk management plan should normally inform the care plan. It should be clearly accessible to relevant staff in the child or young person's records.

The keyworker in the alcohol and drug treatment service who is responsible for co-ordinating risk management (safety) planning should be competent to do so. The multidisciplinary team (MDT) or wider clinical team should have clinical oversight of risk management.

Where risks are high, there is likely to be a multi-agency safety plan, for example a safeguarding plan led by a social worker, or a multi-agency risk management (safety) plan led by a children and young people's mental health professional (see section 23.9.3).

A risk assessment and risk management (safety) plan should be based on the child or young person's individual needs and how to support their immediate and longer-term safety.

Wherever possible, the child or young person should be involved in the process of developing their individual risk management (safety) plan by agreeing to goals and any actions they can take to manage risks. However, there may be safeguarding or other high risks that practitioners will have a duty to act on, even if the child or young person does not agree with the plan. In this case, the practitioner should explain to the child or young person the actions they are taking and why.

Risk management (safety) plans should clearly identify the:

- actions to manage the risks and who will take them
- people and factors that can help in managing risk and increasing safety

- actions the child or young person can take themselves to reduce risk and increase safety

The risks to a child or young person can constantly change, so practitioners will need to regularly review their risk assessments and risk management (safety) plans. Changes in any of the risk areas (such as alcohol and drug use, physical health, mental health or social factors) may affect the level of risk in another area. For example, increased risk related to a child or young person's mental health might increase their overall safeguarding risk, even where their alcohol use has not changed.

A sole keyworker might not be able to see the interaction of risk across all areas, so it is important that the service provides supervision and involvement of the MDT or senior clinician in reviews. Keyworkers will need to amend the identified risk management actions if risks or related factors change, or actions to reduce risks and increase safety have not been effective.

Services need organisational procedures for escalating and managing immediate risks. Keyworkers should have access to advice and supervision from the named child safeguarding lead and relevant members of the MDT or wider clinical team.

All staff in children and young people's services should be trained to respond to safeguarding risks and understand organisational safeguarding procedures, including when and how to make a child safeguarding referral.

It is important that organisational risk management processes should include processes for following up a child or young person with complex needs where there are risks to their safety or health if they disengage from treatment.

23.9.3 Multi-agency care planning including risk management (safety) planning

When a child or young person has complex needs and several services are providing care, professionals from different services will need to make sure everyone has clear expectations about their role and that care is well co-ordinated. They will need to agree who is the lead professional responsible for co-ordinating the person's care across services. This might be the keyworker from the alcohol and drug treatment service. But where risks are high, a professional from another service will normally be the lead professional. For example, a social worker or a mental health professional for children and young people.

All services involved should have information-sharing arrangements and should share information at reviews and in between reviews if there are relevant changes in the child or young person's situation, or any risks.

Services will need to work together and with the child or young person to integrate care plans and risk management (safety) plans so there are no contradictions. Where there is a co-ordinated multi-agency plan such as a safeguarding plan led by a social worker, the key worker (or where appropriate, the specialist clinician) from the alcohol and drug treatment service will contribute to the multi-agency plan. They will also contribute to multi-agency

case conferences, such as child protection conferences or mental health care planning reviews.

Professionals from involved services will need to co-ordinate timetabling of appointments to make it possible for the child or young person to attend them all and not feel overwhelmed.

23.9.4 The care planning process

The care plan is an active document that is adjusted over time. It is the basis for the care planning process which takes place throughout treatment and support.

Goals and goal setting

Practitioners should approach goal setting and reviewing based on the principles and techniques of motivational interventions, which can strengthen engagement.

As well as the keyworker and the child or young person setting goals for the child or young person's alcohol use and other substance use, care planning will involve them setting wider goals for other areas of the child or young person's life.

Each child or young person's care plan should be based on their individual needs, but goals for the plan and for specific interventions commonly include:

- reducing or stopping alcohol use
- reducing or stopping any drug use
- improving their protective factors
- supporting positive decision-making
- enhancing their understanding of actions and consequences
- improving their educational engagement and social functioning
- improving their mental health and wellbeing
- increasing the support they are receiving for any neurodiverse needs or disabilities
- encouraging positive relationships with safe and supportive adults and peers who do not have problem or drug alcohol use or engage in risky behaviours
- involving parents and carers where appropriate and strengthening family relationships

The risk management (safety) plan will identify goals to reduce and manage risks to the child or young person and any risks they might pose to others.

Duration of treatment

The needs of children and young people who engage with alcohol and drug treatment services are very varied, so the duration of support and interventions offered by the service will also vary. Practitioners should always base the duration of an intervention on individual

need and not on a standard length of time. Arbitrary time limits on interventions are not helpful and may make poor outcomes more likely.

Although keyworkers should avoid arbitrary or premature decisions about the length of the treatment episode, practitioners should still agree clear and ambitious care plan goals with the child or young person. This includes planned timescales for action and regular reviews.

Reviewing the care plan

The keyworker should regularly review the care plan with the child or young person, and where appropriate with the parent or carer, and adjust it where necessary. This gives the child or young person (and their parents or carer) a chance to consider whether the interventions are helping, and to monitor progress against agreed goals. The child or young person should have an active role in reviewing and adjusting the care plan and their parent or carer, and other relevant professionals, should contribute to the process where appropriate.

Support after leaving the service

An important part of care planning is preparing the child or young person for when the time comes for them to leave the service.

As the practitioner and the child or young person regularly review progress towards care plan goals, the appropriate duration for the end of support from the service will become clear. The practitioner and the child or young person can then agree a date for ending the treatment episode and allocate enough time to plan for this, as well as making sure support is in place for them after they leave the service.

It is important that the end date leaves time and space to prepare the child or young person for the end of their involvement with the service. For some children and young people, this will involve a transition to another service for children and young people or to an adult service. For others, it may be an end to support from professional services at that time. People can be at increased risk of relapse at transition or ending points without appropriate preparation and support, so careful preparation is important. Section 23.10 provides guidance on transitions.

The keyworker and the child or young person, and where appropriate the parent or carer, should agree a support plan for after they leave the service. This can include:

- their goals as they leave the service
- supportive activities they will be taking part in
- supportive adults and supportive friends
- details of any ongoing or new professional support from other services

Even if a child or young person has reduced or stopped their alcohol use and achieved positive outcomes in other areas of their life, they may still need help for problem alcohol use and related risks in the future. Services need to agree contingency plans to manage their

return to harmful alcohol use and associated risks. This can include actions they can take and who they will contact if they begin to use alcohol problematically again.

The practitioner should make it clear to the child or young person that they can contact the service for support again and how they can do this. The practitioner should encourage them to contact the service as soon as they are having problems, or if they feel at risk of returning to problematic alcohol use.

The practitioner should decide on appropriate follow up appointments, based on individual assessment and supported by the multidisciplinary team. These appointments are to check in with the child or young person and see how they are managing, and these can be weeks or months after they leave the alcohol and drug treatment service. Any appointments like this will depend on their individual situation and whether they will be involved with other services when they leave.

23.10 Transition to adult services

All young people in alcohol treatment who will be transferring to an adult service should have a transitional care plan agreed well before their 18th birthday, so there is time to prepare them for transition. Practitioners should involve the young person, and where appropriate their parent or carer. Transitional plans should meet the NICE quality standard Transition from children's to adult services.

If the young person is involved in more than one service, the lead professional should co-ordinate their transitional care plan across all services. Transition to different services, such as youth offending teams, CAMHS and statutory children's services, occur at different ages or developmental stages. These different arrangements should be detailed in the transitional care plan, so everybody is clear about which agencies are involved, what they are offering and when the support is due to end.

If the young person is moving to an adult alcohol and drug treatment service, the alcohol treatment practitioner, supported by the multidisciplinary team, should prepare the young person. This includes working with the adult service and the young person to make sure there is continuous age-appropriate support for the young person.

The children and young people's alcohol treatment service, the adult alcohol and drug treatment service and the young person should develop a plan. This should be a stepped approach, as follows.

1. Share information about the young person's needs to support the referral to the adult service.
2. Introduce the young person to the adult keyworker and arrange several joint appointments involving the young person and both services.
3. Where appropriate, introduce the young person's parents or carers to the new service and discuss their role in their young person's care.

4. The children and young people's service should develop a new care plan with the adult service and the young person.
5. Both services should make sure that the young person's wider needs are addressed in the care plan. Include details of other children and young people's services involved, what support they are offering and when this support is due to end. Include details of any other adult service that the young person is moving to and what they will offer.
6. Set a review date that the young person, the specialist young person's worker and the new adult services worker will attend.

You should provide services based on a child or young person's need, not just based on their age. If a children and young people's service can meet the needs of a person aged 18 or over better than an adult service, without putting other young people who use the service at risk, then this would be the most appropriate placement. So, commissioners should allow services to be flexible when considering transitional arrangements to make sure that any transfer of an 18 year old into adult alcohol treatment services is in the young person's best interests.

Some children and young people's services continue to work with 18 to 24 year olds on transitional arrangements until professionals working with them assess that it's appropriate for them to transfer to an adult service. Also, some young adults aged 18 to 24, assessed as having needs which would make starting treatment in an adult service inappropriate, can start treatment in a child or young person's service and then transfer to an adult service once professionals assess this as appropriate, as a part of transitional arrangements.

Adult services should provide tailored services and interventions for the needs of young adults, including ensuring there is a safe and appropriate environment for them to receive their support.

23.11 Selecting care packages and interventions

23.11.1 Deciding which interventions to offer

The keyworker and multidisciplinary team should decide which interventions the service will offer based on the child or young person's individual needs. This involves considering the severity of their problem alcohol use and the complexity of their wider needs.

In general, the duration and intensity of interventions, and the extent to which other services are involved, is likely to increase with the severity of problem alcohol use or complexity of co-occurring needs (such as mental and physical health problems, educational, social and safeguarding needs).

For most children and young people with problem alcohol use, the interventions the alcohol and drug treatment service offers will be psychosocial interventions. The service should offer all children and young people structured support (see section 23.13.3) delivered by a named keyworker.

23.11.2 Children and young people with complex needs

Where children and young people have needs in several areas and their protective factors are not strong, they are likely to benefit from:

- a more intensive intervention that might include ongoing structured support
- psychological treatment (see section 23.13.4) from a specialist member of the multidisciplinary team
- care planned interventions from other relevant services

Children and young people with the most complex needs, including children with severe mental health or neurodevelopmental conditions or high safeguarding needs, are likely to need a multi-agency package of care led by a specialist professional, such as a specialist mental health clinician or a social worker. The interventions from the children and young peoples' alcohol and drug treatment service will contribute to this wider multi-agency plan.

23.11.3 Inpatient and residential treatment

It is rare for children and young people to be alcohol dependent but if they are, they will need a more intense specialist alcohol intervention that integrates a pharmacological intervention (medically assisted withdrawal) with psychosocial interventions. Inpatient medically assisted withdrawal in an age-appropriate setting is recommended for children 10 to 17 years old.

Most children and young people should receive support and specialist psychosocial interventions in the community. There is little evidence that residential units and therapeutic communities are effective for young people with problem alcohol use.

A minority of children and young people may be attending residential units. It is likely that those attending residential units will have significant alcohol and drug problems with multiple comorbidities, including conduct disorders. They may also be involved in the criminal justice system and might have been referred by the courts or children's social care. So, these units need to have a skilled multidisciplinary team creating a safe environment in which children and young people can feel secure and engage in multicomponent programmes for both alcohol and other co-occurring mental and physical health conditions.

23.11.4 Information about services

Keyworkers should be familiar with the range of treatment and support options the service offers and be able to provide accurate information on each of these in a way that the child or young person can understand. Information should be verbal and written or in another format such as video.

23.12 Managing co-occurring alcohol and mental health and neurodevelopmental conditions

An example of a care package for a child or young person with complex needs is how the alcohol and drug treatment practitioner and mental health services work together to

manage co-occurring alcohol and mental health conditions or neurodevelopmental conditions.

Occasional alcohol use, persistent use and dependence can all cause or make worse mental health problems and some neurodevelopmental conditions, such as ADHD, and interfere with treatments. Co-occurring mental health and neurodevelopmental conditions and alcohol problems are common among people in children and young people's mental health services and alcohol and drug services.

It is vital that all children and young people with significant alcohol and drug problems receive a comprehensive assessment of their mental health and any neurodevelopmental conditions.

Mental health treatment and treatment for some neurodevelopmental conditions will often involve paediatric services and child and adolescent mental health services. There needs to be active communication and co-ordination between these services and children and young people's alcohol and drug treatment services.

Any treatment for comorbid conditions should be underpinned by carefully co-ordinated care that addresses a young person's personal, family, health and social care needs. Practitioners need to take particular care of children and young people who have alcohol or drug problems and suicidal thoughts. This is because treatment can be challenging and requires a carefully monitored integrated approach between the mental health service provider and the children and young people's alcohol and drug treatment service.

The treatments for comorbid mental health conditions will vary but require:

- more intensive case management
- careful monitoring and co-ordination
- continuity of care
- proactive engagement
- continued training and supervision of all staff

For children and young people with more significant mental health disorders, there needs to be:

- engagement by all professionals involved (including CAMHS clinicians and alcohol and drug treatment services)
- a good working relationship between these professionals
- a named mental health practitioner leading on the child or young person's care
- co-ordinated delivery of multiple psychosocial interventions, alongside pharmacological treatments for mental ill-health, where these have been assessed as clinically appropriate
- multidisciplinary and multi-agency care plans with regular reviews

23.13 Specialist psychosocial interventions

23.13.1 Evidence base

The evidence base for specific psychosocial interventions for problem alcohol use among children and young people aged 17 and under is limited. Recommendations are often made using research from adult, young adult and university student populations and are often based on research from outside the UK.

As with psychosocial interventions for other conditions, meta-analyses have shown that substance use treatment programmes help children and young people to reduce alcohol and drug use, although there is less information on longer term outcomes (Dennis, 2004; Tanner-Smith and others, 2016).

The evidence is inconclusive on recommending one type of intervention above another (Godley and others, 2004). But research suggests that delivering an intervention based on a clear theoretical model is more likely to make a positive difference to outcomes and engagement than offering a less structured intervention.

Some psychotherapeutic factors have been found to be common in effective treatment for all conditions and across all age groups (Peterson, 2019). These common factors are closely related and include:

- a strong therapeutic alliance
- empathy
- warmth and authenticity
- a formulation of the child or young person's problem and how to treat it that is understood and agreed between them and the practitioner

Section 23.13.3 provides guidance on structured support that is based on common factors in effective treatment for problem alcohol and drug use.

23.13.2 Delivering specialist psychosocial interventions

Psychosocial interventions for problem alcohol use in children and young people consist of structured support and formal psychological treatments.

Structured support is generally delivered in community alcohol treatment services by a keyworker who is the named practitioner in the service with an ongoing relationship with the child and young person.

Formal psychological treatments recommended for children and young people are generally provided by a specialist member of the MDT according to individual need, alongside a keyworker who provides structured support.

Alcohol and drug workers in their keyworking role can deliver structured support. Services should provide training and regular clinical supervision to practitioners who provide

structured support to children and young people, which should be underpinned by a quality governance framework.

23.13.3 Structured support

Structured support involves using specific psychosocial interventions which are common to evidence-based psychological treatments for alcohol and drug use (Moos, 2007; Manuel and others, 2011). These common factors (or change mechanisms) include:

- a strong therapeutic alliance
- structure and goal direction
- interventions to develop alternative rewards and activities to alcohol use
- engagement with supportive family and social networks and peer relationships
- building self-efficacy and coping skills

Using these common factors to frame the use of specific psychosocial interventions is a pragmatic and flexible approach to providing treatment and support. These psychosocial interventions can be described as 'evidence-based practices' to highlight the distinction from a comprehensive formal psychological treatment approach (Manuel and others, 2011).

Keyworkers should adapt structured support to a child or young person's individual needs based on individual assessment.

There is guidance on structured support in section 5.5 in chapter 5 on psychosocial interventions. This approach can be used for working with children and young people, but clinicians and keyworkers need to adapt it so it's appropriate for their age and developmental stage. The sections below summarise considerations, based on the above common factors, when providing structured support for children and young people.

A strong therapeutic alliance

You should read about therapeutic alliance in section 5.5.1 in chapter 5 on psychosocial interventions. There is evidence that the therapeutic alliance is a major influence on therapeutic outcomes across all age groups (Peterson, 2019). Research shows that when working with young people, a strong therapeutic alliance with both the young person and parents promotes positive therapeutic outcomes (Murphy and Hutton, 2017). There is evidence for the positive role of the therapeutic alliance in some specialist substance misuse treatment interventions for young people (Shelef and others, 2005; Tetzlaff and others, 2005; Hogue and others, 2006).

Practitioners working with children and young people need capabilities in forming a therapeutic alliance with children and young people of different ages. Practitioners need to understand the child or young person's developmental needs and how these affect the way they should interact with the child or young person to build a trusting relationship.

Many children and young people attending services have experienced trauma and the practitioner should use an age-appropriate trauma-informed approach.

Structure and goal direction

You should read about structure and goal direction in section 5.5.2 in chapter 5 on psychosocial interventions.

There is evidence (outlined in the UNODC and WHO 'International Standards on Drug Use Prevention') that children and young people benefit from a structured (but not rigid) approach.

It is important that the child or young person contributes to the development of their individualised care plan, including the goals that they agree on. A shared understanding between the keyworker and the child or young person of their difficulties and how they will make changes strengthens the therapeutic alliance and leads to positive outcomes.

Some children and young people experience a lack of structure, predictability and safety in their family or their daily life. So, a predictable structure and reliable support from an adult are important to promote a sense of emotional safety, trust and self-confidence. The individual care plan should encourage ambition and confidence in the child or young person's ability to achieve change. See section 23.9 for guidance on care planning.

The keyworker should help the child or young person break down goals into achievable steps so they can have a sense of achievement as they make progress. This can help support their belief that they can make changes.

Interventions to develop alternative rewards and rewarding activities

You can read about rewards and rewarding activities in section 5.5.3 in chapter 5 on psychosocial interventions. It provides guidance on supporting an adult to take part in rewarding and meaningful activities in the context of building recovery from long term problem alcohol use.

One significant difference when offering structured support to children and young people is that 'recovery' and 'recovery-oriented activities' are not usually applicable concepts to children and young people. This is because of their developmental stage (which will vary according to their age) and their different patterns of alcohol use. However, it is important to support children and young people to access meaningful and positive activities. Helping them engage in positive and rewarding activities is about helping them find alternatives to problem alcohol use, but it is also about supporting and promoting their age-appropriate development and strengthening protective factors across all areas of their life.

If a child or young person is not in education, there should be a multi-agency approach to care planning that will usually be led by child safeguarding services. Structured support offered by the keyworker in the alcohol and drug treatment service should contribute to the multi-agency approach, and support actions to help the child or young person get back into education. This is vital for their development and future opportunities and to reduce their vulnerability to harms, including exploitation.

It is also important to help the child or young person to identify activities they would like to take part in or develop and help them to access one or more of these activities. To help

them access an appropriate activity, the keyworker should offer emotional support and encouragement. The keyworker should also help to find suitable activities, and where appropriate obtain consent from parents or carers and make practical arrangements so the child or young person can attend. Taking part in an activity they love or find rewarding can provide them with a sense of meaning, self-efficacy and hope. It can also be a way of meeting other children and young people with shared interests. There is evidence that being involved in positive activities and hobbies can be protective for children and young people with vulnerabilities (Velleman and Templeton, 2018).

Parents or carers being involved in the child or young person's treatment can mean they are supported to attend activities and also receive rewards when they make progress towards their goals. Rewards can be in the form of praise or a treat, such as a family outing.

Family and social networks and peer relationships

You should read about social support and networks in section 5.5.4 in chapter 5 on psychosocial interventions. An essential part of structured support is helping people to establish or re-establish connections with people or groups who can provide useful support. Section 5.5.4 includes guidance on helping adults access mutual aid groups and recovery orientated social networks.

The concepts of recovery and recovery orientated networks are not usually applicable to children and young people (see previous section above) and adult mutual aid groups are not suitable for children and young people. However, supportive family and social networks are vital for children and young people's development, wellbeing and safety.

The keyworker can help the child or young person map their family and social networks and identify adults and peers who are or could be supportive. Keyworkers should help children and young people strengthen existing supportive networks and develop new ones.

Helping children and young people develop supportive networks can include:

- access to interventions to strengthen their relationships with parents, carers and family members (see section 23.13.4)
- helping them access safe, age-appropriate, supportive youth, community or faith-based groups and activities that promote their wellbeing and development and provide an opportunity to make new friendships
- helping them take part in structured groups with peers at the service, including those who have made significant changes in their alcohol use and other areas in their life
- encouraging them to develop peer relationships in their daily lives that do not involve risky or anti-social behaviour

There is guidance in involving parents or carers in the child or young person's care in section 23.7.

Where a child or young person is involved in relationships with adults or peers that put them at risk of significant harm, the keyworker must follow national guidance and organisational procedures for child safeguarding.

If peer relationships do not involve a safeguarding risk but involve other children or young people with problem alcohol or drug use or other risky behaviours, the keyworker can help the child or young person to review these relationships and the potential role of peer pressure in their problem alcohol use.

Self-efficacy and coping skills

You should read about interventions to promote self-efficacy and develop coping skills in section 5.5.5 in chapter 5 on psychosocial interventions.

Supporting a child or young person's belief in their ability to make changes in their alcohol use and in other areas of their life is an essential element of structured support for children and young people whose self-confidence and self-esteem can often be very low. See the next section below for guidance on how keyworkers can use an approach based on motivational interventions to do this.

Keyworkers can also support children and young people to learn age-appropriate coping skills, as described in section 5.5.5 in chapter 5.

Learning skills to resist peer pressure to drink or take part in other risky behaviour is particularly relevant for children and young people. Children and young people often also benefit from learning skills to manage emotions and interpersonal difficulties.

Structured support and motivational interventions

You should read guidance on structured support and motivational interventions in section 5.5.6 in chapter 5.

Motivational interviewing (MI) and motivational enhancement therapy (MET) principles are used extensively in children and young people's treatment services, although the evidence is mainly from adults. There is some evidence to support using MI and MET to reduce problem alcohol use in young people (aged 13 to 15) (Kohler and Hoffman, 2015) and in combination with cognitive behavioural therapy to reduce cannabis use (Dennis and others, 2004). The general clinical consensus is that MI and MET techniques are important in engaging young people in treatment.

Structured support and preparing for treatment to end

An important part of structured support is helping the child or young person prepare for the end of their engagement with the alcohol treatment service and agreeing support after they leave. There is guidance on planning for endings and transitions in section 23.9.4 and 23.10, respectively.

23.13.4 Psychological treatments for young people

Psychological treatments that practitioners could consider for a child or young person's care plan are set out below. These are recognised evidence-based structured interventions that can be offered by a competent practitioner. Practitioners delivering these interventions should:

- be trained in the approach
- have the skills required for the specific intervention offered
- have access to ongoing supervision from an appropriately qualified professional

If the assessment suggests that a child or young person would benefit from one of these interventions, the intervention should be offered alongside structured support and interventions to meet their wider needs.

Elements of these interventions may be integrated into structured support under the oversight of a practitioner trained in the approach and with supporting clinical supervision.

The practitioners can use MI alongside the psychological treatments described in section 23.13.4 as they can be helpful in building the therapeutic alliance and engagement with treatment (Miller and Rollnick, 2023).

Cognitive behavioural therapy

Services can offer cognitive behavioural therapy (CBT) for children and young people aged 10 to 17 years who have alcohol problems and have limited comorbidities (other mental or physical health conditions co-occurring with alcohol problems) and good social support. This is a time-limited, structured psychological intervention. It is recommended by NICE guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115).

CBT can be effective in reducing alcohol use as well as other related problems. You can find guidance on CBT in section 5.6.4 in chapter 5 on psychosocial interventions.

Practitioners should adapt the CBT programme to the child or young person's developmental stage. The learning principles of CBT operate similarly for adults and children and young people. However, the behavioural targets of change, and how rewards for achievement are negotiated, will vary depending on the age and developmental level of the child or young person. For some children and young people, this may involve adding components to the programme to develop basic social and coping skills (Waldron and Kaminer, 2004).

Skills training

Skills training helps children and young people develop the knowledge, attitude and skills they need to cope with difficult life situations and to manage their emotions. These are important factors in supporting them to make healthy choices and to reduce harmful behaviours. This might include skills for resisting social pressure or dealing with feelings of exclusion. Learning new personal or social skills can be a component of CBT interventions, but skills training can also be offered as a standalone approach.

The NICE guideline Drug misuse prevention: targeted interventions recommends skills training is offered to children and young people and to their parents and carers. Practitioners will need to consider whether to offer these training sessions to children and young people and their parents and carers together, or as separate sessions.

Multicomponent programmes including family support and family therapies

Multicomponent interventions combine 2 or more intervention approaches. The exact combination of components in a programme depends on the specific needs of the child or young person. The components of the intervention should be agreed in partnership with the child or young person, their family, the specialist alcohol and drug treatment service and any other services involved in their care.

NICE CG115 recommends multicomponent programmes based on various approaches to family therapy (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for children and young people with significant co-morbidities and limited social support.

These are all intensive programmes provided over an extended period, generally between 3 to 6 months, with family sessions and individual interventions for both the child or young person and their parents or carers. Delivering these interventions needs trained and experienced practitioners, strong supervisory structures, and small caseloads.

NICE CG115 provides more detail on how these therapies can be used to support children and young people, their parents and wider family to make changes that will help the child or young person with their problem alcohol use.

23.14 Pharmacological interventions for children and young people

23.14.1 Medically assisted withdrawal

Alcohol dependence in children and young people is rare. But a minority of children or young people can be dependent on alcohol. Medically assisted withdrawal is needed if a young person is assessed as physically dependent.

Before medically assisted withdrawal

Chapter 10 on pharmacological interventions provides guidance on prescribing for medically assisted withdrawal and chapter 11 provides guidance on community medically assisted withdrawal. This section notes specific considerations and adjustments for children and young people. Clinicians prescribing and managing medically assisted withdrawal should follow the guidance in chapter 10 alongside this section and they should also consult the British National Formulary for Children (BNFC) because prescribing for children and young people is different to prescribing for adults.

Staff responsible for assessing and managing medically assisted withdrawal should be clinicians who are competent in:

- diagnosing and assessing alcohol dependence and withdrawal symptoms appropriate to the settings in which it is managed

- the use of drug regimens for children and young people

Before any treatment for dependence, it is important that a person's clinical history has determined alcohol dependence. It is important that anxiety symptoms or an anxiety disorder are not confused with withdrawal symptoms and inappropriate treatment started.

Polydrug use is an important consideration. Clinicians will need to carefully assess the level of use and dependence on any substance, particularly if the child or young person is using alcohol and drugs (such as opiates and benzodiazepines) together.

There is guidance in section 10.6.1 in chapter 10 on pharmacological interventions about medically assisted withdrawal for people with co-occurring alcohol dependence and drug use or dependence.

The clinician and keyworker in the children and young people's alcohol and drug treatment service should provide information about medically assisted withdrawal and what it will involve to the child or young person and to their parent or carer, including the risks and benefits for the child or young person. They should also inform other professionals involved in caring for and safeguarding the child or young person.

Involving the right people

Age-appropriate pharmacological interventions for problem alcohol or drug use need to involve specialist services and staff such as:

- paediatricians
- practitioners from the specialist alcohol and drug treatment service
- primary care
- CAMHS staff
- addiction psychiatrists
- nursing staff

If a child or young person needs medically assisted withdrawal, staff should involve children's social care.

When a child or young person needs pharmacological management, it is good practice to involve their parents and carers, even if they have been assessed as competent to consent to their own treatment. Practitioners should do as much as they can to make sure parents or carers are involved.

Medically assisted withdrawal should be only one component of a child or young person's care plan, and it should be integrated with psychosocial interventions. It should also be based on a comprehensive multi-agency assessment, including risk assessment.

Pathway to treatment

NICE CG115 provides guidance on delivering alcohol treatment to children and young people aged 10 years and older and includes a specific pathway for those aged 10 to 17 years old.

NICE recommends inpatient admission for medically assisted withdrawal. This should be in an age-appropriate setting with access to specialist alcohol treatment expertise. Children and young people should not be treated in an adult setting.

Any setting, such as a paediatric or CAMHS inpatient setting, that a child or young person is referred to should be registered with the national regulatory body.

There should be a clear local clinical pathway for children and young people who require inpatient medically assisted withdrawal. It should be agreed between commissioners, senior leaders of children and young people's healthcare services, specialist alcohol and drug treatment services and child safeguarding services. These partners should also agree referral and discharge routes. Agreeing the clinical pathway can help reduce unnecessary delay and help to improve patient safety if there is a need for a child or young person to undergo inpatient medically assisted withdrawal.

Settings such as secure estates, residential services, acute or mental health hospitals need to ensure that treatments delivered by specialist alcohol treatment clinicians are available to manage withdrawal, if a child or young person staying there needs it.

Prescribing for children and young people

Clinicians prescribing and managing medically assisted withdrawal should follow the guidance in chapter 10 alongside this section. They should also consult the BNFC.

Many medications for alcohol dependence will be off-label for children and young people aged 17 and under.

There are situations when clinicians might decide that using unlicensed medicines or using medicines outside the terms of the licence (known as off-label use) is in the best interest of the patient, based on available evidence.

Prescribers should be aware of their responsibilities when prescribing unlicensed or off-label medications, outlined in the Medicines and Healthcare products Regulatory Agency guidance Off-label or unlicensed use of medicines: prescribers' responsibilities.

Children and young people respond differently to medications than adults and younger children respond differently than older children. So, clinicians need to show detailed care and attention when making prescribing decisions for children and young people.

For those children and young people who require medically assisted withdrawal, clinicians can use benzodiazepines (chlordiazepoxide or diazepam) with doses adjusted based on their:

- age
- height
- weight

- stage of development

Clinicians should consult the BNFC.

It is important that any child or young person offered medically assisted withdrawal is closely monitored by competent specialist staff. What this looks like in practice will be based on clinical judgement determined on a case by case basis, but prescribing should be regularly reviewed.

You can find more information on pharmacological interventions for children and young people in secure settings in the 2009 Department of Health Guidance for the pharmacological management of substance misuse among young people in secure environments.

23.14.2 Relapse prevention

There is limited evidence from trials investigating the efficacy or use of relapse prevention medications in young people. Also, relapse prevention medications are not licensed for use in people aged 17 and under because of the lack of evidence to guide their use and safety in younger people. There are some pilot placebo-controlled or open-label randomised control trials of acamprosate, naltrexone or disulfiram in young people (mainly 15 to 19 years old). But all the studies are based on small groups and their results should be interpreted very cautiously (Clark, 2012).

NICE CG115 recommends that after a careful review of the risks and benefits, specialist clinicians can consider offering acamprosate or oral naltrexone, along with CBT, to young people over 16 who have not benefited from or engaged with a multicomponent treatment programme.

23.15 Resources

23.15.1 Guidance on children and young people's services

Establishing youth-friendly health and care services sets out 8 standards and associated quality criteria for youth-friendly services that have been developed in partnership with young people.

Multi-agency practice principles for responding to child exploitation and extra-familial harm is part of the Tackling Child Exploitation support programme, funded by the Department for Education and led by Research in Practice with the University of Bedfordshire and The Children's Society. It developed a set of practice principles to inform local and national responses to child exploitation and extra-familial harm. These principles are also helpful for working with children with vulnerabilities in general.

Getting it right for every child is a framework and shared language for promoting, supporting, and safeguarding the wellbeing of children and young people in Scotland. It includes principles and values for working with children and young people.

23.15.2 Resources for schools to teach about alcohol and drug use

The PSHE Association has developed drug education, a resource to support schools to teach about alcohol and drug use, including drug education for children with special educational needs and disabilities (SEND). These resources help teachers to plan age-appropriate lessons and to feel confident about informing young people about the law, risks and consequences associated with alcohol use. This resource is for schools in England.

23.15.3 Legal, statutory and policy frameworks

Specialist alcohol treatment and the competencies for working effectively with young people are different to those for adults. The resources below provide information on the different legal, statutory and policy frameworks for working with children, young people and their families.

Child safeguarding

Child safeguarding legislation and statutory guidance applies to both children and young people's services and adult services. You can find more information on the legislation and statutory guidance for each UK nation in annex 1.

Parental responsibility

All mothers and most fathers have legal rights and responsibilities as a parent. This is known as parental responsibility. You can find out more at Parental rights and responsibilities.

Parental responsibility is defined by UK legislation in the:

- Children Act 1989 for England and Wales (in section 3: meaning of "parental responsibility")
- Children (Scotland) Act 1995
- Children (Northern Ireland) Order 1995

Capacity to consent to treatment

The Care Quality Commission (CQC) has published a brief guide on capacity and competence to consent in under 18s (PDF, 80KB), which summarises the policy position and details relevant guidance and legislation in England.

