



The Evidence of Effectiveness & Minimum Standards for the Provision of Alcohol Identification and Brief Advice in Community Health Settings

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1. INTRODUCTION

Around 9 million people in England regularly drink above the Government's sensible drinking guidelines. Alcohol use is one of the three biggest lifestyle risk factors for disease and death after smoking and obesity and society is paying the price. Alcohol-related harm is now estimated to cost society £21 billion annually. ¹

These 9 million drinkers are not, in the main, dependent on alcohol. Only a minority conform to the public image of the "alcoholic". The majority are people with jobs, cars, families and positions of respect in the community; however their drinking is placing them at greater risk of alcohol related harm and is placing a huge burden on the community.

- Alcohol misuse costs the NHS around £3.5 billion a year²
- 25% of all acute male hospital beds are occupied by someone with alcohol related harm³
- 1 million incidents of alcohol related violence occur each year⁴
- Alcohol related crime costs over £10 billion annually⁵
- 11-17 million working days are lost each year due to alcohol-related sickness absence⁶
- About 1 million children live in a family affected by parental alcohol problems.⁷

Alcohol misuse is a problem for all of us and a challenge to every health, social care, housing and community safety agency in the country. Anyone working in these agencies can expect to meet people at risk of alcohol related harm. This burden is also a responsibility as each of these agencies will see drinkers and have the opportunity to tackle alcohol related harm. However, the majority of these at risk drinkers can benefit from simple, brief advice delivered by professionals without specialism in alcohol misuse management.

This is not wishful thinking. The World Health Organisation and the Department of Health have both acknowledged that over 50, peer reviewed, academic studies demonstrate that *Identification and Brief Advice (IBA)* is both effective and cost-effective in reducing the risks associated with drinking. On average 1 in 8 drinkers who receive this type of support from a healthcare professional will reduce their drinking to within the lower risk guidelines.^{8,9,10} This may be an underestimate of the benefits. Some drinkers will make reductions but not to within lower risk levels. On average, following intervention, individuals reduced their drinking by 15%.¹¹

Identification and brief advice works. It is also quick and easy to do. Ensuring that all professionals are using these tools as part of their daily work will improve the lives of thousands of people, reduce costs to society and ultimately ease the burden on the workers who deliver the IBA.

1.1 STRUCTURE

This report sets out the case for rolling out IBA across agencies working with the public in community health settings such as primary care, pharmacy, midwifery and health visiting, drug services, people working with sexual health and mental health services. It will give managers the evidence to argue for a better response to drinkers. It also contains minimum standards which set out in detail how community health staff should adopt identification and brief advice. A supporting website hosts all these materials as well as additional resources such as leaflets in other languages.

This work has been supported by the Safe Sociable London Partnership and Public Health England – London and, therefore, the first section sets out the case in terms of alcohol's impact on London boroughs. The next section provides an overview of the IBA process itself. This is followed by sections which look at the case for rolling out IBA, the minimum standards and the support which will be required by staff. The appendices contain a range of identification tools and support materials.

1.2 ACKNOWLEDGEMENTS

This report was written by Alcohol Concern, the national alcohol charity, on behalf of the Safe Sociable London Partnership and Public Health England – London. Its joint authors are Alcohol Concern consultants: Mike Ward, Mark Holmes, Lauren Booker and Martyn Penfold. The authors would like to thank: Matthew Andrews, Susan Ismaeel, Ruth Adekoya and David MacKintosh from the Safe Sociable London Partnership and Public Health England (London) for their support.

The work was overseen by an expert steering group comprising:

- Iain Armstrong - Public Health England
- Adrian Brown – St George’s Hospital, Tooting
- John Currie – London Borough of Barking and Dagenham
- Dezlee Dennis – London Probation Trust
- Ranjita Dhital – King’s College London
- Don Lavoie – Public Health England
- James Morris – The Alcohol Academy
- Marion Morris – London Borough of Haringey
- Dr. Dorothy Newbury-Birch – Newcastle University
- Laura Pechey – HAGA (Haringey Advisory Group on Alcohol)
- Professor Paul Wallace - National Institute for Health Research
- Dr. Fiona Wizniacki – Ealing Hospital

Their support was invaluable in validating and improving these materials.

2. LONDON, ALCOHOL AND THE CASE FOR IDENTIFICATION AND BRIEF ADVICE

Alcohol use and alcohol related harm in London is around or slightly below the national average.

- 13% of adults in London are likely to have drunk on five or more days in the previous week: exactly the national average.¹²
- 15% of adults in London drank more than 8 units (if male) or 6 units (if female) on their heaviest drinking day in the last week. Again this was the national average.¹³
- The proportion of adults likely to exceed 4/3 units on their heaviest drinking day is 28% in London. The national average is 31%.¹⁴
- Alcohol specific mortality rates for both men and women are slightly below the national average.¹⁵
- Alcohol specific hospital admissions are also slightly below the national average for both genders.¹⁶

However, this data conceals as much as it reveals. Even areas with average levels of alcohol related harm will experience a considerable impact from alcohol. A London borough of about 250,000 people could expect to have:

- 27,000 Increasing Risk Drinkers
- 8,500 Higher Risk Drinkers
- 4,500 Dependent Drinkers
- 21,500 Binge Drinkers.¹⁷

A borough with an average level of harm would be likely to experience the following:

EFFECT	ANNUAL IMPACT IN A BOROUGH WITH 250,000 POPULATION
Number of people admitted to hospital with an alcohol-related condition ¹⁸	5,000
Victims of alcohol-related violent crime ¹⁹	2,500
11-15 year olds will be drinking weekly ²⁰	1,000
Costs to health service of alcohol related harm ²¹	£14,100,000
Costs of alcohol related crime ²²	£47,100,000
Costs of drink-driving ²³	£2,400,000
Drink-driving deaths ²⁴	2
Alcohol-related sexual assaults ²⁵	90
Victims of alcohol-related /domestic violence ²⁶	1,700
Costs to economy of alcohol related absenteeism, deaths and lost working days ²⁷	£30,200,000
Working days lost due to alcohol related absence ²⁸	66,000
Children affected by parental alcohol problems ²⁹	4,400

More importantly, these average rates of harm across London conceal communities with much higher levels of harm. For example:

- alcohol dependence in London is higher than in most other parts of the country.³⁰ This is probably due to the urban environment attracting heavier drinkers.
- non-white ethnic groups consume less alcohol than white British, white Irish and other white groups. Therefore, the large non-white populations across London (40.2% as against 14.6% in England) may statistically conceal the impact of alcohol on white populations.³¹
- the mean age of the London population (35.6) is lower than the England average (39.3). If this reflects a pattern of people moving outside London as they grow older, it may result in harm being “exported”.³²

Above all, although health problems may be lower, alcohol related crime is particularly high in London. Alcohol attributable crime generally, and attributable violent and sexual crimes specifically, are not only above average in the London region but are all at the highest level of any of the nine regions in England.

