



# The Evidence of Effectiveness & Minimum Standards for the Provision of Alcohol Identification and Brief Advice in Hospital 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. <sup>1</sup>

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 year<sup>2</sup>
- 25% of all acute male hospital beds are occupied by someone with alcohol related harm<sup>3</sup>
- 1 million incidents of alcohol related violence occur each year<sup>4</sup>
- Alcohol related crime costs over £10 billion annually<sup>5</sup>
- 11-17 million working days are lost each year due to alcohol-related sickness absence<sup>6</sup>
- About 1 million children live in a family affected by parental alcohol problems.<sup>7</sup>

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.<sup>8,9,10</sup> 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%.<sup>11</sup>

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.<sup>12</sup>
- 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.<sup>13</sup>
- The proportion of adults likely to exceed 4/3 units on their heaviest drinking day is 28% in London. The national average is 31%.<sup>14</sup>
- Alcohol specific mortality rates for both men and women are slightly below the national average.<sup>15</sup>
- Alcohol specific hospital admissions are also slightly below the national average for both genders.<sup>16</sup>

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.<sup>17</sup>

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

<b>EFFECT</b>	<b>ANNUAL IMPACT IN A BOROUGH WITH 250,000 POPULATION</b>
Number of people admitted to hospital with an alcohol-related condition <sup>18</sup>	5,000
Victims of alcohol-related violent crime <sup>19</sup>	2,500
11-15 year olds will be drinking weekly <sup>20</sup>	1,000
Costs to health service of alcohol related harm <sup>21</sup>	£14,100,000
Costs of alcohol related crime <sup>22</sup>	£47,100,000
Costs of drink-driving <sup>23</sup>	£2,400,000
Drink-driving deaths <sup>24</sup>	2
Alcohol-related sexual assaults <sup>25</sup>	90
Victims of alcohol-related /domestic violence <sup>26</sup>	1,700
Costs to economy of alcohol related absenteeism, deaths and lost working days <sup>27</sup>	£30,200,000
Working days lost due to alcohol related absence <sup>28</sup>	66,000
Children affected by parental alcohol problems <sup>29</sup>	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.<sup>30</sup> 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.<sup>31</sup>
- 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”.<sup>32</sup>

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).<sup>33</sup>

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 hospital staff will be undertaking IBA with all patients. A number of opportunities will be available to introduce one of the AUDIT identification tools (*see below 5.1*). This should be incorporated into standard paperwork:

- As part of an initial screening or assessment
- As part of a treatment regime
- At discharge.

### 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.<sup>34,35,36,37</sup>
- 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.<sup>38</sup>
- 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.<sup>39</sup>
- 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.<sup>40</sup>

### 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 be delivered at relatively low cost and successful interventions will result in health gains. IBA has been shown to achieve quality adjusted life years (QALY) gains whilst remaining well below the recommended NICE cost-effectiveness threshold.
- The same report 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.<sup>41,42,43</sup>
- Department of Health guidance for commissioners advised that one nurse providing IBA in ED will prevent about 40 admissions each year and deliver net savings to the NHS of around £67,000.<sup>44</sup>
- Economic analysis by the University of Sheffield found that IBA in ED settings 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.<sup>45</sup>

## 4. THE CASE FOR INVESTING IN IBA IN HOSPITAL SETTINGS

### 4.1 THE TARGET STAFF

- Hospital inpatient / outpatient staff including doctors, nurses and healthcare assistants

### 4.2 THE IMPACT OF ALCOHOL ON HOSPITAL PATIENTS

The impact of alcohol related harm in hospitals can be clearly and powerfully demonstrated:

- Alcohol misuse costs the NHS £3.5 billion per annum; much of this burden is from hospital care.<sup>46</sup>
- 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.<sup>47</sup>
- Over 14 million people are treated in ED in England each year. The Department of Health estimates that 35% of ED attendances in the UK are attributable to alcohol, increasing to 70% between midnight and 5am.<sup>48</sup>
- Almost one third of London fire deaths are alcohol related.<sup>49</sup>
- 11% of male high blood pressure is alcohol related.<sup>50</sup>
- Over 4,000 people die each year as a result of alcoholic liver disease.<sup>51</sup>
- 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.<sup>52</sup>

