ALCOHOL CHANGE UK

Alcohol assertive outreach: a handbook

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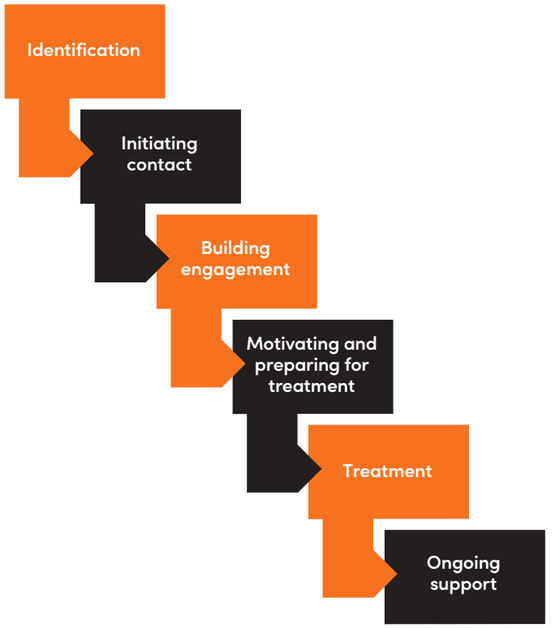
Bridging the gap

The gap between identification and treatment

Alcohol issues are rarely simple. They may arise from past trauma or current adversity. They may be linked to other physical and mental health issues, and to social and relationship difficulties. They may cause, co-occur with, or result from any of these other issues. All these complex needs demand appropriate support, but also create barriers to accessing that support, and it is not always reasonable to expect someone to show obvious motivation to change.

The experience of Alcohol Change UK's Blue Light approach has shown that if people need support but don't come into services, services may need to go out and find them through assertive outreach. That means making time to work with people in their own settings and build engagement with them through persistent and consistent interactions. This handbook is based on a recognition that identifying an alcohol problem does not always lead smoothly and naturally to treating it. In an ideal world, the path to treatment would look something like this:

The reality is more complex. Family members, for example, usually have no problem identifying an alcohol problem in a loved one. A doctor may refer that person for specialist help. They may still never access treatment. For many people needing treatment for alcohol issues, a more effective model of support would look something like this:



Alcohol assertive outreach is a method for moving positively, patiently and persistently with someone across the gap between identification and treatment, and beyond.

This handbook is about how you can implement it effectively in your local area.

What is alcohol assertive outreach?

Introducing alcohol assertive outreach

Many readers of this handbook will have a sense of what is meant by assertive outreach. However, it is hard to create a single definition. Many existing definitions have their foundations in work with street homeless people or people with mental health problems, and in particular the American Assertive Community Treatment model for working with people with severe mental illnesses. However, the focus and style of outreach work will vary between settings and populations.

Rather than try to define 'assertive outreach' in the field of alcohol, we have tried to outline the key features of an effective alcohol assertive outreach approach. As a starting point, we have drawn together and synthesised the features listed by three agencies with considerable experience in this field: the Maudsley Hospital's Assertive Community Treatment in Alcohol Dependence (ACTAD) programme[1], the American National Healthcare for the Homeless Council[2], and the Nottinghamshire Alcohol Long Term Conditions team[3].

Below is a synthesis of the common elements they identify:

- **Outreach:** Taking the service to the people who need it rather than waiting for them to come to the service. Many interactions will need to take place outside of traditional service settings.
- **Assertive:** Persistent and repeated attempts to contact people with an alcohol problem and to overcome barriers to engagement; often contact at least weekly, for a year.
- **Multi-disciplinary working:** An outreach service should always be part of a multi-pronged approach to meeting the needs of people. It cannot sit in isolation. It will need to link closely with mainstream alcohol treatment services, mental health services, housing services, and many other providers.
- **Holistic:** Understanding people's full range of needs, including health, social care, accommodation, meaningful activities, employment, and social contact.
- **Flexible:** Allowing for flexible and varied times when the service will engage with people, at times that suit them not the service, including allowing for unscheduled contacts.

- **Reliable and accessible:** Even if the people the service is engaging with are not always where they say they'll be, practitioners need to be. This is one important way that trust is built and relationships deepened.
- **Non-threatening:** Recognising that people may be suspicious of authority and of offers of help, and that who is engaging with them may be as important as how. For this reason, peer outreach can be particularly powerful.
- **Honest and open:** Practitioners should be explicit with people about their goals from each contact.
- **Responsive:** Listening properly to what people want and acting on this. This means particularly what matters to them right now and what "success" would look like for them in the future.
- **Human:** Successful outreach depends above all on building human relationships. The people a service is working with need to know that practitioners value them as human beings.

Who is alcohol assertive outreach for?

In theory, outreach can be used with many populations, but this handbook focuses on assertive outreach with people who have the most entrenched, long-standing alcohol problems and other serious unmet needs, and who may be considered vulnerable or at particular risk.

This group has the most to gain from assertive outreach and will often also currently be having the most significant negative impact on services, for example by being frequent attendees at hospital, making extensive use of the emergency services, and so on. Working with this group has huge potential to improve their lives while also significantly reducing demand on wider services.

About this handbook

What this handbook covers

This handbook does not aim to be the final or definitive word on assertive outreach with people with alcohol problems. Rather it aims to encourage the use of assertive outreach by highlighting good practice and lessons learned by those who are already using this approach. Our first aspiration is that, after reading this book, more people will have the confidence to try assertive outreach. Our second aspiration is that, in the future, better guidance supersedes this handbook.

This handbook is drawn almost entirely from the voices and experience of people involved in assertive outreach in the UK. It synthesises this evidence into a structured description of the outreach approach. It is not based on an academic evaluation or a randomised control trial of the interventions. It describes what workers have tried and found to be effective, thereby providing a framework for other practitioners and a starting point for future work and guidance. We would also strongly encourage more rigorous evaluations of alcohol assertive outreach as it is rolled out.

Our first aspiration is that, after reading this book, more people will have the confidence to try assertive outreach. Our second aspiration is that, in the future, better guidance supersedes this handbook.

Who this handbook is for

This handbook addresses alcohol assertive outreach at two levels:

- Good commissioning, including making a strategic case for assertive outreach.
- Good practice, covering techniques for delivering assertive outreach on the ground.

Its main audiences are:

- Practitioners undertaking, or wanting to undertake, alcohol assertive outreach.
- Managers of services undertaking, or intending to undertake, alcohol assertive outreach.
- Commissioners who are commissioning, or wanting to commission, outreach services.

Many elements of this handbook will be useful beyond a specialist audience, for example, to hospital alcohol liaison staff, housing services, police officers and community support officers, neighbourhood wardens and other community safety and wellbeing workers, as well as ambulance and fire service personnel.

Methodology and evidence base

In this guidance we have taken a very practical approach, listening to the voices of people who currently deliver and receive outreach services. Most of the content has been taken from 26 interviews with outreach workers and with people who have been supported, from Grampian to Southampton. Where the content does not include a reference to other sources, it has come from these interviews. We have included direct quotes from the interviews throughout the text, but many of the core ideas, whether or not presented as quotes, came from these interviews.

Secondly, the handbook is also informed by research and evaluations undertaken by Alcohol Change UK (under its previous name of Alcohol Concern):

- A review of the Wigan active case management team[4].
- A review of the Nottinghamshire Alcohol Long Term Conditions Team (LTC)[5].
- Separate research into the experience of the people who were supported by the Nottinghamshire Alcohol Long Term Conditions Team[6].
- Development of guidance on working with street drinkers on behalf of a national consortium of Police and Crime Commissioners[7].
- Reviews of hospital services in Stoke, Walsall, Rotherham and Warwickshire[8].

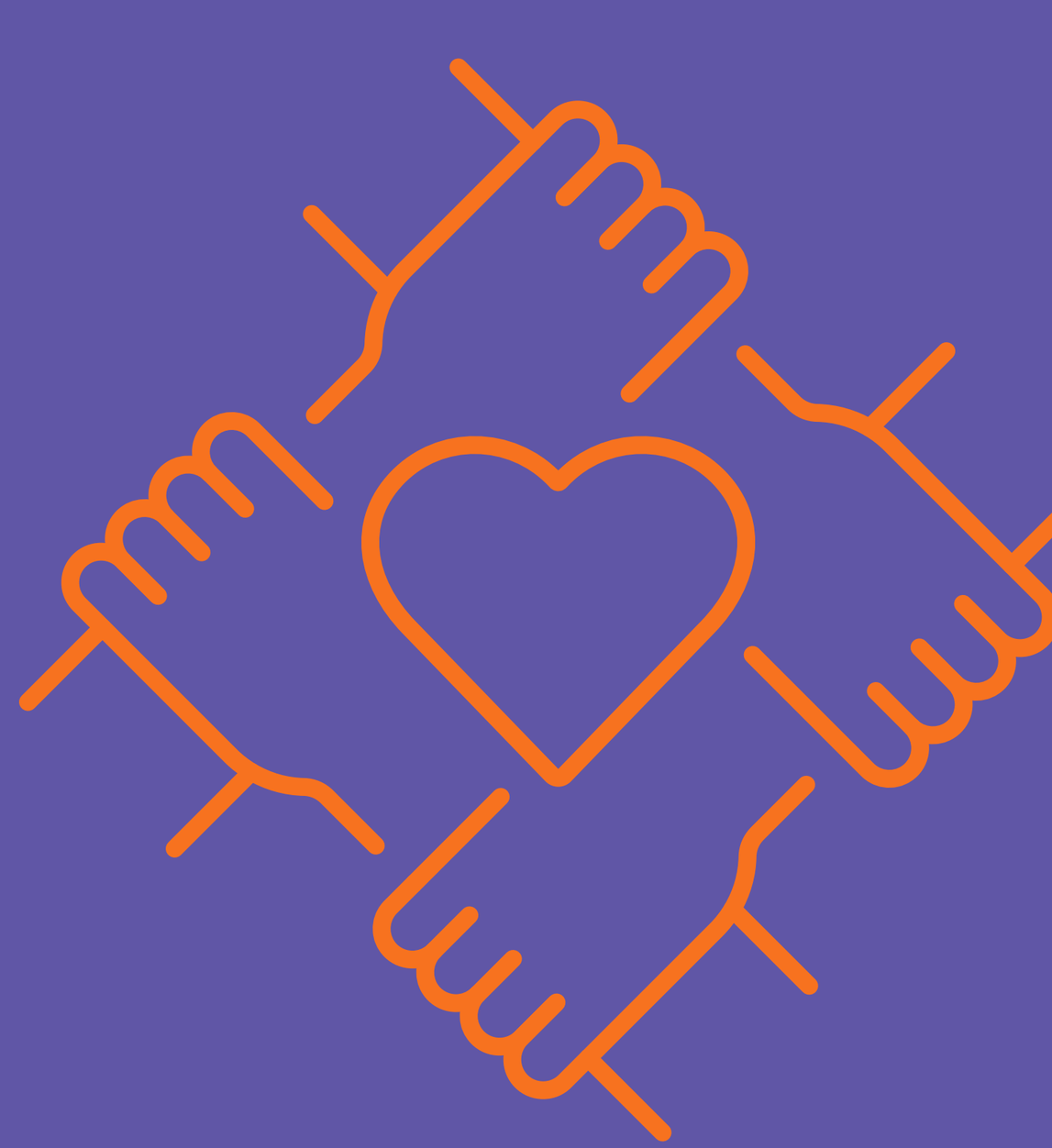
A third source of information is Alcohol Concern's original Blue Light Project[9]. In areas including Lincolnshire, Surrey, Medway, Worcestershire, London, and Cardiff, we developed the Blue Light approach as an award-winning response to the needs of the most vulnerable drinkers.

In this guidance we have taken a very practical approach, listening to the voices of people who currently deliver and receive outreach services.

Fourthly, Surrey Public Health and the local Catalyst drug and alcohol service have been at the forefront of developing outreach services in the UK. The experience of the local Catalyst High Impact (CHI) team has been very helpful and a significant source of expertise in developing this handbook.

Fifthly, Mike Ward and Mark Holmes, the authors of this handbook, have worked in, commissioned, and reviewed outreach services, and their personal experience has informed the overall synthesis of all this content and the production of this handbook.

Finally, the local authorities in Sandwell, Leeds, and Cardiff and the Vale of Glamorgan have generously provided financial support to the development of this handbook to convene local workshops that debated the details of outreach work.



Successful outreach depends above all on building human relationships. The people a service is working with need to know that practitioners value them as human beings.

Good commissioning

Making the case

If you are reading this handbook, you may already be convinced of the value of alcohol assertive outreach. However, you may be undecided; or you may need to convince others of its value. This section sets out the case for alcohol assertive outreach through five arguments:

1. Requiring visible motivation before offering support fails the most vulnerable people.
2. Alcohol treatment services are not equally accessible to everyone.
3. Not all drinkers who need alcohol treatment are ready to access it, and will need support to get to that point of readiness.
4. Despite appearances to the contrary, many people with alcohol problems do want to change.
5. Assertive outreach works: it reduces harms and costs.

Alcohol assertive outreach ends the discriminatory requirement for "visible motivation before support"

One of the most common phrases we hear when working with people who drink very heavily is, "If they don't want to change, there's nothing we can do". While this might sound reasonable, it is far from it. It puts too much onus on the person with the alcohol problem and fails to acknowledge that drinking itself contributes to their apparent lack of motivation.

It defines motivation as "engagement in alcohol treatment services", without looking at the barriers that are erected around such services. It is also rarely the case that the person does not want to change; it may just appear that way.

