Alcohol Change UK's Blue Light Approach

Improving care and support for people with entrenched alcohol dependency

Guidance for practitioners

Second Edition

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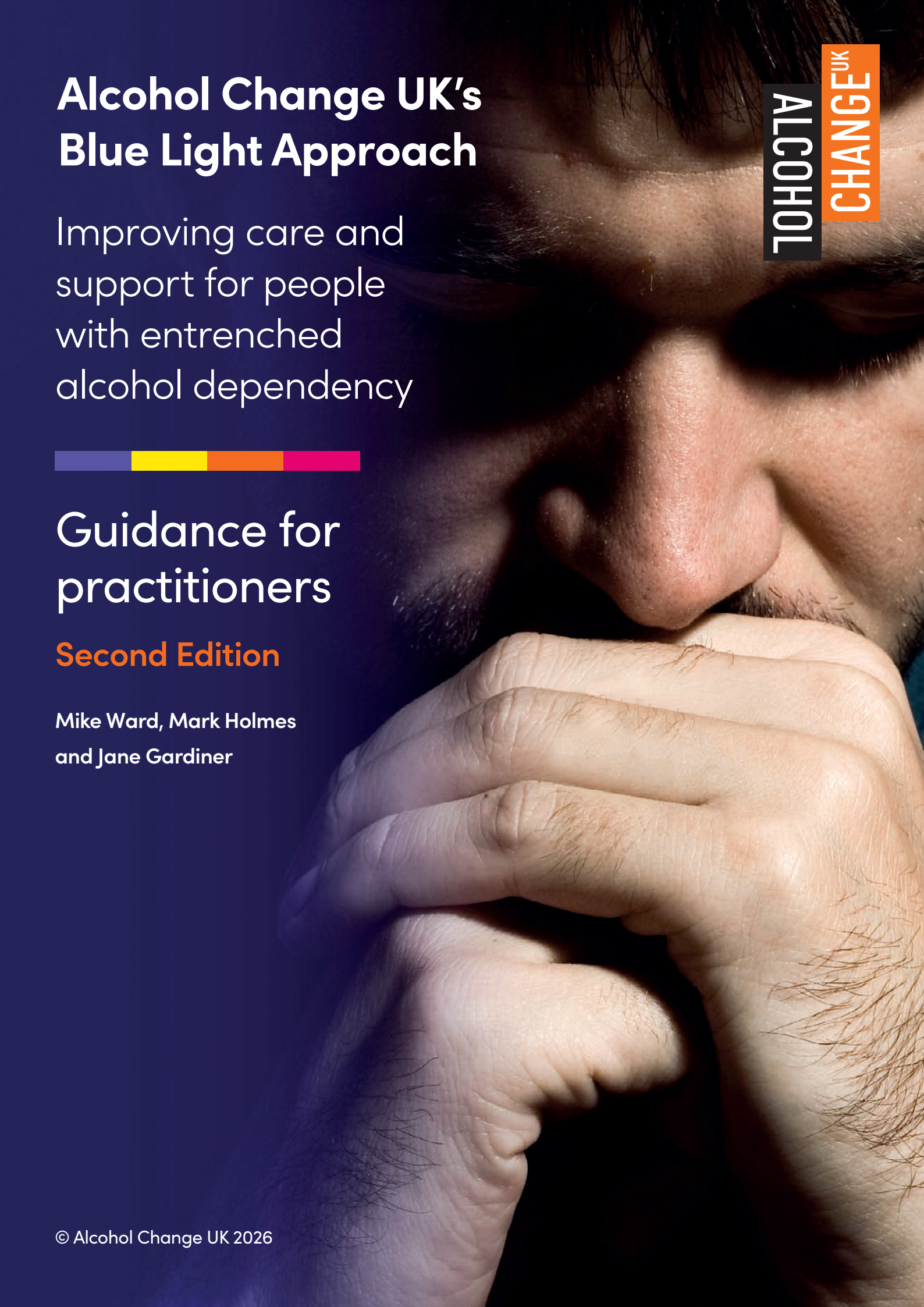

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Introduction:

We can do something about entrenched alcohol dependency

> **"The alcohol agency relies on clients being motivated... Often if people don't attend a couple of appointments their case is closed."** [1]

That quote came from a worker involved in the very first Blue Light pilot, over a decade ago. Sadly, it could have been said yesterday: the problem it describes has not gone away.

Too often, people experiencing entrenched alcohol dependency are labelled 'unmotivated', 'chaotic', or 'making lifestyle choices'. They don't show up to appointments, or drop out, or don't meet service goals, so services disengage. At best, they're handed back to GPs or left with community safety teams. At worst, they are abandoned entirely.

This manual challenges that thinking.

A history of fatalism

In 2011, a man in Rochdale was killed by his ex-wife - a woman he had abused over many years. He had a long-term alcohol use disorder. The Domestic Homicide Review that followed summed up the attitude of many services:

"Appropriate referrals were made to addiction and medical services. He had a stubborn resistance to engaging with them, preferring...to continue his drinking unabated..." It concluded: *"Services cannot be effective unless the client wants to change..."* [2]

The original Blue Light manual opened with this quote, but it's a belief that still echoes today.

In 2018, the Bristol Safeguarding Adults Board (SAB) reviewed the murder of a woman by a man with significant alcohol issues. A key decision? His care coordinator didn't refer him to drug and alcohol services because *"they did not think there was any realistic prospect that Mr X* (the perpetrator) *would engage."* [3]

In 2019, a review into the death of Leanne Patterson in Northumberland noted that services saw her as someone *"'making choices' around lifestyle that were increasing her risk and made her difficult to engage..."* [4] - despite clear signs of exploitation, injury, and escalating risk.

In 2021, Sunderland SAB's Safeguarding Adults Review into "Alan", who died in a fire linked to his drinking, found that professionals involved in his care noted in their reports that *"Alan was a capacitated adult who chose to live a chaotic lifestyle whilst being cognisant of the risks this entailed."* [5] This was despite brain injury, suicidality, and signs of alcohol-related cognitive impairment.

'Lifestyle choice' – or systemic failure?

The phrase 'lifestyle choice' is often used to describe people who are seemingly resistant to engage with services. This was the case with both the Alan SAR and Leanne Patterson SAR mentioned above. It has become a convenient way to rationalise inaction - a label that shifts blame onto people whose lives are shaped by trauma, poor health, structural poverty, and stigma.

But we know this simply isn't true. Calling entrenched alcohol dependency a "choice" is outdated and dangerous. People in such situations are often caught in a perfect storm of addiction, physical illness, trauma, and social exclusion. Many are exploited, many die preventable deaths, and many never even get offered meaningful help.

Even Alcoholics Anonymous, often held up as the gold standard for peer recovery, is clear that the only requirement for membership is a desire to stop drinking.[6] So, what happens to the people who don't yet have that desire - or can't express it?

The Blue Light Approach

The Blue Light Approach was developed as a direct response to this culture of fatalism.

It's not about blaming services. Many are under-resourced, overburdened, and doing their best within rigid systems. But it is about challenging the belief that 'nothing works'.

The Blue Light Approach offers a practical, realistic set of strategies to engage people who seem resistant or ambivalent - not by waiting for them to 'hit rock bottom', but by starting where they are.

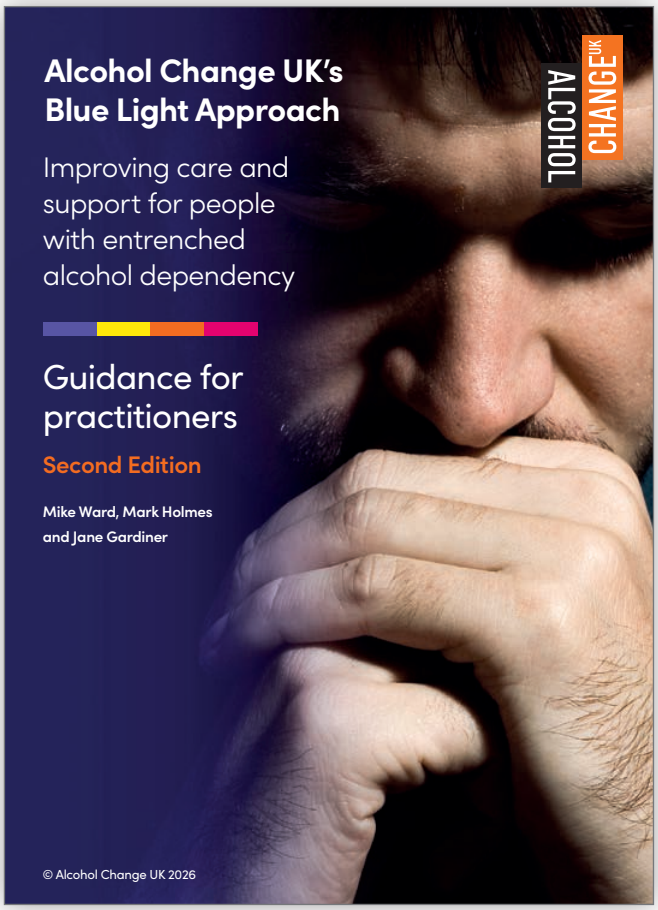
It shows that:

- Progress is possible, even without initial motivation
- Costs to services can be reduced
- Risk and harm can be minimised
- People who are written off can stabilise - and even recover

This manual isn't a magic solution. But it is a toolkit - built from front-line experience - for workers who are tired of watching the same people fall through the same cracks. It sets out strategies and techniques that specialist and non-specialist workers can consider in working with this client group.

However, this guide is just a starting point. This is not meant to be the definitive statement on working with people with entrenched alcohol dependency that services find difficult to engage; its main aim is to inspire workers to think differently.

It's for anyone who believes that doing nothing is the worst option of all.



Why bother?

It's easy - and is all too common - to write off some people with entrenched alcohol dependency as being beyond help.

Often, they don't show up to appointments. They shout at A&E staff. They are arrested, released and then repeat the cycle.

Some professionals - understandably worn down - fall back on the old belief that people only change when they hit "rock bottom".

But here's the problem: for many people, *rock bottom is death*. And without the right support, people remain in repeated crisis contact with services - generating high costs across health, police and social care, and carrying risks that are entirely preventable, remaining some of the most vulnerable and traumatised people in our communities. This section sets out in more detail why action is required – why we should be bothered.

Why bother? The Treatment Gap: most people aren't in treatment

At any given time, the overwhelming majority of dependent drinkers are not in treatment.

Government figures show that just 18% of dependent drinkers in England are receiving support - and in some areas, it's as low as 11%.[7]

This is known as the *treatment gap* - the difference between the number of people who need help and the number who actually receive it.

This matters for the Blue Light client group because they sit at the sharpest end of that gap.

These are individuals who have often been offered support repeatedly, but who - for a whole range of reasons - do not or cannot engage with standard pathways. They are not just in the treatment gap; they are among those most at risk of preventable harm while they remain outside treatment, and they generate the highest levels of crisis contact across services.

The Blue Light Approach exists precisely because traditional treatment systems have not worked well for this group of people. Understanding the treatment gap helps to show that the issue isn't a handful of 'unmotivated' individuals - it is a structural problem that demands a different response.

Evidence on the treatment gap

Across physical and mental health conditions there is always a treatment gap. The median gap for schizophrenia is 32.2%. For depression the gap is 56.3%; however, the treatment gap for alcohol use disorders is the largest of all.[8] The World Health Organisation estimated that the size of the alcohol treatment gap is between 78.1% and 92% - that's at least three quarters of those with a problem not entering help.[9 10]

This isn't just a statistic. It's a clear message: our current systems are not working for the entrenched dependent drinkers who need help most.

Why bother? The human reality: vulnerable, excluded, ignored

Perhaps more importantly, this is a group of people which contains some of the most at-risk, marginalised and vulnerable members of our communities. While these characteristics shouldn't define them, this group will include those with criminal justice histories[11], personality disorders[12] and / or mental illness.[13] They may appear as frequent attenders in hospital, as perpetrators or victims of anti-social behaviour or crime, as repeated arrestees, or as people in repeated crisis contact with emergency services.

A powerful example of this are the cases of "Carol"[14] and "Leanne"[15].

Carol was 39 when she was murdered in her home by two girls aged just 13 and 14. Carol had lived with chronic alcohol dependency and mental health problems for years. She was well known to local services – in the three years before her death, she had over 1,000 recorded contacts with public agencies, including 472 reported incidents to the police. These included calls about anti-social behaviour, concerns for her welfare, and incidents in which she was both a victim and a perpetrator.

She was clearly vulnerable. She had periods of rough sleeping, was exploited by people who came into her flat, and was often found in an intoxicated state. Local alcohol services were involved with Carol for a time, but when she failed to meet treatment goals, support was withdrawn - a year before her death.

Her case illustrates a wider failure: when services are rigid, target-driven, and disengage when people don't 'comply', the most vulnerable can be left entirely alone – with devastating consequences.

Leanne was 36 when she died in hospital. Just three months earlier, she'd moved into a multi-occupancy hostel after experiencing domestic abuse from a previous partner. She had a history of alcohol use and long-term physical health problems.

Once in the hostel, things quickly deteriorated. Her drinking increased. She entered into a new abusive relationship with another resident, who was later evicted for violence against her. After his eviction, Leanne was assaulted on two separate occasions by other residents and admitted to hospital each time, only to be discharged back into the same unsafe environment.

Her condition continued to decline. She was readmitted soon after and died less than two weeks later from complications linked to her longstanding health issues. Several people were charged with assault in connection with the events leading up to her death.

Leanne's story exposes systemic gaps: lack of safeguarding, missed healthcare opportunities, inadequate housing responses, and poor coordination between services.

Carol and Leanne are the answer to the question 'Why bother?'. They were both deeply vulnerable and, as with many in this group of people, their crises drew in multiple services at significant cost. They are not isolated cases. Their stories reflect a wider pattern seen in every local area: a small but significant group of people who fall furthest through the gaps, whose needs remain unmet by traditional systems, and who are often judged for not engaging 'appropriately'.

An approach that only prioritises people who are already motivated will simply perpetuate the exclusion of those who are most socially marginalised. To understand the scale of this challenge, we need to look at the wider picture.

Why bother? The scale and cost of the group

In an average need local authority of 350,000 people, we can estimate there are around 12,600 higher-risk drinkers[16], and about 3,596 dependent drinkers.[17] Of those, more than 80% won't be engaged with any kind of support – around 10,332 higher risk and 2,684 dependent drinkers.

Within that group is a much smaller number – perhaps around 350-400 people – whose unmet need results in intense and repeated contact with services. These are the people repeatedly turning up at A&E, being arrested, evicted, assaulted, neglected. They are traumatised, vulnerable, and often written off. And the costs of their care and safety across emergency and health services is estimated to total a minimum of £22 million per year in just one average borough (as of 2025). This figure is conservative – the true cost is likely higher.[18]

Failing to engage this group of people doesn't save money - it simply shifts the cost onto crisis services, often at a greater human and financial price.

A different approach is possible

Writing people off because they're 'not motivated' perpetuates a cycle of exclusion and harm.

What's needed is not moral judgement or false neutrality - it's practical, persistent engagement that meets people where they are, not where services expect them to be.

Blue Light principles are about just that: proactive, assertive support for people whose needs are high, but whose motivation may appear low. It doesn't mean excusing behaviour or lowering standards.

It means not giving up - because when services stay engaged, change does happen.

The Blue Light Approach has repeatedly shown that people do stabilise; risks do reduce; cost to services drops and people reconnect with support, with families, and with life.

Case study:

Case Study: Mr D and the impact of doing things differently

Mr D was a 54-year-old man supported by an outreach service operating according to Blue Light principles.

He came to attention following repeated incidents in which he drove naked on his mobility scooter to the off-licence – behaviour that triggered multiple police call-outs and wasted officer time. This conduct was a direct consequence of chronic alcohol use and significant underlying health issues.

Mr D suffered from serious respiratory problems requiring oxygen therapy, and there were also concerns about his cognitive functioning. Risks had been raised about the potential for him to accidentally ignite the oxygen tanks in his flat. He was also engaging in regular shoplifting.

Despite the complexity of his presentation, he had been assessed as having the capacity to manage his own affairs. By the time of his referral to the outreach team, he had developed chronic diarrhoea, resulting in him soiling all of his clothes – which partly explained why he was travelling naked to the shops.

At that point, the total cost of responding to Mr D's needs – including health and fire service involvement – was estimated at **£138,000 per year**. This figure did not include the additional costs related to his eight arrests for shoplifting.

However, following a year of intensive support from the outreach team, these costs were reduced dramatically to **£15,000 per year**. The outreach team worked intensively and persistently with Mr D, coordinating health, social care, and community safety responses around him. Their approach focused on practical risk reduction, building trust, and addressing his basic needs, from health management to personal care and daily structure. The techniques used with Mr D reflect the Blue Light principles explored throughout this manual: assertive outreach, multi-agency collaboration, and patient, person-centred engagement.

What do we mean by 'Blue Light'?

The term *Blue Light* was originally adopted to describe the group of individuals whose needs most often bring them into contact with the so-called *blue light* services – police, ambulance, and emergency departments – but whose underlying problems are rarely addressed through those contacts alone.

Over time, the phrase has come to represent something broader and more positive: a way of working across systems to reduce crisis demand, improve wellbeing, and support lasting change. The Blue Light Approach focuses not on blaming individuals or referring to people as 'blue light cases', but on improving how services and systems respond – strengthening collaboration, persistence, and compassion in place of short-term, reactive interventions.

At its heart, the Blue Light Approach is grounded in belief – belief that change is always possible, that no one is beyond help, and that with the right persistence and partnership, even long-entrenched patterns can shift. There are now even 'Blue Light Workers' embedded in health teams across the country, leading by example and changing the ways our vital public services respond to needs of local residents.

In short, the *Blue Light Approach* is about transforming systems, not labelling people.

The core principles of the Blue Light Approach

The Blue Light Approach is built on ten key principles:

1 Take every opportunity

Every contact is a chance to engage, reduce risk, and build trust – even if change isn't immediate.

2 Not everyone will change

This isn't a magic fix. Some people will die from drinking. Some will cause immense harm to others. This guide aims to reduce that harm – it can't eliminate it.

3 Change is not the only goal

Of course we want to support recovery. But in some cases, the focus must shift to managing risk and containing harm.

4 It's a whole-system responsibility

No single agency can manage these individuals alone. A coordinated, multi-agency response is essential.

5 Alcohol is only part of the story

We must address housing, trauma, mental health, relationships, and poverty – not just the drinking.

6 Be trauma-informed

Instead of asking "What's wrong with this person?", we ask "What happened to them?" and "What do they need?"

7 Practice professional curiosity

Look beyond the surface. Behaviour is communication. Keep asking: what else might be going on?

8 Learn lessons when things go wrong

When outcomes are poor, systems must have the courage to reflect and improve – not blame or deflect.

9 Record unmet need

Services must report gaps in care – especially consistent or serious ones – to commissioners and planners.

10 Focus on prevention as well as response

The Blue Light Approach is vital right now, but the long-term goal must be to reduce the number of people reaching crisis in the first place. That means tackling upstream causes – deprivation, trauma, isolation, and stigma – so fewer people ever need a Blue Light intervention.

Using language that supports dignity and change

Throughout this practice guidance, we've aimed to use language that is clear, respectful, and free from blame or stigma. The words we choose matter – not just for accuracy, but because language shapes attitudes, policies, and outcomes.

We recognise that language varies across sectors and organisations – for instance, some services use *"client"*, others *"patient"* or *"service user"*. All have their place. In this manual, we use *"individual"* or *"person"* wherever possible, to keep language human, inclusive, and consistent across settings.

In the first edition of our guidance for practitioners, we used the phrase *"change resistant drinkers"* prominently. As understanding has advanced, we have deliberately moved away from that language. The responsibility for engagement does not sit solely with individuals – it lies with us as practitioners, services, and systems. If someone isn't engaging, we must ask how we adapt what we offer.

Below is a table of terms we have chosen to use (and avoid) in this edition, along with our rationale. It's not a rulebook, but an invitation to reflect on how language in your own organisation could align with dignity and possibility.

Preferred term(s)	Older or less helpful terms	Why we use this wording
"Alcohol use" or simply **"drinking alcohol"**	"Misuse", "abuse"	Older terms carry moral judgement and imply a "correct" way to consume alcohol. Use is more neutral and factual.
"People with chronic alcohol dependency" *(Also: "entrenched alcohol dependency", "dependent drinkers", "highest impact drinkers")*	"Addict", "alcoholic"	These labels reduce people to their difficulties and carry a history of shame and exclusion. More descriptive terms preserve the person behind the problem. However, we know that many people may refer to themselves as an 'alcoholic' or 'addict' and we respect every individual's right to define their identity and relationship with alcohol.
"People that services find difficult to engage"	"Change resistant", "treatment resistant", "hard to reach"	We no longer use these terms. Engagement is a shared responsibility. If someone isn't engaging, services must reflect on how to adapt.
"Person / individual who drinks alcohol"	"Drinker" "Problem drinker"	We avoid defining people only by their relationship with alcohol. Many supported through Blue Light work face multiple, intersecting challenges.
"Person who is not currently drinking alcohol", "abstinent", or **"in recovery"**	"Clean", "sober" (in moral sense)	"Clean" implies moral worthiness and reinforces stigma. Neutral terms like abstinent or in recovery allow space and respect.
"Harm reduction"	"Minimising harm" / "reducing use" as vague catch-all	*Harm reduction* is an established, evidence-based approach recognising safety, stability and partial change as valuable outcomes.
"Recovery" / "living in recovery"	"Recovered", "former alcoholic"	Recovery is rarely a fixed endpoint. Using the process-oriented term acknowledges ongoing journeys, setbacks, and growth.
"Group of people" **"Blue Light client group"**	"Client group" (undefined)	Specifies the population this manual supports: people with severe alcohol dependency whose patterns of crisis contact cross service boundaries. We're aware that people can see this phrase as service-centric not human-centric but we know that many services do still use it and so we will sometimes use it, with caution, in this guidance document.
"Co-occurring conditions"	"Dual diagnosis"	Aligns with current national guidance (PHE/NHSE, NICE) and avoids implying hierarchy or precedence between mental health vs substance use.

A note on evolving language

Language changes, and that change should be welcomed, not feared. What feels respectful and accurate today may feel outdated tomorrow. Our aim isn't to police language but to model choices that support respect, clarity, and the possibility of change. Our hope is that this manual contributes to an ongoing conversation about how we describe the people we support - and how language can be part of creating safety, dignity, and hope.

We also recognise that some people choose to self-identify as "alcoholic", particularly within peer-support and 12-step recovery communities. When used in this personal and empowering context, the term can have positive meaning. Our guidance focuses on professional and service settings, where the aim is to use language that avoids stigma and supports inclusion.

> **"We no longer talk about 'change resistant drinkers'. Language evolves - and so must practice."**

Who is this manual for?

This guidance is for frontline workers and their managers working in areas including: Health (physical and mental), Police, Anti-Social Behaviour / Community Safety, Probation, Adult Social Care, Domestic Abuse services, Housing and Homelessness services.

It will benefit anyone who is in a public-facing role and is likely to meet with people with entrenched alcohol dependency that services are struggling to engage in a professional capacity.

