Filling in the gaps

ALCOHOL CHANGE UK

A guide to supporting people experiencing co-occurring alcohol use and self-harm issues

Contents

Acknowledgements ... 3
Why we wrote this guide ... 4
Ways of talking about alcohol use and self-harm ... 8
Some words we might want to avoid ... 11
Making space for people's own words ... 13
Understanding the relationship between alcohol use and self-harm ... 16
Cause and effect? ... 16
When alcohol use seems like self-harm ... 16
Filling in the gaps between services ... 21
Why people need a holistic offer ... 21
The common ground ... 23
Being trauma-informed ... 24
Practical care for people who are self-harming ... 25
Being needs-led ... 26
Flexible working...and its limits ... 27
Understanding diversity ... 30
Sex, gender and sexuality ... 31
Race, religion and culture ... 34
Neurodiversity ... 37
Working with other services ... 40
When to refer to specialist services ... 42
Sharing information ... 44
Resources ... 46
NICE guidance and standards ... 47
AUDIT and Alcohol Interventions and Brief Advice (IBA) ... 47
Useful websites ... 48
Helplines ... 50
Mobile Apps ... 51
Other resources ... 52
Appendix ... 53
Working with neurodiverse people ... 53
References and links to additional resources mentioned in this guide ... 56

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Why we wrote this guide

Both drinking and self-harming are often coping mechanisms for mental distress, and both are often linked to trauma.

Alcohol problems are rarely simple. They may arise from past trauma or current adversity. They may be linked to other physical and mental health issues, and/or to social and relationship difficulties. They may cause, co-occur with, or result from any of these issues. This complexity cannot always be untangled and parcelled out for a range of specialist services to address – alcohol issues over here, mental health over there, and so on. To be effective, services need to see and support the whole person.[1] The relationship between alcohol use and self-harm is one very clear example of this, and research commissioned by Alcohol Change UK has shown:

- A clear but complex link between alcohol use and self-harm in some people's lives
- A degree of separation between support services for self-harm (and mental health more generally) and alcohol treatment services, leaving gaps in provision through which some very vulnerable people may fall
- A pattern of unmet complex needs, and of people concealing the complexity of their needs (by not revealing either their self-harm or their alcohol use) in order to access services.[2]

In addition, our conversations with practitioners in the fields of self-harm and alcohol use indicate that both sets of services are seeing people whose thoughts, feelings and behaviours are remarkably similar, in that both behaviours – drinking and self-harming – are often coping mechanisms for similar forms of mental distress. In short, the two issues are not as different as we at first supposed, and both are often linked to trauma and adversity.

In this guide, we have sought to examine and understand the experiences of people who are (or have been) both using alcohol and self-harming, and to offer some suggestions for ways for services to better support them. We expect the main audience for this guide to be substance use (drug and alcohol) treatment services and services specialising in self-harm support. However, it will be of use to a wide the range of services likely to encounter people facing these two challenges in life: social services, the emergency services, education providers, healthcare providers, and community and voluntary organisations supporting vulnerable people.

This is not a definitive treatment manual. Each practitioner must use their own professional judgement to tailor the support that they provide. What it does provide is some insights into what people with experience of alcohol use and self-harm say they need from services, and what practitioners have found useful in seeking to work with people in that situation.

Our hope is that this guide will enable workers in both self-harm and alcohol treatment services, and others, to increase their confidence and skills in working holistically with this group, and so improve outcomes and quality of life. We also hope that it will lead to more and better joint working and understanding between services: to the realisation of a "no wrong door" approach, whereby "every door in the…system should provide access to the services needed".[3] Given that both self-harm and harmful alcohol use appear to have increased amongst some of the most vulnerable sections of the population in recent years, this seems more important than ever.[4, 5, 6]

This is the first edition of this guide. We very much hope that it will not be the last, and that there will be future iterations as we learn more and improve our practice. We have made the guide available to download from our website, free of charge, in English and Welsh. If you have any comments or questions about the guide, or if you think there is anything we need to add, remove, or amend, please do get in touch with your views and ideas. We welcome feedback in both English and Welsh.

To arrange training from us on how to improve your organisation's approach to co-occurring alcohol use and self-harm, contact training@alcoholchange.org.uk.

Andrew Misell
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How we wrote this guide

In 2020, Alcohol Change UK commissioned Amy Chandler from the University of Edinburgh and Annie Taylor of Edinburgh Napier University to help us better understand the relationship between self-harm and alcohol use, and the adequacy of services to support people experiencing these co-occurring issues. Their research was based on a review of existing literature and a series of in-depth interviews with people in England and Wales who had experience of both self-harm and alcohol use and who had sought help to deal with one or both of them.

The resulting report, *Alcohol and self-harm: A qualitative study* (which we'll refer to from here on as "the Edinburgh research") was published in 2021.[7] The findings from that research formed the basis of a workshop we convened in 2022, bringing together support workers from the fields of self-harm and alcohol use to discuss their experiences, explore the challenges they face, and investigate potential methods of providing more holistic support. Following that workshop, we drafted this guide and consulted on the draft text with a range of people with personal and professional experience before publishing this first edition.

Anonymised comments by interviewees in the Edinburgh research and by participants in the subsequent workshop and consultation are used throughout this guide to illustrate key points.

Section 1

Ways of talking about alcohol use and self-harm

In this section, we look at how we can talk about alcohol use and self-harm in ways that respect, include and support people.

Ways of talking about alcohol use and self-harm

People talk about alcohol use and self-harm in many ways. Professionals have their terminology. People with personal experience find their own ways of describing their lives. Others use a range of words, reflecting a range of attitudes from compassion to contempt. In this section, we look at how we can talk about alcohol use and self-harm in ways that respect, include and support people.

Terms and definitions

Although we need to take care not to be boxed in by them, it is useful to start with the "official" definitions relating to both self-harm and alcohol use. The National Institute for Health and Care Excellence (NICE) defines them as follows:

Self-harm is any "intentional act of self-poisoning or self-injury". It is an "expression of emotional distress" and may include someone harming themselves "to reduce internal tension, communicate distress, or obtain relief from an otherwise overwhelming situation".[8]

Alcohol use is subdivided by NICE into **lower-risk drinking**, i.e. drinking no more than the recommended maximum of 14 units in any one week; **hazardous drinking**: "a pattern of alcohol consumption that increases someone's risk of harm"; **harmful drinking**: "a pattern of alcohol consumption causing health problems directly related to alcohol"; and **alcohol dependency**, which is "characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences".[9, 10, 11, 12]

These definitions are widely accepted and reflect an international consensus, but are, of necessity, simplifications of complex issues. In the field of self-harm, some agencies have expanded their definition to include disordered eating, conscious risk-taking, and self-neglect or lack of self-care.[13, 14] People with lived experience describe a wide range of behaviours that feel like self-harm to them: cutting, burning, disordered eating and food restriction, hitting, overdosing, attempted suicide, and purposefully putting themselves in high-risk situations – such as taking part in extreme sports or seeking dangerous or violent sexual encounters.[15]

It is worth noting here that the NICE description of self-harm as a means to "communicate distress" should not be taken to mean that self-harm is necessarily

a demand for attention. On the contrary, it is a behaviour that people very often seek to conceal from others and do not seek help for.[16] In all cases, it is important to explore with each person what the role of their self-harm is for them.

The points at which alcohol use becomes a problem are also difficult to define. As NICE have noted, "some would limit [definitions of alcohol harm] to the physical or mental health consequences [of drinking]; others would include the social consequences".[17] And any attempt to put people's alcohol use into neat categories (and, certainly, to categorise people as types of drinkers) will come up against the reality that "many people move between different ways of drinking throughout [their] life course, going from heavy drinking to mild, moderate, and severe dependence and back again, with periods of abstinence".[18]

One question that arose when writing this guide was whether heavy alcohol use could be considered a form of self-harm in itself. We have looked at this in more depth in the section **When alcohol use seems like self-harm** on page 19.

Alcohol use and self-harm as coping mechanisms

Practitioners in the fields of self-harm and alcohol are seeing people whose thoughts, feelings and behaviours are remarkably similar.

At our workshop in 2022, we invited practitioners in the fields of alcohol use and self-harm to tell us how they understood each other's work. Here's what they said:

Self-harm practitioners described problematic alcohol use as:

- Drinking that affects day-to-day life, such as work, relationships or finances
- Drinking that leads to other self-destructive behaviours
- Drinking as a coping mechanism
- Drinking that normalises use that would be considered unusual by others, such as drinking at inappropriate times, in inappropriate places, or in unusually large quantities.

Alcohol practitioners talked about self-harm in the following ways:

- A conscious harmful act directed at oneself

- A way of dealing with emotions, thoughts and feelings
- A way of dealing with overwhelming situations and experiences
- It can include cutting oneself or other self-injury
- It can be both physically and psychologically harmful
- It could be seen as a continuous act of self-punishment.

Most of the comments above reflect a focus on the psychological and social aspects of both behaviours. Linked to this, participants emphasised the benefits they saw of de-pathologising both alcohol use and self-harm: moving away from labelling behaviours as "disorders" and towards recognising them as coping mechanisms.

Workshop participants identified significant common ground across their two sectors, noting that:

- Both alcohol use and self-injurious behaviours exist on a continuum. Chewing fingernails, for example, may be a largely harmless stress-management technique but could be done to such a degree that it causes wounds; alcohol use happens along a spectrum from moderation, through excessive but "social" drinking, to anti-social dependent drinking
- Both behaviours are used by people at different times either to bring themselves out of a dissociative state, or, conversely, to reduce hyperarousal
- The function of behaviours can be more important than the behaviours themselves, and motivation matters: a behaviour may be healthily relaxing for one person but destructive for another.

It is clear that practitioners in the fields of self-harm and alcohol use are seeing people whose thoughts, feelings and behaviours are remarkably similar, in that both behaviours are often ways of managing similar forms of mental distress. People with lived experience have described both alcohol use and self-harm as a response to social situations and as having social functions: drinking was said to increase confidence and reduce feelings of inadequacy in social situations, and self-harm was also framed as a way of coping with difficult situations.[19]

Some words we might want to avoid

Words for alcohol use

Much of the terminology about alcohol is contested.[20] The most obvious example is the term "alcoholic" as a noun, as in "I am an alcoholic". For some people – particularly the millions who have benefited from the 12 Step Movement – that statement is a liberation: an acknowledgment of what is really going in their lives. For others it reduces a person to the sum of their problems.[21] The term "addict" is even more controversial for all the same reasons. Since both words imply a permanent and unchanging state, some fear that there is a danger that they can become a justification for not offering support.