3. WHAT CAN BE DONE TO TACKLE ALCOHOL RELATED HARM?

3.1 IDENTIFICATION AND BRIEF ADVICE

Alcohol is associated with such a wide range of harms that there will never be a simple set of solutions. Appropriate responses will include treatment, social marketing and the effective application of the Licensing Act. The Department of Health has published seven high impact changes which should be pursued locally and commissioners will be advised to review these and consider guidance such as *Signs for improvement – commissioning interventions to reduce alcohol-related harm*. At the heart of these changes is rolling out Identification and Brief Advice (IBA).³³

Many people experiencing or at risk of alcohol-related harm can change their drinking after identification and brief advice provided in non-alcohol misuse specialist services.

The main group who will benefit from IBA are the increasing and higher risk drinkers: around 35,000 people in a borough of 250,000 people. It is likely that the majority of these people will be seen by someone in the health, social care, housing or criminal justice sectors each year.

Therefore, a wide range of staff need to be trained to:

- Identify those at risk of alcohol related harm
- Offer brief advice
- Refer on to appropriate services when required.

Ideally workers will be undertaking IBA with all their patients or clients and a number of opportunities exist to introduce the AUDIT tool (*see page 38*). It should be incorporated into standard processes and paperwork:

- As part of a consultation or health check
- As part of an initial assessment
- As part of an initial care planning session or a review
- Before a break or change in care
- At the end of the care relationship.

3.2 THE BENEFITS OF IBA

Research has proven the benefits of IBA:¹

- 1 in 8 increasing or higher risk recipients of IBA reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years. This compares with 1 in 20 smokers who benefit from stop smoking advice. This may be an underestimate of the benefits. Some drinkers will make reductions but not to within lower risk levels.^{34,35,36,37}
- On average, following intervention, individuals reduced their drinking by 15%. While this may not be enough to bring the individual's drinking down to lower risk levels, it will reduce their alcohol-related hospital admissions by 20% and "absolute risk of lifetime alcohol-related death by some 20%" as well as have a significant impact on alcohol-related morbidity.³⁸
- IBA is an opportunity to educate a wide range of people, who may not already be aware, about units, lower-risk limits and risks associated with alcohol.³⁹
- It is estimated that the use of IBA nationally could result in reduction from higher-risk to lower-risk drinking in 250,000 men and 67,500 women each year.⁴⁰

3.3 RETURN ON INVESTMENT: ECONOMIC AND SOCIAL BENEFITS

NICE Public Health Guidance 24 states that Chief Executives of NHS bodies should prioritise alcohol-use disorder prevention as an 'invest to save' measure.

- NICE Public Health Guidance 24 states that Chief Executives of NHS bodies should prioritise alcohol-use disorder prevention as an 'invest to save' measure.
- The Department of Health's treatment effectiveness review highlights that IBA has the potential to save future costs, as well as bringing individual benefits in terms of reducing risk of premature death and alcohol-related morbidity.
- IBA can also identify individuals who will benefit from further support or treatment and a 10% increase in the uptake of treatment of dependent drinkers will reduce public sector costs by £109 - £156 million annually.^{41,42,43}
- Economic analysis by the University of Sheffield found that IBA in primary care produced estimated cost savings. The analysis suggested that health and social service savings of £124.3 million may be realised over a 30 year time horizon.⁴⁴
- IBA in primary care has been found to be the second most cost effective alcohol intervention for health commissioners, after changes in taxation, with cost savings of £123 per person.⁴⁵
- In needle exchanges there is direct evidence that brief advice can decrease alcohol use among injecting drug users with drinking problems.⁴⁶

4. THE CASE FOR INVESTING IN IBA IN COMMUNITY HEALTH SETTINGS

4.1 THE TARGET STAFF

- Primary care staff including GPs, nurses and health care assistants
- Pharmacists
- Drug workers
- Mental health service staff generally
- Midwives and health visitors
- People working with sexual health.

4.2 THE IMPACT OF ALCOHOL IN SOCIAL CARE SETTINGS

- Alcohol misuse is frequently encountered by community health professionals. It has a significant impact on this sector.
- Alcohol misuse costs the NHS £3.5 billion per annum.⁴⁷
- In 2010/2011 there were 1.2 million alcohol-related hospital admissions. This equated to 7% of all hospital admissions and offers a substantial opportunity to intervene.
- Over 14 million people are treated in A&E in England each year. The Department of Health estimates that 35% of A&E attendances in the UK are attributable to alcohol, increasing to 70% between midnight and 5am.⁴⁸
- 11% of male high blood pressure is alcohol related.⁴⁹
- Over 4,000 people die each year as a result of alcoholic liver disease.⁵⁰
- A National Statistics study found that 27% of people with severe and enduring mental health problems had an AUDIT score of 8 or more in the year before interview, including 14% who were classified as alcohol dependent.⁵¹
- No health without mental health notes a clear association between mental illness and drug and alcohol dependence. People experiencing mental ill health have a higher risk of substance misuse.⁵²

- 60% of young women who are infected with a sexually transmitted infection say they were under the influence of alcohol when they had sex with the infected person.⁵³
- Alcohol increases the risk of unplanned pregnancy, as young people in particular are less likely to use contraception when intoxicated.⁵⁴
- Pregnant women who have received brief advice have been shown to be five times more likely to report abstinence after the intervention compared with women who do not receive it. It can have a powerful effect on health risks and in halting or reversing emerging health problems.⁵⁵
- The National Treatment Outcome Research Study found that 33% of those entering residential treatment or community methadone programmes were drinking at levels above those recommended as safe.⁵⁶
- Alcohol misuse represents a particular problem for drug misusers. It may increase the risk of relapse and overdose and will present serious problems for people who have hepatitis.^{57,58}

4.3 NATIONAL GUIDANCE

- National alcohol strategies from 2004 onwards have highlighted primary care as a key location for IBA.⁵⁹
- The Department of Health's High Impact Changes to reduce alcohol related harm identifies rolling out IBA as a key change required at the local level.⁶⁰
- NICE Guidance recommends that health professionals should routinely carry out alcohol IBA as an integral part of their practice.⁶¹
- The Government recognises that community pharmacy has a role to play in alcohol IBA.⁶²
- *NICE Guidance on Psychosis and substance misuse* emphasises the importance of alcohol training for mental health staff.⁶³
- NICE guidance recommends that identification of alcohol-use disorders should include people with relevant mental health problems such as anxiety, depression or other mood disorders or at risk of self-harm.⁶⁴
- The Royal College of Surgeons of England and the Royal College of Nursing, recommend brief, cognitive advice delivered by nursing staff as part of care for conditions resulting from alcohol misuse.⁶⁵
- The National Treatment Agency's *Promoting safer drinking – A briefing paper for drug workers* recommends that drug workers should be able to identify and assess problem drug users with patterns of increasing, higher risk or dependent drinking, offer them advice, brief interventions and refer on if required.