In addition, alcohol treatment staff and their managers need to consider this guidance as they develop their local responses. Alcohol Change UK provides specific guidance for those who plan and commission services.

The range of guidance produced by Alcohol Change UK as part of the Blue Light Approach has continued to expand as our research and applied best practice has developed. You'll find many publications and resources on our website including:

- Assertive Outreach: A handbook
- How to use legal powers to safeguard highly vulnerable dependent drinkers
- Identifying and addressing cognitive impairment in dependent drinkers
- Improving housing for people with complex needs

Find all these and further resources at:
alcoholchange.org.uk/publications

How to use this guidance

This guidance is designed to be flexible, practical, and grounded in the real-world. You don't need to read it cover to cover – you can dip in, find what's useful, and apply it in your own setting.

Different people will use it differently:

- Frontline workers might head straight for practical techniques
- Managers and commissioners might focus on embedding new ways of working
- Safeguarding leads, social workers or team leads might use it to reflect on challenges or support supervision

Whatever your role, the manual is here to support you.

Part 1: Understanding the challenge

This section sets the scene – who the individuals are, what makes change difficult, and why a different approach is needed. If you want to build insight, shift mindsets, or reflect on the **'why'**, this is the place to begin.

Part 2: What you can do

This is the practical core of the guidance – the **'how'** of the Blue Light Approach. It brings together a wide range of tools, strategies, and ideas you can use to build trust, reduce harm, and support change, even in the most complex situations. It's divided into three sections:

Section 1: Universal approaches and early conversations

Everyday tools for raising the issue of alcohol, building trust, and knowing when to refer. They focus on starting safe, respectful conversations with people drinking at risky or dependent levels and knowing how to respond when alcohol comes up in any setting.

Section 2: Foundational strategies for engagement

The key building blocks of the Blue Light Approach – assertive outreach, multi-agency work, harm reduction and more. These strategies help create the conditions in which change becomes possible.

Section 3: Practical techniques for frontline use

The hands-on tools – small, flexible actions that can make a big difference. Whether it's setting small goals, navigating legal frameworks, or using nutrition and health information to engage someone, these techniques are designed to work in the real world, even under pressure.

You can move between these sections depending on the situation you're facing. You don't need to use every technique, and you don't have to read them in order. Use what fits your role, your team, and the individual you're working with.

Part 3: Sustaining change across systems

This section focuses on what needs to be in place to support consistent, coordinated work, from supervision and leadership to trauma-informed systems and cross-agency collaboration.

Look out for case studies throughout

Case studies appear across the manual to bring the approach to life. They show how techniques have been applied in real settings, the challenges faced, and the outcomes achieved, grounding the ideas in actual real-world impact.

Use this guidance in a way that fits your work and your setting. You can start with a story, a principle, a challenge or a technique – whatever helps you stay connected to what matters: people, safety, and change.

Part 1
Understanding the challenge

Who is the Blue Light Approach for?

Understanding who the Blue Light Approach is for:

- helps local partnerships assess the size and costs of the group; and
- determines the people who are the focus for the interventions described in this manual.

Our suggested definition embraces three inter-connected aspects and typically includes people who:

- have long-standing alcohol dependence;
- are not engaging with or benefiting from alcohol treatment;
- are placing high or complex demand on public services (either directly or via the impact on others e.g. their family).

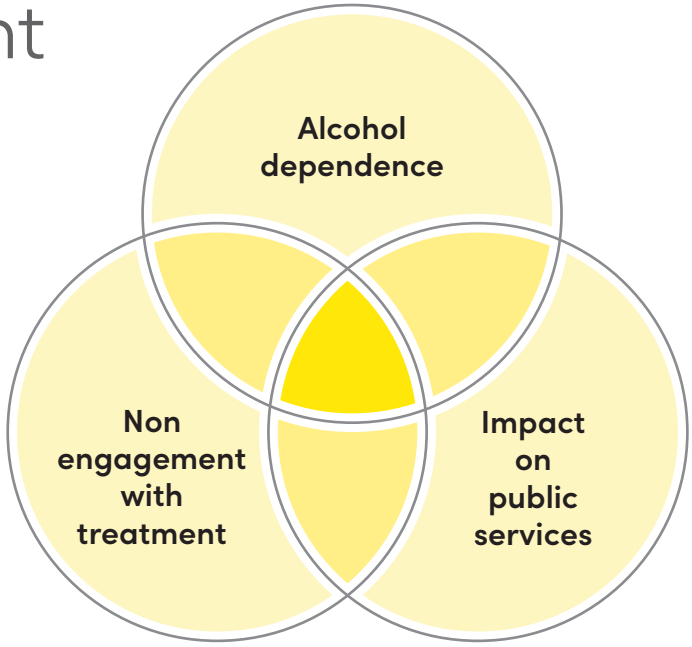


Diagram 1: The *Blue Light* group of people

The Blue Light checklist: does this person meet the definition?

Use this quick reference to identify whether a person may fall into the group of people identified by the Blue Light approach – i.e. dependent drinkers that services find difficult to engage and who place a significant impact on public services.

A Alcohol dependence

Does the person meet one or more of the following:	
	Longstanding alcohol problem (10+ years of harmful or dependent drinking)
	AUDIT score of 20+
	SADQ score in dependent range (16–60)
	Clinical markers of dependence (e.g. high LFTs, elevated ethanol levels)
	Clear pattern of withdrawal symptoms or morning drinking

B Pattern of non-engagement with treatment

Have they:	
	Received alcohol Identification and Brief Advice (IBA)?
	Been referred to treatment services on two or more occasions?
	Failed to attend, dropped out, or stayed engaged but not progressed?
	Been labelled 'non-compliant', 'unmotivated' or 'choosing their lifestyle'?

C Impact on public services

Is there evidence of:	
	Frequent A&E attendances or hospital admissions
	High contact with ambulance, police or fire services
	Repeated arrests, anti-social behaviour (ASB) reports or domestic abuse involvement
	Ongoing involvement with housing, homelessness, or safeguarding services
	Pressure placed on services through their impact on family members

D Significant single risk

Even without frequent service use, the person may meet the criteria if they pose a serious, exceptional risk, such as:	
	Recently released high-risk offender with alcohol-linked behaviour
	Significant safeguarding concern (e.g. risk to children or vulnerable adults)
	Known history of violence, arson, or suicide attempts exacerbated by alcohol

If the person ticks at least one box from section A, and at least one box from section B; and at least one box from section C or Section D - they likely fall within the target group for the Blue Light Approach.

This means they are appropriate for assertive, persistent, person-centred intervention – not discharge or disengagement.

Individuals would be expected to meet all three criteria, but the actual detail of the definition will vary between areas, particularly in terms of the level of impact in section C. In some areas it may be decided that the target is people with three alcohol-related arrests in a month, in others it would be five arrests in a year.

Detailed information to help local area to agree service usage markers is available in Appendix 4.

Challenging the notion of 'denial'

One of the most persistent and unhelpful ideas in alcohol treatment is that some people are 'in denial' - that they don't understand the need to change.

This idea needs challenging.

Motivational interviewing pioneers Miller and Rollnick have shown that what looks like denial is often ambivalence.[19]

Behind the surface may be someone who:

- Is unsure whether they can change
- Believes they are destined to drink, based on family history
- Is afraid of what change might involve
- Has already tried and failed, and now feels hopeless

In fact, studies show that:

- Around 40% of higher-risk or dependent drinkers who appear 'unmotivated' make an attempt to change each year.[20]
- In one study in Scotland, up to 70% of street drinkers reported being unhappy with their current drinking levels and wanting to make positive changes.[21]

People are not binary, that is *either* 'in denial' *or* 'ready to change'. Like everyone else, they hold conflicting thoughts, fears, hopes and beliefs. The task is to reach that more nuanced person behind the façade of denial and offer them something different.

What would a Serious Case Review team think?

A guiding question for this manual is:

> **'What would a Serious Case Review team think if the worst happened?'**

Imagine a person dies in circumstances such as self-neglect, suicide, homicide, or where they have caused the death of another person - and their case is the subject of a formal review. What would reviewers be looking for in terms of best practice? What evidence would demonstrate that all reasonable steps had been taken to reduce risks and provide support?

This isn't about holding services to impossible standards. It's about taking reasonable action to reduce known risk. The 2005 Serious Further Offence Review into the murder of Naomi Bryant by Anthony Rice said:

"It is simply not possible to eliminate risk altogether... But the public is entitled to expect the authorities to do their job properly, i.e. to take all reasonable action to keep risk to a minimum."[22]

That's the standard this guide is based on. Not perfection - but professionalism, persistence, and joined-up thinking, i.e. reasonable action.

Identifying barriers to change

A core message of the Blue Light Approach is this:

> **If we don't understand what's preventing someone from changing, we'll never help them move forward.**

When we focus too quickly on *why someone drinks*, we risk missing the more pressing question:

Why haven't they stopped? Why won't they engage with services?

Unless we explore and address these barriers, people will trip over the same obstacles again and again. This echoes desistance theory in criminology, which argues that too much attention is paid to why people start offending - and not enough to what helps them stop.[23]

Physical barriers are real and serious

One of the least understood facts about dependent drinking is this: **alcohol damages the body and brain in ways that make change harder**. This isn't about excusing behaviour or eliciting sympathy - it's about acknowledging reality.

People in this group are often caught in a 'perfect storm' of physical and neurological problems that reduce their energy, disrupt their thinking, and undermine their ability to organise themselves, remember appointments, or take action.

Common physiological barriers include:

Cognitive and neurological considerations:

- Alcohol-related brain damage (present in 35–40% of dependent drinkers, post-mortem or on brain scans)[24 25]
- Brain injuries from seizures, fights, and falls (affecting up to 50%), adding to the pattern of brain injury. Both alcohol-related brain damage and brain injury will make it difficult for dependent drinkers to organise and motivate themselves.
- Foetal Alcohol Spectrum Disorder (FASD) or Foetal Alcohol Syndrome may also impact on adults in this group
- Impaired memory, planning and impulse control from early heavy drinking as a teenager or in early adulthood[26]
- Pancreatitis, liver disease and urinary tract infections can cause confusional states[27]
- Neurodivergence, often undiagnosed

Energy and motivation depleters:

- Liver disease, which reduces energy, motivation and mobility[28]
- Malnutrition and low appetite, worsening depression and fatigue[29]
- Alcohol impairs sleep quality which can increase cognitive damage and, in the short term, cause tiredness which acts as a demotivator.[30]
- Pain and confusion linked to pancreatitis, urinary tract infections or hepatic encephalopathy.

Psychological and emotional states:

- Alcohol-induced depression (as a result of alcohol's effects on the central nervous system)[31] and anxiety
- Shame, fear of failure, or fatalism ("I'll always be like this")
- Poor self-esteem from repeated relapses or stigmatising labels

Handing someone a leaflet and expecting them to show up two weeks later doesn't cut it.

If we're serious about bridging the treatment gap, we must recognise that change doesn't just take motivation – it takes overcoming real barriers.

Explaining this to people can be powerful, too. It helps them understand that they are not simply 'weak', 'unmotivated' or 'lacking in willpower' – they're facing conditions that make change genuinely difficult, and they're not alone in that.

Not all barriers are physical or clinical

Other common (and often hidden) barriers include:

- Low self-worth
- Shame, stigma or fear of being seen at services
- Fear of withdrawal, seizures, or being sectioned
- Disruptive peers who sabotage attempts to change
- Anxiety about services affecting benefits or triggering unwanted scrutiny
- Other things that may not even occur to us – like the man who resisted going to services because he was worried that he smelled, and that staff would dislike him as a result.[32]

Prejudice

Stigma and prejudice remain significant barriers to change for people who are alcohol dependent. Judgemental attitudes from professionals - whether subtle or overt - can undermine a person's self-worth and make them less likely to engage with support.

One man in his 50s, dependent on alcohol, recalled being told by a hospital nurse that he "didn't deserve to be in that bed." Sadly, this experience is not unique.

People engaged with an alcohol outreach service in Nottinghamshire shared:

"Doctors are judgemental. Even the consultant at the hospital made me feel *that big*."

"The ambulance driver treated me like something you wouldn't put your foot in. I was being talked to like a piece of s**t. When you first go into the hospital, the staff don't want to know you. You are a hindrance."

These experiences reflect deep-rooted stigma that can exist across services. While it is important to acknowledge that some professionals may have faced challenging or even abusive behaviour, responding with negativity only perpetuates harm.

To help someone move forward, we must build their belief in themselves - not erode it.

Checklist of potential barriers to change

This is a simple checklist to help you consider what might be making change harder for the person.

It's not a formal assessment tool, but a prompt to support you to think broadly, compassionately and with professional curiosity about what might be standing in the way.

Does the person have any of the following?
Check all that apply:

✓	Cognitive / Psychological Barriers
	Depression
	Anxiety disorders, panic attacks, agoraphobia
	Bipolar disorder, schizophrenia or other diagnosed mental illness
	Alcohol-related brain damage or brain injury
	Learning disability or neurodivergence (e.g. autism, ADHD)
	Foetal Alcohol Spectrum Disorder / Syndrome[33]
	Compulsive behaviours or co-dependency (e.g. drinking as part of a toxic relationship dynamic, or part of a broader behavioural addiction pattern.)

✓	Beliefs, Fears and Emotional Barriers
	Belief that change is pointless or impossible
	"It runs in the family" – belief in inherited addiction
	Shame, guilt, or fear of being judged
	Fear of failure – of change, of withdrawal symptoms, of seizures
	Low self-worth due to past relapses or stigma

✓	Physical / Health-Related Barriers
	Fatigue or low energy (e.g. liver disease, malnutrition)
	Mobility problems (e.g. liver disease can reduce mobility)
	Sleep disorders - poor sleep or sleep reversal (sleep reversal can be a symptom of liver disease i.e. the person sleeps during the day)
	Pain, confusion, or cognitive impairment (e.g. from pancreatitis or infections)
	Poor nutrition - appetite suppression from alcohol can lead to depression

✓	Social / Practical Barriers
	Homelessness or housing insecurity
	Isolation or lack of positive social contact
	Disruptive peers or family undermining attempts to change
	People who have abused them, or who they owe money to etc. in or near the services?
	Lack of transport or difficulty reaching services
	Literacy or numeracy issues reducing confidence
	Previous negative experiences with services
	Anxieties about how they will appear to others (e.g. do they smell or are they dirty?)
	Session times that don't work for their current routine
	Cultural stigma or shame – around alcohol use or help-seeking, especially in minoritised ethnic or religious communities.
	Language or communication barriers – lack of fluency, hearing impairment, or limited literacy can make engagement feel unsafe or futile.
	Gender-based safety concerns – especially for women who fear being seen at male-dominated services or have experienced male-perpetrated violence
	Fear of being labelled or criminalised – concern that seeking help will result in being criminalised, especially among people with past convictions or those with insecure immigration status

✓	Financial and Safety Concerns
	Fear of losing benefits if they access services
	Debts or threats from people near or within services
	Worries about cost of travel or access to support
	General money worries
	Active exploitation or coercion – someone is using an individual's home, benefits, or body in exchange for alcohol or "protection" (cuckooing).
	Fear of children being removed – a huge unspoken barrier for some parents who drink.
	Fear of revenge or reprisal – especially in shared accommodation or close-knit communities if they engage with services

This tool can help you build a clearer picture of what's getting in the way, and what needs to be tackled before motivation can stick.

Barriers to change – co-occurring conditions

Understanding co-occurring conditions is a core part of assessing risk and readiness for change.

Many in the Blue Light client group will live with mental illness, physical disability, or trauma-related disorders that directly shape their drinking and their ability to engage.

The combination of mental disorders and substance use is a challenge to professionals. This has in the past been named *dual diagnosis*; but is now more commonly referred to as *co-occurring conditions*. This combination is a real barrier to change and help will be required from mental health services. A common assumption among professionals is that if substance use ceases, then mental health problems do too. Often this is incorrect and serves to increase the stigma experienced by those with *co-occurring conditions* and creates barriers to treatment.

The "Carol" Safeguarding Adult Review, mentioned at the start of the practice guidance, is one of many serious case reviews to highlight the challenges posed by this group.[34] However, this is not an area without research and guidance. The following documents provide the framework within which that care should be provided:

- PHE / NHSE – *Better care for people with co-occurring mental health and alcohol and drug use conditions* - 2017[35]
- NICE – NICE Guideline 58 – *Co-existing severe mental illness and substance misuse* - 2016[36]
- Psychosis with coexisting substance misuse – *NICE Clinical Guideline 120* – 2011[37]
- Royal College of Psychiatrists – *CR243: Substance use disorders in people with severe mental illness* – 2021[38]

Staff in many services report finding it difficult to access help from mental health services for people who have alcohol problems.[39] Nonetheless, these documents make it clear that mental health services have the lead responsibility for, at least, some of this client group.

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

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

Good practice:

The West Sussex management of co-occurring conditions protocol

West Sussex has developed a protocol to guide practitioners on pathways for people experiencing co-occurring conditions. Developed collaboratively with the support of Alcohol Change UK, mental health services, primary care, talking therapies, and substance use services, the key principle is that **people should not be denied access to mental health services on account of their substance use (and vice versa)**. The protocol states that there is no value in debating which condition causes what, or in defining which came first, or which is the more important problem. The focus should be on the clinical presentation.

The protocol sets out that joint assessment is preferable where possible, and people with high degrees of complexity (e.g. mental health and substance use) should be assessed by clinical specialists. It also sets out who should have lead responsibility for clinical care and care co-ordination, in a simple quadrant format.

A series of 40 training sessions were rolled out to practitioners and front-line workers across the region to support them in understanding the new pathway and how to work within it.

Crucially, a steering group has been established to oversee the implementation of the pathway, and cases may be referred to the group for direction, should the protocol prove problematic or unworkable in certain situations.

Workers and their managers should press commissioners to ensure that there is a strategy for the management of this group and clear care pathways.

Foetal Alcohol Syndrome / Spectrum Disorder

Foetal alcohol damage may affect 6% of the population and its impacts are not limited to babies and children.[40] Logic suggests that those infants will grow into adults who may carry with them the learning difficulties or behaviour disorders associated with foetal alcohol damage. One expert has suggested, for example, that over 25% of the prison population may have such damage.[41] It is important that this is recognised locally and that agencies understand that they may need to adjust their expectations of what people can achieve because of learning difficulties or behaviour disorders.

Adults with Foetal Alcohol Syndrome / Foetal Alcohol Spectrum Disorder are a group of people who may have difficulty organising themselves, keeping appointments, maintaining boundaries and avoiding impulsive behaviour.[42] They are likely to do poorly in services and, therefore, appear "treatment resistant". This is blaming the person for a condition that they have no control over.

Efforts should be made to recognise the impact of this problem and service responses adjusted accordingly. The impacts can range from below average IQ to Attention Deficit and Hyperactivity Disorder[43] and even hearing problems.[44]

This framework is not the place for a detailed analysis of this problem. The US Substance Misuse and Mental Health Services Administration has published a useful guide on this issue, including a screening tool for adults, which can be found here.

For details on assessment and diagnosis of FAS/ FASD in the UK see the NICE Quality Standard on Foetal Alcohol Spectrum Disorder

Alcohol-related brain damage / injury

Cognitive impairment is very common in dependent drinkers.

People are more likely to drink problematically because of traumatic brain injuries (TBI) or other brain damage experienced before birth, in childhood or in early adult life.

As a drinking career progresses brain damage caused by alcohol and poor nutrition and vitamin deficiency accumulates.

Physical damage to the brain from falls, fights, fits and impulsive self-harm accumulates to similar effect.

This damage impairs memory but also impulse control, executive function and the ability to regulate cognition, emotion, and behaviour, therefore, making it harder to engage with recovery.

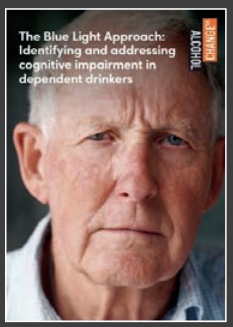
The drinking lifestyle may generate other forms of cognitive impairment e.g. the damage from strokes, poor sleeping patterns or the 'brain fog' associated with hepatitis C.

This accumulating damage generates a downward spiral. As the cognitive impairment increases, impulse control decreases, consequently drinking and the risk of further head injury may also increase. Those head injuries then further impair impulse control leading to the risk of more drinking.

Therefore, anyone working with dependent drinkers needs to be aware of the impact of cognitive impairment.

However, most practitioners will not meet dependent drinkers with a diagnosis of cognitive impairment; they will meet dependent drinkers who are confused, impulsive and possibly self-destructive and who they suspect may have a cognitive impairment. The problem is that the next steps can be very difficult.

Securing a diagnosis may be a challenge. Memory and brain injury services may require someone to be alcohol-free for three months before they can be assessed. The dependent drinkers themselves may be hard to engage into constructive interventions and may struggle to engage in traditional ways of assessing cognitive impairment. Their behaviour may be dismissed as a 'lifestyle choice' or attributed to intoxication rather than brain damage.



We have published comprehensive guidance on cognitive impairment as part of the Blue Light Approach, which is available on the Alcohol Change UK website here.

Considering strengths and motivations

While understanding barriers is essential, it's equally important to explore what strengths, motivations, and personal assets the person possesses.

Recognising someone's strengths:

- helps you understand their support needs
- builds rapport through *positive reinforcement*
- allows you to reference past achievements as reminders of their capability and resilience

For example, strengths or motivations might include:

- a supportive family member or friend
- a previously stable or successful career
- interests or hobbies they used to enjoy
- a past period of sobriety or engagement
- current good health, or a desire to regain it
- a loved one (child, partner, pet) they want to reconnect with
- a fear of deterioration, death, or long-term institutionalisation

We've not included a formal checklist of strengths in this manual.

Many people in this group already feel demoralised. We do not want to risk creating a situation where they're asked to tick off how little they feel they have. Instead, this is a reminder to practitioners: always look for what's *still there* - not just what's gone.

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

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

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

Changing the conversation: language that reduces stigma

Even well-meaning professionals can unintentionally reinforce stigma. These small shifts in language and mindset can make a big difference:

Instead of...	Try saying...
"They're just not engaging."	"I wonder what's making it hard for them to engage right now?"
"They don't want to change."	"Maybe they haven't felt supported enough to try something different yet."
"They're choosing this lifestyle."	"There will be reasons behind their choices that we can explore together."
"They've been offered everything."	"What might we offer differently this time?"
"They're too chaotic."	"They're going through a lot - let's meet them where they are."

Key reminders:

- Curiosity is more effective than judgement.
- Respect is the foundation of trust.
- People change when they feel heard, not when they feel shamed.

Small moments of dignity can lead to big turning points

The Blue Light Approach in Action:

Sandwell: Identifying barriers and changing the story

Background

In March 2021, the Blue Light Project (BLP) received a referral from the SWBH NHS Alcohol Care Team regarding a 59-year-old man living alone in the West Midlands.

A father of three, he was drinking around 4 litres of 7.5% cider daily (approximately 30 units), though this was likely underreported. His physical health was deteriorating, with deranged liver function tests, low sodium, and elevated mean cell volume.