As an alternative to words like these, a movement has grown in favour of "people-first language". As the Scottish Drugs Forum (SDF) have noted, this "personalisation of language" can make us more conscious that we are "speaking about people rather than abstractions".[22] In that spirit, in this guide we have taken a conscious decision to talk about "people with experience of alcohol use and self-harm". We use the term "alcohol use" rather than "alcohol abuse" or "alcohol misuse", since we agree with the SDF that the terms "abuse" and "misuse" suggest that drinking by people experiencing alcohol problems is "wholly distinct from other people's use of the same substance".[23] Similarly, we have used the term "substance use" rather than "substance misuse", unless quoting from Government documents, where the use of the latter term is common.

Words for self-harm

Our work has highlighted four types of language that can create barriers to people accessing support for self-harm:

- Judgemental language
- Dismissive language
- Language that signals a lack of knowledge and understanding
- Reductive language.

In the first instance (and in a similar manner to people facing alcohol issues) people who are self-harming are sometimes accused of having a "self-inflicted" or "invented" problems, of "time wasting", "attention seeking" and not being "real patients", i.e. being morally undeserving of support.[24, 25, 26]

Secondly, their self-harm may not be seen as particularly concerning. "Fobbed off", "dismissed" and "not taken seriously" are some of the phrases people have used to describe the ways they have been treated by healthcare services. Injuries have been described by professionals as "low severity" or "superficial" and overdoses as not having involved large enough quantities of drugs.[27] Linked to this, some people have encountered shame-based persuasion techniques that imply that the impact of their self-harm is cosmetic, for example that their scars make them "ugly" or that "you'd be so pretty if it wasn't for your arms".[28]

One perverse and unintended consequence of dismissive language is that it tempts some people to harm themselves more seriously in order to be taken more seriously:

> "I've just laid out all the stuff to them: that I hurt myself…No one's done anything, which makes you feel a little bit like, well, I mustn't be risky then, which then makes you want to be risky, which is really messed up." [29]

Overall, we advise professions to avoid both downplaying the physical effects of self-harm (e.g. "It's not that bad", "I've seen worse") and catastrophising them (e.g. "Oh, that's terrible!" "What are you doing to yourself?"). It is also important to avoid the use of guilt as a motivation to stop self-harming (e.g. "How must your mother/partner feel, seeing what you've done to yourself?").

Thirdly, barriers may be created by language that demonstrate a lack of understanding of self-harm. Describing it as a "a cry for help", for example, runs contrary to the reality that much self-harming behaviour is a private coping mechanism that people go to some trouble to hide. Similarly, describing it as "deliberate" is inaccurate, in that suggests a degree of choosing to self-harm, whereas it can be experienced as a compulsive behaviour or driven by intrusive thoughts or dissociative states.[30, 31] Practitioners should never seek to elicit promises of reducing or stopping self-harm in the future – an approach which is more likely to lead to shame, concealment and breakdown of trust than any reduction in harm. Requests to reduce or stop self-harm can also problematic if the self-harm is being used as a coping mechanism and (i) there is no change in the situation that someone is self-harming to cope with, and/or (ii) no alternative coping mechanism is apparent to them.

Finally, as noted in **Words for alcohol use** on page 12, we advise against the use of terms that reduce a person to the sum of their problems. Terms such as "self-

harmers" or "cutters" suggest a lack of individual identity and autonomy. Self-harm is something someone does; it is not who they are.[32]

Making space for people's own words

When someone uses apparently negative language about themselves, it can be an opportunity to find out more.

Our advice to avoid using certain words comes with one big caveat: people must be free to find their own ways of talking about their own alcohol use and/or self-harm. That may include terms and statements that practitioners consider self-stigmatising but which people feel comfortable or even empowered using about themselves.[33]

When someone uses apparently negative language about themselves, it can be an opportunity to find out more. Asking someone gently what a word or phrase they use means to them is way of taking them seriously: of showing that you are listening and want to understand them. Learning how people experience and explain their own behaviour can help practitioners understand what could help them to develop alternative, healthier coping mechanisms.

It is also worth remembering that words some people use about themselves may not necessarily be derogatory; they may simply be unfamiliar to a practitioner: they may be new words, street slang, or words used by only one person or a small group. In this case too, it is valuable for practitioners to ask people talk about these words and what they mean to them.

Good practice points

- Allow people to define issues from their own perspective:
    - How do they describe their drinking and/or self-harm?
    - Which of their behaviours do they identify as self-harm?
    - What roles do their behaviours have in their life?
- Ask people what their preferred terms for their behaviours are. Discuss use of language openly and make sure that you are all understanding words in the same way
- Reflect on your response to people's use of derogatory terms for their behaviour(s). Do you want to challenge, discuss, and/or accept it? Consider your reasons for your viewpoint on this
- Explore with people what other coping strategies they have developed that are:
    - Also self-harming
    - Healthier/less harmful alternatives to self-harm and/or alcohol use (including alternatives that may be actively health-promoting).[34, 35]

The overall approach can be summarised using the initialism **ABC**:

- **Ask** people about their alcohol use and self-harming experiences
- **Believe** their accounts and understanding of their behaviours
- **Communicate** to them your understanding of what they have said.

Section 2

Understanding the relationship between alcohol use and self-harm

The relationship between alcohol use and self-harm is clear but complex and can change over time

Understanding the relationship between alcohol use and self-harm

Cause and effect?

The relationship between alcohol use and self-harm is clear but complex. People with experience of both behaviours describe it in different ways, and it can change over time. The following insights by interviewees in the Edinburgh research offer some useful guidance:

- Whilst some saw self-harm and drinking as inextricably linked, none framed alcohol as the of cause their self-harm
- For some, alcohol did, however, bring a loss of inhibitions which facilitated self-harm and could lead to worse injuries (because of altered perceptions of pain and risk)
- Alcohol could become closely associated in a person's mind with self-injury, so that drinking provoked an urge to self-harm
- Feelings of regret or self-loathing after a period of heavy drinking were sometimes a trigger for self-harm
- Alcohol was described as magnifying bad feelings, but this was not necessarily a negative experience: drinking could allow the freer expression of feelings that might be otherwise become a subject of unhealthy rumination
- Some said that alcohol use was a way of avoiding self-harm: offering a less risky (and more socially acceptable) form of release
- As we discuss in the next section, some people frame their drinking habits, in themselves, as a form of self-harm.

When alcohol use seems like self-harm

"My drinking for the last four years, I class as self-harm. Every single drop."

Alcohol use, however heavy, has not usually been considered a form of self-harm. For example, in 2011 the Scottish Government specifically excluded "self-harm through substance misuse" from their self-harm strategy.[36] In their 2015 suicide and self-harm prevention strategy, the Welsh Government stated that "substance misuse" was "generally not considered self-harm" but acknowledged that

"boundaries can be blurred".[37] Several people interviewed during the Edinburgh research said that they had found those boundaries very much blurred:

> *"My drinking for the last four years, I class as self-harm. Every single drop."*
>
> *"It's all part of self-harm, isn't it? Even drinking's self-harm, isn't it really?"*
>
> *"It's when I'm drinking in a way that I would probably classify as self-harm…I think I'm doing both of them [drinking and self-harming] for the same reason at that stage."*[38]

Looking at drinking in this way – as a form of self-harm – it can be said to have distinct social advantages over other self-harming behaviours. It can be hidden in plain sight: conducted openly without censure and is often encouraged by society as a response to emotional pain. One way of thinking about this is the acronym coined by Maggie Turp in 2003 "CASHAs" – culturally accepted (or acceptable) self-harming activities – and this was a term that was used by participants in our workshop. CASHAs are harmful behaviours that are (at least up to a point) socially acceptable but fulfil the same functions as other (unacceptable) behaviours. Turp explained CASHAs with reference to tobacco, but her ideas are equally relevant to alcohol.[39]

It is interesting to note that alcohol treatment practitioners we consulted had not observed alcohol use as a conscious act of self-harm, although they were aware of people who continued to drink despite the harm it was causing, including immediate physical pain. Self-harm practitioners were much more likely to see drinking as self-harm. This difference in perspectives may reflect a difference in what workers in the two sectors are familiar with and looking for.

Understanding the relationship between self-harm and suicide

As well as understanding self-harm itself, it is also important for practitioners to understand the complex relationship between self-harm and suicide. Self-harm is not necessarily a sign of suicidal ideation, and most people who self-harm do not attempt suicide. However, self-harm (particularly self-harm that is treated in hospital) is a risk factor for suicide.[40, 41, 42]

There are also associations between substance use and suicide, and particularly between suicide and co-occurring substance use and mental ill-health.[43] If you are supporting someone who is experiencing self-harm, it is therefore important for you to be alert to the possibility that they may be having suicidal thoughts, particularly if they are also using alcohol or another substance. There is no definitive list of signs that someone is considering suicide, but the following table, adapted from SCHEMA suicide prevention training, sets out some of the possible indicators.[44] It is possible that none of these will be apparent, and their absence should not be taken as a reason for not having open and honest conversations about suicide and self-harm.

Signs someone may be thinking about suicide	
Physical • Self-neglect: neglect of personal hygiene, personal appearance, and/or nutrition • Persistent fatigue • Weeping	**Emotional** • Hopelessness • Sadness • Loneliness • Mood changes/sudden outbursts • Anxiety or agitation • Depression • Not caring when things go wrong
Verbal • Talking about wanting to die/not be alive • Talking about suicide or the suicides of others • Questioning the meaning or purpose of living	**Behavioural** • Reduced activity • Giving away possessions • Withdrawal from family and/or friends • More risk-taking behaviour • More use of alcohol or other drugs • Increased self-harm or new self-harming behaviours • Changes in eating/sleeping habits

Practitioners may feel nervous about asking already vulnerable people about suicide, but the evidence shows that asking someone about suicidal thoughts is one of the best ways of reducing such thoughts.[45] Asking someone about suicide is a way of giving them permission to tell you how they feel, and people who have

felt suicidal often say what a relief it was to have an opportunity to talk freely about it with someone who wanted to listen.[46] They may also appreciate the opportunity to explain any relationship between their self-harm and suicidal feelings.

Good practice points

If you are working with someone who you believe may be contemplating suicide, the following approaches may be useful:

- Ask them directly if they are having thoughts about taking their life: don't be afraid of using the word "suicide" [47]
- Explore with them why they may be having such thoughts
- Establish whether they have a plan for suicide. If they have a viable plan and express intent to act on this, stay with them whilst you explore their intentions further
- Discuss their options for getting help. This might be from their doctor, the Samaritans, or a specialist suicide prevention service [48]
- Emphasise that suicidal feelings are not a personal failing – they are a sign that something is wrong and they can and do pass
- Explore how they can keep themselves safe. You may find it helpful to use the Safety Plan templates created by the Samaritans or 4 Mental Health; and the HOPELINK service from PAPYRUS offers a digital platform for people to revisit and update their suicide safety plans online [49, 50, 51]
- Remind them that they can call 999 if they feel unable to keep themselves safe.