Age of Legal Capacity (Scotland) Act 1991 (Section 2(4)) informs practitioner decisions about the capacity of a child under the age of 16 years to consent to their own treatment.

You can read more about Gillick competency and Fraser guidelines and making decisions about capacity to consent to treatment at the:

- NSPCC learning website's Gillick competency and Fraser guidelines
- CQC's GP mythbuster: Gillick competency and Fraser guidelines
- General Medical Council's 0 to 18 years guidance

Confidentiality

Confidentiality: NHS code of practice provides guidance to NHS and NHS-related organisations about patient information confidentiality issues. It also briefly outlines expectations and exceptions around confidentiality for children and young people.

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24. Pregnancy and perinatal care

How to support women and other people who are pregnant to reduce or stop their alcohol use to reduce risks for the fetus and mother. It covers information and advice, multi-agency care planning, specialist treatment for alcohol dependence and support in the perinatal period.

24.1 Main point

Guidance for maternity services, alcohol treatment services and other healthcare professionals

Alcohol can affect fetal development throughout pregnancy and can cause fetal alcohol spectrum disorder and perinatal complications.

Problem alcohol and drug use, deprivation and multiple disadvantage all increase the risk of a woman or person dying during pregnancy and up to a year after giving birth. Services should be designed to reduce these health inequalities.

Maternity, alcohol treatment and other healthcare professionals should support women and other people who are pregnant to reduce or stop their alcohol use as quickly and safely as possible. This reduces the ongoing exposure to the fetus and the risk and severity of future disability, as well as risks for the mother.

National Institute for Health and Care Excellence (NICE) quality standard Fetal alcohol spectrum disorder (QS204) recommends that:

Midwives and other healthcare professionals should give women clear and consistent advice on avoiding alcohol throughout pregnancy, and explain the benefits of this, including preventing fetal alcohol spectrum disorder (FASD) and reducing the risks of low birth weight, preterm birth and the baby being small for gestational age.

Midwives and other healthcare professionals should advise women and other people who are (or who could be) alcohol dependent not to stop drinking suddenly as this can increase risk to them and to the fetus. They should rapidly refer women or people who are or could be alcohol dependent for a specialist assessment for medically assisted alcohol withdrawal.

In line with NICE QS204, maternity staff should ask women and other people who are pregnant about their alcohol use at antenatal appointments throughout their pregnancy and record this.

Maternity staff should rapidly refer pregnant women and other people who are pregnant who are drinking heavily, are alcohol dependent, or have a history of problem alcohol use to a specialist alcohol treatment service. They should also refer them to the specialist maternity pathway for substance misuse or complex needs.

Women and other people who drink heavily during their pregnancy are often vulnerable and experience multiple disadvantage. Healthcare professionals need to use a non-judgemental and trauma-informed approach and prioritise helping them to engage in antenatal care, alcohol treatment, safeguarding and other services.

Professionals should use a multidisciplinary and multi-agency approach to co-ordinate care during pregnancy and the perinatal period for the mother or parent, baby and father or partner.

Where there is risk of significant harm to the unborn child or baby, professionals must make a child safeguarding (child protection) referral in line with national legislation and guidance and organisational procedures. Infants aged 2 years and under have the highest risk of mortality and serious harm compared to children in other age groups.

When a woman or other person who is pregnant is alcohol dependent, there are specific considerations to provide maternity care during pregnancy, at the birth and in the early postnatal period. The baby will need to be monitored by neonatal paediatricians after the birth and may require specialist interventions.

Where there has been significant prenatal alcohol exposure, the child will need ongoing monitoring. If children do not meet developmental milestones, clinicians should refer them through local FASD diagnostic and support pathways or to the national FASD clinic if there is no local pathway.

Parental alcohol use is an established risk factor for sudden unexpected deaths in infancy. All services should be able to give accurate advice on safe sleeping for babies.

Healthcare professionals, including practitioners in alcohol treatment services, should offer pre-conception information and advice on contraception to women and other people of child-bearing age with problem alcohol use. Where there has been an alcohol exposed pregnancy, they should offer advice on contraception soon after the birth of the baby or refer women and other people to sexual health services for this advice.

Maternity services should ensure that maternity staff have training in the chief medical officer's guidelines on drinking in pregnancy, fetal alcohol syndrome awareness and in alcohol brief interventions. Alcohol treatment services should ensure their staff also have training in these areas.

Guidance for alcohol treatment services

Alcohol treatment services should prioritise referrals for women and people who are pregnant or have a baby, even if they are not currently drinking. This is to reduce risks to the fetus (and after birth, the baby) and to the mother.

Alcohol treatment services should offer flexible support and remove any barriers to engagement. For example, they should offer home visits where possible.

Alcohol treatment services should recognise that pregnancy and the perinatal period is a vulnerable time. During the perinatal period, women and other people have an increased risk of returning to problem alcohol use, mental health problems and domestic abuse. Alcohol treatment services should offer frequent and regular psychosocial support after the birth and extend the period of support where necessary. They should also refer women and other people to appropriate services, including perinatal mental health services.

There are specific considerations for alcohol treatment clinicians when they provide pharmacological interventions during pregnancy and during breastfeeding. See section 10.6.4 in chapter 10 for more information about these considerations.

24.2 Introduction

This chapter includes guidance on:

- providing information on the risks of alcohol use during pregnancy for all pregnant women and other people who are pregnant
- identification, support and treatment for women and other people with alcohol dependence or who drink heavily during pregnancy

The guidance is for clinicians and practitioners working with women and other people during pregnancy and the perinatal period. The term 'perinatal period' used in this chapter means pregnancy and up to one year after birth.

The guidance is relevant for all practitioners working across maternity services, alcohol treatment services and other health services unless there is a statement saying that it is specifically for maternity services or for alcohol treatment services.

24.3 Prenatal alcohol exposure and fetal alcohol spectrum disorder

The UK has the fourth highest estimated prevalence of alcohol use during pregnancy in the world (Popova and others, 2017). Alcohol is a teratogen, which means it can affect fetal development throughout pregnancy and cause birth defects and perinatal complications. NICE QS204 states that alcohol use in pregnancy increases the risks of:

- low birth weight
- preterm birth
- the baby being small for gestational age

Research has also shown that alcohol use in pregnancy has a significant risk of miscarriage in the first trimester (Kesmodel and others, 2002).

Prenatal alcohol exposure (PAE), which occurs when a woman or person who is pregnant drinks alcohol during their pregnancy, can result in FASD. FASD is a term that describes the wide range of outcomes that can result from PAE, including lifelong physical, cognitive, behavioural, and mental health difficulties. FASD can affect facial features and growth. However, it is now well-recognised in research and in clinical practice that the facial features (described in national guidance like NICE QS204 and the Scottish Intercollegiate Guidelines Network (SIGN) guideline156 as 'sentinel' features) are only found in a minority of babies with FASD.

Reducing fetal alcohol exposure reduces the risk of FASD. However, it is not possible to quantify a 'safe' level of alcohol use. The UK chief medical officers' advice on low risk drinking is that women who are pregnant or think they could become pregnant should completely avoid alcohol.

24.4 Risks to women during or up to a year after pregnancy

The report Saving Lives, Improving Mothers' Care 2024 (by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)) found that 9% of the women who died during or up to 6 weeks after pregnancy in the UK in 2020 to 2022 had severe and multiple disadvantages, such as:

- mental health diagnosis
- alcohol and drug use
- domestic abuse

Deaths from mental health-related causes continue to account for a large proportion (34%) of deaths occurring between 6 weeks and a year after the end of pregnancy with deaths due to problem substance use and other psychiatric causes the leading cause of deaths in this period.

There are differences in maternal mortality rates between White women and women from other ethnic backgrounds, including that:

- Black women are 2.9 times more likely to die than White women
- Asian women are 1.7 times more likely to die than White women
- women of mixed ethnicity are 1.3 times more likely to die than White women

Also, women living in the most deprived areas continue to have maternal mortality rates twice that of women living in the least deprived areas.

It is vital that services are designed to respond to these increased risks, and staff are aware of them. Staff need to work together to provide supportive personalised multidisciplinary care to reduce these health inequalities.

24.5 Principles and interventions for working with all women and other people who are pregnant

24.5.1 Principles

The principles for working with women and other people who are pregnant are to:

- provide personalised care during pregnancy and in the perinatal period
- support women and other people who are pregnant to reduce (and when safe to stop) their alcohol use as quickly as possible to reduce the ongoing exposure to the fetus and the risk and severity of future disability
- support women and other people who are pregnant in a non-judgemental, non-stigmatising way

These principles are based on consensus of the alcohol guidelines development group.

24.5.2 Providing advice on avoiding alcohol use in pregnancy

NICE QS204 recommends that:

Midwives and other healthcare professionals should give women clear and consistent advice on avoiding alcohol throughout pregnancy, and explain the benefits of avoiding alcohol, including preventing fetal alcohol spectrum disorder (FASD) and reducing the risks of low birth weight, preterm birth and the baby being small for gestational age.

It also recommends that:

They provide verbal and written advice, based on the UK chief medical officers' low-risk drinking guidelines, that the safest approach is to avoid drinking any alcohol during pregnancy. This includes information that the risk of harm to the baby is likely to be low if only small amounts of alcohol have been consumed but that further drinking should be avoided. They use a non-judgemental approach, discuss any concerns, and provide support and information according to the woman's needs, which may include a structured conversation, help to stop drinking through a brief intervention or referral to specialist services.

Midwives, alcohol treatment practitioners, and other healthcare professionals should advise women and other people who are pregnant and who are (or who may be) alcohol dependent not to stop drinking suddenly. This is because withdrawal complications risk harm to the fetus and the mother or parent. Professionals should rapidly refer them to specialist alcohol treatment to be assessed for medically assisted alcohol withdrawal, so they can stop drinking safely (see section 24.13.1 on assessment for alcohol treatment during pregnancy).

The verbal and written information and advice that services provide should be easy to understand and available in accessible formats including easy read and in a range of languages that reflect the demographics of the population. Services should arrange for independent interpreters (not a family member or friend) to be available for women and other people who do not speak English as their first language.

24.5.3 Asking women and other people who are pregnant about their alcohol use

NICE QS204 recommends that pregnant women are asked about their alcohol use throughout their pregnancy and this is recorded:

Talking about and recording alcohol consumption during pregnancy allows personalised discussions about the risks of alcohol use as part of routine healthcare throughout pregnancy. It also gives opportunities to offer tailored support and interventions if the woman wishes to cut down or stop drinking. This may reduce risks and improve outcomes for the mother and baby. Women should be asked about their alcohol consumption in a sensitive, non-judgemental way. Women who wish to discuss their alcohol use should be asked about the quantity, frequency, and pattern of drinking, and this should be documented in their maternity records. This information may also help support early diagnosis and treatment for children with fetal alcohol spectrum disorder (FASD).

Early diagnosis and treatment of FASD can improve a child's future outcome.

24.5.4 Screening tools

Some services use screening tools when they ask women and other people about their alcohol use. Screening tools are one way of introducing a conversation about alcohol. But if services are using screening tools, these should be used to support the conversation, not replace it. Forming a trusting relationship where the person feels able to talk about their alcohol use is vital. Conversations based on the principles of motivational interviewing can help people to talk about their drinking and consider change.

You can find guidance on motivational interviewing in chapter 5.5.6 on psychosocial interventions.

The advice on levels of health risk that accompanies most alcohol screening tools is based on the UK chief medical officers' low risk drinking guidelines, which refer to health risk for adults. Risk to the fetus is likely to begin at much lower levels than risk to adults. Although reducing fetal alcohol exposure reduces the risk of FASD, it is not possible to quantify a 'safe' level of alcohol use during pregnancy. The guidelines refer to research that shows the risks of low birth weight, preterm birth and being small for gestational age may all be increased if mothers drink above 1 to 2 units per day during pregnancy.

Currently there is only limited evidence for the use of screening tools in pregnancy.

In a systematic review of alcohol use screening tools, the following screening tools were found to be helpful in screening for risky drinking (Burns and others, 2010):

- Alcohol use disorders identification test for consumption (AUDIT-C), available in the guidance Alcohol use screening tests, is a test to quickly identify alcohol harm.
- T-ACE (an acronym based on the subjects of the screening questions: tolerance, annoyance, cut-down, 'eye-opener'), a tool used to screen for risky alcohol use in pregnant women.

However, the review's authors recommended caution, saying that there should be further evaluations of questionnaires for prenatal alcohol consumption. Other research has shown that the effectiveness of these tools may also vary according to cultural context (Russell, 1994). In services that use screening tools, staff should be trained to use them and to interpret the scores to inform an appropriate intervention.

Scotland's SIGN guideline 156 recommends that services consider using AUDIT-C, TWEAK and T-ACE screening tools, but also says there are potential limitations to these tools.

24.6 Initial interventions in maternity services to stop or reduce alcohol use

Guidance in section 24.6 is for staff in maternity services. Maternity staff should also read guidance in the rest of this chapter except section 24.13, which is specific to staff in alcohol treatment services.

Maternity staff and other healthcare professionals should offer women and other people who use alcohol during pregnancy an intervention based on an individual assessment of the level of their alcohol use and other relevant risk factors.

Interventions could include the following.

24.6.1 People with very low levels (low risk) of alcohol use

For very low levels of alcohol use and no other risk factors, services should provide appropriate information and guidance to support decision making. They should then continue to review the woman or person's alcohol use and advise that avoiding alcohol is safest for the fetus and the mother or parent.

24.6.2 People with previous problem alcohol use or co-occurring mental health or physical health conditions

For women or other people who are pregnant who have had previous problems with alcohol use, or who are drinking above very low levels and have additional needs such as a mental health condition, services should offer a:

- brief alcohol intervention (staff should be trained to offer this)
- referral to community alcohol treatment service for psychosocial support

Services should refer the person to a specialist midwife or substance misuse midwife (through local specialist maternity pathways) and other relevant services.

24.6.3 People who may be alcohol dependent

For women and other people who are pregnant and have alcohol dependence, possible alcohol dependence or who are drinking heavily, services should advise them not to stop drinking suddenly, because of the risk of harm to the fetus and themselves.

Services should:

- refer the woman or person and help them to quickly access specialist alcohol treatment
- refer the woman or person to a specialist midwife or substance misuse midwife (through local specialist maternity pathways)
- provide a contact number for a named specialist midwife or doctor
- refer the woman or person to other relevant services, such as children's social care for safeguarding, domestic abuse or mental health

Women and other people who are pregnant will often be involved with several services, so it's important that they can have a consistent relationship with healthcare professionals in those services and that their care is well co-ordinated.

24.6.4 Alcohol as a coping strategy

Healthcare professionals should be aware that women or other people who are pregnant who have a history of using alcohol as a coping strategy are at significantly increased risk from stressful events during pregnancy even if they are not using alcohol regularly. For example, stressful events could include:

- relationship conflict
- domestic abuse
- safeguarding assessments
- pregnancy-related problems

Signposting women or other people who are pregnant to additional support such as mental health support or domestic abuse services and referring them to community alcohol treatment services can help and encourage them to develop alternative self-support strategies.

24.7 Supporting women and other people with alcohol dependence or problem alcohol use who are pregnant

24.7.1 Principles

The following principles are for staff in maternity services, alcohol treatment services, other healthcare staff (midwives, nurses, doctors, health visitors) and staff in other relevant services.

These principles are based on consensus of the alcohol guidelines development group.

Make every effort to provide accessible care and to engage women and other people who are pregnant and who are alcohol dependent or drinking heavily. This could be women or other people in antenatal care, alcohol treatment and other relevant services.

Recognise that women and other people who are pregnant and who are alcohol dependent or drinking heavily:

- are often vulnerable
- experience multiple disadvantage
- can have past or current experience of trauma

So, you should use a trauma-informed approach and treat them with respect. You can read more about this in the Working definition of trauma-informed practice.

A roadmap for creating trauma-informed and responsive change: guidance for organisations, systems and workforces in Scotland also provides extensive guidance on implementing a trauma-informed approach.

Make sure that women and other people who are pregnant have the information they need to make decisions and to give consent, in line with the:

- General Medical Council's guidance on decision making and consent
- Nursing and Midwifery Council's code on professional standards of practice and behaviour
- 2015 Montgomery ruling

Act to safeguard the unborn child and newborn baby in line with national legislation and organisational safeguarding procedures. The duty to act to protect a child at risk of significant harm includes the unborn child (see annex 1 on legislation and guidance).

Make sure the woman or person who is pregnant can access a comprehensive assessment of their needs, including:

- alcohol use
- substance use (including illicit drugs, prescription medication, whether prescribed or obtained illicitly, and over the counter medication or herbal medication)
- smoking
- domestic abuse
- mental health
- housing need

Take a multidisciplinary, multi-agency approach involving maternity services, alcohol treatment services, health visiting and other relevant services such as children's social care, mental health (including perinatal mental health teams) and domestic abuse throughout pregnancy, at birth and after birth.

Involve fathers, partners and family members, unless it is unsafe or inappropriate to do so.

Support fathers, partners and family members in their own right, even where it is not appropriate for them to be involved in the care of the pregnant woman or person.

24.7.2 Understanding and addressing vulnerability and multiple disadvantage

Women and other people who are pregnant who have alcohol dependence or who are drinking heavily during pregnancy are likely to be vulnerable and experience multiple disadvantage (also referred to as multiple and complex needs). NICE clinical guideline Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110) notes that vulnerable women who experience multiple disadvantage are less likely to access and adhere to antenatal care and guidance.

It is vital for the health of the woman or person who is pregnant and the health of the fetus that maternity services, alcohol treatment services, health visitors and other healthcare and social care services can engage and effectively support them. How effectively they are engaged with these services will depend on staff understanding the complex psychological and social factors vulnerable women and other people who are pregnant experience and responding appropriately.

Teenage pregnancies are generally (although not always) unplanned, and they are associated with higher risk. So, services need to treat teenage girls and young women and other young people who are pregnant to reduce these risks where possible and provide support throughout the antenatal and postnatal period.

Many areas have specific antenatal and postnatal pathways for teenage and young parents which may be through the named safeguarding midwife or through a dedicated midwife for teenage parents. Practitioners must act in line with national and organisational child safeguarding guidance, considering safeguarding needs of the mother or parent and the unborn child.

Note that sexual activity with children under 13 years is always illegal and always requires a child protection referral.

24.7.3 Supporting and maintaining engagement

Barriers to getting help

Women and other people who are pregnant who are alcohol dependent or who are drinking heavily can experience anxieties that deter them from seeking help or engaging with support, including:

- problems in forming trusting relationships because of past or current trauma
- fear or guilt about the impact of their alcohol use on their unborn child
- fear that their baby may be removed into care
- anxieties based on previous bad experiences of services

Vulnerable women and other people might be unaware of available help. They may also experience other barriers to accessing services, including:

- inflexible appointment times
- geographically inaccessible services
- service information that is not accessible or easy to understand
- stigma (feeling judged by staff and others accessing services)
- lack of staff with competence to work with vulnerable women and other people

Recent migrants, refugees and asylum seekers may experience language or cultural barriers or have fears about their immigration status. Some vulnerable migrants might have no recourse to public funds and need support in understanding their entitlements.

How services can improve access to support and treatment

Services and staff should work to reduce barriers to engagement by:

- building trusting relationships
- having straightforward access and flexible engagement processes
- providing clear information that encourages shared decision making

Services can build trusting relationships by making sure their staff are trauma-informed and culturally competent. They should provide continuity of care between midwifery and health

visiting services with a consistent team and named practitioner that co-ordinates care during pregnancy, birth and in the postnatal period.

You can find more guidance on continuity of care in NICE guideline Antenatal care (NG201) and guidance 'Care continuity between midwifery and health visiting services: principles for practice' in Supporting public health: children, young people and families.

Antenatal and alcohol treatment services should work to reduce barriers to access by:

- timing appointments to suit the person
- meeting women and other people where they live or at another service they attend
- offering to pay transport costs

Staff should take a proactive and persistent approach, including sending friendly reminder texts or calls for appointments and missed appointments.

Services should provide clear information and advice, including about:

- the risks of alcohol use in pregnancy
- the risks to women and other people with alcohol dependence of stopping drinking suddenly
- accessing their services and other relevant services provided elsewhere
- what to expect after they give birth, including medical care the baby may need
- any potential involvement of child safeguarding services

All information you provide to the woman or person should be accessible and tailored to their particular needs, including considering:

- first language
- literacy
- sensory impairment
- cognitive impairment
- neurodiversity

You can find more guidance on providing information to women and other people during pregnancy in NICE NG201 and CG110.

24.7.4 Safeguarding

Services must make a safeguarding referral, in line with national legislation and organisational safeguarding procedures, where there:

- is a significant risk of harm to the unborn child due to ongoing heavy drinking or alcohol dependence during pregnancy

- are other issues of concern, such as mental health conditions or domestic abuse

Early referral to child safeguarding services helps the agencies to co-ordinate care for the mother and baby and to safeguard the baby after birth. When considering safeguarding referrals, practitioners should consider that reviews of child deaths and serious harm show that infants between 0 and 2 years are the age group at highest risk (NSPCC, 2023). Services should work together to maximise the chance of the ideal outcome of the mother or parent and baby safely remaining together.

You can find more information on child safeguarding guidance (which includes unborn children) in annex 1.

If the safeguarding referral is against the parent's wishes, the practitioner making the referral should explain the reason for the referral and that there is a legal requirement for them to do so (unless informing the parent would put a child at further risk) and respond sensitively to the parent's concerns. The practitioner should try to maintain remote or in-person contact with the parent to support them and review their wellbeing. Women and other people who have had other children removed may be particularly vulnerable.

24.7.5 Multidisciplinary, multi-agency assessment and care planning

All services involved with the woman or person during pregnancy and the perinatal period will need to work together to co-ordinate care and share information appropriately. This will include joint multidisciplinary and multi-agency assessment and care planning, including safeguarding.

Maternity and alcohol treatment services working together

Access to maternity and alcohol treatment services, and engagement with them, is essential for a safe and healthy pregnancy for the woman or person and the fetus. Commissioners, strategic managers and clinical leads for maternity and alcohol treatment services should agree 2-way referral pathways and services should have working relationships with each other. Vulnerable women or other people who are pregnant may also need urgent access to services for co-occurring conditions such as mental health, or social factors like domestic abuse or housing.

The optimal care for women or other people who are pregnant who have problem alcohol use is a specialist multidisciplinary clinic for alcohol and drug use in pregnancy, provided by maternity and specialist alcohol treatment services working together. Where this is not available locally, services will need to co-ordinate multidisciplinary, multi-agency care and appropriate information-sharing arrangements.

What multidisciplinary, multi-agency care planning involves

Multidisciplinary, multi-agency care planning should cover pregnancy, birth and the perinatal period. Maternity and alcohol treatment services need to work together and:

- be clear about the role of each agency and which professional is responsible for each agreed task

- assess, manage and review risks as they change throughout the pregnancy, at the birth and in the perinatal period
- plan maternity care and alcohol treatment interventions
- make sure they include safeguarding (child safeguarding services will lead on the safeguarding plan)
- involve the GP
- address co-occurring conditions including substance use, tobacco use, mental health, physical health complications and social factors such as domestic abuse or housing
- make sure referrals and support to access appropriate agencies are made without any unnecessary delays
- arrange support for parenting during pregnancy and in the perinatal period
- include support for the father or partner in their own right where this is needed
- wherever possible, fully involve the woman or person in the assessment and care planning, taking into account their views on their own needs and those of their unborn child
- keep the woman or person informed of any changes to plans
- involve fathers, partners or family members in assessment and care planning, unless it is unsafe or inappropriate to do so
- make clear agreements between services about sharing information and regularly review and update the information
- share information on attendance, missed appointments and alcohol consumption with members of the team
- align service care plans and consider developing one integrated care plan
- consider developing shared electronic notes which can be seen by relevant professionals

It is always best practice to ask consent to share information. However, you can share information without consent if the unborn or child is at risk of significant harm.

If the mother loses a baby through miscarriage or death, or there are plans to remove the baby into care, you will need to provide support for the parents such as perinatal mental health or bereavement support.

24.7.6 Involving fathers, partners and family

Services should assess strengths and any risks in the family network as part of the multi-agency assessment and child safeguarding services will usually lead on this. Family members can contribute to assessment and care planning, where it is appropriate and with the woman or other person's consent. Family members can play an important role in supporting

the woman or person to stop or reduce their alcohol use during pregnancy and the perinatal period.

Fathers or partners can contribute to supporting the woman or person where there are no indications of risk to them or to the fetus. NICE NG201 recommends that maternity staff ask all women and other people about domestic abuse in a kind, sensitive manner at the first antenatal (booking) appointment, or at the earliest opportunity when she is alone.

Staff should make a careful assessment of the level of any risk posed by the partner and make a child safeguarding referral where there is a risk to the unborn child and the mother or parent. They should work with domestic abuse services to reduce risk and follow relevant legislation and organisational procedures on domestic abuse. The partner should not be involved in assessment and planning for the woman or person's needs in situations where they pose a risk of perpetrating domestic abuse.

Services should offer the father or partner access to information and support where they have a need. If the father or partner also has problem alcohol or drug use, services should encourage them to access alcohol or drug treatment. The Department for Education report Children's needs: parenting capacity (second edition) suggests an association between fathers who drink heavily and increased risk of babies with lower birth weight or heart defects, and spontaneous abortion and neonatal deaths are associated with heavy drinking of either parent. Services should also provide or refer fathers or partners for stop smoking support.

Multidisciplinary, multi-agency care planning should continue after the birth. There is guidance on this in section 24.9.1.

24.8 Maternity care for women or other people who are pregnant who are alcohol dependent or drinking heavily

Guidance in section 24.8 is for maternity services. This guidance should be considered alongside the following NICE guidelines and, for Scotland, SIGN clinical guideline:

- NICE CG110
- NICE NG201
- NICE QS204
- SIGN 156

24.8.1 Additional antenatal appointments and care

NICE NG201 recommends additional or longer antenatal appointments if needed, depending on the woman or other person's medical, social, and emotional needs. This is relevant for women or other people who are pregnant and are alcohol dependent or who are drinking heavily during pregnancy.

If there has been PAE, you should arrange for the woman or other person to have extra growth scans in addition to the 20-week fetal anomaly scan.

Evidence of fetal growth restriction could be due to a variety of reasons, including:

- poor mental health
- poor maternal diet
- perinatal alcohol exposure
- substance use
- maternal health problems, for example with blood pressure

Where there is PAE and poor fetal growth, you should share this information with neonatal paediatric teams for postnatal assessment, because PAE as a cause of poor fetal growth can be overlooked.

Maternity staff should be aware that liver damage due to long term alcohol use or hepatitis C in mothers may increase the risk of transmission of hepatitis C from to the fetus during pregnancy or the baby at or after birth. If the woman or person has a history of injecting drug use, services should offer to test for blood-borne viruses and explain why that is important.

24.8.2 Birth plan

Wherever possible, maternity services should work with women and other people who are pregnant who have alcohol dependence or are drinking heavily, to devise a carefully considered specialist labour and birth plan.

The plan should include and address:

- risk of seizures, especially in association with hypertension
- risk of arriving in an intoxicated state in labour, which may be due to concerns about inadequate pain relief or for other reasons
- safeguarding arrangements

24.8.3 The newborn baby with PAE

Newborn infants with PAE will require monitoring by a specialist neonatal paediatric team. Increased risks to newborn infants include (but are not limited to) intrauterine growth restriction which can lead to complications, such as hypoglycaemia (low blood sugar).

If mothers or parents are alcohol dependent or have recently used alcohol before delivery (within the previous 24 hours), then the baby might not respond normally at the time of delivery and in the early postnatal period. This can lead to an increased chance of needing resuscitation support at the birth.

This can also affect the baby's metabolism and cause drowsiness, resulting in poor feeding. Both these factors increase the risk of hypoglycaemia. Specialist neonatal paediatric teams should test for this regularly according to local protocols. The baby may need feeding support with the help of a nasogastric tube until they are able to feed normally.

Where there has been PAE throughout pregnancy, the baby may show evidence of acute withdrawal in the first couple of days after birth and may develop seizures consistent with acute alcohol withdrawal. Clinicians should follow local protocols for treating and monitoring the baby.

Complex neurodevelopmental problems resulting from FASD may not appear until many years later, although a small number of babies could show features consistent with FASD. If there has been significant PAE, or babies have clinical features consistent with FASD, clinicians working with the baby should identify the baby as being 'at risk of FASD due to PAE' and refer them for follow-up using local pathways.

If a child is adopted and later needs to be assessed for developmental problems, information on PAE should be considered as part of the assessment.

When considering safeguarding issues concerning the newborn infant, clinicians must act in line with child safeguarding legislation and guidance (see section 24.7.4 on safeguarding above). They should carry out any agreed actions recorded in the safeguarding birth plan and share all relevant information with local children's social care services.

24.9 Ongoing care after birth

Section 24.9 contains guidance for all health and social care practitioners, including health visitors and staff in alcohol treatment services.

24.9.1 After the birth: multidisciplinary, multi-agency care planning

Multidisciplinary care plans for women or other people who are alcohol dependent or drink harmfully (including those who stop drinking during pregnancy) should cover the period immediately after the birth and for the first year of the baby's life.

Local services should continue to work together to offer mothers or parents and babies (and fathers or partners) tailored support. These include:

- maternity services
- alcohol treatment services
- health visiting services
- safeguarding services
- GPs and primary care and smoking cessation services
- other relevant services

Support needs can include support for the woman or parent's own mental health, and for the developing relationship between mother or parent and baby and help to manage conflict between parents. This support could come from:

- the perinatal mental health team
- health visitors

- adult mental health services
- other relevant services

In England, referrals to the perinatal mental health team will be fast-tracked for mothers or parents with complex needs, including alcohol and drug problems.

Services should work together to provide appropriate support to maximise the chance of the ideal outcome of the mother and baby safely remaining together.

24.9.2 Ongoing monitoring of the child's development

If you have concerns that children born to mothers or parents with problem alcohol use during their pregnancy have delayed or atypical development outcomes, you should arrange for regular monitoring and review of their developmental milestones. This can be done by a health practitioner such as a health visitor, school nurse or GP.

If children do not meet their developmental milestones, you should refer them through local FASD diagnostic and support pathways. This will usually mean referring the child to local services for children with established neurodevelopmental issues. You should sensitively discuss any need for assessment with the parents in a non-judgemental way. Where local pathways do not exist, you can refer children and adults to the national clinic for FASD (UK wide).

24.10 Contraception and family planning

Section 24.10 contains guidance for healthcare practitioners, including those in alcohol treatment services.

To reduce the risk of alcohol-exposed pregnancies, clinicians and healthcare practitioners (including those in alcohol treatment services) should advise women and other people who are pregnant about the risks of PAE, including FASD.

Services should provide information on the risks and benefits of various contraception options, including long-acting reversible contraception (LARC), to women of child-bearing age and other people who may become pregnant. Services can also refer them to sexual health services for this advice.

If a woman or person has given birth after an alcohol exposed pregnancy, clinicians should discuss contraception with them soon after the birth to reduce the risk of further PAE. Clinicians should be sensitive to where this advice would not be appropriate.

There should be referral pathways in place to sexual health services, including an enhanced pathway for women or other people who are assessed as being at risk of an alcohol exposed pregnancy.

24.11 Reducing risk of deaths in mothers and babies

The guidance in s section 24.11 is for all staff in healthcare services, including maternity staff and health visitors, staff in alcohol treatment services, and in children's services.

24.11.1 Sudden unexpected deaths in infancy

Parental alcohol use is an established risk factor for sudden unexpected deaths in infancy (SUDI). The national 2020 Child Safeguarding Practice Review Panel report Safeguarding children at risk from sudden unexpected infant death found that almost all of the 14 deaths they analysed involved parents co-sleeping in unsafe sleep environments with infants, often when the parents had consumed alcohol or drugs. The finding was consistent with findings from other reviews, including an analysis of 27 serious case reviews of sudden unexplained deaths in infancy that showed the majority of deaths involved the combination of parental problem alcohol or drug use and co-sleeping (parents and babies sleeping in the same bed or on the same sofa or armchair) (Garstang and Sidebotham, 2018). All services should provide consistent advice on safe sleeping arrangements using the NHS advice on reducing the risk of sudden infant death syndrome or equivalent national guidance. This is everyone's responsibility, not just one service or practitioner.

24.11.2 Maternal mental health and deaths

Problem alcohol and drug use and multiple disadvantage (including mental health conditions and domestic abuse) are significant risk factors for maternal death up to a year after birth (see section 24.4 on risks to women during or up to a year after pregnancy above). The 2021 MBRRACE-UK report Saving Lives, Improving Mothers' Care - 2017 to 2019 made the following recommendation for action by all health professionals:

"Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy."

The 2021 MBRRACE-UK report also includes the following 2 recommendations:

New expressions or acts of violent self-harm are 'red flag' symptoms and should always be regarded seriously. New and persistent expressions of incompetency as a mother or estrangement from the infant are 'red flag' symptoms and may be indicators of significant depressive disorder.