### 4.3 NATIONAL GUIDANCE

- National alcohol strategies from 2004 onwards have highlighted hospitals as key locations for IBA.<sup>53</sup>
- The Department of Health's High Impact Changes to reduce alcohol related harm identifies appointing an Alcohol Health Worker in hospital and rolling out IBA as two of the key changes required at the local level.<sup>54</sup>
- NICE Guidance recommends that health professionals should routinely carry out alcohol IBA as an integral part of their practice.<sup>55</sup>
- The 2004 national alcohol strategy flags up models such as St Mary's Hospital in Paddington which applies a customised questionnaire to all entrants and refers those with problems to an alcohol misuse worker.<sup>56</sup> This message was repeated in the 2012 strategy.<sup>57</sup>
- 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.<sup>58</sup>

## 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.

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* )

In inpatient and outpatient settings the full AUDIT should generally be used. The shorter tools can be used in situations where time is very restricted. 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 to help decision making on the next steps to take.

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.<sup>59,60,61</sup>

## 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:

**F**eedback: 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.”*

**R**esponsibility: 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?”*

**A**dvice: **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.”*

**M**enu 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.”*

**E**mpathy: 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.”*

**S**elf-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](http://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.<sup>62,63,64</sup>

# 6. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY EMERGENCY DEPARTMENT STAFF

*Emergency department staff including doctors, NMC registered nurses and healthcare 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. However, a key challenge in ED is time to identify alcohol problems in a busy clinical setting. As a result, studies have validated a variety of tools for ED such as FAST, the Paddington Alcohol Test, M-SASQ or AUDIT-C.<sup>65</sup> *(See appendices 1-5 for these tools)*

The Modified Single Alcohol Screening Questionnaire (M-SASQ) was developed and validated in response to this. Despite being just one question (*“How often do you have six or more units of alcohol Never, Less than monthly, Monthly’, ‘Weekly’ or ‘Daily or almost daily”* with monthly or above being positive) the M-SASQ is still effective at identifying at risk drinkers. When using the M-SASQ it is best implemented universally rather than as a targeted approach.<sup>66</sup>

## 6.2 WHEN TO USE THE AUDIT TOOL

The identification tool should be built in to hospital systems so that staff have to complete it at some point in the process. This will allow data reports on activity levels to be monitored.

All staff in ED should be trained in alcohol identification. It should not be left to hospital Alcohol Liaison staff if these posts have been established. However, each ED will need to decide which staff members are best placed to use the tool, e.g. doctors or triage nurses, and at which point in the process it should be used.

The variety of presentations in ED mean it is hard to identify a single point at which IBA should be used. Attending to immediate medical needs is clearly most important. However, when considering the best time to use the identification tool it is recommended that:

- Patients who are intoxicated are unlikely to benefit.
- Sufficient time is available to give brief advice.<sup>67</sup>

### 6.3 RAISING THE SUBJECT OF ALCOHOL

Nurses and doctors are ideally placed to undertake IBA and can introduce the topic using the M-SASQ question: *“How often have you had 8 or more (6 or more if female) units on one occasion in the last year?”* and show what constitutes a unit: *“Have a look at this leaflet, it shows you how many units are in standard drinks”*.

- Patients who score negative on the tool 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”*.
- If time is limited, patients who score positive (at risk) should be offered brief advice including feedback based on their score on the shorter tool.
- In the ideal situation a positive score should trigger the completion of the full AUDIT.<sup>68</sup>

### 6.4 DELIVERING FEEDBACK AND BRIEF ADVICE

Brief advice can be offered to all patients testing positive for MSASQ 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) e.g. *Change for Life Don't Let Drink Sneak Up On You* ([www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk)).<sup>69,70</sup>

If the full AUDIT is used:

- » Patients 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 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 patient 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](http://www.sips.iop.kcl.ac.uk)) and *Don't let drink sneak up on you* ([www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk)). Leaflets could usefully have stickers with local alcohol service details.

- » Those scoring 20+ should be considered for referral to the hospital alcohol liaison worker or the 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”*.