Practitioners may also wish to undertake suicide prevention training, such as SCHEMA from Forward for Life and ASIST from PAPYRUS.[52, 53]

The Royal College of Nursing (RCN) and Public Health England (now OHID) have produced a toolkit for nurses on preventing suicide among lesbian, gay and bisexual young people, and one on preventing suicide among transgender young people. Both toolkits may also be useful to other professions.[54]

Section 3
Filling in the gaps between services

There is a growing recognition that services must take a “no wrong door” approach, whereby “every door in the…system should provide access to the services needed”.

Filling in the gaps between services

"If I wanted to stop drinking and self-harming, we'd have to deal with the depth of issues that causes it."

Why people need a holistic offer

There is a growing recognition that services for people with complex needs must take a "no wrong door" approach, whereby "every door in the…system should provide access to the services needed".[55] Unfortunately, this ideal was not reflected in the experiences of those interviewed by the Edinburgh researchers, all of whom painted a depressingly consistent picture of services not meeting their needs, in large part because the current service configuration did not allow alcohol use and self-harm to be addressed in the same place at the same time. As one person put it:

> *"There seems to be a line between the two – between the mental health and drug and alcohol services…There shouldn't be a line. It should be all under one banner."*[56]

Two other research reports published in 2022 have come to similar conclusions:

> *"Many of the people we heard from described using alcohol as a coping mechanism for other issues in their lives, like poor mental health, stress, relationship problems, or trauma. Those who were able to get support often found that services struggled to address these issues together."*[57]

> *"Co-occurring mental ill-health and substance misuse resulted in several respondents being excluded from support. This is despite national NICE and Public Health England guidelines requiring the provision of services for people with co-occurring issues."*[58]

The most common reason interviews gave the Edinburgh researchers for being unable to access holistic support was the frequent requirement for them to address their use of alcohol (or any other drug) in order to be eligible for mental health support. This is a cause of considerable frustration, as the following comment illustrates:

> *"I think…the mental health team need to put something else in place instead of saying, 'I'm sorry I can't see you unless you're sober'. But hang on a minute, I'm finding it difficult to become sober. So…they need to…sit down and talk to you about it."*[59]

It is worth noting here that NICE Guidance 58 is very clear on this issue:

> *"Do not exclude people with severe mental illness because of their substance misuse. Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse".*[60]

Just as worrying as the exclusion of some people from mental health support because of their substance use, is the tendency the Edinburgh researchers identified for people to conceal or minimise either their alcohol use or their self-harm in order to access services: to feel "compelled by the structure of existing service provision to choose to seek support either for their self-harm or their drinking, but not both".[61] As one interviewee said:

> *"In order to be eligible to access a mental health service, you cannot have any substance misuse issues…So…I've just said I don't have an [alcohol] issue."*[62]

Given that alcohol use and self-harm are so closely entwined in some people's lives, if they feel unable to be wholly honest with practitioners about either issue, there is a real risk of services having an incomplete understanding of their clients' needs and providing inappropriate or inadequate support.

The common ground

"If I wanted to stop drinking and self-harming, we'd have to deal with the depth of issues that causes it, and get me to a place where I felt able to cope with my difficulties and able to cope with my life circumstances, and generally feel better about myself."[63]

Both alcohol problems and self-harm are often symptoms of something else: ways of dealing with past or current distress. It's not surprising, therefore, that self-harm and alcohol support services see people whose thoughts, feelings, behaviours, and motivations for those behaviours, are remarkably similar. We have summarised in the table below the underlying issues that practitioners in both fields have told us they encounter amongst the people they are seeking to support.

Emotional difficulties

Low self-esteem; shame; lack of trust; lack of acceptance by others; lack of self-acceptance; depression; anxiety; loneliness; social isolation; loss of sense of purpose; emotional isolation; difficulties in recognising, understanding and expressing feelings; anger control issues; attachment disorders

Traumatic experiences

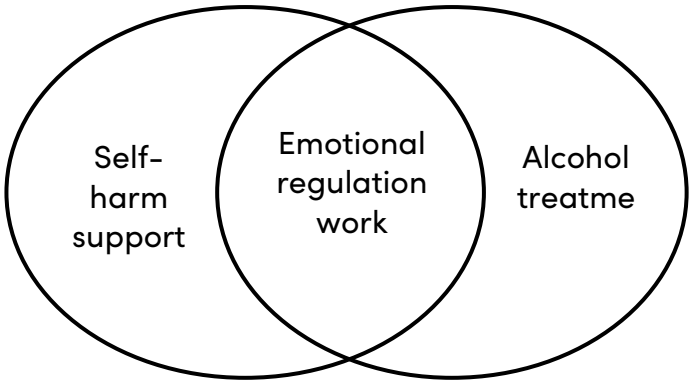
Parental rejection (including in response to sexuality or transgender status); racism and racial abuse; sexism and sexual harassment; adverse childhood experiences; childhood abuse; domestic abuse in adulthood; negative attitudes from services; bereavement; exploitation; accommodation and financial problems; physical illness; unemployment

Harmful behaviours

Non-suicidal self-injury; lack of order or certainty in life; disordered eating; (poly)substance use; overwork; risky sexual behaviours; other risk-taking activities

Neurodiversity
Attention deficit (hyperactivity) disorder; autism

Because of this commonality of underlying issues, practitioners in both fields told us that they often started their therapeutic journey with people by helping them to understand the nature of their distress, identify and label their emotions and stabilise and regulate them, before seeking to deliver effective interventions for self-harm and/or substance use. This common ground between the two fields is set out in the Venn diagram below.



One major cause of distress – and therefore of increased risk of alcohol problems and/or self-harm – is trauma, and we'll look at this in more detail in the next section.

Being trauma-informed

Traumatic experiences may be major external events such as wars and natural disasters; but, as the National Centre for Mental Health have noted, trauma usually occurs within the context of human relationships and often involves people being hurt or betrayed by someone they have trusted or relied on, and this may include services from which they have sought help.[64, 65]

Interviewees during the Edinburgh research described experiences such as bullying (including homophobic bullying), rape and sexual abuse, childhood trauma, bereavement, being in local authority care, and having children removed from their care.[66] Alcohol and self-harm provide a means (however temporary) of coping with the emotional legacy of experiences like these.[67] In the words of one practitioner, "Self-harm is the way some people survive".[68]

When supporting people with a history of trauma, practitioners may find value in Judith Herman's three-stage model of trauma recovery:

- Establishing safety
- Retelling the story of the traumatic event
- Reconnecting with others.[69]

These three stages are intended to address what Herman identified as the essential features of psychological trauma: disempowerment and disconnection from others. Recovery from trauma therefore requires empowerment and remaking relationships (or making new ones). The importance of building relationships of trust was noted very clearly by the Edinburgh researchers:

> *"Although the participants all had different experiences of service provision and different ideas about what types of services they would prefer, they commonly raised the importance of supportive relationships with practitioners".*[70]

Retelling the story of a trauma must be handled with particular care and this work is best done by a qualified and experienced psychotherapist. Although studies have found that talking about past trauma is positive and empowering for most people, rather than re-traumatising, even people who want to talk about their trauma history may underestimate the level of emotion involved. One thing that all practitioners can do, however, is believe people's accounts of their traumatic experiences and demonstrate that belief to them.

Practical care for people who are self-harming

Alcohol is vasodilatory: it causes blood vessels to widen, meaning that bleeding may be more profuse and last longer when someone self-harms whilst intoxicated. Also, if someone has alcohol-related liver damage, their blood may not clot as well after an injury, again leading to worse bleeding. As harm reduction measure, it is important to communicate this information calmly and factually to people who may self-harm under the influence of alcohol and/or who have a history of heavy drinking.

Many people who self-harm wish to hide their injuries and/or scars, and unless there is a clear medical need, practitioners should not ask to see them. It is, however, very helpful for practitioners to offer practical help, such as advice on wound care, bandages, antiseptic, and other first aid supplies. The Kent Community Care NHS Trust leaflet *Staying safer with self-harm* includes wound

care and first aid advice, and there is useful first aid advice on the Self Injury Support website.[71, 72]

Being needs-led

In the section on **Terms and definitions** on page 8 we discussed some of ways professionals and policymakers have sought to classify types of alcohol use and self-harm. People who are experiencing such issues have expressed mixed feelings about these classifications. While some find that having their problem(s) clearly defined is helpful and opens doors to services; others have noted disadvantages:

- Diagnoses and definitions may feel reductive and may not reflect someone's own sense of what is happening in their life or has happened in their past
- More seriously, they may believe they need to "comply with and accept the label in order to access the treatment they need or want" [73]
- A diagnostic threshold may act as a barrier to support for someone whose behaviour is unhealthy or harmful but does not reach that threshold, with an associated perverse incentive to intensify that behaviour in order to meet the criteria.[74]

It is valuable for non-clinical support workers to have some understanding of the criteria for diagnosis and recommended treatments for common mental health issues they will encounter amongst clients – such as depression, personality disorders, bi-polar disorder, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). However, there is also often real benefit to simply being open to the distress in which a person presents themselves – what the Edinburgh researchers called "responsive, needs-led services that do not necessarily require diagnoses but can respond in the ways those seeking support prefer".[75]

According to one workshop participant, taking a needs-led approach is actually simpler and more practical:

> *"Just because we have a complex client, [it] does not mean we need to come up with complex solutions. If your car breaks down, [you] check whether there's petrol before you take the engine out. [We] start with simple questions like: 'What's happening in your life?'."*[76]

There may also be a role for practitioners in supporting people to the meet basic physical needs – such as a clean and safe living space and adequate nutrition – that are the foundation of self-esteem and provide a stepping-stone to further progress. Some people may also be in need of financial/material support, such as access to benefits and/or other funds, and/or access to facilities such as community food pantries.[77] One of most widely used tools for discovering these kinds of everyday needs is the Camberwell Assessment of Need, a group of questionnaires about issues such as accommodation, food, self-care, daytime activities, childcare, money, and relationships, as well as psychological distress and physical health.[78]

The practice guidance developed by Connecting People can be used by practitioners to support people to connect with others beyond health or social care agencies, and so enhance the diversity of their social networks and improve their quality of life.[79]

In the next section, we'll look at some of ways practitioners can go the extra mile to support people, and when to draw the line.

Flexible working...and its limits

Services for vulnerable people need to be rapidly available and responsive to individual need. In 2013 the former National Treatment Agency for Substance Misuse recommended that services ask themselves, amongst other things:

- Do your opening times accommodate people working full-time and/or with childcare or other caring responsibilities?
- Does your assessment process allow for immediate support to address immediate needs?
- Can you offer next day follow-up appointments for service-users when needed?
- Does your service make the most of texts, phone calls and emails to communicate, and do people have the work mobile phone numbers of their keyworkers?
- Do you provide outreach to high-risk groups, or have close links for referrals from separate outreach services?
- Do you have any satellite services close to where people are living?
- Can your services be reached by public transport? [80]

Our own consultations have also highlighted a desire amongst service-users for:

- Flexibility of appointments
- Outreach services
- Out-of-hours support (e.g. at weekends)
- Multimodal contact and support methods for clients e.g. telephone, text, webchat, Zoom, face-to-face, and group work, whilst also recognising that some interventions do not work for some people. For example, some people may be wary of group work or find phone calls challenging.[81, 82]

All of the above approaches are worth considering, but however much practitioners may want to go the extra mile for clients, staff are not superhuman and not every service can do everything. There are limits to everyone's time, energy, and resources.

