Responses and referral.

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<H1> **Abstract**

This chapter is aimed at practitioners who may not have specialist knowledge of how to respond to people who have problems with alcohol, and identifies helpful responses and options for referral. The context of alcohol as a mainstay of many cultures is explored, along with the impact of this upon people who experience problems with alcohol, as well as practitioners who work with people experiencing such problems. Therapeutic principles are emphasised in terms of their paramount importance in providing a useful response. The assessment process is outlined, with discussion on options for appropriate referral. Finally, brief interventions are explored, providing a useful framework for practitioners to facilitate useful engagements even within a short space of time.

<H2> **Learning Outcomes**

- **To understand the impact of individual and societal attitudes towards alcohol, and how these may influence both people's relationship with alcohol and the care they receive**
- **To appreciate the importance of key therapeutic principles in providing useful responses for people experiencing problems with alcohol**
- **To understand the assessment process and options for appropriate referral**
- **To understand brief interventions and how they may help**

<H2> **Key Words**

Alcohol, Socialisation, Therapeutic relationships, Assessment, Referral, Brief Interventions

<H1> **Introduction**

This chapter explores the proper responses and referral process for people experiencing problems with alcohol. People may present to a variety of different services and professionals, many of whom may not be alcohol specialists. However, each presentation should be seen as an opportunity to engage, empathise and, if required, appropriately refer or signpost. We feel it important to firstly appreciate the oft confusing context which people may find themselves in, which may make it difficult to identify when alcohol use has become a problem. We begin with an honest monologue from stand-up comedy:

<Italics>

'That's what I hate about the war on drugs, I'll be honest with you, it's what I can't stand is all day long when we see those commercials: "Here's your brain, here's your brain on drugs". "Just say no." "Why do you think they call it dope?" And then the next commercial is: 'This Buds for you.' Come on everybody let's be hypocritical … It's OK to drink your drug. (laughs) We meant those other drugs. Those untaxed drugs. Those are the ones that are bad for ya. Nicotine, alcohol… good drugs. Coincidentally, taxed drugs. Oh, how does this… work?'

(1, p.37)

<end Italics>

It's hard to argue with the late Bill Hicks, as the comedian/philosopher emphasises the systematic hypocrisy which has seen some drugs demonised and criminalised, yet others normalised and incorporated into everyday life. Any person with alcohol problems living in many (particularly) Western societies may need to navigate their

way through a cultural acceptance of alcohol use, as a drug fitting any occasion, through celebrating the highs to commiserating the lows, and a mainstay of socialisation.

As alcohol is so socially acceptable, the pressure to drink has been felt by people across their lifespan, with pressure experienced as either overt and aggressive, or more subtle and friendly (2). However, despite a pressure to drink, there is also a stigma around drinking too much. People dependent on alcohol have been regarded as responsible for their own predicament, inviting negative emotions, social rejection and discrimination (3).

Although socialisation relying on alcohol may be changing, with innovations such as the world's first alcohol-free bar (4), change is slow. For the moment, the experience of many is contending with two messages; that abstinence is not socially acceptable, but that drinking too much is also not socially acceptable. As both ends of the spectrum can be stigmatised, it may be difficult for many to navigate through this swamp and find the line, the goldilocks zone, of 'just right' drinking.

Thinking about alcohol use and problems as a spectrum rather than in binary terms such as 'alcoholic' and 'social drinker' may be useful.

<begin KP 9.1>

<H1> **Key Point 9.1**

This may help professionals to see **people** rather than labels and avoid simplification, appreciating the complexity of human beings and their relationship with alcohol.

<end KP 9.1>

As authors, we ourselves are aware of the extent to which alcohol has been normalised, even glamorised in our culture. We write this acutely aware of the dangers of alcohol dependence, yet still in awe of the art of brewing, and the exquisite taste, of a good Belgian beer.

Many health and social care practitioners will enjoy using alcohol; it is essential that we are aware of how our own attitudes may influence our practice. Just as people may find it difficult to balance their own use of alcohol, our own perceptions and interactions with alcohol may influence what we define or understand as problem drinking. This may lead to missed opportunities for conversations about the use of alcohol, as we may overtly accept its use, or be worried about looking in the mirror at our own problems. Useful interactions always start with an acute self-awareness.