Over previous months, the man had become well known to police, ambulance services, and housing teams due to repeated anti-social behaviour (ASB) and emergency callouts. He was seen as "treatment resistant" and had been excluded from multiple services for aggressive behaviour. When allocated a BLP key worker, the person was awaiting court for alleged kidnapping and threats to kill two paramedics - charges he denied.

A turning point: Seeing what others missed

At the first meeting, the key worker noticed something crucial: the man couldn't hear her. She had to remove her face mask (in line with COVID safety measures) so he could lip-read. This moment transformed their relationship—and the case.

It became clear he was profoundly deaf but had no hearing aids. His shouting, mistaken for aggression, had led to conflict, bans from his pharmacy, and misunderstandings with neighbours and services. He had never disclosed his deafness due to embarrassment, leaving his disability unrecognised in every setting—including the courts.

The key worker supported him holistically:

- Arranged and attended a medical review with his GP
- Facilitated referrals to audiology and attended every appointment
- Helped him trial hearing aids (which were ultimately unsuitable due to discomfort and distortion)
- Advocated with an audiology consultant who recommended sign language and speech therapy—both of which he declined, still too ashamed to acknowledge his hearing loss
- Raised awareness of his hearing impairment across agencies, including Probation and healthcare

Restoring dignity and reducing risk

The worker personally supported the man to re-establish relationships with professionals who had previously excluded him. She accompanied him to the local pharmacy to explain the situation; the pharmacist, unaware of the deafness, apologised and welcomed him back. Similar breakthroughs occurred with Probation and other agencies.

The worker also liaised with Probation to ensure his hearing impairment was considered in his pre-sentence report. As a result, he received a suspended sentence with an Alcohol Treatment Requirement (ATR), and Probation explicitly requested continued BLP involvement. He attended all appointments - with his key worker present - and completed probation successfully.

Recovery and ongoing impact

With trust built and barriers removed, the man began addressing his alcohol use. Together, he and the key worker developed a slow, manageable reduction plan, aligned with his readiness and health. Over several months, he gradually reduced his intake, and eventually stopped drinking altogether.

Today, the man remains abstinent. He continues to live independently and regularly stops to greet his former key worker when he sees her in town. His probation officer was so impressed with the transformation and inter-agency collaboration that she personally called the BLP worker to express her thanks.

> **"You've changed everything. No one saw him before - just the shouting. You saw the person."**

Understanding diversity and complexity

The barriers discussed above are often intensified when someone's background, health, or way of experiencing the world differs from what services typically expect.

Some groups within those that the Blue Light Approach aims to reach may need distinct approaches, adapted communication, or changes to service design in order to enable them to engage effectively. Recognising and responding to this diversity is central to removing barriers, reducing harm, and building trust.

Some groups where adapted approaches can enable effective engagement include neurodivergent people, older people, and women.

Recognising and responding to neurodiversity

Neurodiversity refers to the natural variation in how people think, process information, and experience the world.

It includes conditions such as autism, ADHD, dyslexia, dyspraxia, and others. These are not deficits but different cognitive styles. However, neurodivergent individuals may face specific challenges in engaging with services that are not designed with these differences in mind.

In the Blue Light client group, neurodivergence is likely to be under-recognised and under-diagnosed. Many individuals may have gone through life unsupported, mislabelled as "non-compliant", "chaotic", or "difficult to engage", when in fact their needs have simply not been understood or met appropriately. For instance, research indicates that up to 43% of individuals with ADHD may develop an alcohol-use disorder over their lifetime, yet many remain undiagnosed.[45]

Neurodivergent people may:

- Struggle with change, ambiguity, or environments that are loud, chaotic, or poorly structured
- Have difficulty processing verbal information or understanding social cues
- Feel overwhelmed by group settings or long appointments
- Be highly sensitive to sensory input, such as lighting, noise, or touch
- Exhibit strong attention to detail or intense focus, especially on specific interests
- Appear withdrawn or rigid, or conversely impulsive and disinhibited - behaviours that may be misunderstood

These traits can affect how someone engages with support, processes information about alcohol harm, and makes decisions about change. When these needs are not recognised, services may inadvertently increase anxiety or reduce trust, making it harder for the person to engage.

Practical approaches include:

- Offering clear, consistent communication - using simple language and avoiding ambiguity
- Providing written information to supplement verbal discussions
- Allowing extra time for processing or decision-making
- Minimising sensory overload in appointment spaces
- Being flexible about how and where support is delivered (e.g. avoiding group work if it's unhelpful)
- Working with neurodiversity-informed staff or accessing external expertise where possible

Recognising and adapting to neurodiversity helps to reduce exclusion and better support people who might otherwise be written off as non-engaging. As with trauma-informed care, this is about removing barriers and creating the right conditions for people to feel understood and supported.

Working with older people

Older people with entrenched alcohol dependency are often under-recognised in services, under-referred, and under-treated.

This may be due to persistent myths that they are "too old to change" or that drinking is a personal choice rather than a serious health risk. In reality, older people often respond well to support, but standard service models may not meet their needs.

Alcohol problems in older adults may be long-standing or develop later in life in response to bereavement, loneliness, chronic pain, or retirement. These issues may be masked by frailty, falls, confusion, or other symptoms that are wrongly attributed to ageing. As a result, alcohol harm in this group is frequently missed.

Older people are often more physically vulnerable and may experience harm from lower levels of alcohol due to changes in metabolism, interactions with medications, and long-term health conditions. They are also more likely to experience isolation, poor nutrition, self-neglect, and cognitive impairment, including alcohol-related brain damage (ARBD).

Working with older people requires a flexible, persistent, and relationship-based approach. Shame, fear of judgement, and anxiety about being "a burden" can all be barriers to engagement. Services may also need to adapt their ways of working, for example, by visiting people in their homes or meeting them in settings where they feel safe and in control.

Key principles include:

- Proactive, assertive outreach - don't expect people to come to you
- Flexibility around communication, environment, and engagement style
- Close collaboration with adult social care, GPs, hospital teams and community health
- Support around housing, furniture, food, benefits, and safety at home
- Gentle but clear conversations around risk, consent and capacity
- A strong focus on restoring dignity, independence and hope

The Blue Light Approach in Action:

Westminster: Restoring dignity for an older man

Background

RW is a 76-year-old man with a long history of rough sleeping and alcohol dependency, regularly consuming over 40 units of spirits per day. He was referred to the Blue Light Project (BLP) following serious welfare concerns: police had recently escorted him home due to his inability to walk unaided.

When visited, RW was living in extreme neglect. His flat contained no furniture, no white goods such as a fridge or cooker, and no bed or chair - only empty whisky bottles scattered across the floor. He had repeatedly refused support and had a long record of services withdrawing due to aggressive behaviour or non-engagement. RW was physically frail and presented with pulmonary oedema and other unresolved health issues.

The Response: Assertive Outreach and relationship building

Despite RW's initial resistance, the BLP team persisted. A tailored, hands-on approach was adopted, focusing on building trust while tackling his most urgent needs:

- Successfully appealed previous rejections from charitable grant providers by showing that earlier funds had never reached RW.
- Used grant funds to purchase essential household items and personally supervised delivery and installation.
- Built flat-pack furniture, supported waste removal, and organised a professional deep clean of his home.
- Liaised with adult social care and secured a package of care—although RW needs continued support to access it.
- Replaced years of sleeping on the floor with a proper bed and chairs. RW now warms food in a microwave and independently makes cups of tea.

During ongoing work, BLP discovered RW had a cancer diagnosis he was unaware of. They worked closely with Enhanced Vulnerability (EV) Nurses to provide compassionate health navigation:

- Arranged for RW to attend his first oncology appointment, purchasing new clothes, helping him change into them, providing breakfast, and organising a calm, supported taxi journey.
- One worker stayed with RW throughout the appointment to maintain emotional safety while the other liaised with clinical staff, helping them understand RW's vulnerabilities and tailor their communication.
- RW is now receiving cancer treatment, anticoagulant medication, and nutritional support drinks.
- Healthcare is delivered flexibly - basic health checks are sometimes carried out in public spaces like park benches, where RW feels more at ease.
- RW has consented to the installation of a key safe and now initiates contact when support is needed. He is also receiving Pabrinex to address nutritional deficiencies.

Impact

Before the Blue Light Project:

- 76-year-old man lying on the floor of an unfurnished flat
- Unmet chronic health conditions
- No engagement with primary care
- Unable to walk independently
- High risk of premature death
- Completely isolated and unsupported

Since the Blue Light Project:

- Fully furnished, clean living environment
- Offered a care package and supported to access it
- All primary health needs now being met
- Actively participating in cancer treatment and nutrition
- Improved mobility, able to walk into the community
- Demonstrating independence and trust—makes drinks, accepts visits, and asks for help
- Still vulnerable, but fully engaged with support

RW's case exemplifies the essence of the Blue Light Approach: persistence, flexibility, and human dignity.

Meeting the needs of women

Women with alcohol dependency may face distinct challenges that require tailored, gender-informed approaches. These include both physiological differences and social factors that can affect how women experience alcohol use, access support, and recover.

- **Safety and gender-based violence:** Many women in the Blue Light group have experienced domestic abuse, sexual violence, or exploitation. These experiences can shape their drinking patterns and create barriers to accessing help. Services must take these risks seriously and offer trauma-informed, safeguarding-aware support.
- **Need for women-only spaces:** Some women may only feel safe and able to engage in support if they have access to women-only environments and female workers. This is particularly important for those who have experienced male violence or control.
- **Physical health and alcohol:** Women's bodies metabolise alcohol differently, often leading to more rapid health deterioration. Alcohol-related liver damage, fertility issues, early menopause, and breast cancer risk are all heightened for women. Menstrual health, contraception, and pregnancy (including the risk of Fetal Alcohol Spectrum Disorder) also need careful, informed discussion.
- **Malnutrition and bone health:** Women with alcohol dependency may be at greater risk of nutritional deficiencies, including anaemia and osteoporosis. This can be linked to both alcohol's effects and to lifestyle factors such as restricted diets or disrupted eating patterns.
- **Stigma and hidden harm:** Women may be less visible to services because of shame, fear of child removal, or social stigma. They may be underrepresented in alcohol services despite experiencing significant harm.

Meeting the needs of women means ensuring services are safe, responsive and flexible, and that they do not take a "one size fits all" approach. Gender-informed care helps remove barriers, increase engagement and improve outcomes.

The Blue Light Approach in Action:

Hywel Dda University Health Board, Wales:
Persistence, safety and a pathway to recovery

Linda, a 61-year-old woman, had a long and complex relationship with alcohol. Her drinking was often marked by heavy binge episodes, sometimes accompanied by other substances.

Over the years, she had become well known to police, ambulance services, and the hospital Alcohol Liaison Nurse (ALN) team due to frequent antisocial behaviour and emergency presentations.

Despite several past referrals to community drug and alcohol services - with periods of good engagement - Linda often returned to harmful drinking and repeated crises once those services withdrew.

In 2023, Linda was admitted to hospital again, this time with alcohol-related pancreatitis. Though receiving floating support to help her maintain her tenancy, this support was due to end, and she had declined referrals to community services and adult social care. With her consent, the hospital ALN referred her to the Blue Light Alcohol Liaison Nurse (BL ALN) - a practitioner working within a harm reduction and engagement-focused framework.

Their first meeting was challenging. Linda was intoxicated and guarded. But the BL ALN persisted, meeting her at least once a week, adapting to her needs and pace. Over time, small but meaningful changes began to emerge. Her use of illicit drugs stopped. Hospital attendances became less frequent. Incidents of antisocial behaviour declined. However, she continued to have high-risk episodes of binge drinking.

After 6 months of steady relationship-building - Linda consented to a referral to a local women-only residential rehab. She attended the interview and two months later she entered the programme. She continues to pursue her recovery journey. Linda's case illustrates the importance of patience, persistence, and the value of a flexible, trauma-informed, harm-reduction approach.

Working across race, ethnicity and culture

Racially minoritised people living with entrenched alcohol dependence often face barriers that are created by structural disadvantage, experiences of discrimination, cultural stigma, and past interactions with services that may not have felt safe or respectful. For some individuals, this can lead to mistrust, withdrawal, or reluctance to engage – responses that can be misinterpreted as "non-compliance" rather than indicators of unmet need or unmet cultural expectations.

Language, expectations of authority, gender dynamics, and community attitudes towards alcohol all shape how a person presents, and how safe they feel to disclose honestly. Some cultures attach intense shame to alcohol use; in others, alcohol is tightly intertwined with social roles, family obligations, or faith. In addition, for some racially minoritised individuals, previous experiences of discrimination in mental health or social care can understandably make engagement feel risky.

Practitioners should routinely consider that a person's cultural and racial identity may be relevant because it influences how people understand risk, harm, and help.

Practical approaches include:

- Asking, not assuming, what alcohol means within the person's culture, family or faith background
- Exploring experiences of discrimination, racism, or mistrust of services where appropriate and safe
- Offering choice of practitioner (e.g. gender, language) wherever possible
- Being sensitive to shame, confidentiality and fear of community judgement
- Understanding that reluctance to engage may be a protective response, not a lack of motivation
- Connecting with culturally specific community organisations, advocates or faith-based organisations
- Ensuring written information is accessible and culturally relevant

Cultural humility - rather than cultural 'expertise' - is key. Workers do not need to know everything, but they do need to remain curious, respectful, and open to learning from the person in front of them. Done well, this reduces misinterpretation, builds trust, and helps people feel understood rather than judged.

Part 2
What you can do

Section 1: Universal approaches and early conversations

Although this manual is mainly about people with entrenched alcohol dependency that services find difficult to engage, at the outset, workers in both non-alcohol specialist and specialist settings should consider these universal and early approaches.

Have you used Identification and Brief Advice (IBA)?

The first step is for non-alcohol specialist staff to:

- Screen all attendees with the AUDIT tool (Appendix 1), identifying those who are at risk of alcohol-related harm and saying something to them: i.e. "brief advice". The AUDIT tool should be used with all those engaging with frontline services at the earliest possible point to avoid missing people at risk.[46 47]

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

- People scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *"Your answers suggest that your drinking is within recommended guidelines – keep up the good work"*
- Feedback and brief advice should be offered to those scoring between 8 and 19 with the AUDIT tool covering:
- Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
- Clear, structured advice about risk and change
- Goal setting: *"What changes would you like to make and how are you going to do that?"*
- Statements to enhance motivation
- Literature for the person to take away
- The offer of further support, if desired.[48]

Leaflets are available to support this work. For example SIPS Brief Advice about Alcohol Risk (www.sips.iop.kcl.ac.uk).

Leaflets could usefully have stickers with local alcohol service details.

Research has proven the benefits of IBA:

- 1 in 8 recipients of IBA (people scoring 8-19 on AUDIT) reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps nine to ten years. This compares with 1 in 20 smokers who benefit from stop smoking advice.[49 50 51 52]
- On average, following intervention, individuals reduced their drinking by 15%. While this may not be enough to bring the individual's drinking down to lower-risk levels, it will reduce their alcohol-related hospital admissions by 20% and "absolute risk of lifetime alcohol-related death by some 20%" as well as have a significant impact on alcohol-related morbidity.[53]

People drinking at very high levels who are seemingly resistant to change are much less likely to benefit from this approach. Nonetheless, evidence exists that even people with entrenched alcohol dependency may benefit. At the least, it allows workers to:

- begin a conversation on the basis of a validated screening tool;
- make a few simple statements about the need to change and the potential benefits;
- remind them that the door is always open for change.

If no-one talks about the drinking, opportunities to change will be missed and the pressure on the person to change will be minimised. Indeed, it may be taken as an indication that nothing is wrong with the drinking.

If you do nothing else - build motivation / promote self-belief

Workers should ensure that all interventions have a positive tone and attempt to **build self-efficacy** - developing the person's belief that change is possible. This is a powerful and evidence-based intervention.[54]

The most important message

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

At times this will be tough – some people seem set on a course that will destroy their lives or the lives of others. However, people do change. Even people who seem to have abandoned all hope of a different life can turn themselves around.

If we do not demonstrate a belief in the possibility of change then we will simply reinforce a sense of hopelessness.[55]

The list below gives some examples of statements to build self-belief, but the possibilities are endless.

Sample statements to build self-efficacy	
•	Thank you for meeting with me.
•	I appreciate how hard it must have been for you to discuss this. You took a big step.
•	It must be difficult for you to accept a daily life so full of stress.
•	You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
•	That's a good suggestion.
•	I'm sure you can do this once you put your mind to it
•	I know how determined you can be – this will be really good for you
•	Thanks for telling me about that.
•	You're the kind of person who speaks up when something bothers you, and that's a real strength.
•	You have a lot of leadership qualities. It's clear that people listen to you.[56]

Referral to specialist services

People scoring 20+ on AUDIT should always be offered referral to local alcohol services: *"I can put you in touch with a service that can support you to make the changes that will really make a difference to you (and your family)."*[57]

The same offer can be made to people who score under 20 but who are having persistent problems making a change following advice.[58 59]

However, for dependent drinkers who appear resistant to change, it will not be enough to simply give information about services or provide an appointment time. A key message about this client group is that:

"Signposting is not enough!"

If we simply give someone with a long-term pattern of heavy drinking a leaflet about their local services or even an appointment time, and then expect them to turn up: we are going to meet with repeated disappointment. It is important to think about what will help that person engage with treatment.

The following suggestions can help:

- Tackle misconceptions. Someone may believe that changing drinking requires total abstinence. This is not the case. Most specialist services offer the option of controlled drinking. It is true that people with high levels of physical damage will need to stop completely in order to prevent potentially fatal problems. However, telling people that treatment may not require total abstinence may encourage some to visit a service. It is for the specialists to then make an assessment as to whether controlled drinking is possible.
- They may have concerns about other people attending the service (e.g. if they owe them money)
- Some people may be deterred because they believe that alcohol treatment always involves groupwork – this is not usually the case, but you should check with local services.
- Has the person had previous negative experiences of services which need to be addressed?
- If the service requires self-referral, it may be useful to smooth the pathway with the service by asking them to be very welcoming and encouraging if the client makes contact.
- If someone is of particular concern, services should be asked to offer a speedier appointment or perhaps even an appointment in the community. Services may also need to be more flexible and not immediately turn people away if they arrive late or mildly intoxicated. These requests may require input at managerial level.
- Ensure that treatment services speedily follow people up if they disengage and report this back to the referrer.
- Are there volunteers or mentors who could be used to accompany people to appointments?
- Think about how you talk about entering treatment. Is it possible to talk about dropping in to have a coffee and chat with someone rather than "making an appointment for an assessment"?
- Don't forget that generic services are able to access specialist drug and alcohol services for advice and support on how to work with people, even if the individual they are working with is not yet ready to engage with that specialist service

Another approach is to offer incentives for attendance. This is also called *contingency management* and is an evidence-based treatment intervention recommended by the National Institute for Health and Care Excellence (NICE) for drug users. It is based on principles of behaviour modification and aims to incentivise and then reinforce changes in behaviour with the aid of vouchers, privileges, prizes or modest financial incentives that are of value to the individual. It is seen as a way to "nudge" people to change their behaviour in a positive direction across a wide range of health and social policy domains.[60]

NICE has recommended that: "Drug services should introduce contingency management programmes…to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment."[61] This model has, however, not been widely used in the alcohol field.

Offering financial incentives may be controversial; however, it can be worth thinking about alternatives:

- Complementary therapies in services may incentivise engagement
- Probation staff could reduce reporting requirements if a person attends treatment
- JobCentre Plus staff could reduce their requirements if a person attends treatment
- Agencies could offer food vouchers and/or assist with access to food banks
- Funds could be sought from local charities which will enable small amounts to be given for clothing
- Some services have offered clothes washing or storage facilities as incentives
- Individuals may value non-material incentives such as medals and certificates

People who do not engage with alcohol services

If non-alcohol specialist staff have screened a person, given brief advice and, when appropriate, referred to services, they have done a good job. If someone is continuing to drink but there is a low risk of harm to self or others associated with the drinking, staff may be justified in doing no more than IBA.

At intervals, repetition will be helpful:

- Reminding people of the risk they run with their drinking in a non-judgemental manner
- Offering leaflets or new insights about the impact of drinking and services available
- Encouraging a belief that change is possible
- Considering whether support can be offered to the person's family

However, if the continued drinking poses significant risk (i.e. the person is in the *Blue Light* client group as defined earlier), workers will need to consider further action. The rest of this manual focuses on how to make this possible.

The most important message

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

At times this will be tough – some people seem set on a course that will destroy their lives or the lives of others. However, people do change. Even people who seem to have abandoned all hope of a different life can turn themselves around.

If we do not demonstrate a belief in the possibility of change then we will simply reinforce a sense of hopelessness.

A word about assessment

In most services, assessment is the starting point. That makes sense, and in many cases, it's a contractual requirement.

But with this client group, insisting on full assessment before engagement can backfire. For people who appear resistant, chaotic, or hard to reach, the first priority isn't collecting data – it's building connection.

If an assessment becomes a barrier to engagement, then it's part of the problem, not the solution. And in practical terms, it's also a waste of time – services are filling in forms that go nowhere, because the individual has already disengaged.

For this group the starting point is engaging them, motivating them and making them, and those around them, safe.

The key outcome of a first appointment should be that a person is willing to attend a second.

That's the real measure of success at this stage.

This is why this manual does not offer a formal assessment framework. Existing agency assessments will be good enough – once you've built enough trust and engagement to use them meaningfully.

What should we focus on initially?

In the early stages of working with someone, there are two essential areas to explore, even informally:

- *What's stopping them from engaging or changing?*
- *What risks or vulnerabilities are present right now?*

To support this, we've included two practical tools:

- **'Checklist of potential barriers to change (on p.13)** – helps explore what's holding someone back from engaging
- **Risk and vulnerability checklist (on p.29)** – helps identify immediate risks to the client or others

These are not formal tools, and they are not meant to replace clinical assessment. They are designed to help frontline workers think clearly and respond proportionately.

This practice guidance challenges the belief that "nothing can be done for dependent drinkers who don't want to change". That belief isn't just incorrect – it's harmful.

Nonetheless, it's fair to ask: "so what can we do with a group that can appear so resistant to change?" The next sections explore the options.

Case study:

"Fight like a tiger"

Jennie Fortune, a Blue Light Assertive Outreach Worker in Westminster highlighted that to secure help for this group, it is sometimes necessary to "fight like a tiger".

That's especially true in the early stages. It may take weeks of effort, persistence, and coordination to get even a basic assessment done. Some people will only tolerate 10 minutes at a time. You might need to gather bits of information across multiple sessions, or from multiple agencies. That's the nature of this work.

But it's worth it – because once someone feels you won't give up on them, that's when things begin to shift.

Assessing risks

If we can do nothing else for entrenched dependent drinkers, we must ensure that their risks and vulnerabilities are properly understood.

That means a thorough and appropriate risk assessment - one that goes beyond surface behaviours and captures the dynamic, often hidden risks linked to chronic alcohol use.