"It is possible to see how much accessibility and positive attitude could be affected by service structure, caseloads, and ultimately service funding. However enthusiastic an individual practitioner is, if they have an overwhelmingly large workload, it will be challenging to form meaningful supportive relationships [with clients]."[83]

Organisations must acknowledge that practitioners have their own support needs, particularly when caseloads are high, and it's important for them to have access to support to process the impact of their work on them.

When working with people with complex needs, there is a real risk that hearing the details of others' trauma can lead to practitioners experiencing "vicarious trauma" or "secondary trauma". This risk can be reduced by monitoring the size of caseloads and providing adequate staff supervision.[84] Staff may also benefit from restorative supervision and from more informal approaches such as peer support.[85]

Practitioners' self-care needs, and healthy coping strategies, can be grouped under the following three headings:

- **Physical self-care:** A healthy diet, sleeping well, exercising, ensuring time for relaxation and leisure activities
- **Emotional self-care:** Opportunities to talk and debrief

- **Professional self-care:** Support, clinical supervision, professional development, time management, and opportunities to address work-related concerns.[86]

In all three cases, it should not be left up to individual practitioners to make sure that these things happen: employers need to play their part in ensuring that workloads allow time for debriefing and supervision, and do not impinge on leisure time.

Good practice points

Self-reflection questions for practitioners:

- What are my self-care practices?
- Are they effective?
- To what extent does my work impact my physical health?
- To what extent does my work impact my mental wellbeing?
- To what extent does my work affect my professional and personal relationships?

Section 4

Understanding diversity

In this section, we look at some of the communities and characteristics that services need to be aware of and understand

Understanding diversity

"Effective services assess the needs of the populations they serve and respond appropriately." [87]

A single model of support will not work for everyone. This is particularly true in the fields of alcohol-use and self-harm, which are both issues that can occur more frequently and more seriously in some sections of the population and for reasons particular to those groups.

In this section of the guide, we have looked at some of the communities and characteristics that self-harm and alcohol treatment services need to be aware of and understand. We have grouped them under three broad headings:

- Sex, gender and sexuality
- Race, religion and culture
- Neurodiversity.

We'll also look briefly at the intersectionality of these and other factors.

Sex, gender and sexuality

Statistics indicate that self-harm is more common amongst women than men, particularly amongst younger people; and while alcohol use has tended to be more common amongst men, the gap between men and women's drinking habits has been closing for decades.[88, 89, 90]

Particular events/periods in many women's lives – such as the postnatal period and the menopause – may bring greater stress and therefore greater risks of harmful coping behaviours.[91, 92, 93] Some research has indicated that women were at greater risk of increased alcohol consumption and worsened mental health during the Covid-19 pandemic, and that may have longer-term implications.[94, 95] It is clear, therefore, that services need to ensure that their provision is recognising and meeting the particular needs of women.

Despite social shifts in recent decades, it is still the case that women are more likely than men to have caring responsibilities, including undertaking the bulk of

childcare. It makes sense for service-providers to enquire about service-users' caring roles and seek to accommodate them, e.g. by scheduling sessions at suitable times of the day or evening, and facilitating access to childcare/respite care where possible.

Offering online support may be one way to ease access to support for some women. Substance use practitioners we spoke with commented that – whereas previously their caseload had been largely male – the move to online support during the Covid-19 pandemic had brought an increase in women seeking help (perhaps because such support could be more easily fitted in around caring roles).

When support is provided face-to-face, it will sometimes be necessary and appropriate to offer women-only sessions, e.g. a meeting with a female practitioner and/or a women-only mutual aid group. This is particularly important for women who have been previously traumatised by men, and the Edinburgh research highlighted that women-only spaces give some women a greater sense of security.[96] Less obvious, but, according to some researchers, "even more pervasive", are the ways in which women may be "made to feel inferior, irrelevant, or invisible within male-dominated settings" and may find that women-only spaces allow them to be themselves and share their thoughts honestly.[97, 98]

Contrary to suggestions made in some news media in recent years, none of this necessitates the routine exclusion of transgender individuals. As Stonewall research noted in 2018, "domestic and sexual violence services in England and Wales have been supporting trans women in their single-sex women-only services for some time" and undertake thorough risk assessments that prevent anyone taking inappropriate advantage of this support, thereby offering a model of trans-inclusion for other services to emulate.[99] This is particularly important given that social pressures on people from sexual and gender minorities often result in higher levels of mental distress and associated coping behaviours, such a heavy alcohol use and/or self-harm.

Some services seek to provide a range of spaces, where possible, recognising that some women will have a clear wish to be in a space that is only for women as defined by biological sex. Different people will have different needs and it is worth all organisations formulating a clear policy that outlines its perspective on this.[100] Where a service is unable to meet a person's needs (for whatever reason) they should always seek to signpost to an alternative service.

"LGBT people don't typically present to substance use services. There is a lot of stigma and uncertainty, partly because they don't encounter practitioners who look or think like them and understand their experiences." [101]

Several studies have shown that LGBT+ people are more likely to experience alcohol problems, including alcohol dependency, and more likely to experience self-harm, and this is often a result of bullying and other forms of mistreatment.[102, 103, 104, 105, 106] There is some evidence that transgender people are at a particularly high risk of self-harm; and one self-harm support service has told us that they have seen a big increase in attendance by non-binary people, who may have particular support needs.[107, 108, 109]

LGBT+ people may also experience difficulties in accessing services.[110] A survey of more than 5,000 LGBT+ people in 2018 found that 13% had experienced some form of unequal treatment from healthcare staff, which may be one reason that 19% had decided not to reveal their sexual identity to any healthcare professional.[111] We've set out below some suggestions for how services can make themselves more welcoming and accessible to LGBT+ people, based on research by the LGBT Foundation in 2021.[112]

Good practice points

- Visible inclusion: displaying posters, literature, inclusion awards, and other signs that the service is welcoming LGBT+ people
- Signposting to LGBT+ affirmative support services, groups, and organisations
- LGBT+ staff champions
- Stating your own pronouns and offering clear opportunities for others to state theirs
- Using inclusive language
- Avoiding assumptions
- Monitoring sexual orientation, gender identity and transgender status – the LGBT Foundation offers specific guidance on this [113]
- Training staff and volunteers on LGBT+ healthcare and inclusive practice. [114]

Race, religion and culture

Many studies over many years have highlighted ethnic/racial inequalities in health outcomes and access to health services, and a resultant lack of trust in healthcare services.[115, 116]

Individual services may not have the means to address underlying equalities, but there is much that we can all do to change policies, procedures, systems and structures that contribute to unequal outcomes.[117] As a starting point, it is important to be aware of the particular reasons that people from minority ethnic communities may be experiencing self-harm and/or alcohol issues.
There are many reasons any individual might experience either or both of these issues, and why they may struggle to get help, but there are some factors that are particular to minority ethnic communities, such as:

- Racism and discrimination
- Unmet language needs
- Migrant status and migration stress [118, 119]
- Difficulties understanding and accessing services.[120]

It is worth all services:

- Understanding the ethnic, cultural, and religious profile of the area they are serving
- Finding out whether there is local demand for information in community languages or bilingually
- Building good relations with local community organisations that may be able to offer insights into local needs and make connections with people in need of support.

At an individual level, we have set out below some suggestions for better meeting the needs of individuals from diverse ethnic communities.

Good practice points

- Try to find out before your first meeting with any client whether an interpreter/translator is needed, and do not rely on family/friends to translate
- Be aware of cultural norms about gender and age: a client may only be

comfortable speaking with someone of the same gender; or they may be reluctant to share with someone much younger than themselves
- Some cultures place a much greater emphasis on family and community, in contrast to Western individualism. So, there may be more reason to involve the family in treatment and/or involve peer-supporters; but always make sure the client has control over who from their family or community is involved
- In communities where shame may be holding some people back from seeking help, it is especially important to emphasise the confidentiality of services
- Be aware of cultural taboos and look out for verbal and non-verbal signs of discomfort or confusion – do not take silence as consent or agreement.[121, 122, 123]

In the field of the Welsh language, the Welsh Government has promoted the concept of an Active Offer, which may also be relevant to other community languages. The Active Offer that means services:

- Identify language need as an integral part of providing a safe, high-quality service
- Take the responsibility off the service-user to ask for a service through the medium of Welsh – by actively offering that provision
- Make the Welsh language as visible as the English language – this third point is one that many services could implement in the context of other community languages, even if they do not have practitioners who can converse in those languages.[124]

Faith is not an exact proxy for ethnicity. Overall, people from ethnic minority communities are more likely to adhere to a religion than white British people and more likely to take their religion seriously and play an active part in it, but this is by no means universal.[125] Various forms of faith and spirituality are still common in all sections of UK society and may be part of how someone understands their self-harm and/or alcohol issues. People's beliefs may be very personal or may be rooted in a well-established religion tradition. People may feel an attachment to a faith tradition even they do not accept some aspects of it. In all cases, it's best to avoid assumptions and ask non-judgemental questions about someone's worldview.

A religious worldview may give someone a very different perspective on health issues and how to grapple with them. For example, their understanding of "healing" may be very different to secular notions of "treatment" and "cure".[126]

Faith may be a positive factor, and engaging with a client's faith can be a real boost to the them in their efforts to improve their life.[127] It can also sometime bring some negative baggage, such as a belief that alcohol use is a moral failing and a cause of shame.[128, 129] Religious identities may be racialised by others – as in the case of Islamophobia and anti-Semitism – meaning that, in work to tackle racism, it may also be necessary to recognise people's experiences of prejudice towards their faith community.[130]

Good practice points

At an Alcohol Change UK and Adfam forum in 2022, we asked people from a variety of faith communities what good substance use support for individuals and families of faith would look like. Here's what they told us:

- Services need to understand in a therapeutic way the role faith plays in life:
    - Meditation, prayer, worship, and reading scriptures can bring insight, hope, understanding and consolation for people
    - If a person of faith is part of a community of worship, that may be the main place they find solace and support
- Staff training in services could be expanded "beyond typical equality and diversity training" to help staff understand more about the role of faith, e.g. as part of their induction, new staff could visit local faith venues
- Practitioners could benefit from guidance around what questions to ask clients about religious beliefs and culture
- There can be real benefits from people of faith sharing their experiences of substance use and recovery with other people of faith who have experienced similar challenges
- There may also be some benefit to encouraging family members to come to appointments, to recognise and work with "that duality of two lives being led" if a person is using alcohol but is part of a community where it is prohibited
- Services can take practical steps, such as having food that reflects the faith(s) of the people they're working with and having meetings in venues the community is familiar with and is happy to access.[131]

Neurodiversity

Neurodivergence or neurodiversity describes someone whose neurological processes and development are significantly different from what is considered typical (or neurotypical) in the population. Both terms are used mostly to refer to the autism spectrum, which is characterised by:

- Differences in processing information and interacting socially
- Restricted and/or repetitive interests and behaviours
- Greater sensitivity to noise, touch, light etc.

