ALCOHOL

Training Pack

TD consultancy

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1. Introduction

Alcohol, Harm, and the Case for Action

Alcohol is the third leading risk factor for disease and disability in England. In 2024, alcohol-specific deaths in England fell for the first time since the pandemic, with 7,673 deaths recorded. This represents a 7.3% decrease from the 8,274 deaths in 2023. Despite this decrease, deaths remain 32% higher than 2019 levels, with male deaths consistently higher (OHID, 2024). There are over 76,000 hospital admissions each year, where alcohol is the primary cause, and alcohol is a contributory factor in around one in four emergency department attendances. In 2023, 10,473 alcohol-specific deaths were registered across the UK, the highest figure since records began (ONS, 2024). These numbers represent immeasurable human suffering: broken families, lost careers, preventable illness, and premature death.

Yet alcohol remains deeply embedded in UK culture. Its production, sale, and consumption are legal and widely normalised. The gap between population-level harm and public awareness, and between need and treatment engagement, is vast. Around 600,000 people in England are estimated to be alcohol dependent; only around 18% are currently in treatment (OHID NDTMS, 2023–24).

Purpose and Audience

This pack is designed to equip frontline workers, drug and alcohol practitioners, health professionals, criminal justice staff, and allied workers with:

- A solid evidence base in the pharmacology, epidemiology, and health consequences of alcohol use
- Practical skills for assessing, engaging with, and supporting people who drink problematically
- An understanding of the treatment landscape and available pharmacological and psychosocial interventions
- Clinical alert awareness — particularly around withdrawal risk, Wernicke's encephalopathy, and the dangers of advising abrupt cessation in dependent drinkers without medical supervision
- Practical tools: AUDIT, CIWA-Ar reference guide, assessment forms, and client handouts

Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce

This training resource aligns with the Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce (NHS England / Office for Health Improvement and Disparities, 2024), which underpins the 10-Year Strategic Plan for the Drug and Alcohol Treatment and Recovery Workforce 2024–2034.

The framework provides guidance on the knowledge, skills and behaviours required for core roles within LA-commissioned drug and alcohol treatment and recovery services. This manual supports workforce development towards those capabilities and is intended to be used as part of a broader training, supervision and professional development plan.

How to Use This Pack

This pack is intended for use in conjunction with training — not in isolation. It is a reference resource to be used before, during, and after training sessions. Not all material will be relevant to all services. The type of service, the client's stage, and the regional context of use will all influence which sections are most relevant.

Trauma-Informed Practice

Services working with people who drink problematically must adopt a trauma-informed approach (NHS England, 2023). Research consistently identifies high rates of adverse childhood experiences (ACEs), domestic abuse, bereavement, and other trauma in people with alcohol use disorder. Many people drink to manage the symptoms of unprocessed trauma. A trauma-informed approach means recognising the widespread impact of trauma, integrating this into practice, and avoiding re-traumatisation. This lens should inform every aspect of how practitioners engage with this population.

Further Reading & Resources
• OHID Commissioning Quality Standards (CQS) 2022 — www.gov.uk/government/publications/commissioning-quality-standards-for-drug-and-alcohol-services
• From Harm to Hope 10-Year Drug Strategy — www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
• NHS England Trauma-Informed Practice (2023) — www.england.nhs.uk
• OHID Alcohol Treatment Statistics (NDTMS 2023–24) — www.gov.uk/government/collections/alcohol-treatment-in-england
• Alcohol Change UK Annual Statistics (2024–25) — www.alcoholchange.org.uk

2. History of Alcohol

Alcohol is one of the oldest psychoactive substances known to humanity. Its history is inseparable from the history of human civilisation — woven into agriculture, religion, medicine, trade, and social life. Understanding this history helps contextualise why alcohol occupies such a unique and contested position in contemporary public health.

Ancient World

7000 BC — Earliest Known Alcohol Production

Archaeological evidence from the Jiahu site in Henan Province, China, reveals fermented beverages made from rice, honey, and fruit — the earliest confirmed alcohol production in human history (McGovern et al., 2004).

5000 BC — Beer in Mesopotamia

Beer brewing is documented in ancient Sumeria (modern Iraq). Barley-based fermented drinks are consumed widely, associated with ritual, trade, and daily sustenance. Ancient Sumerian texts include hymns to Ninkasi, the goddess of beer, with embedded brewing recipes.

3500 BC — Wine in the Ancient Near East

Wine production is documented in the Zagros Mountains region (modern Iran/Georgia). Grape cultivation expands across the Mediterranean over the following millennia, establishing wine as a cornerstone of Greek and Roman culture.

3000 BC — Egypt

Beer and wine are integral to daily life, religious practice, and medicine in ancient Egypt. Workers constructing the pyramids receive daily beer rations of approximately 4–5 litres — understood as a caloric supplement and safer alternative to contaminated water.

400 BC — Hippocrates

The Greek physician Hippocrates documents both the medicinal uses and harmful effects of wine — one of the earliest recorded recognitions of alcohol-related harm in the medical literature.

55 BC — Romans in Britain

Roman legions introduced viticulture to Britain, establishing the foundations of British wine and drinking culture.

Medieval and Early Modern Period

700s–1200s — Islamic Distillation

Islamic scholars — particularly Jabir ibn Hayyan (known as Geber in the West) — significantly advanced distillation technology, refining the alembic still. This development will eventually enable the production of spirits far stronger than anything previously achievable through fermentation alone.

1000s–1400s — Monasteries and Ale

Monasteries across Europe became centres of brewing and winemaking. In medieval England, ale was the staple daily drink — water sources were frequently unsafe, and low-alcohol beer provided safer hydration. The pub (or alehouse) becomes the primary social institution.

1400s — The Birth of Whisky

Spirits ("aqua vitae" — water of life) are distilled in Scotland and Ireland. Whisky production begins, setting in motion a tradition that will define Scottish and Irish cultural identity.

1516 — German Beer Purity Law

The Reinheitsgebot — one of the world's first alcohol regulations — was introduced in Bavaria, requiring beer to be made only from water, barley, and hops. It represents an early attempt to regulate alcohol quality.

1600s — Gin Arrives in England

Gin is introduced to England from the Netherlands following the Glorious Revolution. Initially valued for its medicinal properties, it became widely available and affordable in the early 18th century. Coffee houses and taverns flourish as social and commercial hubs in London.

1720s–1750s — The Gin Craze

The "Gin Craze" produced one of the UK's first modern public health crises. Widespread cheap gin consumption leads to social disorder, increased mortality, neglect of children, and public concern. William Hogarth's contrasting engravings Gin Lane (1751) capture the moral panic. The Gin Acts of 1736 and 1751 attempt regulation, with mixed success.

1784 — Benjamin Rush and the Disease Concept

Benjamin Rush, a physician and signatory of the US Declaration of Independence, published An Inquiry into the Effects of Ardent Spirits on the Human Mind and Body. He is among the first to describe habitual drunkenness as a disease rather than a moral failing — a conceptual foundation for the modern disease model of alcohol use disorder.

19th Century

1830s–1840s — The Temperance Movement

The Temperance Movement grows rapidly in the UK and USA, advocating for abstinence from alcohol. The Band of Hope, founded in Leeds in 1847, became a major force for abstinence education, particularly among working-class communities.

1838 — Magnus Huss Coins "Alcoholism"

Swedish physician Magnus Huss coined the term "alcoholism" to describe a chronic disease pattern associated with heavy alcohol use. Note: this terminology is now clinically discouraged — the preferred terms are "alcohol use disorder" (AUD), "alcohol dependence," or “problem drinker”.

1872 — First Major UK Licensing Legislation

The Licensing Act 1872 introduced the first significant UK regulation of pub opening hours, reflecting growing parliamentary concern about alcohol-related harm.

1898 — First Specialist Treatment Institutions

The first specialist "inebriates" (alcohol) treatment institutions opened in the UK, marking the beginnings of a formal treatment response to dependent drinking.

20th Century

1914–1918 — World War One Licensing Restrictions

Prime Minister David Lloyd George introduced sweeping licensing restrictions to improve wartime industrial productivity. The practice of "treating" (buying rounds for others) is prohibited in some areas. Pub opening hours are significantly restricted. The 11pm closing time becomes standard and remains in force for most of the 20th century.

1920–1933 — US Prohibition

The United States prohibits the production, sale, and transportation of alcohol. While Prohibition is associated with organised crime and speakeasies, public health data suggest that alcohol-related illness fell significantly during this period — evidence cited in debates about minimum unit pricing.

1935 — Alcoholics Anonymous Founded

AA is founded in Akron, Ohio, by Bill Wilson ("Bill W.") and Dr. Bob Smith ("Dr. Bob"). The 12-Step model of recovery — based on mutual aid, spiritual principles, and abstinence — is born. AA spreads globally and establishes in the UK in 1952. Despite debate about its evidence base, AA has helped millions of people achieve and maintain abstinence and remains one of the most widely accessed recovery resources in the UK.

1960s–1970s — Medical Recognition

Growing recognition of alcohol dependence as a medical condition in UK medical circles. The disease model of alcohol use disorder gains clinical traction. The first specialist NHS detoxification units opened. Dedicated NHS funding for alcohol treatment began in 1976.

1979 — Royal College of Psychiatrists Report

The Royal College of Psychiatrists publishes Alcohol and Alcoholism — a landmark report establishing safe drinking guidelines and calling for a comprehensive public health approach to alcohol harm. It marks a pivotal moment in the professionalisation of alcohol treatment in the UK.

1980s–1990s — Brief Interventions and AUDIT

The evidence base for Brief Interventions (BI) has been developed and refined. The AUDIT (Alcohol Use Disorders Identification Test) screening tool was developed by the WHO in 1989, providing a validated, widely usable tool for identifying harmful and dependent drinking. Harm reduction approaches — previously most associated with drug use — begin to be applied to alcohol.

Modern Era

1995 — Revised UK Sensible Drinking Guidelines

UK guidelines are revised to daily unit recommendations (3–4 units/day for men; 2–3 units/day for women). These guidelines were later criticised as insufficiently evidence-based and replaced with weekly guidance in 2016.

2004 — Licensing Act 2003

The Licensing Act 2003 came into force, introducing 24-hour alcohol licensing across England and Wales. Subsequent evidence suggests increases in alcohol-related A&E attendances and harm in some areas, though national trends remain complex.

2016 — New UK CMO Low Risk Drinking Guidelines

The UK Chief Medical Officers publish revised low-risk drinking guidelines: no more than 14 units per week for both men and women (reducing from the previous male-specific higher limit); spread over three or more days; at least two to three alcohol-free days per week. Crucially, the guidelines state that there is no completely safe level of alcohol — these guidelines define low risk, not no risk.