5. THE IBA PROCESS - OVERVIEW

5.1 IDENTIFICATION - THE AUDIT TOOL

The Alcohol Use Disorders Identification Test (AUDIT) is the best evaluated alcohol screening tool available (*see appendix 1*). It was developed by the World Health Organisation and focuses on quickly identifying increasing and higher risk drinking as well as possible dependence. In particular, it identifies those who are drinking at increasing/higher risk levels before their drinking becomes problematic or dependent. It can be easily incorporated into a general health or social care assessment, lifestyle questionnaire or medical history.

AUDIT is a ten question, multiple choice tool which is considered the 'gold standard' in alcohol identification. Each of the ten questions has a maximum score of 4 and therefore, AUDIT will have a score range of 0-40..

0-7 is *No or Low risk*

8-15 is *Increasing risk*

16-19 is *Higher risk*

20+ is *Possible dependence*.

AUDIT can be used with people of all ages and in a wide variety of settings. It is also cross-culturally sensitive and can be used with those with low literacy levels. However, AUDIT may not be suitable for some adults with learning disabilities or cognitive impairment. ^{66,67,68}

AUDIT, at 10 questions long, may be too long for some busy healthcare settings; so, a number of 'initial screening' tools have been developed. They are all shorter versions of the AUDIT:

- FAST (4 questions – *see appendix 2*)
- AUDIT-C (3 questions – *see appendix 3*)
- M-SASQ (1 question – *see appendix 4*).

These can be used in situations where time is very restricted such as primary care or pharmacy. If patients are positive on these initial screening or shorter tools, the full AUDIT tool should generally be used to provide a more reliable score and help decision making on the next steps. However, ideally most community health staff will use the full AUDIT tool with all their patients or clients and it should be incorporated into standard paperwork. The exact point at which it is used will vary from setting to setting.

It can be difficult to know how to start a conversation about someone's drinking, but there are many ways in which it can be brought up, e.g.:

- "As part of a new government campaign, we've been asked to screen everyone of drinking age".
- "This is part of a check-up to make sure we're meeting all your needs".
- During this initial assessment we want to make sure that we take everything into account that may be contributing to your health complaint, , so I'm going to ask you about different aspects of your lifestyle".
- "Alcohol and its contribution to ill health has been in the media a lot lately, so I'm going to ask you a few questions about your alcohol use".

If a shorter screening tool has been used, those who are positive should ideally be screened with the full AUDIT.

- People who score 8-19 on the AUDIT (or are positive on a shorter tool) should then receive *feedback and brief advice* about their drinking.
- People scoring 20+ on AUDIT should be given *brief advice* and considered for referral to specialist alcohol services.^{69,70,71}

5.2 FEEDBACK AND BRIEF ADVICE

Following the AUDIT score people should be given feedback about their score and brief advice about their drinking. This can be:

- A sentence or two of feedback about his/her drinking based on the AUDIT score and the person's circumstances.
- A sentence or two of feedback plus an information leaflet.
- Five minutes of advice based on the FRAMES structure.

The recent SIPS study has demonstrated that a sentence or two of feedback alone based on the AUDIT score can be beneficial.

FRAMES is an evidence-based structure for the delivery of brief advice. It suggests that along with basic information about alcohol, the client can be given brief advice covering:

Feedback: Structured and personalised **Feedback** on risk and harm. *"The score shows that your drinking might be putting you at risk of harm." "Drinking at this level puts you at increased risk of accidents and health problems."*

Responsibility: Emphasis on the client's personal **Responsibility** for change. *"Only you can decide if you want to make some changes." "What do you think you might like to change about your drinking?"*

Advice: **Advice** to the client to make a change in drinking. *"Try to have at least one day off alcohol a week, you'll notice the difference." "You'll feel a lot better if you cut down the amount you drink."*

Menu of options: A **Menu** of alternative strategies for making a change. *"There are some suggestions in this leaflet, which of these would work for you?" "You could try switching to a lower strength alcohol, or having fewer drinks when you do drink."*

Empathy: An **Empathic** and non-judgmental approach. *"What are the pros and cons of your drinking at the moment?" "I know when you're stressed alcohol can seem like a handy pick-me-up."*

Self-efficacy: An attempt to increase the client's **Self-efficacy** or confidence in being able to change behaviour. *"I'm sure you can do this once you put your mind to it." "How confident are you that you can make these changes?"*

(Role play examples of IBA delivery can be found at: www.alcohollearningcentre.org.uk.)

Risky drinking is complex and it should be remembered that it is not the practitioner's responsibility to change the behaviour of every increasing risk, higher risk or dependent drinker.

All that is being asked is that workers routinely use an AUDIT tool with their patients / clients and give brief advice to those who score positively. If they do that, the evidence says that people will change their drinking in such numbers that it will have a measurable impact on costs in the health, social care and criminal justice systems.

At the very least, identifying alcohol related harm and offering help ought to be basic good practice that agencies should be expected to follow with any individual. It is hard to see how a clinician can intervene appropriately without checking whether alcohol is impacting on someone's life.^{72,73}

6. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY PRIMARY CARE STAFF

Primary care staff include GPs, nurses and health care assistants.

