



The Evidence of Effectiveness & Minimum Standards for the Provision of Alcohol Identification and Brief Advice in Adult Criminal Justice Settings (excluding prison)

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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

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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
Victims of alcohol-related violent crime ¹⁸	2,500
Costs of alcohol related crime ¹⁹	£47,100,000
Costs of drink-driving ²⁰	£2,400,000
Drink-driving deaths ²¹	2
Alcohol-related sexual assaults ²²	90
Victims of alcohol-related /domestic violence ²³	1,700
Number of people admitted to hospital with an alcohol-related condition ²⁴	5,000
11-15 year olds will be drinking weekly ²⁵	1,000
Costs to health service of alcohol related harm ²⁶	£14,100,000
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 average²² 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 people 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. It should be incorporated into standard processes and paperwork:

- As part of an initial screening or assessment
- As part of an initial planning session or a review
- Before a break or change in the process
- At the end of the process.

3.2 THE BENEFITS OF IBA

Research has proven the benefits of IBA:

- 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 and local authority bodies should prioritise alcohol-use disorder prevention as an 'invest to save' measure.

- IBA can help to reduce offending related to alcohol misuse.⁴¹
- It can lead to a reduction in re-offending by probation clients.⁴²
- The findings of an independent evaluation of the feasibility and potential effectiveness of using IBA in the community justice setting reported:
 - » reduced alcohol problems to the individual
 - » reduced harm to others
 - » reduced levels of alcohol related crime
 - » improved road and fire safety
 - » reduced costs to the NHS of treating excessive alcohol consumption / addiction
 - » enhanced economic productivity.⁴³
- A cost analysis model used by the Department of Health calculates the cost of delivery of AUDIT and five minutes brief advice by a GP at £17.41, and produces a combined NHS, Criminal Justice and productivity cost saving of nearly 12 to 1 over seven years.⁴⁴
- IBA can 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.^{45,46,47}

4. THE CASE FOR INVESTING IN IBA IN CRIMINAL JUSTICE SETTINGS

4.1 THE TARGET STAFF

- Police custody staff and other staff who work in custody e.g. detention officers, police custody nurses and arrest referral workers
- Probation service staff

This section does not cover prisons or youth offending staff although many of the lessons will be relevant.

4.2 THE IMPACT OF ALCOHOL IN CRIMINAL JUSTICE SETTINGS

Offending behaviour is strongly associated with alcohol use.

- The prevalence of individuals with an alcohol use disorder in the criminal justice setting is three times greater than in the general population.⁴⁸
- As many as 75% of arrestees may be risky drinkers and therefore appropriate for brief advice.⁴⁹
- In 2010/2011 1.4 million people were arrested in England and Wales highlighting police custody as an effective setting to reach around 3% of the adult population annually.
- Self-reported associations between drinking alcohol and the offence were identified in two-fifths of respondents and for 50% of violent crimes.⁵⁰
- 47 % of violent crime is believed to be alcohol related.⁵¹
- 45% of victims of domestic violence say their attacker had been drinking.⁵²
- The national cost of domestic violence to criminal justice, health, social, housing and legal services as well as the economy amounts to more than £5.7 billion a year.⁵³
- A study of arrestees and offenders who had been given brief advice and treatment in police custody or referred elsewhere identified that 40% of respondents found the advice useful.⁵⁴
- 74% of probation clients in a study in South London were AUDIT-C positive.⁵⁵

- A study of Probation OASys data on 120,000 offender assessments in 41 areas over a one year period, identified that 37% of those assessed had alcohol as a criminogenic factor.⁵⁶
- An analysis of offender data found that over one third of offenders had a current problem with alcohol use and a similar percentage had a problem with binge drinking, whilst nearly half (47%) had misused alcohol in the past.⁵⁷
- If all increasing and higher risk drinkers were identified and received IBA, the Department of Health estimated that it would lead to a 4% reduction in general offending 6% in violent re-offending.⁵⁸

IBA can impact on increasing and higher risk drinking in offenders even if alcohol is not related to the offending behaviour.