2018 — Scotland Implements Minimum Unit Pricing

Scotland becomes the first country in the world to implement Minimum Unit Pricing (MUP) at 50p per unit (implemented May 2018, following the legislation passed in 2012 and a five-year legal challenge by the Scotch Whisky Association). Early evaluation data show reductions in alcohol-specific deaths, hospital admissions, and consumption of the cheapest alcohol. The policy debate for England and Wales continues.

2022 — From Harm to Hope

From Harm to Hope: A 10-Year Drug Strategy (HM Government, 2021, published 2022) integrates alcohol within the national drug strategy framework for the first time. OHID (Office for Health Inequalities and Disparities) takes over from Public Health England (PHE) as the lead national public health body for alcohol.

2024–2025 — Record Alcohol Deaths

OHID publishes updated alcohol prevalence and mortality data for England. ONS registers 10,473 alcohol-specific deaths in the UK in 2023 — the highest figure since records began. England's Chief Medical Officer calls for renewed action. Policy debate around Minimum Unit Pricing for England and Wales intensifies.

3. Types of Alcohol and How It Is Produced

What Is Alcohol?

The term "alcohol" in everyday use refers specifically to ethanol (ethyl alcohol; chemical formula CH_3CH_2OH) — the psychoactive compound present in all alcoholic beverages. It is important to distinguish ethanol from other alcohols that are toxic:

- Methanol (wood alcohol, CH_3OH) — toxic; causes blindness and death even in small quantities; produced in illicit or poorly distilled spirits
- Isopropyl alcohol (rubbing alcohol, $(CH_3)_2CHOH$) — used as a disinfectant; toxic if ingested
- Ethanol (drinking alcohol) — psychoactive; metabolised by the liver; toxic in sufficient quantities but safely metabolised in moderate amounts by healthy individuals

Only ethanol is present in regulated alcoholic beverages. Practitioners working with people who drink non-beverage alcohol (methylated spirits, hand sanitiser, screen wash) — typically in the context of severe dependence or homelessness — should be aware of the additional toxicity risks from methanol and additives.

What Is a Unit?

In the UK, one unit of alcohol equals 10ml (8g) of pure ethanol. This standardised measure enables consistent communication about consumption levels regardless of drink type. Calculating units:

Units = ABV% × Volume (ml) ÷ 1000

Example: A pint (568ml) of 5% lager = 5 × 568 ÷ 1000 = 2.84 units.

Most people significantly underestimate their unit consumption. A standard 175ml glass of 13% wine contains 2.3 units — not "one glass = one unit" as is commonly assumed.

How Alcohol Is Produced

Fermentation

Sugars (from grain, fruit, or other sources) are fermented by yeast, producing ethanol and carbon dioxide (CO_2). Fermentation can produce beverages up to approximately 15% ABV without distillation — beyond this level, the alcohol concentration kills the yeast. Fermented beverages include beer, wine, and cider.

Distillation

Fermented liquid is heated; ethanol, which evaporates at a lower temperature than water, is collected and condensed. This concentrates the alcohol content, producing spirits at 40% ABV or higher. Distilled beverages include whisky, gin, vodka, rum, and brandy.

Fortification

Spirits are added to wine to halt fermentation, raising the ABV and preserving residual sugars. Fortified wines (port, sherry, vermouth) typically contain 17–22% ABV.

UK Alcoholic Beverages: Units at a Glance

Type	ABV Range	Typical Serving	Units per Serving	Notes
Regular beer/lager (pint)	4–5%	568ml	2.3–2.8	Commonly underestimated
Strong beer/lager (pint)	7–9%	568ml	4.0–5.1	"Super strength" cans up to 9%
Craft beer (pint)	5–10%	568ml	2.8–5.7	ABV often higher than traditional ales
Wine (175ml glass)	12–14%	175ml	2.1–2.5	Standard restaurant pour
Wine (large glass 250ml)	13%	250ml	3.25	Three large glasses = a bottle
Spirits (25ml measure)	37.5–40%	25ml	0.94–1.0	35ml in Scotland (1.3 units)
Prosecco/Champagne (125ml)	12%	125ml	1.5	Frequently underestimated
Alcopops/RTDs (275ml)	4–5%	275ml	1.1–1.4	Popular with younger drinkers
Cider (pint)	4–8.5%	568ml	2.3–4.8	Significant ABV variation
Fortified wine (50ml)	20%	50ml	1.0	Port, sherry

Congeners

Congeners are non-ethanol compounds produced during fermentation and distillation — including fusel alcohols, aldehydes, esters, and tannins. They contribute to the flavour, aroma, and colour of different drinks. They are also implicated in hangover severity: dark spirits (whisky, brandy, dark rum) and red wine contain significantly higher levels of congeners than clear spirits (vodka, gin), which partly explains why hangovers from dark spirits tend to be more severe.

The Craft Alcohol Market

The craft beer and artisan spirits market has expanded significantly in the UK since 2010. Many craft beers now have ABVs of 6–10% — substantially stronger than traditional ales (3.5–4%). Packaging often emphasises artisanal quality rather than alcohol content. Consumers frequently underestimate the unit content of craft beer.

No/Low Alcohol Options

The no/low alcohol market in the UK has grown substantially between 2020 and 2025, with alcohol-free alternatives now widely available across most beverage categories. Alcohol-free beverages (below 0.5% ABV) may be appropriate to recommend in harm reduction contexts and as part of reduction strategies. However, practitioners should exercise clinical judgement: for some people in recovery, particularly those using AA/12-step frameworks, alcohol-free alternatives that replicate the sensory experience of drinking may not be appropriate. Individual preferences and treatment goals should guide recommendations.

4. How Alcohol Works (Pharmacology & Neuroscience)

Absorption

Alcohol (ethanol) is rapidly absorbed following ingestion. Unlike most drugs, it requires no active transport mechanism — it crosses biological membranes by simple diffusion:

- Approximately 20% is absorbed in the stomach; 80% in the small intestine
- Food in the stomach slows gastric emptying and therefore slows absorption — eating before or during drinking significantly reduces peak BAC
- Carbonated drinks (mixers, champagne, cider) speed absorption — CO_2 accelerates gastric emptying
- Alcohol enters the bloodstream directly and reaches the brain within approximately five minutes of consumption
- Peak blood alcohol concentration (BAC) is typically reached 30–90 minutes after drinking on an empty stomach; 60–120 minutes with food

Distribution

Alcohol is water-soluble and distributes throughout total body water. This has important implications:

- Women typically reach a higher BAC than men consuming an equivalent dose, due to: lower total body water percentage; higher body fat percentage (fat holds less water); lower levels of gastric alcohol dehydrogenase (ADH) — so more alcohol reaches the bloodstream unmetabolised
- Older adults have reduced total body water and often lower liver enzyme activity, increasing vulnerability to harm at equivalent doses
- Body weight affects distribution volume — smaller individuals reach higher BAC than larger individuals consuming the same amount

Blood Alcohol Concentration (BAC): Effects by Level

BAC (g/100ml)	Approximate Effects	Clinical Notes
0.02–0.05	Relaxation, mild euphoria, reduced inhibition, slight impairment of judgement	Driving impairment begins below legal limit
0.05–0.08	Impaired judgement, coordination, and reaction time; reduced risk perception	Legal driving limit in England/Wales is 0.08
0.05	Legal driving limit in Scotland (since 2014)	
0.10–0.15	Slurred speech, pronounced ataxia, emotional lability, nausea in some	Clearly visible intoxication to others
0.15–0.20	Disorientation, significant motor impairment, aggression or emotional distress	High risk of falls and injury
0.20–0.25	Severe impairment; vomiting; blackouts (en bloc or fragmentary amnesia)	Medical attention may be required
0.30–0.40	Loss of consciousness; respiratory depression; hypothermia risk	Medical emergency — call 999

0.40+	Potentially fatal coma; respiratory arrest; death	FATAL DOSE RANGE — emergency resuscitation

> ⚠ **CLINICAL WARNING: Alcohol Poisoning — Medical Emergency**
>
> A person who is unconscious, cannot be woken, has slow or irregular breathing, is blue around the lips, or is vomiting while unconscious is experiencing acute alcohol poisoning. Call 999 immediately. Place in the recovery position if unconscious and breathing. Do NOT leave them alone.
>
> BAC above 0.30g/100ml is a medical emergency. Do not assume someone is "just drunk" and will sleep it off.

Metabolism

The liver is responsible for metabolising approximately 90–95% of ingested alcohol. The rate of metabolism is relatively fixed:

- The liver metabolises approximately one unit of alcohol per hour in a healthy adult — this cannot be meaningfully accelerated by coffee, cold showers, food, or exercise
- Primary metabolic pathway: Ethanol → Acetaldehyde (via alcohol dehydrogenase, ADH) → Acetate (via aldehyde dehydrogenase, ALDH) → Water + CO_2
- Acetaldehyde is the primary toxic intermediate — it causes DNA damage, protein adduct formation, and is responsible for much of alcohol's carcinogenic and organ-damaging effects
- Acetaldehyde is also the target of disulfiram (Antabuse): by blocking ALDH, disulfiram causes acetaldehyde to accumulate, producing the highly unpleasant flushing reaction that deters drinking
- Genetic variation: populations with reduced ALDH2 activity (common in East Asian populations) experience intense flushing, nausea, and tachycardia even from small amounts of alcohol — evidence of the genetic contribution to alcohol metabolism
- Chronic heavy drinking induces an alternative metabolic pathway (the microsomal ethanol oxidising system, MEOS), which generates reactive oxygen species and contributes to liver damage and increased cancer risk

Mechanism of Action in the Brain

Alcohol is a central nervous system (CNS) depressant. Unlike most psychoactive drugs, which act primarily on a single receptor system, alcohol has multiple sites of action in the brain:

Primary Mechanisms

- GABA-A receptor agonism: GABA (gamma-aminobutyric acid) is the brain's primary inhibitory neurotransmitter. Alcohol enhances GABA-A receptor activity, increasing inhibitory signalling — producing sedation, anxiolysis, motor impairment, and anticonvulsant effects. This is why alcohol feels relaxing and why benzodiazepines (which also act on GABA-A receptors) are used to manage alcohol withdrawal.
- NMDA receptor antagonism: Glutamate is the brain's primary excitatory neurotransmitter. Alcohol blocks NMDA (N-methyl-D-aspartate) glutamate receptors, reducing excitatory signalling — contributing to sedation, memory impairment (blackouts), and dissociative effects at high doses.