Loss of a child, either by miscarriage, stillbirth and neonatal death or by the child being taken into care increases vulnerability to mental illness for the mother and she should receive additional monitoring and support.

You can find guidance on self-harm in the NICE guideline Self-harm: assessment, management and preventing recurrence (NG225).

24.12 Training

The guidance in section 24.12 is for midwives working in antenatal care and for practitioners in alcohol treatment services.

NICE QS204 recommends that commissioners should make sure that midwives providing antenatal care:

- are aware of the risks to the fetus of drinking alcohol in pregnancy and the advice in the UK chief medical officers' low-risk drinking guidelines on alcohol consumption in pregnancy
- have training on FASD awareness
- have training in alcohol brief interventions (see chapter 3 for guidance on alcohol brief interventions)

The alcohol clinical guidelines development group recommend that alcohol treatment services make sure their practitioners also have training in the above areas.

NICE CG110 recommends that training should be given to:

- healthcare professionals on multi-agency needs assessment and national guidelines on information sharing
- healthcare professionals on the social and psychological needs of women with alcohol or drug problems
- healthcare staff and non-clinical staff, such as receptionists, on how to communicate sensitively with women with alcohol or drug problems

The alcohol clinical guidelines development group also recommend that:

- training should include trauma-informed practice and awareness-raising about stigma experienced by women and other people who are pregnant and have problem alcohol use, particularly those who have previously had children removed from their care (see section 2.2.2 on stigma in chapter 2 on principles of care)
- healthcare practitioners' knowledge could be enhanced through multi-agency training where maternity care staff, alcohol treatment staff and social workers share their expertise

24.13 Specialist alcohol treatment

The guidance in section 24.13 is for alcohol treatment services. Alcohol treatment clinicians and practitioners should also read the guidance in the rest of this chapter (except section 24.6 and 24.8 which are specific to maternity services).

You should read this section together with section 24.7 on supporting women and other people with alcohol dependence or problem alcohol use who are pregnant.

24.13.1 Assessment for alcohol treatment during pregnancy

You should read this section along with chapter 4 on assessment and treatment and recovery planning, which provides guidance on specialist assessment for alcohol treatment. This section includes additional guidance that is specific to assessment during pregnancy and the perinatal period.

Prioritising women and other people who are pregnant

Women and other people who are pregnant should be regarded as a priority for alcohol treatment and services should fast track them into treatment, engaging them as early as possible. Services should treat women and other people who are pregnant as a priority for both assessment and treatment interventions. Any delay in starting treatment may increase the risk to the mother or parent and the fetus.

Services should urgently assess the needs of the pregnant woman or person, even if they:

- are currently drinking below the usual threshold for accessing an assessment
- have a history of problem alcohol use but are not currently drinking

This is to reduce risks to the fetus and the mother or parent, and to ensure they have appropriate support during a vulnerable period.

Women and other people may also become pregnant while in treatment, so alcohol treatment services should offer pregnancy tests and make it clear these are available. The guidance below is relevant whether the woman or person who is pregnant is a new referral to the service or is already engaged in treatment.

However, it is important to advise anyone who is pregnant or think they could be, not to stop suddenly as this could cause harm to them or the baby. The assessor should arrange an assessment for medically assisted withdrawal as soon as possible.

Initial assessment

At the initial assessment, the assessor should:

- seek to build a trusting relationship using a trauma-informed approach
- discuss antenatal care and make an urgent referral through the local maternity services pathway, if the pregnant woman or person is not engaged with this already
- speak to their GP, maternity services and other relevant services
- make a safeguarding (child protection) referral in line with legislation and organisational safeguarding procedures, where there may be a risk of significant harm to the unborn child (see section 24.7.4 on safeguarding)
- refer the woman or person to sexual health services or to their GP for advice and counselling if they are considering a termination
- provide accessible information and advice on the risks of alcohol use during pregnancy, including FASD, as set out in section 24.5 on principles and interventions for working with all women and other people who are pregnant
- take actions to support and maintain the woman or person's engagement with treatment (see section 24.7.3)
- involve fathers, partners or family members unless it is not safe or appropriate (see section 24.7.6 on partner and family involvement)

Alcohol treatment services should have effective pathways with maternity and midwifery services. In many areas, this will be through their local specialist midwife services or a named substance misuse midwife. If the pregnant woman or person is not yet engaged with antenatal care, the alcohol treatment practitioner should rapidly refer them through these pathways. If there are no local specialist or substance use maternity pathways, the alcohol treatment practitioner should refer the pregnant woman or person to the local named safeguarding midwife or locally designated maternity pathway for problem alcohol or drug use.

Assessing for medically assisted withdrawal and health conditions

If the woman or person is (or may possibly be) alcohol dependent, a specialist clinician in the alcohol treatment service should assess them for medically assisted withdrawal as quickly as possible and refer them for this where required. The plan for medically assisted withdrawal and for subsequent care should involve the obstetrician (see section 24.13.2 on pharmacological interventions below). The obstetrician should discuss with the woman or person:

- the risks and benefits of this intervention
- how these risks and benefits apply to them
- the necessary information for them to make an informed decision about the treatment

Clinicians should consider specialist inpatient medically assisted withdrawal for women and other people who are pregnant, because these settings should have the necessary facilities and staff competencies. The multi-agency team, including the obstetrician, should also assess with the woman or person whether it would be appropriate for them to begin residential rehabilitation after medically assisted withdrawal.

The specialist alcohol treatment clinician should make a thorough assessment of the person's:

- alcohol use
- substance use (including illicit drug use, prescription medication, whether prescribed or obtained illicitly, and over the counter medication or herbal medicines)
- tobacco use
- physical health
- mental health needs

They should make referrals to appropriate health services if needed and provide (or refer to) smoking cessation advice and support where needed.

The clinician should provide ongoing monitoring of the woman or person's physical and mental health and share information with:

- maternity services
- primary and secondary care health services
- safeguarding services
- other relevant services

24.13.2 Pharmacological interventions for alcohol dependence during pregnancy

You can find guidance on pharmacological interventions during pregnancy and during breastfeeding in section 10.6.4 in chapter 10 on pharmacological interventions.

You should read section 10.6.4 if you are considering prescribing for medically assisted withdrawal during pregnancy or during breastfeeding. It includes guidance on medications that should not be used during pregnancy for safety reasons.

Medication for relapse prevention is not normally recommended for someone who is pregnant or breastfeeding, but you should read guidance on this in section 10.6.4 of chapter 10 for further consideration.

Assessing social factors including domestic abuse

The main assessor should make sure they assess social factors, including domestic abuse, since pregnancy is a risk factor for domestic abuse. During pregnancy, domestic abuse may increase or begin for the first time. So, assessors, specialist clinicians and keyworkers should be vigilant and ask sensitively about domestic abuse at assessment and subsequent reviews and make referrals where necessary.

See section 24.7.6 on domestic abuse and also guidance on assessing domestic abuse in section 4.9.12 in chapter 4 on assessment and treatment and recovery planning.

There is more comprehensive guidance in chapter 22 on people experiencing or perpetrating domestic abuse. The assessor should also be aware that women or other people who have experienced sexual trauma may find pregnancy and giving birth stressful and potentially retraumatising. Staff should take particular care to use a trauma-informed approach for all aspects of the woman's care.

24.13.3 Multi-agency assessment and treatment and recovery planning

When carrying out the assessment and developing a personalised treatment and recovery plan with the woman or person, alcohol treatment clinicians and practitioners should make referrals where appropriate. They should also work jointly with other relevant services and contribute to a multidisciplinary, multi-agency approach. You should follow the guidance in section 24.7.5 on a multidisciplinary and multi-agency approach.

It is particularly important that treatment and recovery plans and risk management plans are frequently reviewed. This is because needs and risks could change significantly throughout pregnancy and after the birth.

The personalised alcohol treatment and recovery plan should be aligned with other plans including antenatal plans and safeguarding plans. Services should share relevant information with one another if the needs or risks change.

24.13.4 Assessment and treatment and recovery planning after the birth

Services should recognise that the perinatal period (pregnancy and a year after the birth) can be a vulnerable time where the woman or person may be at greater risk of returning to problem alcohol use and at increased risk of mental health problems. Even if a woman or person did not drink during their pregnancy, she may be at greater risk of returning to problem alcohol use after the birth of the baby.

The alcohol treatment keyworker should seek to re-engage the woman or person soon after the birth and continue to review their alcohol use and offer support regularly. The alcohol treatment service should offer flexible support. For example, the service should consider offering home visits in the early weeks or months after the birth.

The alcohol treatment service should offer ongoing psychosocial support for as long as the woman or person needs it. Services should not stop offering support based on a policy that sets standard limits for length of time in treatment. Decisions about ending alcohol treatment should be part of multidisciplinary, multi-agency care planning and review and should fully involve the woman or person.

The alcohol treatment practitioner should work with other agencies in the multi-agency team to make sure the woman or person can access appropriate support for their mental health and for parenting where needed. For example, this could be support from the perinatal mental health team, health visitors or from children's services and family hubs. You should read the guidance in section 24.7.7 on this.

Services should make sure that staff are aware of and contribute to managing other increased risks during the perinatal period. This is because:

- alcohol is a significant risk factor for sudden unexpected deaths in infants (see section 24.11.1)
- problem alcohol use is a risk factor for maternal deaths in the first year after birth (see section 24.4)
- safeguarding reviews show that infants aged 0 to 2 years are the highest risk group for death and serious harm (NSPCC, 2023)

Where there has been an alcohol exposed pregnancy, services should offer advice on contraception soon after the birth of the baby or refer the woman or person to sexual health services for this advice (see section 24.10).

In some areas there may be specialist services for children, parents and families affected by parental problem alcohol or drug use. Where this is the case, the woman or person should be introduced to this service and offered the option of engaging with it.

Peer support workers who are mothers or parents with past problem alcohol use may be supportive for women and other people during the perinatal period.

24.13.5 Women or other people presenting to the service in the first year after giving birth

Women or other people presenting to the alcohol treatment service for the first time in the year after giving birth should be treated as a priority and offered assessment and treatment as quickly as possible. This is because of the increased risks to mother or parent and baby during this period. Assessment and treatment planning should then follow the recommendations above. If the baby is at risk of significant harm, the service must make a child safeguarding referral and follow national safeguarding guidance and organisational procedures (see annex 1 for information on national legislation and guidance).

24.13.6 Psychosocial interventions

The alcohol treatment service keyworker should offer structured support at regular intervals during pregnancy, and in the year after the birth, to make sure the woman or person is adequately supported around risk of relapse at a vulnerable time.

Where the alcohol treatment service has trained psychologists, they should offer psychological treatments, if the assessment shows these would be appropriate. You can find guidance on psychosocial interventions in chapter 5.

The alcohol treatment service should co-ordinate the psychosocial support they provide with other services in the multi-agency team and provide advocacy where necessary. You can find further information on multi-agency working in section 24.7.5 and 24.7.7.

24.14 References

Burns E, Gray R and Smith LA. Brief screening questionnaires to identify problem drinking during pregnancy: a systematic review. Addiction 2010: volume 105, issue 4, pages 601 to 614 (registration and subscription required for full article).

Garstang J and Sidebotham P. Qualitative analysis of serious case reviews into unexpected infant deaths. Archives of Disease in Childhood 2019: volume 104, issue 1, pages 30 to 36 (registration and subscription required for full article).

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Popova S, Lange S, Probst C, Gmel G and Rehm J. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. The Lancet Global Health 2017: volume 5, issue 3, pages e290 to e299.

Russell M. New assessment tools for risk drinking during pregnancy: T-ACE, TWEAK, and others. Alcohol Health and Research World 1994: volume 18, issue 1, pages 55 to 61.

25. Developing inclusive services

How alcohol treatment services can become accessible and effective for everyone, especially groups who face barriers to accessing care. This includes ethnic minority groups, LGBTQ+ people, women, older adults and people with learning disabilities or neurodevelopmental conditions.

25.1 Main points

Making alcohol treatment accessible to everyone

Alcohol treatment and recovery support should be accessible to everyone who needs it and should be delivered in a way that meets the needs of diverse groups of people and communities.

People experiencing socioeconomic deprivation, multiple disadvantage and some people with protected characteristics experience barriers to accessing alcohol treatment services. Services may not adequately meet their needs unless they reach out to these groups and tailor their treatment offer to them.

Diverse experience and identities

There is wide variation in experience within any group of people. A range of factors intersect and contribute to a person's individual experience and needs including:

- socioeconomic status
- age
- race and ethnicity
- sex
- sexual orientation
- gender identity
- disability

While it's helpful to consider some common experiences or needs shared by particular groups, services should recognise the diversity within each group as well.

Involving different groups in commissioning processes

Commissioners and services should work in partnership when assessing local need, and planning, designing, and delivering services. They should work with people and communities:

- who experience socioeconomic deprivation or multiple disadvantage
- with protected characteristics

Promoting equality, diversity and inclusion

The organisation should have policies, practices and an ethos that promote equality, diversity and inclusion. They should have a diverse staff team that is representative of their local community and trained and supported to be culturally competent.

Promoting and reaching out to particular groups

Services should design service messages and materials in partnership with people from the under-served communities they are aiming to reach. And they should promote the service through various media and in settings people are likely to use.

Services should reach out to people and communities using targeted promotional messages and flexible engagement approaches. These should be designed and delivered in partnership with people from the communities they are aiming to reach.

Having an inclusive and non-judgemental culture

The service should:

- look and feel inclusive
- make reasonable adjustments for disabled people
- meet people's communication needs, such as having independent interpreters available

Practitioners should have a non-judgemental approach based on empathy, trauma-informed practice and cultural competence.

Personalised treatment and recovery planning based on individual needs

Practitioners should never make assumptions about the person's needs because they have a particular protected characteristic or are from a particular socially excluded group. Treatment and recovery plans should be personalised to meet the person's unique goals and treatment needs.

Joint working arrangements

Services should have referral pathways and joint working arrangements with community organisations serving particular groups.

It's important that the main alcohol treatment service works in partnership with local specialist services and peer-based organisations working with particular communities or groups.

Adapting interventions and other arrangements

It can be helpful to make some adaptations to the interventions and other arrangements that are delivered to people from particular groups. Service staff, clinical supervisors and people from the relevant group should be involved in adapting interventions.

25.2 Alcohol harms and health inequalities

People with problem alcohol use have much higher levels of illness and early death than the general population (Institute for Health Metrics and Evaluation, 2024; Roerecke and Rehm, 2013). They also often experience stigma associated with their alcohol use, including in healthcare services.

Within this group of people, many experience further disadvantage or discrimination based on:

- socioeconomic deprivation
- multiple disadvantage
- their protected characteristics

25.2.1 People experiencing economic and social deprivation

People who experience socioeconomic deprivation are disproportionately affected by the harm caused by alcohol dependence and harmful drinking. For example, the National Records of Scotland report Alcohol-specific deaths 2023 showed that the mortality rate for deaths in Scotland caused solely by alcohol was 4.5 times higher in the most deprived fifth of the population than in the least deprived. The Office for National Statistics Socioeconomic inequalities in avoidable mortality in England and Wales data shows that in England in 2023 the mortality rate was twice as high in the most deprived tenth of the population than in the least deprived.

It is important that alcohol treatment services are designed to reach and meet the needs of people in the most socioeconomically deprived areas in the locality they serve. The local needs assessment should involve people and communities from those areas to understand their needs.

Alcohol treatment services should work with partner services, including local voluntary and community sector services, to address barriers to engagement and issues that worsen alcohol harms for people experiencing socioeconomic deprivation.

To support engagement, services should:

- make it clear in promotional literature that the service is free
- be geographically accessible to avoid high transport costs and difficult journeys or areas where transport is poor
- consider offering support with transport costs or mobile phone data

To reduce health harms, services should provide:

- an individual healthcare assessment and where relevant, referrals to primary and secondary healthcare
- health promotion advice and interventions such as smoking cessation
- harm reduction advice and interventions

When people attend an alcohol treatment service, it is a chance to help them address any problems linked to social determinants of health, including poverty and poor housing. Services should help people access:

- advice on welfare benefits and debt
- information on foodbanks and other community services such as warm spaces in winter
- support for problems with housing and homelessness
- social prescribing

To support people's longer term recovery goals and reduce social exclusion, alcohol treatment services should help people access:

- education, training and employment support
- volunteering opportunities
- involvement with peer networks, recovery organisations and mutual aid
- involvement with local community groups and activities

25.2.2 Multiple disadvantage

Many people with problem alcohol use experience multiple disadvantage. In these guidelines, 'multiple disadvantage' is defined as the co-occurrence and interaction of adverse circumstances leading to social exclusion, marginalisation, and extreme inequality.

People can experience complex, intersecting issues that can contribute and worsen disadvantage, including:

- health inequalities
- poverty
- housing instability
- systematic discrimination

People who experience multiple disadvantage often find it very difficult to access healthcare, including alcohol treatment services. They also tend to experience extremely poor physical and mental health compared to the general population and often have poorer health outcomes when they engage with health services.

The barriers people with multiple disadvantage experience accessing services will vary. But there are many barriers, related to the individual and to the services. These include people:

- having difficulty understanding and navigating the healthcare system
- having had past experiences of being turned away from services or being badly treated

- not speaking English or be able to read or write
- being afraid of punitive action after accessing services

At the same time, services may find the complex nature of the person's problems challenging and might not have policies and competencies to respond to them.

Alcohol treatment services need to target groups that experience multiple disadvantage using flexible engagement approaches and tailor interventions to meet their specific needs.

There is guidance on working with groups of people who experience multiple disadvantage in:

- chapter 9 on alcohol assertive outreach and a multi-agency team around the person
- chapter 17 on criminal justice settings
- chapter 21 on people experiencing homelessness

There is also guidance on working with specific groups that experience high levels of multiple disadvantage in section 25.12.

25.2.3 Protected characteristics

There is a public sector equality duty for services in England, Scotland and Wales to consider the need to reduce disadvantage and meet the particular needs of people from protected groups.

The Health and Social Care (Reform) Act (Northern Ireland) 2009 places a duty on each health and social care trust to:

exercise its functions with the aim of improving the health and social well-being of, and reducing health inequalities between, those for whom it provides, or may provide, health and social care.

It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race, including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

These are called protected characteristics. For more information on protected characteristics, read Discrimination: your rights.

People will often have more than one protected characteristic and may experience the cumulative effect of discrimination or disadvantage based on the intersection of those characteristics.

Alcohol treatment services should be designed to reach people and groups with protected characteristics and to make sure that they meet their treatment and recovery support needs.

25.2.4 Designing inclusive services

A number of things can affect how easy it is for people to access and engage with services and whether the treatment and support that services offer meets their particular needs. These include:

- social and economic deprivation
- multiple disadvantage
- discrimination and disadvantage based on protected characteristics

Alcohol treatment services, working with the wider health and care system, can help to promote equality, diversity and inclusion and reduce health inequalities.

They can do this by providing accessible and inclusive services which are designed to meet the needs of everyone experiencing problem alcohol use in their local area. These include the specific needs of people experiencing social and economic deprivation and multiple disadvantage, and people with protected characteristics. Individual treatment and recovery plans and interventions should always be tailored to each person's individual needs.

25.3 Structure of this chapter

The rest of this chapter is in 2 main parts. The first outlines some shared principles that will help to develop inclusive services. The second is a set of summaries showing actions that services could take to become more inclusive and meet the needs of some specific groups of people, including:

- ethnic minority groups
- LGBTQ+ groups
- women
- older people
- people with disabilities
- people with learning disabilities
- people with neurodiverse conditions

- several groups experiencing multiple disadvantage

These summaries give examples of what commissioners, services and practitioners can do to reduce barriers to access and to tailor services for particular groups. Research evidence for these areas is often limited. So, the guidance is based on recurring themes in the research, as well as evidence from practice and lived experience.

25.4 Principles for developing inclusive services

Principles to help develop inclusive services include:

- assessing local need for alcohol treatment, working with people and communities
- promoting equality, diversity and inclusion
- promoting the service to local groups and communities
- using flexible, targeted approaches to reach underserved groups
- supporting people to engage in treatment
- offering alcohol harm reduction interventions
- tailoring treatment and recovery support to the needs of specific groups and to each individual

You can find more information about these principles below.

25.4.1 Assessing local need for alcohol treatment working with people and communities

Equality impact assessments

Local populations vary widely. So, alcohol treatment should be based on a thorough assessment of local need. Commissioners are normally responsible for making local needs assessments, involving strategic partners. Services should be aware of the diverse needs of their local population and can contribute to needs assessments.

Local needs assessments should include equality impact assessment processes to understand the diverse needs of local populations, including people and communities:

- experiencing socioeconomic deprivation
- with multiple disadvantage
- with protected characteristics
- in specific inclusion health groups

Services in Wales should ensure they meet the requirements of the Welsh Language (Wales) Measure 2011 and consider ways of delivering the Welsh Government's Active Offer of Welsh language provision.

Working with local people and communities when assessing need

When assessing need and planning services, commissioners and service providers should seek the views of local people and communities, including community organisations. This should include the views of people from underserved groups.

Commissioners and service providers need to hear about:

- the barriers specific groups experience when accessing and engaging with alcohol treatment
- how these groups think services could improve access

Commissioners, service providers, people with lived experience and local people and communities can then work in partnership to develop a needs assessment and develop services designed to:

- remove service barriers to accessing alcohol treatment and recovery support
- improve the experience of people in treatment
- tailor treatment and recovery support approaches to the needs of particular groups

The resources section at the end of this chapter includes guidance on working together with people and communities.

25.4.2 Promoting equality, diversity and inclusion

Providing equal access and appropriate treatment to diverse populations requires an organisation to be culturally competent. The term 'cultural competence' refers to the ability of organisations and individual practitioners to effectively deliver services that meet the social, faith, cultural, and linguistic needs of people from diverse groups and communities. Cultural competence involves several things at organisational and practitioner level, such as:

- policies
- behaviours
- awareness
- attitudes
- knowledge and skills

These should promote effective interactions with people from diverse backgrounds, and equitable treatment for them. There is more information on cultural competence in section 2.3.2 in chapter 2 on principles of care.

The organisation should have a framework and a service ethos that promotes equality, diversity and inclusion that should include:

- recruiting a diverse staff team, which contributes a range of perspectives to treatment provision

- developing organisational policies and practices that promote equality, diversity and inclusion, including equality audits
- training and supervision in delivering treatment based on principles of equality, diversity and inclusion, with enough time and space for staff to develop their practice
- staff training and support to develop cultural competence
- staff training and supervision on skilfully addressing discriminatory behaviour from colleagues or people accessing treatment, so that people can engage in treatment in a safe space

25.4.3 Promoting the service to local groups and communities

There is international evidence that people with alcohol problems underuse alcohol treatment services (Rehm and others, 2015). Alcohol treatment services should be promoted very widely and in ways that will reach local underserved populations.

There are many ways that services can advertise and promote their services locally, including through:

- local and community media including radio, newspapers, community websites and social media
- attending community events and local meeting places
- public facilities like laundrettes and community centres
- community organisations that represent or have links with specific underserved communities or groups with protected characteristics
- wider health and social care services, including children and family services
- promoting the service in the most socioeconomically deprived areas and isolated rural areas

Some of the most marginalised people may not have access to digital platforms, so it's important to include other forms of media, to make sure there is equitable access to information about treatment for everyone.

The promotional messages and images that you use should be clear that alcohol treatment is free, available to everyone and that diverse populations will be welcomed. Examples include:

- positive images showing diverse populations
- service information or health information tailored to specific groups or communities
- information in languages spoken in the community
- easy read information for people with literacy problems and other accessible formats for people with sensory disabilities or neurodiverse needs

You should involve people from the groups the information is aimed at in designing information and promoting the service and make sure that the images and language you use are not stigmatising.

25.4.4 Using flexible, targeted approaches to reach under-served groups

Some groups of people are unlikely to come to a service for a range of reasons including:

- past experiences of discrimination or marginalisation in services
- perceptions that alcohol treatment services are not inclusive
- difficulty trusting services due to experiences of trauma
- stigma about alcohol linked to religion, culture or gender
- lack of knowledge about problem alcohol use and alcohol treatment services
- language or communication needs
- fears that children may be taken into care
- fears about immigration status
- difficulty making or keeping appointments due to life circumstances (for example, homelessness)
- travel problems for people who are frail or have physical disabilities
- lack of public transport or cost of transport

Alcohol treatment services need to make proactive attempts to reach underserved populations, using flexible, tailored approaches including:

- working in partnership with community organisations and peer support organisations who have established relationships with specific underserved groups
- running in-reach sessions (running sessions in services or organisations attended by under-served groups) or being co-located with partner services or community organisations
- joint working with support workers from organisations that work with specific groups to support individual people
- community awareness raising about alcohol harm and alcohol services
- having open access services so appointments are not necessary
- assertive outreach, including home visits (see chapter 9 on alcohol assertive outreach and a multi-agency team around the person)
- running sessions in general health and wellbeing services, so people do not have to attend an identifiable alcohol treatment service

- having an option of digital interventions so people can make initial contact without coming to a service site
- having independent interpreters or staff who speak community languages available

25.4.5 Supporting people to engage in treatment

Practitioner approach

Practitioners should encourage people to engage with alcohol treatment by:

- having inclusive attitudes
- building trusting relationships
- discussing potential barriers to ongoing engagement with each person

The principles of care in chapter 2 that should underpin all alcohol treatment will help to engage people from groups that experience barriers to accessing and engaging in treatment. These principles include:

- having a non-stigmatising approach
- putting the person at the centre of their own care and personalising treatment
- using trauma-informed practice (see the Office for Health Improvement and Disparities' Working definition of trauma-informed practice for more information)
- cultural competence

Building a therapeutic alliance (a trusting working relationship) is vital to effective treatment and will be particularly important where people from underserved groups are ambivalent or anxious about engaging in treatment. Building a therapeutic alliance takes time and requires attention. So, staff need manageable caseload sizes and people will need to be engaged long enough for them and the practitioner to build an effective therapeutic alliance. Once they have established a therapeutic alliance, it's important for the person to keep the same keyworker because changes in keyworker can be very disruptive. There is guidance on therapeutic alliance in section 5.5.1 in chapter 5 on psychosocial interventions.

Discussing how to reduce barriers to engaging in treatment

At referral, services should make it standard practice to ask if there are any adjustments that the person needs to engage in treatment, so they can make these arrangements before the person attends. For example, services can ask about:

- independent interpreters
- reasonable adjustments for physical, sensory or learning disabilities, alcohol related brain damage and neurodiverse conditions
- mental health conditions, for example social phobia

At assessment, the practitioner can discuss needs with the person in more detail.

Practitioners should discuss with the person how they can work together to reduce any barriers that could stop them engaging in treatment. Barriers can include:

- practical barriers, like appointment times
- physical safety issues, such as women experiencing domestic abuse
- emotional safety issues, for example fears related to previous experiences of lack of understanding, discrimination or trauma

The service should do things that make it easier for people to engage with treatment. For example:

- timing appointments around childcare or working arrangements
- making sure a woman who has experienced intimate partner violence is not seen at the same service or site as the perpetrator
- involving a family member, support worker or peer, with the person's consent
- providing clear information on confidentiality
- offering interventions tailored to a person's individual needs (see section 25.4.7 below)

Wherever possible, it's important that people have a choice about their keyworker or peer support worker. For example, women who have experienced domestic or sexual violence in heterosexual relationships may prefer to have a woman keyworker.

Peer support can often help to support engagement, so the practitioner should introduce the person to peer-based support organisations or individual peers where appropriate. In some areas, there are independent lived experience recovery organisations (LEROs) that some people find more accessible than treatment services. People may approach and engage with a LERO initially and may continue to engage with it instead of treatment services, or the LERO can help them to engage with treatment services when they are ready.

There are more examples of reducing barriers to engagement for particular groups in sections 25.5 to 25.10 below.

25.4.6 Offering alcohol harm reduction interventions

Practitioners should offer alcohol harm reduction interventions where people are not yet ready to enter structured treatment.

If people from underserved populations are unsure about accessing structured treatment but they have established a relationship with a practitioner (for example, an outreach worker), this provides an opportunity to offer harm reduction interventions. These harm reduction interventions may be beneficial in themselves and can help to strengthen a person's engagement in treatment. The practitioner can offer access to structured treatment again at a later stage. There is guidance on harm reduction in chapter 8 and guidance on assertive outreach and a multi-agency team around the person in chapter 9.

25.4.7 Tailoring treatment and recovery support

Personalised treatment and recovery plans

Alcohol treatment services and practitioners should deliver treatment and recovery interventions in a culturally competent way and that meet the person's individual needs.

The person should be at the centre of their treatment and recovery planning and this should be tailored to meet their individual needs and goals. Practitioners should be aware of specific needs that may be relevant for people from particular groups, but they should never make assumptions about the person's needs because they have a particular protected characteristic or are from a particular disadvantaged group. Practitioners should try to understand the person's own unique identity and needs and take account of this when working with them to address their problem alcohol use.

Alcohol treatment services need to work with other organisations to help people access inclusive treatment and recovery support. There are a number of organisations and groups that can help people recover by showing what recovery looks like and giving them tailored support, advocacy and community. These include:

- diverse recovery communities
- peer support networks linked to the service
- community organisations serving specific populations

Tailoring treatment interventions

It may be appropriate to tailor psychosocial interventions, so they are more relevant and effective for specific groups of people. Clinical advisors and people from the group the intervention is targeting should be involved in considering how to tailor interventions. There are some examples of tailoring interventions below in sections 25.5 to 25.12.

Practitioners should make sure any presentations or work sheets that they use in treatment interventions are inclusive. For example, when running a relapse prevention group, they should make sure that any examples of high-risk situations they discuss with the group include the kind of situations that might be risky for people in the group.

Some people with protected characteristics or from socially excluded groups might need or may benefit from having the option of dedicated treatment groups or activities, which are specifically for people with particular characteristics or from particular groups (for example, women-only groups or LGBTQ+ specific groups). This can help to create emotional safety where people feel aspects of their identity and experience may be better understood and accepted, or where people can talk about shared experiences that may have been painful or traumatic.

Addressing discriminatory behaviour in group settings

Many treatment services create shared environments where people in treatment meet with others, like treatment in groups or open access drop-in sessions. Staff need training and

supervision so they can address discriminatory behaviour appropriately in group settings in a treatment service.

25.5 Ethnic minority groups

25.5.1 Language

Language is important and we aim to use inclusive language in this guidance. We realise there are different views on language to write about ethnicity, but these guidelines use the Writing about ethnicity guide.

25.5.2 Prevalence and harms

Alcohol dependence occurs in all ethnic groups. But the evidence on prevalence of harmful or dependent drinking in ethnic minority groups is very limited.

A rapid evidence review of drinking problems and interventions in Black and ethnic minority communities found that overall, there are higher rates of abstinence and lower rates of harmful drinking among ethnic minority groups compared to the White British group (Gleeson and others, 2019). However, there is some evidence that says rates of alcohol dependence may be similar for some ethnic minority groups and White groups (Drummond and others, 2004). Much of the data that exists and was reviewed is now quite old.

The evidence review found concerns about problematic drinking and alcohol harm among:

- South Asian men, and Sikh men in particular (Bayley and Hurcombe, 2011; Galvani and others, 2013)
- refugees and asylum seekers (Horyniak and others, 2016)
- Irish nationals living in England, Wales and Scotland (Hurcombe and others, 2010)
- Polish migrants (Herring and others, 2019)

It also found concerns among service providers that the prevalence of harmful drinking in most ethnic minorities is under reported due to stigma and inadequate recording.

The Scottish Health Survey - topic report: equality groups found that between 2008 and 2011, people in most ethnic minority groups were less likely to drink at hazardous or harmful levels than the national average.

White British and White Irish respondents were most likely to have exceeded the recommended daily limit on their heaviest drinking day in the previous week.

Office for National Statistics (ONS) data on deaths caused by alcohol is not routinely analysed by ethnic group.

Scottish research on health and ethnicity found that Indian men had a 75% higher risk of alcohol related liver disease than White Scottish men (Bahla and others, 2016). It also found that White Irish men and women described as from “any Mixed background” had almost double the risk of alcohol-related diseases, compared to the White Scottish population. However, the causes of these differences in alcohol related diseases are not clear.

There is some evidence from England that South Asian men are over-represented for alcohol related cirrhosis (Douds and others, 2003). And that Sikh men in particular are over-represented for liver cirrhosis (Hurcombe and others, 2010).

25.5.3 Considerations for services

Variation between ethnic minority groups

There is wide variation between and within ethnic minority groups in rates of harmful alcohol use and attitudes to drinking and drinking problems.

Commissioners and services should adapt the guidance in sections 25.5.4 and 25.5.5 to the needs of specific ethnic minority groups in their local area and practitioners should tailor interventions to each individual.

Inequality and discrimination

The NHS Race and Health Observatory Ethnic inequalities in healthcare: a rapid evidence review published in 2022 found strong evidence of ethnic inequalities in access to general healthcare services and in experience of care. Other research shows this is also the case for alcohol treatment (Hurcombe and others, 2010).