Autism is sometimes associated with other conditions such as ADHD, dyslexia and dyspraxia, and more information about the links between autism and these conditions can be found on the National Autistic Society website.[132]

Research undertaken with us by the Centre for Applied Autism Research (CAAR) at the University of Bath in 2018 found that autistic people are as likely to experience alcohol problems as anyone else, but when they do, they may find it more difficult to access support. Barriers to autistic people seeking support include going somewhere unfamiliar, worrying they won't be understood, and being in a crowded or chaotic place.[133]

Studies suggest that autistic people are more likely to self-harm than neurotypical people and that autistic women are more likely to self-harm than autistic men; and the All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention has noted evidence of high rates of self-harm amongst young autistic people.[134, 135, 136, 137] There is a clear imperative for both self-harm and alcohol support services to make sure they are autism-friendly.

Good practice points

Working with Alcohol Change UK, CAAR have developed the following tips for staff practitioners in any field who are working with autistic people. These are explained in more detail in the appendix on **Working with neurodiverse people** on page 55.

- Understand autism, including its strengths, such as honesty and attention to detail
- Be clear with clients about what will happen at each session

- Be consistent but be ready to be flexible
- Use plain language – avoid metaphors and idioms
- Provide written and visual information
- Allow time for processing information
- Discuss hobbies and interests
- Discuss emotions in terms of lived experience, not simply labels.[138]

In many ways, making the necessary adjustments for autistic people should not be a great stretch for services that already have a person-centred focus; and considering whether your offer to clients is autism-friendly can be seen as an opportunity to assess more broadly whether there are any aspects of the way you do things that could exclude some people. As Prof Mark Brosnan at CAAR has said, "Autism-friendly is everyone-friendly".

Intersectionality

The concept of intersectionality was introduced by Kimberlé Crenshaw in 1989, when she criticised the "tendency to treat race and gender as mutually exclusive categories of experience".[139] She called this a "single-axis framework" and in 2017 she explained, "It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times, that framework erases what happens to people who are subject to all of these things".[140] To Crenshaw's list here we can add issues such as disability, neurodiversity, income, language, and belief.

When looking at someone's situation through the lens of intersectionality, it's important to recognise that the aspects identity do not simply accumulate; they cut across each other (intersect) giving each person a unique "social position" or "social space" which affects how they experience the world and how the world treats them.[141, 142] This "social position" may influence their patterns of self-harm and/or alcohol use; how they think about and respond to those behaviours; and how those around them – friends, family, and services – respond to them.

Many people accessing support for alcohol misuse and/or self-harm will have experienced multiple disadvantages and oppression, and it's important to recognise the impact of this. Like any other kind of trauma, discrimination can leave someone with a sense of disempowerment and disconnection from others.[143] If an individual has experienced discrimination because of their gender, sexuality,

ethnicity, neurology and/or mental health condition – particularly if that discrimination was by services – those previous negative experiences may make it difficult for them to engage with support. This may manifest as:

- Missed appointments
- Anxiety about attending appointments
- Mistrust of services
- Reluctance to share personal information
- Difficulties communicating needs
- Difficulties in adhering to care plans
- A sense of hopelessness.

As we noted in in the section on **Being trauma-informed** on page 27, building trust is the most important thing practitioners can do with some who has experienced the trauma of discrimination. Staff may also benefit from training on the needs and experiences of specific groups and communities. Some possible training providers include:

- Self-Injury Support
- Race Equality First
- Show Racism the Red Card
- LGBT Foundation
- Stonewall
- National Autistic Society.

Details of these organisations and others can be found in the **Useful websites** towards the back of this guide. There may also be organisations based in your local area whose local knowledge may enhance their training offer.

Section 5

Working with other services

Services must collaborate if people with complex needs are not to fall through the gaps.

Working with other services

Services must collaborate if people with complex needs are not to fall through the gaps.[144] There are various ways of doing this and it is possible to identify four broad models:

Sequential treatment: A person is treated for one condition first (such as alcohol use) followed by treatment for another condition (such as self-harm). Although commonplace, this model of treatment was strongly criticised by interviewees in the Edinburgh research and said to be characterised by the expression "I'm sorry I can't see you unless you're sober".[145]

Parallel treatment: Both (or all) a person's conditions are addressed simultaneously but the treatments are provided independently of each other. The success of this approach depends on good communication between services.

Integrated treatment: Co-occurring conditions are addressed at the same time by the same treatment provider. This allows for exploration of the relationships between conditions but relies on a service having all the necessary expertise under one roof.

Stepped care: This involves the use of the least intensive and expensive treatment initially, with more intensive or different treatments if less intensive forms prove insufficient. There is an expectation of a pyramidal structure, with high volumes of low-intensity interventions and lower volumes of more intensive treatments.[146, 147]

Whichever model is used, consistency is important to avoid people pinballing around the system. If clients are in contact with a number of agencies, multi-agency planning will help ensure a consistent approach, so that everyone knows who is involved and who is meant to do what, when and why.

It may be appropriate to nominate a care co-ordinator to ensure that the work of all agencies is brought together into a single multi-agency plan. The decision on who should lead the process and develop the plan (and which service they should be based in) will need to be made locally.

In areas where Alcohol Change UK's Blue Light approach is being used to support the most vulnerable drinkers, multi-agency groups have been set up to manage support on a case-by-case basis.[148] Similarly, Gwent Drug and Alcohol Service (GDAS) in south-east Wales have set up the Newport Co-Occurring Gateway (COG), a multi-disciplinary panel for deciding the best pathway for individuals.

Self-harm practitioners we consulted in Wales also mentioned the benefits of using the NEST Framework for supporting young people. NEST is intended to "broaden the conversation away from thinking that only specialist services can provide help" and to "give the grown-ups closest to children of all ages the skills and confidence to understand what they can do to help".[149] Other suggestions made by practitioners at our 2022 workshop included:

- Practitioners shadowing workers in other services, to better understand their work
- Practitioners being seconded between services
- Establish "hot clinics" (drop-in clinics) with multi-disciplinary support at a specific time of each week
- Joint appointments for clients: meeting with practitioners from two or more services together.

When to refer to specialist services

Our hope and our aim are that this guide will help workers in self-harm and alcohol treatment services to increase their confidence and skills in working holistically with people who are facing both these issues. But there will be limits to this.

Practitioners have told us that clients with complex needs sometimes expect that once they access a service, all their issues will be addressed, or that the service will be able to access any additional support on their behalf. One of the best ways services can earn the trust of their clients is by being clear about what they can and cannot do, and it is important for all professionals to:

- Recognise the limits of their abilities and remit
- Refer people to other services if that is needed
- Support people to navigate their route between services.[150, 151]

We have set out below some examples of when practitioners may need to a refer to a more specialist service, although this list is not exhaustive.

Referral into alcohol treatment services
• A persons' AUDIT score is over 19, indicating potential alcohol dependence (see page 48 for details of AUDIT and page 8 for an explanation of alcohol dependency) • They express difficulty controlling their drinking despite repeated attempts • They are experiencing physical withdrawal symptoms when ceasing drinking – a sign of alcohol dependence. If someone has suddenly stopped drinking and is experiencing symptoms such as sweats, shakes, insomnia, cramps, or hallucinations, they are in withdrawal and need urgent medical attention
Referral into specialist mental health services
• A client is expressing suicidal ideas/intentions • Their self-harming behaviours are escalating in severity or frequency • They say that their self-harm is in response to intrusive thoughts (which may be an indication of an obsessive-compulsive disorder) or voices or irrational/fantastical beliefs (which may be an indication of a psychotic disorder)
Always consider making a referral
• When a client requests referral or additional support

For practitioners who are not specialists in self-harm, the Oxford Health NHS Foundation Trust have developed the harmLESS website as a guide to talking about self-harm with a young person, and the site includes an assessment tool to assist in deciding what support it might be beneficial to refer them to.[152]

Practitioners can also support referral by:

- In the first place, developing links and care pathways with other agencies
- Finding out about other agencies' referral criteria, the limits of their service provision, and their philosophy and approach to treatment; and explaining these to clients in appropriate language, so that they understand what to expect when they are referred to another service
- Acknowledging and discussing any concerns people may have about attending a new service
- Offering to support clients to complete any referral paperwork
- Making an appointment with the agency with the client (or on their behalf with them present) rather than leaving them to make (or not make) their own appointment [153]

- If possible, accompanying a client to their first appointment at the new service; or exploring whether a volunteer or peer mentor can accompany them
- If you believe the client may not attend an appointment – or may arrive late, or intoxicated – contacting the receiving services and ask them to be flexible
- Asking the receiving service to let the referring service know if someone does not attend, and establishing how the client would like to be contacted (e.g. by phone or text) if they miss an appointment. [154]

It is possible that some people will be reluctant to be referred to an alcohol treatment agency because they believe they will be required to stop drinking altogether. Most treatment services operate a harm reduction approach that allows for reduced drinking rather than total abstinence, but it may be worth finding out what the philosophy is of any alcohol treatment service you are referring someone to.[155]

Some people may worry that engaging in treatment – and thereby making acknowledging their alcohol problem – may lead to other difficulties for them, such as sanctions from their employer or from social services (particularly if they are parents). You can help reduce these concerns by:

- Emphasising client confidentiality and that agencies don't always have to disclose information to other services; only if they belief that there is a risk of harm
- Emphasising that the person is taking a very positive step by addressing their alcohol use, and that other services will usually view it in that way too.

You may wish to consider directing people to online support and helplines, especially if they prefer these types of interaction. Some of these are listed in the **Useful websites** section on pages 49 to 51.

Sharing information

People seeking support for complex needs have told us that they sometimes feel discouraged and exhausted by the need to repeatedly tell the story of their experiences to different services, and this issue has been highlighted by other researchers.[156]

When making referrals, it may be worth looking at ways of sharing such information more simply (within the confines of appropriate confidentiality). One

option for this is a document that a service-user is happy to co-create with a practitioner, summarising the information that they wish to share with other services.

There are several templates for this from other sectors, such as the University of Edinburgh's *Personal Communication Passport*, Improvement Cymru's *Health Profile*, the Ipswich Hospital NHS Trust's *About Me* document, and the Alzheimer's Society *This is me* leaflet (which is available in English or as a bilingual Welsh and English document).[157, 158, 159, 160] None of these could be used off-the-shelf in the fields of alcohol use and self-harm, but they may provide a useful starting point for creating an equivalent document for people experiencing alcohol use and/or self-harm issues.