Additional Mechanisms

- Dopamine release in the nucleus accumbens (reward pathway): Alcohol triggers dopamine release in the mesolimbic reward system, producing euphoria and reinforcing the behaviour — this is the key neurobiological driver of addiction
- Endogenous opioid system activation: Alcohol triggers the release of endorphins (endogenous opioids) in the nucleus accumbens and orbitofrontal cortex, contributing to pleasurable effects and reinforcement — this is the mechanism targeted by naltrexone
- Serotonin modulation: Alcohol affects serotonin signalling, partly explaining its relationship with mood, anxiety, and impulsive behaviour
- Noradrenaline release: Contributes to stimulant-like effects (increased heart rate, arousal) at lower doses

Tolerance and Neuroadaptation

With repeated heavy drinking, the brain adapts to alcohol's effects — a process of neuroadaptation that is the biological foundation of physical dependence:

- GABA-A receptors downregulate: fewer receptors, reduced sensitivity — the brain requires more alcohol to achieve the same inhibitory (sedating/anxiolytic) effect
- NMDA receptors upregulate: more receptors, increased sensitivity — the brain compensates for alcohol's glutamate blockade by increasing excitatory tone

This neuroadaptation has a critical clinical consequence: when alcohol is removed abruptly in a physically dependent drinker, the brain is suddenly left in a state of CNS hyperexcitability — too little GABA inhibition and too much glutamate excitation. This produces the alcohol withdrawal syndrome, which can cause seizures, delirium tremens, and death (see Section 7).

ℹ️ NICE / GUIDANCE: The Dopamine "Credit Card" — Understanding Craving and Compulsion

A useful analogy: alcohol temporarily "borrows" from the brain's dopamine reward system, flooding it with pleasurable signals. Over time, with repeated heavy use, the brain compensates by reducing baseline dopamine function — "paying back the debt". The result is that the person eventually needs to drink simply to feel normal, not to feel good.

This explains why dependent drinkers often describe feeling flat, anxious, or unable to feel pleasure when not drinking — not because alcohol makes them happy, but because the absence of it feels intolerable. It also explains why willpower alone is rarely sufficient for recovery from physical dependence.

The Hangover

A hangover is the constellation of symptoms following a period of heavy drinking as BAC falls: headache, nausea, fatigue, sensitivity to light and sound, anxiety, and cognitive impairment. Contributing factors include dehydration, electrolyte imbalance, disrupted sleep architecture, acetaldehyde toxicity, congener effects, immune system activation (cytokine release), and rebound excitatory activity as GABA effects wear off. The anxiety and dysphoria often experienced the morning after heavy drinking — sometimes called "hangxiety" — reflect CNS rebound excitation as alcohol's GABA-enhancing effect wears off.

5. Who Is Drinking Problematically?

Current UK Epidemiology (2024–2025)

Alcohol-related harm in the UK is pervasive, costly, and under-addressed relative to its scale:

- Approximately 24% of adults in England drink at levels that increase health risk (more than 14 units/week) (OHID, 2024)
- Around 1.7 million people in England drink at higher-risk levels (more than 35 units/week for women; 50 units/week for men) (OHID, 2024)
- An estimated 600,000 people in England are alcohol dependent — yet only around 18% are in treatment (OHID NDTMS, 2023–24)
- Approximately 76,000 hospital admissions per year in England where alcohol is the primary cause (OHID, 2024)
- Alcohol is a contributory factor in approximately 1 in 4 emergency department attendances
- Alcohol is a factor in approximately 40% of all violent crime in England
- Alcohol-related harm costs England approximately £21 billion per year in public services, NHS costs, crime, and lost productivity
- Highest rates of alcohol-related harm: North East England, North West England, and Yorkshire and the Humber

Drinker Typology

Not everyone who drinks problematically is the same. Understanding where a client sits within a typology framework helps practitioners select appropriate interventions — from brief advice for increasing risk drinkers to medically supervised detoxification for severely dependent drinkers.

Type	Key Characteristics	Typical Intervention
Low Risk Drinker	Drinks within 14 units/week; spread over 3+ days; no adverse consequences; value systems intact	Education; reinforce positive behaviour
Increasing Risk Drinker	Regularly exceeds 14 units/week; pattern establishing; not yet significantly impacting relationships or work; may not identify drinking as problematic	Brief intervention (AUDIT-C); motivational conversation; self-monitoring tools
Higher Risk Drinker	Consistently drinks at higher-risk levels; recognisable pattern; value systems beginning to shift; relationships and work affected; psychological dependence possible	Extended brief intervention; AUDIT full; motivational interviewing; GP referral
Dependent Drinker (Moderate)	Daily or near-daily drinking to manage withdrawal symptoms; physical dependence established; CIWA-Ar indicates moderate risk; drinking to function	Full assessment; CIWA-Ar; medical review; community detox if appropriate; acamprosate/naltrexone post-detox
Dependent Drinker (Severe)	Severe physical dependence; high seizure and DTs risk on cessation; life organised around alcohol; complex comorbidities common (liver disease, mental health, housing, trauma)	Inpatient/residential detox; CIWA-Ar guided prescribing; specialist medical input; intensive psychosocial support

⚠ **CLINICAL WARNING: NEVER advise a physically dependent drinker to stop drinking suddenly without medical assessment.**

For a severely dependent drinker, abrupt cessation without medical support can cause withdrawal seizures and delirium tremens — both potentially fatal.

Always assess the level of dependence (CIWA-Ar, AUDIT C, drinking history) before advising any change. If in doubt, refer to medical services urgently.

Key Population Groups and Intersectionality

Older Adults

Older adults are significantly under-identified in alcohol treatment services, despite high rates of alcohol use disorder. Age-related physiological changes — reduced total body water, slower hepatic metabolism, increased sensitivity to CNS effects — mean that harm occurs at lower consumption levels than in younger adults. Cognitive impairment, falls, and interactions with multiple medications are particular risks.

Women

Rates of alcohol-related harm have risen disproportionately in women over the past two decades. Women reach higher BAC at equivalent doses due to physiological differences (lower body water, lower gastric ADH). Women have higher rates of alcohol-related liver disease than men at equivalent consumption levels. Barriers to treatment include shame and stigma, caring responsibilities, and domestic abuse. Approximately 1 in 5 women in England drink at increasing or higher-risk levels (OHID, 2024).

LGBTQ+ Populations

Higher rates of alcohol use and alcohol use disorder are consistently documented in LGBTQ+ communities. The minority stress model (Meyer, 2003) provides the theoretical framework: exposure to discrimination, stigma, rejection, and violence increases psychological distress, which in turn increases vulnerability to alcohol use as a coping mechanism. Services should be explicitly LGBTQ+ inclusive.

Veterans

Significantly elevated rates of alcohol use disorder are documented in armed forces veterans, driven by military culture, exposure to trauma, difficulties transitioning to civilian life, and underuse of mainstream services.

People Experiencing Homelessness

Very high rates of dependent drinking are documented in people experiencing homelessness, often alongside complex comorbidities including mental health disorders, drug use, physical illness, and significant trauma histories. Outreach-based harm reduction approaches, wet houses, and low-threshold services are the evidence-based response.

Criminal Justice-Involved Individuals

Alcohol is implicated in a very high proportion of offending in England and Wales — including violence, domestic abuse, and driving offences. Drug Rehabilitation Requirements (DRRs) under probation supervision can include alcohol. Practitioners working in criminal justice settings should routinely use AUDIT screening.

Black, Asian, and Minoritised Ethnic Communities

Drinking patterns vary significantly across different ethnic communities, with some communities having substantially lower alcohol use rates. However, those who do drink problematically within these communities may face additional barriers to accessing services — including language barriers, cultural

stigma, lack of culturally specific services, and concerns about confidentiality. Reference: Race Equality Foundation alcohol and ethnicity guidance (2022).

Further Reading & Resources
• OHID Alcohol Treatment Statistics (NDTMS 2023–24) — www.gov.uk/government/collections/alcohol-treatment-in-england
• ONS Alcohol-specific deaths UK 2023 — www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath
• Alcohol Change UK: Alcohol Statistics — www.alcoholchange.org.uk
• Race Equality Foundation: Alcohol & Ethnicity (2022) — www.raceequalityfoundation.org.uk
• OHID Homelessness and Substance Use (2023) — www.gov.uk

6. Health Implications

Alcohol affects virtually every organ system in the body. This section provides an overview of both the acute and long-term physical and mental health consequences of harmful and dependent drinking. Practitioners do not need to be clinicians to recognise these harms, discuss them sensitively with clients, and make appropriate referrals.

6.1 Short-Term Harms

Injury

Alcohol is a factor in approximately 40% of all violent crime in England. It significantly increases the risk of falls, road traffic accidents, industrial injuries, and accidental drowning. The combination of impaired judgement, coordination, reaction time, and risk perception makes injury the most common acute consequence of heavy single-episode drinking.

Acute Alcohol Poisoning

At BAC above approximately 0.30g/100ml, life-threatening acute alcohol poisoning may occur. Risks include: asphyxiation from vomiting while unconscious; respiratory depression and respiratory arrest; hypothermia (particularly outdoors or in cold environments); and cardiac arrhythmias. Death from acute alcohol poisoning can occur at any age and in any setting.

⚠ CRITICAL ALERT: ACUTE ALCOHOL POISONING — Emergency Response
• Call 999 immediately if someone is unconscious, cannot be roused, has slow or irregular breathing, is blue around the lips, or is vomiting while unconscious
• Place in the recovery position if unconscious but breathing
• Never leave a heavily intoxicated person alone — even if they appear to be sleeping safely
• Do not give coffee, food, or cold water — these do not speed up alcohol metabolism or improve level of consciousness

Blackouts

Alcohol-induced amnesia — known as "blackouts" — is caused by NMDA receptor blockade, impairing the hippocampal memory consolidation process. In fragmentary blackouts, the person has a patchy memory of events. In en bloc blackouts, there is complete amnesia for a period, despite the person appearing conscious and functional. Blackouts are not the same as loss of consciousness — they indicate severe acute alcohol toxicity affecting memory circuits. Regular blackouts are a significant risk indicator and a red flag for dependent drinking.

Risky Sexual Behaviour

Alcohol-impaired judgement is associated with reduced condom use, an increased number of sexual partners, and a higher STI and HIV transmission risk. Alcohol is also associated with a high proportion of sexual assaults. Practitioners should address sexual health in the context of alcohol use, using non-judgemental, sensitive language and avoiding victim-blaming framing.

Self-Harm and Suicide

Acute alcohol intoxication significantly increases impulsivity and lowers the threshold for self-harm and suicide attempts. Alcohol is a factor in approximately 20–30% of suicides in England (ONS; OHID). People presenting in crisis following heavy drinking should receive an appropriate mental health assessment, not simply be discharged when sober.