Research evidence also suggests that detainees and offenders are happy to undertake screening.⁵⁹

4.3 NATIONAL GUIDANCE

- The 2004 national alcohol strategy recognised “the nature of the links between alcohol misuse and domestic violence” and the need to “address those links in public policy and in the design of local services.”⁶⁰
- The Department of Health’s *Treatment Effectiveness Review* identifies the possibility of implementing IBA in probation settings and police stations.⁶¹
- The 2007 national alcohol strategy “*Safe Sensible Social*” emphasises that opportunities exist to tackle alcohol-related offending at each stage of the criminal justice system.⁶²
- The *Alcohol Information Pack for offenders under Probation Supervision, Offender Managers Guide*, recommends universal IBA for offenders, stating that it is effective in reducing alcohol-related harm. It suggests the pre-sentence report stage as an opportunity for identifying increasing and higher risk drinking.⁶³
- *Working with Alcohol Misusing Offenders* stresses the importance of early alcohol identification to determine the extent and nature of offenders’ alcohol use whether or not alcohol is directly related to their offending.⁶⁴
- The NOMS *Alcohol Interventions Guidance* recommends the use of the AUDIT tool and brief advice in police custody settings to reduce the risks of self-harm and offender deaths in the days after release.⁶⁵

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*)

These can be used in situations where time is very restricted, which may include the police custody suite. However, ideally staff will use the AUDIT tool with all their 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".
- "We want to make sure that we can put you in contact with any support you may want, so I'm going to ask you about different aspects of your lifestyle".
- "Alcohol 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.^{72,73,74}

6. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY POLICE CUSTODY STAFF

Police custody staff including custody officers, detention officers (police, staff and private), custody nurses, arrest referral and DIP staff.

6.1 WHICH AUDIT TOOL TO USE

AUDIT is considered the 'gold standard' among identification tools; however, it is recognised that a police station can be an extremely busy and chaotic environment. It is, therefore, advisable to use one of the shorter versions of AUDIT, such as AUDIT-C or FAST, which have been validated for use in police custody settings.^{75,76,77} *(See appendix 2 & 3 for the shorter tools)*

The FAST tool identifies the risk category of over half of respondents after just one question.⁷⁸ A further three questions will identify whether other respondents are FAST positive. This reduces the amount of time required to identify candidates for brief advice and enables staff to focus the brief advice effectively.⁷⁹

6.2 WHEN TO USE THE AUDIT TOOL

Detention officers are ideally placed to deliver IBA as they are not police officers and their role already encompasses a remit to engage with detainees and offer appropriate support. Detainees generally do not object to IBA and often find it useful. In 75% of cases IBA takes no longer than 5 minutes.^{80,81}

Police custody is a setting where self-completion of the AUDIT tool may be appropriate because of the time available to detainees.

For maximum efficacy, the AUDIT tool should be used prior to release, rather than soon after arrest. Between 22% and 25% of detainees are reported to be drunk on arrival at police stations therefore an opportunity exists for a "teachable moment". However, intoxicated detainees are less likely to respond to IBA and may pose additional risks to themselves or others. Opportunities such as fingerprinting or when detainees are in cells awaiting disposal are ideal.^{82,83,84,85}

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.⁸⁶

- Introduce the topic: *“We’re asking everyone of drinking age about their alcohol use, to see if your drinking might be putting you at risk. How often have you had 8 or more (6 or more if female) units on one occasion in the last year?”* This is the first question of FAST.
- Show what constitutes a unit: *“Have a look at this leaflet, it shows you how many units are in standard drinks”.*
- Complete the FAST tool.
- Detainees who are 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”.*⁸⁷
- Detainees who score FAST positive should be offered feedback on their score and brief advice.

6.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Feedback and brief advice is a short, structured conversation to motivate and support an individual to think about and/or plan a change in their drinking behaviour. It should be offered to all detainees testing positive for FAST. It should include:

- Feedback about the AUDIT score and its implications (this alone can be effective and should be accompanied by a leaflet).
- Advice about risk and change using the FRAMES model which is set out above under **5.2 Feedback and brief advice.**⁸⁸

- Literature for the detainee to take away. Leaflets are available to support this work. For example SIPS Brief Advice about Alcohol Risk (www.sips.iop.kcl.ac.uk) and Change for Life Don't Let Drink Sneak Up On You (www.orderline.dh.gov.uk).^{89,90,91}
- Leaflets could usefully have stickers with local alcohol service details.

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.



CASE STUDY

Chris, a retail worker, was arrested late on a Thursday night after getting into a fight outside a bar. He was heavily intoxicated and initially uncooperative. After a few hours he was visited in his cell by the custody sergeant, who asked if he would be happy to answer a few questions about his drinking. Chris scored positive for FAST and was offered brief advice.

Chris acknowledged that he “goes a bit over the top” when he’s had a few drinks. He was surprised to learn how many units he typically consumes in a week and began to ask questions about what this meant for his health. Chris identified that his tiredness and low mood were likely to be caused or worsened by alcohol.