In ED, IBA information should be included in an ‘Intervention package’ e.g. a folder that is readily available to staff. This should include a short guide on delivery, the chosen questionnaire, visual material (clarifying the risks or harm caused by alcohol consumption and showing patients how their drinking compares with the rest of the population) and practical suggestions on how to reduce alcohol consumption. This information should also be on the intranet. A self-help leaflet or Patient information Leaflet should also be available and ideally a poster will be displayed in waiting areas.<sup>71</sup>



## CASE STUDY

*Marie, a 34 year woman, attends the Emergency Department following a fall the previous evening. She is presenting with pain in right wrist. At triage the nurse “introduces” the MSASQ screening tool by explaining: “We’re asking everyone of drinking age about their alcohol use, to see if your drinking may be putting you at risk”.*

*She seeks permission to ask Marie about her drinking. Marie agrees. The nurse then uses the MSASQ for a female. “How often do you have six or more units of alcohol, Never, Less than monthly, Monthly’, ‘Weekly’ or ‘Daily or Almost daily ”. She answers most “Fridays nights”. As Monthly or more is considered a positive score, the nurse then asks further permission to talk about this.*

*Marie agrees and the nurse produces the Patient Information Leaflet. Feedback is given using the FRAMES model. The nurse then offers Marie the leaflet and discusses the opportunity of having a follow up appointment with the alcohol liaison team and consents to sharing the information with her General Practitioner.*

*The nurse records the information in the notes and a letter is generated and sent to Marie’s GP in line with ‘Making Every Contact Count’.*

# 7. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY HOSPITAL INPATIENT STAFF

*Doctors, NMC registered nurses and healthcare assistants.*

## 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. However, where time is a concern FAST or AUDIT-C are shortened versions of the full AUDIT. The recommendation is that in the hospital setting the shorter questionnaires are 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 and scoring systems)*

The FAST tool is validated for hospitals and the average administration time is 20 seconds. It was developed and validated in a study of 3000 patients and 100 nurses in the hospital setting. In a recent study both nurses and patients found the FAST acceptable, with the IBA process also described as useful. The nurses did not feel it was a burden on their time.<sup>72,73</sup>

The FAST tool has two stages. The first stage is the initial question, this identifies the risk category of over half of patients after just one question. For those who are not classified, a further three questions will identify whether respondents are FAST positive. This reduces the amount of time required to identify patients for brief advice and enables staff to focus the brief advice effectively.<sup>74</sup>

## 7.2 WHEN TO USE THE AUDIT TOOL

The FAST / AUDIT tool can be used with all patients or can be focused on specific at risk groups. Inpatient staff can raise it with all patients in groups such as people with:

- Maxillofacial injuries
- Fractures
- Mental health problems
- Heart disease
- Liver disease

- Diabetes
- Sexual health problems
- A recent ED attendance.

It can also be undertaken with:

- Men over 45
- Smokers.

As well as with patients where there is a suggestion that alcohol may be a contributory factor e.g. poor sleeping, indigestion, continence problems.

### 7.3 RAISING THE SUBJECT OF ALCOHOL

- You can introduce the topic by saying: *"We're asking everyone admitted to the hospital of drinking age about their alcohol use, to see if your drinking might be putting you at risk."* Then the first question of FAST is asked: *"How often have you had 8 or more (6 or more if female) units on one occasion in the last year?"*
- 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.
- Patients who are FAST negative should be given a leaflet and given 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 FAST positive are at risk and therefore should be offered feedback on their score and brief advice.

Ideally, AUDIT 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 patient has adequate literacy skills, the form can be completed separately and handed to the worker.<sup>75</sup>

### 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.

- Patients 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"*

- 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](http://www.sips.iop.kcl.ac.uk)) and *Change for Life Don't Let Drink Sneak Up On You* ([www.orderline.dh.gov.uk](http://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”*

In the hospital setting IBA information should be included in an ‘Intervention package’ e.g. a folder that is readily available to staff. This should include a short guide on delivery, the chosen questionnaire, visual material (clarifying the risks or harm caused by alcohol consumption and showing patients how their drinking compares with the rest of the population) and practical suggestions on how to reduce alcohol consumption. This information should also be on the intranet. A self-help leaflet or Patient information Leaflet should also be available and ideally a poster displayed in public areas.<sup>76</sup>



