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

Health Innovation Network

Safe Sociable London Partnership

Care about others, care about yourself, care about your drinking

LAMP
London Alcohol Misuse Prevention Advisory Group

CONTENTS

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.

- About 1 million children live in a family affected by parental alcohol problems.[2]
- 1 million incidents of alcohol related violence occur each year[3]
- Alcohol misuse costs the NHS around £3.5 billion a year[4]
- 25% of all acute male hospital beds are occupied by someone with alcohol related harm[5]
- Alcohol related crime costs over £10 billion annually[6]
- 11-17 million working days are lost each year due to alcohol-related sickness absence.[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 an adult or children's social care setting. It will give managers, senior officers and elected members the evidence to argue for a better response to drinkers. It also contains minimum standards which set out in detail how social care 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

Overall alcohol use and alcohol related harm in London is around or slightly below the national average. However, there remain significant levels of harm that can be tackled.

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

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

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

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

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

3.1 IDENTIFICATION AND BRIEF ADVICE

Alcohol is associated with such a wide range of harms that there will never be a simple set of solutions. Appropriate responses will include treatment, social marketing and the effective application of the Licensing Act. The Department of Health has published seven high impact changes which should be pursued locally and commissioners would 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 group who will benefit from IBA are the increasing and higher risk drinkers: around 35,000 people in a borough of 250,000 people. It is likely that the majority of these people will be seen by someone in the health, social care, housing or criminal justice sectors each year.

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

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

Ideally workers will be undertaking IBA with all their clients and a number of opportunities are available to introduce one of the AUDIT tools (***see page 25***). It should be incorporated into standard processes and paperwork:

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

3.2 THE BENEFITS OF IBA

Research has proven the benefits of IBA:

- 1 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 a reduction from higher-risk to lower-risk drinking for 250,000 men and 67,500 women each year.[40]

3.3 RETURN ON INVESTMENT: ECONOMIC AND SOCIAL BENEFITS

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

- The Department of Health's treatment effectiveness review highlights that IBA has the potential to save future costs, as well as bringing individual benefits in terms of reducing risk of premature death and alcohol-related morbidity.
- IBA can also identify individuals who will benefit from further support or treatment and a 10% increase in the uptake of treatment of dependent drinkers will reduce public sector costs by £109 - £156 million annually.[41,42,43]

4. THE CASE FOR INVESTING IN IBA IN SOCIAL CARE SETTINGS

4.1 THE TARGET STAFF

- Social workers and other care staff working in children and families services.
- Social workers and other care staff working in adult social care with older people, people with learning disabilities, physical disabilities and vulnerable adults (mental health services have been covered in a separate guide for health professionals which is also available at http://safesociablelondonpartnership.co.uk/).

4.2 THE IMPACT OF ALCOHOL IN SOCIAL CARE SETTINGS

- Alcohol misuse is frequently encountered by social care professionals. It is a significant factor in 20-40% of all social work cases and 30-60% of child protection cases.[44]
- 2.6 million children live in households where one or more carers is an increasing risk drinker. [45]
- Around 1 million children live in a family where one or other parent is dependent on alcohol.[46]
- In 2007-09 22% of Serious Case Reviews mentioned parental alcohol use.[47]
- Alcohol misuse is a common feature of vulnerable adults cases both among the abusers and to a lesser extent the victims.[48]
- People over 65 drink less than younger age groups; however, simple demographics suggest that the number of people over 65 with alcohol problems will grow over time. The number of older people is rising and the drinking pattern of each successive generation of over 65s has been increasing steadily since the Second World War.[49]

4.3 NATIONAL GUIDANCE

The Department of Health advises that, given the extensive contribution of excessive drinking to the social work caseload, social services provide an important opportunity for IBA.[50]