6.2 Liver Disease

Alcohol-related liver disease (ArLD) is the most common serious physical consequence of dependent drinking and the leading cause of liver-related mortality in the UK.

The Three Stages of ArLD

- Stage 1 — Fatty Liver (Steatosis): Fat accumulates in liver cells due to the metabolic disruption caused by heavy drinking. This stage is reversible with abstinence. It is usually asymptomatic — most people are unaware they have it.
- Stage 2 — Alcoholic Hepatitis: Liver inflammation caused by ongoing alcohol use. Can range from mild to severe (acute alcoholic hepatitis carries a 30-day mortality of up to 30–50% in severe cases). Symptoms include jaundice, abdominal pain, and fatigue. Urgent medical assessment is required for anyone presenting with jaundice and a history of heavy alcohol use.
- Stage 3 — Cirrhosis: Irreversible scarring of the liver, replacing functional liver cells with fibrous tissue. Progressive liver failure, portal hypertension, and risk of hepatocellular carcinoma (liver cancer). Once cirrhosis is established, abstinence can stabilise but not reverse the damage. Liver transplantation may be required in end-stage liver disease.

⚠ CLINICAL WARNING: ArLD Clinical Alert
Any client with a significant history of alcohol use presenting with jaundice (yellow skin/eyes), abdominal swelling (ascites), confusion, or blood in vomit (haematemesis from oesophageal varices) must be referred for urgent medical assessment.
Jaundice + heavy drinking = possible acute alcoholic hepatitis. Do not delay.

UK context: liver disease deaths have increased by over 400% since the 1970s. Approximately 60% of liver disease in England is alcohol-related. England has significantly worse liver disease outcomes than comparable European countries. Reference: NHS England Liver Disease Strategy (2023).

6.3 Cardiovascular Disease

Alcohol affects the cardiovascular system in multiple ways:

- Cardiomyopathy: Alcohol is a direct cardiotoxin. Heavy chronic drinking causes alcohol-induced cardiomyopathy — weakening of the heart muscle, potentially leading to heart failure
- Arrhythmias: Atrial fibrillation (AF) is particularly associated with alcohol use — "holiday heart syndrome" (AF triggered by binge drinking even in otherwise healthy individuals). AF increases stroke risk fivefold
- Hypertension: Even modest regular alcohol consumption elevates blood pressure in a dose-dependent fashion, increasing risk of stroke and cardiovascular disease

- Stroke: Alcohol increases the risk of both ischaemic stroke (from AF, hypertension, and atherosclerosis) and haemorrhagic stroke

ℹ️ NICE / GUIDANCE: The J-Curve Controversy

For decades, observational studies suggested a "J-shaped" relationship between alcohol consumption and cardiovascular disease — implying that low-level alcohol was protective. This claim is now considered largely an artefact of research methodology (notably the "sick quitter" problem — including former drinkers who quit due to illness in the abstainer reference group). Mendelian randomisation studies (2018–2024), which use genetic variants as proxies for alcohol consumption to overcome confounding, consistently fail to find a cardiovascular protective effect. Current UK CMO guidance states there is no completely safe level of alcohol.

6.4 Cancer

Alcohol is classified as a Group 1 carcinogen by the International Agency for Research on Cancer (IARC) — meaning the evidence for causation is conclusive. Alcohol is causally associated with cancers of the:

- Mouth and oropharynx
- Larynx and pharynx
- Oesophagus (squamous cell carcinoma)
- Stomach
- Liver (hepatocellular carcinoma)
- Colorectum (bowel)
- Breast (in women — even at low consumption levels)

The risk begins at the lowest levels of consumption — there is no threshold below which alcohol is definitively safe for cancer risk. In England, approximately 12,000 cancer cases per year are attributable to alcohol (Cancer Research UK, 2024). Despite this, population awareness remains low: surveys consistently show that a majority of UK adults are unaware of the alcohol-cancer link. Raising awareness of this connection is a priority in brief interventions.

6.5 Neurological Complications

⚠️ CRITICAL ALERT: WERNICKE'S ENCEPHALOPATHY — MEDICAL EMERGENCY

Wernicke's encephalopathy is caused by severe thiamine (Vitamin B1) deficiency, extremely common in dependent drinkers due to poor nutrition and impaired absorption.

Classic triad: confusion/altered consciousness + ataxia (unsteady gait) + ophthalmoplegia (eye movement abnormalities)

If untreated or undertreated, it WILL progress to Korsakoff's syndrome — severe, often PERMANENT memory impairment.

Treatment: HIGH-DOSE IV PABRINEX (parenteral thiamine) URGENTLY — oral thiamine alone is INSUFFICIENT in active dependent drinkers.

Do NOT wait for all three features to be present — the full triad is seen in fewer than 20% of cases. Treat on suspicion.

Reference: NICE CG141 (Alcohol-use disorders: physical complications)

Wernicke-Korsakoff Syndrome (WKS)

Wernicke's encephalopathy is an acute, potentially reversible neurological emergency caused by thiamine deficiency. It can occur during active drinking or during withdrawal. Korsakoff's syndrome is the chronic, largely irreversible amnestic state that results from untreated or inadequately treated Wernicke's. Korsakoff's is characterised by profound anterograde amnesia (inability to form new memories), retrograde amnesia, and confabulation (unconscious generation of false memories to fill memory gaps). Patients with Korsakoff's syndrome typically require long-term residential or nursing care.

Peripheral Neuropathy

Chronic heavy drinking causes damage to peripheral nerves (peripheral neuropathy) — producing numbness, tingling, pain, and weakness, typically beginning in the hands and feet. Largely mediated by thiamine deficiency and direct ethanol toxicity. Symptoms may partially recover with abstinence and thiamine supplementation.

Cerebellar Degeneration

Alcohol causes degeneration of the cerebellum, producing progressive ataxia (unsteady gait, poor balance and coordination). Cerebellar damage may be partially reversible with abstinence.

Alcoholic Dementia

Distinct from Korsakoff's syndrome, alcoholic dementia refers to diffuse brain damage from chronic heavy drinking — characterised by impairments in memory, executive function, and social cognition. The precise contribution of alcohol versus nutritional deficiencies is debated, but the clinical picture in severe cases resembles other dementias.

6.6 Gastrointestinal Complications

- Gastritis and peptic ulcer disease: Alcohol damages the gastric mucosa, increasing acid production and impairing mucosal defence
- Pancreatitis: Acute pancreatitis (severe abdominal pain — medical emergency) and chronic pancreatitis (severe pain, malabsorption, exocrine and endocrine pancreatic failure leading to diabetes)
- Oesophageal varices: In cirrhosis, portal hypertension causes dilation of veins in the oesophagus. Rupture causes massive haemorrhage — potentially fatal; emergency 999 response required
- Mallory-Weiss tears: Oesophageal mucosal tears caused by repeated retching, producing blood in vomit — medical review required

6.7 Immune System

Chronic heavy alcohol consumption suppresses immune function, increasing susceptibility to serious infections, including tuberculosis, pneumonia (particularly aspiration pneumonia in people who drink to very high BAC), and post-COVID complications. Wound healing is impaired. Immune dysregulation also contributes to alcohol-related inflammation across organ systems.

6.8 Endocrine Effects

Alcohol disrupts hormonal balance: it suppresses testosterone production in men (causing hypogonadism, reduced libido, testicular atrophy) and disrupts oestrogen balance in women. It significantly disrupts sleep architecture, suppressing REM sleep and causing fragmented, non-restorative sleep. Elevated cortisol from chronic alcohol use contributes to anxiety, immunosuppression, hypertension, and metabolic dysregulation.

6.9 Pregnancy and Foetal Alcohol Spectrum Disorders (FASD)

⚠ CRITICAL ALERT: FASD — There Is No Safe Level of Alcohol in Pregnancy
Alcohol crosses the placenta freely and freely enters foetal circulation. The developing brain is particularly vulnerable.
FASD (Foetal Alcohol Spectrum Disorders) is the leading preventable cause of neurodevelopmental disability in the UK.
Estimated 6,000–7,000 births per year in England are affected by FASD (BMA, 2022).
UK CMO guidance: women who are pregnant or planning pregnancy should not drink any alcohol.
There is no known safe level, safe timing, or safe type of alcohol during pregnancy.

FASD encompasses a spectrum of presentations ranging from Foetal Alcohol Syndrome (FAS) — characterised by specific facial features, growth restriction, and severe CNS abnormalities — to milder learning and behavioural difficulties without the full FAS phenotype. Features include: attention and memory difficulties, learning disabilities, executive function impairment, language and communication difficulties, adaptive behaviour challenges, and social/emotional dysregulation. FASD is lifelong and there is no cure, but early diagnosis and appropriate educational and social support significantly improve outcomes.

Reference: NICE antenatal care guidelines (NG201, updated 2021); BMA report on FASD (2022); FASD Trust (www.fasdtrust.co.uk).

6.10 Mental Health

The relationship between alcohol use and mental health is bidirectional, complex, and often clinically underrecognised:

Depression

Heavy drinking causes and exacerbates depression through multiple mechanisms: direct neurotoxic effects; disruption of sleep; nutritional deficiencies; social and relationship consequences of drinking; and the pharmacological comedown as BAC falls. Importantly, depressive symptoms in heavy drinkers often substantially improve within four to six weeks of abstinence.

Anxiety

Alcohol temporarily reduces anxiety via GABA enhancement — which is why many people with anxiety disorders drink to manage symptoms (self-medication model). However, as BAC falls and GABA effects wear off, rebound CNS excitation produces worsened anxiety. Over time, repeated cycles of relief and

rebound create and maintain anxiety disorders. Practitioners should explore whether anxiety preceded or followed problematic drinking.

PTSD

Very high rates of alcohol use disorder are documented in trauma survivors. Alcohol's sedating and dissociative properties provide temporary relief from intrusive memories, nightmares, and hyperarousal. However, heavy drinking impairs PTSD recovery and makes trauma-focused therapies less effective. Integrated trauma and alcohol treatment — addressing both simultaneously — produces better outcomes than sequential treatment. Reference: NICE guidance on PTSD (NG116, 2018).

Psychosis

Alcohol can trigger psychotic episodes, particularly in vulnerable individuals. Delirium tremens (see Section 7) involves psychotic features, including visual, auditory, and tactile hallucinations. Korsakoff's psychosis is distinct, associated with confabulation and memory impairment. Alcohol-induced psychotic disorder (ICD-11: 6C41) may also occur in chronic heavy drinkers independently of withdrawal.