Experience of institutional and interpersonal racism in treatment services has led to a lack of trust that prevents people accessing services. Tackling inequality and discrimination in services and building trust should be a priority.

Stigma and shame

Harmful alcohol use is stigmatised across British society. But in some ethnic minority groups there is additional stigma associated with mental ill health and with religious prohibitions on alcohol use. This is most often reported for South Asian ethnic minority groups.

Culturally, alcohol use can be considered and experienced as a source of individual, family and community shame, so people are less likely to seek help from outside the family. Alcohol use or alcohol problems among women in South Asian ethnic groups and Muslim groups more widely is often considered unacceptable and more likely to remain hidden, including from the family (Gleeson and others, 2019). Services should work with local people and communities to find acceptable ways for them to access treatment.

Monitoring ethnicity

It's important that services record a person's (self-defined) ethnicity so they can have information about alcohol treatment access and outcomes for different ethnic minority groups. Services should make sure they carry out ethnic monitoring consistently. People should be able to choose whether they want their ethnicity to be recorded.

Vulnerable migrants

Most migrants to the UK come to work or study and are young and healthy. However, there are some groups of migrants who may have increased health needs associated with their experiences before, during and after migration.

Section 25.12.3 provides a definition and guidance for working with vulnerable migrants.

25.5.4 Reducing barriers to treatment

Assessing need for alcohol treatment among ethnic minority groups

Commissioners should use census, national and local data, and information from local services on ethnicity and religion to identify which ethnic minority groups in their area are underserved. However, available data will be limited. Commissioners should work with people from under-served ethnic minority groups, including people with lived experience of problem alcohol use and alcohol treatment, when carrying out the needs assessment and the equality impact assessment.

Working in partnership with people from ethnic minority groups and communities

Commissioners and services should have an ongoing partnership with local ethnic minority people and communities because building trust and developing accessible and culturally appropriate interventions takes time. This work requires:

- leadership
- dedicated managerial and staff capacity
- resources for promoting the service in community languages through different media and interpreters

Commissioners and service providers should work with a range of people from local ethnic minority communities to do the needs assessment and improve access to treatment. This includes:

- community organisations
- community leaders
- treatment staff
- people in treatment and their family members
- peer-support organisations

Partnerships should include people and community leaders representing different perspectives within an ethnic minority group or community, including different:

- ages
- sex
- gender identity
- sexual orientation
- abilities
- religions (including people with no religion)

Partnerships can then co-produce:

- a needs assessment
- an understanding of barriers to accessing treatment and what can help people to access it
- interventions to engage and appropriately support people from ethnic minority communities

There is guidance on working with people and communities to reduce health inequalities in the resources section.

Recruiting an ethnically diverse workforce

Services should aim to recruit a workforce at all levels of seniority that is diverse and as representative of local ethnic groups as possible. Staff from ethnic minority groups should be able to contribute to service planning and development. Services should make sure there are equal opportunities for staff from ethnic minority backgrounds, including for:

- training
- supervision
- career development

Working with ethnic minority peer networks

Services should support and work with ethnic minority and faith peer networks, recovery communities and services who understand the needs of their communities. Peer involvement can help to build trust and reduce stigma by providing a range of support including co-delivering community outreach.

Being proactive and flexible in helping people to access the service

Services should help people to access treatment in flexible ways as described in sections 25.4.3 and 25.4.4. They should tailor those principles to meet the needs of the specific ethnic minority groups they are aiming to engage. An example of a flexible, targeted approach to reaching a community is the Under the Influence Recovery Podcast produced by the Sikh Recovery Network and Turning Point (see resources section 25.13 for more details).

Research reports differences among people from ethnic minority groups about how they prefer to seek help. For example, some would prefer to access help through a GP, while others would prefer to access help from their family and would prefer home visits. (Hurcombe and others, 2010). So, services should provide different options.

Reducing language barriers

Language is repeatedly identified as a major barrier to accessing services. Services can do several things to reduce this barrier, including having:

- a service policy for working with interpreters

- resources for trained, independent interpreters and translation services
- a range of formats for communicating information, including video or audio
- basic training for staff in working with interpreters and considerations for practice
- allowing additional time for sessions with interpreters because everything is repeated
- where appropriate, employing staff who can speak community languages

You should avoid translation software because it may not be accurate for describing complex health problems and alcohol treatment needs.

The migrant health guide has useful guidance on language interpretation and translation.

Ensuring confidentiality and anonymity

When reaching out to communities where alcohol is religiously prohibited or there is cultural stigma associated with alcohol problems, services should:

- offer appointments in generic healthcare settings like GP practices or health and wellbeing centres
- offer home visits and online contact
- emphasise confidentiality and anonymity in all their promotional messages

Community awareness raising about alcohol and alcohol treatment

If services think that local ethnic minority communities lack knowledge about alcohol harms and alcohol treatment services, they should offer awareness raising sessions tailored to the needs of these communities. These sessions could be part of broader sessions on health and wellbeing (in person or online) to avoid the stigma associated with alcohol use. Ethnic minority community representatives should be involved in identifying need for community awareness raising, as well as planning and delivering the sessions.

Reducing financial barriers

People from ethnic minority groups are over-represented among those experiencing the highest levels of socioeconomic deprivation, so recommendations in section 25.2.1 may be relevant.

25.5.5 Tailoring treatment for ethnic minority groups

Cultural competence

Research repeatedly shows that treatment services need cultural competence. There is a description of cultural competence in chapter 2 on principles of care.

Organisational cultural competence

Quality governance audits should include equality audits.

Services should make sure their staff receive training and supervision to develop cultural competence.

The culture of the service should feel inclusive to diverse ethnic groups. For example, service arrangements should take account of:

- religious or ethical dietary requirements
- religious requirements such as prayer times
- religious and cultural festivals

Practitioner cultural competence

Practitioner cultural competence includes offering treatment and support that take account of the person's cultural and faith-based perspectives and experiences but does not make stereotypical assumptions.

Practitioners need skills in building a therapeutic alliance with people from cultures that are different to their own and to be able to reflect on how their own culture and background influences their perspective. Services should support them through training and supervision to challenge unconscious bias that can affect their practice.

Cultural competence can also involve understanding the impact of racism or discrimination on the person's wellbeing and whether they see this as a factor in their alcohol use.

Diversity within ethnic minority groups

Services and practitioners should recognise the diversity within any ethnic and cultural group. People from the same ethnic, cultural or faith background are diverse and will have different intersecting identities and experiences. These include:

- sex
- gender identity
- age
- sexual orientation
- disabilities
- socioeconomic status

If a person has several intersecting factors that are protected characteristics or are associated with social exclusion, they are likely to experience more discrimination and disadvantage. This can then affect their problem alcohol use, their experience of healthcare, and their individual treatment needs.

Treating the person as an individual

Practitioners should always offer treatment based on understanding the person as an individual and not make assumptions based on their ethnicity or faith. They should tailor

interventions to meet the person's unique needs. Treatment should be based on the principles of care set out in chapter 2, including a non-stigmatising, empathic, trauma-informed approach.

Considering women's needs

Women who drink harmfully or dependently experience more stigma than men in all communities across British society (Gleeson and others, 2019). In ethnic minority groups where alcohol use is religiously prohibited and culturally unacceptable, women experience additional stigma. This often leads to their drinking being hidden or not discussed, including at times within the family. It also puts women at increased risk of harm if they feel they cannot ask for help. Services should target information for women in those ethnic minority groups, offering free, confidential and discrete support in a women only setting. See resources (in section 25.13) for information about guidance on providing alcohol support for South Asian women.

Adapting psychosocial interventions

There have been no UK-based randomised controlled trials of psychosocial alcohol interventions adapted to meet specific cultural or religious needs. Evaluations of specialist projects contain some examples of adapted interventions (see resources section below). If services want to adapt interventions, they should work with their senior clinical staff and members of ethnic minority groups to develop adaptations.

Working with family members

Some people will not want to involve family in their treatment because of stigma and shame. But where there is consent, services should involve families in supporting the person's treatment.

In communities where alcohol problems are often not spoken about outside the family, women are more likely to ask about help on behalf of a family member. There may be particular stress on women who usually provide care and support within the family, as well as potential risks like domestic abuse. So, services should make sure women family members can access culturally appropriate support for their own needs. You can read more on working with families in chapter 5 on psychosocial interventions.

Considering specialist projects or services

Commissioners, service providers and community representatives should consider whether specialist projects or services should be commissioned alongside mainstream alcohol treatment services. The limited evidence reports mixed stakeholder views on whether alcohol services designed for people from particular ethnic or faith-based groups, or for people from ethnic minorities in general, would be more helpful than mainstream alcohol treatment services. But the evidence would support local areas considering if it's appropriate to have a specialist service (Hurcombe and others, 2010; Gleeson and others, 2019).

There are examples of specialist projects for ethnic minority communities in the resources (see section 25.13) below. If there are local specialist services that offer support to people from ethnic minorities with problem alcohol use, alcohol treatment services should work with them. Even where there are local specialist services for ethnic minority groups, mainstream alcohol treatment services should still be culturally competent and provide appropriate treatment for people from ethnic minority groups. People should always have a choice of which service they want to attend and it may be appropriate for them to attend both.

Alcohol treatment service providers can discuss with people from ethnic minority or faith groups whether a dedicated group or activity within the service programme would help meet their needs.

25.6 LGBTQ+ people

25.6.1 Language

LGBTQ+ stands for lesbian, gay, bisexual, transgender, queer (or questioning) and other identities. We realise that there are versions of this acronym that include other sexualities and identities like intersex, asexual and non-binary, but we use LGBTQ+ in this guidance.

25.6.2 Prevalence and harms

Studies of alcohol use in LGBTQ+ populations consistently show higher rates of increasing risk (hazardous) and higher risk (harmful) drinking as defined by the UK chief medical officers' low risk drinking guidelines.

An analysis of data from the Health Survey for England found that around 7% of lesbian, gay or bisexual adults reported drinking at harmful (higher risk) levels from 2011 to 2018. This was higher than the approximately 4% of heterosexual adults reporting drinking at higher risk. For more information, see Health Survey England Additional Analyses - Health and health-related behaviours of Lesbian, Gay and Bisexual adults

All studies in a review of alcohol use among sexual and gender minority communities in the UK found higher rates of drinking above low risk levels (as defined by UK chief medical officers' low risk drinking guidelines in LGBTQ+ populations compared to heterosexual or cisgender populations (Meads and others, 2023)).

There is little UK research on alcohol and trans people (Glynn and van den Berg, 2017) but the Trans Mental Health Study 2012 found that 47% of trans people who responded were drinking above low risk levels defined by the UK chief medical officers' low risk drinking guidelines. About 24% of the heterosexual population and 32% of the lesbian, gay and bisexual population in England drink above low risk levels.

There is a lack of evidence about alcohol related harm among LGBTQ+ people, but because their rates of harmful drinking are higher, they are likely to experience increased health harms compared to the heterosexual population.

There is evidence that lesbian, gay and bisexual people have considerably higher rates of substance misuse, mental illness and higher risk of self-harm and suicide than the heterosexual population (King and others, 2008). Discrimination and prejudice contribute significantly to these higher risk levels.

The Stonewall report LGBT in Britain - Health (2018) found that:

- 1 in 8 lesbian, gay, bisexual and trans (LGBT) people aged 18 to 24 (13%) said they had attempted to take their own life in the last year
- almost half of trans people (46%) had thought about taking their own life in the last year, compared to 31% of lesbian, gay and bisexual people who were not trans
- 41% of non-binary people said they had harmed themselves in the last year, compared to 20% of LGBT women and 12% of gay, bisexual and trans men

Mental health conditions and problem alcohol use commonly occur together (Weaver and others, 2003; Delgadillo and others, 2012) and alcohol is a risk factor for self-harm and suicide (Ledden and others, 2022).

Estimates of prevalence of homelessness and LGBTQ+ people vary widely, but they show that LGBTQ+ people are at higher risk of homelessness than the rest of the population. Census 2021 data of people experiencing homelessness in England and Wales showed that 7.7% of people identifying as homeless also identified as LGBTQ+ (compared to 3.2% of the rest of the population). Young LGBTQ+ people can be particularly at risk of homelessness if their family withdraws support for them.

25.6.3 Considerations for services

Explanations for higher prevalence of problem alcohol use

Explanations for higher prevalence of problem alcohol use among LGBTQ+ people compared to the heterosexual population vary. Two research reports, London Friend's Out of your mind and the report 'What are LGBTQ+ people's experiences of alcohol services in Scotland?' (Dimova and others, 2022a; Dimova and others, 2022b) identify the following themes.

LGBTQ+ social activities tend to centre on bars and clubs, and this may be the first place LGBTQ+ people explore their sexual and gender identity with others.

Alcohol use has an important role in LGBTQ+ communities and drinking above low risk levels is often the norm.

LGBTQ+ people may use alcohol:

- to boost self-esteem and confidence in social situations
- as an attempt to cope with the stress of discrimination or harassment

Some people see experiences and feelings linked to their LGBTQ+ identity as a cause of their problem alcohol use, and some see other factors as more relevant.

Emotional and physical safety in alcohol treatment services

The same research reports highlight concerns about emotional or physical safety in alcohol treatment services for LGBTQ+ people.

LGBTQ+ people often reported that they:

- anticipated that alcohol treatment services would not be LGBTQ+ inclusive
- experienced or witnessed discrimination based on sexual orientation or gender identity in alcohol treatment services

The research findings on alcohol treatment services are consistent with research on LGBTQ+ people's experience of wider healthcare services. The Stonewall report LGBT health in Britain found that in the last year before the report:

- 1 in 7 (14%) LGBT people had avoided treatment for fear of discrimination because they are LGBT
- 1 in 8 LGBT people (13%) had experienced some form of unequal treatment from healthcare staff because they are LGBT
- 6% of LGBT people, including 20% of trans people, had witnessed negative or discriminatory remarks about LGBT people from healthcare staff

The Out of your mind report and the report on LGBTQ+ people's experiences of alcohol services in Scotland found that LGBTQ+ people's experience of alcohol treatment services was that staff:

- often made assumptions based on heterosexual norms
- did not usually ask about their sexual orientation or gender identity
- were often not aware of aspects of LGBTQ+ experience

They were also concerned that heterosexual and cisgender peers at the service would not be LGBTQ+ inclusive and would judge them negatively or would not understand their experience.

Under-representation of LGBTQ+ in needs assessments

Although there is evidence that LGBTQ+ people are at higher risk of harmful alcohol use, the 'Out of your mind' report found that LGBTQ+ people's alcohol and drugs needs were poorly represented in local needs assessments.

25.6.4 Reducing barriers to treatment

Commissioners and services should work with LGBTQ+ people and organisations to identify their needs as part of their local needs assessment. They should also involve LGBTQ+ people and organisations in planning services to meet their needs. They should consider where different LGBTQ+ people may have separate and distinct needs.

Services should record sexual orientation and gender identity so that commissioners and services can monitor take-up of the service and outcomes for LGBTQ+ people. But people should have the choice whether to have this information recorded.

Service equality, diversity and inclusion policies and processes should explicitly include the needs of LGBTQ+ people.

Commissioners and services should make sure that all staff are trained and culturally competent to work with LGBTQ+ people. The report on LGBTQ+ people's experiences of alcohol services in Scotland (Dimova and others, 2022a; Dimova and others, 2022b) found that staff were anxious about making mistakes and would welcome training. Training could include:

- improved understanding of LGBTQ+ people's experiences and their needs in alcohol treatment services
- a particular focus on the experience and needs of trans people because research suggests that staff have particularly low levels of understanding of the experience and needs of trans people and high levels of discrimination
- challenges to stereotypes and assumptions based on heterosexual and gender identity norms
- information about alcohol use among LGBTQ+ populations
- information about higher levels of mental health conditions, self- harm and suicide among LGBTQ+ populations
- appropriate ways to ask people about their sexual orientation and gender identity
- how to discuss if their LGBTQ+ identity is a factor in their alcohol use
- how to challenge discrimination or lack of understanding about LGBTQ+ people in group settings

Services should target promotional messages for LGBTQ+ people (see section 25.4.3) and actively reach out to LGBTQ+ people and communities to support them to engage in alcohol treatment (see section 25.4.4).

Commissioners and services can consider carrying out an LGBTQ+ audit of the alcohol treatment service to find any gaps in inclusive practice and develop a plan to address these. There is an example of an LGBTQ+ audit tool in appendices A to C of the 'Out of your mind' report. It includes LGBTQ+ audit tools and guidance for commissioners, services and practitioners.

It may be helpful for services to appoint an LGBTQ+ champion to share information and promote good practice.

25.6.5 Tailoring treatment to meet the needs of LGBTQ+ people

Asking about sexual orientation or gender identity

At initial assessment, practitioners should avoid assumptions about a person's sexual orientation or gender identity. If the person does not share this information, practitioners should sensitively ask about their sexual orientation or gender identity.

Providing a safe environment

Safe and confidential care is vital for everyone in alcohol treatment services. A significant proportion of LGBTQ+ people identified a need for better safety in alcohol treatment services, as outlined in the 'Out of your mind' and 'What are LGBTQ+ people's experiences of alcohol services in Scotland?' reports. So, services and practitioners should take particular care to provide treatment that helps them feel safe. A number of things can contribute to creating a safe environment, including:

- service policies
- service ethos
- inclusive service information
- staff training

It is vital that the therapeutic approach of practitioners establishes a feeling of safety so people can focus on changing their alcohol use. The principles of care set out in chapter 2 including a non-judgemental, empathic and trauma-informed approach are important in developing a therapeutic alliance and a safe therapeutic space.

Personalise treatment and recovery plans

Practitioners should always treat people as unique individuals. Practitioners should not make assumptions about the person's sexual orientation or gender identity or how these might relate to their problem alcohol use. Treatment and recovery plans should be personalised and developed with the person.

Identifying mental health conditions and assessing risk

Identifying mental health conditions and assessing risk of self-harm and suicide should be a standard part of assessment for everyone in alcohol treatment. Practitioners should be aware of the higher levels of mental health conditions and higher levels of risk for self-harm and suicide among LGBTQ+ people, particularly trans people. There is guidance on assessment, including mental health and self-harm, in chapter 4 on assessment and treatment and recovery planning.

Specialist LGBTQ+ services

There is a lack of research on whether specialist services are more effective for LGBTQ+ people, but the 'Out of your mind' report found that respondents were positive about the benefits of a specialist LGBTQ+ service. Many felt it was a safer environment where they felt understood. LGBTQ+ respondents had different views on whether they preferred a specialist service or an inclusive generic alcohol treatment service, but thought there should be options.

Commissioners can consider whether a specialist LGBTQ+ service, working in partnership with the main alcohol treatment service, would be appropriate on a local or a regional level.

Even if there is a local specialist LGBTQ+ alcohol service, general alcohol treatment services should still be inclusive and effective for LGBTQ+ people. This could include offering dedicated LGBTQ+ groups or spaces.

Alcohol-free activities

Since alcohol plays an important role in many LGBTQ+ social settings, people can benefit from the option of LGBTQ+ alcohol-free spaces and activities. Services and practitioners should be aware of local LGBTQ+ peer-based groups and mutual aid groups, and other LGBTQ+ groups that do not involve drinking and support people to access them.

Diversity among LGBTQ+ people

Services and practitioners should recognise the diversity within LGBTQ+ groups. LGBTQ+ people and communities include people with a range of sexual orientations, genders, gender identities and related experiences.

The Stonewall report shows differences in levels of alcohol use, mental health and self-harm between lesbians, bisexual women, bisexual men, gay men and trans women and men (see section 25.6.2). It also shows differences in reports of discrimination in healthcare settings. A notable finding, echoed in other reports, was that trans people have higher levels of alcohol use, mental health conditions and self-harm and suicide than LGBTQ+ people who are not trans.

LGBTQ+ people also have different intersecting identities and experiences that include:

- age
- ethnicity, culture and religion
- disabilities
- socioeconomic status

If a person has several intersecting factors that are protected characteristics or are associated with social exclusion, they are likely to experience more discrimination and disadvantage. This can then affect their problem alcohol use, their experience of healthcare, and their individual treatment needs.

For example, women can benefit from gender specific groups and spaces.
Among LGBTQ+ people interviewed for the report ‘What are LGBTQ+ people’s experiences of alcohol services in Scotland?’, lesbians and bisexual women reported more negative reactions in services than bisexual and gay men.

LGBTQ+ people from minority ethnic groups can benefit from support from others who have had similar experiences.

Young LGBTQ+ adults (age 18 to 24) have a particularly high risk of suicide and helping them to access appropriate mental health support and social support including housing is vital.

Services and practitioners should consider all intersecting aspects of a person's identity and experience.

25.7 Women

25.7.1 Prevalence and harms

The Health Survey for England, 2022 part 1 reported that:

- 4% of women in England were drinking at harmful (higher risk) levels
- 6% of men in England were drinking at harmful (higher risk) levels

The ONS report Alcohol-specific deaths in the UK: registered in 2023 shows there were 3,490 female alcohol-specific deaths (deaths from conditions only caused by alcohol).

Over the last 20 years, female deaths in each of the England, Scotland, Wales and Northern Ireland typically account for around a third of all alcohol-specific deaths.

25.7.2 Considerations for services

Health harms for women

Women experience health harms at lower levels of alcohol consumption than men. The UK chief medical officers' low risk drinking guidelines advise that the risk of harmful (higher risk) drinking begins at 35 units per week and above for women, and at 50 units per week for men. Chapter 19 on people with co-occurring physical health conditions describes health harms, including the risk of breast cancer in women, which increases at levels as low as 2 units per day.

Multiple disadvantage

Many women using alcohol treatment services experience multiple disadvantage which is made worse by the fact that they also experience it as women. Women in alcohol treatment services are often vulnerable and a high proportion have experienced both childhood and adult trauma, including sexual abuse, sexual exploitation and domestic abuse.

Diversity among women

Women are diverse and have different intersecting identities and experience which contribute to their individual identity, experience including:

- age
- sexual orientation
- ethnicity, culture and religion
- abilities
- socioeconomic status

If a person has several intersecting factors, they are likely to experience more discrimination and disadvantage. This can then affect their alcohol problem and their experience of healthcare, and their individual treatment needs will vary.

Pregnancy

Alcohol use, especially harmful or dependent alcohol use, poses significant risks to the pregnant woman and fetus. Alcohol treatment services should prioritise treatment for pregnant women and women in the perinatal period.

You should read the guidance on pregnancy and perinatal care in chapter 24.

Women as parents and carers

Women are more often responsible for childcare than men. Services and practitioners should consider the needs of parents or carers when planning services and developing individual treatment and recovery plans. There is guidance on working with parents in alcohol treatment in chapter 26.

25.7.3 Reducing barriers to treatment

Commissioning and planning services

Commissioners and services should consider the needs of women as part of equality impact assessment processes when carrying out a needs assessment and planning services. They should involve:

- women with lived experience of alcohol dependence and alcohol treatment
- women working in alcohol treatment services
- local specialist organisations for women, including those working with women experiencing multiple disadvantage

The distinct needs of different groups of women should be considered in the assessment taking into account differences in:

- age
- sexual orientation
- gender identity
- abilities
- socioeconomic status
- women who are parents and carers and those who are not

A gender sensitive non-stigmatising approach

Research shows that stigma experienced by people with alcohol problems in society is greater for women than for men (Schober and Annis, 1996). Feelings of shame and

anticipation of stigma from services are barriers to women accessing treatment (Thom, 1987).

Services and practitioners should provide:

- a non-stigmatising service culture that treats women with dignity and respect
- service information with positive strengths-based images and messages targeted at women (you can find more information on taking a strengths-based approach in section 2.2.7)
- practitioners with non-judgemental, empathic attitudes who show they understand the impact of stigma on women

Services and practitioners trained to work with domestic abuse

Current or recent domestic abuse can be a barrier to women accessing treatment, because the perpetrator, or fear of the perpetrator can prevent the woman from attending.

If the service knows the woman is experiencing or at risk of domestic abuse, they should check whether the woman feels safe coming to the service site or whether alternative arrangements are needed. For example, the service could offer an assessment at a domestic abuse service if the woman is attending one.

If the perpetrator is attending the local alcohol treatment service, the service should arrange for the woman to be seen by another service, or at least on a separate site in a completely confidential setting.

Services and practitioners should be trained to work with women experiencing domestic abuse. There is guidance on working with victims and perpetrators of domestic abuse in chapter 22.

Parent friendly services

Women can feel anxious and receive conflicting messages, where they are labelled bad mothers because of their alcohol use. But they also experience barriers to treatment like lack of childcare and fear of losing their children to social services (Peralta and Jauk, 2011).

Services and practitioners should offer:

- a non-judgemental and empathic approach to mothers with alcohol problems
- appointment times to take account of childcare responsibilities
- access to appropriate childcare or flexibility so the woman can arrange childcare
- transparent information about safeguarding responsibilities, confidentiality and information sharing

There is guidance on working with parents in chapter 26.

Reducing financial barriers

Women in treatment may have fewer financial resources than men in treatment.

Services should:

- make it clear the service is free in their promotional literature
- be geographically accessible so transport costs are not too much
- consider offering support with transport costs
- provide information on how the service can provide access to individualised employment support

Reaching women who are unlikely to approach alcohol treatment services

Services should follow the guidance in section 25.4.3 on promoting the service and section 25.4.4 on reaching people. They should use these approaches with women, including specific groups of women who are less likely to approach services. For example, section 25.5.4 and 25.5.5 has advice on reducing barriers for women in some ethnic minority groups affected by cultural norms that particularly stigmatise women who drink or have alcohol problems.

Chapter 9 on assertive outreach and a multi-agency team around the person provides guidance on working with people who experience multiple disadvantage.

25.7.4 Tailoring treatment for women

Gender responsive service culture

Being gender-responsive means creating an environment that reflects an understanding of the realities of the lives of women and responds to their strengths and challenges (Covington and Bloom, 2007).

The service should understand and acknowledge that gender makes a difference to some of the causes of people's alcohol problems and to their alcohol treatment needs. For example, there should be an organisational understanding of how women experience safety, or lack of it, and barriers they can experience in mixed gender environments.

Women only services and spaces

Some women will feel intimidated by mixed gender services, where there are normally more men than women. Women who have experienced traumatic abuse from men may not feel physically or emotionally safe in mixed gender alcohol treatment services.

Services should:

- be in locations that reduce physical risks (such as being well–lit, accessible through open streets not narrow alleys or subways and well-staffed)
- increase emotional safety by offering women only groups or spaces where women can share aspects of their experience as women in an environment that is free from mixed gender dynamics

- based on individual assessment, provide the option of women-only residential treatment
- promote a culture where women are supported to report any sexual harassment they experience at the service
- consider offering women only services

A gender sensitive trauma-informed approach

A high proportion of women with alcohol dependence have experienced trauma including:

- childhood abuse (emotional, physical or sexual)
- adult abuse including domestic abuse, sexual violence or exploitation

Services and practitioners should take a trauma-informed approach, which takes account of the kind of trauma women are more likely to experience than men. Women are more likely than men to experience abuse from people they are in relationship with, which erodes trust in relationships.

For women who have experienced multiple traumas, it is likely to take time to build trust. Practitioners should be trained and supervised to develop a therapeutic alliance using a trauma-informed approach.

A personalised treatment and recovery plan

Each woman should be at the centre of her own care. The practitioner should work with her to develop a treatment and recovery plan that addresses her unique personal goals and needs and not make assumptions based on her gender or other aspects of her identity.

For women who have experienced trauma, at an appropriate stage in the woman's treatment, the multidisciplinary team should consider with the woman whether a referral to a specialist psychological service for post-traumatic stress is appropriate.

There is guidance on treatment and recovery planning in chapter 4.

Working in partnership with organisations that work with women and women's issues

Services should have pathways with local women's organisations and practitioners should support women to access relevant organisations. This should include support to access women-only mutual aid and peer-based recovery support.

A strengths-based approach

Women with alcohol dependence who have experienced abuse and multiple disadvantage often have very low self-esteem. A strengths-based approach can help to gradually build confidence and a belief in their ability to change. Support from women peers who are further on in recovery can also show that change is possible.

Health assessment and harm reduction advice for women

Since women experience health harms at lower levels of alcohol consumption than men, it is important that alcohol services provide them with information on health harms, including the increased risk of breast cancer.

Services should provide information about the risks of drinking during pregnancy to any woman who could become pregnant.

The healthcare assessment offered by the service should include information on sexual health and contraception and signposting to sexual health services. Women should be able to access pregnancy tests at the alcohol treatment service and signposting for counselling if they are considering a termination.

Chapter 19 provides guidance on physical health harms and chapter 8 provides guidance on harm reduction.

Working with women during pregnancy and the year after birth

Alcohol treatment services should prioritise treatment for pregnant women because harmful drinking and alcohol dependence are associated with risk of harm to the mother and the fetus. The service should:

- ensure pregnant women drinking harmfully, or who have alcohol dependence are assessed without any delay and treated by a competent alcohol specialist clinician with input from an obstetrician (see section 10.6.4 in chapter 10 on pharmacological interventions)
- help pregnant women to access specialist antenatal care and perinatal care after the birth of the baby
- contribute to a multi-agency response to safeguarding the fetus, and after birth the baby, and support the mother throughout
- consider home visits in the weeks or months after the birth

Alcohol treatment services should be aware that the year after birth can be a challenging time for women who are at higher risk of return to problematic drinking, mental health problems and death. Services should continue to prioritise support for the woman and work with other services involved with the woman and her baby.

Alcohol treatment services should be aware that a woman who loses a child through death or removal into care is at increased risk of return to problematic drinking as well as at increased risk of mental health problems and suicide. They should continue to offer support to the woman.

There is guidance on pregnancy and perinatal care in chapter 24.

Supporting women to gain education and employment skills

Education, training and meaningful employment are important aspects of recovery and services should support women to access education, training and employment if they want this. Financial independence provides increased opportunities for women to be

autonomous. If women are parents or carers, employment support should be tailored around their childcare responsibilities.

25.8 Older people

This section summarises the main points for reducing barriers and tailoring treatment for older people in alcohol treatment. The Royal College of Psychiatrists (RCPsych) report Our invisible addicts provides detailed guidance on working with older people with alcohol and drug problems.

25.8.1 Prevalence and harms

Throughout the UK, the evidence is that older age groups are more likely than other age groups to exceed the 'UK chief medical officers' low risk drinking guidelines'.

The age groups that had the highest proportion of people drinking 14 units and over each week (increasing (hazardous) or higher risk (harmful) drinking) were:

- 55 to 64 years in England and Scotland (from the Health Survey for England, 2022 part 1 and The Scottish Health Survey 2022 - volume 1: main report)
- 45 to 64 years in Wales (from the National Survey for Wales: adult lifestyles by age and gender, 2020 to 2021 onwards)
- 45 to 54 years in Northern Ireland (from the Health Survey Northern Ireland: first results 2023 to 2024)

Alcohol use and associated harm is increasing more among people between 65 and 74 in England, Scotland and Wales, and between those aged 60 and 75 in Northern Ireland, than in any other age group (IAS, 2020).

The Adult Psychiatric Morbidity Survey 2014 shows that between 2007 and 2014 in England, overall levels of harmful and dependent drinking remained stable but trends varied between age groups. Harmful drinking became less common among 16 to 24 year olds (6.2% in 2007, 4.2% in 2014), but more common in 55 to 64 year olds (1.4% in 2007, 2.8% in 2014).

The ONS report Alcohol-specific deaths in the UK: registered in 2023 shows 61% of alcohol-specific deaths were of people over 55 years old. It also found 53% of alcohol-specific deaths were of people aged 55 to 75 years (premature deaths).

25.8.2 Considerations for services

Age sensitive treatment

The RCPsych report 'Our invisible addicts' notes that the ageing process makes people more susceptible and at risk of the physical and mental health harms caused by alcohol.

They are also more likely to:

- have other mental health conditions
- have other physical health conditions

- be taking medication that can interact negatively with alcohol, by reducing or compounding its effects

This means it is very important to identify older people who are drinking harmfully or dependently and offer them age sensitive treatment.

Conditions associated with ageing

Older people are particularly likely to be vulnerable to alcohol related brain damage (RCPsych, 2018).

Alcohol use in later life can exacerbate or accelerate the start of conditions that are associated with ageing, such as:

- cognitive impairment
- high blood pressure
- imbalance
- increased risk of falls and injuries, particularly when a person is also taking prescription or over the counter medication

Harmful and dependent alcohol use can lead to greater bone density loss for post-menopausal women and alcohol may worsen feelings of anxiety and depression that are related to hormonal fluctuations (Hannan and others, 2000).

Alcohol use in older adults

The 'Evaluation of the Drink Wise, Age Well programme', available at the Professional resources page on the Drink Wise, Age Well website, notes that older adults who drink alcohol harmfully or dependently fall broadly into 3 categories. They are people who have:

- continued their previously unproblematic use into older age, but age-related changes in metabolism have resulted in harms later in life
- had problem alcohol use for many years
- developed problem alcohol use as older adults

People with a long history of problem alcohol use which persists into later life often have a number of comorbidities and health conditions associated with ageing. These people may have had previous unsuccessful experiences of treatment and be reluctant to try again. The majority of older people experiencing alcohol harm are in this group.