- NICE Public Health Guidance 24 makes it clear that IBA is a responsibility for local authorities. [51]
- IBA meets the requirements of the *Framework for the Assessment of Children in Need and their Families.*[52]
- The Department of Health's *Models of Care for Alcohol Misusers* advocates the delivery of IBA in a wide range of specialist settings including social services departments and that it is suitable for residential settings such as domestic abuse services.[53]
- The British Association of Social Workers advocates the use of IBA delivered by frontline workers. [54]
- BASW's *Health First: an evidence-based alcohol strategy for the UK* recommends that all health and social care professionals should be trained to routinely provide early IBA to their clients.[55]

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 alcohol 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 clients of all ages and in a wide variety of settings. It is also cross-culturally sensitive and can be used with clients with low literacy levels. However, AUDIT may not be suitable for some adults with learning disabilities or cognitive impairment.[56,57,58]

Shorter versions of the AUDIT exist:

- FAST (4 questions – ***see appendix 2***)
- AUDIT-C (3 questions – ***see appendix 3***)

These can be used in situations where time is very restricted. However, ideally social care 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".
- "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 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.[59,60,61]

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 could 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 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 social worker can develop a care plan without checking whether alcohol is impacting on someone's life.[62,63,64]

6. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY ADULT SERVICES SOCIAL CARE STAFF

Social care staff, in both statutory and voluntary sectors, working with older people, people with physical disabilities, some learning disabilities and other adults.

6.1 WHICH AUDIT TOOL TO USE

All adult social care staff should be able to deliver IBA. They should be using the full AUDIT tool with all of their clients other than those with serious learning disabilities or cognitive impairment.

6.2 WHEN TO USE THE AUDIT TOOL

Given that social workers will regularly encounter alcohol as part of their work, the topic should ideally be raised as part of all assessments to determine a client's support needs. However, it can also be targeted at populations at higher risk e.g.:

- people at risk of, or perpetrating, domestic abuse
- people with physical disabilities which result from their alcohol use
- clients with mental health problems.[65,66]

AUDIT is effective when included as part of a general assessment, but could be used:

- as part of an initial care planning session or a review; or
- before a break or change in care; or
- at the end of a short care intervention.

6.3 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.[67] Sample sentences include:

- *"To make sure that we can meet all your needs I'm going to ask you some lifestyle questions, starting with alcohol use".*
- *"It will help me to get a complete picture of your strengths and challenges if I can get a picture of other areas of your life."*

Ideally, the AUDIT tool will be completed "interview style", with the social 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

6.4 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.

Brief advice is most effective when delivered immediately after AUDIT.[68]

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

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

- Feedback about the AUDIT score (this alone can be effective, and should be accompanied by a leaflet)
- Clear, structured advice about risk and change
- Goal setting: *"What goals might work for you?"*
- Statements to enhance motivation
- Literature for the client to take away
- The offer of further support, if desired.

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

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

CASE STUDY

Glenda is 79. Her husband, James, died two years ago and she has become increasingly frail since then. She was assessed by Jill, a worker from the Older Adults Team. During the initial assessment Jill asked Glenda about her alcohol use and completed the AUDIT tool. Glenda confided that she liked a "little drink" during the day if she was feeling lonely. This had been steadily increasing since James' death.

Glenda's AUDIT score fell into the 'increasing risk' category. Jill chatted to Glenda about her drinking and pointed out that a recent fall and some of her memory problems may be because she was drinking in the afternoons. Glenda was surprised to hear this but admitted that it was possible. She felt that if she had something to fill her time, she would be less likely to drink. Jill was able to put Glenda in touch with a local charity that provides companionship for older members of the community.

7. MINIMUM IDENTIFICATION AND BRIEF ADVICE STANDARDS FOR DELIVERY BY CHILDREN AND FAMILIES SOCIAL CARE STAFF

Social workers and other care workers working with children and families in a variety of community and residential settings in both statutory and voluntary sectors.

7.1 WHICH AUDIT TOOL TO USE

All children and families staff should be able to deliver IBA and all parents / adult family members involved with children and families services should receive alcohol IBA.