Suicide

Alcohol is a factor in approximately 20–30% of suicides in England (ONS; OHID data). Acute intoxication dramatically increases impulsivity and lowers the threshold for acting on suicidal thoughts. All practitioners working with people who drink problematically should conduct routine suicide risk assessment, particularly during or following heavy drinking episodes and during early abstinence (when emotional dysregulation is common).

7. Alcohol Dependence and Withdrawal

Diagnosing Alcohol Dependence

Alcohol dependence is a recognised medical condition. Accurate diagnosis guides appropriate treatment — particularly the level of medical support required for safe withdrawal.

ℹ️ NICE / GUIDANCE: ICD-11 Diagnostic Criteria — Alcohol Dependence (Code 6C40.2)
1. Strong internal urge (craving) to use alcohol
2. Impaired ability to control the onset, frequency, amount, or cessation of drinking
3. Alcohol use takes priority over other activities and obligations
4. Tolerance: need for increasing amounts to achieve the same effect
5. Withdrawal symptoms or use of alcohol to avoid withdrawal
6. Continued drinking despite evidence of significant harm
Diagnosis requires three or more features present over a 12-month period.

ℹ️ NICE / GUIDANCE: DSM-5-TR — Alcohol Use Disorder (AUD)
11 criteria assessed over a 12-month period. Severity:
• Mild AUD: 2–3 criteria met
• Moderate AUD: 4–5 criteria met
• Severe AUD: 6 or more criteria met
Criteria include: craving; impaired control; social impairment; risky use; tolerance; withdrawal.

Screening Tools

AUDIT — Alcohol Use Disorders Identification Test

The AUDIT (Babor et al., WHO, 1989; updated) is the gold standard screening tool for identifying harmful and dependent drinking. It is a 10-item self-report questionnaire covering: frequency of drinking; amount consumed; frequency of heavy sessions; loss of control; failure of expectations; morning drinking; guilt; blackouts; injury; and concern expressed by others.

Scoring and risk categories:

AUDIT Score	Risk Category / Recommended Action
0–7	Lower risk — routine education and positive reinforcement
8–15	Increasing risk — brief advice; self-monitoring; AUDIT-C follow-up
16–19	Higher risk — extended brief intervention; consider GP referral
20+	Possible dependence — full assessment; medical review; specialist referral

AUDIT-C (3-item brief version): Items 1, 2, and 3 only — scored out of 12. Score of 5 or more in men, 4 or more in women, suggests harmful or hazardous drinking and warrants fuller assessment.

Alcohol Withdrawal: Why It Can Kill

Alcohol withdrawal is potentially fatal. It is critical that all practitioners working in drug and alcohol services understand the mechanism and the clinical urgency.

As described in Section 4, chronic heavy drinking causes neuroadaptation: GABA-A receptors downregulate and NMDA receptors upregulate. When alcohol is removed, the brain is suddenly unbalanced — too little inhibition (GABA) and too much excitation (NMDA). The result is CNS hyperexcitability, which can produce seizures, delirium tremens, cardiovascular collapse, and death.

Withdrawal Timeline

Time After Last Drink	Symptoms	Clinical Priority
6–12 hours	Tremor, sweating (diaphoresis), anxiety, nausea/vomiting, tachycardia, hypertension, insomnia	Begin CIWA-Ar assessment; medical review if high risk
12–24 hours	Above worsening; possible hallucinations (visual, auditory, or tactile) — "alcoholic hallucinosis"	Medical review; consider prescribing if not already started
24–48 hours	PEAK RISK: grand mal (tonic-clonic) withdrawal seizures	⚠ HIGH RISK — medical review essential; hospital admission if seizure occurs
48–72 hours	Risk of Delirium Tremens (DTs): confusion, severe agitation, fever, vivid hallucinations, tachycardia, hypertension, cardiovascular collapse	🚨 LIFE-THREATENING — inpatient management essential
5–7 days	Acute withdrawal resolving in most cases; Post-Acute Withdrawal Syndrome (PAWS) may follow	Ongoing psychosocial support; relapse prevention planning

⚠ CRITICAL ALERT: DELIRIUM TREMENS — MEDICAL EMERGENCY

Delirium tremens (DTs) occurs in approximately 5% of people undergoing alcohol withdrawal and carries a mortality of 5–10% if untreated.

Features: severe agitation, confusion, fever (>38°C), intense visual/tactile hallucinations (classically "seeing insects"), tachycardia, hypertension, sweating.

Anyone presenting with features of DTs MUST be admitted to hospital IMMEDIATELY — call 999.

Do NOT attempt community management of DTs.

Untreated DTs can cause death from cardiovascular collapse, hyperthermia, or airway compromise.

⚠ CLINICAL WARNING: The Kindling Effect — Increased Risk with Repeated Withdrawals

Each episode of alcohol withdrawal sensitises the brain to subsequent withdrawals — a phenomenon called "kindling". People who have previously experienced withdrawal seizures or DTs are at significantly higher risk of more severe withdrawal on subsequent attempts.

Always obtain a full withdrawal history: Has the person ever had fits or seizures related to stopping drinking? Have they ever experienced DTs? This information is essential for risk stratification.

CIWA-Ar — Clinical Institute Withdrawal Assessment for Alcohol

The CIWA-Ar is the validated clinical tool for measuring withdrawal severity and guiding prescribing decisions. It assesses ten domains, each scored 0–7 (except one scored 0–4), giving a maximum score of 67.

CIWA-Ar Domain	What is Assessed
Nausea/vomiting	Presence and severity of nausea; retching or vomiting
Tremor	Outstretched arms; severity of hand tremor
Sweating	Observation of diaphoresis
Anxiety	Self-reported and observed anxiety
Agitation	Observed psychomotor agitation
Perceptual disturbances	Visual, auditory, or tactile hallucinations/misperceptions
Headache/fullness in head	Self-reported
Clouding of sensorium	Orientation to time, place, date; ability to do serial additions
Paroxysmal sweats	Sudden episodes of sweating
Tremor severity	Reassessed during clinical contact

Interpreting CIWA-Ar scores:

Score	Severity / Recommended Action
< 8	Mild — monitor; may not require pharmacotherapy; community detox may be appropriate
8–14	Moderate — prescribing indicated; review medical suitability for community detox
15–19	Moderately severe — medical review essential; consider inpatient management
20+	Severe — inpatient management required; high seizure/DTs risk

⚑ PRACTITIONER NOTE: CIWA-Ar is a clinical tool requiring trained administration.

This section provides a brief reference guide for frontline workers. Full CIWA-Ar administration requires clinical training. Non-clinical practitioners should use the scale to understand risk categories and escalation thresholds, and ensure appropriate medical referrals for all clients assessed as moderate-severe.

Post-Acute Withdrawal Syndrome (PAWS)

Beyond the acute withdrawal period (days 1–7), many people experience a protracted withdrawal syndrome lasting weeks to months. PAWS symptoms include:

- Anxiety, irritability, and emotional dysregulation

- Depression and anhedonia (inability to feel pleasure)
- Insomnia and disturbed sleep
- Poor concentration and cognitive fog
- Intense cravings
- Fatigue and reduced stress tolerance

PAWS is a major factor in relapse. It requires acknowledgement, psychoeducation, and psychological support. Clients should be informed that these symptoms are a normal part of recovery — not evidence that they cannot get better. Symptoms generally diminish over weeks to months with sustained abstinence.

8. Harm Reduction

The UK CMO Low Risk Drinking Guidelines (2016)

The UK Chief Medical Officers' Low Risk Drinking Guidelines (CMO, 2016) define low-risk alcohol consumption as:

- No more than 14 units per week for both men and women
- Spread over three or more days — not "saved up" for one or two heavy sessions
- Having several alcohol-free days each week
- Women who are pregnant or planning pregnancy should not drink any alcohol

Important note: "low risk" does not mean "no risk." The CMO guidance explicitly states there is no completely safe level of alcohol consumption. The 14-unit limit represents a risk level that most healthy adults can accept — not a licence to drink up to the limit every week.

⚠ **CLINICAL WARNING: Critical Harm Reduction Alert: Do Not Advise Abrupt Cessation Without Assessment**
For physically dependent drinkers, sudden cessation can cause withdrawal seizures and delirium tremens — both potentially fatal.
ALWAYS assess the level of physical dependence before advising any reduction or cessation.
If a client reports morning drinking, drinking to stop shaking, or a history of withdrawal symptoms, urgent medical assessment is required before any reduction advice is given.
Community-based harm reduction supports reduction and controlled drinking for increasing/higher risk drinkers — NOT for physically dependent drinkers without medical oversight.

Sensible Drinking Strategies for People Not Ready to Stop

For clients who are not yet dependent and not ready for formal treatment, the following strategies can support harm reduction:

- Keep a drinking diary — track units consumed each day using the MyDrinkaware app or NHS unit calculator
- Alternate alcoholic and non-alcoholic drinks throughout a session
- Eat before and during drinking — food slows absorption and reduces peak BAC
- Set a weekly budget for alcohol spend — financial cost is often a powerful motivator
- Plan alcohol-free days and activities to fill the time that drinking previously occupied
- Avoid the "rounds" culture when trying to reduce — feel empowered to decline or buy your own
- Switch to lower ABV alternatives where possible — e.g., session beers (3–4%) rather than premium lager (5–6%)
- Have a ‘spacer’, not a ‘chaser’
- Hydrate with water alongside and after drinking
- Avoid drinking when emotionally distressed, lonely, or under pressure — use the HALT check (Hungry, Angry, Lonely, Tired)
- Identify triggers and plan for high-risk situations (see Appendix 7: Triggers and Cravings handout)

Harm Reduction for Dependent Drinkers

For people with physical dependence, harm reduction requires a different approach — led by medical assessment, with pharmacological support where indicated:

- Supervised reduction: where immediate abstinence is the goal, a medically supervised tapering regime using chlordiazepoxide or diazepam (see Section 9) reduces withdrawal risk
- Nalmefene (Selincro): a pharmacological harm reduction option — taken as needed before anticipated drinking — for people not aiming for immediate abstinence but wanting to reduce consumption (see Section 9)
- Thiamine supplementation: all dependent drinkers should receive oral thiamine 100mg three times daily; anyone presenting acutely or who is malnourished requires IV Pabrinex (parenteral thiamine) — see Section 9
- Hydration and nutrition: dependent drinkers are often severely malnourished and dehydrated; nutritional support is a harm reduction priority
- Wet housing and managed alcohol programmes: for people with severe dependence unable to achieve abstinence, wet housing models (managed alcohol provision) reduce chaotic use and have been associated with improved health and social outcomes in the UK and internationally