People who turn up for treatment in a structured and timely manner are likely to be those who are more robust physically and psychologically – people who can remember appointments and negotiate transport systems, who are physically mobile and have the degree of confidence and self-belief required to enter an unfamiliar environment and talk with professionals. They are, therefore, likely to be the least vulnerable.

Building an alcohol treatment system that requires demonstrations of motivation at the outset is one that is already set up to fail the most vulnerable, chaotic, risky and socially excluded.

Alcohol assertive outreach accepts that alcohol treatment services are not equally accessible to everyone

Not everyone has equal access to alcohol treatment services. Services are often set up in ways that exclude people. Multiple barriers exist (usually unintentional) which the most motivated people can overcome but which can be too much for those who are less motivated or less ready:

- Services are often based in a specific physical location. Limited finances and limited access to transport may make the journey to a treatment facility daunting to some.
- Physical health problems (often caused by alcohol) may limit people's mobility and ability to make their way to a treatment facility.
- Brain damage caused by long-term heavy drinking (sometimes coupled with head injuries from falls and fights) may have impaired their cognitive functioning, impulse control, organisation skills and motivation, making sticking to a particular appointment time on a particular date hugely challenging for some people.
- People with very poor personal hygiene, such as chronic diarrhoea, no access to shower or laundry facilities, and so on, are rarely ignorant of this. Indeed, they are often acutely aware of

their situation. Being asked to attend a building with other people is likely to cause embarrassment and unease.

- Meeting professionals (who are often seen as 'authority figures') can be extremely intimidating for people who may have had negative experiences of authority figures throughout their life: in school, in care, in prison, in medical services, and so on.
- Going into a professional setting further puts a person at a psychological disadvantage. They are somewhere unfamiliar to them, yet in a place where the professional they are meeting appears very comfortable. This reinforces the disproportionate power dynamic and exacerbates the sense of being intimidated.

Alcohol assertive outreach doesn't assume that everyone with an alcohol problem is ready to access treatment

There are many reasons that someone may not be ready to take up an offer of alcohol treatment services:

- Depression and/or anxiety, which may be worsened by their alcohol use and poor nutrition, can be a huge barrier.
- If they have used and been discharged from alcohol services in the past, they may be feeling very embarrassed or uneasy about re-engaging, for the fear of being seen to have "failed" the service or wasted the previous resources spent on them.
- They may be experiencing peer and/or family subversion: the people around them may be obstructing their route to recovery and seeking to keep them in their drinking life. Fellow heavy drinkers may be their main social network, and they may be reluctant to lose or alienate these friends.
- They may have very legitimate concerns about the effects of alcohol withdrawal.
- They may have low expectations, low self-esteem, a sense of low agency and low self-efficacy. They may believe that they don't have the ability to sustain any change or even that they don't deserve a better life.

Alcohol assertive outreach unlocks people's hidden desire to change

It is easy to assume that drinkers who fail to attend services are not interested in change: that they are "in denial". This view must be challenged. Behind that veneer of denial is usually a more ambivalent person. They may be uncertain about whether they can change. They may believe that their family history destines them to be a heavy drinker. They may be scared of what change entails. But that does not mean they don't want to change.

Research has shown that 40% of apparently non-changing higher-risk and dependent drinkers try to change their drinking habits every year[10]. Three separate studies of street drinkers have shown that between 40% and 70% of them report being unhappy with their current drinking levels and want to make positive changes[11, 12, 13]. With the right approaches, this latent desire to change can be harnessed.

> Without assertive outreach and ongoing support, dependent drinkers can bring significant costs for public services.

Alcohol assertive outreach works

One of the most powerful arguments for outreach is also the simplest: it works. It brings a substantial return on initial investment by reducing the demands on a range of services and reducing the harm that drinkers cause to themselves and others.

Without assertive outreach and ongoing support, dependent drinkers can bring significant costs for public services. Their drinking is likely to be linked to a range of other problems, which may include repeated hospital use, domestic abuse, other forms of violence or abuse, anti-social behaviour, financial and/or sexual exploitation[14]. They are some of most the vulnerable and costly individuals in any community; but evidence from services around the country shows that outreach to this group can substantially reduce this burden:

- Data from Wigan's Active Case Management Team, which works to engage frequent attenders in the hospital system, has shown a 52% reduction in hospital admissions for people who have received outreach[15].
- Salford Royal NHS Foundation Trust's hospital-led alcohol assertive outreach service has achieved a 59% reduction in Emergency Department attendances and a 66% reduction in average monthly hospital admissions among the 30 most frequent alcohol-related patients in the three months after intervention[16].
- Data published by the Home Office indicates that in Lincolnshire, after five months of operation, there was a 67% reduction in police incidents relating to people with alcohol problems targeted by outreach services[17].
- In Surrey, 69% of high impact drinkers targeted with outreach were subsequently engaged in services[18].
- In the first year of its operation in Sandwell, a multi-agency group actively identified 16 high-impact drinkers who had cost services more than £300,000 between them in the previous year. The group reduced these costs by around £150,000 and achieved a return on investment of over 400%[19].

The essentials of commissioning

Once there is local agreement to develop an outreach service, the next stage is for service commissioners and providers to agree on its design, structure, and operation. Commissioners vary in the degree of detail that they specify in contracts with providers. Some will describe the operation and management of a service in great depth; others will provide broader aims and outcomes, leaving the detailed design to the provider.

Whatever approach is taken, there are some issues that will always need to be considered. Here is a checklist of thirteen of the key issues:

1. What is the aim of the outreach team: to engage people in treatment, or to provide longer-term support?
2. Which people is the service targeting for help and how will they be reached?
3. Should outreach be based within existing local alcohol services or be a new standalone service?
4. How can multi-agency working be maximised?
5. Should the service use a team approach or an individual approach?
6. What size should the team be?
7. What skills/competencies and personal characteristics are required for staff?
8. How will staff receive appropriate supervision?
9. Are risk-assessment and risk-management arrangements robust?
10. Are appropriate protocols and policies in place?
11. How is assessment, care planning and other data collection undertaken?
12. Should the people who are supported be included on NDTMS returns?
13. What performance indicators and outcome measures should be used?

The following sections provide some suggestions on how to answer each of these questions, although the final form of any service will depend on local needs, preferences and circumstances. If your locality or service is looking for more support to develop its own service specification, Alcohol Change UK has developed a template which we can provide on request, and we would also be happy to provide bespoke advice.

What is the aim of the outreach team?

Scope

The first question to answer is whether the service will seek to engage people in treatment, or to provide longer-term support. Although it might seem strange to start with the endpoint, our experience is that this is exactly the right place to start. Different services will want to have different end goals, reflecting different local circumstances. For example, the focus may be on:

- Encouraging people into alcohol treatment.
- Reducing other harms, e.g. crime or homelessness.
- Being a long-term holistic support service to improve life chances and reduce costs to services, e.g. ambulance, police, housing, benefits.

Getting this clear right at the start is essential if the service is to succeed.

Timescale

Outreach services have limited resources and some boundaries will need to be set on how long they

work with people. The length of time contact continues is almost always dependent on the need of the person being supported and the aim of the service as defined above. In one service that we spoke with, the length of engagement was based on repeating 12-week blocks, but in most other areas the length of engagement was open-ended. An expected period of engagement of a year or more was common.

Given the importance of a trusting, persistent and consistent relationship, it could be argued that outreach workers should support people for as long as they need it. However:

- Outreach workers need to balance time spent with people currently being supported with the time needed to reach newly identified people.
- It is vital to prevent anyone becoming overly reliant on the outreach worker, thereby impeding their engagement with mainstream services and their progress to greater autonomy and control in their lives.

Who is the service trying to reach and how will it reach them?

Outreach services will not be able to reach everyone. We recommend focusing on the highest impact and most vulnerable people. While this can increase costs, it is likely to deliver so much more benefit, both financially and in human terms.

Each outreach service that contributed to this handbook focused in slightly different ways and reached people through different routes. We've summarised the range of approaches as follows.

- In Worcester, an outreach worker based within Swanswell worked with people prioritised by the local Blue Light multi-agency group, which manages support for high-impact drinkers[20].
- In Salford, the outreach service targets frequent hospital users and is therefore, based on hospital intelligence, largely via the alcohol liaison service in the local hospital.
- Merton's outreach team focused on people with alcohol problems within the caseload of the Community Multi-Agency Risk Assessment Conference (MARAC) which is responsible for safeguarding people at high risk of domestic abuse[21].
- In Surrey, the Catalyst High Impact (CHI) team takes referrals from local multi-agency risk management groups and from frequent attender services in the hospitals[22]. The team has a broader remit than some other outreach teams, in that it attends not just to people with alcohol problems but also to other individuals who are having a significant impact on the community.
- In Lincolnshire, the outreach team targeted the most prolific alcohol-related offenders, on the basis of police data[23].
- In Grampian, the local alcohol and drug service has outreach workers who follow up people who disengage from their service.
- Southampton and Tower Hamlets both have teams who work with people with alcohol problems in the context of street homeless populations. In Southampton the focus is on people who are known to the street homeless prevention team. In Tower Hamlets, people are reached using general local intelligence or by finding people through street work.

Services may also set more specific criteria for deciding whether to work with someone; based on local commissioning priorities. For example:

- Someone is known to be drinking problematically but is not engaged with community alcohol services.
- Someone who has had two alcohol-related hospital admissions in a month.
- Someone with an alcohol problem who is, or is at risk of being, street homeless.

> Different services will want to have different end goals, reflecting different local circumstances.

Based within existing local alcohol services or a new standalone service?

We have identified successful outreach services in a range of settings. These include standalone voluntary sector services (formerly in Lincolnshire), standalone teams within statutory NHS services (Nottinghamshire and Salford), and services that are integrated into pre-existing voluntary sector substance misuse services (Croydon, Wigan and Surrey). There is currently no firm evidence that any one approach is better than the others, and each appears to have advantages and disadvantages.

The advantages of undertaking outreach from within an established service include:

- Systems of staff support and supervision, and risk management will already be in place, and outreach workers may feel less isolated.
- Staff can be given a variety of work, sometimes in assertive outreach, sometimes in more standard alcohol treatment work, enabling them to develop more skills and protect themselves from burnout.
- The existing service will already have contacts and referral agreements with a range of other agencies, which a new standalone service may need to establish from scratch.
- When the people being supported by assertive outreach workers are ready to engage in alcohol treatment, they do not have to be passed on to a new agency that is unfamiliar to them.

The advantages of undertaking outreach as a standalone service include:

- Some existing services may have a negative reputation with people who have had difficulties with them in the past.
- Assertive outreach work is the sole focus, avoiding workers being drawn away from outreach work into more mainstream work.
- Alcohol assertive outreach workers can develop real specialism in their field and in-depth knowledge of the locality and the people they are working with.

How can multi-agency working be maximised?

Alcohol assertive outreach cannot work in isolation from other services, especially other local alcohol and drug services. It will require strong and continuous links with the police, community safety, mental health, other health services, adult social care, housing and homelessness services among many others. These links are needed in order to:

- Secure referrals
- Build a joint plan
- Undertake joint interventions
- Provide a route for onward referrals

Evidence from the roll-out of our Blue Light approach across the country, and from the development of the CHI outreach team in Surrey, suggests that assertive outreach works best when it is supported by a multi-agency group. Surrey's CHI assertive outreach team targets its work through district and borough level groups focused not just on people with alcohol problems, but all individuals who are having a significant impact on the community. In Worcester, the outreach work is directed by an alcohol-specific group.

> Alcohol assertive outreach cannot work in isolation from other services, especially other local alcohol and drug services.

Multi-agency working has a number of clear advantages:

- Ensuring information-sharing and reducing duplication of work, especially when multiple services have identified a person who needs support.
- Allowing the identification of unmet needs.
- Developing a consistent and co-ordinated action plan: one area called this a "tag team" approach with each agency reinforcing the same message.
- Supporting workers who may be becoming very negative about the possibility of change.
- Challenging poor practice by other agencies.
- It's cost-effective: in the first year of its operation in Sandwell, a Blue Light multi-agency group identified 16 high impact drinkers who had cost over £300,000 in the previous year. The group reduced costs by around £150,000 and achieved a return on investment of over 400%[24].

Should the service use a team approach or an individual approach?

In the 1990s, assertive outreach in mental health services was often built around a 'team approach' i.e. the people being supported did not have named workers and could be seen by anyone within a team. This, it was argued, allowed for more comprehensive and continuous care, with the people being supported benefitting from meeting a range of staff with different expertise, and not feeling abandoned if a worker was ill, on holiday, or moved roles. The person being supported also learnt to relate to a range of other people.

On the other hand, there is an advantage in someone building a long-term, trusting relationship with a single worker: one trusted adult who understands their situation in greater detail.

There is no clear evidence to date about which approach is better. Clearly, both have benefits. However, most of the teams we interviewed allocated a single named worker to each person. One manager commented: "I don't like workers swapping around a lot. I think you need to build up trust."

What size should the team be?

The smallest team we have looked at had one worker (Worcestershire). The largest had eight (Wigan). Local need is going to be a determining factor, especially the number of people that you want to support. It is recommended that each worker supports between 10 and 12 people. We would argue against a single lone worker unless, as in the case of Worcestershire, they are part of a robust wider support structure (in that case provided by an alcohol service).

What skills/competencies and personal characteristics are required?

The starting point for this role must be a person specification which reflects the specific challenges of assertive outreach to drinkers who are reluctant to engage. In our interviews with commissioners and providers, there was agreement that the role needs "can doers": people with initiative who can work remotely and have "get up and go". Whilst it is important to maintain a professional approach and have appropriate boundaries, a friendly personality is vital. Workers will need to present themselves in a friendly and open manner in order to encourage people they have never met to engage with them.