This guidance is aimed at adult clients, however:

- Drinking by teenagers and possibly pre-teens should be considered, because children in the looked after system will be vulnerable to alcohol related harm.
- AUDIT is a validated tool for assessing 16 & 17 year olds.
- Tools exist for screening younger age groups; however it is best to agree a joint approach to identification with this age group with your local young people's substance misuse services.[69,70]

7.2 WHEN TO USE THE AUDIT TOOL

Given the high incidence of alcohol misuse in child protection cases, the topic should be raised as part of all assessments. It should certainly be used in cases of people at risk of, or perpetrating, domestic abuse.[71,72]

If AUDIT is not included as part of a general assessment, it should be used:

- As part of an initial care planning session or a review; or
- At the end of a short care intervention.

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.[73] Ways of introducing the AUDIT questions might include:

- *"To make sure that we can meet all your needs I'm going to ask you some lifestyle questions, starting with alcohol use".*
- *"It will help me to get a complete picture of your strengths and challenges if I can get a picture of other areas of your life."*

Ideally, the AUDIT tool will be completed "interview style", with the social 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.[74]

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.

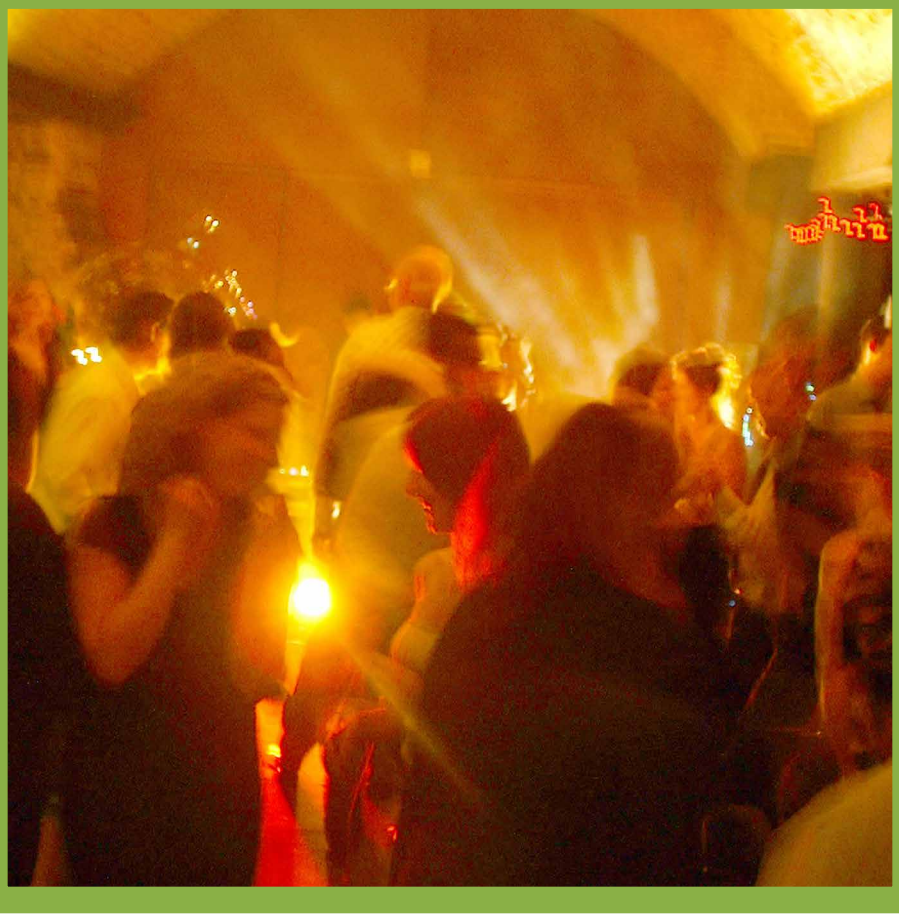
» People scoring 7 or less on AUDIT should be given praise for their lifestyle choices and encouragement to continue: *"Your answers suggest that your drinking is within the lower risk guidelines – keep up the good work"*

» Brief advice should be offered to those scoring between 8 and 19 on the AUDIT tool using the FRAMES model which is set out on page 12. 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 considered for referral to local alcohol services: *"I can put you in touch with a service that can support you to make the changes that will really make a difference to you and your family"* .