6.1 WHICH AUDIT TOOL TO USE

The AUDIT tool is a quick, evidence based method of identifying those who are drinking at increasing/higher risk levels before their drinking becomes problematic or dependent. However, for a number of years most primary care practices have been using FAST or AUDIT-C as an initial screening with new patients. These are shortened versions of the full AUDIT. The shorter questionnaires should be used initially and if the person is positive on these, the rest of the questions that make up the full AUDIT are then asked. (See appendices 1-3 for all these tools)

6.2 WHEN TO USE THE AUDIT TOOL

Alcohol IBA has been a routine part of primary care new patient registration for a number of years. However, it should not be limited to the new patient registration but extended to wider groups. It might focus on all patients or on specific at risk groups. Primary care staff could raise it with all patients in particular groups:

- People with heart disease
- People with diabetes
- People who have recently attended A&E
- Men over 45
- Smokers.

It can also be undertaken with patients where there is a suggestion that alcohol may be a contributory factor e.g. poor sleeping, indigestion, continence problems.

6.3 RAISING THE SUBJECT OF ALCOHOL

Whilst some staff may feel uncomfortable discussing drinking with patients who are not alcohol dependent, research shows that patients generally expect to be asked about their use and do not find it intrusive.⁷⁴

This should be introduced to the patient as a standard or routine process.

- Introduce the topic: “We’re asking everyone about their alcohol use, to see if your drinking might be putting you at risk.”
- Show what constitutes a unit: “Have a look at this leaflet, it shows you how many units are in standard drinks”.
- Complete the AUDIT-C or FAST tool.
- Patients who are AUDIT-C or FAST negative should be given a leaflet and encouragement for their low risk drinking: “It looks as though your drinking is in the low risk category. Take the leaflet with you, it has more information about alcohol and how it can affect your health”.
- Patients who score positive on these tools should have the remaining questions of the full AUDIT completed.

Ideally, the AUDIT tool will be completed “interview style”, with the clinician asking the questions and recording the results on the form. If time does not allow for this, providing the client has adequate literacy skills, the form can be completed separately and handed to the clinician.

6.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Brief advice should be offered to all patients testing positive on the full AUDIT and it should include clear structured advice about risk and change using the FRAMES model (which is set out above under 5.2 Feedback and brief advice) and a Patient Information Leaflet (PIL) How much is too much?.^{75,76,77,78}

Brief advice is most effective when delivered immediately after using the AUDIT tool.⁷⁹

- » People scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *“From your answers you seem to be drinking within the lower risk guidelines. That’s the safest option and if you carry on drinking at this level you are unlikely to experience alcohol related harm.”*

- » Brief advice should be offered to those scoring between 8 and 19 on the AUDIT tool using the FRAMES model which is set out under the heading **5.2 Feedback and brief advice above**. It should include:
 - Feedback about the AUDIT score (this alone can be effective, and should be accompanied by a leaflet)
 - Clear, structured advice about risk and change
 - Goal setting: *“What goals might work for you?”*
 - Statements to enhance motivation
 - Literature for the client to take away
 - The offer of further support, if desired.

Leaflets are available to support this work. For example SIPS *Brief Advice about Alcohol Risk* (www.sips.iop.kcl.ac.uk) and *Change 4 Life Don't Let Drink Sneak Up On You* (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

- » Patients scoring 20+ can be considered for referral to local alcohol services: *“Would you like to speak to someone who can help you to make changes so that you can reduce your risks when drinking?” “I can put you in touch with a service that can support you to succeed at making changes.”*^{80,81,82,83}



CASE STUDY

Alison goes to her GP to discuss her recent problems with sleeping. The GP examines her and asks a number of questions related to physical ill-health, diet and drug use. The doctor then says that it would be important to check how much she is drinking as this can affect sleep patterns.

Alison agrees with some reluctance and the GP completes the first three questions of AUDIT with her (i.e. AUDIT-C). She scores 8 on these 3 questions. This is a positive score and the doctor then works with Alison to complete the other seven questions.

The total score is 16. The GP explains that this places her in the higher risk group of drinkers and asks her if her score surprises her. Alison then begins to talk about the stress she is under at work and how she is drinking when she comes back: often quite late at night.

She agrees to cut down her drinking, have a couple of days of each which without alcohol and not to drink late in the evening in order to see if this will have a beneficial impact. The GP gives Alison a leaflet and asks her to make an appointment to talk about this again in a couple of weeks.

7. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY COMMUNITY PHARMACISTS

Community pharmacists.

7.1 WHICH AUDIT TOOL TO USE

The AUDIT tool is a quick, evidence based method of identifying those who are drinking at increasing/higher risk levels before their drinking becomes problematic or dependent.

Finding the time to use AUDIT could be a challenge in a busy shop. The ten question tool may be considered too long, in which case the three question AUDIT-C tool should be used. (See appendices 1-4 for these tools)

At the very minimum pharmacies should stock alcohol information leaflets and advise people about interactions between prescribed medications, or those purchased over the counter, and alcohol.

7.2 WHEN TO USE THE AUDIT TOOL

The pharmacy setting provides the opportunity to offer either opportunistic or targeted identification. The AUDIT tool could be used with:

- People who come in to purchase medications where there is an interaction with alcohol e.g. antihistamines, sedating cough mixtures
- Those who purchase over the counter medications to manage symptoms of alcohol misuse, such as gastrointestinal remedies and pain killers
- People who present with prescriptions for medications for chronic conditions such as heart disease, diabetes, depression/anxiety, or gastro-intestinal disease. Especially chronic conditions which are adversely effected by alcohol misuse
- People receiving a medicines use review service
- People prescribed medications where there is an interaction or contraindication with alcohol
- Those receiving emergency hormonal contraception service
- People during a smoking cessation consultation, health check or weight management service

A private consultation area will be necessary for IBA. Over three quarters of community pharmacies in England and Wales now have such a facility.⁸⁴

7.3 RAISING THE SUBJECT OF ALCOHOL

Whilst some staff may feel uncomfortable discussing drinking with people who are not alcohol dependent, research shows that customers do not generally find it intrusive.⁸⁵

This should be introduced as a standard or routine process.

- Introduce the topic: *"We're asking everyone about their alcohol use, to see if your drinking might be putting you at risk."*
- Show what constitutes a unit: *"Have a look at this leaflet, it shows you how many units are in standard drinks"*.
- Complete the AUDIT-C or FAST tool.
- Clients who are AUDIT-C or FAST negative should be given a leaflet and encouragement for their low risk drinking: *"It looks as though your drinking is in the low risk category. Take the leaflet with you, it has more information about alcohol and how it can affect your health"*.
- Clients who score positive on these tools should receive brief advice.

Ideally, the AUDIT tool will be completed "interview style", with the pharmacist asking the questions and recording the results on the form. If time does not allow for this, providing the client has adequate literacy skills, the form can be completed separately and handed to the pharmacist in the consultation room to review.