They will need to demonstrate:

- Empathy
- A good sense of humour
- A non-judgemental approach
- A person-centred approach
- Good communication skills, such as non-verbal communication and active listening skills
- Conflict resolution skills
- Motivational interviewing skills
- The ability to advocate for someone[25]

Given that assertive outreach takes place with vulnerable and challenging people in potentially risky settings, outreach staff will also benefit from knowledge of and experience in:

- Assessment, care-planning and risk-management
- Keeping accurate records
- How alcohol affects the body and brain (both short- and long-term) in order to recognise and address emerging alcohol-related health problems
- How improved nutrition supports recovery
- Safeguarding vulnerable adults
- Use of mental health legislation
- The boundaries of one-to-one working and maintaining personal safety

People working with chronic dependent drinkers regularly face challenging behaviour and verbal abuse. Staff should always be clear that such abuse is unacceptable but may sometimes need to be able to manage it when it happens, while still engaging with the person. Walking away the first time you're shouted at is not necessarily the right approach. Workers therefore need to be thick-skinned and personally resilient[26].

How will staff receive appropriate supervision?

Outreach work is stressful and workers will need regular peer support and management supervision. At the everyday level this will help ensure that:

- Resources are well-focused
- Workers are pursuing the most appropriate approaches, and
- Good communication occurs

A stressed outreach worker can become cynical and lose sight of the possibility of change in the people they are working with. A worker who is expressing negative views, beginning to avoid certain tasks, or is taking unnecessary risks, is someone who needs support. This is an occupational hazard and should be treated as such:

- Managers and colleagues need to be alert to this possibility and provide support and supportive challenge if someone is losing sight of the needs of the people they are working with.
- Workers need to be expected to practise self-care, e.g. turning phones off out of hours.
- Working in pairs can also help when an outreach worker is experiencing stress.

Outreach work presents practical managerial challenges. How do managers know what workers are doing and whether what they are doing is appropriate? While people in outreach roles need to be trusted, they also need to be accountable and to accept sensitive oversight of their work. Some possible approaches to this include:

- Regular supervision and debriefings.
- Outreach workers can be asked to phone their manager or another colleague to report on each outreach visit (or on certain specified visits).
- They can be asked to record their visits on an IT system their managers can access.
- Again, working in pairs can be of benefit, allowing any inappropriate practices to be spotted early.

> Outreach work is stressful and workers will need regular peer support and management supervision.

Are risk assessment and risk management arrangements robust?

Assertive outreach takes place with people who are vulnerable themselves and may also be a risk to others, and so good risk-assessment and risk-management are vital. We've listed below some potential risks vulnerable drinkers face:

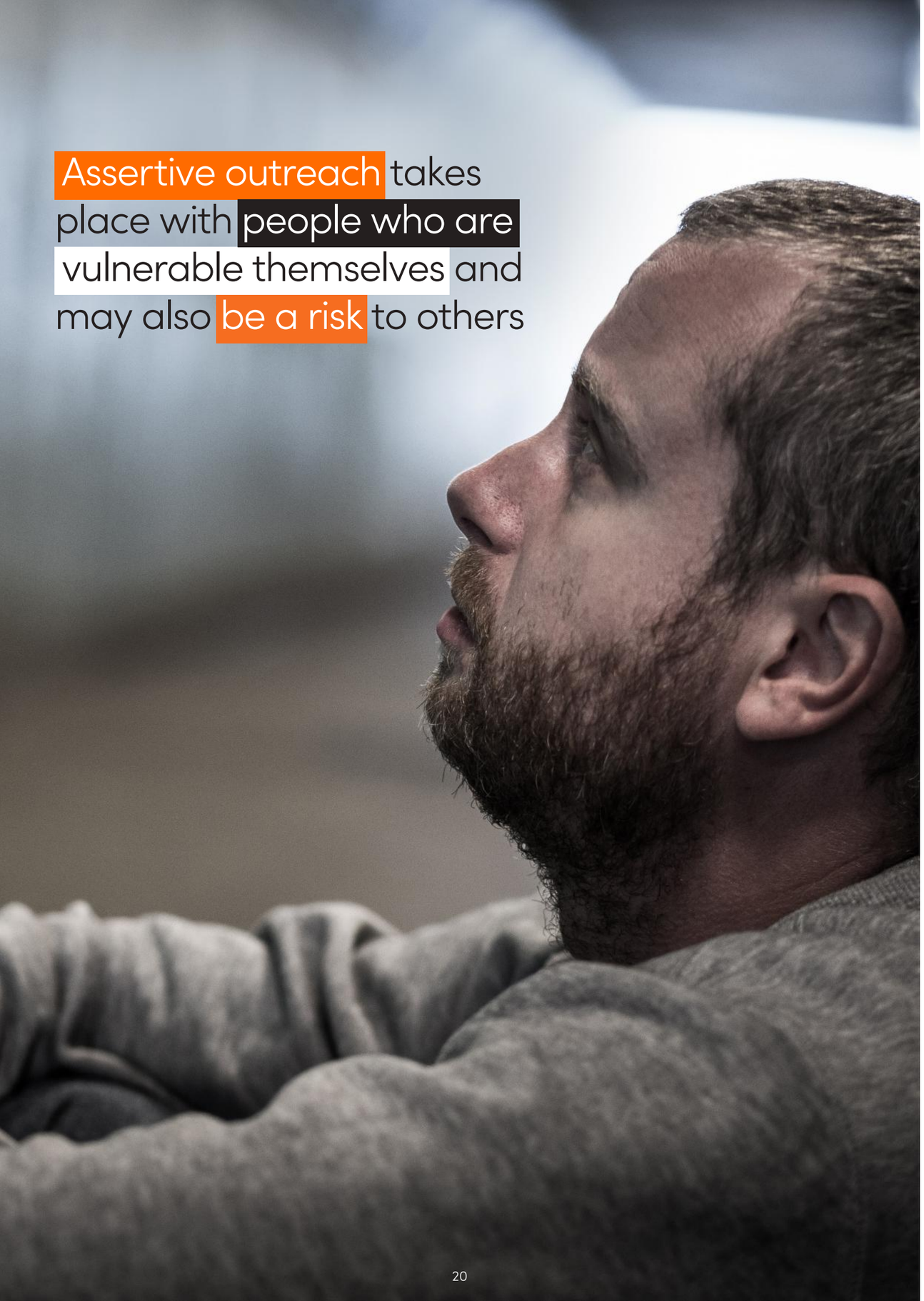
- Combined use of alcohol and illicit drugs
- Drug-related paraphernalia in the home
- Self-neglect, e.g. poor hygiene
- Disordered eating leading to malnutrition
- Self-harm and/or suicidal thoughts
- Animals in the home, who may be neglected and/or adding to hygiene problems
- Accidental fires, e.g. from cooking or smoking when intoxicated
- Being a victim and/or a perpetrator of crime – violent and/or acquisitive
- Poor money management, sometimes leading to reliance on predatory lenders
- Abuse or exploitation by family, so-called 'friends' (often other dependent drinkers), and/or neighbours. This abuse may be physical, emotional, financial (such as demanding money or alcohol when state benefits are received), and or/sexual
- Occupation of a vulnerable person's home as a location for buying and selling illicit drugs ('cuckooing') sustained by threats of violence
- Being a nuisance or violent to others

The Blue Light manual contains a risk assessment checklist that may be useful to remind outreach workers of things to look out for and include in their risk assessment and risk management work[27]. However, it is not a replacement for a proper risk assessment.

Outreach workers are at some risk themselves from the people they are working with and their family, friends and associates. This should not be overstated: dependent drinkers generally pose the greatest risk to themselves, rather than to others. Nonetheless, when working with people who are disinhibited or confused, there is some risk of physical and verbal abuse. Assertive outreach services need to pursue safe working practices, and these need to be set out in procedures that workers know well and can implement when needed.

Our interviews with staff highlighted a range of ways outreach workers seek to keep themselves safe, which we have summarised below. Not every service will want to adopt all of these measures, but they provide some useful pointers based on experience in the field:

- Find out what you can about the person you are meeting before meeting them, so as to better understand and manage any risks. Other workers may be able to advise you on their history, behaviour and sensitivities.
- Try to avoid making a first visit alone – go with other workers known to and trusted by the person you are visiting. After the first visit, you can make a decision about the possibility of visiting alone.
- After knocking on the door (or otherwise announcing your arrival), step back in order not to appear too threatening. When working in pairs, it may be a good idea for one worker to stand back from any conversations, so as not to be intimidating.
- Be aware of the risk from other people in the building where the person is. Ask the person to tell you who is currently there and whether any visitors are expected, and consider ending the session if the other people in the property pose a potential risk.
- Identify exits from any property. If the person is staying in a disused building where there is a risk of injury or becoming trapped, it may be appropriate to try to meet somewhere else. For example, one service arranges to meet people in a local GP surgery. You may be able to identify other neutral sites locally. But remember that part of the point of assertive outreach is to go to the places where the person is and feels comfortable.
- Outreach workers need to have mobile phones that are charged and ready with on-call numbers, and should tell the office when the appointment will end and to expect a phone call then. The phone should be on the worker and easy to get to, e.g. in a jacket not a bag, and it's worth checking the signal strength before entering a property. Some services agree an organisational code word to use in case the worker is trapped in a property. Some outreach workers carry a personal attack alarm to attract attention in a crisis.



- When undertaking outreach in risky street settings, CCTV operators can be asked to monitor the situation.
- Remember that some drinkers may feel unsafe and as a result may carry a weapon[28]. They may not intend or wish to use it, but if they are agitated or afraid they may injure themselves or others.
- If the person is too intoxicated to understand enough of what you are saying, it may be best to leave before the situation becomes too intense.
- On the most basic and intuitive level: trust your instincts. Workers commented, "If I get a bad feeling, I will not go in. I go with my gut"; "If someone tells you to f**k off, you go."

Be aware that the people you are working with may also be carrying infectious diseases, ranging from the common cold to tuberculosis, and may have open and/or untreated wounds. Workers need to take sensible precautions, including having the relevant vaccinations and carrying hand wipes and disinfectant liquids or sprays.

Are appropriate protocols and policies in place?

Any assertive outreach service will need to be supported by an appropriate range of protocols and policies covering:

- Outreach/street working/lone-working and/or working in people's homes
- Health and safety
- Management of violence
- Risk management
- Adult safeguarding and child protection
- Staff conduct

How is assessment, care planning and data collection undertaken?

Since it takes place 'in the field', outreach work makes completing assessment and care planning documents far more complicated. On the most practical level, there may be nowhere suitably private, quiet or clean to fill out forms or write notes. On a more personal level, it is essential for outreach workers to pay more attention to the person they are supporting than to their paperwork. Workers we interviewed described a range of techniques for managing information-gathering in these circumstances:

"We have a shorter assessment than other workers – five pages. It is a snapshot of what is going on for the person."

"We don't bombard them with questions. We observe. There is an alcohol and drug assessment, but we complete this subtly. I have a little notepad that I make notes on and do it over a period of weeks."

"We have a brief assessment form – name, date of birth, national insurance number, and where [they've been] sleeping for the last three months. We then do a risk assessment and offer an appointment for a proper assessment."

"We don't write case notes any more. We write actions and comments."

Clearly, there will always be a balance between completing the necessary administrative work (which may be required for audit and inspection purposes) and addressing the present needs of the person being supported. This will need to be resolved according to local policies and procedures. It is important to emphasise that form-filling can often take place immediately after an interaction, or voice notes captured immediately after, to be written up later.

It is worth emphasising that the people being supported genuinely appreciate the efforts of outreach services to minimise form-filling. The following comments are from people who used Nottinghamshire's outreach service:

"You never see paperwork. They are talking to you and only you."

"At the first session, the worker did not want to go into too much detail."

"[There was] a bit of paperwork but it didn't get in the way."

"The only paperwork was the care plan, which is not a lengthy document. That is different from other services."

Should people be included on National Drug Treatment Monitoring System returns?

The National Drug Treatment Monitoring System (NDTMS) is a comprehensive database of information on the presenting needs, treatment undertaken and outcomes for people with substance misuse issues in England[29]. Equivalent (although not exactly comparable) data is collected via Welsh National Database for Substance Misuse (WNDSM), the Scottish NHS Information Services Division, and the Information Analysis Directorate of the Northern Ireland Department of Health[30, 31, 32].

In general, the work of outreach services is regarded by services as 'pre-treatment' and therefore not for inclusion in returns to databases like the NDTMS. This is in part because, as noted previously, it is generally desirable to reduce the amount of information-gathering and record-keeping when doing assertive outreach. Nonetheless, this is a matter that needs to be decided locally, and arguments could be made that the intensity of the support relationship and the seriousness of the needs of the people you are working with suggest that alcohol outreach work is itself a form of treatment that should be recorded on the relevant national database.

> Outreach workers are at some risk themselves from the people they are working with and their family, friends and associates.

What performance indicators and outcome measures will be used?

Although outreach is a challenging task undertaken with people who often have high, multiple needs, the measurement of its impact is still very possible.

Broadly speaking, there are three types of impact.

First, there are 'engagement' impacts: changes in the way that the person being supported relates to outreach workers and to their situation, examples of which can include:

- Number of interactions with a worker
- Length of interactions
- Number of interactions with a worker that involve any mention of making a positive change
- Number of interactions that end positively; or that don't end negatively
- The worker's assessment of whether the person is pleased to see them and/or seems happy with the idea of them coming back
- The person being supported making a decision or commitment to a specific 'change action', e.g. seeing a GP about a particular issue, changing their friendship group

These engagement impacts are particularly important to monitor early on in the engagement process, as they can help workers to show progress, not least to themselves.