Attitudes play a significant role in how care is delivered and received. People experiencing problem alcohol use (as well as people experiencing problem drug use) are the most stigmatised group, within an already highly stigmatised group (people with mental disorders) (5, 6, 7, 8). An awareness of this stigma, and a checking-in about our own attitudes and beliefs may challenge any negative attitudes we bring into the room with us.

<begin RPE 9.1>

<H1> **Reflective Practice Exercise 9.1**

Thinking/reflection point:

- Consider your own relationship with and beliefs about alcohol.
- How might your own experiences impact on the care you deliver to others?

<end RPE 9.1>

<H1> **Important therapeutic principles**

Practitioners may be fearful and feel out of their depth in collaborating with people experiencing alcohol problems. At times they may feel that they lack the necessary skills and competence to be useful. However, whilst an appropriate referral can be incredibly important, knowing that there is specialist care on the other side of the referral should never allow any practitioner to overlook their own role in providing a therapeutic response.

One could furthermore argue, that without the following key therapeutic skills, any engagement, whether it be screening, assessment, or brief intervention, may not be as comprehensive or effective as it otherwise could be. We would strongly argue that one of the most important tasks of any practitioner, which could be considered an intervention, is creating a true connection, rapport and relationship. One is more likely to be useful to another through listening and hearing to understand a person's perspective, than ritualistically following any tick-box approach to assessing a person's human experience. The key skills and considerations briefly discussed below should be part of any therapeutic response (*See* Box 9.1).

<begin RPE 9.2>

<H1> **Reflective Practice Exercise 9.1**

Thinking/reflection point:

- If you were seeking help from someone, what kinds of things would be important to you?

<end RPE 9.2>

<begin Box 9.1>

<H1> **Box 9.1** (9,10,11,12):

- Trauma informed care
- Empathy
- Positive regard
- Congruence
- Mentalizing conversations

<end Box 9.1>

<H1> **Trauma informed care**

Trauma informed care encourages all practitioners to consider the life experiences and context which may link to the current difficulties of the people they are working with. Felitti et al.'s (13) now seminal study on adverse childhood experiences (ACEs) in the USA, argued that many public health problems may be personal solutions to the trauma people have experienced. Alcohol thus may be considered as something a person may use to self-medicate and manage their distress. Whilst people consume alcohol for many reasons and trauma is not an inevitability, it is important that any practitioner looks through the trauma lens and has the curiosity to consider it as a possibility.

It may be worth considering that if alcohol is a person's solution, what alternative solutions are available to them? Simply telling someone not to do something without offering an alternative, when it is being done for a purpose, is at best useless, and at worst patronising and punitive. Whilst we would not place an expectation that the problems will be resolved and alternative coping mechanisms will be discovered by the end of an interaction, it is at least an area worthy of exploration, provided it is explored with empathy.

<begin KP 9.2>

<H1> **Key Point 9.2**

Key principles of trauma informed practice are listed below (12):

- Being mindful that people who you work with may have experienced trauma and adversity
- Ensuring that the person feels safe
- Being mindful not to inadvertently retraumatise people, particularly through power dynamics which replicate earlier 'power over' relationships
- Being trustworthy and transparent
- Adopting a truly collaborative approach
- Empowering people and offering them as much choice and control as possible

<end KP 9.2>

<H1> **Core conditions**

Additionally, and crucially, Carl Rogers' (10,11) core conditions of the therapeutic relationship (empathy, congruence and unconditional positive regard - Box 9.2) are a

necessary platform for any therapeutic interaction and are as relevant now as when they were first discussed many years ago.