7.4 DELIVERING FEEDBACK AND BRIEF ADVICE

People who are negative on FAST or AUDIT-C should be given praise for their lifestyle choices and encouragement to continue: *"From your answers you seem to be drinking within lower risk guidelines. That's the safest option and if you carry on drinking at this level you are unlikely to experience alcohol related harm."*

Brief advice should be offered to everyone testing positive on FAST or AUDIT-C. It can include simple statements such as:

- In the long term drinking alcohol every day can contribute to a number of health issues.
- You are much more likely to have an accident when you've been drinking.
- Mixing alcohol and medication can have serious side effects.

It can also include clear structured feedback and advice about risk and change using the FRAMES model (which is set out above under **5.2 Feedback and brief advice**) and a Patient Information Leaflet (PIL). Leaflets are available to support this work. For example SIPS Brief Advice about Alcohol Risk (www.sips.iop.kcl.ac.uk) and *Change4life Don't let drink sneak up on you* (www.orderline.dh.gov.uk).^{86,87,88,89} Leaflets could usefully have stickers with local alcohol service details.

Brief advice is most effective when delivered immediately after using the AUDIT tool.⁹⁰

People who appear to have more serious problems can be offered information on local alcohol services: *"Would you like to speak to someone who can help you to make changes so that you can reduce your risks when drinking?" "I can put you in touch with a service that can support you to succeed at making changes."*^{91,92,93,94}



CASE STUDY

Lucy is a 23 year old who has just started work after college and a gap year. She comes into a community pharmacy and while buying toiletries asks the pharmacist to recommend something for a fairly regular pattern of what she calls “heartburn and stomach soreness”.

The pharmacist asks her about her diet and if she drinks alcohol. Lucy explains she drinks 3 pints most nights and more during the weekend. The pharmacist offers the chance for a conversation in private which Lucy accepts. The pharmacist suggests they check her drinking as this is a very common cause of her symptoms. Together they complete the three questions of AUDIT-C.

Lucy scores 10 (maximum 12) and the pharmacist points out that this indicates that she may be drinking too much which is a possible cause of her problems. Lucy had not realised drinking maybe linked of her indigestion. Lucy also explains she has trouble sleeping at night. . The pharmacist explains drinking can affect sleep and may make her feel more tired the next day.

The pharmacist asks Lucy how she feels about her drinking. Lucy mentions she’d like to cut down as she didn’t realise how it could be negatively affecting her health. The pharmacist and Lucy discuss how she could reduce her drinking. Lucy decides she will stick to two pints when going out this Friday and try to drink within the safe limits over the next few weeks and have a couple of days each week without drinking. “This will allow you to see whether alcohol is a part of the problem or not,” the pharmacist explains and gives Lucy a leaflet showing her the units and safe limits guidance.

8. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY MIDWIVES AND HEALTH VISITORS

NMC registered Midwives and Health Visitors

8.1 WHICH AUDIT TOOL TO USE

A number of questionnaires have been developed and validated for use in this area. TWEAK and T-ACE are both appropriate for the identification of alcohol misuse during pregnancy.⁹⁵

In a recent systematic review, AUDIT-C (comprising the first three questions of the full AUDIT tool) was shown to have the best sensitivity and specificity of seven tools in identifying harmful drinking during pregnancy.⁹⁶ (*See appendices 1-7 for the tools*)

8.2 WHEN TO USE THE AUDIT TOOL

The alcohol identification tool should be used with all patients at the first face to face meeting.^{97,98}

8.3 RAISING THE SUBJECT OF ALCOHOL

Whilst some staff may feel uncomfortable discussing drinking with people who are not alcohol dependent, research shows that patients generally expect to be asked about their use and do not find it intrusive.⁹⁹

- Introduce the topic: *"We're asking all women planning pregnancies or who have become pregnant about their alcohol use, to see if drinking might be putting you or your developing baby at risk".* Then ask the first question of the AUDIT-C. *"How often do you have a drink containing alcohol?"*
- Show what constitutes a unit: *"Have a look at this leaflet, it shows you how many units are in standard drinks".*
- Complete the AUDIT-C tool.
- Those who are AUDIT-C negative should be given a leaflet and encouraged to continue low risk drinking or abstinence: *"It looks as though your drinking is in the low risk category. Take the leaflet with you, it has more information about alcohol and how it can affect your health and your developing baby".*
- Women who score AUDIT- C positive should be offered brief advice.

Ideally, the tool will be completed “interview style”, with the clinician asking the questions and recording the results on the form. If time does not allow for this, providing the client has adequate literacy skills, the form can be completed separately and handed to the clinician.¹⁰⁰

8.4 DELIVERING FEEDBACK AND BRIEF ADVICE

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

Brief advice should be offered to all women testing positive on AUDIT-C and it should include clear structured advice about risk and change using the FRAMES model, which is set out above under **5.2 Feedback and brief advice**, and a Patient Information Leaflet (PIL).

Brief advice should include:

- Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
- Clear, structured advice about risk and change
- Goal setting: *“What changes would you like to make and how are you going to do that?”*
- Statements to enhance motivation
- Literature for the client to take away
- The offer of further support, if desired.

Leaflets are available to support this work. For example SIPS *Brief Advice about Alcohol Risk* (www.sips.iop.kcl.ac.uk) and *Change4life Don't let drink sneak up on you* (www.orderline.dh.gov.uk). Literature in community languages can be found at “the leaflet library” at www.alcohollearningcentre.org.uk. The NHS Pregnancy Book also has a section on units and a guide on alcohol use.^{101,102} Any literature could usefully have stickers with local alcohol service details.

Pregnant women who show signs of alcohol dependency should be referred to the local specialist substance misuse midwife or local alcohol services.

NB: Midwives will identify far fewer positives than other workers. Many women will have already changed their drinking before or after pregnancy. As a result, managers will need to reinforce the need to carry out screening even if it is identifying few positives.



CASE STUDY

Steph is a 31 year woman attending her booking appointment and she estimates she is 8 weeks pregnant. It is her first pregnancy. As part of her consultation the midwife “introduces” the AUDIT-C tool by explaining “We’re asking all women planning pregnancies or are have become pregnant about their alcohol use, to see if your drinking might be putting you or your developing baby at risk.