Why risk assessment with drinkers is different - and difficult

Standard risk assessments often fall short. They tend to focus on general risks like self-harm or violence, and may miss alcohol-specific issues such as:

- House fires due to smoking or cooking while intoxicated
- Recurrent flooding from leaving taps running
- Bed bugs, infestations, or poor hygiene
- Home invasion (previously called 'cuckooing') or exploitation
- Repeated 999 calls or nuisance complaints
- Risk to others via vulnerable adults or children in the home

Risk is also highly dynamic.
With this client group, risk can change:

- From hour to hour – depending on intoxication level
- From place to place – e.g. home vs street
- Based on who they're with – certain peers raise risk
- Based on income cycle – risk often spikes around benefit payments
- As health declines – someone once posing a risk may now be extremely vulnerable

Example:
The woman drinking on the street with four intoxicated men may appear to be at risk - but she may feel safer in public view than alone at home with them.

A smarter, more practical approach

Risk assessment for this group needs to be:

- Person-centred – What's going on for this person in this context?
- Context-aware – Who are they with, where are they, what's changed recently?
- Time-sensitive – Is this a low-risk morning or a high-risk payday evening?
- Ongoing – Not one-and-done, but revisited as circumstances change

Smoke alarms... and the small risks that spiral

Nearly 50% of fire deaths in the UK are alcohol-related.[62]

This statistic alone justifies one very practical question being part of any alcohol-related risk assessment:

"Do you have a working smoke alarm?"

This one question can save lives, yet it's often overlooked in standard practice.

Conversely, seemingly small risks can have serious consequences: a person flooding the neighbour's flat because they fell asleep in the bath might not be in mortal danger, but they may still face eviction and become homeless.

The case for home visits

Risk is best assessed where people live, not just where services are delivered.

- Home visits can identify risks like fire hazards, falls, infestations, or noise nuisance
- If your agency can't visit, another agency in contact with them may be able to
- Be realistic: expect that asking a confused or intoxicated person to come to your office may itself pose a risk - both to them and others

The checklist below will assist in undertaking the risk assessment. This is designed to support, not replace, existing tools. It prompts workers to think holistically and practically about real-world risks that may otherwise be missed.

The issues raised in this checklist, and how to address them, are discussed in more detail in the section Practice 4. There is a list of harm reduction techniques on page 38.

Risk and vulnerability checklist

Health	✓
Do they require vitamin therapy?	
Are there dangerous drug combinations?	
Are they forgetting to take medications or repeating doses when intoxicated?	
Are they stockpiling medications?	
Is alcohol itself or consequent liver damage changing the effectiveness of any medication?	
Do less-mobile individuals dip in and out of withdrawals and thereby increase cognitive impairment (which can result from repeated detoxification)?	
Have they had a recent physical and dental health check?	
Have they attempted to take their own life?	
Do they have a history of self-harm?	
Is there a smell of urine, faeces or even rotten flesh which may indicate health problems?	
Is their diet adequate?	
Have you checked the content of their fridge/cupboards?	
Are they smoking?	
Is there adequate heating in the home?	
Is there a risk of hypothermia?	
Is there a risk of sunburn/dehydration from street drinking?	

Practical risks	✓
Are they drinking and driving (including bicycles and mobility scooters)?	
Are they using any other machinery?	
Are they drinking in isolation? Will anyone know if they come to harm?	
Are they drinking in risky locations?	
Do they have a smoke alarm fitted?	
Are there other indicators of a fire risk?	
Are they cooking in dangerous ways e.g. deep frying when intoxicated?	
Do they lack the coordination, balance or vision to cook safely?	
Do their heating methods suggest a fire risk e.g. are they using portable picnic barbecues as heaters? Are they opening their gas oven door to heat the house?	
Are there trip hazards in the house e.g. have urine or alcohol spills rotted the carpet?	
Do they allow baths to overflow or fall asleep in the bath?	
Does the property have bed bugs?	
Are there any other environmental hazards such as an unstable television or simply the risks of general clutter or hoarding?	
Is there noise nuisance to neighbours?	
Are there cigarette burns on clothes or carpet indicating a fire risk?	
Is there glass, or bottles, littered in the home?	

Risk and vulnerability checklist

Practical risks (cont.)	✓
Are there bodily fluids in the house?	
Is the way they are buying alcohol putting them at risk e.g. are they asking others to buy alcohol for them, placing themselves at risk of theft or further exploitation?	
Are they causing a nuisance on public transport?	
Do they use gas in their house? Electric cookers or microwaves may be safer.	
Is their disposal of refuse causing neighbour nuisance or putting their tenancy under threat?	

Time	✓
Are there particular times / dates which increase risk e.g. birthdays or anniversaries, benefit payments days etc.?	

Abuse and exploitation	✓
Is alcohol (and drugs) safely stored if young people have access to the property e.g. grandchildren?	
Do they have safe storage facilities for drugs or cash?	
Are they at risk of exploitation e.g. for their benefits?	
Are they at risk of sexual exploitation?	
Is their property used by others for drug dealing etc?	

Abuse and exploitation (cont.)	✓
Does someone else hold keys to the property, so that they can access their home if they lose keys when drunk?	
Are they responsible for children or grandchildren?	
Do they have any animals under their care?	
Are they reliant on other people for their own care? Do these people use substances?	
Are letter boxes secure?	
Are they being targeted by illegal money lenders?	
Are they putting themselves at risk of becoming victims of crime and mugging?	
Are they vulnerable to cuckooing or home invasion?	

Note:

Services may also find it useful to build and share a history of risk incidents across agencies. This will help identify patterns and risk factors for that individual.

Section 2: Foundational strategies for engagement

Bridging the gap between identification and treatment

The Blue Light Approach revisits the traditional method of alcohol interventions. The 2004 Alcohol Harm Reduction Strategy[63] summarised the pathway as:

Identification through screening > Referral to treatment

This is a classic healthcare pathway: the problem is identified and the person is referred to specialist help. The challenge is that most dependent drinkers sit in the gap between identification and treatment: they have been identified, but do not engage in treatment.

A simple 'identify-treat' care pathway cannot bridge this gap. It will also fail to help the people who are of concern to the police, housing or community safety or who have a disproportionate impact on health care.

A system which expects the severely dependent drinker to be identified and immediately engage in treatment is comparable to a lifeboat spotting a drowning man and asking him to swim over for help, or to asking a woman with a broken leg to walk to hospital.

A more effective alcohol care pathway covers both identification and treatment but also recognises the gap between those two points and might look something like this:

This section looks at eight broad approaches to working with people with entrenched alcohol dependency that services find difficult to engage. We call them the foundational strategies for engagement.

1. **Assertive outreach**
2. **Multi-agency management**
3. **Motivational interventions**
4. **Peer support**
5. **Harm reduction**
6. **Trauma informed care**
7. **Professional curiosity**
8. **Maintaining boundaries**

These are broad descriptions of the way the worker will approach this challenge. Section 3 looks at specific practical techniques that individual workers can use.

The Blue Light Approach in Action:

Western Bay, South Wales: Reaching people others missed

In Western Bay, the Blue Light Approach has reshaped how services work with people who were once considered 'unreachable'. Over the past four years, a partnership-led model has evolved that proactively identifies high-impact drinkers and takes support directly to them - reducing 999 calls, re-engaging people previously unknown to services, and proving that change is possible.

The Frequent Attendee Forum: From concern to coordination

A key catalyst was the establishment of the Frequent Attendee Forum, led by Swansea Bay University Health Board's Emergency Department. Partners include South Wales Police, Welsh Ambulance Service Trust (WAST), and local authority housing and support services.

The forum reviews individuals with frequent emergency service contact - often for non-urgent issues linked to alcohol or substance use. Many had been completely unknown to treatment services. Using the Blue Light framework, the group shifted from passive signposting to assertive, community-based intervention.

Partnership in practice

A turning point came through collaboration between the South Wales Police Mental Health Liaison Officer and the Blue Light team. They developed a joint approach combining harm reduction and mental health outreach, delivering coordinated support in the community.

This partnership has enabled:

- Shared risk management and joint care planning
- Faster information exchange
- Improved engagement with people at highest risk

What's worked

- Personalised, trauma-informed outreach
- Flexible responses: joint home visits, rapid referrals, community health input
- Assertive engagement: taking support to where people are

One person saw a 76% reduction in police contact and a 64% drop in ambulance callouts within a year.

A final reflection

The Blue Light Approach has challenged the belief that some people 'don't want help' and replaced it with evidence that, with the right approach, people *do* engage and lives *do* change. It's shown that the job isn't to wait for people to come to services - it's to take services to them.

An assertive outreach approach

As the Blue Light Approach has been rolled out across the country, the evidence suggests that assertive outreach is the best approach to this high impact client group.

This may be a specific assertive outreach service, or it may be more generic staff incorporating elements of the outreach model. Either way, the key message is:

> ***Build as much of an outreach approach into your intervention as possible.***

The effectiveness of this approach has long been evidenced in the mental health field.[64] Miller and Rollnick's *Motivational Interviewing* quotes evidence supporting this approach with drinkers as far back as 1991.[65] Above all, the 2025 publication of the *UK clinical guidelines for alcohol treatment* supports this.[66]

More recent research evidence from services around the country shows that outreach to this group can both help these individuals and reduce the impact and cost from some of the most risky and costly individuals in the community. Most compellingly, evidence from the ACTAD project in South London has shown that £1 spent on assertive outreach to dependent drinkers can save £3.42 in individual costs.[67 68]

The characteristics of the assertive outreach approach

Most readers will have a sense of the nature of assertive outreach. However, if other workers are to try and emulate the assertive outreach approach, it will be necessary to remind people of its main characteristics. Assertive outreach is:

- Built on **meeting people where they are**: at home, in the community or wherever best suits the individual.
- Focused on **building a relationship**: it prioritises engagement before treatment.
- **Flexible and person focused**: looking at what the person wants to discuss rather than focusing solely on alcohol.
- **Holistic:** looking at the whole person, not just the drinking. Focusing only on alcohol, rather than the whole person and all their needs and interests is likely to fail. As one worker said:

> **"If you want to work with a dependent drinker, don't start with the drinking."**

- **Coordinated** – draw on other agencies and the assistance they can offer.
- **Consistent and persistent** - people will often push back at help in the first instance, however, agencies must be prepared to keep trying.

Above all, the outreach approach will **require time**: it may have taken 20-30 years of drinking to reach this point in someone's life. Organisational and worker patience is required. Time limited interventions are unlikely to work for this client group. One outreach worker said: *"clients do not switch on like a traditional light bulb, they come on slowly like an energy saving bulb"*.[69] Time and patience are unlikely to be extended to everyone with an alcohol problem; however, it is in the community's interest to pursue this approach with the highest impact drinkers. If current attempts to support an individual are costing £130,000 across different public services, taking time to find a better approach is easily justified if it reduces costs in the long term - not to mention the ultimate impact of finally securing lasting change for the person at the centre.

Outreach without an outreach team

Since 2015, there has been an increase in the number of outreach services for this client group. However, most areas of England and Wales still lack specialist outreach for people with alcohol problems.

In these areas it may be worth considering whether:

- an individual assertive outreach care package can be purchased through local authority funds in England under the Care Act 2014. Many of these individuals will meet the "critical" criteria for support under the Act. The broadly equivalent Social Services and Well-being (Wales) Act 2014 may also provide a route to accessing outreach support;
- another service in the community could undertake outreach;
- appropriately trained and supported volunteers or peer mentors can take on elements of this role;
- greater use of texts and phone calls can improve the level of support.

Another alternative is to manage people via a multi-agency group. A focused multi-agency group can create a "team around the person" which "mimics" the outreach approach. This is explored in the next section.

More comprehensive guidance on alcohol assertive outreach has been developed by Alcohol Change UK and can be found online here.

The Blue Light Approach in Action:

Sandwell: Saving lives through persistence

Background

The Sandwell Blue Light Project was asked to support a 54-year-old woman living alone, referred by West Midlands Fire Service. She was known for frequently calling 999 for police, ambulance, and fire crews, often while severely intoxicated. On arrival, responders found she had no memory of calling and was often confused, reporting that she'd been attacked or set herself on fire, though there were no signs of injury or disturbance.

She was experiencing memory loss, confusion, and liver damage, though it was unclear whether this was due to alcohol-related brain injury or the effects of active drinking. Despite her high risk, she was not engaged with any formal support.

Building trust and coordinating support

A Blue Light worker visited her, and she agreed to work together. Initial steps included arranging a GP appointment for medical and medication review and bringing in floating support to help assess her housing and benefit needs. Together, they ensured she was on the correct benefits, successfully applied for Personal Independence Payment (PIP), and worked with StepChange to address significant debts — all of which were eventually cleared.

Throughout, the worker provided harm reduction advice, healthy eating guidance, and co-developed a reduction plan, though the individual struggled to adhere to it. Recognising the seriousness of her liver condition, the worker proactively reached out to a liver consultant who confirmed she was known to the clinic and arranged a specialist appointment. The Blue Light worker picked her up and attended the appointment with her, continuing to accompany her to all medical contacts.

Assertive Outreach saves a life

After six months, she began repeatedly cancelling appointments. Concerned, the worker decided to visit unannounced while in the area. On arrival, the worker found her jaundiced with yellow skin and eyes and clearly unwell. Although she declined to go to A&E voluntarily, the worker called an ambulance, and she was admitted to hospital, where she remained for nine weeks receiving urgent treatment.

Following discharge, the Blue Light worker continued supporting her briefly before referring her to the Cranstoun core treatment team for relapse prevention. By this time, she had been abstinent from alcohol for six months and recognised that any return to drinking would be life-threatening. At her own request, she was later discharged from services.

Reflections

This case demonstrates the importance of assertive outreach. Without the worker's persistence - particularly the unannounced home visit when concerns escalated - the person's severe health crisis might have gone unnoticed until it was too late. Assertive, multi-agency, relationship-based working not only stabilised her immediate health and social needs but created the conditions for long-term recovery and self-determined abstinence.

Multi-agency management

A key element in the roll out of the Blue Light project has been the development of multi-agency individual management groups. A multi-agency focus will facilitate:

- the shared identification of the highest risk drinkers in the community
- building a team around the person
- the development of a multi-agency plan
- a consistent and persistent approach
- support to workers who are struggling to work with an individual they find difficult to engage
- challenging negative agency practice
- the identification of unmet need: e.g. an expansion of outreach.

Evidence of positive impact from this approach is available, with perhaps the best example from the Blue Light multi-agency group in Sandwell, West Midlands. You can read more about their impact in a blog on the Alcohol Change UK website here.

The Sandwell Blue Light operational group was launched in November 2015 with the aim of managing the highest impact drinkers in the borough. In the first year, 16 individuals were identified as meeting the eligibility criteria. In the year prior to the group's establishment, it was estimated that the individuals had collectively cost police, ambulance, hospital and accident and emergency services £244,154. Data on nine of these individuals who were involved for a full year showed a reduction in costs to £92,730, representing a return on investment of 471%.

Overall, this evaluation suggests that:

- the multi-agency Blue Light process offers the potential for a significant return on investment, with modest up-front cost;
- the effectiveness and cost-effectiveness of the approach is measurable;
- client benefit is significant and demonstrable through evidence of engagement with substance misuse services.

As a result of this evidence, Blue Light in Sandwell won a Guardian Public Service Award and a Royal Society for Public Health Award in 2019.

However, it is not always necessary to establish a specific Blue Light multiagency group. This role can be incorporated into a wider multi-agency risk management group. Perhaps the best example of this approach in action is Surrey. For 20 years, each of the 11 district and borough councils in the county has had a Community Harm and Risk Management Meeting: multi-agency groups focused on anti-social behaviour, repeat offending and vulnerability. These groups now provide a focus for working on high impact and change-resistant drinkers.

Whichever route is pursued – specialist or generic group – it is vital that each area has a multi-agency structure or structures with a clear responsibility for the management of high impact change-resistant drinkers. If this work is to be included in the role of a wider, non-alcohol specialist group, it will be necessary to provide training to group members on working with change-resistant drinkers. Again, this was the route pursued in Surrey.

The Blue Light Approach in Action:

Gwent: Two Pathways, One Purpose

Gwent began applying the Blue Light Approach in 2016. Since then, a flexible support model has developed that recognises the different needs of two key groups: housed high-impact drinkers presenting in hospital, and street-homeless individuals with complex co-occurring issues.

1. Hospital-based engagement:

A dedicated Alcohol Care Team works with people identified as high-impact drinkers through the Health Board's multidisciplinary High Impact Service. These individuals are typically housed and alcohol-dependent, rather than using multiple substances. The team also maintains a watch-list of frequent attenders likely to require support in the near future.

2. Community-based assertive outreach:

A separate team works as part of GDAS (Gwent Drug and Alcohol Service), a multi-agency public and third sector consortium. This team focuses on people experiencing homelessness, often using a mix of substances including alcohol. This group tend to be more vulnerable, with additional risks around exploitation, safeguarding, and disengagement from traditional services.

While these are separate pathways, the two teams work collaboratively and ensure that people can access tailored alcohol treatment and wraparound support, whether they enter through a hospital ward or a street outreach contact.

This dual-route model shows how the Blue Light principles can flex to local structures, ensuring no one is left behind – even if their presentation, housing status, or substance use pattern differs.

Even better: Outreach supported by a multi-agency group

The evidence above suggests that both assertive outreach and multi-agency management are effective interventions. We do not have the same level of evidence for this, but practice to date suggests that an even better approach is:

Assertive outreach targeted and supported by a multi-agency group.

'This is the approach being used in a number of areas. In Surrey, the Catalyst High impact (CHI) team provides specialist alcohol-related assertive outreach support to the local generic risk management groups mentioned above. A similar model operates in Sandwell and Northumberland. This ensures that the outreach workers are targeting the right people and that every other agency is supporting these interventions. Above all, this approach is supported by the National Clinical Guidelines for Alcohol Treatment.

The Blue Light Approach in Action:

Northumberland Blue Light Operational Group: Joining the dots

Established in 2019, Northumberland's Blue Light Operational Group brings together partners from health, social care, housing, criminal justice and emergency services to better support people with high-risk, alcohol-related needs. Its aim: to improve outcomes for individuals, reduce community risk, and lessen demand on local services.

The group, independently chaired by Alcohol Change UK, includes Northumbria Police, Northumberland County Council Adult Social Care, Housing and Public Health, The Probation Service, Northumbria Healthcare NHS Foundation Trust, the Northumberland Recovery Partnership (NRP) and the North-East Ambulance Service (NEAS).

Meeting monthly, the group reviews referrals, coordinates plans, and shares responsibility for individuals who have significant contact with multiple services. Since inception, it has supported 95 people, with around 8-12 active at any one time.

A review of the first two years showed that over half of the 57 people referred had stabilised and were successfully engaging with services following Blue Light involvement. Arrests and criminal justice contact reduced, and the approach was found to be cost-neutral - while highly valued by partners.

Real impact

One individual was calling NEAS up to 15 times a month and frequently in contact with police due to violent and high-risk behaviour. Following referral to the Blue Light group, a coordinated plan was put in place involving NEAS, the person's GP, social care, police, and NRP.

A service-specific management plan supported ambulance crews, safeguarding measures were coordinated, and risk was monitored through regular multi-agency discussion.

Over time, the person began engaging with treatment and wider support. Since discharge from the Blue Light group, there have been no further domestic incidents, safeguarding alerts or emergency service callouts. They are now settled in supported accommodation with appropriate ongoing care.

The group has strengthened partnership working, improved safety for individuals and professionals, and reduced strain on emergency services - demonstrating the value of the Blue Light Approach in practice.

The importance of using a motivational interviewing approach

All of the interventions in this manual will be enhanced by having specialist and generic staff who are trained in motivational interviewing (MI).

MI is a technique developed by Miller and Rollnick in the 1980s. Their book, *Motivational Interviewing*[70], is the key text and can be used by both specialist and non-specialist services. Its aim is to move a person from ambivalence to change. The approach offers a wide range of techniques. These cannot be summarised here; however, three approaches are worth emphasising in this context:

- Asking permission to talk about the drinking and offering permission to disagree with your view. This gives the individual a sense of control in the process.
- Encouraging the individual to believe that change is possible and to non-judgementally develop reasons why change should be tried.
- Rolling with resistance – this vital principle is explored in the next section.

These skills can be used to build engagement, promote harm reduction or encourage change.

This practice guidance is not a MI training resource. Training is readily available via agencies such as Alcohol Change UK. Miller and Rollnick's book is the key text[71] but two free resources are available on the internet:

- *Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35* is a 200+ page US government guidance document on using MI with people with alcohol problems which is available for download at[72]: http://www.ncbi.nlm.nih.gov/books/NBK64967/
- The Motivational Enhancement Therapy guidance booklet used in the large and influential US research programme Project Match is available for download at: http://casaa.unm.edu/manuals/met.pdf

*Another tool which could be used to develop motivation is the **Outcomes Star™ for Alcohol Recovery**. This was designed as an outcome monitoring and care planning tool. However, its focus on a range of needs which are measured using a series of scales allows workers to set small targets for change in areas other than alcohol use. It, therefore, provides a framework for an intervention which is both motivational and looks at the whole person rather than simply the alcohol. These tools can be found at Home - Outcomes Star*

Rolling with resistance

A central tenet of MI is what is often called: *rolling with resistance*. This is an important characteristic of all work with change-resistant drinkers: do not try and force the issue. If someone with a 30-year history of problem drinking, alcoholic liver disease and a pattern of drink related offences denies point blank that alcohol is a problem, it is tempting to try and persuade them that they are wrong. This is unlikely to be effective.

Rather than talking about the alcohol, the best starting point may be sorting out their finances or encouraging them to eat and put on weight. Everyone is motivated in some way, but the shape of that motivation may differ. We need to start with their motivation and build from there. Families may also need to be helped to understand the importance of this approach through education and advice.

One American commentator described the approach as *"dancing not wrestling"*.[73] Don't try to overpower the drinkers and "nag" them into sobriety, instead explore their priorities and interests and allow those conversations to bring you back to the alcohol.

Peer support

People with personal experience of alcohol harm, who are in visible recovery, can play a vital role in engaging those who may be resistant to traditional services.

Peer supporters can offer empathy, credibility, and hope in ways that professionals sometimes cannot, showing that change is both possible and worth pursuing.

Their involvement can take many forms: informal befriending, regular phone calls, attending appointments alongside the person, or co-facilitating groups. In Medway, the Blue Light multi-agency group arranged for a peer supporter to make regular calls to a woman who was difficult to engage. This simple, human connection led to improved trust and greater willingness to work with services.

However, supporting high-impact, change-resistant drinkers can be complex and emotionally demanding. People in recovery who take on this role need:

- **Clear boundaries** to protect both themselves and the person they support
- **Training** in communication skills, safeguarding, and handling crisis situations
- **Regular supervision and debriefing** to maintain their own wellbeing and recovery
- **Recognition** as valued members of the multi-agency team

When done well, peer support complements professional interventions, reduces isolation, and can be the bridge that enables someone to take the first step towards change.

Good practice:

Peer support

Founded in 2011, Recovery Cymru is a peer-led, mutual-aid recovery community serving Cardiff and the Vale of Glamorgan. It works to empower and support people to enter recovery and move forward in it, to develop skills and interests and improve their quality of life, and to maintain their recovery while also supporting others to do the same. As a lived-experience recovery organisation (LERO) Recovery Cymru seeks to share knowledge and experience, so that more people can benefit from the power of peer support. Guidance on their First Steps peer support programme can be found here.