Second, there are impacts about individual wellbeing. These will consist of both intermediate well-being impacts (those one might hope to see after the first few weeks and months of support) and the longer-term impacts (that one might not see until over a year of working with the person):

Intermediate impacts

- Better diet or putting on weight
- More structured regular and undisturbed sleep
- Better hydration
- Moving from smoking to vaping
- Better money management
- Attending GP appointments
- Improved physical activity
- Shift in friendship groups away from heavy drinking friends
- Change in accommodation status, e.g. moving from street homelessness into accommodation, beginning to create a stable home for themselves

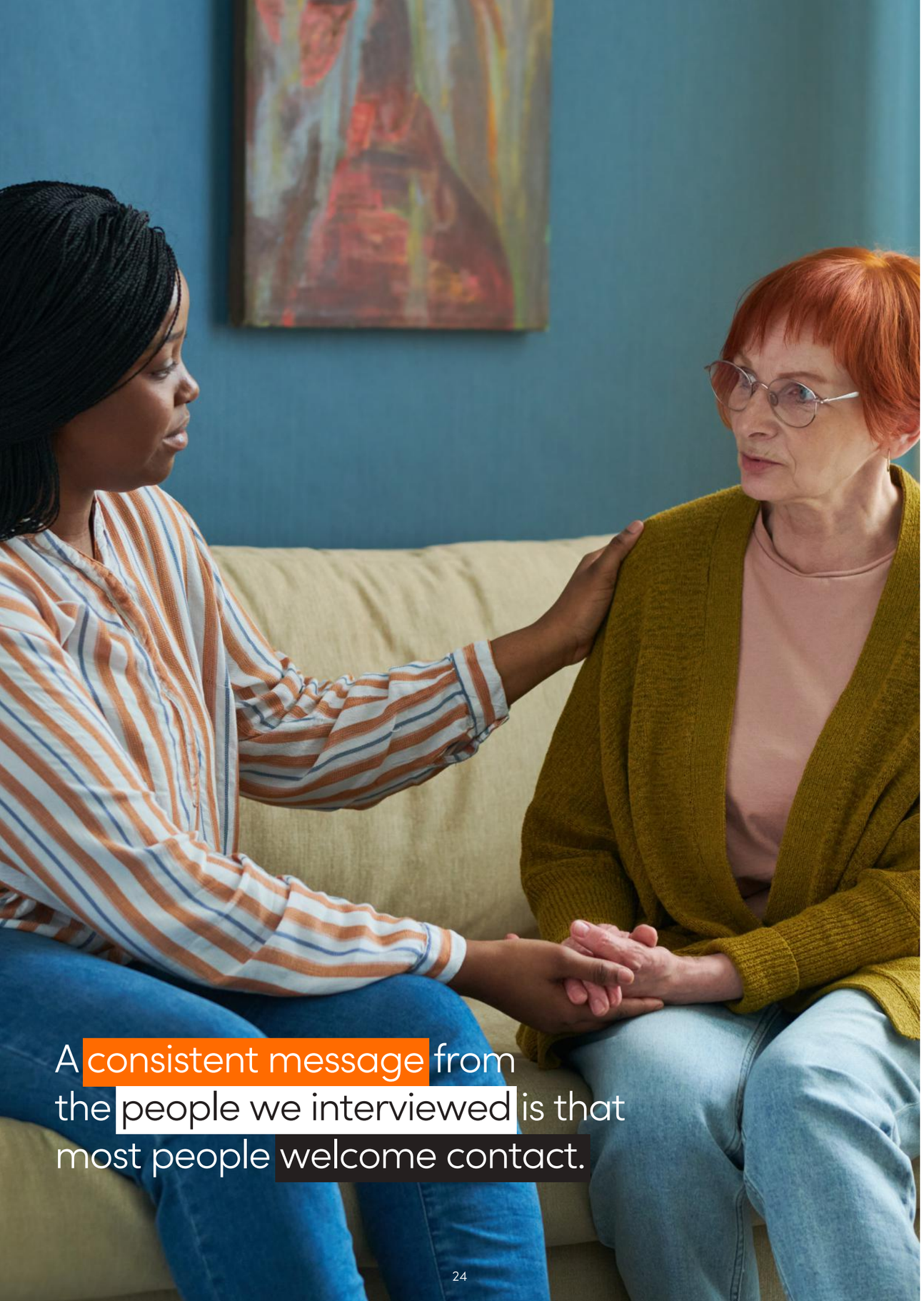
Longer-term impact

- Improved physical health
- Improvements in standard wellbeing measures, e.g. Personal Wellbeing Index
- Length of engagement with services
- Level of planned used of alcohol services and/or other healthcare services; in contrast to the unplanned episodic use of services made by chaotic drinkers

Third, there are 'service-level' impacts which are particularly relevant where the people being supported have been targeted because of the demands they are making on services and the impact they are having on their community. These can be quantified through evidence such as:

- Arrests and crime reports
- Reports of anti-social behaviour, e.g. by neighbours to police and/or the local authority
- Recorded periods of homelessness
- Incidents of street drinking and/or related disruptive behaviour
- A&E attendances and hospital admissions

Trends in this third group of measures can be monitored over time to quantify the impact of outreach and subsequent engagement with services. In many cases, these impacts can be costed, enabling the case for maintaining an assertive outreach programme to be made using the return on investment (ROI) approach[33].



Good practice

A framework for alcohol assertive outreach

In this section, we consider how alcohol assertive outreach can be made to work on the ground. We will provide a range of ideas about how to engage with people and motivate them.

An outreach worker's role can appear unstructured. Fixed appointments and desk-bound work are rare. The role can be very reactive: responding to opportunities and crises presented by the people they are working with. It requires a range of techniques and tools and its requirements change over time. One worker described it as "keeping all the plates in the air, while running"[34].

That said, however fluid the role seems, there is a broad pattern to it. From an analysis of the experiences of many outreach workers and the people they are working with, we have identified five broad phases of outreach.

We'll look at each of these phases in turn:

- Finding people ('identification')
- Initiating contact
- Building engagement
- Motivating the person forward and into treatment
- Ending the outreach relationship

These phases may not always follow each other in a neat or linear fashion: people who have been engaging may disappear from the radar and need to be found again; people who are moving forwards may disengage; motivation may subside; trust may have to be rebuilt. Nonetheless, it is worth keeping this five-phase framework in mind and using it as a way for managers and commissioners to track and analyse what is happening, and most importantly for outreach workers to manage the progress of the people they are working with.

Finding people

Finding people

Outreach starts with actively finding the people who need support. The nature of these efforts will vary across three types of outreach:

- Hospital-initiated outreach ('in-reach')
- Outreach to those with their own accommodation
- Outreach to street populations

Hospital-initiated outreach ('in-reach')

In some ways, this is the most straightforward form of outreach. The person to be supported is known to be at a specific location (and is usually there for an alcohol-related reason) for a certain period of time. They will be identified by the hospital alcohol care team, or by other clinical staff at the hospital, as likely to benefit from the support from an outreach worker. Ideally the hospital team will discuss the opportunity with the person and secure consent from them for an outreach worker to make contact.

The initial face-to-face contact can take place in the hospital, but this is not universal. In Salford, for example, the team's preferred option is a home visit or a community setting such as a GP clinic or community centre after discharge from hospital, as this appears to increase the chances of positive engagement and better outcomes. The outreach team usually sends a letter or telephones the person being supported to arrange to meet them somewhere other than the hospital. The Salford

team reports that few people refuse to see them, with engagement rates of 80%.

It is possible that this in-reach model could be applied within prisons and police cells. We are not aware of custodial settings being used as a consistent starting point for outreach but are keen to hear from teams that have developed or tried this approach.

Outreach to those with known accommodation

This is also a relatively straightforward method, since the person's location is known. The CHI team in Surrey, for example, usually receives the name and address of someone who could benefit from their support. Their next steps will then be one or more of the following:

- Phoning the person to arrange a visit and allay any anxieties about what is happening
- Undertaking an accompanied home visit with a professional who already knows the person being supported. Ideally, the person is notified of the visit beforehand, but this is not always possible and difficulties notifying the person are not taken as a reason not to visit
- Meeting the person at another service that they attend, such as a GP surgery or a day centre that they use
- Potentially meeting them on the street if they are also spending time in public places

> The workers we spoke to identified a range of techniques to find people who would benefit from support.

Outreach to street populations

Some people will require an active effort to find them on the streets or in other public settings. The workers we spoke to identified a range of techniques to find people who would benefit from support:

- Ensure referring agencies do all they can to identify the person's current location, whether that is a specific address or a place where they can often be found. Outreach workers may have to be assertive in obtaining this information from agencies.
- Ask for a photo of the person. This will be covered by the same information governance as other information about them.
- Walk around locations, such as a station, Job Centre, post office, pharmacy or a piece of waste ground that may be a known meeting point. Ask other agencies, such as the police and the local authority, about the places street drinkers gather. Go out with a police officer, PCSO, or neighbourhood warden who may have some idea where the person can be found.
- Other people using the service can be a source of information about a person's location. Caution does need to be exercised about this because there may be information governance issues. In particular, we must avoid revealing that a particular person is engaged with the outreach service if that information is not already known. At the same time, this does not deter us from inquiring after a particular person if all parties are well known to each other.
- Let other agencies know that the outreach service is looking for a particular person and wants to be notified if they encounter them. This may include local hospitals, police stations, housing offices etc.
- If you or others know what the person looks like, you may be able to find them using police or local authority CCTV cameras.
- Above all, be persistent in looking for the people you are trying to reach.

Some people will require an active effort to find them on the streets or in other public settings.

Initiating contact

"We walk out on the street, no pens and paper, and then say, 'Hello my name is X and this is who we are'. There are times we are rejected, but in the majority of cases they are happy to meet us and be listened to".

"It is very rare that people tell you to f**ck off."

"We don't realise how powerful the following question can be: 'How are you today?' And what about: 'Tell me more about that'."

Comments from outreach workers in Essex, Worcestershire and Croydon

Having found the person they are looking for, the outreach worker will need to initiate contact. This is usually more challenging in street settings. Someone in a hospital bed will expect, and often welcome, professionals talking to them. If the worker has arranged to see the person in their own home, they will be expecting a conversation. However, with people who are being approached for the first time in the street or in a day centre, workers will often be approaching them 'cold'.

> Being nervous about making initial contact is normal and does not make you unsuitable for outreach work.

Embracing contact

Some people have the ability to walk up to someone on the street and make contact, in the same way that some people are able to talk to a stranger on a train or at a party. Other outreach workers will find this very challenging. However, this can often be overcome by adopting some key techniques. Being nervous about making initial contact is normal and does not make you unsuitable for outreach work. A consistent message from the people we interviewed is that most people welcome contact. Most lone street drinkers will welcome conversation, and even groups of drinkers may welcome some variety in conversation.

A successful approach

The Framework Housing Association in the East Midlands has identified twelves elements of a successful outreach approach:

1. Introduce yourself by name.
2. Or ask another drinker in the group to introduce you.
3. Listen to what people say to you. Echo back to what they said (without parroting!). This assures them that you are listening.
4. Make sure you find out and use the person's name. Not "chuck", "mate" etc.
5. Body language says a massive amount about you – keep it open and friendly.
6. Carry yourself in an easy-going and confident manner, giving the impression that chatting to them is normal to you.
7. Do not stand over someone: always get yourself to their physical level.
8. Smile.
9. Have a sense of humour.
10. Don't promise anything that you cannot deliver.
11. Be honest.
12. Be persistent but be friendly.

Our interviews with outreach workers highlighted a number of helpful techniques for making initial contact easier:

- ☑ Start with the basics of human contact: shake hands, smile, give eye contact (without too much of this), give your name, ask their name and use it back to them, ask them how they are, make complimentary remarks, e.g. if they have a good coat or hat.
- ☑ Listen to them. Focus on building the relationship. Find out what they are interested in.
- ☑ Think about body language: touch appropriately (e.g. a handshake), smile, lean forward a little but without being intimidating. Sit or stand level with them, so you're not looking down at them. That may mean squatting or sitting on the pavement.
- ☑ Think about your appearance. Clothes that suggest wealth and/or status may not be well received: "Don't wear bling."
- ☑ Think about the time of day. Morning may be the best time to engage with street drinkers because they will often have only just started drinking and are likely to be less intoxicated. Over time, you'll work out the best times of day to contact particular people, depending on their habits and routines.
- ☑ Explain who you are and what your role is as clearly and simply as possible. It may help to take an ID badge to show who you are.
- ☑ Consider going out in pairs: this increases safety and may boost your confidence to approach people. It may help to go out on to the streets with someone who already knows the people you are supporting, e.g. a street homelessness service or a PCSO, who can make an introduction.
- ☑ Slowly introduce the idea that you can help. Ask if there is anything they want. Have something to offer them there and then such as a hot flask of soup, a breakfast bar, toiletries, socks and hats, water and high-factor sun cream in the summer.
- ☑ Don't flood them with information and don't default to conversations about alcohol and what they should be doing differently.
- ☑ Be clear that what you're offering is harm reduction: it's not your intention or your job to try and get them to stop drinking or to judge what they might see as their choices.
- ☑ Make them aware of places where they can get food and company, get washed and/or wash their clothes.
- ☑ Consider organising your own engagement event for vulnerable drinkers, at a neutral venue (such as a community centre or church hall) and offer free food and drink alongside stalls offering advice, support, health checks and flu jabs, haircuts, etc.
- ☑ Be persistent but be alert to signs that someone has had enough of the conversation. Someone may have a good reason for not wanting to talk at a particular time. For example: "If they are begging, you should realise that they are at work and conversation may not be welcome." If a person doesn't want to talk, be prepared to leave and come back another time. Tell them where they can find you at other times if they want to.