Thiamine: A Critical Harm Reduction Priority

⚠ **CRITICAL ALERT: THIAMINE (Vitamin B1) — Prescribe Proactively**
All alcohol-dependent patients must be prescribed oral thiamine 100mg three times daily.
Anyone presenting acutely with symptoms of Wernicke's encephalopathy, those who are malnourished, or those admitted for detoxification MUST receive IV Pabrinex (parenteral thiamine) — oral thiamine is insufficient as absorption is severely impaired in heavy drinkers.
Do NOT wait for signs of Wernicke's before prescribing parenteral thiamine — by that point irreversible brain damage may already have occurred.
Reference: NICE CG141

Alcohol and Driving

- England and Wales legal limit: 80mg per 100ml blood (0.08g/100ml)
- Scotland legal limit: 50mg per 100ml blood (0.05g/100ml) — introduced in December 2014
- Approximately 2 units consumed in one hour raises most people in England/Wales to approximately the legal limit — individual variation is significant
- There is NO reliable way to calculate when you are below the limit after drinking the previous night — the only safe choice is not to drive after drinking
- The "morning after" problem: alcohol consumed the evening before may still be present the following morning, particularly after heavy sessions

Alcohol and Medications: Dangerous Interactions

Medication	Interaction with Alcohol	Risk Level
Benzodiazepines (diazepam, etc.)	Synergistic CNS/respiratory depression	VERY HIGH
Opioids (codeine, morphine, tramadol, heroin)	Synergistic respiratory depression; risk of fatal overdose	VERY HIGH
Disulfiram (Antabuse)	Severe acetaldehyde accumulation reaction — nausea, flushing, collapse	VERY HIGH
Metronidazole (antibiotic)	Disulfiram-like reaction — severe nausea, vomiting	HIGH
Warfarin	Increased bleeding risk; erratic anticoagulant effect	HIGH
Paracetamol (heavy drinking)	Hepatotoxicity risk significantly increased; lower toxic dose threshold	HIGH
Antidepressants (SSRIs, TCAs)	Enhanced CNS depression; impaired antidepressant efficacy	MODERATE-HIGH
Antipsychotics	Enhanced sedation; hypotension; QT prolongation risk	MODERATE-HIGH
Pregabalin/gabapentin	Enhanced CNS depression; respiratory depression risk	MODERATE-HIGH
NSAIDs (ibuprofen, naproxen)	Increased GI bleeding risk; gastric ulceration	MODERATE

Alcohol and Sexual Health

Practitioners should routinely address sexual health in the context of alcohol use using a non-judgemental, trauma-informed approach:

- Heavy drinking is associated with reduced condom use, increased number of sexual partners, and higher STI and HIV transmission risk
- Sexual assault: alcohol is involved in a high proportion of sexual assaults in the UK. Practitioners must address this sensitively, without victim-blaming language. The RASASC (Rape and Sexual Abuse Support Centre) guidance is a useful reference for appropriate framing.
- Signpost to sexual health services as appropriate: local GUM clinics; BASHH (British Association for Sexual Health and HIV); HIV testing

9. Treatment Approaches and Medications

Effective treatment for alcohol use disorder combines evidence-based psychosocial interventions with pharmacological support where indicated. Treatment should be tailored to the individual's level of dependence, readiness to change, physical and mental health status, social circumstances, and personal goals (which may include abstinence or controlled drinking, depending on the level of dependence).

9.1 Screening and Brief Interventions

Brief Intervention (BI) following AUDIT or AUDIT-C screening is the most cost-effective intervention in the alcohol harm reduction toolkit. NICE recommends BI in primary care, A&E, antenatal services, and other opportunistic settings (NICE PH24).

The 5-As Framework

- Ask: screen using AUDIT or AUDIT-C; ask routinely about alcohol use
- Advise: give personalised feedback based on screening results; link to guidelines
- Assess: determine readiness to change; assess dependence level
- Assist: provide brief advice, motivational conversation, and self-help resources
- Arrange: follow-up; refer to specialist services where indicated

FRAMES Framework

- Feedback: personalised feedback about current use and risk
- Responsibility: the choice and responsibility for change belongs to the individual
- Advice: clear, non-judgemental advice about reducing harm
- Menu of options: provide a range of options for change
- Empathy: warm, empathetic, non-confrontational style
- Self-efficacy: support the individual's belief in their ability to change

9.2 Psychosocial Interventions

Intervention	Evidence & Application
Motivational Interviewing (MI)	First-line approach; particularly effective in precontemplation and contemplation stages; collaborative, evocative, autonomy-supportive. Miller & Rollnick (4th ed., 2023). NICE-endorsed.
Cognitive Behavioural Therapy (CBT)	Evidence-based for relapse prevention; addresses thoughts and behaviours that maintain drinking; relapse prevention planning. Reference: NICE CG115.
Behavioural Couples Therapy	Strong evidence base for people in relationships; addresses relationship dysfunction as a maintaining factor in drinking; involves the partner directly in treatment.
Community Reinforcement Approach (CRA)	Comprehensive evidence-based treatment; addresses social, environmental, and behavioural maintaining factors; restructures reinforcement to favour sobriety.
12-Step Facilitation (AA)	Evidence of effectiveness particularly for maintaining abstinence; widespread UK network; free to access; NICE-endorsed as an adjunct to professional treatment.

SMART Recovery	Secular, cognitive-behavioural alternative to 12-step; based on REBT and CBT principles; growing UK network; online and in-person. www.smartrecovery.org.uk
Mindfulness-Based Relapse Prevention (MBRP)	Growing evidence base (Bowen et al., 2014–2023); combines mindfulness practices with CBT-based relapse prevention; reduces automatic craving responses.
Contingency Management (CM)	NICE TA934 (2023) recommends CM for stimulant use; emerging evidence for alcohol; some UK services piloting CM for alcohol treatment.

9.3 Detoxification

Medical detoxification is required for all physically dependent drinkers. It cannot be safely managed without medical oversight.

Detox Setting	Criteria & Approach
Community Detox	Appropriate for mild-moderate dependence; no history of seizures or DTs; adequate social support; CIWA-Ar <15. Requires daily medical review; prescribing of chlordiazepoxide or diazepam. Reference: NICE CG100.
Residential/Inpatient Detox	Required for: severe dependence; CIWA-Ar ≥15; history of withdrawal seizures or DTs; polydrug use; complex comorbidities; inadequate social support. CIWA-Ar-guided prescribing; 24-hour medical cover. Reference: NICE CG100, CG141.

9.4 Pharmacological Treatments

Chlordiazepoxide (Librium)

First-line benzodiazepine for alcohol detoxification. Long-acting; reduces seizure risk. Standard regimen: reducing dose over 5–7 days in community; longer in inpatient settings. Must be prescribed by a medical professional. Example community regime: 30mg QDS days 1–2; 20mg QDS days 3–4; 10mg TDS days 5–6; 5mg BD day 7; then stop. Individual doses vary by clinical assessment.

Diazepam

Alternative to chlordiazepoxide. Sometimes preferred in severe liver impairment (active metabolites are also long-acting but prescribers should exercise caution); used in symptom-triggered prescribing protocols in inpatient settings.

NICE / GUIDANCE: Acamprosate (Campral) — NICE-Recommended First-Line Relapse Prevention

Acamprosate reduces cravings by modulating the glutamate/GABA balance disrupted by dependence — essentially helping to normalise the neuroadaptive changes. Licensed in the UK. NICE recommends as first-line relapse prevention (CG115) when combined with psychosocial support.

Key facts: start after detoxification is complete; taken three times daily; suitable for patients with liver disease (renally excreted); avoid in severe renal impairment; no interaction with alcohol (does not cause illness if the person drinks).

NICE / GUIDANCE: Naltrexone — NICE-Recommended First-Line Relapse Prevention

Naltrexone is an opioid receptor antagonist that blocks the euphoric and reinforcing effects of alcohol via the opioid pathway, and reduces craving. Licensed in the UK for alcohol dependence. NICE-recommended (CG115) alongside psychosocial support.

Key facts: contraindicated in active hepatitis or liver failure (hepatotoxic at higher doses — monitor LFTs); contraindicated in people currently using opioids (will precipitate immediate withdrawal); also available as injectable extended-release formulation (Vivitrol) for adherence-impaired patients.

Disulfiram (Antabuse)

An aversive pharmacological agent: disulfiram inhibits aldehyde dehydrogenase (ALDH), causing acetaldehyde to accumulate if alcohol is consumed. This produces a highly unpleasant reaction — intense flushing, nausea, vomiting, tachycardia, hypotension, and potentially severe cardiovascular effects. It is reserved for highly motivated patients who wish to use it as an "insurance policy" against impulsive drinking. Supervised consumption (by a family member, key worker, or pharmacist) is strongly recommended.

Contraindications: cardiovascular disease, severe liver disease, psychosis, pregnancy. Reference: NICE CG115.

Nalmefene (Selincro)

Licensed in the UK (NICE TA325, 2014) for reducing alcohol consumption in adults with alcohol dependence at high drinking risk levels who do not require immediate detoxification and who continue to have a high drinking risk level. It is taken "as needed" before anticipated drinking — a harm reduction pharmacological approach. Nalmefene is distinct from naltrexone: it is a partial agonist/antagonist at opioid receptors and is specifically indicated for consumption reduction rather than abstinence. Appropriate for people not yet aiming for immediate abstinence.

Baclofen

A GABA-B receptor agonist is increasingly used off-label for alcohol dependence in the UK and licensed in France (Bacloville trial, 2017). Some evidence for reducing cravings and alcohol use, particularly in patients with liver disease for whom naltrexone is contraindicated. Requires careful dose titration; risk of CNS depression and seizure at high doses. NICE does not currently recommend routinely — flagged for specialist prescriber consideration.