Harm reduction

Harm reduction is one of the most effective tools we have - both for saving lives and for building relationships.

It has long been central to drug treatment: methadone prescribing, supervised injecting, and needle exchanges are standard practice. These interventions accept that while someone may not be ready to stop using, we can still reduce the harm they cause to themselves and others.

But in alcohol treatment, harm reduction is less common, less standardised, and often misunderstood. That needs to change.

Why harm reduction matters in alcohol work

Harm reduction is about reducing risk. But it's also:

- a way of **"rolling with resistance"** - engaging people without demanding immediate abstinence
- a means to **build trust and credibility** with people who are used to being judged or written off
- a **pre-treatment strategy** - helping people become physically, mentally and practically more ready to engage in structured support.

It's about safety, but more than that, it's about relationship, readiness, and respect.

Examples of alcohol-related harm reduction

There's no universal list of interventions as every person is different. But the following are common areas to explore:

Physical health and nutrition

- Encourage regular food intake; support with access to food or meal services
- Suggest vitamin B1 (thiamine) supplementation to prevent Wernicke's encephalopathy
- Offer information about alcohol-related seizures and safe reduction strategies

Medication safety

- Monitor for medication hoarding, particularly where there is suicide risk
- Advise on dangerous drug interactions (e.g. alcohol with benzodiazepines or opioids)

Home safety

- Ask about fire risks: Is the person using open flames to cook or heat their home?
- Check for trip hazards or unsafe environments (e.g. loose carpets, cluttered stairs)
- Ensure they have a working smoke alarm

Personal safety and safeguarding

- Explore risks of falls, self-neglect, or exploitation
- Support access to safe accommodation where needed
- Offer guidance around safer drinking strategies if abstinence is not being considered

Alcohol-specific strategies

- Encourage spacing drinks out
- Encourage hydration between drinks
- Discuss avoiding high-strength "white" cider or spirits
- Offer practical tips for reducing drinking where possible

Harm reduction is more than advice

Don't forget:

- Information sharing is harm reduction
- Multi-agency working is harm reduction
- Engagement itself is harm reduction
- A consistent worker and a consistent response is harm reduction

Every time we reduce risk, prevent a hospital admission, or help someone feel heard rather than punished, we're practising harm reduction.

Remember...

You don't need permission to offer harm reduction.

You don't need someone to be "ready" to change.

You just need to ask:

> **"What can I do today to make things a bit safer for this person, and a bit easier for them to come back tomorrow?"**

You will find a list of harm reduction techniques on page 58.

Good practice:

The importance of thiamine

Thiamine (vitamin B1) is essential for brain and nerve function. Heavy, prolonged alcohol use depletes thiamine stores, increasing the risk of Wernicke's encephalopathy – a potentially life-threatening neurological condition. If untreated, Wernicke's can progress to Korsakoff's syndrome, causing permanent memory damage and cognitive decline.

People who drink heavily are often malnourished, have poor absorption of nutrients, and may go days without eating - all of which worsen thiamine deficiency.

Key points for practice:

- Thiamine (oral or injectable) should be considered for dependent drinkers, especially those with poor diet, recent weight loss, vomiting, or confusion. Prescribers should follow current clinical guidance when making decisions about supplementation.
- *(Note: Thiamine injections have been known by the brand name "Pabrinex". Check current NHS or local prescribing guidance to confirm the brand or formulation used in your area.)*
- Thiamine should be given before any glucose-containing fluids in at-risk patients, as glucose can trigger or worsen Wernicke's.
- Community workers can encourage daily oral supplementation and check whether thiamine has been prescribed.
- Include thiamine awareness in all alcohol-related training, so no opportunity to prevent brain injury is missed.

Prompt thiamine supplementation is a simple, inexpensive intervention that can prevent irreversible harm. It's one of the most effective forms of alcohol-related harm reduction.

The Blue Light Approach in Action:

Westminster's Test and Learn Model

Westminster City Council has partnered with Alcohol Change UK to adopt and adapt the Blue Light Approach, building alternative care pathways for individuals often seen as "beyond help." The work here is rooted in the belief that change is possible, and demonstrates how local systems can shift - practically and strategically - to support those most marginalised.

Strategic Foundations

This work is sponsored by the Westminster Safeguarding Adults Executive Board, giving it cross-agency visibility and buy-in. Strategic ownership has been key to enabling training, engagement, and momentum.

Training has been delivered across both specialist and non-specialist services, including sessions on:

- Cognitive impairment and safeguarding,
- Legal powers and frameworks for this cohort,
- Person-centred, trauma-informed practice.

Operational Model: Test and Learn

A small "test and learn" cohort was created to develop live insight into barriers and opportunities. This group was supported with assertive outreach and trauma-informed support, to better understand what real-world change could look like.

A simple monthly workshop format has brought partners together to:

- Deliver quick-win initiatives,
- Build shared understanding and practice,
- Begin systems change work in three core areas: cognitive impairment, vitamin B1 therapy, and communication needs.

This structured collaboration has allowed Westminster to turn insight into action, building bridges between services and using existing resources more effectively.

Outcomes for the Cohort (10 Individuals, 2023)

Specialist input secured:

- Four individuals referred to Speech and Language Therapy, supporting better communication and understanding.
- One individual assessed by a neuropsychologist.
- Two safeguarding appeals accepted after initial rejection.
- One person entered detox successfully.

Community access:

- Four individuals accepted by a befriending service.
- One mobility scooter secured for an individual who had become housebound due to frailty.

Housing stabilisation:

- Two individuals in significant arrears are now making regular payments.

Harm reduction and health:

- Eight individuals now accepting regular vitamin B1 injections.
- All are now attending medical appointments, supported by strong relationships with the multiple disadvantage nurse team.

Partnership working has enabled:

- More streamlined, lower-stress appointments,
- Active Urgent Care Plans (UCPs) for medically complex individuals, ensuring consistent, psychologically informed care across professionals.

Cost avoidance and system impact

One high-impact individual achieved dramatic reductions from 2022 to 2023:

- 76% reduction in police calls (144 → 34)
- 64% reduction in ambulance contacts (117 → 42)

These figures show that person-centred, assertive, integrated support can reduce demand on emergency services, while also improving individual outcomes.

Professional curiosity

Professional curiosity is the capacity and willingness of practitioners to explore what is happening in someone's life beyond the surface.

It means noticing red flags, asking difficult questions sensitively, and not accepting initial explanations at face value when concerns persist. It involves being open-minded, questioning assumptions, and piecing together information from different sources to see the fuller picture.

This approach is particularly important when working with individuals in the Blue Light client group, where presentations may be chaotic, inconsistent, or seemingly resistant. Without curiosity, there is a risk that practitioners disengage too early or overlook serious safeguarding concerns.

Several Safeguarding Adult Reviews (SARs) have highlighted cases where a lack of professional curiosity contributed to tragic outcomes. In the "Alan" SAR (Sunderland), professionals described him as "choosing a chaotic lifestyle" despite evidence of significant cognitive impairment and physical vulnerability. In the Leanne Patterson SAR (Northumberland), assumptions were made about her "lifestyle choices", even after repeated assaults and escalating health issues. In both cases, a more inquisitive, joined-up approach might have uncovered unmet needs or prompted a safeguarding response sooner.

Professional curiosity requires time, supervision, and a culture that values reflective practice. It also requires confidence to challenge decisions, escalate concerns, and test the narratives presented by people or other agencies.

Sometimes, well-meaning professionals fall into the trap of "professional optimism" - hoping that someone is coping, improving, or safe, despite evidence to the contrary. Optimism is valuable, but it must be balanced with curiosity, critical thinking and healthy scepticism. In cases involving alcohol dependency, self-neglect, or exploitation, optimism alone is not a plan - curiosity is the safeguard.

By fostering professional curiosity, we strengthen our ability to respond effectively, reduce risk, and ensure that people in the most vulnerable circumstances do not fall through the gaps.

Signals that warrant professional curiosity

These signs should prompt further exploration, discussion with colleagues, or escalation. They may indicate that the situation is more serious or complex than it first appears:

- Frequent missed appointments or disengagement from services without clear explanation
- Conflicting information from the individual, carers, or agencies
- Rapid physical or mental deterioration, especially when dismissed as "lifestyle"
- A carer or partner speaking on behalf of the person, or controlling access to them
- Repeated hospital admissions, police call-outs or emergency service use
- A history of trauma, violence, or exploitation, especially when minimised
- Concerns from neighbours, friends, or community members
- Living conditions deteriorating — signs of self-neglect, hoarding, or hazards
- Signs of cognitive impairment, confusion, or memory loss
- The individual appears fearful, withdrawn, or unusually compliant

If something feels 'not quite right', it probably isn't. Curiosity is an essential safeguard.

Case study:

Mr L – Looking beyond the behaviour

Mr L was placing a significant and sustained demand on police and other public services.

He was drinking heavily every day – typically a one-litre bottle of whisky and several cans of 8% lager. His behaviour frequently triggered police involvement, with at least three alcohol-related incidents a month, often involving verbal or physical aggression towards the public or officers.

His criminal justice history included convictions for assault, possession of weapons (including a firearms offence), and a hostage-taking offence. He was considered high risk to professionals, with warning markers in place for both suicide risk and vulnerability.

Mr L's physical health was poor: he had pancreatitis, migraines and limited mobility. However, he rarely engaged with treatment, often refusing medication and failing to attend follow-up appointments.

An outreach worker was tasked with engaging Mr L and supporting him to stabilise. This included:

- Providing one-to-one support to complete a physical health check and attend follow-up care
- Coordinating a multi-agency meeting and improving communication between Mr L and the services involved
- Addressing housing and transport issues
- Offering consistent, person-centred support
- Helping him build coping skills to manage day-to-day life

As a result of this intervention, Mr L's impact on emergency services has reduced.

A trauma informed approach

Many people in the Blue Light client group have lived through significant trauma, whether from adverse childhood experiences (ACEs), abuse, neglect, violence, or systemic disadvantage.

Trauma shapes how individuals relate to others, manage stress, and use substances like alcohol to cope. It also deeply affects physical health, increasing the risk of chronic illness and cognitive decline, especially in combination with long-term alcohol use.

A trauma-informed approach reframes behaviour not as resistance or non-compliance, but as a possible response to pain or mistrust. It shifts the question from "What's wrong with you?" to *"What's happened to you?"*

The Blue Light Approach recognises trauma as a key driver of alcohol dependency. Trauma-informed care helps to:

- **Build trust and reduce fear**, improving engagement with people who have been let down or harmed by services in the past
- **Improve outcomes**, by reducing shame, supporting emotional safety, and tailoring care to people's lived experiences
- **Support staff wellbeing**, by equipping workers with tools to understand complex behaviours and avoid burnout
- **Align with harm reduction**, by focusing on relationship-building and gradual change

Core principles of trauma-informed practice

1. **Safety –** creating environments where people feel physically and emotionally secure
2. **Trust and transparency –** being consistent, open, and respectful
3. **Peer support –** valuing personal experience and non-judgemental spaces
4. **Collaboration and choice –** involving individuals in decisions about their care
5. **Cultural and identity awareness –** acknowledging the impact of background and inequality on trauma

Trauma-informed care within the Blue Light Approach involves:

- **Flexible, non-linear care** – recognising that progress may involve setbacks, and rigid expectations may re-trigger trauma
- **Reducing power imbalances** – listening without judgement, respecting autonomy, and offering choice
- **Creating safety-first services** – physically and emotionally, through calmer spaces, consistent contact, and predictable routines
- **Working across agencies** – bringing together housing, health, justice, and social care in coordinated, compassionate ways
- **Supporting workers** – offering reflective practice, supervision, and space to process emotional strain

Putting trauma-informed care into practice

While the principles are clear, day-to-day practice can be challenging. Here are some practical strategies for frontline staff:

Slow down - Avoid rushing conversations, appointments, or transitions; trauma survivors may need more time to process and respond.

Explain and prepare - Clearly outline what will happen next, especially in assessments, meetings, or interventions, to reduce feelings of uncertainty or loss of control.

Offer choices where possible - Even small choices (e.g. where to sit, when to meet) can help restore a sense of agency.

Pay attention to triggers - Be mindful of tone, language, and body language that may inadvertently trigger fear or shame.

Use grounding techniques - Help someone manage emotional overwhelm by focusing on the present moment, using calming or sensory tools.

Practice non-judgemental listening - Validate the person's feelings without minimising or rushing to problem-solve.

At the organisational level:

Trauma-informed care is not just a set of frontline practices, it requires whole-system commitment.

Policies and procedures should reflect trauma-awareness, ensuring services avoid re-traumatisation.

Supervision and staff wellbeing need to be prioritised, recognising the emotional toll on workers engaging with trauma-affected individuals.

Commissioning and leadership should actively support flexible, person-centred approaches rather than rigid, compliance-driven models.

Data and outcomes should focus not only on treatment completion but also on engagement, safety, and trust-building.

When trauma-informed principles are embedded across services, people are more likely to feel seen, respected, and motivated to change. Workers are better equipped to cope. Systems become more sustainable.

Trauma-informed practice means understanding people in context. It strengthens the Blue Light Approach by placing empathy and safety at the centre of behaviour change.

Maintaining professional boundaries

Working with people who are highly vulnerable, complex, and often socially isolated requires warmth, compassion, and persistence. However, effective support also depends on maintaining clear and appropriate professional boundaries.

Professional boundaries are not barriers to connection, rather they are what allow safe, ethical, and sustainable relationships to develop. In the context of the Blue Light Approach, where workers may be involved over long periods and take on varied roles (from emotional support to crisis response), boundaries can easily become blurred if not actively maintained.

Why boundaries matter:

- They **protect the person** from dependency, confusion, or unrealistic expectations.
- They **protect the worker** from burnout, emotional over-involvement, or being drawn into unsafe situations.
- They **maintain the integrity** of the support relationship and help clarify what the role is and isn't.

Examples of boundary challenges may include giving out personal contact details, providing support outside agreed hours, taking on tasks beyond the role (e.g. lending money), or becoming a "rescuer" figure in the individual's life.

Good practice includes:

- Being clear about your role, availability, and limitations from the outset
- Reflecting regularly - individually or with supervision - on how the relationship is developing
- Recognising warning signs of over-involvement (e.g. feeling solely responsible for someone's progress or distress)
- Holding difficult conversations if boundaries are being tested or misunderstood
- Seeking support if you feel conflicted, stuck, or emotionally overwhelmed

Supporting people with entrenched alcohol dependency can evoke strong emotional responses. Maintaining boundaries isn't about being distant, it's about being safe, clear, and effective. The most lasting change often comes from consistent, boundaried relationships built on respect and trust.

Boundary Red Flags: Things to notice and reflect on

If you notice any of the following, it may be a sign that professional boundaries are becoming blurred. These aren't necessarily wrong, but they do warrant reflection:

- You feel solely responsible for the individual's progress or safety
- You are thinking about the person outside of work hours more than usual
- You've shared personal contact details (e.g. mobile number or social media)
- You avoid raising difficult issues for fear of "damaging the relationship"
- You feel the individual is becoming dependent on you, or you on them
- You're keeping things from your team or not documenting contact fully
- You're working beyond normal hours without team oversight
- You feel guilty when setting boundaries, or avoid setting them altogether
- Other professionals raise concerns about your involvement

If in doubt, speak to someone.
Use supervision, team debriefs, or peer support to stay grounded and supported.

Aspiration: residential rehab

The ideal care pathway for many of these individuals would probably have been inpatient detoxification followed by a longer period of residential care/ rehabilitation in an alcohol or drug-free environment.

Dame Carol Black's Review of drugs part two: prevention, treatment, and recovery (which also covers alcohol) states: *"Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs."*

Such a placement would have enabled:

- A time away from their home situation.
- A chance to properly assess their physical and mental health.
- The opportunity to develop an appropriate long-term care plan that addresses the alcohol use disorders.

This would not have been an easy answer to problems and it may have been a challenge to engage him with such an offer. In addition, it is possible that there would have been problems finding appropriate placements and the budget for such rehabilitation is often limited.

Nonetheless, this review suggests that, given the range of possible care packages, a detoxification followed by some form of "dry" residential rehabilitation would have been a good option. Therefore, it is important that:

- Persistent efforts should have been made to "sell" this approach by all professionals;
- Funding should be available (probably via Alcohol and Drug Commissioners) for this approach without unreasonable barriers if interest is expressed;

Section 3: Practical techniques for frontline use

The previous sections outlined the foundations of the Blue Light Approach. But structure alone isn't enough.

The next challenge is practical:

What do you actually do with someone in front of you who's drinking daily, not turning up to appointments, and putting themselves or others at risk?

This section moves from strategy to action - offering practical techniques you can use right away. Some are clinical, some are creative, and many are about the small, day-to-day actions that build trust and open doors.

These tools are grouped around four key themes that reflect the areas most likely to influence a person's drinking and engagement:

1. **Health and wellbeing** - supporting physical stability and recovery
2. **Relationships and social connection** - strengthening support networks and reducing isolation
3. **Practical and environmental stability** - helping people build safety, structure, and control in daily life
4. **Harm reduction and legal frameworks** - managing risk and ensuring protection where needed

Each of these is a lever for change. Not every approach will apply to every person, but used flexibly and creatively, they can help unlock progress where other methods have stalled.

Key practical techniques for working with dependent drinkers

We've seen that focusing solely on alcohol is often a dead end. For many people, it's not the first - or even the fifth - thing they're ready to talk about.

That's why real engagement often begins somewhere else.

The techniques that follow are all ways of "rolling with resistance" - working with the person, not against them.

They're also useful in their own right: building trust, improving wellbeing, and laying the groundwork for longer-term change.

Health and wellbeing

The importance of food and nutrition

It is hard to over-state the importance of good diet and nutrition for those drinking alcohol at very high levels.

Eating well will protect the body against the effects of alcohol more than anything other than reducing alcohol consumption. This is particularly true of people with entrenched alcohol dependency that services find difficult to engage.

People with chronic alcohol problems may be poorly nourished[74]:

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

Poor nutrition will increase the likelihood of a variety of health problems, depression, cognitive damage, and intoxication. All of these will make it harder for people to find motivation and engage with treatment.

Diet and engagement

A number of nutritional issues impact on engagement both through reduced energy levels and lowered mood. These are just examples of the range of impacts:

- In the long term, vitamin B1 (thiamine) deficiency can result in alcohol-related brain damage leading to confusional states which can appear similar to dementia. This will make it hard for people to structure themselves to engage with interventions. This has been seen as a state which is associated with a small group of very heavy and lifelong drinkers. However, alcohol-related brain damage probably affects heavy drinkers earlier than was previously understood and, therefore, affects a much larger number.
- Other B vitamin deficiencies (e.g. B3 and B9) can increase cognitive problems or cause confusion and /or aggression.
- Magnesium is needed in energy production. It is poorly absorbed even in a normal diet and a lack of magnesium in the diet will again reduce energy levels. Similarly, potassium deficiency leads to fatigue and mental impairment
- Vitamins B2 and B6 can lead to stomatitis (cracks in the sides of the mouth) and glossitis (an inflamed tongue). Cracked mouths and enlarged tongues make it harder to eat again leading to the problems above.
- Vitamin D deficiency can lower mood.

Poor diet can also impact on other health problems:

- Vitamin D is essential for calcium absorption. When people are deficient in vitamin D - often due to poor diet, limited sunlight exposure, or liver disease - the body cannot absorb calcium effectively. This weakens bones, increases fracture risk, and can lead to avoidable hospital admissions.
- Magnesium is also important for cardiac health. Its lack can lead to cardiac arrhythmias and shakes. Some apparent alcohol-related shakiness can be due to magnesium deficiency. It may also cause tingling in the hands.
- Peripheral neuropathy can also be the result of poor diet.
- Small physical size increases the impact of alcohol.
- Drinking without eating increases the risks of liver damage up to threefold.[75]

The British Liver Trust says the key messages about liver health are to reduce alcohol, eat a good diet, drink water, exercise and maintain a healthy weight.[76]

Addressing poor nutrition

Many dependent drinkers under-eat or consume a limited range of foods, leading to malnutrition. Lack of Vitamin B1 (thiamine) is a particular issue for heavy drinkers and can lead to severe brain damage. Many approaches can help drinkers improve their nutrition:

- GPs can provide vitamin therapy. Gastro-enteritis may mean some drinkers have difficulty absorbing vitamins via the gut, and so it may be worth seeking medical advice about intravenous or intramuscular high-dose Vitamin B therapy (known as Pabrinex)

Alternative approaches exist:

- Vitamin pills can be purchased over the counter in pharmacies and supermarkets, as can supplements of important minerals such as magnesium.
- All white and brown bread sold in the UK has Vitamins B1 and B3 added to it, and wholemeal bread has these vitamins naturally.
- Vitamin B1 can also be found in spreads like marmite, cheese spread and peanut butter.
- Vitamins B2 and B6 can be found in meat, fish and eggs.
- Dental problems may make it harder to eat – bananas may be easier to eat than apples in the short term and dental treatment may help in the longer term.

- Treating diarrhoea can help: someone may not be eating to avoid incontinence and only eat late and at home.
- Liquids may be easier to consume for some people.
- Pot Noodles and similar cook-in-a-cup products are warming, calorific and easy to prepare, and could be a good start for some people who are not eating.
- The British Liver Trust highlights evidence that drinking two to three cups of coffee per day may be beneficial for liver health. This is a small benefit and needs to be treated with caution if it is impacting negatively on sleep or hydration.

The bottom line is: make sure you are doing everything you can to improve nutrition.

Don't forget hydration

The risk of dehydration exists with some drinks, particularly stronger drinks including spirits, wine and fortified wines. Hot weather will also have an impact.

Dehydration has a range of effects on those drinking at high levels:

- Dehydration will quite simply increase intoxication and consequent physical harm.
- Drinking when dehydrated increases liver damage.
- The body needs fluids to help combat confusion and lethargy.
- Dehydration increases the likelihood of a range of conditions including urinary tract infections (UTIs).
- UTIs will lead to the prescription of antibiotics which can lead to diarrhoea which will lead to more dehydration. Regular vomiting will also reduce hydration.

If you do nothing else, encourage people to drink more water. Even ice lollies or ice cubes in drinks can help with hydration.

Lateral thinking

One way to address hydration is by giving people a chart about urine colour. Hydration will help a drinker's health and someone's current status is readily seen when urinating. Knowing about the need to keep hydrated will be a personalised education message every time they go to the toilet!
Urine colour charts are readily available on the internet.

Good practice:

Feeding Recovery

Alcohol Change UK's Feeding Recovery Project sought to understand more about the interpersonal and community aspects of cooking and eating as part of recovery from alcohol problems. Through conducting cooking and food sharing sessions in Swansea and Cardiff, researchers found that people valued the social connections, dignity and sense of safety created through the sharing of cooking and mealtimes:

- "It was more enjoyable cooking with others. Sometimes, when you're on your own, you can't be bothered to cook, but cooking with other people, it's nice."
- "We sit like a family. Most people don't have that. That's the best part of it."
- "I can't be bothered [to cook] for myself, honestly. You go into yourself. I didn't bother cooking [when I was drinking]."