Don't be an authority figure!

The most significant potential obstacle to outreach is that drinkers may see outreach workers as representatives of authority and therefore as a potential threat. They may be concerned that you are arriving to move them on or to oblige them to do something. It's important to make clear early in the intervention, both with words and with demeanour, that this is not the case.

Building engagement

Once contact has been initiated, the role of an outreach worker is to build the relationship, to help people make positive changes in a range of areas, and then to think about moving towards alcohol treatment. That's what we'll look at next.

We recommend that you read this chapter in conjunction with our Blue Light handbook, which offers:

- A barriers-to-change checklist
- The 12 Questions Tool for identifying emerging alcohol-related physical harm
- A risk checklist specific to people with alcohol problems
- A harm-reduction checklist[35]

> Outreach workers' focus should be on the person they are seeking to support: on their needs, on the avoidable harms they are suffering; not moralising, judging them, or deciding things for them.

Possibly the key difference between assertive outreach and other approaches is that it is not initially about offering a particular intervention. Or to put this another way, in its early stages, the assertive outreach and the building of rapport and trust is the intervention. This recognises that the key to moving forward is a positive relationship between the person being supported and the outreach worker. As one worker told us, "Once you get a good rapport, things will move". When we interviewed people who had been supported through assertive outreach, they particularly valued their relationship with the workers:

> "It was about their personality: a friendly personality. It is someone you can turn to: a friend. Someone you can relate to and talk to. People respond by connecting to someone. You need to build a connection."
>
> "I was able to tell them everything and I really believed in their confidentiality. Everything feels easy. That is what is good: I trust her."
>
> "They are not friends, they are professionals, but they are nice people to be with".

Our interviews with workers identified ten general principles that help to build the relationship.

1. Meeting people in the places where they are
2. Spending time with people
3. Thinking about the best timing for any conversation
4. Listening to people and what they want
5. Not necessarily focusing on alcohol
6. Building trust through a focus on the ordinary
7. Being consistent: making and keeping commitments
8. Building peoples' confidence and self-belief
9. Being positive
10. Being persistent

The rest of this section explains these principles in a little more detail.

Meeting people in the places where they are

Assertive outreach requires meeting people in their homes, in community settings or on the street. In the interviews with people using outreach services, this was one of the things they appreciated most:

> "They came to the house. They asked what I wanted to do. I live up the road from the [River] Trent, and we would go for a walk and a coffee. It is about what you want to do. It is all so personal."
>
> "The beauty is that they come to you. That makes a big difference."
>
> "It does make a difference that they come to your house. I live alone. For some people it is really important not [to be] waiting outside an office for an appointment."

Another way to be in touch with people wherever they are is by phone. The people who were supported that we interviewed specifically mentioned the value of being able to contact the worker by phone:

> "The fact that I can ring and contact her when I need to, and the flexibility on when I am seen, is a real positive."
>
> "If you have a problem, you can ring them. It's nice to have the support. They are there at the end of the phone."

Offering support by phone or text can significantly add to workers' ability to stay in touch with the people they are supporting, as well as normalising contact and enabling workers to be in touch more frequently. They can send text messages, reminders of appointments, and encouragement, as well as Christmas, New Year and birthday greetings. One outreach worker made the following comments about the important role that mobile phones can play: "Phones can save huge amounts of staff resources in finding people, reminding them of appointments, and asking what else they need, so we can be prepared for an appointment or trip out." In Medway, the Blue Light group used a volunteer to regularly phone a very ill vulnerable drinker and build engagement with her.

To facilitate contact, some services buy affordable phones for the people they are working with. One should not assume that these phones will be carelessly treated, sold or bartered – many people will greatly appreciate the phone and will look after it. As one worker commented, "We input all the important numbers into the phone. The people love that they have been given a phone. Some people have not been given anything before". However, it may be wise to limit how many phones you will issue to one person, e.g. a maximum of three.

Spending time with people

Building positive engagement will take time and workers need to be prepared to take as long as is needed. Any expectation that things will move swiftly will simply set up the worker and the person being supported to fail. As one worker said, "It's the time...Key workers in other services don't have time." Another said, "Sometimes you have to take it slowly...They are often socially isolated and we may be the only people they see. It takes time for them to learn to socialise again and to trust us."

People using outreach services certainly value workers' ability to give them time:

"They used to come for a couple of hours at a time. I felt I mattered to them."

"They are not clock-watching."

"They don't rush you. They don't expect you to get better quickly. They are patient, which the doctors aren't. They understand you may relapse."

The frequency of contact will depend on the person's needs and wishes. Workers report that it can range from daily to weekly, and may change over time.

Thinking about the best timing for any conversation

It will be useful to work out the best times and days for a visit and perhaps develop a routine. There are a few of reasons for this:

- There may be some times of the day/week when the person being supported is doing particular things (such as meeting friends) and does not wish to miss that.
- There will usually be times when they are less likely to be intoxicated and so better able to engage.
- Knowing that a worker will be visiting at a particular time helps the person to realise that they have someone they can rely on; and developing a weekly routine may help create stability more generally in their life.

One worker told us, "I always try to do morning appointments. I used to tell one person I was working with that I would arrive after Jeremy Kyle". Another said, "I have a guy in accommodation who drinks and gambles. I work out when he will be sober and do more work then. For example, on Mondays he has usually run out of money".

Listening to people and what they want

An essential step in building the relationship is making a deliberate effort to listen to the person you are supporting. All lives are different and all alcohol problems are different. Each person will have a story, often one which will involve significant personal challenges, and if you take the time to hear what they have to say about themselves, your chances of being able to help reduce the harm they are experiencing will improve significantly. Many vulnerable drinkers are used to not being heard. The simple act of listening to them can make a big difference. Workers commented:

"We go and get involved with things they are already doing. [We] go to the places they go. The skill is empathy – listening, being non-judgemental, going to where they are. Sometimes you just have to listen."

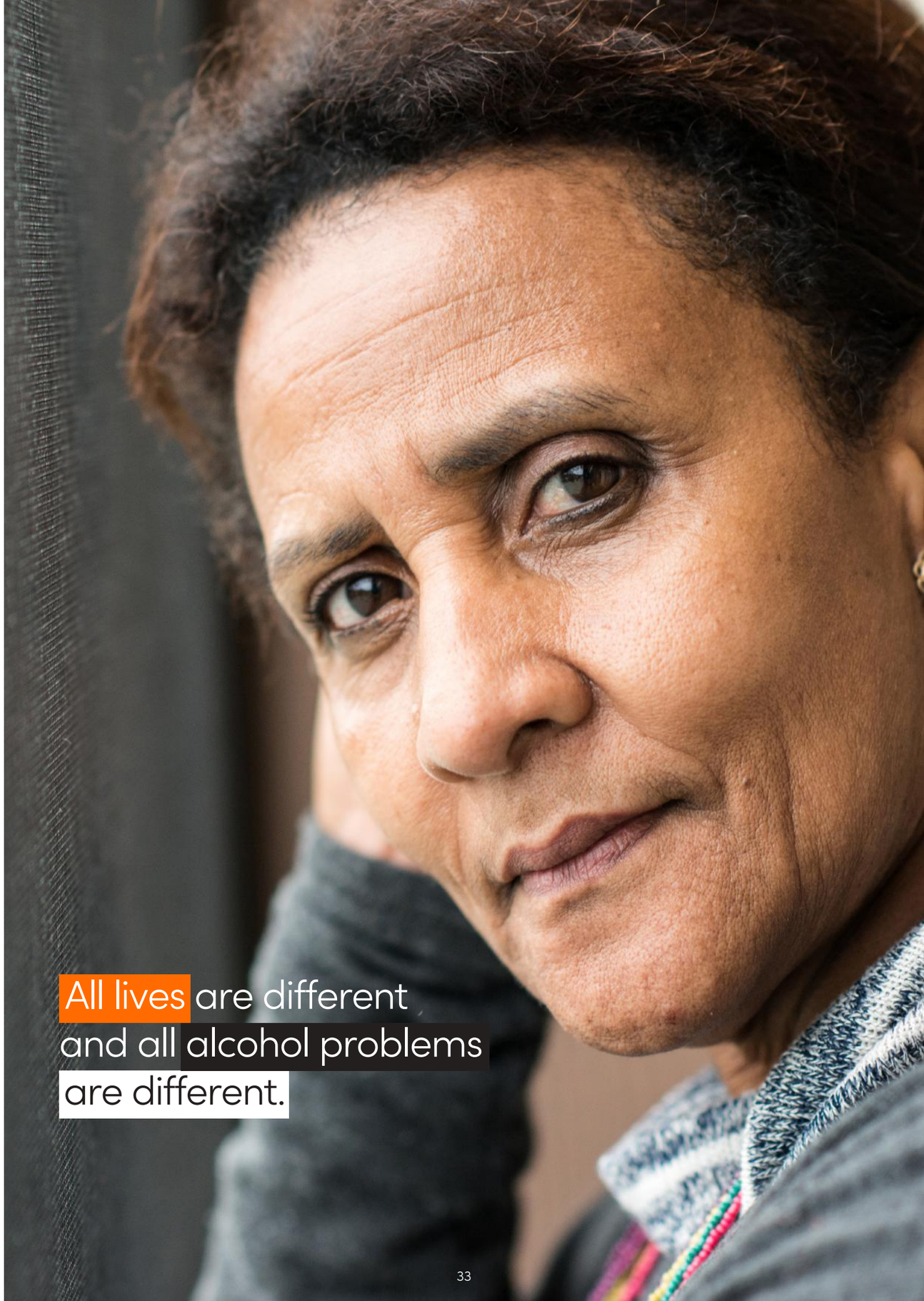
"It is vital to find out what they want."

"For me it is not trying to fit people into a box. The first thing I do is to listen to what they see as their barriers."

"We look at what they want. We offer treatment options but won't push it. Often, they change their minds about what they want. This isn't a problem to us."

"No-one usually listens to them. We change that."

"A quiet detective approach is required. Gather information and think about why this person is not engaging successfully [with] services."



The aim is to recognise the real person, with their memories and stories, quirks and characteristics, hopes and ambitions, hidden beneath the drunken presentation. Listening to that person will often throw up unexpected information that may point the way to a more positive future. For example:

"I went to see a guy in prison once. He seemed to have resigned himself to a life of addiction and prison. I just ignored all that and asked, 'OK, what do you want?'. He said, 'Ultimately, I'd like to get a driving licence'. No-one had asked [him] that before."

Not necessarily focusing on alcohol

Throughout our interviews, both workers and the people they were supporting agreed that workers should avoid trying to persuade anyone to change their drinking at the start of the relationship. Often, trust is best built through ordinary conversations about everyday things that may have little or nothing to do with alcohol but which help outreach workers to understand what motivates each person[36].

A central tenet of Motivational Interviewing (MI) is that workers should never try to persuade a person to change. Instead, they should give information and options in a non-judgemental way. If the person responds negatively, workers should "roll with resistance" and move on to finding alternative approaches such as focusing on other health issues that the person is ready to discuss[37, 38, 39].

Workers commented:

"Alcohol is important, but it is not the issue we focus on at first. Throwing lots of ambitious changes at them, that come from you, just won't work."

"We don't focus on the alcohol initially."

"We probably do not go straight into the drinking. We come to that later. We need to focus on what they want to do. We need to build a trusting relationship. We don't go in and be forceful about treatment."

The people who were supported by an outreach worker and who we interviewed noticed and appreciated that their outreach workers did not focus on alcohol in the way that they had expected, or experienced in other services:

"At first it was general chat. Drink was not the main thing. It is not straight in with the drinking. That made things a lot easier."

"We talk about different things. It is not all alcohol focused."

"There is no pressure not to drink[40]."

> Building positive engagement will take time and workers need to be prepared to take as long as is needed.

Building trust through a focus on the ordinary

Most people appreciate someone taking an interest in them and their ordinary, everyday needs, including the need for friendly company. One outreach project in Essex summarised their approach as follows:

We try to do something, anything: little things, often unrelated to their alcohol consumption, things like:

- Buying them breakfast
- Providing access to a phone
- Taking them for a walk along the canal
- Accompanying them to the GP
- Listening to their story and reflecting back what they say
- Making them smile!

Someone may also have various interests they enjoy talking about, such as a favourite food, a hobby, or a favourite football team. All these kinds of ordinary topics of conversation can be ways of building a relationship.

Being consistent

A repeated mantra from outreach workers is the need for them to keep the commitments that they make to the people they are working with. This is not simply polite; it is absolutely central to showing the person being supported that they matter to the worker. This may be the first time in their life that the person being supported has felt they matter to someone, which can be incredibly powerful. Vulnerable drinkers are used to people letting them down; and sometimes it is all they have known.

Outreach workers must keep every promise they make, and so must not make promises that can't be kept. This builds trust and boosts the person's self-esteem[41]. In the interviews, workers were very clear how important it was to be a reliable presence in the lives of the people they are working with:

"We say we will come back and [we] do come back. Don't make promises that you can't keep. They are looking for you to let them down. We go back regularly to build up trust."