## CASE STUDY

*Stephen is a 46 year old man admitted to the hospital via the Emergency Department with breathing difficulties. As part of the assessment paperwork the nurse “introduces” the FAST tool by explaining “We’re asking everyone admitted to the hospital of drinking age about their alcohol use, to see if your drinking may be putting you at risk”. The nurse asks if he can ask him about his alcohol intake. Stephen agrees.*

*The nurse then asks the first question of the FAST tool for a male. “How often do you have eight or more units of alcohol, Never ,Less than monthly , Monthly’, ‘Weekly’ or ‘Daily or Almost daily”. He answers: “almost daily”. Stephen’s response means he is either an increasing risk, high risk or dependent drinker, therefore the nurse then asks further permission if it is ok to talk about this further. He then administers the remaining questions of AUDIT. Stephen’s full AUDIT score is 22.*

*The nurse produces the PIL and feedback is given about the AUDIT score and its meaning using the FRAMES model. The nurse then offers Stephen the leaflet and discusses the opportunity of being referred to the team (alcohol health worker) and asks for his consent to share the information with his General Practitioner. The nurse records the information in the notes and a letter is generated to Stephen’s GP in line with ‘Making every contact count’.*

## 8. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY HOSPITAL OUTPATIENT STAFF

*Doctors, NMC registered nurses and healthcare assistants*

### 8.1 WHICH AUDIT TOOL TO USE

The Alcohol Use Disorders Identification Test (AUDIT) is considered the 'gold standard' among screening tools. It is widely used in health settings across the country; however, a key challenge is having the time to screen in a busy clinical setting.

When time is tight a shortened screening tool is recommended and an array of such tools is available. The FAST screening tool has been shown to be valid and useful across a range of medical services with the average administration time being 20 seconds. The development work of FAST has primarily been in busy medical settings such as ED departments and out-patient departments, and has been successfully used in a maxillofacial, fracture and lipid clinics.

In a recent study both nurses carrying out the screening, as well as the patients, found the FAST screening tool acceptable, with the screening process and brief intervention being described as useful. The nurses did not feel it was a burden on their time.

The FAST screening tool has two stages. The first stage is the initial question which identifies the risk category of over half of the patients after just one question. For those who are not classified, a further three questions will identify whether respondents are FAST positive. This reduces the amount of time required to identify patients for brief advice and enables staff to focus the brief advice effectively. (See appendices 1-3 for these tools)

### 8.2 WHEN TO USE THE AUDIT TOOL

The FAST / AUDIT tool can be used with all patients or be focused on specific at risk groups. Outpatient staff can raise it with all patients in particular groups e.g. people in clinics for:

- Maxillofacial injuries
- Fractures
- Lipids

- Mental health problems
- Heart disease
- Liver disease
- Diabetes
- Sexual health problems.

Or with

- 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.

### 8.3 RAISING THE SUBJECT OF ALCOHOL

- You can introduce the topic by saying: *"We're asking everyone attending the hospital of drinking age about their alcohol use, to see if your drinking might be putting you at risk."* Then the first question of FAST is asked: *"How often have you had 8 or more (6 or more if female) units on one occasion in the last year?"*
- 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.
- Patients who are FAST negative should be given a leaflet and given 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 FAST positive are at risk and therefore should be offered feedback on their score and brief advice.

Ideally, AUDIT 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 patient has adequate literacy skills, the form can be completed separately and handed to the worker.<sup>77</sup>

### 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 patient an alcohol leaflet and briefly going through the main points with them.

- » Patients scoring 7 or less on the full 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”.
- » Brief advice should be offered to those scoring between 8 and 19 on AUDIT 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 patient 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](http://www.sips.iop.kcl.ac.uk)) and *Change for Life Don't Let Drink Sneak Up On You* ([www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk)). Leaflets could usefully have stickers with local alcohol service details.

- » Those scoring 20+ should be offered referral to the hospital alcohol liaison worker or the 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*”.