Read more on the Alcohol Change UK website here.

Good practice: Breakfast Buddies

Saturday mornings, warm food and no judgement

When most services are closed and loneliness hits hardest, Breakfast Buddies, a small, registered charity based in Maidstone, Kent, offers a simple but powerful intervention: a hot breakfast, a hot drink, and a warm welcome - all from a car park.

There's no agenda, no forms, and no pressure to talk - just food, kindness, and a consistent, safe space to be.

"People come because they're hungry or lonely, but they stay because they're treated like human beings, not problems to be fixed."

This ethos of unconditional positive regard underpins every interaction - accepting people as they are, without judgement, and creating the safety needed for trust and change to grow.

The charity supports people affected by alcohol use and other challenges. Volunteers use quiet moments over breakfast to check in on wellbeing, notice changes in health, and build the kind of trust that can lead to support or change later on.

Over time, attendees begin to open up - whether about needing a GP referral, a phone charge, or simply someone to listen.

Key benefits:

- Improves basic nutrition and hydration
- Reduces isolation and promotes dignity
- Creates opportunities for gentle health prompts (e.g. signposting to liver scans, dentists, GPs)
- Acts as a low-threshold entry point to further support

Attendees describe the difference it makes:

"It's so nice to have a seat up at a table with others. It makes us feel human."

"What you've built here is incredible. It feels like a family."

Learn more: breakfast-buddies.co.uk

Smoking and e-cigarettes

Smoking is likely to be significantly worsening the problems experienced by people with entrenched alcohol dependency that services find difficult to engage.

70-80% of dependent drinkers smoke.[77] They are, probably, the identifiable population group with the highest rate of smoking in England. Evidence from the United States indicates that people who are dependent on alcohol are three times more likely than those in the general population to be smokers.[78]

Anyone working with dependent drinkers will be aware of the toll taken by COPD, pneumonia and lung cancer. These diseases will contribute to the number of hospital admissions related to alcohol misuse. Indeed, it has been suggested that smoking kills more dependent drinkers than alcohol (this does not mean they are not sick with alcohol-related problems but the disease that actually kills them is smoking-related).[79]

Perhaps more crucially, smoking is not just bad for drinkers as it is for anyone else, but it causes specific problems for drinkers. Smoking worsens diseases associated with alcohol misuse e.g. oral cancers, liver disease and coronary heart disease. Smoking may contribute to the depletion of vitamin B1 from the body through reduced appetite. Tackling smoking would also have other benefits, for example, reducing fire risks.

Poorly managed nicotine addiction may also impact on people's ability to engage with services. If someone is left waiting in a hospital or other setting for a long period of time, the desire for a cigarette may overwhelm any desire to wait for the appointment. If someone goes outside to smoke, they may meet people who change their mind about staying, or even forget the reason for coming in the first place.

Expecting a dependent drinker to give up smoking may be unrealistic, and may even be unhelpful, if attempts are also being made to change their drinking. However, it is now possible to help drinkers switch to e-cigarettes or vaping. Promoting vaping may represent an opportunity to both address health problems and increase engagement and motivation.

The evidence on this is at an early stage of development. For example, we are unclear whether giving out vaping materials could be used as a positive means of encouraging engagement with alcohol services and enabling health checks. However, looking at the balance of risk, vaping offers a valuable route to harm reduction for many smokers, including drinkers who smoke, and could be used as another "roll with resistance" technique.

The benefits of exercise and movement

While the direct impact of exercise on alcohol metabolism or the prevention of specific alcohol-related conditions is less clear than with nutrition[80], the broader health benefits of physical activity are undeniable. Regular movement improves cardiovascular health, supports immune function, and plays a significant role in boosting mood, self-confidence, and self-belief.

Crucially, there is strong evidence that physical activity can help alleviate symptoms of depression[81] and anxiety - both of which are common among people with problematic alcohol use. Even low-intensity movement, such as walking, can increase levels of serotonin and endorphins, helping to regulate mood and reduce stress. This makes exercise not just a physical intervention, but a vital part of emotional recovery too.

That said, expecting someone whose health and motivation have been eroded by heavy drinking to suddenly embrace vigorous activity is unrealistic. Work with individuals to set small, achievable goals that feel manageable to them. A walk around the park or to the local shop may be a far more useful and realistic starting point than a structured exercise class or team sport.

Always consider any underlying health conditions - musculoskeletal issues, chronic fatigue, or cardiovascular risk - that might make certain activities difficult or unsafe.

The aim is to build positive associations with movement, not add to someone's sense of failure or risk.

Giving enhanced, personalised health feedback

One of the most powerful ways to engage people with entrenched alcohol dependency is through enhanced personalised feedback about the impact of alcohol on that person. This approach draws directly on motivational interviewing approaches.

People who won't speak to GPs or Nurses will often open up with frontline, non-specialist workers about pain, symptoms, or fears about their bodies. This isn't just a route to rapport - it's an opportunity to prevent long-term harm or even save lives.

This isn't about becoming a clinician - it's about being the bridge between someone's reality and the care they've stopped accessing.

However, when talking to chronic drinkers, it is easy to resort to statements like: "If you don't stop drinking, you're going to die!" This may be done from the best of motives but is too broad to be effective. A better approach is to offer simple statements that encourage people to think about the specific impact of alcohol on them. These statements:

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

This approach is rooted in factual information and framed around support.

This is a challenge for non-alcohol specialists, because it will require some knowledge about alcohol's impacts. Two tools already highlighted in this manual will assist this approach:

- The AUDIT tool (see appendix 1) and
- The risk assessment checklist (see above)

Information emerging from these tools should be fed back to the person, with permission, in a non-judgemental manner.

Evidence suggests that information about physical impact can also be motivational.[82] Therefore, the individual should always be encouraged to have a physical health check with their GP and a dental check. The latter will also help identify oral cancer risks and may improve self-confidence in those concerned about bad breath or damaged teeth.

A consultation with a dietitian or nutritionist could also be useful.

The individual may well need support to attend:

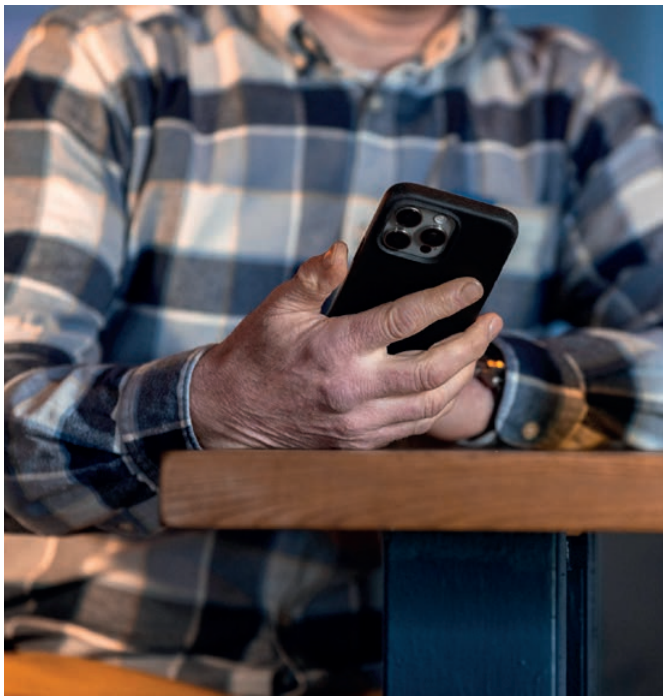
- *"I understand you don't want to stop drinking, so let's make sure you stay a healthy drinker for as long as possible."*
- *"I am happy to come with you to the appointment."*
- *"I can try and arrange for the doctor to see you at a relatively quiet time in the practice."*

The latter two will require worker input to arrange appointments.

However, this section introduces a practical tool: the *12 Questions for the generic worker to ask about alcohol-related physical ill health*, developed specifically for use by non-medical staff. It gives workers a safe, structured way to explore potential alcohol-related health issues, build trust, and gently motivate change (see below).

It sets out questions that someone with no medical training can ask to help identify potentially serious health problems.

Many dependent drinkers live for long periods with chronic pain, coughing blood or passing blood from the back passage without seeking help. Used well, this tool can prompt life-saving action - and also help clients understand that health decline is not inevitable, but often treatable.



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

Workers' questions to service users

Below is a list of 12 questions that will be useful to ask when speaking to a service user about their physical health. We are not expecting you to be a medic but here are some simple questions to ask. Please refer to the explanatory notes and encourage them to see their GP with any health issues.

Some people have suggested that this is a task for doctors or nurses. However, if we only wait until they see a clinician, we will be missing real opportunities to prevent health problems.

It is suggested that an open-ended question is used at the beginning of the conversation such as:

Alcohol increases the risk of over 60 different diseases. Have you had any recent health problems?

Then get permission to ask the further 12 questions:
Can I run through some other health related questions?

1	Do you have a sensation of numbness, pain or pins and needles in your feet or hands?
2	Have you noticed blood in your stools or have they become looser than normal?
3	Have you had difficulty swallowing solid foods?
4	Do you have any mouth ulcers that won't heal?
5	Do you experience, or have you ever experienced, a severe dull pain around the top of the stomach that develops suddenly?
6	Have you or a relative expressed concerns about your memory?
7	Have you ever experienced fits or seizures; or have you had a history of head injuries (including non-alcohol-related and as a child)?
8	Have you coughed up blood or noticed blood in your vomit?
9	Have you ever noticed or has someone else commented that the whites of your eyes or skin have turned yellow?
10	Have you had your blood pressure checked in the last year?
11	Have you had a liver investigation or a fibroscan in the last 2 years to identify liver damage?
12	If you're female, are you regularly checking your breasts for lumps? (Trans men and non-binary people may also need screening.)

The original *12 questions* were developed by Mike Ward and Mark Holmes with clinical input from Professor Stephen Ryder Consultant Hepatologist at Nottingham University Hospitals NHS Trust. You can find a video of Mark Holmes explaining how to use the 12 Questions tool on the Blue Light Approach pages of the Alcohol Change UK website.

Explanatory notes: 12 questions for the generic worker to ask about alcohol-related physical ill health

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

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

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

2 Have you noticed blood in your stools or have they become looser than normal?

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

Seek urgent medical attention

3 Have you had difficulty swallowing solid foods?

This could indicate cancer of the gullet *(Oesophageal cancer)*. Alcohol increases the risk of cancer of the gullet. This risk increases even more in smokers and is directly related to the amount of alcohol consumed. Any patient with difficulty swallowing solid foods, with a 'blockage' or a feeling that food gets 'stuck' should be encouraged to get an urgent appointment with their GP who is likely to refer them to a specialist for assessment.

4 Do you have any mouth ulcers that won't heal?

Alcohol increases the risk of mouth or throat cancer. This risk increases even more in smokers and is directly related to the amount of alcohol consumed. Mouth cancer can start in the lips, gums or soft sides of the mouth or in the oropharynx, the part of the throat just behind the mouth. This can cause a lump inside the mouth or may cause an ulcer that doesn't heal after a couple of weeks. Anyone with these problems should see a dentist or doctor for a check-up within two weeks.

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

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

6 Have you or a relative expressed concerns about your memory?

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

7 Have you ever experienced fits or seizures; or have you had a history of head injuries (including non-alcohol-related and as a child)?

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

8 Have you coughed or noticed blood in your vomit?

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

Seek urgent medical attention

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

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

⚠ **Seek urgent medical attention**

10 Have you had your blood pressure checked in the last year?

This can detect high blood pressure which is common in very heavy drinkers. If left unmanaged this can lead to a range of potentially fatal cardio-vascular diseases such as heart failure and stroke.

11 Have you had a liver investigation or a fibroscan in the last two years to identify liver damage?

A fibroscan can identify liver damage. Liver disease such as cancer or cirrhosis (scarring of the liver), is a major cause of premature death in the UK but shows no outward symptoms until it reaches a critical stage. Earlier detection of liver fibrosis can change behaviour – 65% of heavy drinkers who are diagnosed with liver disease, stop drinking.

12 If you're female[i] are you regularly checking your breasts for lumps?

Women aged 50+ should attend breast screening appointments when invited. Regular alcohol consumption increases the risk of breast cancer, the most common type of cancer in the UK. The risk of breast cancer in the general population is 1 in every 100 women. This risk increases as alcohol consumption increases. Drinking 30 units (3 bottles of wine) per week raises the risk to 3 in 100. There is a good chance of recovery if this cancer is detected in its early stages, it is therefore vital that women get any changes examined by their GP.

[i] Trans men and non-binary people may also need screening

FibroScan: a simple tool with powerful impact

A FibroScan is a non-invasive medical device that assesses liver damage by measuring how stiff the liver is. A probe is placed on the skin over the liver, sending out a vibration wave. The device then analyses how quickly the wave travels - the stiffer the liver, the faster the wave.

This test is painless, quick, and gives immediate results. It can:

- Distinguish between healthy liver tissue, early-stage fibrosis, and advanced cirrhosis
- Provide simple, personalised health feedback
- Help people understand the real (and sometimes hidden) harm caused by alcohol.

Many services now use a traffic-light system (red/amber/green) to communicate the results. Research shows this visual tool can increase motivation and reduce drinking, even in people who were previously disengaged from services.

Why it works

Research by Professor Nick Sheron (University of Southampton) found that many people with early liver disease had normal liver blood tests – but FibroScan picked up the damage. When given clear feedback, especially when categorized using a traffic light system, people were more likely to reduce or stop drinking.[83]

The Scarred Liver Project in Nottingham built on this work.[84] They showed that community-based FibroScan testing could:

- Detect hidden liver disease early
- Improve engagement with health services
- Prompt changes in drinking behaviour among at-risk individuals

More information on this innovative work is available at The Scarred Liver Project

Availability varies across the country. Ask your local Alcohol or Liver service about access to FibroScan testing in your area.

Relationships and social connection

Family involvement

Family or carer involvement in care planning can help improve engagement and increase the likelihood that a care plan will succeed.

NICE clinical guideline 115 specifically recommends encouraging families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.[85]

Although many in this client group will be living alone, a study of street drinkers in Bristol highlighted that half still had family they were in contact with.[86] Safeguarding Adult Reviews highlight both the presence of family and the importance of involving them.[87]

Family can be a powerful motivator. One of the authors spoke with a man who knew he was dying and whose main motivation in life was to re-contact his family. People engaged with the Nottinghamshire outreach service appreciated help re-engaging with family. One said that the worker: *"suggest(ed) ways of getting back with family. My family wouldn't have anything to do with me. You have to atone. The worker agreed to talk to my family members."*[88]

However, in the early stages of a relationship, individuals may be wary of engaging with family and workers may have to work patiently over time to encourage family engagement. Questions about next of kin in assessments or some of the questions in AUDIT (e.g. questions 9 and 10) offer an opportunity to identify and discuss family and family problems.

On the other side, family members will also find education useful, especially to understand the barriers and challenges that the drinker experiences. The Adfam / Alcohol Concern Blue Light Families project manual offers tools that support this.[89]

This approach needs to be undertaken with a realistic recognition that a minority of family members are inappropriate for involvement because they may subvert the drinker's attempt to change. Some family members may also have feelings of guilt, e.g. the mother of an adult with Foetal Alcohol Syndrome, or a family member who believes they could have done more to stop someone drinking.

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

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

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

At the very least, workers should consider whether any family members or informal carers are at risk from the drinker. If so, risk management strategies need to be considered. Domestic Homicide Reviews have highlighted how dangerous the combination of two drinking partners can be. The combination appears to significantly increase the risk of violence and the seriousness of the outcomes of violence.[90]

Creating safe spaces

There are things that services can do to make their spaces more accessible and welcoming to try to reduce barriers that people may have in relation to physically attending appointments or previous negative experiences of services.

In their video 'Top tips for GPs to support people with multiple disadvantage'[91], Groundswell in Westminster offer practical examples to help people experiencing multiple disadvantages access their GPs effectively. Many of these examples are useful for services more broadly and are not simply confined to GPs. The examples came directly from the Blue Light workers experience in Westminster and are grounded in their adoption of the Blue Light Approach.

- The confinements of professional settings with rigid rules, strict appointment times can present huge barriers to engagement. Try to remember that this is a conversation between two people.
- Providing a warm welcome in an informal environment can help to redress power imbalances. Reception staff can be key in this.
- Allow people to wait for their appointments outside if that is their preference. Sitting in small waiting areas around others who may be judgemental can be a barrier to attending appointments
- Provide a more flexible appointment system. Longer appointments and a drop-in rather than rigid appointment times.
- Work together with the individual on their concerns and help them to prioritise this. Think collaboratively in your support.
- Give the individual multiple options – don't expect your advice to always be implemented in the way that you would like it to be.
- Adopt a trauma-informed approach and signpost to appropriate services
- Ensure that there is no stigma associated with the appointment, develop the relationship so that the individual feels able to come back to you again.

"On visiting a treatment centre as a professional, staff apologised to me for not being able to offer me a coffee on arrival. It was explained to me that there used to be a coffee machine in the reception area, but they had removed it as all of the service users had kept turning up to help themselves to free coffee…

I thought what a shame that was, that the centre had accidentally stumbled across such an excellent engagement tool, but had chosen to withdraw it because it was too well used!"

M – Social Worker

Tackling enabling factors

It may be worth considering whether there are people, organisations or other aspects of someone's life which support or enable the drinking behaviour.

- Are there family members who are providing alcohol or money to buy alcohol?
- Are local shops providing alcohol on credit?
- Is there a pub selling to people when intoxicated?

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

In particular, a small group of drinks are having a significant impact. Contrary to certain urban myths, this is not because certain drinks have additional ingredients or particularly toxic properties. It is simply that high-strength cheap drinks like the white ciders, some cheap, strong lagers, and low-cost vodkas and other spirits allow people experiencing alcohol dependency to drink very large amounts of alcohol for a relatively small amount of money. The challenge of these drinks will need to be primarily tackled at local and national government level. This is already happening in Scotland and Wales, where minimum unit pricing for alcohol has significantly raised the price of some drinks and more-or-less eliminated some others from the market. In a number of localities in England, local police and licensing officers have worked to encourage off-licences not to sell high-strength beers and ciders.

At an individual level, it may be beneficial to encourage people to switch to lower-strength drinks and/or small container sizes. For example, white ciders vary in strength from 7.5% to 5% ABV and are sold in containers ranging from 2.5 litres to 500ml. Even a small drop in size and/or strength of drinks consumed can bring real benefits. Encouraging someone to buy their drink in 500ml rather than 2.5 litre increments may also slow their drinking as it introduces into the drinking process more decisions about whether to have another drink.

Practical and environmental stability

Money

For many people, money management is a significant source of problems in their lives. This may be because, for example, they are not accessing the right benefits. However, in many cases, their very access to money may be a cause of considerable problems.

- They may be receiving money on a monthly or fortnightly basis which is leading to a binge pattern of drinking followed by a period in which they struggle to buy alcohol but also, consequently, food and other necessities. This pattern may also risk repeated lapse into withdrawals and a consequent risk of cognitive damage.
- They may receive a particularly large sum of money from delayed benefits, an inheritance or other source, which promotes chaotic drinking.
- Most worryingly, poorly managed money makes them a target for exploitation by drug dealers, associates and even friends or family.

Many people will be much safer and potentially healthier if their money is well managed. This could involve:

- Sorting out the right to benefits and other income.
- Seeking an appointeeship to manage their money – this is a trustworthy adult who manages the benefits of someone who cannot manage their own affairs
- Using a *JamJar* account from a Credit Union – which controls access to money needed for bills.
- Asking their bank to place specific limits on how money is accessed e.g. daily limits, only in-branch withdrawals.
- Simply ensuring that they are not carrying their pin number around with them on scraps of paper or have it written on the back of the card, making them vulnerable to exploitation.

More information about welfare benefits for dependent drinkers can be found in our document *The Blue Light Approach: Improving accommodation options – Part Two*, on the Alcohol Change UK website here.

People engaged with Nottinghamshire's outreach team particularly appreciated work on their finances:

> **"They helped me with benefits and housing to make me safe. If I had any letters, they would sort them out and help me to sort them out. They are always available to offer help."** [94]

> **"The team is helping me with a welfare benefit claims. They are taking me to a place where we can get help and look at my welfare rights."** [95]

Creating structure

This group are likely to have little structured activity in their life. Without a job or a family, a key challenge will be filling time.

Simple boredom is likely to encourage and facilitate drinking. Therefore, an important task will be to find ways for people to fill time. This may range from the worker spending time with someone, through to developing a programme of activities involving attending day centres or therapeutic groups.

In interviewing people engaged with the Nottinghamshire outreach service, one of the things that they particularly liked was just going out and undertaking practical activities together.

One of the benefits of an outreach approach is that it can offer sufficient time for such activities:

> **"We go out for a coffee or something like that." [96]**

> **"They encourage me to get out more. I can't do big physical things; but I can go to the library. I try and get out; when you are on your own a small acorn can grow into a big forest in 10 minutes. I have lost lots of friends recently but I can handle it now." [97]**

> **"They concentrated on practical things. I had a stroke and my memory was poor so they helped me with practical things. They got me out of the house." [98]**

> **"If I had any letters, they would sort them out and help me to sort them out. They are always available to offer help." [99]**

Examples of practical activities have included cleaning cupboards together, manicuring someone's nails or going shopping.

Setting small targets

A key principle is not setting a person up to fail with overly ambitious goals. A focus on small goals will not only improve health or well-being, but it will also build self-belief and motivation. This can apply to both alcohol targets or more practical targets.

On the alcohol side small unit reductions – even one or two units can be positive. Obviously much larger reductions run the risk of precipitating withdrawals. If someone will not reduce unit consumption; think about Blood Alcohol Concentration. Are there ways in which people can lower the impact that their regular consumption of alcohol is having? For example:

- Eating more
- Staying hydrated
- Gaining weight if they are underweight

Other small targets can be set, such as:

- Taking a walk to take a look at where the alcohol service is located (without necessarily entering the premises on the first occasion)
- Agreeing to text a family member this week

Having an engagement plan

Government guidance has recommended that anyone deemed at risk of disengaging from alcohol treatment should have an engagement plan included in the overall care plan.[100]

This could identify what will help the person engage and stay engaged with the service. In particular, it could include contingency plans stating what will happen if they disengage or lapse. This should cover:

- Potential triggers and risk situations for lapse or disengagement
- What the person should do if faced with a risk situation or if they lapse
- Clarifying what the agency should do following disengagement e.g. should they call, visit, contact a friend or relative

Planning for lapse: An interesting example of efforts to improve engagement comes from a Service in South London.

They asked all new referrals to write themselves a letter which was kept on file and sent if the person dropped out of treatment. The letter was encouraging the person him or herself to keep going or try again. Other services use a postcard.

Case study:

Ms S – Planning for persistence

Ms S was a 47-year-old woman who came to the attention of a hospital-based Alcohol Assertive Outreach Team due to frequent presentations and admissions.

Her hospital attendances were linked to heavy intoxication and expressions of suicidal ideation. On several occasions, she was reported missing from home, triggering intermittent police welfare checks.