She asks permission if she can ask Steph about her alcohol intake. Steph agrees. The midwife then asks the questions on AUDIT-C. Steph scores 5 on the tool. As she has scored positive the midwife then asks permission to talk about her alcohol use further. Steph agrees and the midwife introduces the PIL. Feedback is given using the FRAMES model.

The midwife then offers Steph the PIL and discusses the opportunity of having a follow up appointment by the team. She also gets agreement that she can share the information with her GP. The midwife also asks if she can ask her about her drinking in future appointments. The nurse records the information in the notes and a letter is generated to Steph’s GP in line with ‘Making every contact count’.

9. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY MENTAL HEALTH SERVICE STAFF

Mental health service staff include staff working in inpatient and community settings, whether they are working for statutory, third sector or commercial organisations.

9.1 WHICH AUDIT TOOL TO USE

Mental health staff should be using the full AUDIT tool with all of their adult clients.

9.2 WHEN TO USE THE AUDIT TOOL

- For maximum coverage the tool should be used at assessment but given that people may be in a distressed state this will not always be possible.
- The first care planning or key working session will be a sensible alternative.
- If the person is an inpatient, staff can use AUDIT prior to discharge.

The point at which AUDIT is used will vary from person to person and setting to setting, but it is important to ensure it occurs.

9.3 RAISING THE SUBJECT OF ALCOHOL

- Introduce the topic: *“Alcohol can have a major impact on mood and various medications, therefore we ask everyone about their alcohol use, to see if drinking might be putting you at greater risk.”*
- Show what constitutes a unit: *“Have a look at this leaflet, it shows you how many units are in standard drinks”.*
- Complete the AUDIT tool.

Important: a positive score on AUDIT is not a diagnosis. It is, therefore, not a reason to discharge someone from mental health services. Work with alcohol services should form part of a wider care plan.

9.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Regardless of AUDIT score, all clients can be offered information about units, safe limits and the risks associated with excessive drinking. This can be achieved by handing the client an alcohol leaflet and briefly going through the main points with them.^{103,104,105}

- » Respondents scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *“Your answers suggest that your drinking is within lower risk guidelines – keep up the good work.”*
- » Brief advice should be offered to adults scoring between 8 and 19 on the AUDIT tool using the FRAMES model which is set out above under 5.2 Feedback and brief advice. It should include:
 - Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
 - Clear, structured advice about risk and change
 - Goal setting: *“What changes would you like to make and how are you going to do that?”*
 - Statements to enhance motivation
 - Literature for the client to take away
 - The offer of further support, if desired.

Leaflets are available to support this work. For example SIPS Brief Advice about Alcohol Risk (www.sips.iop.kcl.ac.uk) and Change4life Don't let drink sneak up on you (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

- » People with mental health problems should be given advice specific to the risks associated with their conditions and any medication they are taking.
- » Respondents scoring 20+ should be considered for referral to local alcohol services: *“I can put you in touch with a service that can support you to make the changes that will really make a difference to you and your family”*^{106,107,108}



CASE STUDY

Keith is a 51 year old man who is admitted to an inpatient psychiatric unit after a suicide attempt. Once he has stabilised the psychiatrist undertakes a complete assessment including the AUDIT tool. Keith scores 17 on AUDIT and it becomes clear that increased alcohol use has contributed to his low mood and the eventual suicide attempt. The doctor gives brief advice about drinking and its depressive effects and discusses the opportunity of having a follow up appointment with the local alcohol service. He also provides a leaflet about the service. The doctor records the information in the notes and the letter sent to Keith's GP includes information on the IBA.

10. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY DRUG SERVICE STAFF

Many drug services are provided jointly with alcohol services; therefore, alcohol assessment will be automatic. However, where drug services are provided separately it will be important to ensure all staff are trained to undertake alcohol IBA.

10.1 WHICH AUDIT TOOL TO USE

Drug service staff should be using the full AUDIT tool with all of their clients.

10.2 WHEN TO USE THE AUDIT TOOL

- For maximum coverage the tool should be used at assessment but, if this is not possible, the first care planning or key working session will be a sensible alternative.
- If the person is an inpatient, staff can use the tool prior to discharge.

10.3 RAISING THE SUBJECT OF ALCOHOL

- Introduce the topic: *“Alcohol use is a major risk for people who use drugs, therefore we ask everyone about their alcohol use, to see if drinking might be putting you at greater risk.”*
- Show what constitutes a unit: *“Have a look at this leaflet, it shows you how many units are in standard drinks”.*
- Complete the AUDIT tool.

10.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Regardless of AUDIT score, all clients can be offered information about units, safe limits and the risks associated with excessive drinking. This can be achieved by handing the client an alcohol leaflet and briefly going through the main points with them. ^{109,110,111,112,113,114,115}

- » Respondents scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *“Your answers suggest that your drinking is within lower risk guidelines – keep up the good work”*

» Brief advice should be offered to adults scoring between 8 and 19 on the AUDIT tool using the FRAMES model which is set out above under the heading **5.2 Feedback and brief advice**. It should include:

- Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
- Clear, structured advice about risk and change
- Goal setting: *“What changes would you like to make and how are you going to do that?”*
- Statements to enhance motivation
- Literature for the client to take away
- The offer of further support, if desired.

Leaflets are available to support this work. For example SIPS *Brief Advice* about Alcohol Risk (www.sips.iop.kcl.ac.uk) and *Change4life Don't let drink sneak up on you* (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

» People with drug problems should be given advice about the risk of overdose and any other relevant risks.

» Respondents scoring 20+ should be considered for further in-house help or referral to local alcohol services if these are provided separately from local drug services: *“I can put you in touch with a service that can support you to make the changes that will really make a difference to you and your family”*^{116,117,118}



CASE STUDY

Sarah is a 29 year old woman with a long history of injecting opiate use. She has attended services on a number of occasions over the last 5 years but has never engaged with treatment. She has now come for a drop-in appointment at her local community drug team. She receives a triage assessment including AUDIT. She scores 19 on the tool and reports regular patterns of heavy drinking. Her worker gives feedback on the score and highlights the risks involved in drinking in this way in conjunction with opiates especially the risks of overdose.

11. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY SEXUAL HEALTH WORKERS

Clinical practitioners who are specialists in reproductive health and genito-urinary medicine, outreach workers, staff in sexual health services, including counsellors, sexual education workers, and volunteers.