A call to action: making services work for people

This section is what is called a "conclusion" in most documents, but we wanted to leave our readers with something a bit more inspiring than a summary of what we've already said.

This handbook is about two difficult topics that make a lot of people nervous – including some professionals – and about the complex interface between them. We hope that we have been able to dispel some of that nervousness and give practitioners in the fields of both self-harm and alcohol use greater confidence in working with people whose lives sit at that interface. As we've found, the two issues are often more similar than someone might suppose and are both often coping mechanisms for similar forms of mental distress.

We would encourage workers in self-harm services and alcohol treatment services to make use of this handbook, to make connections across professional boundaries, to work together more, and to offer people the holistic support they need to improve their quality of life.

Section 6
Resources

Resources

NICE guidance and standards

NICE Guideline 25: *Self-harm: assessment, management and preventing recurrence*: nice.org.uk/guidance/ng225

NICE Quality Standard 34: *Self-harm*: nice.org.uk/guidance/QS34

NICE Guideline 115: *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence*: nice.org.uk/guidance/cg115

NICE Quality Standard 11: *Alcohol-use disorders: diagnosis and management*: nice.org.uk/guidance/qs11

NICE Guideline 58: *Coexisting severe mental illness and substance misuse: community health and social care services*: nice.org.uk/guidance/ng58

NICE Quality Standard 188: *Coexisting severe mental illness and substance misuse*: nice.org.uk/guidance/qs188

AUDIT and Alcohol Interventions and Brief Advice (IBA)

The Alcohol Use Disorders Identification Test (AUDIT) is an internationally recognised 10-question questionnaire providing a robust picture of drinking behaviour and its impact. Use of AUDIT can identify risks associated with increased consumption on individual occasions (such as drunkenness leading to increased incidence of low mood associated with self-harming behaviours) and risks linked to frequency of drinking episodes. Repeating the AUDIT over a period of weeks or months can also help show how an someone's drinking patterns have changed over time.

When considering mental health alongside alcohol use, AUDIT questions such as "Have you felt guilt or remorse after drinking?" and "Have you failed to do what was normally expected of you after drinking?" give insight into the direct impact of alcohol consumption on feelings and behaviours.

When we discussed the use of AUDIT with self-harm practitioners, some were concerned that a formal questionnaire would be less effective than gathering

information organically during conversations with clients. To avoid this pitfall, AUDIT can be used as the basis of a semi-structured interview rather than as a questionnaire.

The AUDIT tool and associated guidance can be found here: gov.uk/government/publications/alcohol-use-screening-tests

Anyone can complete the AUDIT questionnaire anonymously online on the Alcohol Change UK website: alcoholchange.org.uk/alcohol-facts/interactive-tools/check-your-drinking

Alcohol Interventions and Brief Advice (IBA) (also known simply as "brief interventions" or "brief advice") is a short follow-up conversation when sharing a person's AUDIT results with them. There is a good body of evidence that a structured intervention like this, of just five minutes, leads to behaviour change in one in eight recipients. You can find out more about IBA at: e-lfh.org.uk/programmes/alcohol/.

Alcohol Change UK delivers an e-learning IBA course as well as face-to-face and online training in IBA. Contact: training@alcoholchange.org.uk

Useful websites

Adfam
Information and support for the families and friends of people experiencing problems with alcohol, other drugs and/or gambling.
adfam.org.uk

Alcohol Change UK
Alcohol Change UK works for a society that is free from the harm caused by alcohol. The website includes links to local support services across the UK, an online AUDIT screening tool, and information about training on alcohol issues.
alcoholchange.org.uk

Autism Wales
A bilingual website offering information for autistic people and their families, and for practitioners, about autism and about the services and training that are available online and at locations across Wales. The website is part of the Welsh Government's work to ensure that Wales is an autism-friendly nation.
autismwales.org

Bi Cymru
The all-Wales network for bisexual people, people attracted to more than one gender, and those who think they may be bisexual or attracted to more than one gender.
facebook.com/groups/5601885683/

Connecting People
Resources to help practitioners support people to connect with others beyond health or social care agencies, and so enhance the diversity of their social networks.
connectingpeople.net

Harmless
A charity providing support, information, training and consultancy about self-harm to individuals, friends and family, and to professionals.
harmless.org.uk

LGBT Foundation
Established in 1975, LGBT Foundation exists to support the needs of the diverse range of people who identify as lesbian, gay, bisexual and trans. They offer training on improving LGBT+ inclusivity and support for LGBT+ people.
lgbt.foundation

National Autistic Society
The UK's leading charity for people on the autism spectrum and their families, providing support, guidance and advice, as well as campaigning to create a society that works for autistic people.
autism.org.uk

Papyrus
A national charity dedicated to the prevention of suicide and the promotion of positive mental health and emotional wellbeing in young people.
papyrus-uk.org

Race Equality First
Providing support, advice, leadership, and an influential voice for people who face discrimination, harassment, hate crime and disadvantage.
raceequalityfirst.org

Rethink Mental Illness
Advice, information and advocacy on a range of mental health issues.
rethink.org

Self-Injury Support
A multi-channel support service for women and girls affected by self-injury, trauma and abuse, plus information and self-help tools for anyone to use.
selfinjurysupport.org.uk

Show Racism the Red Card
One of the UK's leading anti-racism educational charities, providing educational sessions to more than 50,000 people each year.
theredcard.org

Staying Safe
Support to make a safety plan for anyone experiencing suicidal thoughts or self-harming, including a downloadable safety plan template and resources for professionals.
stayingsafe.net

Stonewall
Information, advocacy and support for lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+) people.
stonewall.org.uk

Support After Suicide
The Support After Suicide Partnership brings together suicide bereavement organisations and people with lived experience, to ensure that everyone bereaved or affected by suicide is offered timely and appropriate support.
supportaftersuicide.org.uk

Helplines

Community Advice and Listening Line (CALL)
24-hour mental health helpline for Wales
Call 0800 132 737 or text 'help' to 81066

Crisis Text Line
Text support line for people in crisis to connect with a trained volunteer counsellor.
crisistextline.org

DAN 24/7
Free 24-hour bilingual drug and alcohol helpline for Wales.
Call 0808 808 2234 or text DAN to 81066

Drinkline
Free, confidential helpline for anyone who is concerned about their drinking or someone else's.
Call 0300 123 1110, weekdays 9am–8pm, weekends 11am–4pm

HOPELINEUK
If you are having thoughts of suicide, or are concerned for a young person who might be, you can contact HOPELINEUK for confidential support and practical advice.
Call 0800 068 4141, text 07860039967, or email pat@papyrus-uk.org, 9am-12 midnight every day of the year

Local NHS urgent mental health helplines in England
This website allows you to find the number for mental health helplines for different parts of England: nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

Samaritans
24-hour support for anyone experiencing thoughts of suicide.
Call 116 123 or email jo@samaritans.org. For support in Welsh, call 0808 164 0123, every day 7pm-11pm

Stonewall
Information and support for LGBT communities and their allies.
Call 0800 0502020, 9:30am-4:30pm Monday to Friday.

Mobile Apps

All these apps are available free of charge for Apple and Android from the App Store and Google Play.

Calm Harm
An app to help people manage or resist the urge to self-harm. Calm Harm was developed for the teenage mental health charity stem4 by Clinical Psychologist Dr Nihara Krause, in collaboration with young people and using principles of Dialectical Behaviour Therapy.
calmharm.co.uk

distrACT
Developed in Bristol, the distrACT app provides easy, quick and discreet access to general health information and advice about self-harm. While the app is mainly aimed at young people in the UK, other people may also find it useful.
expertselfcare.com/health-apps/distract/

Calm Urge
A self-harm tracker, enabling people to keep a daily record of their emotions and worries and identity triggers to self-harm. It also offers activities to help someone resist the urge to self-harm.

I am – Daily Affirmations
A daily affirmations app encouraging daily positive thoughts, to reduce negative thought patterns and build self-esteem.

Moving On
The Moving On app is based on the Moving On In My Recovery programme in north Wales. It draws on the lived experience of people in recovery from substance use and is also underpinned by Acceptance and Commitment Therapy. It includes a range of practical resources to support you on your recovery journey and can be used in English or Welsh.

Try Dry
Alcohol Change UK's Try Dry app enables you to track your own drinking, set yourself goals and record your progress in seeking to moderate or abstain. The app can be used in English, Welsh, French, German and Norwegian, with more languages in the pipeline.

Other resources

The Kent Community Care NHS Trust leaflet *Staying safer with self-harm* is written for anyone who self-harms, and includes helpful suggestions about taking care of yourself.[161]

The Northern Ireland Public Health Agency's leaflet *Improving the lives of people who self-harm* is for people who self-harm and their families, carers and friends. It provides a useful summary of the main issues in friendly, easy-to-read language.[162]

Appendix

Working with neurodiverse people

The following advice on working with neurodiverse people was developed in 2019 by the Centre for Applied Autism Research (CAAR) at the University of Bath with Alcohol Change UK.

Understand autism:

- Understand the psychological mechanisms that characterise autism, including potential strengths – such as a fondness for logic and honesty, and attention to detail – and the impact of highly co-morbid conditions such as anxiety
- Usual assessments of "motivation to change" may not be appropriate to autistic ways of thinking

Get prepared:

- Provide a photo of the therapist and/or the therapy room before the session
- Consider how the client will get to the session (e.g. transport) and discuss this with them
- Consider what is the best time of day: 9am starts may be difficult for an autistic person with disrupted sleep
- When possible, hold the first meeting in a familiar place for the autistic person
- Consider sensory issues before, during and after the session – be aware that excessive light or sound may be distressing
- Consider if the support can be provided online, and find out if this is what the client wants

- Check with the autistic person before any session starts – ask "What do you need to feel at ease in this session?"

Maximise structure and consistency, but retain flexibility:

- Have a regular slot, with the same person, but be ready to adapt this to the individual
- Sessions may need to be longer, if clients need to be supported in self-regulation before therapy can begin
- Some autistic people are more likely to miss sessions, and any sanctions (such as being discharged from the service) will need be used with more caution

Use plain language

- Avoid metaphors, jargon, and acronyms
- Avoid non-literal language, such as "Pull your socks up"
- Remember: keep it simple and straightforward

Be explicit:

- Always explicitly explain why something is happening in the session
- Always have clear aims, with reminders throughout and afterwards as to what the aims were
- Allow time for processing information (verbal or written)

Discuss individual hobbies and interests as part of therapy:

- This can be useful for identifying motivations and developing resilience
- Always be clear why this is being done: to get to know you, to calm down, etc.