Thiamine (Vitamin B1)

Not a treatment for dependence per se, but a critical adjunct for all alcohol-dependent patients:

- Oral thiamine 100mg three times daily for all alcohol-dependent patients
- IV Pabrinex (two pairs twice daily for three days, or as clinically indicated) for anyone presenting in acute withdrawal, who appears malnourished, or in whom Wernicke's encephalopathy is suspected
- Reference: NICE CG141 — prescribers must not wait for signs of Wernicke's before administering parenteral thiamine

9.5 Treatment Pathway Overview

Stage	Actions	Tools / Reference
1. Identification / Screening	AUDIT/AUDIT-C in primary care, A&E, antenatal, criminal justice, workplace	AUDIT; NICE PH24
2. Brief Intervention	Personalised feedback; 5-As; FRAMES; self-help resources for low/increasing risk drinkers	NICE PH24; CG100
3. Assessment	Full drinking history; AUDIT full; CIWA-Ar; physical health; mental health; social; risk; goals	NICE CG100; Appendix tools
4a. Community Detox	CIWA-Ar <15; daily review; chlordiazepoxide reducing regime; thiamine; social support confirmed	NICE CG100
4b. Inpatient/Residential Detox	CIWA-Ar ≥15; history of seizures/DTs; complex needs; 24-hour medical cover	NICE CG100, CG141
5. Relapse Prevention	Acamprosate or naltrexone + psychosocial intervention (CBT, MI, AA/SMART); start post-detox	NICE CG115
6. Recovery Support	Mutual aid (AA, SMART Recovery); peer mentors; employment and housing support; recovery capital	OHID CQS 2022

9.6 Mutual Aid and Recovery

- Alcoholics Anonymous (AA): 12-step model; widespread UK network; online and in-person; www.alcoholics-anonymous.org.uk
- SMART Recovery: secular, CBT-based alternative to 12-step; growing UK network; www.smartrecovery.org.uk
- Al-Anon and Alateen: support for families and friends of people with alcohol problems; www.al-anonuk.org.uk

Recovery capital — housing, employment, social networks, identity, and purpose — is as important as treatment in sustaining long-term recovery. Treatment services should actively support the development of recovery capital alongside clinical interventions.

Further Reading & Resources

- NICE CG100: Alcohol-use disorders — diagnosis, assessment and management — www.nice.org.uk/guidance/cg100
- NICE CG115: Alcohol-use disorders: harmful drinking and alcohol dependence — www.nice.org.uk/guidance/cg115
- NICE TA325: Nalmefene for reducing alcohol consumption — www.nice.org.uk/guidance/ta325
- NICE TA934: Contingency management (2023) — www.nice.org.uk/guidance/ta934
- Miller, W. R. & Rollnick, S. (2023). Motivational Interviewing: Helping People Change and Grow (4th ed.). Guilford Press
- AA UK — www.alcoholics-anonymous.org.uk | SMART Recovery UK — www.smartrecovery.org.uk

10. Attracting People to Services / Working with Families

Attracting People to Services

The treatment gap in alcohol services is enormous. Around 600,000 people in England are estimated to be alcohol dependent, yet only around 18% are in formal treatment. Stigma, shame, denial, and a lack of awareness of available services are the primary barriers. Services must actively work to reduce barriers and increase accessibility.

Reducing Stigma and Shame

Shame is the most powerful barrier to help-seeking in alcohol use disorder. Practitioners can help by:

- Using non-stigmatising language consistently ("person with alcohol dependence" not "alcoholic")
- Explicitly challenging the moral failing narrative — alcohol use disorder is a recognised medical condition with a neurobiological basis
- Sharing recovery narratives — with consent — from people who have been through treatment successfully
- Ensuring physical environments are welcoming, discreet, and free from institutional stigma

Digital Engagement

Digital channels increasingly provide the first point of contact for people ambivalent about accessing services:

- NHS alcohol support pages and self-help tools (nhs.uk/live-well/alcohol-advice)
- Drinkaware (www.drinkaware.co.uk) — unit calculator, self-assessment tools, MyDrinkaware app
- Drinkline: 0300 123 1110 — free, confidential national alcohol helpline
- One You NHS digital tools for behaviour change
- Online AA and SMART Recovery meetings — particularly valuable for people not yet ready for face-to-face contact

Opportunistic Screening and Brief Intervention

The most effective routes to early identification and engagement are opportunistic settings where people are already presenting for other reasons:

- Primary care: GPs and practice nurses are ideally placed to screen; NICE PH24 recommends routine AUDIT screening in primary care
- Emergency departments: NICE recommends BI in A&E; alcohol specialist nurses (ASNs) in A&E are highly cost-effective
- Workplace health programmes: EAPs (Employee Assistance Programmes) provide a low-stigma route to help-seeking
- Criminal justice settings: arrest referral, drug treatment requirements, probation — all provide opportunities for early intervention
- Antenatal services: routine alcohol enquiry in pregnancy is recommended; NICE NG201

Lived Experience and Peer Mentors

Peer mentors and people with lived experience of alcohol use disorder are powerful in reducing stigma, building therapeutic alliance, and inspiring hope. OHID's co-production framework supports the integration

of lived experience voices into service design and delivery. Where possible, services should employ peer support workers in recovery and provide them with appropriate training and supervision.

Criminal Justice Pathways

Alcohol-related offending accounts for a significant proportion of all crime in England and Wales. Practitioners working in criminal justice settings should:

- Use AUDIT screening routinely at every contact point
- Be aware that Drug Rehabilitation Requirements (DRRs) under probation supervision can include alcohol treatment conditions
- Understand that court-mandated treatment, while complex ethically, can be effective when combined with genuine therapeutic engagement
- Reference: Alcohol Change UK and OHID Criminal Justice Alcohol Data (2023–24)

Working with Families and Carers

Families and carers of people with alcohol use disorder are often profoundly affected — experiencing anxiety, depression, financial hardship, and the strain of managing unpredictable behaviour. They should be assessed and supported in their own right, not merely as a route to engaging the person who drinks.

NICE / GUIDANCE: Care Act 2014 — Carer Assessment Duty

Under the Care Act 2014, local authorities have a duty to assess carers who may have support needs. This duty applies to carers of people with substance use disorders. Practitioners should ensure carers are offered a carer assessment and informed of their rights under the Act.

Evidence-Based Approaches for Families

Approach	Description
CRAFT (Community Reinforcement and Family Training)	Evidence-based approach that equips family members with skills to: (1) reduce enabling behaviours; (2) improve their own wellbeing; (3) increase the likelihood of the person with AUD entering treatment. Meyers & Smith (1995, updated). Stronger evidence than Al-Anon or Johnson Intervention for increasing treatment uptake.
The 5-Step Method (Orford et al.)	Developed in the UK; practical framework for supporting family members to understand and manage their difficult situation in five steps: information, stress identification, coping response analysis, social support, and wellbeing enhancement.
ADFAM UK guidance	National charity for families affected by drug and alcohol use; provides guidance, resources, and a service directory for practitioners and families. www.adfam.org.uk
Behavioural Couples Therapy	Where the person with AUD is in treatment, involving their partner has a strong evidence base for improving outcomes for both parties.

Children of Dependent Drinkers

An estimated 700,000 children in England live with a dependent drinker (OHID). Growing up in a household where alcohol use disorder is present significantly increases risk of adverse childhood experiences (ACEs), mental health difficulties, educational disruption, and later development of AUD. The Hidden Harm agenda — originating from drug services but equally applicable to alcohol — requires practitioners to:

- Ask routinely about dependent children whenever working with a person with alcohol use disorder
- Follow safeguarding protocols where there is concern about a child's welfare
- Refer to children's social care as required under Working Together to Safeguard Children (2023)
- Connect families with support services for children (e.g., Nacoa — the National Association for Children of Alcoholics: www.nacoa.org.uk)

⚑ PRACTITIONER NOTE: Trauma-Informed Practice with Families

Many carers and family members have their own significant trauma histories — including domestic abuse, bereavement, or their own childhood experiences of parental alcohol use. Practitioners should approach family work with the same trauma-informed lens applied to direct work with clients. Avoid reinforcing shame, blame, or the idea that families have "caused" AUD.

Further Reading & Resources

- ADFAM UK — families affected by drugs and alcohol — www.adfam.org.uk
- Nacoa — National Association for Children of Alcoholics — www.nacoa.org.uk
- CRAFT: Meyers, R. J. & Smith, J. E. (1995). Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach. Guilford Press
- Orford, J., Templeton, L., Velleman, R., & Copello, A. (2010). The 5-Step Method. Drugs: Education, Prevention and Policy
- OHID: Hidden Harm guidance — www.gov.uk

Appendix 1: Alcohol Referral Form

For completion by referring worker, GP, or self-referring client

Field	Response
Client name (or reference)	
Date of birth	
Gender (include: Man / Woman / Non-binary / Prefer to self-describe / Prefer not to say)	
Ethnicity (ONS 2021 Census categories)	
Preferred contact method and number/email	
GP name and surgery	
Referral source	Self □ GP □ A&E □ Criminal justice □ Social care □ Employer □ Other: ___
Primary presenting concern	

Alcohol Consumption

Field	Response
Typical units per day	
Typical units per week	
Duration of current drinking pattern	
Morning drinking?	Yes □ No □ Sometimes □
Drinking to stop shaking or withdrawal symptoms?	Yes □ No □ Sometimes □
Previous withdrawal history (fits, shakes, DTs)?	Yes □ No □ Unsure □
Previous detoxification attempts?	Yes □ No □ If yes, number: ___ Outcome: ___

Other Information

Field	Response
Other substance use	
Physical health concerns (liver, cardiac, neurological)	
Mental health concerns	
Safeguarding concerns (children / adults at risk)?	None □ Children □ Adults at risk □ → Refer to safeguarding if yes
Consent to share information with GP	Yes □ No □ Declined □
Thiamine prescribed?	Yes □ No □ Not applicable □

Notes for receiving service	
Worker name and contact	
Date of referral	

Appendix 2: AUDIT — Alcohol Use Disorders Identification Test

Full 10-item version (WHO / Babor et al.) — for clinical screening use

Instructions: Circle the answer that best describes your drinking over the past year. Score each question and total at the end.

Question	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times/month	2–3 times/week	4+ times/week
2. How many units do you drink on a typical day when drinking?	1–2	3–4	5–6	7–9	10+
3. How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
4. How often in the last year have you found you could not stop once you had started?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
5. How often in the last year have you failed to do what was normally expected because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
6. How often in the last year have you needed a drink in the morning to get yourself going?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
7. How often in the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
8. How often in the last year have you been unable to remember what happened because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative/friend/doctor expressed concern about your drinking?	No		Yes, but not in the last year		Yes, in the last year

AUDIT Total Score	Risk Category
0–7	Lower risk — brief education and positive reinforcement
8–15	Increasing risk — brief advice; self-monitoring tools; AUDIT-C follow-up
16–19	Higher risk — extended brief intervention; GP referral recommended
20+	Possible dependence — full assessment; specialist referral; medical review

AUDIT-C (3-item brief version): Questions 1, 2, and 3 only. Scores: Men: 5+ = hazardous drinking. Women: 4+ = hazardous drinking. Follow up with full AUDIT.