11.1 WHICH AUDIT TOOL TO USE

Sexual health workers should be using the full AUDIT tool with all of their clients. Evidence suggests that simply using the AUDIT tool alone can affect alcohol consumption levels in sexual health clinic attendees. The tool came out top of comparison trials for use of alcohol identification tools in a sexual health setting.¹¹⁹

This guidance is aimed at adult clients, however:

- AUDIT is a validated tool for assessing 16 & 17 year olds.
- Tools exist for screening younger age groups; however it will be best to agree a joint approach to identification with this age group with local young people's substance misuse services.^{120,121}

11.2 WHEN TO USE THE AUDIT TOOL

As alcohol use is often associated with unsafe sex and sexually transmitted infections (STIs), routine use of AUDIT is likely to identify clients whose drinking is putting their sexual health at risk. The AUDIT tool can be used with clients presenting with a variety of needs including pregnancy tests, pre and post coital contraception, testing for STIs, abortion advice and counselling and sexual problems.

Risk-taking sexual behaviour correlates positively with transmission of STIs and targeting IBA at these populations may prove particularly effective.

11.3 RAISING THE SUBJECT OF ALCOHOL

Research shows that the prevalence of harmful alcohol use in populations attending sexual health clinics is greater than in the general population. Alcohol contributes to risky sexual practices; therefore, the topic should be raised as part of any assessment to determine a client's support needs. Whilst some sexual health workers may feel uncomfortable discussing alcohol use with clients who are not presenting for alcohol problems, studies suggest that patients are willing to respond to questions about their alcohol use and found brief advice useful.^{122,123}

- Introduce the topic: “Alcohol use is associated with unsafe sex therefore we ask everyone about their drinking, to see if it might be putting you at greater risk.”
- Show what constitutes a unit: “Have a look at this leaflet, it shows you how many units are in standard drinks”.
- Complete the AUDIT tool.

Ideally, the AUDIT will be completed interview style, with the worker asking the AUDIT questions and recording the results on the form. If time does not allow for this, providing the client has adequate literacy skills, clients can receive an AUDIT questionnaire on arrival for completion whilst awaiting their appointment with a worker.

11.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Evidence suggests that IBA in sexual health settings can reduce incidents of unprotected sex.¹²⁴

Regardless of AUDIT score, clients should be offered information about units, safe limits and the risks associated with excessive drinking. Handing the client an alcohol leaflet and briefly going through the main points with them can achieve this.

- » Respondents scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *“From your answers you seem to be drinking within lower risk guidelines. That’s the safest option and if you carry on drinking at this level you are unlikely to experience alcohol related harm.”*
- » Brief advice should be offered to adults scoring between 8 and 19 on the AUDIT tool using the FRAMES model which is set out in **5.2 Feedback and brief advice**. It should include:
 - Feedback about the AUDIT score (this alone can be effective and should be accompanied by a leaflet)
 - Clear, structured advice about risk and change
 - Goal setting: *“What goals might work for you?”*
 - Statements to enhance motivation
 - Literature for the client to take away
 - The offer of further support, if desired.

Leaflets are available to support this work. For example SIPS *Brief Advice about Alcohol Risk* (www.sips.iop.kcl.ac.uk) and *Change4life Don’t let drink sneak up on you* (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

- » Respondents scoring 20+ should be considered for referral to local alcohol services: *“Would you like to speak to someone who can help you to make changes so that you can reduce risks when drinking?” “I can put you in touch with a service that can support you to succeed at making changes.”*



CASE STUDY

Kerry is a 20-year-old student. She visited her local sexual health clinic to access the morning after pill. Whilst she was there, the nurse asked whether she would mind answering some questions about her alcohol use. Kerry agreed and completed an AUDIT with the nurse. During the AUDIT she confided to the nurse that she'd had a bit of a scare as she woke up that morning to find a male acquaintance in her bed. She vaguely remembered having sex with him but didn't recall whether they'd used a condom and felt too embarrassed to ask. The nurse explained that excessive drinking can lead to sexual risk-taking and helped Kerry to explore ways to avoid this in future. As well as a supply of condoms, Kerry left with an understanding of units and a plan to set limits on her weekend drinking by tallying units using an app on her mobile phone.

12. FOLLOW UP (ALL SETTINGS)

In settings where the person is seen regularly it is important to monitor progress. At subsequent appointments, if the patient has successfully implemented changes or is working towards the goals: offer praise and encouragement. If the patient is struggling to make or maintain changes, offer further support from a local specialist agency.

Alcohol treatment agencies provide leaflets and information about their services, opening times and the procedures for referral. (Agencies may also have information in local community languages.) These can be offered to the patient or, if the patient is willing, a referral/appointment can be made immediately by the worker. For this reason, it is important staff are aware of the referral criteria and processes of local alcohol treatment agencies.

Managers should ensure that information on local specialist services, including referral processes, access, location and range of support provided, is regularly updated and disseminated to staff delivering IBA.

13. MAKING IT HAPPEN (ALL SETTINGS)

13.1 ORGANISATIONAL OWNERSHIP

In order to maximise the long-term use of IBA the following support needs to be in place:^{125,126}

- Organisations and individual managers should show an understanding of the relevance, importance and effectiveness of IBA in order to embed it into normal practice.¹²⁷
- Agencies should develop protocols which provide clear guidance on when, and how to use IBA.
- An IBA champion should be appointed in the organisation to promote its use.
- Services should provide access to the resources needed to deliver IBA (e.g. training, leaflets, supervision).
- Managers should raise the use of IBA in staff supervision settings to ensure it is being used or keep it as a standing item on team meeting agendas.

13.2 TRAINING

Staff required to deliver IBA will need training. This may take as little as 1-2 hours and can be done making use of e-learning resources. Organisational commitment will be required to providing IBA training regularly to ensure existing and new staff have access to these skills.

- Training can be through e-learning modules or 'face-to-face' with external trainers delivering in-house sessions.
- Online training and training materials can be accessed at: www.alcohollearningcentre.org.uk.
- Drug and Alcohol National Occupational Standards AH10 (see <http://www.skillsforhealth.org.uk/>) provides a useful set of training competencies.
- Cascade training will also be possible, with one or two staff members attending longer training courses and then disseminating the training to colleagues. However, cascade training will require support through written or on-line materials.
- IBA train the trainer courses are available from agencies such as Alcohol Concern.
- Training should be considered for managers to help them explain the process and support staff to carry out IBA.

13.3 SUPPORT MATERIALS

Further support materials, including useful background reading can be found at www.xxx

13.4 INTEGRATION

The introduction of IBA in an agency should not be undertaken in isolation.