She was eventually admitted with pancreatitis, which led to chronic pain and persistent vomiting. At this point, the outreach team took her on for active case management.

This involved regular home visits and focused relationship-building work aimed at exploring her readiness to address her alcohol use. Over time, this engagement led to a gradual, supported detoxification from alcohol.

Alongside this, she was supported to access psychological therapy, which began to help her process longstanding trauma, including a history of abuse.

Ms S is now abstinent from alcohol, continues to attend a drop-in service, and reports significantly improved relationships with her family.

A sample engagement plan

Identify what will help engage the person with the service	
Sample targets: ■ Keep an up-to-date appointment card. ■ Advise your family/friends when your appointments are so they can remind you. ■ Agree mutually suitable appointment times with your key-worker. ■ What has affected your attendance in the past?	
Do you want us to text or call you to remind you of appointments? Yes / No?	
What do you want us to do if you fail to attend an appointment e.g. phone you, text you, visit you?	

Harm reduction

Harm reduction techniques – a general checklist

The following table sets out a range of harm reduction techniques. The first six should be used as a bare minimum with all people with entrenched alcohol dependency that services find difficult to engage.

Have you encouraged these core techniques:	
Vitamin therapy to prevent alcohol-related dementia and other conditions?	
Drinking water alongside the alcohol? (Among other benefits hydration reduces the risk of liver damage).	
Eating (preferably nutritiously) while drinking? Monitoring weight may help with this.	
If they smoke, can they move to e-cigarettes or stop completely with nicotine replacement therapy?	
Having a home fire safety check?	
Having a physical health check?	

Other approaches to consider:

Medication:	
Are there dangerous drug combinations? Remember, the risks of death from a paracetamol overdose go up in someone with liver damage.	
Is alcohol reducing the effectiveness of any drugs?	
Are medications being taken as prescribed?	
Do they need dosette boxes for medication regimes?	
Do they need locked boxes for specific medications?	
Are they hoarding medication?	
Are other drugs over the counter, legal highs or illicit substances being used?	
Have they had a flu jab?	
Have they had a TB vaccination, Hep A and B vaccination?	
With people who have stopped, has there been a conversation with a doctor about the use of relapse prevention drugs such as acamprosate, antabuse, nalmefene and naltrexone?	

Has the family been educated about:	
The risks they may face?	
The impact of diet and vitamins?	

Diet:	
Is the person having a nutritious diet?	
Can the person change the type of alcohol consumed?	
Can they be encouraged to cook before drinking not the other way around?	
Do they need a nutritionist referral?	
Can their cooking skills be improved?	
Do people with peripheral neuropathy need an electric can opener?	

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

Fire safety:	
Do they have a smoke alarm fitted? Have they had a home safety check from the fire service?	
Should furniture be moved away from fires?	
Do they use gas?	
If smoking and drinking presents a fire risk, have they considered using a sand bucket as an ashtray? A bucket is harder to miss than a small ashtray balanced on the arm of a sofa.	
Are they cooking in dangerous ways e.g. deep-frying chips when intoxicated?	
Do their heating methods suggest a fire risk?	
Do poor mobility or conditions such as peripheral neuropathy (with consequent loss of sensation in the hands) increase the risks of preparing food, especially hot food.	
Do they put a timer on when they cook?	
Are they using broken plug sockets?	

Other practical hazards:	
Is drinking and driving an issue, (even mobility scooters or bicycles)?	
Do they have safety catches on high windows to prevent falls?	
Are they using any other machinery?	
Are there trip hazards in the house, e.g. holes in the carpet at the top of stairs?	
Are there any other environmental hazards such as an unstable television or simply the risks of general clutter?	
Does someone else hold keys to the property, so that they can access their home if they lose keys when drunk? Or would they benefit from a key chain or lanyard? Would they be better off with a deadlock rather than a Yale lock?	
Are there animals in the house?	
Would they benefit from using a timer when they run a bath in case they fall asleep?	
Do they fall asleep in the bath?	
Are they tampering with their electricity meter?	
Could a community response alarm help the person and stop 999 calls?	
Is a poor mattress or bed impairing sleep?	
Do toenails need clipping to protect against tripping?	

Abuse and exploitation:	
Are both alcohol and drugs safely stored if young people have access to the property? This is not simply about the person's own children. Grandchildren and other relatives may visit the house. In some areas, vulnerable individuals have been exploited by local young people who have stolen drink or drugs.	
Do cash and other valuables require a safe or other safe storage to avoid exploitation or theft?	
Are they using taxi drivers or other home delivery to access alcohol?	
Are they leaving security doors or windows open?	

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

Money:	
Have they considered taking less money when they go out?	
Have they considered not taking a bank card when they go out?	
Would an appointeeship help? (Someone is voluntarily appointed to receive benefits to help manage the flow of money)	
Make sure they don't have their pin number written on the back of their card or on pieces of paper in their pocket.	
Would they benefit from a JamJar account from a Credit Union which is designed to ensure key bills are paid?	

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

Support:	
Send daily text messages and other telehealth contact. *Evidence exists that simply keeping in regular text contact can help people maintain reductions in their drinking.*[101]	
Involve any members of the family in care planning	

Incentives to engagement:	
Offer food vouchers	
Offer alternative therapies e.g. acupuncture	
Is a behaviour contract possible?	

Monitor alcohol:	
Ask them to keep a drink diary	
Ask them to put empty bottles into a plastic bag, or a bag for each day, so that the number can be monitored. Bottle lids or ring pulls could be collected as an alternative	
Use breathalysers to monitor change	

Worker impact:	
Remember the importance of a positive attitude: promote self-belief. Change is possible!	
Consider the timing of sessions so that the person is more sober	
Use home visits instead of requiring an office visit	
Don't set unrealistic goals	
Be consistent and persistent	

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

Legal frameworks

Legal frameworks for managing dependent drinkers

At the end of the Blue Light pathway, even if all the approaches outlined above have been pursued, there will still be a group of dependent drinkers who are not moving forward.

Practitioners will, therefore, need to consider whether legal frameworks can be used to protect the individual or the wider community. This manual is not the place for a debate about the rights and wrongs of compelled treatment.

A number of powers do exist and Alcohol Change UK has published separate guidance on these:

How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales.

This explores the use of

- The Care Act 2014 (England) / The Social Services and Well-being (Wales) Act 2014 - some dependent drinkers may be being exploited or abused because of their drinking and lifestyle; others may be self-neglecting. Safeguarding powers in the Care Act may then become relevant.[101] https://www.legislation.gov.uk/anaw/2014/4/contents
- The Mental Capacity Act 2005 – this is certainly applicable to people with alcohol-related brain damage and may be applicable in a much wider range of circumstances.[103]
- The Mental Health Act 1983 and 2007 - if they also have a mental disorder (which can include, for example, alcohol related cognitive damage) or the suspicion exists that they have a mental disorder, the Act may come into play.[104 105]
- The Human Rights Act 1998 – it may be possible to build a case for action on the basis that someone's human rights are likely to be infringed (e.g. Article 2 - the right to life) if steps are not taken by appropriate agencies.[106]
- Civil Injunctions and Criminal Behaviour Orders (which replaced Anti-Social Behaviour Orders).[107] These powers provide the opportunity to impose *positive requirements* e.g. to receive *support and counselling* or attend *alcohol awareness classes*.[108] The Act also introduced other powers which may be useful in this context: the Community Trigger and the Closure Orders. Those interested should consult the statutory guidance mentioned above. Alcohol Change UK has also published a report which discusses these powers and their benefits in more detail.
- Alcohol Treatment Requirements (ATR) - i.e. a Probation Order with a Condition of Treatment.[109] It should be noted that these can be used to require both community and residential interventions.
- Respect Orders – at the time of writing these new orders are being proposed and will cover alcohol related anti-social behaviour; however they are yet to be clearly defined or piloted.

Using these powers may, in some cases be controversial. However, the Blue Light Approach has always argued that such action may be better than allowing people "to die with their rights on"[110]

Alcohol Change UK has also published a report, Learning from Tragedies which looks at the role of alcohol in Safeguarding Adult Reviews and provides more detail on the use of the Mental Capacity Act and the Mental Health Act with complex dependent drinkers – this is available here.

Environmental health powers

Some chronic drinkers live in unhealthy or verminous premises. Powers exist to deal with accommodation which poses a threat to public health and workers should be familiar with these.

- Public Health Act 1936 - Contains the principal powers to deal with filthy and verminous premises.[111]
- The Public Health Act 1961 - Section 36 Power to Require Vacation of Premises During Fumigation.[112]
- Housing Act 2004 - Allows the local authority to carry out risk assessment of any residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm.[113]
- Building Act 1984 Section 76 - Available to deal with any premises which are in such a state as to be prejudicial to health.[114]
- Prevention of Damage by Pests Act 1949 - Local authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice.[115]
- Fire and Rescue Services Act 2004 – This defines the circumstances under which a fire officer can enter premises and the powers they have on entry.[116]

Other frameworks

Other approaches might include:

- Conditional Cautioning – a custody sergeant can choose not to pursue a prosecution if a person attends a named service. If the person does not attend the prosecution can be taken up again.[117]
- Driver and Vehicle Licensing Agency contact – in some cases doctors are required to notify the DVLA that someone is physically impaired by chronic alcohol use and should therefore be banned from driving.[118]
- The risk of eviction or benefits sanctions may also be considered as forms of compulsion in this context.

The prison pathway

Many of these high-impact drinkers will spend short periods in prison. This should be an opportunity to intervene positively: offering a supervised detoxification, ensuring a health check and linking the person into services on discharge. Whether this happens will depend on the quality of the local system. Workers should ensure that prison is not a missed opportunity to engage someone.

The Blue Light Approach in Action:

Beryl's story: Using legal powers with compassion

Our unique team is made up of highly skilled social workers who apply a huge breadth of experience and theory to support some of Manchester's most severely disadvantaged, multi-excluded and traumatised people.

Practitioners work with this highly complex cohort who have been seen sleeping rough over an extended period of time. These people often refuse to come indoors or find it difficult to stay indoors.

"People do not choose to be entrenched rough sleepers. There is always a complex story behind the person. These people are living on the outskirts of society. They are constantly in survival mode, living hour by hour. They must consider how they will wash, eat, sleep, and manage their life on the streets – in that community. It is a highly intense and difficult way to live." **Team member.**

We embrace the blue light principles by ensuring we are relational and use the power of human connection and seeing the value in everyone, meeting people where they are at, without judgement. This could be not focusing on any current issues of problems, but having conversations from a place of companionate enquiry, professional curiosity, to find out what is important to the person. This is a 'slowly, slowly' approach, that looks to build epistemic trust, the catalyst for change. Often people we work with have experienced adverse childhood experiences and trauma, have difficulties with attachments, working with this takes time, tenacity, hope and sowing seeds for change over time!"

Beryl's story

Our experience with Beryl will show you how we can take our time with a Blue Light Approach and using legal powers within the Care Act, in our assessments, support planning and safeguarding, alongside the executive functioning wheel and relational social work, to enable people to have better outcomes and better lives.

Beryl had been known to our team for 10 years, as a lady with chronic and dependent alcohol addiction who said she did not want to work with services or receive help with her drinking.

Using the Blue Light Approach, we moved our focus from her alcohol addiction and homelessness, during the Everyone In initiative, and tried to understand 'why' she would behave in this way, the context in which her struggles appeared started to become unveiled.

I used the Care Act provision to override a refusal of assessment when someone is experiencing, or at risk of, abuse or neglect, and a team around the person approach, to gain an understanding of Beryl's life story.

Understanding the 'why'

Using the Blue Light Approach to get to know Beryl, we found out that Beryl had experienced adverse childhood experiences and significant trauma; she lost her baby in a car accident, she experienced a head injury and later witnessed her partner being murdered. Beryl drank all day, every day, because she was too scared to stop.

Beryl's behaviour became so distressing to herself and the wider public that we had to use police powers under section 136 of the Mental Health Act 1983 to take her to a place of safety and then placed her under section 2 of the MHA for a period of assessment. These decisions are not taken lightly, using the Alcohol Change UK document: 'How to use legal powers to safeguard highly vulnerable dependent drinkers' guided practice to ensure Beryl was moved through a legal framework that gave her back her dignity, choice and control and self-worth.

Following the section 2, Beryl was then moved through the legal framework of section 3 of the MHA and responded to treatment.

She states that this was the first time, in as long as she could remember, that her mind became safe and calm, enabling her to communicate in a way she wished to. It was during this time that she was diagnosed with ADHD, post-traumatic stress disorder and an acquired brain injury.

Whilst 'labels' may not always be helpful, Beryl had lived with hidden disabilities, with limited quality of life, believing that she was a moral failure for her alcohol dependency.

Being who you want to be

Beryl now lives in supported accommodation; she attends Alcohol Anonymous and supports other peers in their own recovery from addiction. Beryl states that, for the first time, she has the ability and capacity to be who she wants to be.

See more on Beryl here: Ellie Atkins: Episode 1 What you need to know, to end rough sleeping

Other positive techniques in practice

Since the Blue Light Approach was first developed, the authors have continued to identify a large number of techniques and interventions that appear to be good practice. These are unevaluated, but are included to encourage people to think more laterally.

- One worker printed information about alcohol on the back of information from the internet about something more interesting that the person actually wanted to read about.
- Going to the funeral of someone the services supported to show the value of the person and taking other people to the funeral to build engagement and motivation.
- Encouraging people living on the streets to wear bright clothing in case of collapse.
- A worker sitting with someone and doing her nails while talking.
- Catching people "doing things right" not "doing things wrong".
- Active talking - engaging someone while doing something else.
- Focusing on small issues to build up the relationship.
- Using a chronology to understand the person's needs, triggers, patterns etc.
- Learn from people what went wrong – why did they not return? Why did they drop out?
- Planning the journey to and from services.

Part 3

Sustaining change across systems

The strategies in Parts 1 and 2 focus on understanding individuals and taking effective action in day-to-day work. But sustaining progress with the Blue Light client group also depends on the systems around these individuals, and around us.

Without organisational backing, skilled leadership, and genuine cross-agency commitment, even the best frontline work can lose momentum or be undermined.

This section looks at what needs to be in place to ensure that progress is not just achieved, but maintained. From learning lessons after deaths or serious incidents, to embedding trauma-informed practice, to making sure staff are trained, supported, and recognised - these are the structures that hold the work together.

Sustaining change is about creating systems where consistent, coordinated, and compassionate responses are the norm, not the exception.

Learning lessons from deaths and other serious incidents

Several formal review processes exist to help agencies learn from deaths and serious incidents, each with a slightly different focus but the same overarching aim - to identify lessons and prevent future harm.

Drug and Alcohol Death Reviews (DADRs)

In September 2024, the Office for Health Improvement and Disparities (OHID) released updated guidance on conducting Drug and Alcohol Death Reviews (DADRs)[119]. These reviews are structured, multi-agency processes aimed at understanding the circumstances surrounding drug- and alcohol-related deaths and near-fatal overdoses. The primary goal is to identify systemic issues and implement changes to prevent future fatalities.

Key elements of the DADR process include:

- **Formation of Multi-Agency Panels:** Local partnerships are encouraged to establish panels comprising representatives from various sectors, such as public health, healthcare, social care, criminal justice, and voluntary services. This collaborative approach ensures a comprehensive understanding of each case.
- **Comprehensive Case Reviews:** Panels should examine all relevant information, including medical history, social circumstances, and service interactions, to identify factors contributing to the death or near-fatal incident.
- **Implementation of Preventative Measures:** Findings from DADRs should inform actionable changes across services to address identified gaps and prevent similar occurrences in the future.
- **Governance and Information Sharing:** Establishing clear terms of reference, governance structures, and protocols for information sharing is essential to the effectiveness of the review process.

By integrating DADRs into local strategies, partnerships can enhance their understanding of at-risk populations and develop targeted interventions to reduce drug and alcohol-related harms.

Safeguarding Adult Reviews / Adult Protection Reviews

Safeguarding Adult Reviews (SARs) and Adult Protection Reviews (APRs) are a requirement under the Care Act (2014) England and The Social Services and Well-being (Wales) Act 2014. Required under the Care Act 2014 when an adult with care and support needs dies or suffers serious harm, and there is concern about how agencies worked together. They take a broad safeguarding view, covering issues such as abuse, neglect, self-neglect, and system failings. Alcohol often appears as a contributing factor, even if it is not the direct cause of death.

Domestic Abuse Related Death Reviews (DARDRs)

Formerly known as *Domestic Homicide Reviews (DHRs)*, DARDRs examine deaths (including death by suicide) where domestic abuse was a factor. They review how agencies responded to domestic abuse concerns, identify missed opportunities for protection, and recommend actions to reduce the risk of similar tragedies.

For direct access to DARDR case examples, visit the Domestic Abuse Related Death Reviews Library on GOV.UK[121]

Why these reviews are relevant to the Blue Light client group

Although SARs and DARDRs have different criteria, both share key aims with DADRs:

- Focus on learning, not blame
- Examine how agencies worked together
- Highlight missed opportunities to intervene and protect
- Produce recommendations for change in policy, commissioning, and practice

The learning from SARs and DARDRs is often directly relevant to people with entrenched alcohol use, as alcohol can be central or contributory in both contexts. Systemic issues identified, such as poor information-sharing, lack of professional curiosity, or failure to recognise risk, often mirror the challenges practitioners face when supporting the Blue Light client group.

Staff training and support

Working with people with entrenched alcohol dependency that services find difficult to engage is uniquely challenging and uniquely rewarding.

Individuals often present with complex, chronic needs; they may be confrontational or deeply vulnerable, or both. Supporting them effectively requires a consistent, persistent, and non-judgemental approach.

This is why robust managerial, team, and peer support structures are essential. Regular supervision, reflective practice, and space to debrief help workers stay resilient, maintain empathy, and continue doing the difficult work of long-term engagement.

Equally, specialist training is critical. Supporting this group requires a skillset of:

- Strong interpersonal and motivational skills
- Knowledge of the physical effects of alcohol and its intersection with mental health
- Awareness of the specific risks, vulnerabilities, and safeguarding needs of this population
- Understanding of relevant legal frameworks and the tools available for managing complex situations

More information about specialist training to support people working with people who drink, including training in the Blue Light Approach, can be found at: alcoholchange.org.uk/help-and-support/training/for-practitioners

Celebrate and publicise success

Finally, it's important to share success stories across teams and agencies. While always respecting confidentiality and individual consent, highlighting positive outcomes helps build the belief that change is possible.

Celebrating progress reinforces motivation, promotes good practice, and keeps hope alive even in the most challenging cases.

Embedding change for the future

The Blue Light Approach reminds us that even in the most complex situations, change is possible – for individuals, for services, and for systems.

Every act of persistence, curiosity, and compassion makes a difference.

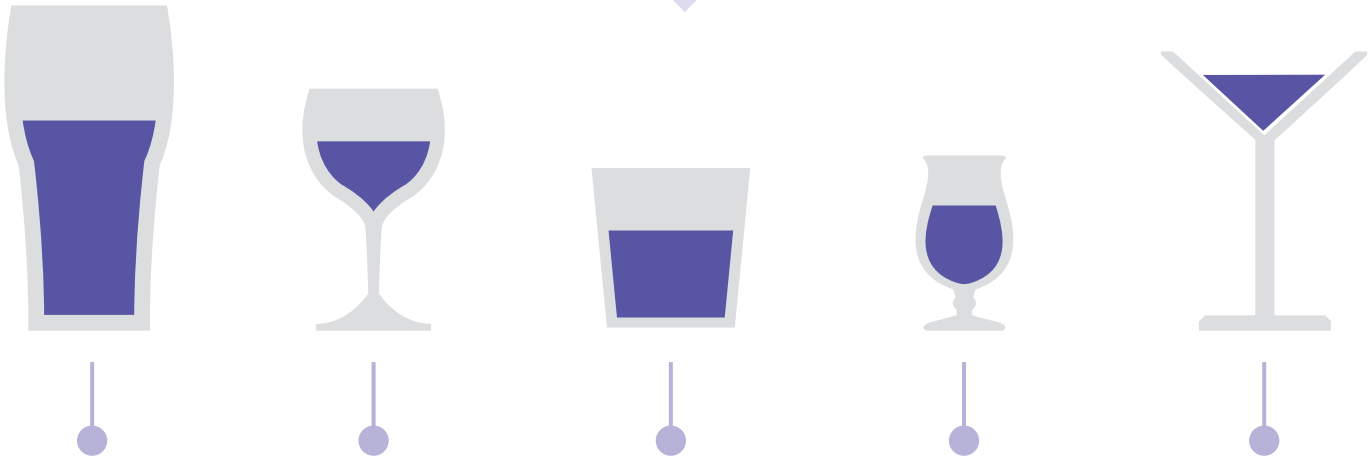
By working together across agencies, and by refusing to give up on those who have been written off, we not only reduce harm, we rebuild hope.

The challenge ahead is to make this approach business as usual:

a system that reaches everyone, not just those who shout the loudest or fall the furthest.

Appendix 1:
AUDIT Tool

These are **ONE** unit of alcohol...



Half a pint of regular beer, lager or cider

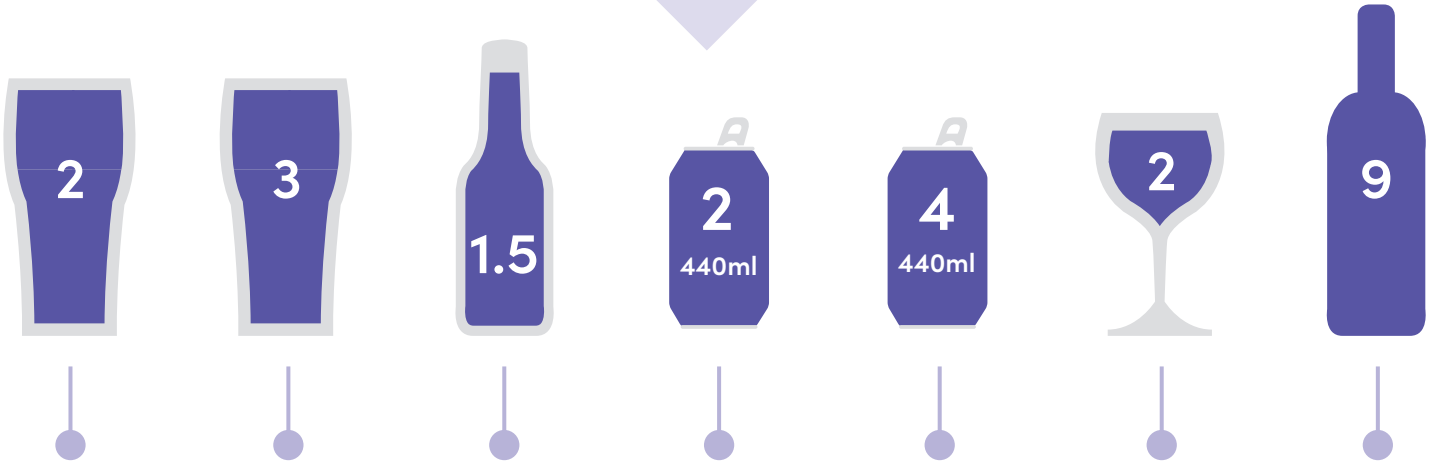
One small glass of wine

One single measure of spirits

One small glass of sherry

One single measure of aperitifs

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



Pint of regular beer, lager or cider

Pint of premium beer, lager or cider

Alcopop or can/ bottle of regular lager

Can of premium lager or strong beer

Can of super strength lager

Glass of wine (175 ml)

Bottle of wine

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

Scoring:

0 – 7 Lower risk,

8 – 15 Increasing risk,

16 – 19 Higher risk,

20+

Appendix 2:
Glossary of acronyms and key terms

ACEs – Adverse Childhood Experiences

Potentially traumatic events in childhood (e.g. abuse, neglect, household dysfunction) linked to poor adult health outcomes, including substance use

ARBD/ARBI – Alcohol-Related Brain Damage/Injury

Cognitive damage caused by prolonged alcohol use, often including conditions like Wernicke's encephalopathy and Korsakoff's syndrome.