In the hospital setting IBA information should be included in an ‘Intervention package’ e.g. a readily available folder. This should include a short guide on delivery, the chosen questionnaire, visual material (clarifying the risks or harm caused by alcohol consumption and showing patients how their drinking compares with the rest of the population) and practical suggestions on how to reduce alcohol consumption. This information should also be on the intranet. A self-help leaflet or Patient information Leaflet should also be available and ideally a poster will be displayed in public areas.<sup>78</sup>



## CASE STUDY

*Mark is a 43 year old man with raised cholesterol levels. He was referred to a Lipid clinic after a GP consultation. As part of the outpatient paperwork the nurse “introduces” the FAST screening tool by explaining “We’re asking everyone of drinking age about their alcohol use, to see if your drinking may be putting you at risk”. The nurse asks as part of this, permission if they can ask him about his alcohol intake. Mark agrees.*

*The nurse then asks the questions of the FAST screening. “How often do you have eight or more units of alcohol, Never ,Less than monthly , Monthly’, ‘Weekly’ or ‘Daily or Almost daily ”. He answers: “almost daily”. Mark’s response means he is FAST positive, therefore the nurse completes the full AUDIT tool.*

*Mark scores 17 on the full AUDIT and the nurse asks if she can give him some feedback.*

*Mark agrees and the nurse produces the PIL. Feedback is given by using the FRAMES model. The nurse then offers Mark the leaflet and discusses the link with alcohol use and his presenting condition of raised cholesterol. Mark was completely unaware of this link The nurse discusses the opportunity of having a follow up appointment with the alcohol health worker and gains consent to share the information with his General Practitioner. The nurse records the information in the notes and a letter is generated to Stephen’s GP in line with ‘Making every contact count’.*

## 9. FOLLOW UP (ALL SETTINGS)

Many hospitals now have Alcohol Care Teams, Hospital Alcohol Health Workers or Alcohol Liaison Nurses. The next step may be referral to these staff. Whether this is the case or not, the following should be considered.

- If the patient wants further information about changing their drinking, they should be signposted to a local alcohol service: *“Would you like some more information, or to speak to someone who can help you with ways to succeed at making changes to your drinking?”*
- Consent should be sought to share information with their GP as part of their discharge letter in line with Making Every Contact Count.

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 clinician. 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. This type of information should be kept up-to-date on an accessible web-site for hospital teams.

If there are subsequent appointments with the patient it is important to monitor progress. If the patient has successfully implemented changes or is working towards the goals: offer praise and encouragement. If however, the patient is struggling to make or maintain changes, offer further support from a local specialist agency.

# 10. MAKING IT HAPPEN (ALL SETTINGS)

## 10.1 ORGANISATIONAL OWNERSHIP

In order to maximise the long-term use of IBA the following support needs to be in place:<sup>79,80</sup>

- Organisations and individual managers should show an understanding of the relevance, importance and effectiveness of IBA in order to embed it into normal practice.<sup>81</sup>
- Hospitals should develop protocols which provide clear guidance on when, and how to use IBA.
- The role of Alcohol Care Teams, Alcohol Liaison Nurses or workers should be clear to all staff.
- An IBA champion should be appointed in the hospital to promote its use; this should be someone more senior than the liaison staff. This could be part of the role of the Making Every Contact Count champion.
- Hospital managers 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.

## 10.2 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](http://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.

### 10.3 SUPPORT MATERIALS

Further support materials, including useful background reading can be found at [www.safesociablelondonpartnership.co.uk](http://www.safesociablelondonpartnership.co.uk)

### 10.4 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.<sup>82</sup>

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’*”.<sup>83</sup>

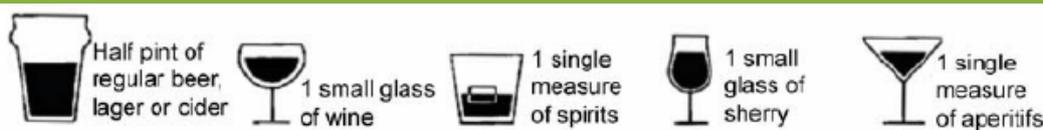
### 10.5 MONITORING AND IDENTIFYING AREAS FOR FURTHER DEVELOPMENT

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...**



**...and each of these is more than one unit**



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

<b>This is one unit of alcohol...</b>	 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		
<b>...and each of these is more than one unit</b>	 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

<b>FAST</b>	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	
<b>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).</b>						
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

**YOUR SCORE:**

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

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

## 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

<b>This is one unit of alcohol...</b>	 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
<b>...and each of these is more than one unit</b>	 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*

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.