CASE STUDY

Denise and Graham are long-term foster parents to two teenage girls. They have known the girls' social worker, Grace, for two years. During one routine visit Graham mentioned that he was having a stressful time at work and was finding the girls a bit of a handful. Grace asked what strategies he was using to relax and Denise joked that he did nothing but relax as he was in the pub most evenings with his mates.

Grace asked Graham if he thought drinking might be making things worse rather than better and suggested they have a look at how many units he was consuming. Graham agreed and Grace completed the AUDIT with him. Graham agreed that it would be a good idea to cut down.

He decided to keep a drink diary to identify situations/days/events which made him more likely to drink. After a couple of weeks he discovered that there were certain triggers that he responded to by going to the pub. He decided to limit his pub visits to twice a week and switched to a lower strength brand of lager.

8. FOLLOW UP (ALL SETTINGS)

At subsequent appointments it is important to monitor 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.

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

9.1 ORGANISATIONAL OWNERSHIP

In order to maximise the long-term use of IBA the following support should be in place: [75,76]

- Organisations and individual managers should show an understanding of the relevance, importance and effectiveness of IBA in order to embed it into normal practice.[77]
- Agencies should develop protocols which provide clear guidance on when, and how to use IBA.
- An IBA champion could be appointed in the organisation to promote its use.
- Services should provide access to the resources needed to deliver IBA (e.g. training, leaflets, and 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 ensure existing and new staff have access to these skills.

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

9.3 SUPPORT MATERIALS

Further support materials, including useful background reading can be found at http://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 (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.

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'*".[79]

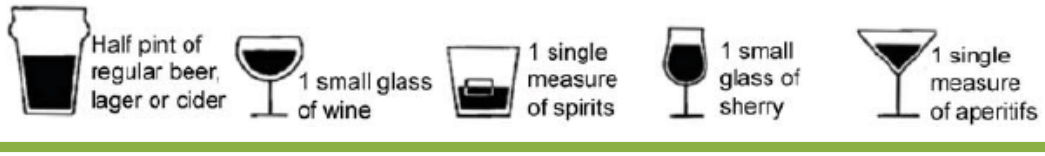
9.5 MONITORING AND IDENTIFYING AREAS FOR FURTHER DEVELOPMENT

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.

- 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	

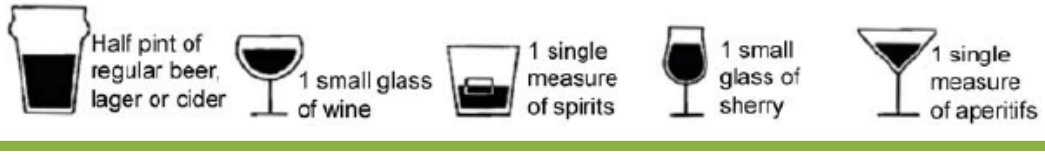
SCORING:

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

YOUR SCORE:

APPENDIX 2 - FAST

This is one unit of alcohol...



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

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

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

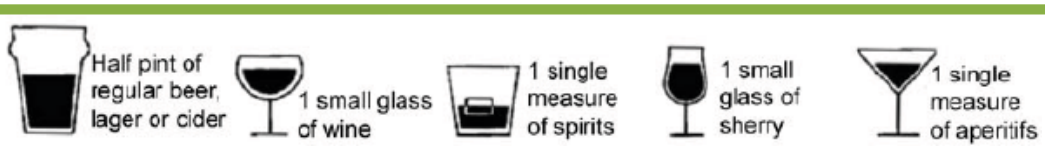
Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often 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

This is one unit of alcohol...



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

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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EARLY INTERVENTION AND PREVENTION

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