<begin Box 9.2>

<H1> **Box 9.2**

- **Empathy – an attempt to understand the perspectives and experiences of another through their frame of reference**
- **Congruence – The practitioner engaging as their genuine self and being open about their own experiences of the engagement, where this may be beneficial to the person**
- **Unconditional Positive Regard – Accepting and valuing a person's worth. Setting aside our own judgement regarding their thoughts, feelings and behaviours that may otherwise get in the way of providing care and support for the person**

<end Box 9.2>

The core conditions encourage us to imagine the experiences of the people we are working with, connect with their emotional experiences, stay out of judgement, and be genuine, walking the line between our professional and personal selves. If we remove any one of these conditions, we quickly lose our usefulness to other humans, being blind to their experiences and mental states, judging them, and being experienced as robotic or false. Whilst a reminder of these may feel patronising, they can be too easily forgotten.

<H1> **Mentalizing conversations**

Mentalization, defined as:

<quote>

…the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes' (9, p. 11), is a useful concept and frame for conversations. Mentalizing focuses on the mind rather than behaviour and understands what people do based on what they think and feel. This will allow conversations to move beyond drinking and alcohol use, to what the person is thinking and feeling.

Importantly, mentalizing encourages thoughts not only about ourselves, but also others around us. As one person reflects on their relationship; 'my ex-wife who I always thought, through my drunken years, hated my guts', later realised 'she didn't – she just wanted me to get back to living again' (14). It could be argued that encouraging mentalizing others, even in a brief interaction, could hugely benefit people's relationships. The more significant, caring and trusted others around anyone experiencing problems with alcohol, the better.

<H1> **Initial Assessment/Screening** (*See* Chapter 10)

Opportunistic alcohol screening should be an integral part of the care we provide. It may not be possible to screen everyone. However NICE (15) recommends that screening is particularly focused on people who have alcohol-related conditions… such as hypertension or liver disorders… and those who may be at an increased risk of harm from alcohol… such as people who often experience:

- accidents or minor traumas

- people at risk of domestic abuse
- people who self-harm
- people with relevant mental health problems e.g. anxiety, depression or other mood disorders.

'Screening' is the process of using a validated alcohol questionnaire such as the Alcohol Use Disorders Identification Test (AUDIT - 16) to identify people whose current contact with services is not about seeking help with an alcohol problem but who may require support around their alcohol use. Screening tools such as the AUDIT can be used to inform decisions about whether to offer a person a brief intervention (and, if so, what type) or whether to make a referral to specialist alcohol services. If time is limited, an abbreviated screening tool can be used ((such as AUDIT-C, AUDIT-PC, SASQ (severity of alcohol dependence questionnaire) or FAST (fast alcohol screening test), 17)). Screening tools should be appropriate to the setting, for instance, in an emergency department FAST or PAT may be most appropriate due to their brevity (17 – *See* Table 9.1).

INSERT TABLE 9.1 HERE – The Alcohol Use Disorder Identification Test: interview version (16)

Alcohol problems do not discriminate between demographics thus professionals should be aware when screening not to overlook potential issues based on societal expectations around gender, age, ethnicity, or social class. Any conversations between different social groups offers potential for misunderstanding therefore whilst these conversations around alcohol use should be navigated with cultural sensitivity,

they must not be avoided for fear of offending (*See* Chapter 3). The therapeutic principle of transparency allows an honesty in telling people your concerns, and also telling the person about your worries around 'getting it wrong.'

<begin KP 9.3>

<H1> **Key Point 9.3**

Whilst communication between humans is always complex, people usually respond well to honesty.

<end KP 9.3>

<H1> **Brief Interventions** (*See* Chapter 17)

The term 'brief intervention' refers to a session that aims to help a person to reduce or abstain from alcohol consumption. This can take the form of either a short session between a practitioner and a person experiencing an identified alcohol problem that consists of structured brief advice from the practitioner around the person's alcohol use. Or a longer session (called an extended brief intervention) that is based more on the principles of motivational interviewing (*See* Chapter 23). Both types of brief intervention can safely be carried out by non-alcohol specialists. For people aged 18+ years, NICE (15) recommends screening and structured brief advice as a first step. People who do not respond to this structured brief advice should then have an extended brief intervention.

A person who may be dependent on alcohol should not be offered simple brief advice. Instead, they should be referred to specialist alcohol services. If a person who may be dependent on alcohol is reluctant to accept a referral to specialist alcohol services,

then they should be offered an extended brief intervention. Offering an intervention is less likely to cause harm than failing to act when we have concerns, however if in doubt we should seek to contact relevant specialists to discuss.