Appendix 3: Alcohol Assessment Form

For use in structured assessment by trained practitioners

A. Drinking History

Field	Response
Age of first drink	
Age when drinking became problematic	
Current daily consumption (units)	
Current weekly consumption (units)	
Typical drinking pattern	Daily □ Most days □ Weekends □ Binge □ Other: ___
Preferred drinks	
Drinking context	Home alone □ Social □ Work-related □ Mixed □
Morning drinking	Yes □ No □
Drinking to manage withdrawal?	Yes □ No □ Sometimes □
Longest period of abstinence and when	

B. Dependence Indicators (CIWA-Ar Reference)

Indicator	Present?
Tremor (shaking hands/body)	Yes □ No □
Sweating (particularly on waking)	Yes □ No □
Anxiety/agitation on waking	Yes □ No □
Nausea/vomiting when not drinking	Yes □ No □
Hallucinations (visual, auditory, tactile)	Yes □ No □ If yes, describe: ___
Previous withdrawal seizures (fits)	Yes □ No □
Previous delirium tremens	Yes □ No □
CIWA-Ar score (if completed)	
Medical risk level	Low □ Moderate □ High □ → Refer urgently if high

C. Physical Health, Mental Health & Social Circumstances

Area	Notes
Physical health concerns	
Current medications	
Thiamine prescribed?	Yes □ No □ Not yet □ → Prescribe if dependent
Mental health history	
Current mental health treatment	
Trauma history	

Suicidal ideation	None □ Present □ → Crisis pathway if present
Housing	
Employment/education	
Social support	
Caring responsibilities	
Safeguarding concerns	None □ Children □ Adults at risk □ → Refer

D. Recovery Capital & Treatment Goals

Area	Response
Client's treatment goal	Abstinence □ Controlled drinking □ Harm reduction □ Unsure □
Strengths and assets	
Support network	
Previous treatment and response	
Recommended intervention	
Referrals to be made	
Follow-up appointment	
Assessing worker and date	

Appendix 4: CIWA-Ar Brief Reference Card

Quick reference for frontline workers — not a substitute for clinical training

The Clinical Institute Withdrawal Assessment for Alcohol (Revised) — CIWA-Ar — is the validated tool for assessing withdrawal severity. This card summarises the key domains and scoring thresholds.

CIWA-Ar Domain	Scale / What to Observe
Nausea / Vomiting	0 = None; 4 = Intermittent nausea; 7 = Constant nausea, retching, or vomiting
Tremor	0 = No tremor; 4 = Moderate tremor with arms extended; 7 = Severe tremor even at rest
Paroxysmal sweats	0 = No sweating; 4 = Beads of sweat on forehead; 7 = Drenching sweat
Anxiety	0 = No anxiety, calm; 4 = Moderately anxious/guarded; 7 = Equivalent to panic state
Agitation	0 = Normal; 4 = Moderately fidgety/restless; 7 = Paces constantly, wringing hands
Perceptual disturbances	0 = None; 4 = Moderate hallucinations; 7 = Continuous hallucinations
Headache/fullness in head	0 = None; 4 = Moderately severe; 7 = Extremely severe
Clouding of sensorium	0 = Fully oriented; 2 = Uncertain about date; 4 = Disoriented in place and/or time

Total Score	Severity / Action
< 8	Mild — monitor; may not require pharmacotherapy; community detox potentially appropriate
8–14	Moderate — benzodiazepine prescribing indicated; assess for community vs inpatient detox
15–19	Moderately severe — medical review essential; consider inpatient management
20+	Severe — inpatient detox required; high seizure and DTs risk

⚑ PRACTITIONER NOTE: This is a reference guide only. Full CIWA-Ar administration requires clinical training.

Non-clinical practitioners should use these thresholds to understand risk categories and escalation decisions — and refer to medical services for all clients assessed as moderate or severe.

Appendix 5: Alcohol Monitoring Form

Weekly drinking diary, mood and craving tracker — for client use

Use this form each week to track your drinking, mood, and cravings. Bring it to your sessions.

Day	Units Drunk	What / Where / With Whom	Mood (1–10)	Craving (1–10)	Triggers Identified
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
TOTAL					

Reflection	Notes
My goal this week was:	
Did I meet my goal?	Yes □ Partially □ No □
What helped me?	
What made it harder?	
Trigger patterns I noticed:	
What I want to work on next week:	

Appendix 6: Client Handout — Understanding Your Drinking

Information for clients about units, guidelines, and the impact of drinking

WHAT IS A UNIT?

One unit = 10ml (8g) of pure alcohol. To calculate units: multiply the ABV% by the volume in millilitres, then divide by 1000.

Drink	Approximate Units
Pint of regular lager (4%)	2.3 units
Pint of strong lager (5.5%)	3.1 units
175ml glass of wine (13%)	2.3 units
Large glass of wine (250ml, 13%)	3.3 units
Single spirit (25ml, 40%)	1 unit
Bottle of wine (750ml, 13%)	9.75 units
Can of lager (440ml, 4%)	1.8 units
Pint of cider (5%)	2.8 units

THE UK GUIDELINES

No more than 14 units per week for men and women. Spread over 3 or more days. Have several alcohol-free days each week. There is no completely safe level — 14 units is low risk, not no risk.

WHAT DOES YOUR DRINKING COST YOU?

Area	Think about...
Money	How much do you spend on alcohol each week? Each month? Each year?
Health	How does your drinking affect your sleep, energy, physical health, and mood?
Relationships	How has your drinking affected your family, partner, friends, or colleagues?
Work	Has your drinking affected your performance, attendance, or relationships at work?
Time	How much time does drinking (and recovering from drinking) take up in your week?

Appendix 7: Client Handout — Triggers and Cravings

A trigger is anything that makes you want to drink. Understanding your triggers is the first step to managing them.

Type of Trigger	Examples	My Personal Triggers (write here)
Emotional	Stress, anxiety, boredom, loneliness, anger, sadness, feeling happy and wanting to celebrate	
Environmental	Walking past a pub, seeing a bottle of wine, certain times of day (5pm), being at home alone	
Social	Being with certain friends, work drinks, parties, someone offering you a drink	
Physical	Feeling tired (HALT), hunger, physical pain, after exercise	
Cognitive	"I deserve a drink", "just one won't hurt", "I'll never be able to stop"	

MANAGING CRAVINGS

- Urge surfing: observe the craving without acting on it — it will peak and pass like a wave (usually within 20–30 minutes)
- Distraction: physical activity, calling a friend, making tea, going for a walk — anything that breaks the automatic link between trigger and drink
- HALT check: Am I Hungry? Angry? Lonely? Tired? Address the underlying need instead
- Delay: tell yourself you'll wait 20 minutes — the urge will often pass
- Contact your support network or key worker
- Remember your reasons for changing — keep them visible

Appendix 8: Client Handout — Alcohol and Your Body

Heavy drinking affects nearly every part of your body. The good news is that many of these effects improve — sometimes dramatically — when you reduce or stop drinking.

Part of the Body	What Alcohol Does / What Can Improve
Liver	Fatty liver (reversible), hepatitis, cirrhosis (permanent scarring). Stop drinking: fatty liver can reverse within weeks.
Brain	Memory impairment, blackouts, nerve damage. Some recovery possible with abstinence and thiamine.
Heart	Raises blood pressure, can cause irregular heartbeat, weakens heart muscle over time. Blood pressure often improves quickly with stopping.
Stomach/Gut	Gastritis, ulcers, pancreatitis. Symptoms often improve with stopping.
Immune system	Heavy drinking suppresses immunity — increased infections. Improves with abstinence.
Sleep	Disrupts deep sleep; causes waking at night. Sleep quality typically improves significantly within weeks of stopping — though it may initially worsen.
Mental health	Depression and anxiety are both worsened by heavy drinking. Most people see significant improvement in mood within 4–6 weeks of stopping.

⚠ CRITICAL ALERT: IMPORTANT — Never stop suddenly if you are dependent

If your body has become dependent on alcohol, sudden stopping can cause serious medical problems including fits (seizures). Always talk to a doctor before stopping completely if you drink heavily every day or if you have experienced shaking, sweating, or anxiety when you haven't drunk for a few hours.

Appendix 9: Client Handout — Planning Alcohol-Free Days

Having regular alcohol-free days helps your body recover, breaks habitual patterns, and gives you evidence that you can control your drinking.

TIPS FOR ALCOHOL-FREE DAYS

- Plan in advance — choose specific days that suit your week
- Tell someone you trust — accountability helps
- Have alternative drinks ready (sparkling water, nice squash, alcohol-free beer if it suits your recovery)
- Fill the time: what activities can you do that you enjoy and which don't involve alcohol?
- Avoid trigger situations on your alcohol-free days, especially at first
- Notice how you feel the day after — better sleep? Better mood? More energy?
- Reward yourself — use some of the money you've saved for something you enjoy

MY PLAN

Day	My Planned Alternative Activity
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Appendix 10: Client Handout — Dangerous Situations

Some situations, people, or feelings make it much harder to stay in control. Identifying them in advance — and making a plan — is one of the most powerful things you can do to protect your recovery.

Dangerous Situation	My Plan B
Specific people I drink heavily with	
Places where I always drink	
Times of day / week that are high risk	
Emotional states that trigger heavy drinking	
Social pressures ("you have to have one")	
When I'm angry / lonely / anxious	

PLAN B STRATEGIES

- If I feel like drinking dangerously, I will call: _____
- If I relapse, I will not give up — I will call my key worker or attend my next appointment
- Emergency contacts: Drinkline 0300 123 1110; NHS 111; Samaritans 116 123

Appendix 11: Client Handout — Understanding Relapse

A lapse (having a drink when you didn't plan to) is very common during the process of change. It does not mean you have failed. It is an opportunity to learn.

RELAPSE IS PART OF RECOVERY FOR MANY PEOPLE

Most people make several attempts before achieving sustained change. Each attempt builds self-knowledge and resilience. What matters is not whether you lapsed, but what you do next.

If you have a lapse...	What to do
Don't catastrophise	One drink is not a disaster unless you let it become one. Stop.
Be honest with yourself	What triggered the lapse? What warning signs were there?
Contact your support	Call your key worker, sponsor, or a trusted person as soon as possible.
Use your plan B	Refer to your dangerous situations plan and your coping strategies.
Don't isolate	Isolation after a lapse increases the risk of escalation.
Attend your next appointment	Do not avoid your service out of shame — they are there to help you.

EMERGENCY CONTACTS

- Drinkline: 0300 123 1110 (free, confidential, 9am–8pm weekdays, 11am–4pm weekends)
- NHS 111 (24/7 — mental health and medical support)
- Samaritans: 116 123 (free, 24/7)
- FRANK: 0300 123 6600 (www.talktofrank.com)
- Your key worker: _____

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