For people who developed problem alcohol use as older adults, this is usually associated with difficult life transitions such as retirement, bereavement or loss of sense of purpose (Holley-Moore and Beach, 2015).

Psychosocial factors such as social isolation, financial problems, life events, pain and insomnia also have strong associations with problem alcohol use in older adults (RCPsych, 2018).

Agism and age discrimination

A study of drinking in older people (Wadd and others, 2017) found:

- examples of ageism and age discrimination in the alcohol sector
- several residential treatment services did not accept people over a certain age

25.8.3 Reducing barriers to treatment

Including age in equality impact assessments

Commissioners and services should include actions to address inequalities based on age in their impact assessments. Older people with lived experience and organisations working with older people should contribute to the equality impact assessment, service design, planning and where possible, delivery.

Making sure referral criteria are not based on age alone

Commissioners, community alcohol treatment services and residential treatment services should all make sure that decisions about referring a person, and accepting a person for community or residential treatment, are based on whether the person can benefit from the service, and whether the service can meet their treatment needs, not on age alone. Age is a protected characteristic under the Equality Act 2010 (see section 25.2.3).

Raising awareness about alcohol use and older people among relevant organisations

Professionals in health and social care services often are not aware of alcohol harm among older people and do not identify their problem alcohol use. There is also evidence that healthcare professionals are more likely to refer older people with problem alcohol use for clinical management of alcohol harms such as rehydration or vitamin supplementation, or general community or residential care rather than referring them for alcohol treatment to make changes in their alcohol use. This can be based on an assumption (wrongly) that older people cannot make changes in their alcohol use (Wadd and others, 2017).

Alcohol treatment services should work with local organisations for older people, such as Age UK, and broader health and social care services including those targeted at older people to:

- raise awareness among staff of the increasing level of problem alcohol use in older people and how to recognise signs of an alcohol problem
- promote routine screening of older people in health and social care services using a validated tool such as the alcohol use disorders identification test (AUDIT) (see chapter 3 on identification and brief interventions)
- agree and review pathways between services so older people can be easily referred for alcohol treatment

Barriers related to attitudes and awareness of older people

Older people may be less willing to approach services than other adults because they are:

- particularly concerned about stigma and feel asking for help is shameful
- reluctant to try again after previous unsuccessful experiences of treatment
- unaware of treatment services

Approaches for promoting the service (see section 25.4.3) and flexible processes for engagement (see section 25.4.4) targeted to the needs of older people are important to attract and encourage them into treatment.

Adapting screening thresholds

Services that carry out alcohol screening should have a lower threshold for referring older adults into alcohol treatment because they are likely to experience harm at lower levels of consumption than other adults. Referral criteria for alcohol treatment services should take account of the fact that older people can need treatment at lower levels of consumption.

Staff training and support to challenge ageism

Service policies and training for staff should challenge beliefs about older people that can act as a barrier to them accessing treatment. For example, some professionals might believe that it is too late for older people to change, even though there is evidence that older people achieve better alcohol treatment outcomes than younger adults (Oslin and others, 2002).

Disability reasonable adjustments

Older people who are frail or physically disabled may need reasonable adjustments so they can access services and receive appropriate support if they have sensory disabilities. Even where people do not have disabilities, there are simple adjustments that can help older people such as:

- having higher chairs that make it easier to get up from
- offering appointments on the ground floor to avoid stairs
- having toilets nearby

If older people are unable to access the service site, services should provide home visits.

Avoiding busy waiting rooms

Busy waiting rooms in alcohol and drug treatment services where most people are younger can feel stressful for older people. Services should find ways of managing this. For example, they can offer appointments for older people at designated ‘quiet’ times or at alternative sites.

25.8.4 Tailoring treatment for older people

Referral

At referral, practitioners should ask if there are any disability adjustments the person needs so they can access and make use of the service, for example full disabled access or large

print information. Services should invite carers and family members to the assessment, with the person's consent.

Age sensitive assessments

To make age sensitive assessments of older people's needs, you should consider the following.

Assessment of dependence

The RCPsych report 'Our invisible addicts' advises that the standard criteria for assessing alcohol dependence were developed in younger people, so the assessor should bear this in mind. Where possible, a geriatrician and a specialist in old age psychiatry should contribute to the assessment as well as the alcohol treatment specialist.

Physical and mental health and cognitive function

Physical health and mental health assessment, and screening for alcohol related brain damage as part of a comprehensive assessment, are particularly important for older people. They are at higher risk of alcohol-related and other physical and mental health problems including anxiety and depression and alcohol related brain damage.

There is guidance on comprehensive assessment in chapter 4 on assessment and treatment and recovery planning.

Alcohol treatment services should routinely carry out a brief cognitive assessment, such as the mini Addenbrooke's Cognitive Examination (mini ACE) or Montreal Cognitive Assessment (MoCA). If this brief assessment shows possible cognitive decline, the person should be referred for a specialist neuropsychological assessment. This is particularly important for older adults because they are at higher risk of alcohol related brain damage and cognitive decline from other conditions.

There is guidance on alcohol related brain damage including on adapting interventions in chapter 20.

Other needs to consider

Other areas that may be particularly important to consider when assessing and planning treatment and recovery for older people include:

- diet and nutrition
- risk of dehydration
- safety in their home such as fire and trip hazards
- social networks and community support
- drink driving risks (see annex 2 for guidance on fitness to drive)
- adult safeguarding concerns
- mental capacity to make the decision in question (see glossary)

More frequent re-assessment

It is particularly important to review assessments frequently and if there is a change in the person's circumstances. This is because older people often have multiple health conditions and there can be quite rapid changes in physical health, mental health, cognitive function and day to day functioning. Support and care needs may change quite rapidly.

Multi-agency assessments and treatment and recovery planning

Older people can have several health and social care needs, so it is important to work with other professionals who are supporting the person, to co-ordinate care and to integrate or align care plans. It is often important to consult with specialists who work with older people. There is guidance on multi-agency treatment and recovery planning in section 4.10.4 in chapter 4. It is also often helpful to involve family members or carers with the consent of the person.

Practitioners developing treatment and recovery plans with the person should identify any age-related motivating factors such as maintaining independence and improvements in memory, sleep and energy levels.

Psychosocial interventions and recovery support

Length and frequency of sessions may need to be adapted to the older person's individual needs.

When planning and providing psychosocial interventions, practitioners should consider issues that can affect older people including:

- difficult life transitions such as retirement
- bereavement
- loss of former capacities
- serious illness
- loss of sense of purpose
- social isolation

A focus on day-to-day functioning and on social support may be helpful.

Social isolation can be a problem in older age, so helping people to access peer networks and recovery organisations, including peer activities designed for older people is important.

A strengths-based approach is important. Practitioners should work with older people to find and access other activities that will promote independence, long term resilience and recovery. For example, older people often have experience and skills they can offer as volunteers or peer supporters. They may also want to take part in community-based social activities, education or part-time employment. National Institute for Health and Care Excellence (NICE) guideline Older people: independence and mental wellbeing (NG32)

provides guidance on identifying older people most at risk of a decline in their independence and mental wellbeing and suggests a range of activities.

Pharmacological interventions

When assessing for and providing pharmacological interventions, the clinician needs to consider age related adjustments. You should read the guidance on prescribing for medically assisted withdrawal and for relapse prevention in section 10.6.2 in chapter 10 on pharmacological interventions.

Older people often take (and may misuse) prescribed and over the counter medications where alcohol can interact negatively and cause adverse effects. So, the clinician should make sure they have information on all medicines and substances the person is taking. They should also consider the impact of the person's alcohol use, all their medications and any illicit substances on the pharmacological interventions they offer (RCPsych, 2018).

Age specific support

Evidence suggests that older people can achieve good outcomes from standard treatment and that age specific treatment may produce even better outcomes (RCPsych, 2018). Older people respond well to age specific groups and peer-based support, so services should offer these where possible. It may be helpful for older peer support workers to introduce these groups and accompany the person to them initially.

25.9 People with disabilities and reasonable adjustments

Under the Equality Act 2010, organisations in England, Scotland and Wales have a legal duty to make changes in their approach or provision to ensure that services are as accessible to disabled people as they are for everybody else.

Health and social care organisations must make reasonable adjustments to ensure that disabled people are not disadvantaged.

Details of reasonable adjustments a person requires should be clearly noted and flagged in their record on the service case management system. Wherever possible, a practitioner should ask for information about adjustments required at the referral stage, so they know this before the first appointment.

In England, the Reasonable adjustment flag is included in the national care record. The digital flag shows a person needs extra support and may include details about their disabilities or conditions and necessary adjustments.

25.10 People with learning disabilities

25.10.1 Definition of learning disability

Mencap defines learning disability as a "reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life". They highlight that "people with a learning disability

tend to take longer to learn and may need support to develop new skills, understand complicated information and interact with other people".

25.10.2 Prevalence and harms

There is a lack of evidence on the prevalence of harmful drinking or alcohol dependence in people with learning disabilities. People with profound learning disabilities have limited opportunities to consume alcohol problematically. However, people with mild learning disabilities and living independently in the community may be vulnerable to problem use.

Some evidence suggests that prevalence of harmful drinking in people with learning disabilities may be lower than the general population. But this may be an underestimate because prevalence estimates are normally based on people with learning disabilities who are already in in specialist services (Robertson and others, 2000; Reis and others, 2017).

There is some evidence that larger proportions of adolescents with mild learning disabilities are abstinent, but young men who begin to drink are at an increased risk for intoxication and subsequent at-risk behaviours (Reis and others, 2017).

There is no evidence available on alcohol-specific deaths among people with learning disabilities.

People with learning disabilities are at increased risk of several health conditions compared to the general population including:

- epilepsy
- gastro-oesophageal reflux disease
- some cancers
- accidents
- nutritional problems

Harmful alcohol use can make these conditions worse (Williams and others, 2018).

People with learning disabilities have an increased risk of mental health conditions, which harmful alcohol use can also make worse.

25.10.3 Considerations for services

Health and health inequalities

People with learning disabilities have poorer health compared to the general population as well as poorer access to NHS services. People with learning disabilities have an increased risk of several physical and mental health conditions. But there is also evidence that they have high levels of unmet health need and a higher risk of avoidable medical causes of death (Michael, 2008).

Possible reasons for vulnerability to alcohol use

Research found people with learning disabilities described the main reasons for using alcohol and other drugs was to self-medicate against life's negative experiences (Taggart, 2008). These negative experiences included:

- psychological trauma caused by bereavement or abuse
- social distance from their community
- isolation
- loneliness

Other studies have identified peer pressure and low self-esteem as risk factors for alcohol use (Reis and others, 2017).

Identifying people with learning disabilities

People with mild learning disabilities have not always been formally diagnosed with a learning disability and may be difficult to identify in alcohol services. For some people, their disability can co-exist with alcohol related brain damage. Screening for cognitive impairment as part of comprehensive assessment in alcohol treatment services can help services identify people with learning disabilities. There is guidance on screening for cognitive impairment in section 4.9.10.

Adult safeguarding

People with mild learning disabilities living in the community can be victims of exploitation and abuse, so services should consider adult safeguarding needs as part of assessment.

25.10.4 Reducing barriers to access services

Commissioning and service planning

People with learning disabilities and the organisations that work with them should be involved in equality impact processes as part of needs assessment for alcohol treatment services. Services should also involve people with learning disabilities and relevant support organisations in service planning, so that their needs can be met.

The National Development Team for Inclusion's Green Light Toolkit helps mental health services to effectively support people with learning disabilities and is relevant for alcohol treatment services. This has been designed for services in England, but the content could be relevant for other UK nations too.

Staff training and support

Staff in alcohol treatment services should be trained to be sensitive to, and aware of, the specific needs of people with learning disabilities. They should also be trained to know about human rights and the Equality Act. Services should provide staff with clinical support and supervision to help them work effectively with people with learning disabilities.

Services can consider creating roles for staff who are specifically trained and supervised to enable them to work with people with learning disabilities.

Working with learning disability services

Alcohol and learning disability services should work together to develop and maintain pathways between services. They should also raise awareness of problem alcohol use and alcohol services with local groups for people with learning disabilities. Learning disability services, family members, carers and advocates can all play an important role in identifying problem alcohol use among people with learning disabilities and should be an important part of the referral into alcohol services.

Easy read information

Services should promote themselves in ways that are accessible and meaningful to people with learning disabilities, such as providing information in easy read formats. There are some examples of easy read booklets on alcohol use in the resources section.

Involving family and carers in helping people access treatment

Many people with formally identified learning disabilities are supported by family or professional carers to a greater or lesser extent. With the person's consent, services should encourage family members or carers to help the person access and remain engaged with services and provide information and support to family members.

Learning disability champions

Alcohol services should consider having learning disability champions who can:

- work with local learning disability services
- share expertise with alcohol service staff
- co-ordinate adaptations, such as providing easy read or video versions of psychoeducational interventions
- arrange training on alcohol for learning disability staff, and training on learning disability for alcohol treatment service staff

25.10.5 Tailoring treatment for people with learning disabilities

Involving family or professional carers in treatment

As well as helping people to access treatment, with the person's consent, family members or professional carers can be involved in their treatment, for example supporting them between sessions to remember and work towards their agreed alcohol use goals, or goals in other areas of their life. There is guidance on involving family members and offering them support in their own right in section 5.6.6 in chapter 5 on psychosocial interventions.

Highlighting reasonable adjustments at referral

Services should ask the referrer or the person about any disabilities they have at referral stage. And if the person has a learning disability or literacy difficulties, they should put a note on the referral record. This will help the assessor to make any reasonable adjustments before the assessment and from that point on.

Screening for cognitive impairment

Screening for cognitive impairment should be a routine part of comprehensive assessment for alcohol treatment. But screening is particularly important if the assessor thinks the person has a learning disability or the person tells the assessor that they have one.

If screening shows there may be cognitive impairment, the assessor should refer the person for a more specialist cognitive assessment or occupational therapy-led functional assessment and support them to access this.

Health assessment

A health assessment should be a part of comprehensive assessment for all people in alcohol treatment. People with learning disabilities have an increased risk of several physical health and mental health conditions.

NICE quality standard Learning disability: behaviour that challenges (QS101) recommends that GPs should provide an annual learning disability health check. Clinicians in alcohol treatment services can help people to access this health check if they are not supported by specialist services to do so. This is important because there is evidence of high unmet health needs and avoidable deaths in people with learning disabilities (Michael, 2008).

People with literacy and numeracy difficulties

Many people in the general population will have literacy or numeracy difficulties and many of the adjustments for people with learning disabilities are relevant for those people as well.

Personalised treatment and recovery plan that includes strengths

The practitioner should work with the person (and their family or carer where appropriate) to develop a personalised treatment and recovery plan that the person can understand. The plan should recognise strengths as well as needs and include interventions that support appropriate independence and new opportunities. Longer term recovery goals are important and people with learning disabilities should be supported to access volunteering or employment if they want this. In some areas there are specialist employment projects for people with learning disabilities.

People with learning disabilities can experience social isolation and loneliness. Peer led networks and recovery organisations can be a supportive environment offering social connection. The person may also benefit from involvement in community projects, including specific projects for people with learning disabilities.

Individual sessions

People with learning disabilities may not all benefit from group work, so services should make sure that they have the option of individual work with keyworkers.

Understanding behaviour that staff experience as challenging

People with learning disabilities may not be able to express their feelings easily in words and this can make it difficult to accurately assess their problem alcohol use. For some people

with learning disabilities, difficulties in expressing feelings in words can lead to behaviour that staff experience as challenging. A person's apparent lack of co-operation may be due to a lack of understanding or communication difficulties rather than a lack of motivation to engage in treatment. Services should be flexible in how they recognise and respond to these needs.

Adjusting length and number of sessions

People with learning difficulties are likely to find face to face appointments easier than online appointments.

Services should consider adjusting the length and number of sessions to take account of varying levels of understanding and need. Practitioners might need extra time to do assessments and plan interventions, but it may be more useful to carry out assessments and treatment planning over several shorter but more frequent sessions than they normally would.

When providing psychoeducational interventions, practitioners will often need to repeat information and exercises, particularly when there is more than a week between sessions. They will also often need to recap the coping skills the person has been practising.

Focus on behaviour

Practitioners should consider focusing less on cognitive elements and more on behavioural elements of psychosocial interventions.

Breaking down questions

Practitioners should break down questions with multiple components and ask each element one at a time.

Accessible resources

Practitioners should use accessible resources that the person can take away with them, which can include:

- easy read formats
- audio and video recordings

They can use visual prompts and pictures to help explain important concepts. They can also adapt mapping techniques. You can read more about mapping techniques in Routes to recovery from substance addiction.

The person with learning disabilities can also use audio or video as an alternative to a written drink diary or to record thoughts and feelings instead of writing them down.

Mental capacity to make the decision in question

People with learning disabilities should be able to make decisions about their own lives as far as possible. So, when a practitioner is working with people with learning disabilities, if

they have a proper reason to believe that the person lacks capacity to make the decision in question, the practitioner will need to carry out a capacity assessment.

There should be clinical support for practitioners to make decisions about mental capacity, such as assessing a person's capacity to make the decision in question and making best interests decisions. There is information on mental capacity legislation and statutory guidance in annex 1.

All staff should be trained so they fully understand their responsibilities under mental capacity legislation.

Safeguarding

People with learning disabilities can be vulnerable to exploitation. For example, they can:

- be financially abused
- be coerced into sex work
- be working in the drug trade
- have their homes taken over for selling drugs
- experience harassment

Some people with learning disabilities and mental health conditions can be at risk due to self-neglect. Practitioners should be aware of this when conducting risk assessments and they must follow the relevant legislation, guidance and organisational guidelines on adult safeguarding. There is information on adult safeguarding legislation and guidance in annex 1.

Consultation or clinical supervision

Alcohol service staff should have working agreements with services for people with learning disabilities. They should consult specialist staff for advice on making appropriate adjustments, and where possible access clinical supervision, for work with people with learning disabilities. In turn, staff from alcohol treatment services can offer consultation, and where possible clinical supervision, to services for people with learning disabilities working with people with problem alcohol use.

25.11 Autism and attention deficit hyperactivity disorder

Autism and attention deficit hyperactivity disorder (ADHD) are neurodevelopmental conditions that affect the development of brain function and can lead to significant difficulties with everyday activities. Appropriate support and environmental adjustments can help to mitigate these impacts.

Autism and ADHD often co-occur. Some research suggests around 40% of autistic people also have ADHD (Rong and others, 2021) and 20% to 50% of people with ADHD are also autistic (Van de Meer and others, 2012).

25.11.1 Defining autism and ADHD

Autism

Autism is a lifelong condition that affects how people perceive the world and communicate and interact with others. Autistic people experience differences in social interactions, sensory processing and information interpretation. They may also demonstrate different behavioural preferences, such as a need for routines and behaviours that regulate sensory experiences. Autism affects people to varying degrees so some people will require more help and support than others.

ADHD

ADHD is a condition that affects people's experience of the world and sometimes their behaviour. It is defined by the World Health Organization as a persistent pattern of inattention or hyperactivity-impulsivity that has a direct negative impact on academic, occupational or social functioning. NICE estimates that 3% to 4% of adults and 5% of children and young people have ADHD.

Symptoms of ADHD involve a person's ability to pay attention to things (being inattentive), having high energy levels (being hyperactive) and ability to control impulses (being impulsive). ADHD affects people in different ways and to varying degrees so some people will require more help and support than others.

25.11.1 Problem alcohol use and harms among people with autism and ADHD

Problem alcohol use among autistic people is under-researched and recent estimates of prevalence vary widely. A recent evidence review (Barber and others, 2025) estimated the prevalence of alcohol use disorders (AUD) among autistic people including an estimated:

- 1.6% in large population registers (including population health registers, insurance registers)
- 16.1% in clinical populations (for example, people in alcohol services and autism services)

By comparison, the most recent estimate of higher risk drinking AUD in England is 4.8% of the general population. The evidence review concludes that overall, autistic people may be at somewhat lower risk than the general population for developing AUD. However, the authors note that co-occurring conditions such as ADHD and anxiety put autistic people at increased risk for AUD. They also note that autistic people may turn to alcohol to manage sensory processing differences or for greater confidence in social interactions.

There is limited research into the relationship between ADHD and alcohol use specifically, with most research focusing on the link between ADHD and substance use more broadly.

One piece of research (Luderer and others, 2021) found that:

- people with ADHD are at increased risk of AUD due to impulsive decision making
- ADHD was present in up to 20% of people seeking treatment for AUD
- co-occurring ADHD in people with AUD is under-recognised and undertreated

- symptoms of ADHD and alcohol use in adolescence mutually affect the severity of the other, potentially increasing the impact of ADHD symptoms and the risk of developing AUD
- adults with ADHD and AUD are associated with increased severity of both conditions, several other conditions and worse treatment outcomes

25.11.2 Considerations for working with autistic people and people with ADHD

Making reasonable adjustments and adaptations to treatment

This guidance on autism and ADHD is not about providing specialist support for these conditions. People who need support for autism and ADHD should have access to a service or clinician with expertise in those conditions.

This guidance (in section 25.11) is a brief summary of reasonable adjustments and adaptations alcohol treatment services can make to reduce barriers for autistic people and people with ADHD in accessing alcohol treatment and adapting interventions. There is more information in the resource section.

Staff training, supervision and support

Staff in alcohol treatment services should be trained to have a broad understanding of autism and ADHD, including up-to-date evidence on the likely risk factors that contribute to AUD in both groups. Training should also include information about appropriate adjustments and adaptations they should consider. It should also build awareness of the risks of additional co-occurring mental health difficulties, including increased risk of suicide, among autistic people and people with ADHD. Practitioners should have supervision and support from a multidisciplinary team or a senior clinician.

The National confidential enquiry into suicide and safety in mental health annual report 2024 suggests clinicians may require specific training to recognise and support autistic people and people with ADHD. It also recommends that clinicians are aware of the high rates of suicide-related internet use among autistic people before suicide. Due to their increased risk of suicide and suicidal thoughts, the Suicide prevention strategy for England: 2023 to 2028 includes autistic people as a priority group for providing tailored and targeted support.

Alcohol treatment practitioners can also consult a specialist autism or ADHD team for advice on supporting people with these conditions in the alcohol treatment service. Services should make sure staff are aware of local services with specialist expertise in autism and ADHD.

Co-occurring autism and ADHD with mental health conditions and suicide risk

Although autism and ADHD are different conditions, they have some features in common and the 2 often co-occur. Also, autistic people and people with ADHD are significantly more likely to have co-occurring mental health conditions than the general population.

An evidence review estimated that 1 in 4 autistic people are affected by an anxiety disorder at any given time and 42% experience an anxiety disorder in their lifetime (Hollocks and

others, 2019). Rates of depression are similarly high. Autistic people are also around 3 times more likely to die by suicide, with greater risk for autistic women (Santomauro and others, 2024; Kirby and others, 2019).

Evidence shows that mental health conditions and ADHD often co-occur (Kessler and others, 2006). Other evidence (Chen and others, 2018) describes a number of psychiatric conditions that are over 9 times more likely in adults with ADHD than those without ADHD.

Mothers with ADHD are at increased risk for both depression and anxiety disorders after birth. And this group are 5 times more likely to be diagnosed with either an anxiety or depressive disorder during that period (Andersson and others, 2023). Adults with ADHD are known to be 5 times more likely to attempt suicide, with 1 in 4 women with ADHD attempting suicide (Fuller-Thompson and others, 2020).

A review of studies on the association between ADHD and self-harm (Allely, 2014) found evidence to support that ADHD is a potential risk factor for self-harm in adults and children. The author noted the limitations of the studies involved in the review and recommended more research in this area.

Undiagnosed autism and ADHD

Clinicians often mistake autism and ADHD for other conditions, so misdiagnose people with autism and ADHD. Adults are more likely to be undiagnosed or misdiagnosed than children and this is also the case for more women than men. Girls are more likely to be undiagnosed or misdiagnosed than boys (O'Nions and others, 2023; Luderer and others, 2021).

If the keyworker thinks that the person might be autistic or have ADHD, they should refer the person to an appropriate clinician. This could be someone from either the alcohol treatment service or a mental health service. The clinician can then refer the person for assessment if clinically indicated.

25.11.3 Reducing barriers to access treatment

Involving autistic people and people with ADHD

Commissioners and service providers should involve autistic people and people with ADHD in the local needs assessment and in planning and delivering the service, so they can advise on appropriate adjustments and adaptations. Service providers can also consult national and local peer support and advocacy organisations for autistic people and people with ADHD when planning and delivering their service.

See section 25.4.1 for guidance on involving people in the needs assessment and service plans.

Making reasonable adjustments at referral stage

It is important to make reasonable adjustments to reduce barriers based on each person's individual needs. If you know that the person is autistic or has ADHD when they are referred to the alcohol treatment service, you should:

- ask what adjustments might help them navigate the care pathway, such as attending appointments and communicating with the service
- clearly document any adjustments made and highlight this information in their notes
- make sure these adjustments are in place before the first appointment because the person's first experience of the service will be a significant factor in whether they continue to attend

The NHS England guidance meeting the needs of autistic adults in mental health services provides information about reasonable adjustments and examples of these.

Many of the adjustments that can help autistic people and people with ADHD to engage with a service can also be helpful to other people accessing that service. For example, making information about the service accessible and available in multiple formats.

Adjusting the environment

Autistic people can experience extreme sensitivity to sights, sounds and smells, which can be overwhelming, distressing and can deter them from approaching services. People with ADHD can also find environments with lots of stimulation distracting and overwhelming.

So, you should consider how you could reduce sensory stimulation or manage it in the waiting room and therapy room, to reduce the risk of the person becoming overstimulated and overwhelmed. If you cannot adapt the waiting room sufficiently, you should identify a designated quiet waiting space or an alternative setting in case it is needed. These should be calm, quiet spaces with low light, comfortable seating and minimal objects in the room and on the walls.

Providing information in an appropriate way

Autistic people and people with ADHD often process information differently, which can make it harder to remember or act on information provided by services. Autistic people and people with ADHD can also find new and unfamiliar environments and situations anxiety provoking, which can become a barrier to them engaging with services.

You can adjust for this by providing clear, concise and specific written information about what to expect from the service and the first appointment (as a minimum) in advance. You should provide this in hard copy, not only digitally.

It is often helpful to supplement this written information with visual representations of important information, such as:

- a map showing where the service is located and how to get there if possible
- pictures of relevant rooms in the service
- pictures of staff the person will be meeting

You can also consider creating a web-based access guide for your service through AccessAble.

Make sure to include details like:

- how long the session will last
- what you expect the person attending to do and say
- who they can contact to discuss reasonable adjustments to help them access the service

It is also important to stick to communicated schedules and timings, particularly for autistic people, who may experience distress if there are last-minute changes to plans.

People with ADHD may benefit from appointment reminders. These could be by text, email or phone, or a combination. Discuss the person's individual needs with them.

Informing people that they can attend with someone to support them

Make it clear that the person can be accompanied by a family member, friend or advocate at the initial appointment and throughout their time at the service.

25.11.4 Tailoring treatment

Discuss adjustments and adaptations at assessment

If the referral describes that the person is autistic, or has ADHD, and sets out their adjustment needs, it is helpful to:

- check in with the person to ensure that the adjustments they requested have been put in place and these needs met (so far)
- ask if they need any change to their adjustments, or any additional adjustments, to help them engage effectively with the service

If the person says they are autistic, or have ADHD, at the assessment appointment, you should:

- discuss whether there are any adjustments or adaptions that would help them engage with the service and interventions
- ensure any adjustments or adaptions are clearly documented and highlighted in their notes
- provide information on their next appointment in line with these adjustments, to the best of your ability
- check in with the person at their next appointment, to ensure their access needs are being met

If it's not possible to meet their adjustment needs immediately, agree how this will be done, for example by following up in writing.

Once these adjustments are in place, it is important to review them regularly throughout the time the person is in treatment to make sure their needs are still being met. Autistic people and those with ADHD can find it difficult to communicate additional requests or the need for change unless invited to.

Involving other services that the person is working with

If the person is receiving specialist support for autism, ADHD or co-occurring mental health conditions, with the person's consent, involve the practitioner they are working with in their assessment, treatment and recovery planning so care plans can be aligned. Seek advice from specialist services where needed.

Involving people in developing their treatment and recovery plan

Involve the person in developing their individual treatment and recovery plan and make it clear that adaptions can be made throughout the process.

Offering flexibility around length of treatment and appointments

Autistic people and people with ADHD may need longer in treatment than average. It may take time for them to form a relationship with the practitioner, and for the practitioner to understand and adapt to how the person presents, and their communication style.

Offer flexibility around appointments. Autistic people and people with ADHD may prefer:

- longer appointments to provide extra time for the person to process information or for movement breaks
- shorter appointments for those who find social interaction tiring or find it difficult to sustain their attention

Discuss with the person what they would prefer and check periodically if this is still working for them.

Understanding the person's communication style and adapting your communication

Ask the person about how they prefer to communicate and adapt communication as far as possible to meet those needs. It may be helpful to:

- provide a written summary of the session for the person
- allow time for the person, or someone accompanying them, to make notes
- have someone accompany them to the appointment, who can also listen and retain information
- recap the main points at the end of the session to support understanding and retention
- consider using diagrams or visual symbols as these can be easier to understand or remember
- use clear, direct and unambiguous language

- ask specific questions and be clear what information you are asking for
- avoid using jargon or metaphors
- check for mutual understanding between the keyworker and the person

Discuss with the person what they would prefer and check regularly if this is still working for them.

Being aware of an increased risk of suicide among autistic people and people with ADHD

Be aware that autistic people and people with ADHD are at higher risk of self-harm and suicide (see section 25.11.2).

You can find guidance on working with autistic people, including managing increased risk of suicide, in the resources section.

Accessing peer support

Provide information about local peer support groups and national resources for autistic people and people with ADHD and help people to use these groups and resources.

Autism peer support workers can also offer support to autistic people. These roles are for autistic people to provide support to other autistic people who are experiencing health difficulties, based on their own lived experience of autism. You can find more information on the skills and capabilities required at Autism Peer Support.

Peer support can help to reduce social isolation and help people learn about how others manage their condition.

Structured recreational activity

Where this is acceptable to the person, encourage them to take part in some form of structured activity involving their interests as this may act as a distraction from alcohol and enable the person to meet other people.

If the person does not feel comfortable or able to join a group activity, some individual structured recreational activity can still be helpful. For example, physical exercise may help people with ADHD to meet other people and channel their energy.

If it's acceptable to the autistic person or person with ADHD to attend group activities, peer support for people with lived experience of problem alcohol can be helpful. Even if there are no other members with neurodiverse conditions, they may experience peer support as inclusive.

Tailored employment support

Individualised, employment support that includes people with neurodiverse conditions can help autistic people and people with ADHD to:

- find employment that is suited to their strengths and needs and navigate the process of applying for and starting work

- help those in employment, and their employers, understand what reasonable adjustments to remove disadvantages that autistic people, or people with ADHD, may experience at work

It is a legal requirement for employers to make reasonable adjustments, under the Equality Act 2010.

Involving family members, friends or advocates

Ask people if and how they would like family members, friends or an advocate to be involved in their treatment. Provide information for family members in line with the person's preferences.

Pharmacological interventions

If alcohol treatment for autistic people or people with ADHD involves pharmacological interventions, these should be provided by an experienced specialist clinician who is aware of specific considerations when prescribing for people with these conditions.

25.12 Specific groups experiencing multiple disadvantage

25.12.1 Inclusion health groups

Inclusion health groups is a term used to describe specific groups of socially excluded people likely to experience multiple disadvantage. These groups experience barriers that prevent them accessing healthcare and lead to extremely poor health outcomes. People from these groups are often unaccounted for in health records.

A systematic review of ill health and deaths in several inclusion health groups found very high levels of physical and mental ill health and much lower average age of deaths compared to the general population (Aldridge and others, 2018).

Inclusion health includes any population group who is socially excluded. People with problem alcohol and drug use can be considered an inclusion health group. Within the broader group of people with problem alcohol use, some people experience particularly high levels of social exclusion. This includes but is not limited to:

- people experiencing homelessness
- vulnerable migrants
- Gypsy, Roma and Traveller (GRT) groups
- sex workers
- people in contact with the criminal justice system
- victims of modern slavery

25.12.2 Reducing barriers to services for inclusion health groups

Alcohol treatment services have expertise in working with people with multiple disadvantage who are socially excluded and can extend this expertise so they can meet the needs of specific inclusion health groups.

Section 25.2.2 provides guidance on working with people and groups experiencing multiple disadvantage.

Services and practitioners should follow the guidance Inclusion health: applying All Our Health. It provides information to help frontline health and care staff, managers and strategic leaders to improve access and health outcomes for inclusion health groups. It includes resources for working with several inclusion health groups.