<H1> **Brief advice**

Training in brief advice on alcohol should be available and accessible to people working in a range of settings and services, including healthcare services, social services, criminal justice services, further and higher education and other public services. Having identified, through screening, that a person is drinking a hazardous or harmful amount of alcohol a professional should immediately offer the person a session of structured brief advice. In exceptional circumstances where it is not possible to offer this session at once then an appointment for this should be offered as soon as possible after identification. A brief advice session should last 5-15 minutes in total and should use an evidence-based resource that is based on the FRAMES (18 – Box 9.3) principles.

<begin Box 9.3>

<H1> **Box 9.3**

<H2> **FRAMES**

- **Feedback** – The professional should provide the person with verbal feedback that is personally relevant to them and their situation. This should include information about the person's alcohol use and problems derived from the assessment or screening that has been carried out e.g. their score from the AUDIT screening tool. The feedback can also include information about personal risks due to the person's current pattern of alcohol use and more general information about

alcohol related risks and harms. If the person's current presentation is potentially linked to alcohol use, then it is also important to highlight this link.

<begin KP 9.4>

<H1> **Key Point 9.4**

Many people are unaware that their drinking is at a hazardous or harmful level and highlighting the risks related to this can be a powerful motivator for behaviour change.

<end KP 9.4>

- **Responsibility** – Empowering the person to acknowledge that they retain personal responsibility and control over their behaviours, decisions and consequences has been shown to play an important part in motivation for behaviour change and in reducing resistance to change in people with alcohol problems.

- **Advice** – People should be provided with advice about the risks and harms related to the continuation of their current pattern of alcohol use. It is often the case that people are unaware of the potential risks (health or otherwise) that their current pattern of drinking may pose. Providing advice that reducing or ceasing alcohol use will reduce the person's risk of future problems enhances the person's understanding of their personal risk and helps to provide them with reasons to consider changing their pattern of alcohol use. It is important to ensure that any advice that is provided is unambiguous and easy to understand.

- **Menu** – Professionals delivering brief interventions (*See* Chapter 17) should provide the person with a range of alternative strategies that they can use to help

change their alcohol behaviours. Providing a range of options allows the person to exercise choice over which strategies may be most useful and suitable for them and reinforces the sense of personal responsibility and control that can be useful in strengthening their motivation for change.

Examples of alternative strategies include:

- Putting aside money that would usually be spent on alcohol to be spent on something else.
- Providing information on peer support or self-help resources that the person can access.
- Keeping an alcohol use diary.
- Alternating alcoholic drinks with soft drinks.
- Having regular alcohol-free days.
- Identifying other hobbies/interests to engage in that do not involve alcohol.
- Identifying personal high-risk situations and developing strategies for avoiding them.

- **Empathy** – A good therapeutic alliance is a strong predictor of reduced alcohol use at follow-up (19) and this cannot be achieved through the use of an authoritarian, directive, confrontational or coercive approach. Professionals must use an empathic, warm, understanding, reflective style to work collaboratively with the person to consider the risks, harms and reasons for change.

- **Self-efficacy** – It is important that professionals express hope and encourage people's confidence in their ability to make change happen in relation to their alcohol use. Working to elicit self-efficacious statements about changes in

alcohol use is a key component of brief interventions as people are likely to trust the things they hear themselves say. People who believe that they are likely to make changes are far more likely to succeed in doing so than people who feel powerless or helpless to make changes (19).

<end Box 9.3>

The word 'advice' in the name of the approach and in these principles could lead to an unhelpful interpretation of what is required by professionals. This could lead to professionals taking an authoritarian or paternalistic approach, however if there is a most important principle here it is empathy.

<begin KP 9.5>

<H1> **Key Point 9.5**

A person who does not feel listened to or understood by a professional is unlikely to place importance on the advice given by that professional.