Provide written and visual information during the session:

- Use "easy read" versions of documents where appropriate, and allow enough time for the person to digest the information

Educate about emotions:

- Emotions need to be discussed in terms of lived experience, not simply labels
- "Meltdowns" can be misinterpreted as aggressive; they are often just a response to overwhelming emotions
- Be aware that clients may well have experienced trauma in the past

Involve a family member or partner or advocate in sessions:

- If this is agreed with the autistic person
- The decision should be regularly revisited
- With the autistic person's consent, separate sessions for the family/ partner/ advocate may be appropriate
- The autistic person should remain in control.[163]

References and links to additional resources mentioned in this guide

[1] Department of Health and Social Care (2021) *Review of drugs part two: prevention, treatment, and recovery*, online, available at: https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

[2] Chandler, A. and Taylor, A. (2021) *Alcohol and self-harm: A qualitative study*, online, available at: https://alcoholchange.org.uk/publication/alcohol-and-self-harm-a-qualitative-study

[3] Australian Government Department of Health (2016) *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, online, available at: https://comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf

[4] HM Government (2021) *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*, online, available at: https://www.gov.uk/government/publications/suicide-prevention-in-england-fifth-progress-report

[5] Public Health England (2021) *Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary*, online, available at: *https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic/monitoring-alcohol-consumption-and-harm-during-the-covid-19-pandemic-summary*

[6] Alcohol Change UK (2020) *Research: drinking in the UK during lockdown and beyond*, online, available at: https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond

[7] op. cit. Chandler, A. and Taylor, A. (2021).

[8] NICE (2020) *Self-harm: What is it?*, online, available at: https://cks.nice.org.uk/topics/self-harm/background-information/definition/

[9] NICE (2020) *Alcohol-use disorders: prevention: Glossary*, online, available at: https://www.nice.org.uk/guidance/ph24/chapter/7-Glossary#lower-risk-drinking

[10] Department of Health (2016) *UK Chief Medical Officers' low risk drinking guidelines*, online, available at: https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

[11] NICE (2020) *Alcohol-use disorders: prevention: Glossary*, online, available at: https://www.nice.org.uk/guidance/ph24/chapter/7-Glossary#hazardous-drinking-increasing-risk-drinking

[12] NICE (2011) *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence*, online, available at: https://www.nice.org.uk/guidance/cg115/chapter/introduction

[13] Self-Injury Support (2022) *What is self-injury?*, online, available at: https://www.selfinjurysupport.org.uk/what-is-self-injury

[14] Mind (2022) *Self-harm*, online, available at: https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/about-self-harm/

[15] op. cit. Chandler, A. and Taylor, A. (2021).

[16] McManus, S. et al. (2019) *Prevalence of non-suicidal self-harm and service contact in England, 2000-14: repeated cross-sectional surveys of the general population*, Lancet Psychiatry, July 2019, 6(7):573-581.

[17] op. cit. NICE (2020) *Alcohol-use disorders: prevention: Glossary*.

[18] op. cit. Chandler, A. and Taylor, A. (2021).

[19] ibid.

[20] Scottish Drugs Forum (2020) *Moving beyond people first language: A glossary of contested terms in substance use*, online, available at: https://www.sdf.org.uk/wp-content/uploads/2020/10/Moving-Beyond-People-First-Language.pdf

[21] The 12 Step Movement includes fellowships such as Alcoholics Anonymous and Narcotics Anonymous.

[22] op. cit. Scottish Drugs Forum (2020).

[23] ibid.

[24] op. cit. Chandler, A. and Taylor, A. (2021).

[25] Chandler, A. (2018) *Seeking secrecy: A qualitative study of younger adolescents' accounts of self-harm*, online, available at: https://www.research.ed.ac.uk/en/publications/seeking-secrecy-a-qualitative-study-of-younger-adolescents-accoun

[26] Donskoy, A-L., (2011) *"Starting from scratch": An exploration of the narratives of the pathways leading up to the first episode of self-wounding*, MPhil thesis, University of Bath, online, available at: https://researchportal.bath.ac.uk/en/studentTheses/starting-from-scratch

[27] op. cit. Chandler, A. and Taylor, A. (2021).

[28] ibid.

[29] ibid.

[30] Nielsen, E. (2016) *Mind your 'C's and 'S's: The language of self-harm and suicide (and why it matters)*, Institute of Mental Health blog (Nottingham), online, available at: https://imhblog.wordpress.com/2016/01/22/emma-nielsen-mind-your-cs-and-ss-the-language-of-self-harm-and-suicide-and-why-it-matters/op. cit. Nielsen, E. (2016).

[31] op. cit. Sutton, J. (2005).

[32] op. cit. Nielsen, E. (2016).

[33] op. cit. Scottish Drugs Forum (2020).

[34] See: https://www.selfinjurysupport.org.uk/distractions-and-alternatives

[35] See: https://www.selfinjurysupport.org.uk/Pages/FAQs/Category/distractions-and-displacement

[36] Scottish Government (2011) *Responding to self-harm in Scotland: Final report*, online, available at: https://www.webarchive.org.uk/wayback/archive/20150218232100/http://www.gov.scot/Publications/2011/03/17153551/0

[37] Welsh Government (2015) *Suicide and self-harm prevention strategy 2015 to 2022*, online, available at: https://gov.wales/suicide-and-self-harm-prevention-strategy-2015-2020

[38] op. cit. Chandler, A. and Taylor, A. (2021).

[39] Turp, M. (2003) *The physicality of the self*, PhD thesis, University of Hertfordshire, online, available at: https://uhra.herts.ac.uk/handle/2299/14152

[40] op. cit. Welsh Government (2015) *Suicide and self-harm prevention strategy 2015 to 2022*.
[41] op. cit. HM Government (2021) .
[42] Geulayov, G. et al. (2019) *Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study*, The Lancet Psychiatry, Vol. 6, no. 12, pp. 1021-1030.
[43] Welsh Government (2015) *Service framework for the treatment of people with a co-occurring mental health and substance misuse problem*, online, available at: https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf
[44] See: https://forwardforlife.org/schema/
[45] HM Government (2012) *Preventing suicide in England: A cross-government outcomes strategy to save lives*, online, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[46] Samaritans (2022) *Supporting someone with suicidal thoughts*, online, available at: https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/supporting-someone-suicidal-thoughts/
[47] Papyrus (2022) *How do I know if someone is suicidal?*, online, available at: https://www.papyrus-uk.org/how-do-i-know-if-someone-is-suicidal/
[48] Samaritans (2022) *Supporting someone with suicidal thoughts*, online, available at: https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/supporting-someone-suicidal-thoughts/getting-additional-help-someone/
[49] Samaritans (2022) *Creating a 'safety plan'*, online, available at: https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/supporting-someone-suicidal-thoughts/creating-safety-plan/
[50] See: https://stayingsafe.net/
[51] See: https://www.papyrus-uk.org/hopelink/
[52] See: https://forwardforlife.org/schema/
[53] See: https://www.papyrus-uk.org/
[54] See: http://www.queerfutures.co.uk/queer-futures-project-one-year-report/
[55] op. cit. Australian Government Department of Health (2016).
[56] op. cit. Chandler, A. and Taylor, A. (2021).
[57] Samaritans (2022) *Insights from experience: alcohol and suicide*, online, available at: https://www.samaritans.org/about-samaritans/research-policy/alcohol-suicide/
[58] Irving, A, and Harding, J. (2022) *Tackling trauma, ending homelessness*, Northumbria University on behalf of Oasis Community Housing, online, available at: http://www.oasiscommunityhousing.org/trauma-homelessness/
[59] op. cit. Chandler, A. and Taylor, A. (2021).
[60] NICE (2026) *Coexisting severe mental illness and substance misuse: community health and social care services*, online, available at: https://www.nice.org.uk/guidance/ng58/chapter/Recommendations
[61] op. cit. Chandler, A. and Taylor, A. (2021).
[62] ibid.
[63] ibid.
[64] NCMH (2020) *Supporting people who have experienced traumatic events*, online, available at: https://www.ncmh.info/wp-content/uploads/2020/05/Supporting-people-who-have-experienced-traumatic-events.pdf
[65] Scottish Government (2021) *Trauma-informed practice: toolkit*, online, available at: https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/
[66] op. cit. Chandler, A. and Taylor, A. (2021).
[67] op. cit. Irving, A, and Harding, J. (2022).
[68] Comment by workshop participant, February 2022.
[69] Herman, J. (2015) *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*, New York, Basic Books.
[70] op. cit. Chandler, A. and Taylor, A. (2021).
[71] Kent Community Care NHS Foundation Trust (2019) *Staying safer with self-harm: Words that may help*, online, available at: https://www.memorialmedicalcentre.co.uk/wp-content/uploads/sites/520/2019/11/Staying-safer-with-self-harm.pdf
[72] See: https://www.selfinjurysupport.org.uk/Pages/FAQs/Category/first-aid
[73] op. cit. Chandler, A. and Taylor, A. (2021).
[74] ibid.
[75] ibid.
[76] Comment by workshop participant, February 2022.
[77] See: https://www.yourlocalpantry.co.uk/
[78] Research Into Recovery (2022) *Camberwell Assessment of Need (CAN)*, online, available at: https://www.researchintorecovery.com/measures/can/
[79] https://connectingpeople.net/
[80] National Treatment Agency for Substance Misuse (2013) *Turning evidence into practice. Helping service users to engage with treatment and stay the course*, online, available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20170807160623/http://www.nta.nhs.uk/uploads/teip_engagement_jan2013.pdf
[81] All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2020) *Inquiry into the support available for young people who self-harm*, online, available at: https://www.samaritans.org/about-samaritans/research-policy/appg/
[82] Ward, M. and Holmes, M. (2014) *Alcohol Concern's Blue Light Project: Working with change resistant drinkers: The project manual*, online, available at: https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project
[83] op. cit. Chandler, A. and Taylor, A. (2021).
[84] op. cit. Australian Government Department of Health (2016).
[85] Wallbank, S. (2016) *The restorative resilience model of supervision: A reader exploring resilience to workplace stress in health and social care professionals*, Shoreham-by-Sea, Pavilion Publishing.
[86] op. cit. Australian Government Department of Health (2016).