25.12.3 Vulnerable migrants

Vulnerable migrants living in the UK

Groups of vulnerable migrants living in the UK include:

- asylum seekers and refugees
- unaccompanied children
- people who have been trafficked
- undocumented migrants (people who are living in the UK with no legal status)
- low paid migrant workers

Vulnerable migrants experience barriers to accessing services, related to their life circumstances and their immigration status.

The migrant health guide provides comprehensive guidance on working with vulnerable migrant groups.

Treatment needs of vulnerable migrants

Most migrants to the UK come to work or study and are young and healthy. However, there are some groups of migrants who may have increased health needs associated with their experiences before, during and after migration.

The migrant health guide says that practitioners should be "alert to whether a migrant is subject to vulnerability and be particularly vigilant for potential physical and mental health problems in those who are vulnerable".

You can find advice and guidance on the mental health needs of vulnerable migrants on the mental health page of the migrant health guide.

Entitlement to care

It is essential that alcohol treatment service providers and practitioners are aware of vulnerable migrants' entitlements to NHS care so they can access the care they need. There is different guidance for each UK country, which you can find at:

- NHS entitlements: migrant health guide (England)
- Healthcare for overseas visitors: immigration health surcharge (Scotland)
- Overseas visitors and the NHS (Wales)
- Entitlement to NHS services and first time registration (Northern Ireland)

Practitioners may need to advocate for people to access primary care.

Alcohol treatment services and practitioners in England should be aware of guidance NHS cost recovery - overseas visitors. This explains that community drug and alcohol treatment services (which it calls a "first point of contact service") are free to overseas visitors, regardless of immigration status, if the providers consider that the services they provide are equivalent services to primary medical services.

Supporting vulnerable migrants to access services

To help vulnerable migrants access treatment, services will likely need access to independent interpreters. Treatment staff also need training to work with the interpreters. Services should follow guidance on interpretation and translation when working with vulnerable migrants.

Vulnerable migrants will be unfamiliar with UK healthcare systems and unaware of alcohol treatment services. Services need to work with relevant local support organisations to promote the service and arrange access where appropriate.

25.12.4 Gypsy, Roma and Traveller groups

Data on alcohol use

Specific data on alcohol use among people from GRT backgrounds in the UK is not currently available. It is also not currently possible to measure alcohol-related ill health in GRT populations because the ethnicity classifications for GRT groups are not included in hospital statistics data.

There is health data available that shows high levels of health inequality in GRT groups in the UK.

Life expectancy

The House of Commons Women and Equalities Committee report Tackling inequalities faced by Gypsy, Roma and Traveller communities found that people in GRT communities have life expectancies of between 10 and 12 years shorter than the general population.

Mental health

Friends, Families and Travellers' Focus report on Gypsy, Roma and Traveller communities found they are nearly 3 times more likely to be anxious than others, and just over twice as likely to be depressed.

The Traveller Movement's Policy briefing addressing mental health and suicide among Gypsy, Roma and Traveller communities in England reports that in Ireland, the Irish Traveller suicide rate is 6 to 7 times higher than the general population and that anecdotal evidence shows disproportionately high rates of suicide in GRT communities in England.

Reducing barriers to treatment

The ONS report Gypsies and Travellers in England and Wales: lived experiences found evidence of difficulty accessing healthcare as outlined in the sections below.

Registering with a GP

Gypsies and Travellers in England and Wales described challenges in registering with a GP surgery without a fixed address, particularly among people living in Gypsy and Traveller sites or on the roadside. This can result in delays in diagnosis and treatment.

It is essential that alcohol treatment service providers and practitioners are aware that people can access primary care without a fixed address or proof of immigration status. Practitioners may need to advocate for people from GRT communities to access primary care. You can find more about this in chapter 15 on primary care and community health services and in the resources section below.

Lack of trust in services based on experiences of discrimination in healthcare

The ONS study found that anticipation and experiences of discrimination and derogatory attitudes of healthcare staff led to concerns among participants about the likelihood of receiving help and fears of facing negative judgement or discrimination.

If there are GRT communities in a local area, the alcohol treatment commissioners and services should work with local organisations representing those communities to identify any need for alcohol treatment and design a plan with them to reach out to those communities. If there are no local organisations, services can consult national organisations representing GRT groups (see resources section below).

Low levels of literacy and lack of information

The ONS study found that low levels of literacy in GRT communities and lack of information about services also create barriers to accessing healthcare.

Stigma and shame about problem alcohol use

Telling our own stories: an exploratory study of alcohol use and harm by people who identify as Roma, Gypsies and Travellers found that people in GRT communities considered it shameful to have an alcohol problem and ask for help from a service. This is a barrier to them accessing treatment.

Since there is shame and stigma about alcohol problems, it might be helpful for the alcohol treatment service to work with any generic healthcare services who are reaching out to GRT communities. They can then provide information on alcohol harms and on alcohol

treatment services as part of a broader approach to health. Information should be tailored to people with low literacy levels. It is important to stress that services are confidential.

It could be helpful to have a dedicated practitioner who is allocated time to build up a relationship with members of local GRT communities. All staff need to be culturally competent and to have knowledge about the culture of GRT communities and the discrimination and health inequalities they face.

25.13 Resources

Working with people and communities

Health and wellbeing: a guide to community-centred approaches outlines evidence-based community-centred approaches to health and wellbeing, including community engagement service planning and co-production projects.

NHS England's Working in partnership with people and communities: statutory guidance supports effective partnership working between people and communities to improve services.

The Health equity assessment tool (HEAT) provides resources and e-learning to support systematic action on health inequalities and equalities.

The Alcohol Change UK report Exploring communities of belonging around drink looks at how being a member of a 'community of belonging' affects drinking behaviour and engagement with services. It also asks if it is possible to reduce drinking and maintain your links with your original community of belonging. It focuses on Polish, South Asian and LGBTQ+ communities across Yorkshire and the Humber in rural and urban settings.

Ethnic minority groups

The Sikh Recovery Network and Turning Point has produced a number of videos of their Under the Influence Recovery Podcast You can find them by searching YouTube for 'under the influence recovery podcast'. The podcast involves culturally sensitive conversations about recovery.

Culture, connection and belonging: a study of addiction and recovery in Nottingham's BAME community reports on qualitative findings from research exploring the experiences of people from ethnic minority backgrounds who face severe and multiple disadvantage. The study also examines BAC-IN, a peer-led, culturally sensitive drug and alcohol recovery support service, and compares it with other services.

The Alcohol Change UK resource Supporting solutions for South Asian women: Developing models for alcohol support, contains:

- a study that focuses on the lived experiences of South Asian women who use alcohol and other drugs, exploring their problematic use, and their engagement with support
- 'Supporting South Asian women with problematic substance use: policy and practice guidance', which includes a tool for improving existing alcohol treatment services

- ‘Alcohol, Izzat and me: South Asian women in recovery’, which focuses on the experiences of 18 women from South Asian communities in the UK

Minority Communities Addiction Support Services is a Scottish charity that helps and supports people and their families affected by addiction issues in minority communities. They provide services in Glasgow and the surrounding areas.

The Alcohol Change UK report Understanding the association between mental health and alcohol use in minority ethnic communities looks at how the association between mental health and alcohol use varies between ethnic groups.

Women

The report ‘Understanding domestic abuse interventions for women experiencing multiple disadvantage’ is a report that is part of the Evaluation of the Changing Futures programme. It looks at what domestic abuse interventions work for women experiencing multiple disadvantage.

Older people

The Professional resources page on the Drink Wise, Age Well website presents the research, recommendations and advice developed through the Drink Wise, Age Well programme, which took place between 2015 and 2020 across the UK. The programme aimed to:

- challenge stereotypes of drinking and older people
- raise awareness about alcohol use and harms in older people
- reach more hidden older drinkers
- deliver interventions that focus on building resilience and social connection

People with learning disabilities

Substance misuse in people with learning disabilities: reasonable adjustments guidance summarises the resources that can be used by health professionals, social care staff and families to support people with learning disabilities and substance misuse problems.

Easy health provides easy-read information on alcohol. Registration is free.

Autism and ADHD

The National Autistic Society Good practice guide aims to help mental health professionals adapt talking therapies for autistic adults and children. The guide describes simple adjustments and adaptations which can make a huge difference. It includes advice on what services can do to improve the experience of autistic people, and suggestions for therapy sessions.

The Sensory-friendly resource pack outlines projects commissioned by NHS England in a resource pack for local health systems to use to support autistic children, young people and adults and prevent mental health crisis.

The Royal College of Psychiatrists has produced an online resource Autism and mental health, which explains what autism is, how it is diagnosed and what care autistic people with mental health problems are entitled to. It is aimed at autistic adults and their family and carers but may also be helpful for younger people. The information may also be useful for clinicians working with autistic people.

The British Psychological Association guidance Working with autism provides best practice guidance for practitioner psychologists who work with autistic people and their families and carers.

NHS resources for working with autistic people

Future NHS resources are for anyone working in health and social care across the UK. To access the resources, you will need to create a free account (by following the instructions on the website).

The website has guidance on working with autistic people, which supports NHS England guidance Staying safe from suicide. It also includes guidance on reasonable adjustments that services should make when working with autistic people. Many of these adjustments will also be relevant for people with ADHD.

Inclusion health groups

The Inclusion health audit tool is an online tool designed to help organisations in the voluntary, community and social enterprise sector audit their engagement with inclusion health groups to help address health inequalities.

GP access cards for England, Scotland, and Wales provide information about the right to access a GP that people can show to GP surgeries.

The Alcohol Change UK report Telling our own stories: an exploratory study of alcohol use and harm by people who identify as Roma, Gypsies and Travellers is based on a study of alcohol use and harm among four diverse ethnic and cultural groups who had a background of nomadism, using community based participatory research methods.

Friends, Families and Travellers developed a guide for tackling health inequalities in Gypsy, Roma and Traveller communities, which is based on the experiences and knowledge of staff, volunteers and people from GRT communities.

Improving Roma health: a guide for health and care professionals supports health and care professionals to improve services by better understanding the health outcomes that some people in the Roma community face.

25.14 References

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26. Parents in alcohol treatment services

How alcohol treatment services can support parents and their children, including safeguarding responsibilities, working with children's social care and assessment and making referrals.

26.1 Main points

Adult alcohol treatment services and practitioners should help parents and their children to access support, and if required, protection.

Adult and children and young people's alcohol treatment services and practitioners have a statutory responsibility to safeguard and promote the welfare of the children.

Services should have arrangements in place to safeguard children, including policies and procedures and a designated safeguarding practitioner or safeguarding lead.

Alcohol treatment services are responsible for making sure their staff have training at the right level for their role, supervision and appropriate competencies to carry out their safeguarding responsibilities.

Alcohol treatment services should provide training for their staff so they understand the various ways parental problem alcohol use can affect children and the importance of their role in helping parents and their children access appropriate support.

Services and practitioners should work to reduce organisational and personal barriers for parents to engage in treatment.

Assessment should identify and practitioners must act on or escalate any child safeguarding concerns. Assessment and review should be ongoing. Practitioners should reassess risk to children as the circumstances of the person and the family change.

Alcohol treatment services and practitioners should consider the needs of parents and children whether or not there are current safeguarding concerns. Helping a parent and their children to access universal services or targeted early help (support for vulnerable children and families) is more effective than reacting later.

Parents may want to consider goals around their parenting or family life as part of their treatment and recovery plan.

Alcohol treatment practitioners should contribute to multi-agency assessments, plans and reviews for children in need and child protection and early help.

Appropriate and timely information sharing between services is essential to safeguard children and promote their welfare. Alcohol treatment services should have information sharing policies that specify information sharing processes, as well as having information sharing agreements with children's social care and other relevant agencies.

Adult alcohol treatment commissioners and services should work in partnership with local organisations with statutory responsibility for child safeguarding at a strategic level to agree

joint working arrangements. This includes referral pathways and information sharing agreements.

26.2 Introduction

This chapter provides guidance on how adult alcohol treatment services and practitioners can support parents or carers and help their children to access support, and if required, protection. Direct work with children and families requires specialist skills and is outside the scope of these guidelines.

Throughout the chapter we will use the term 'parents' to include anyone caring for a child.

You can find guidance on pregnancy and the perinatal period in chapter 24 and guidance on supporting adult family members in section 4.9.16 in chapter 4 on assessment and treatment and recovery planning and in section 5.8 in chapter 5 on psychosocial interventions.

Services and practitioners must work within their national legislation and guidance on child safeguarding. Annex 1 summarises this legislation and guidance for each UK nation.

26.3 Impact of parental problem alcohol use on children

Not all children of parents or carers with an alcohol problem will experience harm, but they are at a greater risk of doing so. Parental problem alcohol use is a common factor in cases of child abuse, neglect and deaths.

An analysis of serious case reviews between 2014 and 2017 found that parental alcohol use was recorded as present in over a third of the cases (Brandon and others, 2020). Parental problem alcohol use is often associated with other problems, such as parental mental health conditions or domestic abuse (Cleaver and others, 2011; Brandon and others, 2020). And children often face other adverse experiences and associated negative behavioural, health and social outcomes in adulthood (Hughes and others, 2017).

The quality of care received by children is an important determinant of their future development and wellbeing (Pajulo and others, 2006). Problem alcohol use can reduce parenting capacity, sensitivity and attachment (Canfield and others, 2017). Parents or carers with problem alcohol use have often experienced childhood trauma, maltreatment, and adversity themselves and this can also affect their parenting capacity and ability to form attachments with their children (Stith and others, 2009).

26.4 A child-centred approach to safeguarding

Although most adult alcohol treatment services will not have direct contact with the children of adults in treatment, they have statutory responsibilities to safeguard and promote the welfare of children.

26.4.1 Organisational safeguarding arrangements

All alcohol treatment services should have comprehensive child safeguarding policies and procedures. Child safeguarding policies and procedures should include:

- an outline of relevant legislation and statutory guidance
- accountability and governance arrangements
- provision of training
- procedures for acting on and escalating safeguarding concerns
- procedures for learning from incidents and near misses
- safer recruiting processes
- responding to allegations of child abuse against staff members

As described in Working together to safeguard children 2023 (England), section 11 of the Children Act 2004 states:

Places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

There is equivalent child safeguarding legislation and guidance across all UK nations. Alcohol treatment commissioners and services should be aware of the arrangements they should have in place. You can find information on child safeguarding legislation for each UK nation in annex 1.

26.4.2 Training, supervision and support

Service providers are responsible for ensuring their staff are competent to carry out their responsibilities for safeguarding and promoting a child's welfare. They should also create an environment where staff feel they can raise concerns and are supported in their safeguarding role. They should provide staff with:

- access to appropriate training and supervision in child safeguarding
- an induction to familiarise them with child protection responsibilities and the procedures they must follow

26.4.3 Safeguarding leads or designated practitioners

Organisations and agencies specialising in providing alcohol treatment should have a senior board level member with appropriate competencies to act as lead responsible for organisational safeguarding arrangements.

The statutory guidance 'Working together to safeguard children 2023' (England) and equivalent national statutory safeguarding guidance makes it clear that there should be a designated practitioner for child safeguarding in the organisation. The role of the designated practitioner includes support for other colleagues to recognise the needs of children, including protecting them from possible abuse, neglect and exploitation. It also says the role of safeguarding leads should always be clearly defined in job descriptions and to fulfil their responsibilities effectively, organisations should give them enough:

- time
- funding
- supervision
- support

26.5 How adult alcohol treatment services can support children affected by parental alcohol use

Practitioners must refer children to children's social care where they have concerns about a child's welfare or safety, but their role in supporting parents and children should be wider than that.

If parents stop or reduce their alcohol use, this is likely to benefit their children. However, this is often not enough on its own to meet the needs of vulnerable children affected by parental alcohol use and other problems.

Alcohol treatment services should make sure their staff are trained to understand the various ways that parental problem alcohol use can affect children. They should also understand the important role they can play in improving outcomes for children by helping parents and children to access support. This could include:

- making a safeguarding (child protection) referral
- working with children's social care, contributing to child in need and child protection assessments and plans
- using a trauma informed approach and building a trusting relationship (while maintaining professional curiosity) so that parents feel able to discuss their concerns about their parenting or their children
- helping parents and their children to access early help from universal services (open to all) or targeted services (for families with complex needs)
- supporting parents to achieve their parenting goals as part of treatment and recovery planning
- helping parents to access practical support that impacts on the family, for example housing support, welfare rights support and employment support

For practitioners helping parents and their children to access early help services, this could include:

- parenting programmes or support from parenting professionals
- direct support or therapeutic interventions for their children or family
- universal services (open to all) such as children's centres and youth projects

26.6 Addressing barriers to engaging in treatment

Parents and carers can face significant barriers that prevent them from accessing or engaging in alcohol treatment. All services should consider ways to help remove these barriers. They could:

- offer appointment times that take account of a person's childcare responsibilities
- make arrangements with regulated childcare providers so children can be looked after while a parent attends treatment appointments
- offer accessible alcohol treatment and support outside of the usual setting (for example, home visits or at targeted early help services)
- make sure that practitioners understand about stigma (and the resulting fear and shame that parents may experience) and respond empathically
- address parents' fears of involvement from children's social care by providing information on the circumstances in which a practitioner would make a safeguarding referral and the role of social workers
- offer support through partnerships with children's services or family nurse partnerships for young parents (for example, an alcohol treatment practitioner co-located in a children and families service on a regular basis, or participating in joint visits to a family)
- offer the option of a women only space to provide emotional safety for women
- make arrangements so that victims do not have to attend a service attended by an abusive partner or ex-partner
- encourage peer support from parents who are further on in recovery, including those who have experienced intervention from children's social care, which is no longer necessary
- involve parents, and where appropriate children and young people, in planning and developing services

26.7 Identifying the needs of parents, children and families

Chapter 4 on assessment and treatment and recovery planning provides guidance on comprehensive assessment. Comprehensive assessment in alcohol treatment services should always include assessment of the need of parents for parenting support and the needs of their children.

26.7.1 Introducing the conversation about children

Parents are often worried that children's social care services will become involved with their family or that their children will be taken into care. Assessors should not avoid asking questions because of this, but they need to approach the conversation about children sensitively and thoughtfully. It may be helpful to explain that as part of their safeguarding responsibility as a service, they routinely ask questions to all parents or people living with children.

26.7.2 Recording details at initial assessment

At initial assessment, the assessor should record details of the person's children and those they are in contact with and identify any child safeguarding risks. Section 4.8 in chapter 4 on assessment and treatment and recovery planning sets out what details an assessor should record at initial assessment.

26.7.3 Identifying potential safeguarding (child protection) risks

As part of comprehensive assessment, the assessor should identify any concerns about the welfare of the child and whether there is reasonable cause to suspect a child is suffering or likely to suffer significant harm (see definition of significant harm in the glossary). This includes considering both risk and resilience factors.

The assessor should use a trauma-informed and non-judgemental approach when asking about parenting and children and they should also maintain professional curiosity. This means they should be aware that for various reasons including fears that children may be removed, the parent may not share all information about their family situation. Where possible, they should speak to other services the family is involved with to gain a fuller picture.

Identifying the impact of the parent's alcohol use on the safety and wellbeing of children

When assessing whether a child may be at risk, assessors should consider the effect of alcohol use on parental functioning. This includes:

- how much the parent (or parents) is drinking and the pattern of their drinking
- hangovers or withdrawal symptoms or complications
- any additional drug use
- whether both parents or other adults in the household have alcohol or drug problems

Assessors should consider the effect of the parent's alcohol use on their ability to:

- supervise and adequately protect children and young people from danger
- attend to children's basic needs for food, clothing, housing, health appointments and any medical needs
- protect children and young people from contact with potentially inappropriate adults (who may also be intoxicated)
- notice signs that children and young people are being drawn into anti-social or criminal behaviour, including involvement with gangs or organised crime groups, being sexually exploited, abused on-line or drawn into radicalisation
- maintain family routines, for example getting children to school on time
- maintain age-appropriate boundaries for children and young people

- manage the family's essential income, such as whether their income is being spent on alcohol
- be emotionally available for their children and their ability to show emotional warmth
- provide emotional stability, such as whether their children are subjected to a parent's unpredictable mood swings if the parent drinks episodically or experiences withdrawal symptoms

Assessors should also consider any other potential impacts on parenting and family life likely to result from individual circumstances.

The assessor should also consider whether a child is a young carer. This means they have caring roles, either for the parent or for other family members, which would normally be carried out by an adult.

Identifying other risk factors

Problem alcohol use often occurs alongside other problems which can cause harm to the child.

Examples of other problems that can cause harm to a child include:

- the impact of the parent's mental health (known to be a particular issue in cases affecting serious injury and mortality of vulnerable infants aged 2 and under) or physical health on parenting
- any risks from the other parent or adult members of the household
- the impact of any parental conflict on parenting, the family environment and children's wellbeing
- domestic abuse (see below for more information)
- possible physical or sexual abuse
- possible exploitation by people outside the family
- any concerns about a child or young person's development, wellbeing or mental health
- other people supporting the child, for example family members and their fitness to provide that support
- frequent changes in partners living in the household

Seeing, hearing or experiencing the effects of domestic abuse causes significant harm. Safeguarding legislation in all 4 UK nations takes full account of the effects of domestic abuse. In England and Wales, the Domestic Abuse Act 2021 recognises affected children as victims of domestic abuse in their own right.

See annex 1 for legislation and guidance on domestic abuse across the UK.

The assessor should also ask about potential protective factors. This can include:

- effective strategies the parent has for mitigating the impact of their alcohol use on their child (for example, limiting heavy alcohol use to times when children are cared for elsewhere)
- qualities or coping skills the child or young person has
- strengths in parenting and family life, such as stable routines and emotional warmth towards children
- family members or close friends who can provide appropriate care
- other support the parent may have (for example, from their local community)
- any professional support for the parent or the child that is already in place
- support networks or activities that the child or young person is involved in
- a supportive adult that the child can talk to (for example, a teacher)
- supportive, positive friendships for the child or young person

26.8 Acting on concerns about the welfare of a child

26.8.1 Making a child safeguarding referral to children's social care

If the practitioner has concerns about a child's welfare, they should make a referral to local authority children's social care. They should do this immediately if there is a concern that the child is suffering significant harm or is likely to do so. The practitioner should follow organisational procedure and consult with the relevant accountable person in their organisation. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response. The service should have policies to escalate concerns within the organisation and with other agencies if safeguarding concerns are not addressed.

Services should make sure that all staff know how to:

- identify risk factors
- follow organisational child safeguarding procedures
- make a safeguarding referral and are familiar with the referral processes in their local area

26.8.2 Informing the parent

The assessor should inform the parent that they will be making a referral to children's social care. They should do this unless they think informing the parent would put a child at further risk or impede a police investigation. It is important that the practitioner uses an empathic approach while being clear about their concerns for the child and the reasons for the referral. They should allow space for the parent to respond to this information.

It is preferable if the parent gives consent to make the referral, but their consent is not necessary if a child is experiencing or at risk of experiencing significant harm.

This is likely to be an anxious time for parents and they may not know what to expect. Practitioners should explain what will happen after the referral and offer them support as they go through the process of referral and any assessment. Practitioners should make every attempt to keep in contact with the parent, offering another appointment and following up with a friendly text or call if the parent or carer does not attend.

26.9 Young carers

Where a child or young person is identified as a young carer, they should have access to a formal young carer's assessment if they have support needs or they or their parent request one. Community alcohol treatment services should know how to refer young people for formal young carer's assessments and encourage the parent to discuss this with the child. The young carer might benefit from support from young carer's services or activities and in some areas there are specialist services for young carers of parents with problem alcohol or drug use. These services can help young carers to feel less alone and less stigmatised.

You can find more information on carers (including young carers) in annex 1 on relevant legislation and guidance.

26.10 Early help

Practitioners should still consider children's potential support needs even if they find no risks that meet the threshold for a safeguarding (child protection) referral.

The statutory guidance 'Working together to safeguard children 2023' notes the importance of intervening at an early stage:

Early help is a system of support which aims to support children and families as soon as problems emerge. Some early help support is described as 'targeted early help' and is provided to children and families who are identified by practitioners to have multiple or complex needs requiring a specialist and/or multi-agency response but where statutory intervention is not needed.

Based on individual needs, children and young people can benefit from direct support, for example psychotherapeutic support or involvement with activity-based support services. Children and young people may also benefit from interventions that support the relationship between the parents and child.

Support from parenting professionals or programmes can help parents gain parenting skills and this can also support their alcohol use goals. A review of the effectiveness of psychosocial treatment found that interventions that incorporated parenting skills into the treatment programme had the most effect on reducing parental alcohol (or drug) use (McGovern and others, 2021).

If a child has been diagnosed with, or suspected of having, fetal alcohol spectrum disorder (FASD), they should receive specialist assessment and support through the

local FASD diagnostic and support pathways. Typically, these pathways are for children with neurodevelopmental disorders. If specialist pathways are unavailable locally, you can refer children to the national (UK) clinic for FASD.

In some areas, there are specialist services for children and families affected by problem parental alcohol (and drug) use. These services can provide specialist interventions and help children and families affected by parental problem alcohol (or drug) use feel they are not alone.

Adult alcohol treatment services should make sure their staff:

- are aware of locally determined thresholds for levels of need in children and families
- know how to refer children and families to appropriate services
- know how to contribute to early help assessments

Where the threshold for a safeguarding referral outlined in statutory guidance is not met, the parent's consent is required for a referral to children's services or another agency for early intervention and support.

26.11 Ongoing assessment

Assessing for child safeguarding risks or support needs for children and young people is not a one-off event. Assessment should be an ongoing process. Risks may escalate or decrease as the parent's or the family's circumstances change. The alcohol treatment practitioner working with the parent, supported by the multidisciplinary team, should regularly review their assessment and monitor risks. They should share information on any potential increase in risk with children's social care and other agencies involved.

26.12 Including goals around parenting and family life in the parent's treatment and recovery plan

Practitioners working with all parents, whether or not there are safeguarding concerns, should ask them about any goals or aspirations they have about their children or family life when agreeing a treatment and recovery plan. A parent's concerns for their children can often be a motivating factor to make changes in their alcohol use. They can also consider what sort of support they might need to manage some of the challenges of parenting. Agreeing a treatment and recovery plan is also an opportunity to identify parenting strengths so that risks or needs are not the only focus.

Services should have information on universal children's services (open to all) and targeted services (for children and families with multiple or complex needs) for parents to consider.

26.13 Multi-agency working with children's social care and other services

26.13.1 Contributing to multi-agency assessments and plans

A core principle of 'Working Together to Safeguard children' is that safeguarding is everybody's responsibility. Alcohol treatment services and practitioners should be aware of

and follow the published arrangements set out by the organisations responsible for safeguarding in the local area. This is so they can collaborate effectively with other services.

Practitioners in alcohol treatment services should contribute to:

- multi-agency assessments
- child in need and child protection plans
- reviews led by children's social care services
- early help assessments, plans and reviews

If children's social care services are already working with a parent who needs to be referred to the alcohol treatment service, the referral should be considered a priority, due to the risks to the children.

26.13.2 Information sharing

Effective information sharing between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe.

Serious case reviews (Sidebotham and others, 2016) have highlighted that missed opportunities to record, understand the significance and share information in a timely way can have severe consequences for the safety and welfare of children. This applies when problems are first emerging or identified and when children are already known to children's social care.

Alcohol treatment services should develop agreements with other local agencies outlining why, how and when it is appropriate to share information, as well as on how data will be handled once it is shared.

'Working together to safeguard children 2023' provides statutory guidance on information sharing.

Information sharing advice for safeguarding practitioners is non-statutory guidance for people who provide safeguarding services to children, young people, parents and carers (in England only).

26.13.3 Strategic partnerships

Alcohol treatment commissioners and service providers should work with organisations responsible for safeguarding across systems in the local authority.

Local areas need strong leadership and strategic partnerships so that practitioners can work well together across organisations and systems. There should be agreed working arrangements between children and family services and adult and young people's service and other relevant services. Muti-agency working arrangements are best supported by a written protocol. In England, the local safeguarding partnership provides multi-agency governance arrangements and data sharing arrangements for the system.

Agreements can be about:

- the role of alcohol treatment services (adult and young people) in local safeguarding arrangements
- information and data sharing
- the process for early help assessments and interventions for parents with alcohol problems
- the process and thresholds for referrals to children's social care where there are safeguarding concerns
- the process for referrals into alcohol treatment services from children's services
- multi-agency safeguarding training
- governance and evaluation

In some areas, services may be commissioned or agree to provide services in partnership. For example, this might include an alcohol treatment practitioner based for part of the week in children's social care, or a local authority social worker providing regular consultation to staff in alcohol treatment services.

26.14 Resources

Families affected by drug and alcohol use in Scotland is a framework for holistic family approaches and family inclusive practice for working with families affected by parental alcohol and drug use.

26.15 References

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27. Armed forces

How to treat problem alcohol use in UK armed forces personnel and veterans. It covers evidence-based interventions adapted for armed forces settings, the transition to civilian life and tailored support for veterans in community alcohol treatment services.

27.1 Main points

Armed forces community

The Armed Forces Covenant is a promise by the nation ensuring that those who serve or have served in the armed forces, and their families, are treated fairly. For more information, see Armed Forces Covenant: guidance and support.

Alcohol treatment for armed forces serving personnel

UK armed forces personnel have a higher prevalence of harmful (higher risk) drinking and alcohol dependence compared to a similar demographic in the general population. This includes people serving in the:

- Royal Navy
- Royal Air Force
- British Army

In line with the principles of the Armed Forces Covenant, serving personnel should have access to evidence-based alcohol treatment equivalent to that available to the general population.

Defence primary healthcare and mental healthcare staff should use every opportunity to identify serving armed forces personnel with increasing risk, higher risk or dependent drinking and offer brief interventions or evidence-based alcohol treatment. Line managers, welfare support staff and peer support recovery champions can also help people to access treatment.

Alcohol treatment provided by the Ministry of Defence (MOD) Defence Medical Services for armed forces serving personnel should meet recognised standards of good practice. These are set out in the National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) and these alcohol treatment clinical guidelines. Clinicians should deliver interventions that are tailored to the armed forces setting.

Clinicians should promote continuity and consistency of care between Defence Medical Services and external specialist alcohol treatment services. Defence and external alcohol treatment services should work together and set up partnership agreements to provide risk-managed and evidence-based treatment for people with alcohol dependence who require specialist treatment.

All clinicians responsible for treating serving armed forces personnel should:

- be trained and competent in alcohol identification and delivering brief advice
- have the necessary specialist treatment competencies
- receive ongoing support and clinical supervision

There should be a framework in place to enable clinicians to provide good quality care suitable for deployed armed forces, using of remote consultations based on defence clinical guidance which meets the guidelines set out in NICE CG115.

Important concerns for clinicians treating serving armed forces personnel are supporting occupational fitness and managing occupational risk. The latter should reflect the access to weapons that exists for most personnel and the potential that they may undertake safety critical duties as part of their role.

Defence primary healthcare commissions and provides safe and effective healthcare to meet the needs of patients and manage occupational risk. It should continue to implement the alcohol treatment pathway in line with NICE CG115 and adapt it for the armed forces.

Transition from the armed forces to civilian life

Continuity of care and a smooth transition between services is vital for serving personnel in need of alcohol treatment and support who are transferring from the armed forces to civilian life. Defence healthcare and local alcohol treatment services need to agree referral pathways and processes to support this.

Alcohol treatment for veterans

Veterans have a higher prevalence of harmful (higher risk) drinking including alcohol dependence than the general population. The Office for Veterans' Affairs report Health and wellbeing study of serving and ex-serving UK armed forces personnel (PDF, 11.2MB) also looked at post-traumatic stress disorder (PTSD). It found that veterans who were exposed to combat during deployment in Afghanistan or Iraq have a higher prevalence of probable PTSD than the general population and serving personnel.

While most veterans make the transition to civilian life without difficulty, a minority experience difficulties and require additional or specialist support.

Veterans access alcohol treatment through services provided for the general population. To meet the needs of veterans, it is vital that alcohol treatment services:

- reduce barriers to accessing alcohol treatment for veterans
- tailor alcohol treatment interventions to meet the needs of veterans
- provide information and support for veterans to access other relevant services, including specialist organisations for veterans

Veterans' families have specific needs. Alcohol treatment practitioners should ask about the needs of family members, and where appropriate involve them in the person's treatment.

They should also offer family members support or refer them to services for carers or veterans' charities that offer some support to families (see resources in section 27.10).

27.2 Harmful (higher risk) drinking and alcohol dependence among serving armed forces personnel

The guidance in section 27.2 is for clinicians in the Defence Medical Services and clinicians in other services who provide alcohol treatment to serving personnel.

27.2.1 Overview

There is strong evidence that heavy alcohol consumption in the UK armed forces is more common than in the general population. Research has suggested that harmful drinking and alcohol dependence (or alcohol misuse) is one of the most often reported conditions in the armed forces.