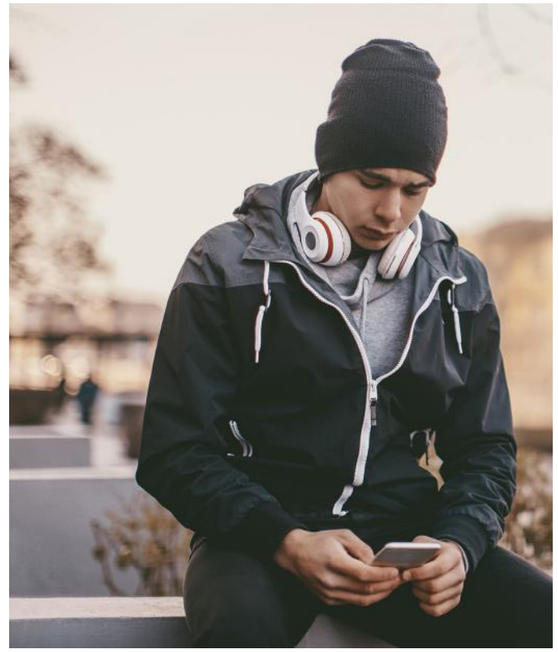
"Forgetting to call back or missing a scheduled check-in with a change-resistant drinker…can often scream rejection, again. [It says], 'There's no point!' again, 'What a waste of time!' again, 'Hopeless!'. Some of these vulnerable or at-risk drinkers should be a priority. That call-back could make a huge difference."

This level of reliability may necessitate considerable advance planning. Cranstoun's outreach worker in Worcestershire said that they needed to plan their programme of outreach to day centres three months in advance, in order to get it in the diaries with partner agencies, and so ensure that they were not letting people down.

Building peoples' confidence and self-belief

One of the most important things you can do as an outreach worker is demonstrate to the people you are supporting that you believe in their ability to change themselves and their circumstances. By demonstrating you believe they can change, you start to build that belief in themselves, promoting self-efficacy[42].

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 our belief in the possibility of change then we will reinforce a sense of hopelessness in the person we're supporting. Our role is to give them enough confidence, sustained over time, to give them the best chance possible to believe they can change their own lives, even if just in small ways at first[43].

> One of the most important things you can do as an outreach worker is demonstrate to the people you are supporting that you believe in their ability to change themselves and their circumstances.

Building confidence need not be complicated and doesn't require great eloquence. Workers can say simple positive things like "I'm proud of you" or "You look better", as well as referring to positive things that people have previously done in life[44]. It may be necessary to repeat these simple affirmations and to insist on the truth of them, if the person you are working with denies them. Interviews with people

who had been supported by the Nottinghamshire outreach service highlighted the importance of positive feedback from workers:

> "It was not so much what they said [as how they said it]. They gave me positive comments about how I was doing."
>
> "They make you feel more confident. They are not telling you off. They say things like: 'You're not a bad lad', 'Anyone can fall into that trap."
>
> "They do confidence building. You feel you are rubbish, [at] the bottom of the pile. They help you build your confidence. They talk about the things that you have done, your jobs and family."

Low-level physical contact, such as a hand on the arm or shoulder or a handshake, can also help build people's self-esteem. Many dependent drinkers will not receive much human contact. They may also be painfully aware that they smell of alcohol or that their hands and/or clothes are not clean. A person being willing to touch them in a welcoming and accepting fashion (such as with a handshake) can break down barriers and boost a sense of self-worth. Clearly, caution needs to be exercised in this area:

- Respect their personal space and be aware that some people won't want to be touched.
- If the person being supported is female, they may understandably be wary of physical contact from male workers, so keep any contact well away from anything that could be misinterpreted.
- Offer a handshake and wait for it to be accepted; don't take offence if it isn't.
- You may accept a hug if it's offered; but don't assume you can offer one.

A number of workers also noted that some people tended to open up most when they are not in direct eye contact, such as when sitting in a car or walking side-by-side[45]. This approach might be worth trying with some people.

Being positive

Beyond promoting self-belief, workers should try to help the person they're supporting to adopt a more positive view about other aspects of their life.

For example, someone may have a negative view of certain services (such as housing or healthcare services) even though they may need them. Outreach workers need to acknowledge that this negativity may be well-founded: people may well have been poorly treated by services in the past. What is needed is some reassurance that those previous experiences don't have to be repeated, and that the outreach worker can help the person navigate the system.

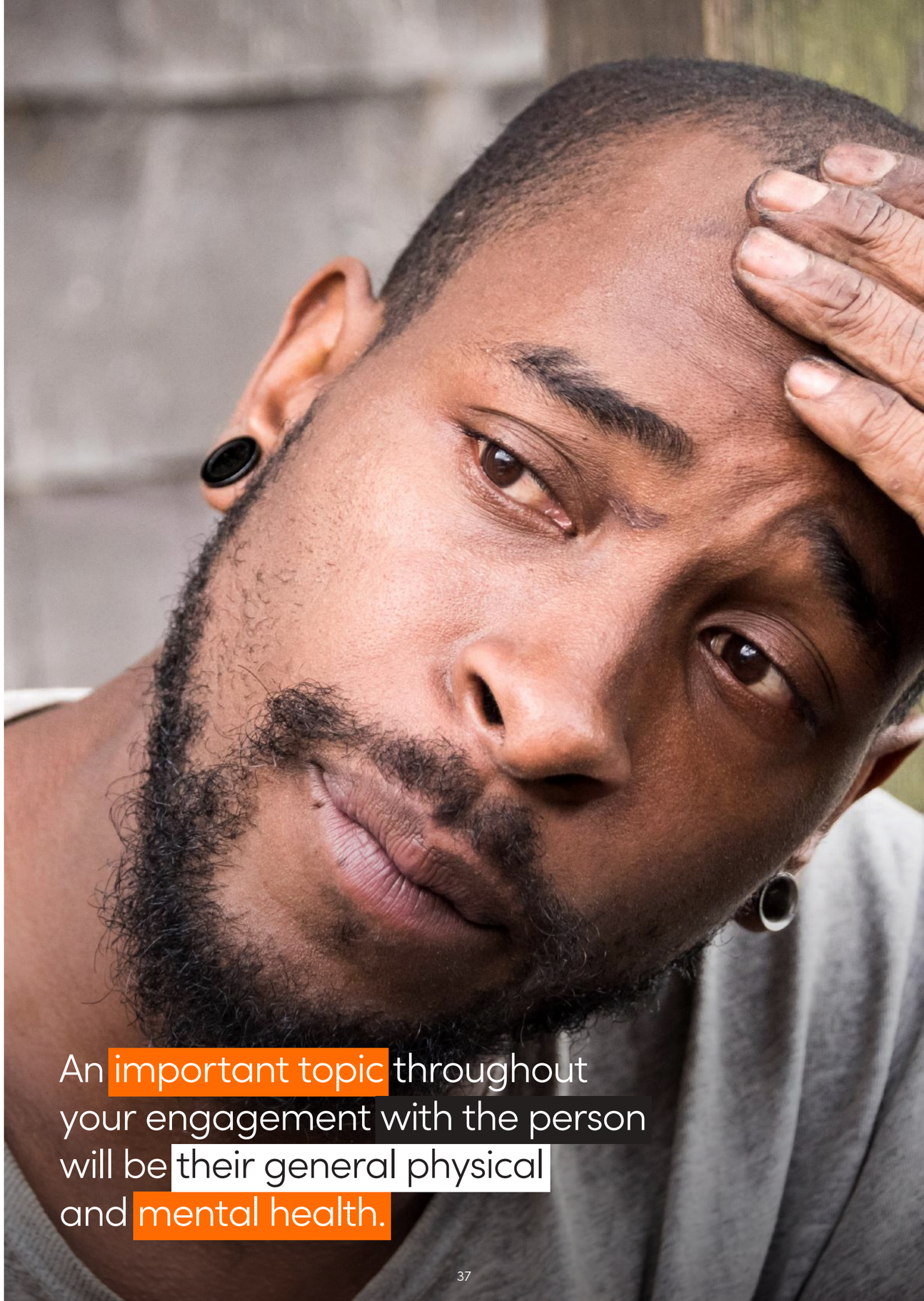
It's common for the people with long-term alcohol issues to have become estranged from their family members. It's important again to acknowledge past problems. They may have very good reasons for feeling aggrieved by things that family members have done or not done. But there may be some real benefits of them getting in touch with members of their family, so it will be important to focus on these, and on the possibility of things going well. As with all aspects of a drinker's life, this will probably have to be taken gradually, one small step at a time. We discuss the positive roles that family members can play in more detail in the section on Family on page 37.

It's common for the people with long-term alcohol issues to have become estranged from their family members.

While it helps to be positive, outreach workers may, at times, need to talk about negatives. This may include both negatives in the person's life, for example talking about their poor diet in order to stimulate a discussion about making a change, and negative impacts that the person can have on others, such as on their friends, on a hospital nurse or ambulance worker, or on their family. Clearly this needs to be done with care and caution and without criticism or accusation; and generally much later on in the engagement process.

Being persistent

Finally, the outreach workers we talked with agreed that what works is persistence: a quiet determination to stick at it. You don't need to cajole and persuade the person you're working with; you do need to keep making clear that the offer of support is always there and that you always believe in their ability to change, when they are ready.



Engagement tools

Part of the work of building a relationship with someone will be undertaking practical work to reduce harm and improve their quality of life. Workers have described the early stages of the relationship as being about "hand-holding":

> "At the outset, we buy them food and coffee. We are simply being around, chatting to them, getting them support. We sit with them and arrange appointments. It is the hand-holding stuff that really works."

In Motivational Interviewing terms, these early stages can be described as "rolling with resistance in action"[46, 47]. Instead of focusing on the alcohol, outreach workers find other practical ways of improving people's quality of life and thereby improving engagement. Workers identified eight alternative issues to focus on instead of alcohol:

1. Diet
2. Smoking
3. General health
4. Housing
5. Money management
6. Family
7. Addressing problems with the criminal justice system
8. Going out

We have looked at these eight topics in more detail below.

Of course, one of your ultimate aims is to prepare people for alcohol treatment (as described in Chapter Eleven) but any achievement across these other topics is beneficial in its own right, helping the person to feel healthier and happier; builds their confidence in their ability to change; and increases their desire for other changes.

Diet

Outreach workers can do a lot to improve someone's physical health and their mood by helping them eat better. The simple action of giving a person food, or helping them to obtain it, is also a very effective engagement and relationship-building tool. Interventions might include:

- Buying the person a cup of coffee or a sandwich.
- Taking cereal bars or soup onto the streets.
- Ensuring they are hydrated and drinking water, especially in hot weather.
- Arranging for them to visit a food bank and accompanying them there.
- Encouraging them to make use of soup-runs and other free food provision (often provided by local faith groups).
- Setting small goals such as putting on weight.
- Encouraging them to take up vitamin therapy (either oral or, preferably, injected). Long-term heavy drinkers are at risk of vitamin deficiency, particularly lack of vitamin B1 (thiamine), which can lead to alcohol-related brain damage such as Wernicke-Korsakoff's Syndrome[48].

Where facilities exist, working with the person to make a meal together can also be motivating and fun, especially if it's a team effort between you and them, with both of you eating together, or even cooking for others. This can be an excellent way to build up their confidence, develop rapport, have fun, perhaps purchase a few key pieces of equipment (a saucepan, a wooden spoon, a couple of new plates), gently show them what healthier eating can look like, and develop their skills. If this becomes a regular event, such as weekly, it can lead to meaningful change.

Smoking and e-cigarettes

Most alcohol-dependent drinkers smoke, and smoking is likely to be significantly worsening their health. Anyone working with people with alcohol problems will be aware of the toll taken on them by COPD, pneumonia and lung cancer. Indeed, it has been suggested, although not verified, that smoking kills more alcohol-dependent drinkers than alcohol itself.

Smoking also causes specific problems for drinkers on top of the general harms:

- It can contribute to the depletion of vitamin B1 from the body through reduced appetite.
- It worsens diseases associated with alcohol misuse, e.g. oral cancers, liver disease and coronary heart disease.
- It brings a risk of death from fire.

Expecting a dependent drinker to give up nicotine altogether may be unrealistic. However, it may be possible to encourage them to switch to e-cigarettes/vaping. 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 means of encouraging people to engage with outreach workers. However, it is clear that vaping is likely to be better for drinkers' health than cigarettes.

General health

An important topic throughout your engagement with the person will be their general physical and mental health. Outreach workers might consider:

- Encouraging people to undergo a health check from a doctor or nurse.
- Ensuring they are registered with a GP and helping them to do that if they are not.
- Arranging a dental check-up. Dependent drinkers often have poor dental hygiene, and the pain of tooth decay may be masked by alcohol.
- Assessing the person's weight, usually visually, and usually with a view to encouraging them to eat more.
- Encouraging them to keep an eye on how often they are going to the toilet and to monitor their own urine colour, which is a good indicator of their state of hydration/dehydration: if their urine is dark, they probably need to drink more water.
- Encouraging conversations about feeling worried, feeling low; and feeling calm and happy; and the things that help and hinder with these feelings.

Outreach workers are also in a good position to identify emerging physical health risks and will benefit from familiarising themselves with the key symptoms associated with alcohol-related ill-health. The Blue Light handbook includes the 12 Questions Tool, which can be used by non-clinicians to identify emerging physical health problems. It is not a diagnostic tool and is not intended to replace the clinical judgement of a doctor or nurse. It will, however, give workers a better idea of whether someone needs medical or nursing attention[49].

People supported by the Nottinghamshire outreach team said that they particularly valued worker's knowledge about physical health and effects of alcohol on it:

> "The first thing [they do] is look at [your] physical condition, and only then is the drinking discussed."
>
> "They tell you what you are doing to your body. They do that technical stuff and how to deal with it."
>
> "They put the medical side in layperson's terms. They don't try to impress or confuse you."
>
> "Their knowledge is really detailed. Other workers blag it. If they don't know, they find out for you."