<end KP 9.5>

During the session the professional should collaborate with the person to look at the potential harm caused by their drinking and explore reasons for changing this, including the potential health and well-being benefits. It is important to carefully and empathically explore potential barriers to change with the person and empower the person to generate strategies for overcoming these (addressing the self-efficacy principle (outlined in box 9.3)). The professional can outline practical strategies for reducing alcohol consumption, or better still, the person may be able to offer some strategies for this. The discussion should lead the person to set goals for the reduction of their alcohol consumption. It can be easy for the professional to forget the

importance of collaboration and set goals for the person. However, self-efficacy is of prime importance in health behaviour change so the professional must resist this 'righting reflex' and instead collaborate with the person, allowing the individual to set their own goals that are both meaningful and achievable for them.

Where the professional has an ongoing relationship with the person there should be regular discussion about the person's progress towards achieving their goals. Where necessary, the person can be offered an additional session of structured brief advice, or where the person does not seem to have benefited from brief advice an extended brief intervention should be offered.

<H1> **Extended brief interventions**

As with brief advice, training for extended brief interventions should be available and accessible to all professionals who may meet people who are at risk of harm from alcohol use. This type of session should be offered to people for whom structured brief advice has not proved useful. An extended brief intervention should last 20-30 minutes and should use motivational interviewing (19) or motivational-enhancement therapy, (20) to help a person reduce their alcohol use to low risk levels, reduce any risk-taking behaviour or to consider abstaining from alcohol use.

<begin KP 9.6>

<H1> **Key Point 9.6**

It is very important to collaborate with the person rather than telling them what they should do.

<end KP 9.6>

People who have received an extended brief intervention should be followed-up in order to monitor any progress and any need for further sessions or referral on to specialist alcohol services.

<H1> **Referral on to specialist alcohol services**

Professionals should not offer brief interventions to people who show signs of moderate or severe alcohol dependence (as indicated by a screening tool such as the AUDIT). People who show signs of severe alcohol-related impairment or people who have a related co-morbid condition, (for example liver disease or alcohol-related mental health problems). Instead, these people should be referred to specialist alcohol services at the earliest opportunity. Additionally, people who have not benefited from structured brief advice and an extended brief intervention should be referred to specialist alcohol services if they wish to receive further help.

<H1> **Service design and accessibility**

Ideally, services should provide a facility for people to self-refer in order that opportunities for seeking help are not missed through the, sometimes lengthy, process of referral to first appointment at the specialist service.

Unfortunately, there can be problems with service design that make it difficult for a person to access specialist help after a referral. Some services still operate on a 9am-5pm, Monday-Friday basis, which will exclude those who tend to be awake through the night and asleep through the day. Other areas have separate alcohol and drug services, and exclude people referred to alcohol services if they use any other drugs.

This can miss an opportunity to find out from the person, who should be at the centre of care, which service they might be most likely to engage with and why. Some find themselves in the ridiculous position of being excluded from specialist alcohol services due to issues with mental disorders (See Chapter 5) whilst at the same time being excluded from other mental health services due to their alcohol dependence. Whilst we accept that 'dual diagnosis' is a term recognised by health and social care services, we would argue that no diagnosis can ever comprehensively describe the difficulties and distress of any human being, and furthermore 'dual diagnosis' may encourage us to look at separate issues, rather than the person as a whole.

<H1> **Conclusion**

This chapter has explored ideas around the context of alcohol in our society, important principles when engaging with people experiencing alcohol problems, some key interventions, and considerations for service design. However, if we would like you to take one thing away from this chapter, it would be this… many people experience alcohol problems and overcome these. Whilst we always need to respond to people with empathy, moreover we need to do this with hope in our hearts.

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TABLES

Table 9.1 The Alcohol Use Disorders Identification Test (AUDIT): Interview Version.

AUDIT

The Alcohol Use Disorders Identification Test: Interview Version (16)

Read questions as written and record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by"alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never (skip to Questions 9 and10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	**6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7,8, or 9 (4) 10 or more	**7. How often during the last year have you had a feeling of guilt or remorse after drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0	**8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	**9. Have you or someone else been injured as a result of your drinking?** (0) No (2) Yes but not in the last year (4) Yes during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	**10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?** (0) No (2) Yes but not in the last year (4) Yes during the last year
	Record total of specific items here