The Office for Veterans' Affairs report Health and wellbeing study of serving and ex-serving UK armed forces personnel (PDF, 11.2MB) found that 8.4% had problems with alcohol misuse. This is substantially higher than the general population. Previous studies had found alcohol misuse declining but this has levelled off (Stevelink and others, 2018).

The health harms associated with harmful (higher risk) alcohol use are not always recognised. One research report (Jones and Fear, 2011) observed that:

"Some doctors viewed it as wholly harmful to both social and occupational function and to health, while others argued that alcohol had a specific role in lifting morale, aiding unit cohesion and protecting soldiers from adjustment disorders. Although alcoholism has always been identified as incompatible with military service, the effects of habitual heavy drinking among military personnel are less well understood."

27.2.2 Summary of relevant research

Drinking at increasing or higher risk levels

Increased alcohol use in the military has been linked to perceived social pressure (Irizar and others, 2020) and a social network that includes heavy drinking associates (Anderson and others, 2020).

Alcohol screening has recently been included as part of dental inspections for serving UK armed forces personnel. MOD statistics on alcohol use in the armed forces (from 1 June 2016 to 31 May 2017) shows that 61% of personnel reported drinking at increasing or higher risk levels. This may underrepresent the true rates, since people in the military can under-report their levels of drinking due to the perceived consequences of disclosing that information (Sheppard and others, 2013).

A large-scale study found that half of UK serving and ex-serving military personnel experiencing problem drinking do not self-report their drinking behaviour as problematic (Spanakis and others, 2023). The study found that people with "greater problem drinking severity, poorer mental or physical health, and negative life experiences" are more likely to recognise their harmful alcohol use as a problem.

Alcohol use and specific issues faced by armed forces personnel

Harmful drinking and alcohol dependence have been linked to work strain and functional impairment (Jones and Coetzee, 2018; Rona and others, 2010). People who have undergone particularly stressful military experiences are at greatest risk of harmful drinking, including alcohol dependence (Jones and Fear, 2011). Reservists may be particularly vulnerable (Harvey and others, 2011).

The Office for Veterans' Affairs report 'Health and wellbeing study of serving and ex-serving UK armed forces personnel' found that a substantial minority of currently serving personnel experienced mental health conditions. This included:

- 27.9% with common mental health disorders, such as anxiety and depression
- 7.4% with probable PTSD
- 7.6% with alcohol misuse

Effectively treating armed forces personnel

Research points to complex environmental, cultural and individual factors connected with armed forces personnel having increased drinking harms. However, there is a lack of work focusing on potential treatment approaches and effectiveness in serving military populations (Doherty and others, 2017).

Recent work in the UK and USA has highlighted the promising role of digital or remote interventions. These emphasise self-management of hazardous and harmful alcohol use, for serving and ex-serving armed forces personnel, where they do not need specialist pharmacological interventions. These include delivering interventions by phone and through websites and smartphone apps (Brief and others, 2013; Puddephatt and others, 2019; Walker and others, 2017).

Family and partners

There is some research on the family situation of armed forces personnel who are managing problem alcohol use, although the majority of work is based in the USA. This includes research that found encouragement from partners was important to service personnel seeking care (Trail and others, 2017). This is consistent with findings on partner or family encouragement and involvement in care for people with problem alcohol use in the civilian population (Copello and others, 2009).

27.3 Alcohol treatment for serving UK armed forces personnel

The guidance in section 27.3 is for clinicians in the Defence Medical Services and clinicians in other services who provide alcohol treatment to serving personnel.

Chapters 1 to 12 of these guidelines contain guidance on the core elements of alcohol treatment. Most of these core elements are relevant for clinicians providing alcohol treatment or referring patients to specialist alcohol treatment provision. However, there are some specific considerations for delivering these interventions in an armed forces setting.

27.3.1 The Armed Forces Covenant

The Armed Forces Covenant sets out the nation's commitment to ensuring that those who serve or have served in the Armed Forces, and their families, are treated fairly.

It sets out that members of the armed forces community "should face no disadvantage compared to other citizens in the provision of public and commercial services" and that "special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved".

For more information, see Armed Forces Covenant: guidance and support.

27.3.2 Defence primary care and mental health services

Armed forces personnel and members of the military reserve force who are actively mobilised are entitled to care provided by Defence Medical Services. Alcohol identification, brief interventions, assessment and treatment are carried out by defence primary care and mental health clinicians. Mental health services are staffed by uniformed and civilian mental health professionals including psychiatrists, clinical psychologists and mental health nurses. For remote locations, including overseas, satellite support is provided by mental health teams.

Professionals with alcohol and drug expertise are embedded in defence medical teams. There are various pathways to receiving alcohol assessment and treatment in defence primary care and mental health service settings, including:

- medical referral
- self-referral
- following direction to attend from line managers
- signposting from peer support initiatives

There is ongoing work to implement a more integrated defence alcohol treatment pathway led by good practice evidence. This includes defence primary healthcare developing detailed clinical guidance for treatment, based on NICE CG115 with interventions adapted for an armed forces population.

27.3.3 Medically assisted withdrawal

Assessment for patients requiring medically assisted withdrawal is provided by defence mental health teams working alongside defence primary care clinicians. Inpatient medically assisted withdrawal is provided through defence contracted inpatient service providers (a consortium of NHS trusts) for serving personnel who need this level of care.

27.3.4 Local and overseas arrangements

To optimise patient care, some defence medical teams have agreements with local specialist alcohol treatment services available to the general population. These services provide alcohol treatment interventions for serving personnel.

For overseas locations, patients with acute mental health conditions who need treatment in the UK can be medically evacuated. On-site or 'field' mental health teams provide support to personnel directly involved in military operations, including those of a combat nature.

Additional arrangements cover medical care of dependants of armed forces personnel and UK civil servants living on overseas bases.

27.3.5 Approach to alcohol and drug use in the armed forces

The MOD's Joint Service Publication (JSP) documents provide overall rules, policy and guidelines that apply across the armed forces. Some JSP documents are relevant to managing problems with alcohol and other substances. There are different policies for managing problem alcohol use compared to drug use in the UK armed forces.

JSP policy and guidance is based on a view that harmful alcohol use and alcohol dependence are preventable and recoverable. This provides an approach involving education, awareness and regulation alongside medical support. In some circumstances, disclosure of medical information by medical officers to the chain of command will be justifiable in the public interest. In such cases, MOD guidance is that medical officers work with patients to obtain consent for disclosure where possible and help them to engage with treatment.

Harmful alcohol use including alcohol dependence may lead to administrative action, and this can include discharge from the armed forces.

The MOD sees illicit drug use (not including alcohol) as inconsistent with military service and has a zero-tolerance policy. This means personnel who use illicit drugs can expect to be removed from the armed forces.

The Armed Forces Act 2011 allows testing for drugs and alcohol to be carried out in specified circumstances. So, there is routine random compulsory testing for controlled drugs.

JSP 835: alcohol and substance misuse testing (PDF, 575KB) sets out that exceeding the alcohol limit for prescribed safety-critical duties is an offence under section 20A of the Armed Forces Act 2006. It sets a limit on the amount of alcohol a person subject to service law can have in their breath, blood or urine for prescribed safety-critical duties. A commanding officer can require a person to be tested if they are suspected of being over the limit (there is no minimum accepted limit for illegal drugs).

27.4 Principles for providing alcohol treatment and recovery support under Defence Medical Services

The guidance in section 27.4 is for clinicians in the Defence Medical Services and clinicians in other services who provide alcohol treatment to serving personnel.

27.4.1 General principles

Principles of care for armed forces personnel should ensure that they are able to freely access evidence-based alcohol treatment equivalent to that available to the general population. Personnel are entitled to safe and effective treatment across the range of armed

forces environments where they are required to work and live. Alcohol treatment interventions can be provided by:

- Defence Medical Services, in some cases in partnership with local alcohol treatment services used by the general population, or by
- defence-commissioned NHS services for inpatient medically assisted withdrawal

27.4.2 Maintaining operational effectiveness and managing risk

Defence medical teams have a principal role in maintaining the operational effectiveness of the armed forces and managing risk, including performing safety critical duties. This includes:

- strengthening communication between different healthcare providers
- providing clear protocols for risk assessment and management
- involving other relevant people, including line managers, when necessary

Assessment and treatment of harmful (higher risk) drinking and alcohol dependence should be guided by evidence on effective intervention approaches as described in chapters 1 to 12 of these guidelines.

27.4.3 Optimising engagement and recovery

Armed forces personnel might not disclose harmful alcohol and drug use to avoid potentially negative consequences for their employment.

To increase the chance of successful treatment, clinicians should carry out thorough assessment using a motivational approach, including building readiness for treatment and commitment to it. Interventions should emphasise general health and wellbeing and create opportunities to encourage people to disclose problem alcohol and drug use. Defence primary care and mental health teams are well placed to identify and treat co-occurring physical health and mental health conditions.

Interventions should take account of social factors linked with maintaining harmful drinking and alcohol dependence and should include peer support options. Clinicians should signpost personnel to peer support where necessary. This includes putting them in touch with armed forces recovery champions with lived experience of recovery from alcohol dependence, and external mutual aid organisations.

See chapter 4 for guidance on assessment and treatment and recovery planning.

27.4.4 Addressing the needs of the mobile armed forces population

Armed forces personnel are a mobile population subject to changes in geographical base, sometimes at short notice. Regulations restrict alcohol consumption in certain locations or during certain operational circumstances. For example, no alcohol during some periods of training or active assignment (including when off duty).

Care pathways should provide comprehensive alcohol support and treatment across different locations and when changes occur to a patient's geographical base. Assessment of alcohol use should take account of the effects of occupational requirements and implications for treatment.

On-site or 'field' mental health teams provide support to personnel directly involved in military operations, including those of a combat nature.

Remote or digital consultations (phone, video link, online) may be particularly useful in addressing the needs of deployed armed forces, and clinicians should make use of this capability. For example, to enable continued care following a change of geographical location, or when sites overseas lack facilities for in-person appointments. Where appropriate, as well as delivering interventions, clinicians should promote evidence-based digital tools and apps to help provide information, self-monitoring and for using self-help strategies.

27.4.5 Medically assisted withdrawal

The inpatient pathway for armed forces personnel who need medically assisted withdrawal includes treatment from a contracted inpatient service provider. If assessed as appropriate for the person, Defence Medical Services can provide community-based medically assisted withdrawal (also called ambulatory medically assisted withdrawal). In some areas this might involve working in partnership with local community alcohol treatment services.

When providing medically assisted withdrawal, clinicians should:

- follow clear risk assessment and management protocols
- prepare the patient for medically assisted withdrawal
- provide follow-up support with a long-term recovery focus

There is guidance on medically assisted withdrawal in:

- chapter 10 on pharmacological interventions
- chapter 11 on community medically assisted withdrawal
- chapter 12 on specialist inpatient medically assisted withdrawal

27.4.6 Sociocultural influences

The drinking culture in the armed forces is heavily influenced by social factors such as peer pressure and perceived approval of drinking by others. Defence public health initiatives (including alcohol pricing and availability on bases) should be developed as part of a broader strategy that includes promoting health and wellbeing initiatives within the organisation.

27.4.7 Future developments

Defence primary healthcare provides and commissions healthcare to meet the needs of patients and to manage organisational risk. It should continue to implement the defence

primary care alcohol pathway to support the provision of alcohol prevention and treatment in the armed forces. Senior defence clinicians have endorsed the pathway.

Implementing and adopting the pathway in a sustained way will include:

- using organisational links between the medical, public health and people support groups in defence headquarters, enabling a comprehensive approach to address the drinking culture in the armed forces
- using a combined approach that involves defence medical teams delivering treatment alongside defence public health initiatives that include price and availability controls, awareness raising, screening and referral to treatment
- strengthening governance processes for the alcohol treatment pathway
- integrating initiatives to promote healthy lifestyles and encourage a recovery ethos
- developing care and treatment pathways that take account of a person's family situation, including affected family members (who might also be higher risk drinkers) and addressing the risk of domestic abuse and intimate partner violence
- working towards greater consistency in arrangements for how defence regional mental health networks partner with locally commissioned alcohol treatment services for the general population
- working with peer support groups and having links to outside mutual aid organisations which include online groups
- the Defence Medical Services gambling treatment pathway that links to alcohol care and connects people with specialist external treatment if required, including NHS gambling treatment clinics

27.5 Continuity of care during transition from serving in the armed forces to civilian life

The guidance in 27.5 is for clinicians within Defence Medical Services and for clinicians and practitioners in community alcohol treatment services.

Defence mental health teams treat higher risk alcohol use including dependence, and co-occurring alcohol use and mental health conditions.

JSP 950 on defence mental health services covers continuity of care (which is available for internal use in the armed forces only). It outlines that any service personnel identified with a mental healthcare need can continue to access local mental healthcare for up to 6 months after leaving the armed forces. This applies to service personnel:

- already receiving treatment through a department of community mental health (DCMH), which offer specialist outpatient mental healthcare for serving armed forces in the UK
- identified by primary care and referred to DCMH before their last day in service

Continuity of care and a smooth transition between services is vital for serving personnel with problem alcohol use who are transferring from the armed forces to civilian life. Defence healthcare and local community alcohol treatment services need to agree referral pathways and processes to support this. There should be individual plans in place so there is no gap in care, and the person is prepared for the transition.

Arrangements should be based on individual needs and circumstances. Some people may continue to receive care from Defence Medical Services during the 6 months following their last day of service, or they could move to alcohol treatment services for the general population before that.

27.6 Alcohol treatment and recovery support for veterans

The guidance in section 27.6 is for practitioners in specialist alcohol treatment services and practitioners in other settings who provide alcohol treatment.

A veteran is defined as anyone who has served for at least one day in the UK armed forces (regular or reserve) or merchant mariners who have seen duty on legally defined military operations.

These guidelines use the term 'veteran'. Some people may prefer to use the term 'ex-serving military personnel' or 'ex-armed forces', so it is helpful to ask the person you are working with which term they prefer to use to describe themselves.

27.6.1 Summary of evidence on veterans and alcohol use

The Office for Veterans' Affairs report Health and wellbeing study of serving and ex-serving UK armed forces personnel (PDF, 11.2MB) found the following.

Veterans had substantially higher levels of alcohol misuse (harmful drinking including alcohol dependence) than the general population.

Veterans reported higher levels of probable PTSD and complex PTSD (C-PTSD) than the general population and serving personnel. Veterans who were deployed to Iraq and Afghanistan and exposed to combat reported higher levels of PTSD and C-PTSD than those who were not deployed.

Loneliness was associated with alcohol misuse in veterans. It is not clear whether loneliness causes harmful drinking or harmful drinking causes loneliness. Research on the general population shows that loneliness and common mental health problems can each influence the other.

In other research (Irizar and others, 2020), alcohol misuse (harmful drinking including alcohol dependence) has been found to be more common in serving and ex-serving armed forces personnel who said they drank:

- to cope with stress, mental health conditions or social pressure
- alone and at home

There is evidence that PTSD is associated with higher levels of alcohol use in veterans (Osborne and others, 2022).

Other work has pointed out factors linked to problem alcohol use for veterans including:

- using other substances (Gunn and others, 2019)
- depression and suicide risk (Mrnak-Meyer and others, 2011)
- gambling (Davis and others, 2017)

27.6.2 Armed Forces Covenant commitments to veterans

The Armed Forces Covenant Legal Duty is a legal obligation on certain public bodies to have due regard to the covenant principles when carrying out certain functions in healthcare, education and housing. The public bodies subject to this legal duty include local authorities and various NHS bodies.

For more information, see Armed Forces Covenant: guidance and support.

Organisations that do not have any legal obligation can still sign up to or work to the principles of the Armed Forces Covenant. Organisations providing alcohol treatment are eligible to sign up to the Armed Forces Covenant and several large service provider organisations in Great Britain have done so.

The Armed Forces Covenant sets out that armed forces veterans should receive priority treatment for a condition which relates to their service, compared to the general population with the same level of clinical need.

27.6.3 General healthcare and alcohol treatment for UK veterans

When veterans leave the armed forces, their general healthcare needs are the responsibility of the NHS and the vast majority use services in the same way as any other citizen. Veterans with problem alcohol use will use specialist alcohol treatment services in the same way as any other citizen. Specialist alcohol treatment services are available in every local area across the UK. Commissioning arrangements for specialist alcohol treatment services vary between England, Scotland, Wales and Northern Ireland.

A minority of veterans will require additional support from specialist services for veterans that can help with a range of needs relating to their time in the armed forces and their transition into civilian life. The NHS offers some specialist mental health and physical health services for veterans. Several armed forces charities provide information and services across the UK. MOD also provides services, including welfare support for some veterans.

You can find more information about services and support for veterans across the UK in section 27.7.

27.6.4 Considerations when working with veterans

While most veterans make the transition to civilian life without difficulty, a minority find it difficult and require appropriate support. It is vital to:

- reduce barriers to accessing alcohol treatment
- tailor treatment to meet their needs
- help them to access other relevant services

Some veterans find it difficult to make social connections in the civilian community and so experience isolation and loneliness. They may miss the camaraderie, shared culture and structure of the armed forces but may not feel comfortable approaching civilian support organisations.

Issues that deter many people from accessing alcohol treatment such as stigma or lack of trust in services can be particularly relevant for veterans. Armed forces culture places high value on fitness, self-sufficiency and overcoming challenges, and some veterans can perceive seeking help for alcohol or mental health problems as a weakness.

Veterans who have been exposed to combat may have experienced trauma and like many people with problem alcohol use, they may also have experienced childhood trauma.

Some veterans who have been exposed to combat may have witnessed or done things that went against their moral values. This can lead to feelings of guilt and shame and a wish to avoid talking about their personal experience and emotions.

Veterans can also be concerned that staff in civilian organisations will not understand their experience in the armed forces and may have found a lack of understanding in the past when approaching civilian support services.

There are of course differences between veterans. Some prefer to approach specialist services or support from the armed forces community including specialist charities, but some may prefer to seek help from civilian services and separate themselves from specialist armed forces organisations.

As there is a culture of heavy drinking in the armed forces, veterans may not recognise their alcohol use is a problem until a late stage.

Veterans may also be unaware of services that are available and how to navigate these.

While most veterans find employment on leaving the armed forces, a minority do not. They can find it difficult to negotiate civilian recruitment procedures or lack confidence in transferring their skills. They can experience a loss of sense of purpose after leaving the armed forces and unemployment can contribute to this.

Managing finances, including housing costs, in civilian society differs from managing finances in the armed forces, as some day-to-day costs are taken directly from the salary in the armed forces. Veterans who are unprepared for the difference can find financial management challenging, especially when living on a low income. Loss of housing and financial problems can lead to social exclusion.

27.6.5 Increasing access to alcohol treatment services for veterans

There are several actions commissioners and providers of alcohol treatment services can take to increase access to alcohol treatment for veterans.

Commissioners and providers of community alcohol treatment services should be aware of the approximate numbers of veterans living in their local area. They should work with any local armed forces charities and veterans with lived experience to include the needs of veterans in their local needs assessment. Commissioners can find statistics on the veteran population at constituency level in Constituency data: UK armed forces veterans. Commissioners can also create a custom data set using the 2021 census on the Office for National Statistics website to access data for other local footprints. Regional or local veterans' charities may also be able to provide information on the local veteran population.

Alcohol treatment services should make sure their staff have a basic understanding of armed forces culture and some of the specific needs that veterans can have, including veterans who have been exposed to combat. Armed forces charities can provide information on armed forces culture and specific needs of veterans (see resources section 27.7).

Anonymity can help to reduce concerns about stigma and services should consider offering appointments for veterans at a satellite site that is not publicly identifiable as an alcohol treatment service.

Community alcohol treatment services and local defence healthcare services need to agree referral pathways and processes to support transition for people at the end of their time in service. See section 27.5 for more guidance on supporting people making this transition.

Alcohol treatment services should have pathways with NHS veterans' healthcare services and national and local veterans' charities that provide individual support. Effective pathways should enable two-way referrals, specialist advice and information sharing.

Alcohol treatment services should work to the 2 main principles of care for people with co-occurring problem alcohol use and mental health conditions. These principles are 'everyone's job' and 'no wrong door'.

You can read more about these principles in section 2.3.4 of chapter 2 on principles of care.

Alcohol treatment service literature and information displayed in alcohol treatment services should be inclusive of veterans. Armed forces charities and people with lived experience can advise on how service literature could be designed to attract veterans. Using only images of veterans with physical disabilities is not helpful, because veterans may interpret this as meaning that only veterans with physical disabilities need support.

If there are veterans with lived experience among peer support organisations, it can be helpful for them to be involved in welcoming the person to the service or answering their questions at an early stage.

27.6.6 Tailoring treatment to meet the needs of veterans

Identifying veterans during assessment

Services should consider adding a standard question as part of their assessment that asks people whether they have ever served in the armed forces in a regular or a reserve role and record this. This is so the service is aware of that person's experience and can also inform them of specific services for veterans if the person might benefit from these. If there is referral information that the person has been in the armed forces, the assessor should ask about their experience and its possible relationship to their alcohol use.

The assessor should also ask if their GP knows they have served in the armed forces and encourage them to let their GP know if they have not. This is so their GP can refer or signpost them to specialist services if the person might benefit from them. Some GPs are accredited as 'veteran friendly GPs' (see resources in section 27.7 for more information).

Understanding armed forces culture

Staff who work with veterans need a basic understanding of armed forces culture and the kind of experiences veterans may have had. A practitioner should be able to communicate to the person that they are interested in their experience in the armed forces and though there may be things they do not yet know about, they are interested to learn so they can better understand and work with the person.

See resources in section 27.8 for information on free training on healthcare for veterans.

The person's role and rank and which service they were in while serving in the armed forces is likely to be important to them, so asking about this will show interest in their armed forces experience.

Using a trauma informed approach and identifying PTSD

Veterans may have experienced trauma through exposure to combat. Like other people accessing alcohol treatment, they may also have experienced childhood trauma. A trauma informed approach is important for helping the person to engage and to build a therapeutic relationship. You can read more about a trauma-informed approach in the guidance Working definition of trauma-informed practice.

Practitioners should not assume a veteran has PTSD. But they should be able to identify possible signs of PTSD (including complex PTSD) and offer a referral for specialist assessment through one of the following:

- a suitably qualified clinician within the service
- a local mental health service that can assess and treat PTSD
- specialist mental health service for veterans (see resources in section 27.7)

Therapeutic relationship

Good practice in building a therapeutic relationship that applies to everyone accessing services can be particularly important for working with veterans. The ability to communicate honesty, transparency, respect and reliability is essential.

Choice and continuity of care

There is a wide range of services and support available to veterans. Practitioners should be able to inform people of these and support them to access any services that are relevant for them. Specialist support and activities can help people feel connected to the veterans' community. However, the person may choose not to be involved with specialist services or support and it is important that they have the choice. You can find information on relevant organisations in the resources section.

Good practice in continuity of care can be particularly important for veterans. Practitioners should make sure that:

- transitions from one service or one practitioner to another are smooth
- the veteran has been involved in planning the transition
- all arrangements are clear to the veteran before the transition takes place

Multi-agency working

As with other people in treatment, where a veteran is accessing more than one service at the same time, effective multi-agency working and care co-ordination is vital, so there is a holistic approach to their needs.

See chapter 4 for guidance on:

- multi-agency assessment (in section 4.4.5)
- multidisciplinary and multi-agency treatment and recovery planning (in section 4.10.4 and 4.10.5)

Veterans accessing alcohol treatment services often experience co-occurring problem alcohol use and mental health conditions. Chapter 18 provides guidance on working with people with co-occurring problem alcohol use and mental health conditions.

Social connections and employment

If a veteran experiences social isolation and loneliness after leaving the armed forces, this should be addressed in the treatment and recovery plan. Local recovery-oriented peer support and activities can be helpful in building social connections and identifying purposeful activities they enjoy. There is an online SMART (self-management recovery training) veterans programme (see resources in section 27.7).

Specialist veteran organisations can also help veterans make social connections and feel a sense of belonging if they wish to continue their involvement with the armed forces community.

For guidance on helping people to access recovery-oriented peer support including mutual aid groups, see section 5.5.4 of chapter 5, and chapter 6.

Veterans who are unemployed should be offered personalised employment support. Where a veteran needs support with financial planning, benefits, debt or housing problems, support for these needs can be offered through:

- the alcohol treatment service
- local partner organisations
- specialist veterans organisations

Access to this support will depend on availability and the person's preferences.

Diversity among veterans

Treatment should always be based on individual need and take into account diverse aspects of the person's identity and experience. Although the majority of veterans are White men, veterans are diverse in terms of age, gender, race and ethnicity, religion, sexual orientation, gender identity and disability. These aspects of identity will have played a part in how they experienced life in the armed forces. As in wider society, they may have experienced prejudice, harassment or discrimination on the basis of these characteristics. There is guidance on tailoring treatment to diverse needs in chapter 25 on developing inclusive services.

LGBT veterans: support and next steps provides guidance on restorative measures, support and services for those impacted by the pre-2000 law banning same-sex sexual activity or the policy banning LGBT people from serving in the armed forces.

Lead practitioner for veterans

It can be helpful for alcohol treatment services to have a lead practitioner or champion for veterans who can share expertise and promote good practice specific to veterans.

27.6.7 Veterans' families

Families and carers of veterans including bereaved families are part of the armed forces community and the Armed Forces Covenant sets out commitments to them. Families of veterans may need support and practitioners should ask veterans about the support needs of their families. There is relevant guidance for alcohol treatment services on working with families in section 5.8 of chapter 5 on psychosocial interventions.

Families of veterans can experience specific stresses. While the veteran was serving in the armed forces, their families may have had to move home many times, and they may have been absent for long periods of time. This could result in:

- a disjointed CV for spouses affecting their employment opportunities
- mixed schooling for children
- complex family dynamics

Family life changes for all veterans after transition to civilian life. Veterans' families can benefit from information and advice on how to support their family member who is experiencing problem alcohol use and may also be experiencing co-occurring mental health or physical health conditions. They may also need psychological or practical support for themselves. There are veterans' organisations that provide specialist information and

support for families, including bereaved families. The resources section in 27.7 includes information on veterans' charities that provide support for families.

27.7 Resources

Healthcare resources

Healthcare for the armed forces community provides information and links to services provided by the NHS for the armed forces including reservists, veterans and family members of someone who is serving or who has served. This includes a step-by-step guide for service leavers.

The Royal College of GPs and NHS England Veterans' health hub is a free support programme for GPs and their teams in England. This can help to identify, understand and support veterans and, where appropriate, refer them to specialist healthcare services designed especially for them.

Support for veterans

Veterans UK is part of the MOD. It provides free support for veterans and their families, including a helpline, veterans welfare service, defence transition services and injury and bereavement compensation scheme payments.

Royal British Legion is the largest armed forces charity and is at the centre of a wide network of services and organisations supporting the armed forces community. It provides lifelong support to serving and ex-serving personnel and their families, from expert advice and guidance to recovery and rehabilitation, through transitioning to civilian life. It can help people access other armed forces support organisations.

Soldiers', Sailors' and Airmen's Families Association (SSAFA) provides welfare, health and support services for serving military personnel, veterans and their families.

Mental health support for veterans

Combat Stress is a charity that provides clinical treatment and support for veterans, focusing on those with complex mental health issues resulting from their experiences during military service.

Forces in Mind Trust works to support the armed forces community by funding research on the mental health needs of veterans.

Mutual aid

SMART Recovery's veterans programme provides a national network of mutual aid groups and online training and tools for veterans affected by alcohol problems and other addictive behaviours.

Resources for Scotland, Wales and Northern Ireland

The Scottish Government's armed forces and veterans community provides a range of measures to support the veterans and armed forces community across healthcare, housing, education, justice, skills and employability.

NHS Wales' veterans page provides information on a specialised priority services for veterans in Wales who are experiencing mental health difficulties related specifically to their military service.

Support for veterans and their families in Northern Ireland provides information on welfare, specialist healthcare and advocacy support available to veterans and their families in Northern Ireland.

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Annex 1: relevant legislation and guidance

An overview of relevant legislation and guidance from across the UK's 4 nations, covering child and adult safeguarding, mental capacity, carers and domestic abuse.

Safeguarding children and adults

Overview

Across the 4 countries of the UK, the protection of children and adults at risk sits within different legislative and implementation frameworks. Each UK nation is responsible for its own policies and laws around education, health and social welfare. This covers most aspects of safeguarding and child protection. However, similar basic principles apply.

Relevant legislation, guidance and practice resources supporting the application of the basic principles in service delivery are detailed below.

Child safeguarding

England and Wales

Children Act 1989 places duties on local authorities, courts, parents and other agencies to ensure children are safeguarded and their welfare is promoted.

Children Act 2004 is about multi-agency working. It reinforces the idea that all people and organisations working with children have a responsibility to help safeguard children and promote their welfare.

Children and Social Work Act 2017 amended the Children Act 2004. It places duties on the police, integrated care boards and the local authority, as statutory safeguarding partners, to make arrangements to work with other local partners to safeguard and promote the welfare of all children in their area.

Working together to safeguard children 2023 is statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Information sharing advice for safeguarding practitioners is guidance on information sharing for staff who provide safeguarding services to children, young people, parents and carers. It's for England only.

Wales

Social Services and Well-being (Wales) Act 2014 provides the legal framework for improving the wellbeing of people who need care and support, and carers who need support, and for transforming social services in Wales.

The Welsh Government has a collection of safeguarding guidance to help professionals in Wales to follow the law on safeguarding people. It includes statutory guidance relating to part 7 of the Social Services and Well-being (Wales) Act 2014. Guidance in the collection that covers safeguarding children includes:

- safeguarding people: an introduction

- safeguarding children at risk from abuse and neglect
- safeguarding children from child sexual exploitation

Single unified safeguarding review: statutory guidance was issued by the Welsh Government under section 139 of the Social Services and Well-being (Wales) Act 2014. It applies from 1 October 2024. It replaces the guidance Working together to safeguard people volume 2 (child practice reviews) and volume 3 (adult practice reviews).

Well-being of Future Generations (Wales) Act 2015 focuses on improving social, cultural, environmental and economic wellbeing. It also requires public bodies in Wales to:

- think about the long term impact of their decisions
- work better with people, communities and each other
- prevent persistent problems, such as poverty, health inequalities and climate change

Regulation and Inspection of Social Care (Wales) Act 2016 provides the statutory framework for the regulations on workforce registration and regulation, as well as service provider standards in various settings.

Northern Ireland

The Northern Ireland Executive, through the Department of Health, is responsible for child protection in Northern Ireland. They set out policy, legislation and statutory guidance on how the child protection system should work.

The Safeguarding Board for Northern Ireland (SBNI) co-ordinates and ensures the effectiveness of work to protect and promote the welfare of children.

The Children (Northern Ireland) Order 1995 is the principal statute governing the care, upbringing and protection of children in Northern Ireland.

The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 regulates the provision for checking persons seeking to work with children or vulnerable adults, and for barring those considered to be unsuitable for such posts.

Safeguarding Board Act (Northern Ireland) 2011 is the legislative framework for the creation of the regional SBNI and the establishment of safeguarding panels to support the SBNI's work at a health and social care trust level.

Children's Services Co-operation Act (Northern Ireland) 2015 places a duty on children's authorities, as defined by the act, to co-operate where appropriate as they deliver services aimed at improving the wellbeing of children and young people.

Criminal Law Act (Northern Ireland) 1967 makes it an offence not to report a 'relevant offence' to the police. This includes offences against children.

Co-operating to safeguard children and young people in Northern Ireland 2017 provides the overarching policy framework for safeguarding children and young people in the statutory, private, independent, community, voluntary and faith sectors.

Regional core child protection policies and procedures for Northern Ireland (SBNI, revised 2018) provides detailed operational guidance and explains the actions that must be taken when there are concerns about the welfare of a child or young person.

Children and young people's strategy 2020 to 2030 sets out the strategic framework to improve the wellbeing of all children and young people in Northern Ireland.

Understanding the needs of children in Northern Ireland guidance is used to assess a child's needs and the most appropriate forms of intervention to meet the identified needs of the child or young person and prevent problems from escalating.

It also provides guidance about when and how to refer a child to children's social services when it has been assessed that their needs warrant this.

Guidance on information sharing for child protection purposes sets out high level principles and guidance that staff in children's social services should follow when sharing information for child protection purposes.

Scotland

The Scottish Government is responsible for child protection in Scotland. It sets out policy, legislation and statutory guidance on how the child protection system should work.

Child protection committees are responsible for multi-agency child protection policy, procedure, guidance and practice.

Social Work (Scotland) Act 1968 regulates the provision for promoting social welfare in Scotland, including the care and protection of children, and the supervision and care of persons put on probation or released from prison.

Children (Scotland) Act 1995 outlines the legislative framework for Scotland's child protection system. It covers parental responsibilities and rights, and the duties and powers local public authorities have for supporting and promoting the safety and welfare of children.

Children and Young People (Scotland) Act 2014 protects the rights of children and young people in Scotland.

Children's Hearings (Scotland) Act 2011 established a new national body, under the leadership of the National Convener, to protect the safety and wellbeing of infants, children and young people.