AUDIT – Alcohol Use Disorders Identification Test

A 10-question screening tool developed by the WHO to assess levels of alcohol consumption, risk, and dependence.

Blue Light Approach

A harm reduction strategy for people who are alcohol dependent but not engaging with treatment, focusing on multi-agency collaboration and "doing things differently."

COPD – Chronic Obstructive Pulmonary Disease

A long-term lung condition often worsened by smoking and alcohol use.

DADRs – Drug and Alcohol Death Reviews

A multi-agency review process that examines the circumstances surrounding a drug- or alcohol-related death, aiming to identify missed opportunities, improve system responses, and reduce future harm.

FASD – Foetal Alcohol Spectrum Disorder

A group of conditions that can occur in individuals exposed to alcohol in the womb, affecting cognitive, behavioural, and physical development.

FibroScan

A non-invasive device that measures liver stiffness to detect fibrosis or cirrhosis, often used as a motivational tool in alcohol treatment.

FRA – Fire Risk Assessment

An evaluation of an individual's risk of fire-related harm, particularly relevant for individuals drinking heavily or smoking in unsafe environments.

IBA – Identification and Brief Advice

A structured intervention for hazardous or harmful drinkers, often used in healthcare settings to prompt reflection and support behaviour change.

LFT – Liver Function Test

A blood test measuring enzymes and proteins that indicate liver health; sometimes used to assess alcohol-related liver damage.

MHA – Mental Health Act (1983)

Legislation allowing for the assessment, treatment, and rights of individuals with mental health conditions, referenced in safeguarding case

MI – Motivational Interviewing

A counselling method designed to help people resolve ambivalence about behaviour change, especially useful in supporting alcohol-dependent individuals.

SADQ – Severity of Alcohol Dependence Questionnaire

A self-report tool used to measure the intensity of physical and psychological alcohol dependence.

SAR – Safeguarding Adult Review

A statutory review carried out when an adult with care and support needs dies or is seriously harmed, to learn from the case and improve future practice.

UCP – Urgent Care Plan

A documented plan to coordinate health and emergency care for individuals with complex needs, referenced in outreach support examples.

Appendix 3:

Acknowledgements

The original report thanked a large number of people, those thanks still stand especially to Carol Lyons (Wigan) who was the first person to support the initiative. Since then a large number of people have been involved and we would like to thank all of them, in particular:

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We also extend our thanks to everyone who shared their experiences of applying the Blue Light Approach in their local areas. These real-world insights bring the approach to life, and we are deeply appreciative of the time, openness, and commitment shown by all who contributed.

Appendix 4:

Markers of the impact on public services

Each area will require a definition or description of the individuals who will be targeted through Blue Light Approaches.

To make this definition usable it will be necessary to agree markers of service usage. In some settings this is straightforward: in hospital, admissions and attendances provide the marker. A measure such as three alcohol related admissions per year can be used as the indicator of repeated usage. However, in areas such as social care the marker is more complex.

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

Health	Marker	Indicative level at which the impact on services becomes significant, and eligibility for a Blue Light approach is recommended
Emergency Department	■ Attendances per year[i]	12 attendances per year[ii]
Hospital	■ Admissions per year. [iii]	3 or more admissions per year[iv]
Primary care	■ Appointments /call outs per year ■ PARR (Patient at Risk of Readmission) score ■ Number of agencies involved	12+ appointments per year[v]
Ambulance and Fire service	■ Call outs per month[vi]	10+ call outs per month[vii] [viii]

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

Domestic violence/MARAC		
Repeat abuse	■ Incidents per annum ■ Alcohol related MARAC clients	All clients who meet the first two elements of the definition and are high risk cases on the DASH risk assessment. [xii]

Social care		
Adult services	■ Level of risk plus either ■ Multiple referral or ■ Number of agencies involved[xiii]	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite[xiv]
Adults involved with Children and Families services	■ Level of risk plus either ■ Multiple referral or ■ Number of agencies involved[xv]	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite[xvi]
Housing and homelessness services	■ Failed tenancies ■ Excessive rent arrears ■ Repeated abuse of accommodation or ASB	■ 3 failed tenancies in 5 years[xvii] ■ 3+ complaints or referrals for ASB per year[xviii]

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

Street drinking		
Street drinking	■ The number of people street drinking in area[xxi]	All regular street drinkers[xxii]

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

[i] Marker used in most hospital alcohol liaison teams

[ii] Queens Medical Centre Nottingham

[iii] Public health outcomes framework

[iv] Research in hospitals in SW London and Wigan

[v] Research into GP practices in Wandsworth

[vi] Marker used in ambulance services

[vii] Information from West Midlands Ambulance Service

[viii] http://www.londonambulance.nhs.uk/health_professionals/caring_for_frequent_callers/patient_referral,_review_and_c.aspx

[ix] Ward M. – Review of alcohol related arrests in Wandsworth 2010 – NHS Wandsworth - 2011

[x] Discussion with London Probation Trust and other Probation Trusts in England

[xi] It is assumed that all alcohol related MAPPA clients fall into this category because of the risk involved and this definition includes all MAPPA clients except for those who are accused of child sex offences.

[xii] Discussions with Blue Light partners 2014

[xiii] Discussion with social services in NE England

[xiv] Discussions with Blue Light partners 2014

[xv] Discussion with social services in NE England

[xvi] Discussions with Blue Light partners 2014

[xvii] Discussions with Blue Light partners 2014

[xviii] Discussions with Blue Light partners 2014

[xix] Discussions with Blue Light partners 2014

[xx] Discussions with Blue Light partners 2014

[xxi] Models of Care for Alcohol Misuse - 2005

[xxii] Discussions with Blue Light partners 2014

References

1 Worker comment from Alcohol Change UK's 2018 report: The Hardest Hit

2 Rochdale Safer Communities Partnership, Domestic Homicide Review. Victim Male 1, Died August 2011. See: Section 6.3.3

3 Bristol Safeguarding Adults Board. Caroline. (2018).

4 Northumberland Safeguarding Adults Board: Leanne Patterson, Safeguarding Adults Review (2019)

5 Sunderland Safeguarding Adults Review (2011). Alan. Available at: https://www.sunderlandsab.org.uk/wp-content/uploads/2021/08/Alan-SAR-Summary-v4.docx

6 Alcoholics Anonymous, SMF-92 A.A. Preamble. Available at: http://www.aa.org/assets/en_US/smf-92_en.pdf

7 UK Public Accounts Committee (2023). Government not taking "appalling" harms from alcohol seriously enough. Available at: https://committees.parliament.uk/committee/127/public-accounts-committee/news/195391/government-not-taking-appalling-harms-from-alcohol-seriously-enough/

8 Bulletin of the World Health Organisation, Volume 82 Issue 11.

9 US Surgeon General, US Department of Health and Human Services (2016). Facing Addiction in America.

10 For example: Kohn et al (2004). WHO Bulletin 2004:82 858-868: "92% of drinkers are not engaged".

11 Joe (1998); Magura (1998) and Lang (2000) quoted in Ward M. (2002) Research into Engagement in Substance Misuse Services – DPAS.

12 Kessel and Walton (1969); Dean (1995) and Ravndal (1999) quoted in Ward M. (2002). Research into Engagement in Substance Misuse Services – DPAS.

13 Geelan (1998); Marsden J. (2000); O'Connell (1990); Hansen (1997); Dixon (1999) and Lang (2000) quoted in Ward M. (2002). Research into Engagement in Substance Misuse Services – DPAS.

14 Teeswide Adult Safeguarding Board (2017). Safeguarding Adult Review "Carol". Available at: https://nationalnetwork.org.uk/SCIE%20Library%202015-2018/17%20Teeswide%20Carol%20Overview%20report%20June%202017.pdf

15 North Tyneside and Northumberland Safeguarding Adults Board. Safeguarding Adults Review in Respect of Leanne Patterson. Available at: https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Care%20support%20for%20adults/safeguarding%20adults/Adult-U-Executive-Summary-report-PUBLISH.pdf

16 Increasing risk (or hazardous) drinkers (who are at an increasing risk of alcohol-related illness) are defined as:

- Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
- Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

Higher risk (or harmful) drinkers (who have a high risk of alcohol-related illness) are defined as:

- Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week
- Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

17 This scale estimate is based on figures from The Office for Health Improvement and Disparities (OHID) which estimates that there are 1.9 million higher risk drinkers in England, of whom 600,000 are dependent drinkers.

18 The original *Blue Light* project estimated a crude minimum average of just under 400 people falling into this client group in an average need local authority of 350,000 people. This group will cost this community at least £20 million per year. Both these figures are estimates and have been deliberately calculated using conservative costings. The basis for these two calculations is set out in appendices 2 and 3 of the original manual and the costs have been adjusted for inflation. Available at: https://alcoholchange.org.uk/publication/working-with-change-resistant-drinkers-the-blue-light-manual-first-edition

19 Miller W. and Rollnick S. (1991). Motivational Interviewing, Guilford Press.

20 Taken from a presentation by Professor Colin Drummond to South London Health Improvement Network, May 2014.

21 Ross et al (2004). An exploration of street drinking in Drumchapel, Scotland. Available at: https://academic.oup.com/her/article/20/3/314/854474

22 HM Inspectorate of Probation (2006). An Independent Review of a Serious Further Offence case: Anthony Rice. Available at: http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_06_probation.pdf

23 For example: McNeill, F., Farrall, S., Lightowler, C., and Maruna, S. (2012). How and why people stop offending: discovering desistance. Other. Institute for Research and Innovation in Social Services.

24 Wilson K. (2011). Alcohol-related brain damage in the 21st century, Br J Psychiatry. 2011 Sep;199(3):176-7.

25 Glenys Dore (2014) APSAD Conference Keynote presentation. Available at: http://www.youtube.com/watch?v=DA_3uou6nyQandindex=2andlist=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD

[26] US Surgeon General, US Department of Health and Human Services (2016). Facing Addiction in America.

[27] John Hopkins Medicine. Gastroenterology and Hepatology. More information here: https://www.hopkinsmedicine.org/health/conditions-and-diseases/pancreatitis

[28] British Liver Trust. More information here: http://www.britishlivertrust.org.uk/liver-information/living-with-liver-disease/looking-after-yourself/

[29] NCHPAD. Food and your mood: Nutrition and Mental Health. Available at: https://www.nchpad.org/resources/food-and-your-mood-nutrition-and-mental-health/

[30] British Liver Trust. More information here: http://www.britishlivertrust.org.uk/liver-information/living-with-liver-disease/looking-after-yourself/

[31] Royal College of Psychiatrists. Alcohol, mental health and the brain. More information here: https://www.rcpsych.ac.uk/healthadvice/problemsdisorders/alcoholdepression.aspx

[32] Case study from a Probation Officer in Northumberland as part of the Blue Light project, 2014.

[33] Damage to the unborn child due to the mother's drinking during pregnancy. It is associated with, for example, poor organisational ability and impulsive behaviour in adulthood.

[34] Teeswide Adult Safeguarding Board (2017). Safeguarding Adult Review "Carol". Available at: https://nationalnetwork.org.uk/SCIE%20Library%202015-2018/17%20Teeswide%20Carol%20Overview%20report%20June%202017.pdf

[35] Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[36] National Institute for Health and Care Excellence. NICE Guidance. Available at: https://www.nice.org.uk/guidance

[37] National Institute for Health and Care Excellence. NICE Guidance. Available at: https://www.nice.org.uk/guidance

[38] Royal College of Psychiatrists (2025). Co-occurring substance use and mental health disorders (CoSUM). Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr243---cosum.pdf

[39] Information from Alcohol Concern's consultancy projects 2001-2014.

[40] McQuire, C. et al. (2018). Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study. Preventive medicine.

[41] Information provided to Alcohol Change UK in the course of research into Foetal Alcohol Spectrum Disorder. Source not disclosed.

[42] SAMHSA (2013). Addressing Fetal Alcohol Spectrum Disorders, Treatment Improvement Protocol (TIP) #58.

[43] Bhatara V, Loudenberg R, Ellis R. (2006). Association of attention deficit hyperactivity disorder and gestational alcohol exposure: an exploratory study. J Attention Disord. 2006;9:515–522.

[44] Bharti Katbamna, PhD, CCC-A (2010). Fetal Alcohol Syndrome: Effects on the Auditory System. Available at: https://www.audiologyonline.com/articles/fetal-alcohol-syndrome-effects-on-845

[45] Lee, S. S., Humphreys, K. L., Flory, K., Liu, R., and Glass, K. (2011). Prospective association of childhood attention-deficit/hyperactivity disorder (ADHD) and substance use and abuse/dependence: a meta-analytic review. Clinical Psychology Review, 31(3), 328–341. Available at: https://doi.org/10.1016/j.cpr.2011.01.006

[46] NICE Public Health Guidance 24 (2010). Alcohol-use disorders: preventing harmful dinking. Available at: https://www.nice.org.uk/Guidance/PH24

[47] Babor et al., World Health Organisation (2001). Brief Intervention for Hazardous and Harmful Drinking. A Manual for Use in Primary Care.

[48] NICE Public Health Guidance 24 (2010). Alcohol-use disorders: preventing harmful dinking. Available at: https://www.nice.org.uk/Guidance/PH24

[49] Primary Healthcare European Project on Alcohol (2005). Are brief interventions effective in reducing hazardous and harmful alcohol consumption?

[50] Scottish Intercollegiate Guidelines Network (2013). The management of Harmful Drinking and Alcohol Dependence in Primary Care. Section 3 Brief Interventions for Hazardous and Harmful Drinking.

[51] Raistrick D., Heather N., Godfrey C. / National Treatment Agency (2006). Review of the Effectiveness of Treatment for Alcohol Problems.

[52] Kaner, E.F.S. et al. (2007). Effectiveness of brief alcohol interventions in primary care populations [Systematic Review]. Cochrane Database of Systematic Reviews (2).

[53] Department of Health data, based on unpublished analysis by Dr. Peter Anderson (former WHO advisor) of the Whitlock study.

[54] This is a key element of the brief advice approach. For example, NICE Public Health Guidance 24 (2010) Alcohol-use disorders: preventing harmful dinking. Available at: https://www.nice.org.uk/Guidance/PH24

[55] Miller W. and Rollnick S. (1992). Motivational Interviewing.

[56] Taken from:

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

[57] NICE Public Health Guidance 24 (2010). Alcohol-use disorders: preventing harmful dinking. Available at: https://www.nice.org.uk/Guidance/PH24

[58] NICE Public Health Guidance 24 (2010). Alcohol-use disorders: preventing harmful dinking. Available at: https://www.nice.org.uk/Guidance/PH24

[59] Department for Health and Social Care (2025). Clinical guidelines for alcohol treatment. Available at: https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment

[60] NICE clinical guideline 115 supports the use of "contingency management" with this client group.

[61] NICE (2007). Drug misuse in over 16s: psychosocial interventions. Available at: https://www.nice.org.uk/Guidance/CG51

[62] Home Office (2023) An in-depth review of fire-related fatalities and severe casualties in England, 2010/11 to 2018/19. Available at: https://www.gov.uk/government/publications/an-in-depth-review-of-fire-related-fatalities-and-severe-casualties-in-england-2010-to-201819/an-in-depth-review-of-fire-related-fatalities-and-severe-casualties-in-england-201011-to-201819

[63] Cabinet Office (2004). Alcohol Harm Reduction Strategy for England.

[64] For example, the Sainsbury Centre for Mental Health (1998), The Keys to Engagement.

[65] See for example 1992 edition, page 27.

[66] UK Government (2025). Clinical guidelines for alcohol treatment. Available at: https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment

[67] Alcohol Concern (2012). Evaluation of the Active Case Management (ACM) of patients with high alcohol-related readmission rates in Wigan. And Alcohol Concern (2015). An evaluation of The Nottinghamshire Alcohol-related Long Term Condition Team.

[68] Alcohol Change UK (2018). The Hardest Hit.

[69] Ward M. and Holmes M. / Alcohol Change UK (2020). Good Practice Guidance on Assertive Outreach.

[70] Miller W. and Rollnick S. (1992). Motivational Interviewing, page 27.

[71] Miller W. and Rollnick S. (1992). Motivational Interviewing.

[72] Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (1999). Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35. HHS Publication.

[73] Jason Coombs, Brick House Recovery TV.

[74] Anne S Henkel, Alan L Buchman (2006). Nutritional Support in Chronic Liver Disease - Nat Clin Pract Gastroenterol Hepatol. 2006;3(4):202-209.

[75] Steidl P. and Ferenci (1998). Journal of Clinicians in Liver Disease.

[76] Information on British Liver Trust website. Available at: https://britishlivertrust.org.uk/

[77] Office for National Statistics (2012). Drinking Habits Among Adults.

[78] Alcohol and tobacco (2007). Alcohol Alert Number 71, January 2007. Rockville, MD: National Institute of Health, National Institute on Alcohol Abuse and Alcoholism.

[79] Marshall E.J. et al (2010). The Treatment of Drinking Problems 5th edition.

[80] NHS. Can exercise offset some of the harms of regular drinking?

[81] The BMJ (2024). Effect of exercise for depression: systematic review and network meta-analysis of randomised controlled trials. Available at: https://www.bmj.com/content/384/bmj-2023-075847

[82] Sheron N. et al / University Hospital Southampton NHS Foundation Trust (2017). Detecting underlying health harms in heavy and dependent alcohol misuse: A Clinical Review of the "12 Questions Tool" for Public Health England.

[83] Sheron N, Moore M, Bricknell H, et al. (2012). Use of non-invasive biomarkers to identify hazardous drinkers in primary care: a cross-sectional study. *BMJ Open*. 2012;2(6):e001823.

[84] Health Innovation East Midlands, The Scarred Liver Project. Available at: https://healthinnovation-em.org.uk/our-work/previous-projects/1125-the-scarred-liver-project

[85] NICE clinical guideline 115 recommends encouraging families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.

[86] Porter K. (undated). Bristol Streetwise - street drinkers evaluation.

87 For example: Teeswide Adult Safeguarding Board (2017). Safeguarding Adult Review "Carol". Available at: https://nationalnetwork.org.uk/SCIE%20Library%202015-2018/17%20Teeswide%20Carol%20Overview%20report%20June%202017.pdf

88 Alcohol Concern (2015). An evaluation of The Nottinghamshire Alcohol-related Long Term Condition Team.

89 Available on request from Alcohol Change UK.

90 For example: Rochdale Safer Communities Partnership. Domestic Homicide Review - Victim Male 1 - Died August 2011, Section 6.3.3.

91 Groundswell (2023). Top tips for GPs to support people with multiple disadvantage. Available at: https://groundswell.org.uk/wpdm-package/top-tips-for-gps-to-support-people-with-multiple-disadvantage/

92 Interviews with staff from Suffolk County Council and Equinox in Brighton, 2014.

93 For example, see Money Helper: https://www.moneyhelper.org.uk/en/everyday-money/budgeting/managing-your-money-using-the-jam-jar-approach

94 Interviewee 6

95 Interviewee 4

96 Interviewee 7

97 Interviewee 6

98 Group interview

99 Interviewee 6

100 NTA care planning practice guide, 2006.

101 Lucht MJ, Hoffman L, Haug S, Meyer C, Pussehl D, Quellmalz A, Klauer T, Grabe HJ, Freyberger HJ, John U, Schomerus G / Department of Psychiatry and Psychotherapy, University of Greifswald at HELIOS Hanseklinikum Stralsund, Stralsund, Germany (2014). A Surveillance Tool Using Mobile Phone Short Message Service to Reduce Alcohol Consumption Among Alcohol-Dependent Patients. Copyright © 2014 by the Research Society on Alcoholism.

102 UK Government (2014). Care Act 2014. Available at: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

103 UK Government (2005). Mental Capacity Act 2005. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents

104 UK Government (1983). Mental Health Act 1983. Available at: http://www.legislation.gov.uk/ukpga/1983/20/contents

105 UK Government (2007). Mental Health Act 2007. Available at: http://www.legislation.gov.uk/ukpga/2007/12/contents

106 UK Government (1998). Human Rights Act 1998. Available at: https://www.legislation.gov.uk/ukpga/1998/42/contents

107 Home Office (2025). Anti-social Behaviour, Crime and Policing Act 2014: Anti-social behaviour powers Statutory guidance for frontline professionals. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332839/StatutoryGuidanceFrontline.pdf

108 As 107.

109 Jay Gormley and Melissa Hamilton / Sentencing Hub (2025). Alcohol Treatment Requirement (ATR). Available at: https://sentencinghub.sentencingacademy.org.uk/effectiveness-bulletin/alcohol-treatment-requirement/

110 Quote taken from YouTube video of 2014 APSAD Conference. Available at: http://www.youtube.com/watch?v=DA_3uou6nyQandindex=2andlist=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD

111 UK Government (1936). Public Health Act 1936. Available at: http://www.legislation.gov.uk/ukpga/Geo5and1Edw8/26/49/enacted

112 UK Government (1961). Public Health Act 1961. Available at: http://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents

113 UK Government (2004). Housing Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/34/contents

114 UK Government (1984). Building Act 1984. Available at: http://www.legislation.gov.uk/ukpga/1984/55

115 UK Government (1949). Prevention of Damage by Pests Act 1949. Available at: http://www.legislation.gov.uk/ukpga/Geo6/12-13-14/55/contents

116 UK Government (2004). Fire and Rescue Services Act 2004. Available at: https://www.legislation.gov.uk/ukpga/2004/21/contents

117 Office for Criminal Justice Reform. Revised code of practice for conditional cautions – Adults. Available at: https://assets.publishing.service.gov.uk/media/5a7ca762ed915d6969f4667e/9789999098144.pdf

118 Driver and Vehicle Licensing Authority (2025). Drug or alcohol misuse or dependence: assessing fitness to drive. Available at: https://www.gov.uk/guidance/drug-or-alcohol-misuse-or-dependence-assessing-fitness-to-drive

119 Office for Health Improvements and Disparities (2024). Preventing drug and alcohol deaths: partnership review process. Available at: https://www.gov.uk/government/publications/preventing-drug-and-alcohol-deaths-partnership-review-process

120 National Network of Adult Safeguarding. SAR National Library. Available at: https://nationalnetwork.org.uk/search.html

121 Home Office. Domestic Homicide Review Library. Available at: https://homicide-review.homeoffice.gov.uk/

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