Housing

For many outreach workers, but particularly those working with street populations, housing will be an obvious issue to address early on. This may be a matter of finding temporary accommodation – such as securing a place in a cold weather shelter or a hostel – or may mean seeking more permanent accommodation. Across the UK, there has been an increasing recognition of the concept of Housing First, i.e. that people experiencing homelessness may benefit from moving into independent and permanent housing, with additional support and services provided as needed[50, 51, 52].

However, it is clearly important not to see housing as the only solution that the person needs. Many alcohol-dependent people will have problems managing their own accommodation, and may lay themselves open to problems of debt, or exploitation by people using their accommodation, sometimes known as "cuckooing". For many such drinkers, regular ongoing support from outreach workers will be vital once they are housed. For example, outreach workers in Surrey said they sometimes held spare sets of keys for the people they were supporting, so that if a confused or

intoxicated person loses his or her door-keys, they are not stuck out on the street.

Related to this is the more general issue of helping people to safeguard their material possessions, which may include items of personal and sentimental importance and essential practical items (such as sleeping bags and winter clothing). One obvious way to deal with this is to support them into secure accommodation, but some outreach workers noted the option of renting secure storage space where people can keep their belongings.

> For many outreach workers, but particularly those working with street populations, housing will be an obvious issue to address early on.

Money management

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

Comment by a service user in Nottinghamshire

Sorting out debts, clarifying benefit entitlements, making benefits claims, and making sure that money is kept safe and managed well, can be important steps towards someone getting back in control of their life. Merton's outreach team has developed specific expertise in this area and suggested five techniques:

- Organising a bank account for people so that important bills are paid directly and regularly. One option for this is to set up a JamJar account (in which money is held in different pots for different expenses) through a credit union[53].
- Asking a bank to refer the person being supported to their team that work with vulnerable people and accompanying the person to their appointments. Some banks offer the option for people to only be able to access money through a secure phone call, stopping other people taking money out of their account via an ATM.
- Assisting with benefits applications and accompanying the person to benefits interviews.
- Becoming an appointee to receive someone's benefits on their behalf. This arrangement is offered by the Department for Work and Pensions, whereby a suitable person can apply for the right to deal with the benefits of someone who cannot manage their own affairs[54].
- The outreach worker being named as the person for the bank to contact if there is unusual activity on the bank account of the person they are supporting.

Family

People who are living chaotic drinking lives are likely to have complex, sometimes strained, family relationships. They may have alienated, exploited, or even abused their family members; or been shunned, exploited, or abused by them. So, family relationships can be a source of risk; but they can also be an incentive to change; and a source of support.

Most of the people you support will value the idea of renewed contact with at least some family members. National guidance states that care plans for people with alcohol problems should involve their families where possible[55]. However, this needs to be approached with caution and a clear assessment of the risks involved – both to the person you're supporting and to their family.

> People who are living chaotic drinking lives are likely to have complex, sometimes strained, family relationships.

Outreach workers interviewed supported the appropriate involvement of family members:

> "Family support is helpful to establishing a more stable life."
>
> "People were more likely to successfully change their behaviour if they had a relationship with their family[56]."

People who were using outreach services also saw closer family contact as important:

> "They suggest ways of getting back with [my] family. My family wouldn't have had anything to do with me. You have to atone. The worker agreed to talk to my family members."
>
> "[My] family are involved. The worker has spoken to [my] family and knows them all. That is very helpful."
>
> "The worker suggested that [my] family can talk to the team if they wanted. That was helpful."

Usually, family members will not live with the person you are supporting but may be prepared to offer "care at a distance", whether that is practical assistance or simply (but importantly) developing or maintaining a relationship. From a purely pragmatic view, family members represent a huge untapped resource for promoting change and reducing harm among people with alcohol problems.

Outreach workers can also usefully offer advice to families on how to respond to someone's drinking behaviour (e.g. warning them against pouring away the drinker's alcohol)[57]. Clearly, workers will need the consent of the person they are working with before contacting any family members. As with other elements of outreach, this may be refused at first, but workers need to be patient and persistent and encourage people to view family contact positively.

You can find out more working about with families in this context in the Blue Light Family Manual, produced jointly by Adfam and Alcohol Change UK[58].

Addressing problems with the criminal justice system

Interactions with the criminal justice system – police, probation and prisons – are common among people with serious alcohol problems. The offences they are arrested for are often (but not always) minor, and sentences short, meaning there may be regular journeys through the criminal justice system.

From a positive point of view, time spent in custody (much like time spent in hospital) can provide opportunities for these people to be identified and for outreach workers to make connections with them – to undertake "in-reach" (see Hospital-initiated outreach on page 23).

It is therefore worth outreach workers establishing links with local probation services; and understanding which prisons the people they are supporting are most likely to be sent to. The period immediately after release is when people are often highly vulnerable, and outreach workers may wish to arrange to meet people when they are released.

More generally, if the person you are supporting is in the criminal justice system at any point, they may need help navigating the system: understanding charges, attending court, paying fines or explaining themselves to police officers, solicitors and court officials.

Going out

> "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."

Comment by a person being supported in Nottinghamshire

The people outreach workers are supporting often have low confidence, low financial resources and can struggle with their social skills. As a result, occupying their time constructively can be challenging for them.

The CHI team in Surrey commented that one of their roles is to help people build a structure to their day. A routine of purposeful visits to locations (such as the library or a café or shop) where people can get the things they need or meet people outside their usual social circle, can provide the building blocks of that structure.

For the people who used the Nottinghamshire service, one of the benefits of a process that combines sufficient time and a focus on the person's needs was that staff had time to go out with them:

> "We go out for a coffee or something like that."
>
> "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 [i.e. a worry or problem] can grow into a big forest in ten minutes. I have lost lots of friends recently, but I can handle it now."

Outreach workers can also usefully offer advice to families on how to respond to someone's drinking behaviour.

Outreach workers described to us a range of approaches they have used to help people get out more:

- Accompanying people to prearranged appointments – partly in order to ensure they attend, partly to support them when they are there, and partly in order to spend time with them.
- Accompanying them during difficult but important social events, e.g. the funeral of a friend.
- Finding new and welcoming social activities, such as a community gardening project, cooking, or recreational activities offered by local substance misuse services.
- Introducing people to peer mentors – people who have had similar experiences to their own who have succeeded in moving on.
- Providing access to acupuncture and other complementary therapies. This has two obvious benefits: it takes the person out of their usual space; and it can give them a rare sense of having their needs attended to.
- Offering incentives to go out, e.g. offering to pay for lunch.
- Finding a comfortable setting, away from their usual drinking environment. Venues might include a day centre, or (in fine weather) a park, or a café (sitting outside if they are self-conscious about going in).
- Arranging an open event at a community venue and inviting people to attend. For example, in Kingston-upon-Thames the service ran a drop-in each Wednesday to which they invited people and provided food, clothes, blankets, etc.
- After any activity, discussing with the person where to find them next time. Pick a location that is convenient for them.

Motivating and preparing for treatment

"I am a friendly professional, not a professional friend."

Comment by an outreach worker in Wigan

This chapter focuses specifically on preparing the person you are working with to engage with alcohol treatment services. An outreach worker is not intended to be anyone's main long-term provider of change-focused interventions. The aim is to move drinkers into other services that can help them to rebuild their lives and reduce the amount of alcohol-related harm they experience.

As we've seen, two key factors in enabling people to move on are taking the time to actively listen (see page 30) and building self-belief (see page 32)[59]. As workers commented:

"The motivating factor is the time we can put into people. We have the time to help build their motivation."

"Help them believe they can change. Demonstrate that you believe they can change."

"Highlight past achievements. [Say to them] 'You have stopped using heroin. You can change your drinking'."

Alongside this, there are five other important elements that outreach workers will need to address in order to prepare someone's path into treatment:

1. Understanding barriers to change
2. Mapping existing service contacts
3. Seeking and achieving consent
4. Being an advocate
5. Using legal powers

Understanding barriers to change

An important step on the journey to change is to understand why someone is not changing. It is easy to dismiss a person with an alcohol problem as simply "unmotivated" or "in denial". In reality, the situation will always be more complex. The Blue Light handbook contains a checklist of barriers to change and suggestions about how to address them[60]. In particular, alcohol dependency itself can significantly reduce someone's ability to make changes to their lives:

- Alcohol-related brain damage/injury (ARBD or ARBI), leads to difficulty comprehending situations, reasoning and planning[61].
- Poor nutrition, produces low mood and lack of energy, as well as contributing to cognitive impairment (through Vitamin B1 deficiency)[62].
- Liver disease reduces energy, worsens mood and disrupts sleep.
- Depression resulting from alcohol's effects on the central nervous system and/or general underlying depression, anxiety or personality disorders, all of which may be undiagnosed[63].

Other barriers to change could include low self-esteem, previous setbacks when attempting to change, unreasonable service expectations, or fellow drinkers who sabotage change.

> An important step on the journey to change is to understand why someone is not changing.

This final issue – of others sabotaging change – can be particularly difficult to manage, since a drinker may be very much reliant on a social circle or quasi-family of other dependent drinkers whom they are reluctant to leave and who in turn don't want them to move on. The work you'll have been doing so far, to spend time with them (see page 30) and listen to them (see page 30), build their confidence (see page 32), address their housing issues (see page 36), help them reconnect with their family (see page 37) and go out and socialise in new ways (see page 38) will all have helped them to build new friendships, relationships and social skills, making it easier for them to manage this possible "break-up".

Mapping existing service contacts

Most of the people outreach workers are working with will have contact with other agencies, such as social services, housing services, and/or criminal justice. It is important to know which other agencies are working with a person, and make contact with those agencies. The aim is to ensure that workers from different agencies are aware that the person is going to try to address their drinking and that they support this and do nothing that could undermine it.

> It is easy to dismiss a person with an alcohol problem as simply "unmotivated" or "in denial".

At times it will be useful to have a network meeting about a particular person to coordinate activity. This is an approach we strongly recommend as part of the Blue Light approach[64].

Seeking and achieving consent

To ease a person's path into alcohol treatment services it will be necessary to seek their consent to refer and share information. This will enable the alcohol treatment service to make proactive contact with them. Many people are unlikely to give consent the first time they are asked, and encouragement to consent may require repetition, possibly with different workers or agencies reinforcing the point.

Clearly, this is a sensitive topic. Drinkers cannot be bullied or cajoled into giving consent, but they can be consistently offered opportunities to engage from people they have learned to trust and who they know have their best interests at heart.

Outreach workers identified a number of techniques that can be used to motivate and support people into services:

- Emphasise the benefits of treatment – sell it to them. For example, discuss possible improvements to their health, possibly using the 12 Questions Tool in the Blue Light handbook[65]. Identify other possible benefits of addressing their drinking, e.g. improving their housing situation and/or their finances. Identify any interests that they may be able to better pursue through treatment, e.g. a chance to learn computer skills.
- Think about what has helped motivate them in the past, e.g. what helped them come off other drugs.
- Reduce their fears by informing them about the options. For example, remind people that abstinence is not the only option offered by most community alcohol services. Where relevant (and available) offer the chance for the person to move away from the locality into a residential rehab. Tackle any of their misconceptions about various services, e.g. alcohol services are not like a mental health unit (where they may have previously been detained).
- Seek family support and involvement (see page 37).
- Don't oversell it. Be honest about what is involved in treatment. Review the positives and negatives of change. Acknowledge and address their previous bad experiences with services. Be upfront with them that entering services can be challenging, and make clear that they will not be seen as a failure if it takes time to make changes.
- Smooth the person's pathway with services that require self-referral by asking services to be very welcoming and encouraging if the person makes contact.
- If you're the one making the referral, follow it up to ensure the person you are supporting has been in contact with the service. Ask services to follow people up quickly if they disengage and report this back to the referrer. Encourage services to show some leniency on time and sobriety and not to write the person off just because they are a little late or a bit drunk.

Being an advocate

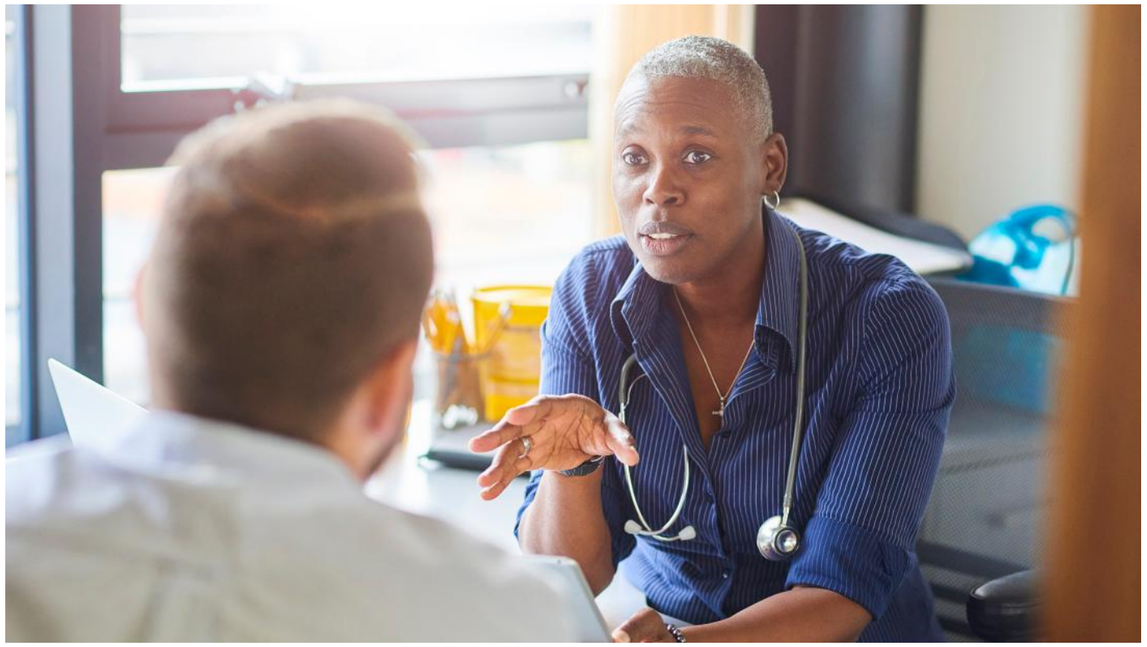
As an outreach worker you will need to be an advocate for the people you are working with. Whilst the end goal is for people to manage their own lives and argue their own cause, you will, at first, need to make appointments for them and accompany them (or find volunteers or peer mentors who can accompany them).