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       
 (office use only)

# PADDINGTON ALCOHOL TEST 2011

## 'make the connection'

### PATIENT IDENTIFICATION STICKER:

NAME

D.O.B.

A. PAT **for** TOP 10 presentations – *circle as necessary*

B. Clinical Signs **of alcohol use**

C. Blood Alcohol Concentration (*refer direct from resusc. room if BAC>80mgs/100ml*) BAC =.....**mgs/100ml**

- |  |                          |                                    |                                     |
|--|--------------------------|------------------------------------|-------------------------------------|
| 1. FALL ( <b>incl. trip</b> )                                  | 2. COLLAPSE (incl. fits) | 3. HEAD INJURY                     | 4. ASSAULT                          |
| 5. ACCIDENT  | 6. UNWELL                | 7. GASTRO - INTESTINAL             | 8. CARDIAC ( <i>i. Chest pain</i> ) |
| 9. PSYCHIATRIC ( <b>incl. DSH &amp; OD</b> ) please state..... |                          |                                    |                                     |
| 10. REPEAT ATTENDER  |                          | Other ( <b>please state</b> )..... |                                     |

### EARLY IDENTIFICATION TO REDUCE RE-ATTENDANCE

**Only proceed after dealing with patient's 'agenda,' i.e. patient's reason for attendance.**

**"We routinely ask all patients having ...(above presentation)...about their alcohol use."**

### 1 HOW OFTEN DO YOU DRINK ALCOHOL ?

Never

**PAT ends**

Less than weekly

\_\_\_\_ times per week

**Advise against daily drinking.**

Every day

**May be dependent. Consider thiamine (? Nutrition) & chlordiazepoxide (? CIWA).**

(continue to next question)

### 2 WHAT IS THE MOST YOU WILL DRINK IN ANY ONE DAY?

(UK alcohol units)

If more than **twice** daily limits **(8 units/day for men, 6 units/day for women)** PAT +ve

Use the following guide to **estimate** total daily units. (Standard pub units in brackets; home measures often three times the amount!)

Beer /lager/cider	Pints (2)	<input type="text"/>	Cans (1.5)	<input type="text"/>	Litre bottles (4.5)	<input type="text"/>
Strong beer /lager /cider	Pints (5)	<input type="text"/>	Cans (4)	<input type="text"/>	Litre bottles (10)	<input type="text"/>
Wine	Glasses (1.5)	<input type="text"/>	750ml bottles (9)	<input type="text"/>	<b>ALCOPOPS</b>	
Fortified Wine (Sherry, Port, Martini)	Glasses (1)	<input type="text"/>	750ml bottles (12)	<input type="text"/>	330ml bottles (1.5)	<input type="text"/>
Spirits (Gin, Vodka, Whisky etc)	Singles (1)	<input type="text"/>	50ml bottles (30)	<input type="text"/>	(continue to Q3 for all)	

### 3 DO YOU FEEL YOUR ATTENDANCE AT A&E IS RELATED TO ALCOHOL?

YES (PAT+ve)

NO

If PAT +ve **give feedback** e.g. "Can we advise that your drinking is harming your health".

*"It is recommended that you do not regularly drink more than 4 units/day for men or 3 units/day for women".*

**We would like to offer you further advice.**

YES

**Would you be willing to see our alcohol health worker?**

NO

(Remember direct referral if BAC>80mgs/100ml)

If "YES" to Q5 **give ANS appointment card and leaflet and make appointment in diary @ 9am to 10am.**

**Other appointment times available, please speak to ANS or ask patient to contact (phone number on app. card).**

**Give alcohol advice leaflet ("Units and You") to all PAT+ve patients, especially if they decline AHW appointment.**

Please note here if patient admitted to ward.....

Referrer's Signature ..... Name Stamp ..... Date:.....

ANS OUTCOME:

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