The officer was able to reassure him that, although his current patterns of consumption were risky, he could make some changes that would improve his health. Chris was given a leaflet and agreed that he would be happy to try some of the suggestions in the leaflet for cutting down.

7. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR PROBATION STAFF

Probation staff include probation officers, probation service officers and other staff working with offenders e.g. accredited programme staff or substance misuse partnership workers.

7.1 WHICH AUDIT TOOL TO USE

Probation staff should be using the full AUDIT tool with all of their adult clients. The AUDIT tool should be in the pre-sentence report pack and the licence pack along with a client information leaflet. If time is significantly limited, it is acceptable to use one of the shorter versions such as AUDIT-C or FAST. However, if the person is positive on either tool, the remaining questions of the full AUDIT should then be completed. *(See appendix 1-3 for the tools).*

7.2 WHEN TO USE THE AUDIT TOOL

The AUDIT tool should be used with all clients of the Probation Service at the earliest stage possible to avoid missed opportunities with people who may not receive a community order or suspended sentence.

- AUDIT should be used in both fast delivery reports and standard delivery reports.
- If time pressures do intervene at the Pre-Sentence report stage, the focus should be on clients where alcohol was an aggravating factor in the offence.
- If the AUDIT tool is not used at assessment, then it should be used at an early stage in the relationship with the offender manager.
- It is important to record AUDIT scores for clients on the Delius system. The Trust will benefit from being able to report accurate data to commissioners and, thereby, identify unmet need.

7.3 RAISING THE SUBJECT OF ALCOHOL

Whilst some staff may feel uncomfortable discussing drinking with clients who are not alcohol dependent, research shows that clients generally expect to be asked about their use and do not find it intrusive.⁹²

- 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 tool.

- Clients who are AUDIT 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 AUDIT positive should be offered feedback on their score and brief advice.

Ideally, the AUDIT tool will be completed “interview style”, with the worker 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 worker.⁹³

7.4 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.

- People 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 recommended guidelines – keep up the good work”*
- Feedback and brief advice should be offered to those scoring between 8 and 19 with 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 Change for Life Don't Let Drink Sneak Up On You (www.orderline.dh.gov.uk). Leaflets could usefully have stickers with local alcohol service details.

- Those scoring 20+ should be offered 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”*

7.5 ALCOHOL CHAMPIONS

London Probation Trust has an alcohol “champion” in most offices. Staff with questions or problems around IBA should talk to the office lead. During the changes associated with the Transforming Rehabilitation agenda, it is particularly important that alcohol remains high up the probation agenda.



CASE STUDY

Daniel has been found guilty following an assault on a work colleague after a Christmas party last year. Prior to sentencing he meets with a Probation Officer. As part of the preparation of the pre-sentence report the Probation Officer undertakes an AUDIT screening. Daniel scores 19.

The Probation Officer gives Daniel some feedback about what the score means and hands him the Client information Leaflet in the PSR pack.

Daniel acknowledges that alcohol is a problem for him and that the assault was alcohol fuelled. He says that he has cut down since then but agrees his drinking is still putting him at risk.

Although Daniel scored 19, the Probation Officer suggests that given the alcohol related nature of the offence, it could be useful to seek help from the local community alcohol service. Daniel agrees to call them and make an appointment.

8. FOLLOW UP (ALL SETTINGS)

In the police custody setting it may be difficult to offer any follow up. However arrest referral workers and, certainly, probation officers will be able to monitor the impact of the IBA.

At subsequent appointments it is important to review client progress. If the client has successfully implemented changes or is working towards the goals: offer praise and encouragement. If however, the client 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 client or, if the client 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.

Senior officers and 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.

9. MAKING IT HAPPEN (ALL SETTINGS)

9.1 ORGANISATIONAL OWNERSHIP

In order to maximise the long-term use of IBA the following support needs to be in place:^{94,95}

- Organisations and individual managers should show an understanding of the relevance, importance and effectiveness of IBA in order to embed it into normal practice.⁹⁶
- 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.

9.2 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 (<http://www.alcohollearningcentre.org.uk/eLearning/Training/WorkDev/SkillsHealth/>) 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.

9.3 SUPPORT MATERIALS

Further support materials, including useful background reading can be found at www.safesociablelondonpartnership.co.uk

9.4 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.⁹⁷

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’*.”⁹⁸

9.5 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. In Probation this data should be recorded on the Delius system. NOMS have agreed codes for recording.

- 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 =**

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