In particular, you may have to challenge other services (mental health, other healthcare, housing, substance misuse, etc.) to provide support that reflects the person's needs, preferences and level of risk, given your knowledge of them. If the necessary services are not available or not suitable, then workers need to record and report unmet need, via managers, to local commissioners.

> As an outreach worker you will need to be an advocate for the people you are working with.

Our interviews with people who were supported by the outreach service in Nottinghamshire highlighted how often people with alcohol problems experience negative attitudes from some professionals:

> "[The outreach service] is very non-judgemental. People do feel judged in hospitals and elsewhere. Some of the nurses on wards make you feel you have brought this on yourself, and are unsympathetic."
>
> "You do find doctors and staff who are really unpleasant. One doctor made me feel it was self-inflicted and I didn't want to bother."
>
> "I have experienced negative stuff from A&E – from a nurse who was a bit abrupt, which upset me a bit. It didn't seem very caring. 'You are costing us millions,' [she said]. I was in a bad place at the time and I didn't want to know."



As a result, people very much valued it when the outreach workers accompanied them and advocated on their behalf:

> "The worker came for my PIP [Personal Independence Payment] assessment and to enrol me at the Recovery College[66]. They were both quite stressful [appointments]. It was useful to have someone."
>
> "The worker comes to other appointments with me, [such as] the doctor, and helps me to explain things."
>
> "I felt really embarrassed about being an alcoholic. [The outreach team] help with practical things like going to the hospital. Consultants and GP surgeries fob you off."

Using legal powers

At some points, and with some people, the use of legal powers may need to be considered as means to oblige them to receive help. This is not necessarily negative and may provide either the motivation someone needs or the protection that is required. At its most basic level, it may protect others from the impact of the drinker. The key powers for use in England and Wales are contained in:

- The Mental Health Act 1983 (and 2007 revisions)
- The Mental Capacity Act 2005
- The Care Act 2014 and the Social Services and Well-being (Wales) Act 2014
- The Crime and Anti-Social Behaviour Act 2014

We cannot set out these powers in detail here. However, outreach workers will need to be familiar with them. More information can be found in the following sources:

- The Blue Light handbook[67].
- The ARBD section of the Alcohol Change UK website, which includes factsheets on the use of legislation around lack of decision-making capacity[68].
- Alcohol Change UK's 2016 guidance (as Alcohol Concern) on working with street drinkers[69].
- Alcohol Change UK's 2018 report (as Alcohol Concern and Alcohol Research UK) on the use of the 2014 anti-social behaviour powers with problematic drinkers[70].
- Alcohol Change UK's 2019 report Learning from tragedies[71].
- Alcohol Change UK's 2021 guide How to use legal powers to safeguard highly vulnerable dependent drinkers[72].

Ending the relationship

> "You get to the point eventually where you realise how far you have come and how much you can do without alcohol. To me, nothing is worth the downsides of drinking."

Comment by a service user in Nottinghamshire

Alcohol assertive outreach work may be long-term but it is not forever. Ultimately, workers will need to consider how to draw the engagement and support to a close.

There is a risk that people can become dependent on the outreach service and/or on a single outreach worker. Workers have noted how some people will start to cross boundaries in the later stages of the relationship, for example, asking lifts for journeys they are well able to make themselves, treating workers as a free taxi service. Workers emphasised the need to set limits that are appropriate to each person, so that everyone knows where they stand and that the relationship remains professional and bounded.

> Ideally too, the end of the outreach relationship will be anticipated and planned for.

There is also a risk that someone can become too comfortable receiving the outreach service, not wanting to move on despite having the potential to do so, and that's where the outreach worker needs to raise expectations, even in simple ways, such as asking them to come to an office for meetings.

The engagement process may be ended by the client – sometimes because they feel they have got what they needed from it. In some cases, where there is no progress after a prolonged engagement, an outreach service may need to pull away and focus resources on other people. However, in such cases, workers should:

- Discuss the decision with managers and partners in the multi-agency network.
- Record all the reasons and any contingencies.
- Ensure ongoing responsibility has been allocated to another agency.
- Explain the situation clearly, honestly, and kindly to the person who was being supported.

In the ideal situation, closure will occur after the person has engaged with a specialist alcohol service and made positive changes to their drinking behaviour. Ideally too, the end of the outreach relationship will be anticipated and planned for. Workers identified four techniques for doing this successfully:

Building up gradually to a natural endpoint

"Ideally, this is planned and discussed with the person because we have reached our goals"; "We mention ending at the start of the process". By making clear to people what the outreach service is, and what it isn't, there is less scope for the person to be resentful or feel abandoned when it ends."

Planning the exit

"We have a case conference about people with other staff and decide what to do about the person. We try and network them back into the community."

Not simply letting someone go with no follow-up

"We explain that we will still be there if they need them. We're ending the intensive support, but we are still there for them." "For some people we retain loose contact. For others we cease regular contact and offer our phone numbers. But there can be unplanned exits and they will almost certainly re-present"; "In many cases, we keep tabs on people but have less contact."

Advance care planning

"In Nottinghamshire, people were asked to choose what they would like the outreach workers to do if they subsequently relapse, such as "contact me my mobile" or "visit my home" or "find me on the streets."

The people we spoke with who had used the Nottinghamshire service talked positively about how workers were planning for endings:

"The sessions have now got shorter with me and they are spending more time with people who need it."

"The worker suggested I did the peer support workers course. That helped me and got me through a lapse. It was a short lapse."

"At the beginning, they came a lot. They have been good at judging when you need to see them. But now, they ask when you want to see them. But I am worried they will discharge me. It is nice to know someone is there for you [if you need them]."

"I have now gone down to monthly appointments, but this has been my choice."

"You get to the point eventually where you realise how far you have come and how much you can do without alcohol. To me, nothing is worth the downsides of drinking."

There is a risk that people can become dependent on the outreach service and/or on a single outreach worker.

Alcohol assertive outreach work is not always easy, but it can be incredibly rewarding.

Final thoughts

We hope that this handbook inspires commissioners, providers, and individual alcohol workers to develop new alcohol assertive outreach services, and that its practical tips and techniques are of use to people in the field. We also hope that it will inspire researchers and evaluators to pay more attention to outreach services and to further explore what makes them most effective.

Alcohol assertive outreach work is not always easy, but it can be incredibly rewarding. It is a route to reducing the harm that some of the most vulnerable people in our communities are causing themselves and others. It can lead to real reductions in the demands on and costs of public services. Most importantly, it can help people restore their health and regain control of their lives and look forward to a better future.

References

1. Kraybill, K. (2002) *Outreach to people experiencing homelessness,* Nashville, National Health Care for the Homeless Council
2. Gilburt, H. et al. (2012) *Assertive community treatment for alcohol dependence (ACTAD): study protocol for a randomised controlled trial,* Trials, Vol. 13, Article 19.
3. Alcohol Concern (2015) ***An evaluation of the Nottinghamshire Alcohol Related Long Term Condition Team,*** London Alcohol Concern.
4. Ward, M. (2012) *The Wigan Active Case Management Team: Defining the outreach role with hard to engage problem drinkers,* London, Alcohol Concern.
5. op. cit. Alcohol Concern (2015).
6. Ward, M. (2016) *The experience of the clients of the Nottinghamshire alcohol Long Term Conditions Team,* London, Alcohol Concern,
7. Ward, M. (2016) *Tackling Street Drinking,* London, Association of Police and Crime Commissioners.
8. Unpublished reviews of alcohol hospital teams in the West Midlands in 2013.
9. Ward, M. and Holmes, M. (2014) *Alcohol Concern's Blue Light Project: Working with change resistant drinkers: The Project Manual,* London, Alcohol Concern.
10. Presentation by Professor Colin Drummond to South London Health Improvement Network in 2014.
11. Ross, A. et al. (2005) *An exploration of street drinking in Drumchapel, Scotland,* Health Education Research: Theory & Practice, Vol. 20 (3), pp. 314–322.
12. Russell S. (2010) *Evaluating the effectiveness of an assertive outreach service for street drinkers in Liverpool,* Liverpool, Centre for Public Health, Liverpool John Moores University.
13. Cullen N. (2005) *Street drinking in Hounslow,* London, Hounslow Drug & Alcohol Action Team and the Metropolitan Police.
14. For example Safer Guildford (2013) *Report into the death of Adult A.*
15. Alcohol Concern (2012) *Evaluation of the Active Case Management (ACM) of patients with high alcohol related readmission rates in Wigan,* London, Alcohol Concern.
16. Hughes, N.R. et al. (2013) *Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions,* Frontline Gastroenterology, Vol. 4(2), pp. 130-134.
17. Child H. (2017) *Blue Light Project Year 1,* Lincoln, Lincolnshire County Council.
18. Surrey County Council Public Health (2016) *High Impact Complex Drinkers Pilot: Final Report,* Reigate, Surrey County Council.
19. Bailey, M et al. (2017) *Review of the Blue Light Multi-Agency Group,* London, Alcohol Research UK.
20. Ward M. & Holmes M. (2014)
21. See: https://www.merton.gov.uk/assets/Documents/0458_marac_leaflet_for_victims.pdf
22. See: https://www.catalystsupport.org.uk/chi-catalyst-high-impact/
23. op. cit. Child, H. (2017).
24. op. cit. Bailey, M et al. (2017).
25. op cit. Ward, M. (2012).
26. ibid.
27. Ward, M. and Holmes, M. (2014).
28. See for example: Wiltshire Domestic Homicide Review (2012) *Overview report into the death of Adult Y.*
29. See: https://www.ndtms.net/
30. See: https://dhcw.nhs.wales/information-services/health-intelligence/substance-misuse/
31. See: https://www.health-ni.gov.uk/articles/alcohol-statistics
32. See: https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/
33. Blue Light evaluations can be found on the Alcohol Change UK website
34. op. cit. Ward, M. (2012).
35. Ward, M. and Holmes M. (2014).
36. op. cit. Ward, M. (2012).
37. Miller, W. and Rollnick, S. (1991) *Motivational Interviewing: Preparing people to change addictive behavior,* New York, Guilford Press.
38. See: https://www.stephenrollnick.com/about-motivational-interviewing/
39. op. cit. Miller, W. and Rollnick, S. (1991).
40. Ward M. (2016) *The experience of the clients of the Nottinghamshire alcohol Long Term Conditions Team* Alcohol Concern
41. op. cit. Ward, M. (2012).
42. See: https://www.uky.edu/~eushe2/Bandura/banconfidence.html for a useful definition of the difference between self-efficacy and self-belief
43. Ward, M. and Holmes M. (2014).
44. op. cit. Ward, M. (2012).
45. op. cit. Ward, M. (2012).
46. See: https://www.stephenrollnick.com/about-motivational-interviewing/
47. op. cit. Miller, W. and Rollnick, S. (1991).
48. Alcohol Concern (2014) *All in the mind: Meeting the challenge of alcohol-related brain damage,* Cardiff, Alcohol Concern.
49. op. cit. Ward, M. and Holmes M. (2014).
50. See: https://hfe.homeless.org.uk/about-housing-first
51. See: https://gov.wales/sites/default/files/publications/2019-03/housing-first-principles-guidance-for-local-authorities.pdf
52. See: https://homelessnetwork.scot/housing-first/
53. See: https://www.moneyadviceservice.org.uk/en/articles/managing-your-money-using-the-jam-jar-approach
54. See: https://www.gov.uk/become-appointee-for-someone-claiming-benefits
55. For example, NICE clinical guideline 115 recommends encouraging families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.
56. Porter, K. (2013) *Bristol Streetwise: Street drinkers' evaluation,* Bristol, Safer Bristol
57. op. cit. Ward, M. (2012).
58. Adfam (2016) *Supporting family members to respond to change resistant drinkers: The Blue Light family project,* London, Adfam.
59. op. cit. Miller, W. and Rollnick, S. (1991).
60. op. cit. Ward, M. and Holmes M. (2014).
61. op. cit. Alcohol Concern (2014).
62. ibid.
63. op. cit. Ward, M. and Holmes M. (2014).
64. ibid.
65. ibid.
66. See: https://www.nottinghamshirehealthcare.nhs.uk/nottingham-recovery-college
67. op. cit. Ward, M. and Holmes M. (2014).
68. See: https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-related-brain-damage
69. op. cit. Ward, M. (2016).
70. Alcohol Concern and Alcohol Research UK (2018) *Tackling alcohol-related anti-social behaviour through Civil Injunctions and Criminal Behaviour Orders: A missed opportunity?,* London, Alcohol Concern and Alcohol Research UK.
71. Alcohol Change UK (2019) *Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017,* London, Alcohol Change UK.
72. Alcohol Change UK (2021) *How to use legal powers to safeguard highly vulnerable dependent drinkers,* London, Alcohol Change UK.

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