Adoption and Children (Scotland) Act 2007 restates and amends the law relating to adoption in Scotland and makes other provisions relating to the care of children.

National guidance for child protection in Scotland 2021 - updated 2023 helps social workers, police, health professionals and others protect vulnerable children, including areas of practice such as keeping children safe online and child trafficking.

Getting it right for every child provides a framework for people working with children and their families ensuring children get earlier, effective and integrated support from all agencies

to prevent problems escalating. It also provides guidance on sharing information about children.

UK

The legislation and guidance adopted in each of the 4 nations needs to be understood in the context of international conventions that have been incorporated into UK legislation. This includes the following.

United Nations Convention on the Rights of the Child, 1990 is the most widely ratified human rights treaty in history, protecting human rights for under 18s.

Human Rights Act 1998 incorporates the European Convention on Human Rights into UK legislation. Public authorities, like a local authority or the NHS, must follow the act. It includes the:

- right to life
- right to respect for private and family life
- right to freedom of religion and belief

Adult safeguarding

England

Part 1 of the Care Act 2014 sets out the law relating to care and support for adults and the law relating to support for carers, and makes provision about:

- safeguarding adults from abuse or neglect
- integrating care and support with health services

This legislation is supported by the Care and support statutory guidance, which includes information on:

- safeguarding
- person-centred care
- partnership working
- moving between areas
- the role of the principal social worker

Wales

Social Services and Well-being (Wales) Act 2014 provides the legal framework for improving the wellbeing of people who need care and support, and carers who need support, and for transforming social services in Wales.

Working together to safeguard people volume 6: safeguarding adults at risk of abuse or neglect is issued under the Social Services and Well-being Act 2014. It sets out clear

expectations about the ways in which agencies and professionals should work together to safeguard adults at risk. It also provides an overview of effective safeguarding systems and advice on carrying out assessments and care and support plans.

Working together to safeguard people volume 4: safeguarding adults – adult protection and support orders is issued under the Social Services and Well-being Act 2014. This guidance provides a single point of reference on adult protection and support orders, including when and how they can be used.

Regulation and Inspection of Social Care (Wales) Act 2016 covers the regulatory processes applying to social care services, and covers the regulation of the social care workforce, as well as providing for information sharing and joint working.

Northern Ireland

Adult safeguarding: prevention and protection in partnership 2015 aims to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect for the purpose of reducing the prevalence of harm.

Northern Ireland is currently developing an Adult Protection Bill. New statutory guidance will accompany this legislation.

Scotland

Adult Support and Protection (Scotland) Act 2007 deals with the protection of adults at risk of harm, including:

- duties on local authorities
- a requirement for specified bodies to co-operate on adult protection investigations
- a range of protection orders
- the establishment of multidisciplinary adult protection committees

This is supported by the Adult Support and Protection (Scotland) Act 2007: Code of Practice, which provides guidance about the performance of functions by councils and other professionals under the Adult Support and Protection Act.

Mental capacity

Mental capacity legislation aims to provide a framework to allow legally valid decisions to be made about a range of matters including finances, welfare and medical treatment where the individual lacks mental capacity to make the decision in question.

England and Wales

Mental Capacity Act 2005 provides a legal framework for making decisions relating to persons who lack or may lack capacity to make the decision in question.

This is supported by the Mental Capacity Act code of practice, which provides guidance to anyone who is working with or caring for adults who may lack capacity to make a particular decision.

Northern Ireland

Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity and for those who now have capacity but wish to make preparations for a time in the future when they lack capacity.

This is supported by the guidance Mental Capacity Act (NI) 2016 code of practice, which provides practical information for how the Mental Capacity Act (NI) works. It also explains the legal obligations for specific agencies and professionals to have regard to when working with people who lack, or may lack, capacity.

Scotland

Adults with Incapacity (Scotland) Act 2000 sets out the principles that must be applied when making decisions about the needs of adults who lack capacity.

This is supported by Adults with incapacity: forms and guidance, which is a collection of forms and guidance relating to adults with incapacity.

Carers

There's an entitlement to a carer's assessment in each of the devolved nations, but the process for this is slightly different and it's a different legislative framework in each nation.

England

Part 1 of the Care Act 2014 sets out the law as it relates to care and support for adults and the law relating to support for carers (see part 1 of the Care Act under the section on adult safeguarding).

Wales

Social Services and Well-being (Wales) Act 2014 provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales.

This is supported by the following guidance.

Assessing care and support needs of individuals: code of practice sets out the requirement of local authorities to assess the needs of individuals for care and support.

Meeting people's care and support needs: code of practice provides for the circumstances in which needs for care and support, or support for carers, may or must be met by local authorities.

Strategy for unpaid carers sets out national priorities for unpaid carers, including on education and employment.

Northern Ireland

Carers and Direct Payments Act (Northern Ireland) 2002 gives carers the right to an assessment and to be considered for services to meet their assessed needs.

This is supported by the Northern Ireland single assessment tool and guidance, which provides a framework for assessing the support needs of family carers, designed to capture information required for holistic, person-centred assessment of the older person.

Scotland

Carers (Scotland) Act 2016 supports carers' health and wellbeing and help make caring more sustainable, with specific duties for local authorities to support carers.

This is supported by the Carers (Scotland) Act 2016: statutory guidance for local authorities, health boards and integration authorities on effectively implementing the provisions of the Carers (Scotland) Act 2016.

Domestic abuse

England and Wales

Domestic abuse legislation

Domestic Abuse Act 2021 outlines provisions to:

- promote awareness of domestic abuse
- protect and support victims and their families
- prioritise victim safety
- encourage co-ordinated responses to domestic abuse across all local areas, agencies and sectors
- recognise children as victims in their own right

The act is supported by Domestic abuse: statutory guidance. This guidance aims to increase awareness and inform the response to domestic abuse. It sets out standards and good practice for organisations and individuals that work with victims or perpetrators of domestic abuse.

Serious Crime Act 2015 sets out provision for law enforcement agencies to address serious and organised crime. It also introduces measures to enhance the protection of vulnerable children, including by strengthening the law to tackle female genital mutilation and domestic abuse.

Controlling and coercive behaviour: statutory guidance framework is issued under section 77 of the Serious Crime Act 2015. This guidance provides information on identifying and prosecuting controlling or coercive behaviour. It includes information on reducing the risk of harm to the victim, supporting the victim and their family (including how other agencies and support services can assist) and managing the perpetrator.

Abuse carried out by or at the request of family members

Mandatory reporting of female genital mutilation: procedural information gives relevant professionals and the police an understanding of the female genital mutilation mandatory reporting duty.

Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence in England, Wales and Scotland to force someone to marry. Section 121 relates to the offence in England and Wales and section 122 relates to the offence in Scotland.

Wales

Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 focuses on preventing domestic abuse and sexual violence, protecting victims and supporting those people affected by these issues.

Northern Ireland

Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021 deals with domestic abuse as an offence, and with civil proceedings, including cross-examination and special measures in civil and family proceedings.

This is supported by Abusive behaviour in an intimate or family relationship – domestic abuse offence: statutory guidance. This guidance is to be used by agencies investigating domestic abuse offences, and to assist the work of non-governmental organisations and voluntary organisations and to raise awareness of the new domestic abuse offence.

Scotland

Domestic abuse legislation

Domestic Abuse (Scotland) Act 2018 creates a specific statutory offence of domestic abuse and makes a number of associated changes to criminal procedure, evidence and sentencing in domestic abuse cases.

Domestic Abuse (Protection) (Scotland) Act 2021 introduces additional protective measures for victims of domestic abuse and also additional police powers.

Under section 5 of the Domestic Abuse (Scotland) Act 2018, an offence of domestic abuse is aggravated if it involves a child. The National Guidance for Child Protection in Scotland takes full account of domestic abuse.

Abuse carried out by or at the request of family members

Prohibition of Female Genital Mutilation (Scotland) Act 2005 provides specific legislation for Scotland that prohibits female genital mutilation.

Responding to female genital mutilation: multi-agency guidance provides a framework for agencies and practitioners to develop and agree processes that promote the safety and wellbeing of women and girls.

Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence in England, Wales and Scotland to force someone to marry. Section 121 relates to the offence in England and Wales and section 122 relates to the offence in Scotland.

Annex 2: fitness to drive

This annex explains when people and healthcare professionals must notify the relevant agency about conditions such as alcohol use disorders that may affect driving safety.

Reporting responsibilities for people with harmful drinking and alcohol dependence

The Driver and Vehicle Licensing Agency (DVLA) guidance Drug or alcohol misuse or dependence: assessing fitness to drive states that "persistent alcohol misuse" and alcohol dependence are conditions that can affect a person's fitness to drive safely. This means they must not drive and must notify DVLA.

DVLA's general information for medical professionals about assessing fitness to drive helps healthcare professionals and doctors understand their roles and responsibilities for assessing fitness to drive.

This guidance says that:

"Applicants and licence holders have a legal duty to:

- notify DVLA of any injury or illness that would have a likely impact on safe driving ability (except some short-term conditions that are unlikely to continue beyond 3 months)
- respond fully and accurately to any requests for information from either DVLA or healthcare professionals
- comply with the requirements of the issued licence, including any periodic medical reviews indicated by DVLA"

This guidance also says that:

"Doctors and other healthcare professionals should:

- advise the individual on the impact of their medical condition for safe driving ability
- advise the individual on their legal requirement to notify DVLA of any relevant condition
- treat, manage and monitor the individual's condition with ongoing consideration of their fitness to drive
- notify DVLA when fitness to drive requires notification but an individual cannot or will not notify DVLA themselves"

Similar rules apply in Northern Ireland for notifying the Driver and Vehicle Agency (DVA). You can read more about this at How to tell DVA about your medical condition.

Healthcare professionals reporting concerns to DVLA or DVA

The DVLA guidance acknowledges the challenge for healthcare professionals on issues of consent and to the relationship with their patient when notifying DVLA if a person cannot or will not notify DVLA themselves. It directs healthcare professionals to General Medical

Council (GMC) guidance Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA.

Healthcare professionals considering notifying DVLA or DVA of the person's condition should read the GMC guidance before taking this action.

The GMC guidance sets out the steps a doctor should take to inform decisions about disclosing relevant medical information directly to DVLA or DVA when a person's failure or refusal to stop driving exposes others to a risk of death or serious harm. The guidance recognises the duty of confidentiality doctors owe to their patients but also acknowledges their wider duty to protect and promote the health of patients and the public.

Drug or alcohol misuse or dependence guidance

DVLA's guidance 'Drug or alcohol misuse or dependence: assessing fitness to drive' will help clinicians to give appropriate advice to people with alcohol dependence or drinking at harmful levels.

People who drink heavily and daily may not appear or feel intoxicated because they will have developed tolerance to alcohol. Tolerance is the need to drink more alcohol to get the same or desired effect, and it develops in people who drink heavily and regularly. They are likely to be over the legal driving limit on a daily basis and should be advised not to drive and to notify DVLA (or DVA) about their condition. The practitioner should explain that although they may not feel intoxicated, their functioning and judgment will still be affected.

Annex 3: alcohol withdrawal symptoms

A summary of common alcohol withdrawal symptoms and serious complications of alcohol withdrawal. Alcohol treatment staff should be able to understand and recognise the signs of alcohol withdrawal.

Common alcohol withdrawal symptoms

People who are mildly dependent may experience some milder symptoms of alcohol withdrawal including:

- sweating
- nausea
- shaking (mild tremor)

Generally, people experiencing these milder symptoms do not require medical treatment. However, those who are moderately or severely alcohol dependent will develop acute alcohol withdrawal syndrome when they abruptly stop or substantially reduce their alcohol consumption. This can lead to severe complications requiring an urgent pharmacological response.

The National Institute for Health and Care Excellence clinical guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115 full guideline) (PDF, 10.7MB) notes that common symptoms of alcohol withdrawal include:

- tremor
- nausea
- sweating
- headache
- mood disturbance including anxiety and agitation
- disturbed sleep pattern
- hyperacusis (sensitivity to sound)
- hyperthermia (increased body temperature)
- tachycardia (increased pulse rate)
- increased respiratory rate
- tactile and visual disturbances (itching, burning and double or blurry vision)

Serious complications of alcohol withdrawal

The alcohol guidelines development group notes that serious complications of alcohol withdrawal include:

- seizures (fits)
- auditory and visual hallucinations
- delirium tremens (severe shaking, agitation, fever, tachycardia, profound confusion, delusions and hallucinations)
- Wernicke-Korsakoff syndrome (short and long term memory problems, impaired eye movements or unsteady walking)

Alcohol withdrawal symptoms can be life threatening in severe cases, requiring urgent medical attention.

You can find guidance on managing the symptoms and complications of alcohol withdrawal in the chapter 10 on pharmacological interventions.

Annex 4: development group and other contributors

Members of the expert guidelines development group, the experts through experience group and small groups advising the development of these guidelines.

Chair

The chair of the alcohol clinical guidelines development group was Dr Louise Sell MRCP(UK) FRCPsych, Consultant Psychiatrist, Pennine Care NHS Foundation Trust, Non-Executive Director, Stockport NHS Foundation Trust and Trustee, Early Break.

Members

Members of the alcohol clinical guidelines development group were as follows.

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Glossary

An alphabetical list of technical words and terms and their meanings and definitions that are used in the UK clinical guidelines for alcohol treatment.

A

Abstinence

Completely avoiding drinking alcohol.

Acute alcohol withdrawal (or acute alcohol withdrawal syndrome)

The physical and psychological symptoms that people who are alcohol dependent can experience when they suddenly stop drinking or reduce the amount of alcohol they drink. In acute alcohol withdrawal, symptoms can be severe and can include severe complications (see annex 3 for a description of common withdrawal symptoms and severe complications).

Alcohol care teams (ACTs)

Teams of clinicians with alcohol specialist expertise, based in acute general hospitals. They provide specialist support, predominantly to alcohol-dependent inpatients admitted for any condition, whose alcohol use may be putting their health at risk.

Alcohol dependence

These guidelines use the definition of alcohol dependence from the International Classification of Diseases 11th Revision (ICD-11)](https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1580466198), which is as follows:

Alcohol dependence is a disorder of regulation of alcohol use arising from repeated or continuous use of alcohol. The characteristic feature is a strong internal drive to use alcohol, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use alcohol. Physiological features of dependence may also be present, including tolerance to the effects of alcohol, withdrawal symptoms following cessation or reduction in use of alcohol, or repeated use of alcohol or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if alcohol use is continuous (daily or almost daily) for at least 3 months.

An alcohol use disorder identification test (AUDIT) score of 20 and over indicates a person may possibly be alcohol dependent, but a clinical assessment is necessary to diagnose alcohol dependence.

Alcohol harm (or alcohol-related harm)

Alcohol harm is the physical health, mental health or social harm caused either entirely or partly by alcohol. This harm can be experienced by a person drinking and also by their partners, families or the wider community.

Alcohol use disorder

We use alcohol use disorder to include any pattern of alcohol use that significantly increases risks to health, either harmful (higher-risk) drinking or alcohol dependence.

B

Binge drinking

The term binge drinking in these guidelines means any drinking episode that results in acute alcohol intoxication, increasing risk of harm on that occasion.

In the AUDIT questionnaire and in some surveys, 6 or more units for women or 8 or more units for men on a single occasion is defined as binge drinking.

Brief intervention

Alcohol brief intervention is a general term used to describe a short, structured conversation that encourages and supports people with hazardous or harmful patterns of drinking to reduce their consumption towards low-risk levels.

You can find more information on brief interventions in chapter 3.

C

Care plan

See definition of 'treatment and recovery plan (or care plan)' in this glossary.

Carer's assessment

Anyone who is an unpaid carer for a family member or friend has the right to have their own needs assessed by their local authority social care services (or a service the local authority commissions). This assessment is for the carer and is separate from the needs of the person they care for. The local authority uses the assessment to decide what services they can offer. The right to an assessment is underpinned by legislation and statutory guidance (see annex 1 for more information).

Child in need

A child in need is defined under the Children Act 1989 as a child:

- who is unlikely to achieve or maintain a reasonable level of health or development without the provision of services
- whose health and development is likely to be significantly or further impaired without the provision of services
- who is disabled

Local authorities have a duty to provide support to a child in need.

Child protection

Statutory guidance Working together to safeguard children defines child protection as:

part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

See definition of 'significant harm' in this glossary. Also, see definition of 'safeguarding (children)'.

Clinical supervision

In these guidelines, clinical supervision is defined as a collaborative, formal process between a supervisor and supervisee that takes place in a service or workplace. It is part of the overall training and development of clinicians and alcohol and drug workers.

Clinical supervision helps the supervisee to:

- develop their competencies
- ensure that they follow current ethical, organisational and professional standards in their practice
- promote their wellbeing

It is important that clinical supervision involves reflective practice (as defined in this glossary).

Clinician

In these guidelines, a clinician is a registered professional (see definition in this glossary) delivering interventions to people with problem alcohol use. For example, this includes:

- doctors
- nurses
- clinical psychologists
- counsellors
- allied registered health and care professionals

Common mental health conditions

Common mental health conditions include depression, and anxiety disorders such as:

- generalised anxiety disorder
- panic disorder
- obsessive-compulsive disorder
- social anxiety disorder
- phobias
- post-traumatic stress disorder

Complex needs

In these guidelines, complex needs refer to needs that significantly affect people's functioning. They may be caused or made worse by alcohol use or may be independent of it. Complex needs can include but are not limited to:

- other substance use
- mental or physical health conditions
- conditions affecting cognition such as alcohol related brain damage
- domestic abuse
- sexual exploitation and violence
- homelessness
- interaction with the criminal justice system

When a person has several of these needs, this is often referred to as 'multiple and complex needs', 'multiple disadvantage' (see definition in this glossary) or 'severe and multiple disadvantage'.

Controlled drinking

See the definition of 'moderate drinking' in this glossary.

Co-occurring conditions

Co-occurring conditions is when a person has more than one condition or illness at the same time. In these guidelines, this usually means when a person has problem alcohol use alongside mental or physical health conditions or problem drug use. Co-occurring conditions are also sometimes referred to as 'comorbidities'.

You can find more information on co-occurring conditions and an alcohol use disorder in:

- chapter 18 on people with co-occurring mental health conditions
- chapter 19 on people with co-occurring physical health conditions

Controlling or coercive behaviour

Controlling or coercive behaviour is a form of domestic abuse. It is a pattern of behaviour whereby a person repeatedly controls the behaviour of another person that they are personally connected to (for example, an intimate partner, ex-partner or family member).

A perpetrator using controlling or coercive behaviour aims to make the victim feel scared, inferior and/or dependent. Controlling or coercive behaviour can include but is not limited to:

- controlling who the victim has contact with, including cutting the victim off from personal and professional support

- controlling daily aspects of the victims' life, such as what they wear, where they go and what money they spend
- threats or humiliating and intimidating actions aimed at harming, frightening or punishing the victim

For a full legal definition of the offence of controlling or coercive behaviour, see relevant national domestic abuse legislation in annex 1.

Cultural competence

In this guideline, cultural competence means the ability of organisations and individual practitioners to effectively deliver services that meet the social, faith, cultural and linguistic needs of people from diverse communities. See section 2.3.2 for a more detailed description of cultural competence.

D

Decision in question

The 'decision in question' refers to the specific decision that needs to be taken (for example, consenting to proposed medical treatment), at the time it needs to be made. For more information, see the Mental Capacity Act code of practice.

Domestic abuse

England, Wales, Scotland and Northern Ireland each have national legislation that defines domestic abuse. The legislation is:

- England and Wales: Domestic Abuse Act 2021
- Wales: Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Scotland: Domestic Abuse (Scotland) Act 2018
- Northern Ireland: Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021

You can find more details on all this legislation and related guidance in annex 1.

F

Formulation

Formulation is a framework for understanding information gathered in an assessment and helping the person to make sense of their situation. It informs treatment and recovery planning.

The formulation helps the practitioner and the person to understand:

- how the person's alcohol problem began and developed
- the factors that maintain the person's alcohol problem

- potential resources to address the person's alcohol problem

There is more information on formulation in section 5.4 in the chapter on psychosocial interventions.

FRAMES

FRAMES is an acronym that identifies common components of a brief intervention. These are:

- feedback (on the person's level of risk of alcohol use disorder)
- responsibility (change is the person's responsibility)
- advice (identifying reasons for change, ideally using open questions)
- menu (identifying options and strategies for change, ideally using open questions)
- empathy (non-judgemental and understanding)
- self-efficacy (helping the person to be optimistic about their ability to change)

H

Harmful drinking (also called higher-risk drinking)

This guideline uses the ICD-11 definition of harmful drinking, which is outlined in the entry Harmful pattern of use of alcohol:

A pattern of alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of alcohol use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous.

Consumption levels of 50 units and over per week for men and 35 units and over per week for women are sometimes used as proxy indicators of harmful drinking. This is because drinking at those levels risks causing harm to a person's health or to the health of others.

Harm reduction

A harm reduction approach or philosophy sees the aim of alcohol treatment as reducing harms associated with a person's alcohol use. Harm reduction can be understood as a continuum, with small changes at one end of the continuum and complete abstinence at the other. See chapter 8 for guidance on harm reduction.

Hazardous drinking (also called increasing-risk drinking)

A pattern of alcohol use that increases lifetime risk of harm to the physical or mental health of the person drinking or to others. Hazardous drinking has not yet reached the level of having caused harm.

You can find a more detailed definition of hazardous drinking in the ICD-11 entry Hazardous alcohol use.

Consumption levels of between 15 units and 49 units per week for men and between 15 units and 34 units per week for women are sometimes used as proxy indicators of hazardous drinking. This is because drinking at those levels, increases the risk of causing lifetime harm to a person's health or to the health of others.

I

Identification (screening)

Identification is using validated tools (such as AUDIT) to identify people who may have an alcohol use disorder. Staff can carry out identification in health, social care and community services to identify people who are not seeking alcohol treatment but may be increasing their lifetime risk of alcohol ill health or have an alcohol use disorder. Identification can also be used in alcohol treatment services as part of an initial assessment.

Identification is sometimes called screening. In this guideline, the term screening does not refer to the national screening programmes such as those recommended by the UK National Screening Committee.

Independent living

Independent living (sometimes called 'supported living') includes schemes that allow people with support needs to live in their own home or in alternative housing in their local community. Care and support are provided to help the person to live as independently as possible.

In-reach

In-reach are services provided within a partner service by practitioners with a specialism, often on a regular weekly basis. For example, alcohol treatment services can provide in-reach to local health, social care or community services. This can help make alcohol treatment more accessible and improve referral pathways. Local partner services can also provide in-reach within alcohol treatment services.

Intoxication (alcohol intoxication)

Alcohol intoxication is a clinically significant short-term condition that develops during or shortly after a person drinks alcohol. Intoxication is characterised by disturbances that are caused by the known pharmacological effects of alcohol on the central nervous system, including in:

- consciousness
- cognition
- perception
- affect (expression of emotional state)
- behaviour
- co-ordination

The intensity of these effects is closely related to the concentration of alcohol in the bloodstream. ICD-11 distinguishes between mild, moderate and severe intoxication. Alcohol intoxication can significantly increase the risk of suicidal ideation or behaviour.

You can find a more detailed definition of alcohol intoxication in the ICD-11 entry Alcohol intoxication.

K

Keyworker

In alcohol treatment services, a keyworker is the staff member allocated to co-ordinate care and provide structured support to help the person through their treatment and initial recovery (see the definition of 'structured support' in this glossary). An important part of their role is to build and maintain a therapeutic relationship with the person.

L

Lived experience recovery organisations

Lived experience recovery organisations (LEROs) are autonomous projects or organisations led by people with lived experience of alcohol or drug problems and recovery. LEROs can form an important part of a recovery-oriented system of care (see definition of 'recovery-oriented system of care' in this glossary).

There is a more detailed description of LEROs in section 6.3.1.

M

Medically assisted (alcohol) withdrawal

Medically assisted withdrawal (often called detoxification or detox) is a treatment to help a person who is dependent on alcohol to stop drinking safely. It involves medication and clinical management to reduce withdrawal symptoms and prevent severe complications such as seizures, delirium tremens and Wernicke's encephalopathy.

Moderate drinking (also called controlled drinking)

In this guideline, moderate drinking means drinking within the UK chief medical officers' low risk drinking guidelines.

For adults who drink regularly or frequently (most weeks), the chief medical officers' guideline says that, to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis.

It also recommends that, if a person regularly drinks as much as 14 units per week, it is best to spread their drinking evenly over 3 or more days.

Multi-agency team

A multi-agency team is a group of professionals from different agencies (or services) who work together as a team to share information, co-ordinate care and deliver interventions. Multi-agency teams often work with people who have multiple needs.

Multidisciplinary team

A multidisciplinary team involves a number of professionals with clear individual responsibilities to help deliver and co-ordinate care of the person in treatment. Members of a multidisciplinary team can be staff of one organisation, or they can come from several different organisations (see definition of multi-agency team above).

Multiple disadvantage

In these guidelines, multiple disadvantage is defined as the co-occurrence and interaction of adverse circumstances leading to social exclusion, marginalisation and extreme inequality.

Complex, intersecting issues that can contribute to compounded disadvantage include:

- health inequalities
- poverty
- housing instability
- systemic discrimination
- family and individual history including adverse (traumatic) childhood experiences

As well as problem alcohol use, people can experience a range of other problems, for example:

- other substance use
- mental or physical health conditions
- conditions affecting cognitive functioning such as alcohol related brain damage
- domestic abuse
- sexual exploitation and violence
- homelessness
- interaction with the criminal justice system

N

Neurodiversity

Neurodiversity describes variations in the way people's brains work, and the ways they think, learn and behave. It describes variations as differences, rather than deficits. The word neurodiversity refers to the diversity of all people, but it is often used in the context of autism, as well as other neurodevelopmental conditions such as attention deficit hyperactivity disorder, or dyslexia.

P

Practitioner

In this guideline, a practitioner is any person who is employed to provide care and support to people in health and care services, including alcohol treatment services. It includes both clinicians and alcohol workers.

Problem alcohol use

Problem alcohol use describes any pattern of alcohol use that causes a problem for the person who is drinking or for others. This will usually be harmful drinking or alcohol dependence. However, some people experience problems at lower levels of consumption. For some people, drinking any alcohol at all is a risk. For example, abstinence is vital for the health of people with advanced liver disease, including cirrhosis.

Psychoeducation

A psychoeducational approach involves the practitioner providing information and psychosocial support to the person so they can better understand and make changes in their alcohol use and associated problems.

R

Recovery

There are several definitions of recovery. In this guideline, we have used the definition used by Witkiewitz and others (2020):

a dynamic process of change characterized by improvements in health and social functioning, as well as increases in well-being and purpose in life.

Recovery is:

- an individual process or journey of moving on from problem alcohol and drug use
- built on hope to sustain motivation and support expectations of an individually fulfilled life
- about enabling people to gain a sense of control over their own problems, the services they receive and their lives
- about helping people to find opportunities to be active and contributing members of society

Recovery capital (also referred to as recovery resources)

Recovery capital is the range of life resources that can help a person to recover, such as:

- housing
- education
- employment

- supportive peers, family members and social networks
- health and wellbeing

Recovery-oriented system of care

A recovery-oriented system of care (ROSC) is a network of local services and community groups that help people to start and sustain recovery. A ROSC incorporates the insight and work of people with lived and living experience and their families at all levels of planning and delivery to:

- offer choice by providing a flexible and inclusive menu of services, community support and opportunities (including lived experience initiatives), recognising that there are many pathways to recovery
- provide a range of responsive and inclusive support and opportunities for people in recovery and their families
- build on the strengths and resilience of individuals, families, recovery communities and the wider community

Reflective practice

Reflective practice is a process that enables supervisees to engage in analytical thinking about a situation and understand how it has affected them and/or their practice. It enables the supervisee to identify areas for learning and development, and develop self-awareness. It also supports sharing and learning from colleagues, and offers a space for the supervisee to think about their own wellbeing.

Registered professional

As defined in the Professional Qualifications Act 2022: guidance for regulators, the 'regulated workforce' refers to roles that require an essential level of training for registration with a professional body to be able to fulfil the role.

A registered professional is a person who has completed the relevant training and has registered with the professional body for their role.

Relapse

In this guideline, relapse is when a person who has been maintaining a goal of abstinence or moderate drinking returns to a pattern of problematic drinking. Relapse is sometimes distinguished from lapse, where lapse is an occasion or short episode when a person does not maintain their drinking goal, after which they return to a pattern of abstinence or moderate drinking.

Relapse prevention

Relapse prevention is using psychosocial or pharmacological interventions to help a person maintain their drinking goals and reduce their risk of returning to a pattern of problematic alcohol use.

Psychosocial relapse prevention approaches include specific strategies to:

- help a person recognise and manage potential triggers for problematic drinking
- learn from any relapses

They also include interventions to support broader coping skills and interventions to support recovery.

Risk formulation

The Royal College of Psychiatrists' information on formulating risk outlines that risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these.

Risk formulation should aim to answer the following questions:

- how serious is the risk?
- how immediate is the risk?
- is the risk specific or general?
- how volatile is the risk?
- what are the signs of increasing risk?
- which specific treatment, and which management plan, can best reduce the risk?

S

Safeguarding (adults)

The care and support statutory guidance, available on the Care Act 2014: supporting implementation page, defines adult safeguarding as follows:

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Safeguarding (children)

Statutory guidance 'Working together to safeguard children' (linked under 'Child protection' in this glossary) defines safeguarding and promoting the welfare of children as:

- providing help and support to meet the needs of children as soon as problems emerge
- protecting children from maltreatment, whether that is within or outside the home, including online
- preventing impairment of children's mental and physical health or development

- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children
- taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's social care national framework

Severe mental health condition

In this guideline, severe mental health conditions include:

- schizophrenia, schizotypal and delusional disorders
- bipolar affective disorder
- severe depressive episodes with or without psychotic episodes

Significant harm

NSPCC child protection definitions describe significant harm as follows:

"Harm is the "ill treatment or the impairment of the health or development of the child" (Section 31, Children Act 1989; Article 2, Children (Northern Ireland) Order 1995; Scottish Government, 2023).

"Seeing or hearing the ill-treatment of another person is also a form of harm (Section 120, Adoption and Children Act 2002; Section 28, Family Homes and Domestic Violence (Northern Ireland) Order 1998; Scottish Government, 2023).

"Harm can be determined "significant" by "comparing a child's health and development with what might be reasonably expected of a similar child".

"Although there is no absolute criteria for determining whether or not harm is "significant", local authorities such as social services, police, education and health agencies work with family members to assess the child, and a decision is made based on their professional judgement using the gathered evidence. For more information, see:

- Section 31 of the Children Act 1989 (England and Wales)
- Article 2 of the Children (Northern Ireland) Order 1995
- The National guidance for child protection in Scotland (Scottish Government, 2023)."

Structured support

Structured support is the use of specific psychosocial interventions that are common in evidence-based psychological treatments for alcohol and drug use. In alcohol treatment services, the keyworker is usually responsible for offering structured support. There is a detailed description of structured support in section 5.5.

T

Tolerance

Tolerance is the need to consume more alcohol to get the same desired effect, and it develops in people who drink heavily and regularly. The effect of blood alcohol concentration on a person will decrease as tolerance develops. Tolerance decreases after a period of abstinence or reduced drinking.

Treatment and recovery plan (or care plan)

A treatment and recovery plan (or care plan) is a plan that is agreed between the assessor or allocated keyworker and the person in treatment. It is a record that specifies the person's treatment and recovery goals, and interventions and actions to meet those goals.

The keyworker, supported by the multidisciplinary team, should regularly review the treatment and recovery plan with the person. They should adjust the plan at any time if it's clear that it is not helping the person to meet their goals.

You can find more detailed information about treatment and recovery planning in chapter 4.

U

Unit of alcohol

The National Institute for Health and Care Excellence public health guideline Alcohol-use disorders: prevention describes units of alcohol as follows:

In the UK, alcoholic drinks are measured in units. Each unit corresponds to approximately 8g or 10ml of ethanol. Serving volumes vary and the same volume of similar types of alcoholic drink (for example, 2 different brands of lager) can contain a different number of units, depending on the drink's strength (that is, its percentage of alcohol by volume).

There is more information on the NHS Alcohol units page.

V

Vulnerable adult

In these guidelines, the term vulnerable adult broadly means an adult with care and support needs.

[Care and support statutory guidance (updated 2023 and linked previously under 'Safeguarding (adults)') says that a vulnerable adult may also be in need of safeguarding if the adult:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs, is unable to protect themselves from either the risk or experience of abuse or neglect

W

Withdrawal

The physical and psychological symptoms that people who are alcohol dependent can experience when they stop drinking or reduce the amount of alcohol they drink.

Symptoms can vary in severity and how long they last. They are generally more severe in people who are severely dependent but there is wide variation among individuals. People experiencing acute withdrawal can experience serious complications. There is a list of common withdrawal symptoms and serious withdrawal complications in annex 3.