[87] op. cit. National Treatment Agency for Substance Misuse (2013).
[88] op. cit. Geulayov, G. et al. (2019).
[89] NICE (2020) *Self-harm: How common is it?*, online, available at: https://cks.nice.org.uk/topics/self-harm/background-information/prevalence/
[90] Plant, M. and Plant M. (2006) *Binge Britain: Alcohol and the national response*, Oxford, Oxford University Press.
[91] Mangla, K. et al. (2019) *Maternal self-harm deaths: an unrecognized and preventable outcome*, American Journal of Obstetrics and Gynecology, October 2019, 221(4):295-303.
[92] Milic, J. et al. (2018) *Menopause, ageing, and alcohol use disorders in women*, Maturitas, May 2018, 111:100-109.
[93] Kulkarni, J. (2018) *Perimenopausal depression – an under-recognised entity*, Australian Prescriber, December 2018, 41(6):183-185.
[94] Clay, J.M. et al. (2021) *Associations between self-reported inhibitory control, stress, and alcohol (mis)use during the first wave of the COVID-19 pandemic in the UK: a national cross-sectional study utilising data from four birth cohorts*, International Journal of Mental Health and Addiction, online, available at: https://pure.port.ac.uk/ws/portalfiles/portal/29176180/Clay2021_Article_AssociationsBetweenSelf_report.pdf
[95] Garnett, C. et al. (2021) *Factors associated with drinking behaviour during COVID-19 social distancing and lockdown among adults in the UK*, Drug and Alcohol Dependence, online, available at: https://pubmed.ncbi.nlm.nih.gov/33454159/
[96] op. cit. Chandler, A. and Taylor, A. (2021).
[97] Jones, C. (2014) *Women centred working: Defining an approach*, online, available at: http://www.womencentredworking.com/wp-content/uploads/2014/08/WCW-defining-an-approach-document.pdf
[98] Drugscope and AVA (2013) *The challenge of change: Improving services for women involved in prostitution and substance use*, online, available at: https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Challenge-of-change_policy-briefing.pdf
[99] Stonewall (2081) *Supporting trans women in domestic and sexual violence services: Interviews with professionals in the sector*, online, available at: https://www.stonewall.org.uk/system/files/stonewall_and_nfpsynergy_report.pdf
[100] Equality and Human Rights Commission (2022) *Separate and single-sex service providers: a guide on the Equality Act sex and gender reassignment provisions*, online, available at: https://www.equalityhumanrights.com/en/advice-and-guidance/separate-and-single-sex-service-providers-guide-equality-act-sex-and-gender
[101] Comment by workshop participant, February 2022.
[102] Institute of Alcohol Studies (2021) *LGBTQ+ people and alcohol online*, available at: https://www.ias.org.uk/wp-content/uploads/2021/07/LGBTQ-Briefing-Final.pdf
[103] Stonewall (2018) *LGBT in Britain: the health report*, online, available at: https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf
[104] Chakraborty, A. et al. (2011) *Mental health of the non-heterosexual population of England*, British Journal of Psychiatry, online, available at: https://pubmed.ncbi.nlm.nih.gov/21282785/
[105] Royal College of Psychiatrists (2018) *Supporting transgender and gender-diverse people*, online, available at: https://www.rcpsych.ac.uk/pdf/PS02_18.pdf
[106] Marzetti, H, et al. (2022) *"Am I really alive?": Understanding the role of homophobia, biphobia and transphobia in young LGBT+ people's suicidal distress*, Social Science & Medicine, April 2022, 298:114860.
[107] Arcelus, J. et al. (2016) *Risk factors for non-suicidal self-injury among trans youth*, Journal of Sexual Medicine, March 2016, 13(3):402-12.
[108] Virupaksha, H.G. et al. (2016) *Suicide and suicidal behavior among transgender persons*, Indian Journal of Psychological Medicine, November-December 2016, 38(6):505-509.
[109] See: https://lgbt.foundation/who-we-help/trans-people/non-binary
[110] Queer Futures (2016) *Queer Futures: Exploring LGBT youth self-harm, suicidal feelings and help-seeking: Results*, online, available at: http://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Summary-Report.pdf
[111] op. cit. Stonewall (2018) *LGBT in Britain: the health report*.
[112] LGBT Foundation (2021) *Pride in Practice LGBT patient experience survey 2021*, online, available at: https://lgbt.foundation/publications
[113] LGBT Foundation (2017) *Good practice guide to monitoring sexual orientation*, online, available at: https://lgbt.foundation/publications
[114] op. cit. LGBT Foundation (2021) *Pride in Practice LGBT patient experience survey 2021*.
[115] Welsh Government (2022) *An anti-racist Wales: The race equality action plan for Wales*, online, available at: https://gov.wales/sites/default/files/consultations/2022-06/race-equality-action-plan-an-anti-racist-wales.pdf
[116] Kapadia, D. et al. (2022) *Ethnic inequalities in healthcare: A rapid evidence review*, NHS Race and Health Observatory, online, available at: https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf
[117] Welsh Government (2022) *An introduction to an anti-racist Wales*, online, available at: https://gov.wales/sites/default/files/publications/2022-06/an-introduction-to-an-anti-racist-wales.pdf
[118] OHID (2022) *Mental health: migrant health guide*, online, available at: https://www.gov.uk/guidance/mental-health-migrant-health-guide
[119] Virupaksha, H.G. et al. (2014) *Migration and mental health: An interface*, Journal of Natural Science, Biology and Medicine, July 2014, 5(2):233-9.
[120] Gleeson, H. et al. (2019) *Rapid evidence review: Drinking problems and interventions in black and minority ethnic communities*, online, available at: https://alcoholchange.org.uk/publication/rapid-evidence-review-drinking-problems-and-interventions-in-black-and-minority-ethnic-communities
[121] op. cit. Australian Government Department of Health (2016).
[122] op. cit. Gleeson, H. et al. (2019).
[123] op. cit. National Treatment Agency for Substance Misuse (2013).
[124] Welsh Government (2015) *More than just words...Delivering the 'Active Offer': Information pack – social services and social care*, online, available at: https://socialcare.wales/cms_assets/file-uploads/150928activeoffersocialservicesen.pdf
[125] ONS (2020*) Exploring religion in England and Wales: February 2020*, online, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/exploringreligioninenglandandwales/february2020

[126] op. cit. Australian Government Department of Health (2016).
[127] Galvani, S. (2020) *Not consultation – partnership: lessons from alcohol services' work with Punjabi communities*, online, available at: https://alcoholchange.org.uk/blog/2020/not-consultation-partnership-lessons-from-alcohol-services-work-with-punjabi-communities
[128] op. cit. Gleeson, H. et al. (2019).
[129] Galvani, S. (2013) *Developing a community alcohol support package: An exploratory study with a Punjabi Sikh community*, online, available at: https://uobrep.openrepository.com/bitstream/handle/10547/603551/CASP-Final-Report-December-2013.pdf
[130] op. cit. Welsh Government (2022) *An anti-racist Wales: The race equality action plan for Wales*.
[131] "Faith, families and recovery", an online forum hosted by Alcohol Change UK and Adfam on 12 May 2022.
[132] National Autistic Society (2022) *Related conditions – a guide for all audiences*, online, available at: https://www.autism.org.uk/advice-and-guidance/topics/related-conditions/related-conditions/all-audiences
[133] Brosnan, M. (2019) *Making alcohol treatment more autism-friendly*, online, available at: https://alcoholchange.org.uk/blog/2019/making-alcohol-treatment-more-autism-friendly.
[134] National Autistic Society (2022) *Self-harm*, online, available at: https://www.autism.org.uk/advice-and-guidance/topics/mental-health/self-harm
[135] Cassidy, S.A. et al. (2020) *Advancing our understanding of self-harm, suicidal thoughts and behaviours in autism*, Journal of Autism and Developmental Disorders, October 2020, 50(10):3445-3449.
[136] op. cit. All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2020).
[137] The National Autistic Society makes an important distinction between intentional self-harm and the various ways in which some autistic people may hurt themselves when under stress – such as banging their head, biting their hands, or pulling their hair – where self-harm is not the intent.
[138] Brosnan, M. (2019) *Working with neuro-diverse drinkers*, online, available at: https://alcoholchange.org.uk/get-involved/campaigns/events/wrexham-2019-programme/prof-mark-brosnan-centre-for-applied-autism-research-university-of-bath
[139] Crenshaw, K. (1989) *Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics*, University of Chicago Legal Forum: Vol. 1989: Issue 1, Article 8, online, available at: http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8
[140] Columbia Law School (2017) *Kimberlé Crenshaw on intersectionality, more than two decades later*, online, available at: https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later
[141] Bowleg, L. (2008) *When black + lesbian + woman ≠ black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research*, Sex Roles (2008), 59:312–325
[142] Brossard, B. and Chandler, A. (2022) *Explaining mental illness: Sociological perspectives*, Bristol, Bristol University Press.
[143] op. cit. Herman, J. (2015).
[144] Welsh Assembly Government (2008) *Working together to reduce harm: The substance misuse strategy for Wales 2008-2018*, online, available at: https://phw.nhs.wales/topics/substance-misuse-drugs-alcohol/evidence/alcohol/alcohol-documents/working-together-to-reduce-harm-sm-strategy-2008-2018/
[145] op. cit. Chandler, A. and Taylor, A. (2021).
[146] op. cit. Australian Government Department of Health (2016).
[147] National Psychological Therapies Management Committee (2017) *Matrics Cymru: Guidance for delivering evidence-based psychological therapy in Wales*, online, available at: https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/psychological-therapies/resources-psychological-therapies/matrics-cymru-guidance-for-delivering-evidence-based-psychological-therapies-in-wales/
[148] op. cit. Ward, M. and Holmes, M. (2014).
[149] See: https://collaborative.nhs.wales/networks/wales-mental-health-network/together-for-children-and-young-people-2/the-nest-framework/
[150] Op. cit. Scottish Government (2021) *Trauma-informed practice: toolkit*.
[151] op. cit. Welsh Government (2015) *Service framework for the treatment of people with a co-occurring mental health and substance misuse problem*.
[152] See: https://harmless.nhs.uk/
[153] op. cit. Australian Government Department of Health (2016).
[154] op. cit. Ward, M. and Holmes, M. (2014).
[155] ibid.
[156] op. cit. Australian Government Department of Health (2016).
[157] See: https://www.communicationpassports.org.uk/home/
[158] See: https://phw.nhs.wales/services-and-teams/improvement-cymru/our-work/learning-disability-health-improvement-programme/health-profile/health-profile-for-professionals/
[159] See: https://www.wsh.nhs.uk/CMS-Documents/Health-passports/About-Me.pdf
[160] See: https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me
[161] Kent Community Care NHS Foundation Trust (2019) *Staying safer with self-harm: Words that may help*, online, available at: https://www.memorialmedicalcentre.co.uk/wp-content/uploads/sites/520/2019/11/Staying-safer-with-self-harm.pdf
[162] Public Health Agency (2015) *Improving the lives of people who self-harm*, online, available at: https://www.publichealth.hscni.net/publications/improving-lives-people-who-self-harm
[163] op. cit. Brosnan, M. (2019) *Working with neuro-diverse drinkers.*

Get involved

We cannot reduce alcohol harm alone. The more we all work together, the faster change will happen.

Alcohol Change UK

Alcohol Change UK works for a society that is free from the harm caused by alcohol.

The problem is complex, and so the solutions aren't simple. But Alcohol Change UK are ambitious to create evidence-driven change by working towards in key areas: improved knowledge, better policies and regulation, shifted cultural norms, improved drinking behaviours, and more and better support and treatment.

Find out more and get involved at
alcoholchange.org.uk

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