- Joint IBA training should be considered across a range of agencies, making it more cost-effective and improving joint working.
- The tools, interventions and messages used in an area should be consistent so that they reinforce each other.

NICE Public Health Guidance 24 (PH24) emphasises that IBA should be set in a wider context of public health interventions ranging from action on the price of alcohol, to the use of licensing powers and social marketing. It will be useful to ensure that individual advice is reinforced by regular health promotion campaigns. It may also be helpful to sit IBA alongside other lifestyle interventions such as for smoking and obesity.¹²⁸

This NICE guidance also highlights that a whole system approach is required to meet the likely increase in referrals to specialist alcohol services as a result of IBA. “These services should be properly resourced to support the stepped care approach recommended in ‘Models of care for alcohol misusers’”.¹²⁹

13.5 MONITORING AND IDENTIFYING AREAS FOR FURTHER DEVELOPMENT

All agencies undertaking IBA should record output data on when IBA has been undertaken and when advice has been given and / or referral made to specialist services.

- This should be able to identify basic demographic data and information on the key health or social needs of those receiving the intervention.
- This data should be reviewed by the agencies undertaking IBA to ensure that coverage is appropriately extensive, that advice is being given and referrals made.
- Anonymised output data from all agencies undertaking IBA should be collated and reviewed by public health commissioners to ensure that IBA is being used and whether any further training or development work is required.

APPENDIX 1 - AUDIT TOOL

This is one unit of alcohol...	 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs		
...and each of these is more than one unit	 2 Pint of Regular Beer/Lager/Cider	 3 Pint of Premium Beer/Lager/Cider	 1.5 Alcopop or can/bottle of Regular Lager	 2 440ml Can of Premium Lager or Strong Beer	 4 440ml Can of Super Strength Lager	 2 Glass of Wine (175ml)	 9 Bottle of Wine

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

SCORING:

0 – 7 Lower risk

8 – 15 Increasing risk

16 – 19 Higher risk

20+ Possible dependence

YOUR SCORE:

APPENDIX 2 - FAST

This is one unit of alcohol...	 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs		
...and each of these is more than one unit	 Pint of Regular Beer/Lager/Cider	 Pint of Premium Beer/Lager/Cider	 Alcopop or can/bottle of Regular Lager	 Can of Premium Lager or Strong Beer	 Can of Super Strength Lager	 Glass of Wine (175ml)	 Bottle of Wine

FAST	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

SCORING:

If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.

An overall total score of 3 or more is FAST positive.

YOUR SCORE:

WHAT TO DO NEXT?

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

SCORE FROM FAST (OTHER SIDE):

REMAINING AUDIT QUESTIONS

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT SCORE

(ALL 10 QUESTIONS COMPLETED):

0 – 7 *Lower risk*

8 – 15 *Increasing risk*

16 – 19 *Higher risk*

20+ *Possible dependence*

YOUR SCORE:

APPENDIX 3 - AUDIT-C

This is one unit of alcohol...	 Half pint of regular beer, lager or cider  1 small glass of wine  1 single measure of spirits  1 small glass of sherry  1 single measure of aperitifs
...and each of these is more than one unit	 2 Pint of Regular Beer/Lager/Cider  3 Pint of Premium Beer/Lager/Cider  1.5 Alcopop or can/bottle of Regular Lager  2 440ml Can of Premium Lager or Strong Beer  4 440ml Can of Super Strength Lager  2 Glass of Wine (175ml)  9 Bottle of Wine

AUDIT- C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

SCORING:

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

YOUR SCORE:

SCORE FROM AUDIT- C (OTHER SIDE):

REMAINING AUDIT QUESTIONS

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

SCORING:

- 0 – 7 *Lower risk*
- 8 – 15 *Increasing risk*
- 16 – 19 *Higher risk*
- 20+ *Possible dependence*

YOUR SCORE:

AUDIT C Score (above) + Score of remaining questions **TOTAL SCORE =**

APPENDIX 4 – M-SASQ

TO BE COMPLETED BY CLINICAL STAFF
Screening procedure

For the following question - 1 standard drink = 1 unit of alcohol, an indication of standard drinks is provided in the diagram below.

This is one unit of alcohol...	 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs		
...and each of these is more than one unit	 2	 3	 1.5	 2 440ml	 4 440ml	 2	 9
	Pint of Regular Beer/Lager/Cider	Pint of Premium Beer/Lager/Cider	Alcopop or can/bottle of Regular Lager	Can of Premium Lager or Strong Beer	Can of Super Strength Lager	Glass of Wine (175ml)	Bottle of Wine

Please place a cross in the relevant box.

MEN: How often do you have EIGHT or more standard drinks on one occasion?

WOMEN: How often do you have SIX or more standard drinks on one occasion?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

SCORING THE M-SASQ

If the patient's response is 'Monthly', 'Weekly' or 'Daily or almost daily' the score is M-SASQ positive.

If their response is 'Never' or 'Less than monthly' the score is M—SASQ negative.

Please indicate the result of the screening procedure by placing a cross in the appropriate box below.

Positive Negative

If the result is **negative** thank the patient, terminate the interview and store the survey securely, to be collected by research staff.

If the result is **positive** explain the study to the patient, provide an information sheet and request written consent.

Is the patient willing to provide written informed consent? Yes No

If yes continue with the consent details overleaf.

If no terminate the interview and store the survey securely, to be collected by research staff.

Remember to provide the patient with a Patient Information Leaflet.

Patient ID

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(office use only)

APPENDIX 6 TWEAK

TWEAK is a five-item scale developed originally to screen for risk drinking during pregnancy. It is an acronym for the questions below (Russell, 1994):

T—Tolerance*—“How many drinks can you hold?”

W—Worried—“Have close friends or relatives worried or complained about your drinking in the past year?”

E—Eye-opener—“Do you sometimes take a drink in the morning when you first get up?”

A—Amnesia—stands for blackouts—“Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?”

K—K/Cut Down—“Do you sometimes feel the need to cut down on your drinking?”

A score of three or more is considered positive for alcoholism/heavy drinking.

APPENDIX 7 T-ACE

- T** **Tolerance:** How many drinks does it take to make you feel high?
- A** Have people **annoyed** you by criticising your drinking?
- C** Have you ever felt you ought to **cut down** on your drinking?
- E** **Eye-opener:** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

A score of 2 or more is considered positive. Affirmative answers to questions A, C, or E = 1 point each. Reporting tolerance to more than two drinks (the T question) = 2 points.

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