Report No.
ES16069

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**PUBLIC PROTECTION AND SAFETY POLICY DEVELOPMENT AND SCRUTINY COMMITTEE**
Date:	**29th November 2016**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**ALCOHOL USE IN BROMLEY**
Contact Officer:	Dr Agnes Marossy, Consultant in Public Health E-mail: agnes.marossy@bromley.gov.uk
Chief Officer:	Dr Nada Lemic, Director of Public Health
Ward:	All Wards

1. Reason for report

This report provides information on alcohol use in Bromley/

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2. RECOMMENDATION(S)

2.1 **To consider and comment on issues identified within the report.**

Corporate Policy

1. Policy Status: Existing Policy
2. BBB Priority: Healthy Bromley Children and Young People Excellent Council Quality Environment Safer Bromley Supporting Independence

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Financial

1. Cost of proposal: Not Applicable
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: N/A
4. Total current budget for this head: £N/A
5. Source of funding: N/A

Personnel

1. Number of staff (current and additional):
2. If from existing staff resources, number of staff hours:

Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected):

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: N/A

Alcohol Use in Bromley

1. Introduction

In many parts of the world, drinking alcoholic beverages is a common feature of social gatherings. Nevertheless, the consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties.

In addition to the chronic diseases that may develop in those who drink large amounts of alcohol over a number of years, alcohol use is also associated with an increased risk of acute health conditions, such as injuries, including from traffic accidents.

According to the World Health Organisation[1]:

- Worldwide, 3.3 million deaths every year result from harmful use of alcohol, this represent 5.9% of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in disability- adjusted life years (DALYs).
- Alcohol consumption causes death and disability relatively early in life. In the age group 20 – 39 years approximately 25% of the total deaths are alcohol-attributable.
- There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other non-communicable conditions as well as injuries.
- Causal relationships have been established between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

2. Epidemiology of Alcohol Misuse[1]

Alcohol is a psychoactive substance with dependence-producing properties. Alcohol consumption can have an impact not only on the incidence of diseases, injuries and other health conditions, but also on the course of disorders and their outcomes in individuals. Alcohol-related harm is determined, apart from environmental factors, by three related dimensions of drinking:

- the volume of alcohol consumed
- the pattern of drinking
- and, on rare occasions also the quality of alcohol consumed.

[1] World Health Organisation Global Status Report on Alcohol and Health, 2014.

Alcohol Consumption has been identified as a component cause for more than 200 diseases, injuries and other health conditions.
A component cause may be one among a number of components, none of which alone is sufficient to cause the disease. When all the components are present, the sufficient cause is formed.
For most diseases and injuries causally impacted by alcohol, there is a dose–response relationship. For example, for all alcohol-attributable cancers, the higher the consumption of alcohol, the larger the risk for these cancers.

Pattern of Drinking also affects the risk of harm. For example, a pattern of drinking while eating seems to be associated with less harm from chronic diseases than the same pattern of drinking at other times.
The cardio protective effect of low-risk patterns of alcohol consumption disappears completely in the presence of heavy episodic drinking (HED).
HED is the consumption of 60 or more grams of alcohol (7.5 units) on at least one single occasion at least monthly. The volume of alcohol consumed on a single occasion is important for many acute consequences of drinking such as alcohol poisoning, injury and violence, and is also important wherever intoxication is socially disapproved of. HED is associated with detrimental consequences even if the average level of alcohol consumption of the person concerned is relatively low.

Quality of Alcohol Consumed may impact on health and mortality for instance when home-made or illegally produced alcoholic beverages are contaminated with methanol or other very toxic substances, such as disinfectants.

2.1 Mechanisms of Harm in an Individual

There are three main direct mechanisms of harm caused by alcohol consumption in an individual. These three mechanisms are:

- toxic effects on organs and tissues;
- intoxication, leading to impairment of physical coordination, consciousness, cognition, perception, affect or behaviour;
- dependence, whereby the drinker's self-control over his or her drinking behaviour is impaired

2.2. Factors Affecting Alcohol Consumption and Alcohol-Related Harm[1]

A variety of factors have been identified at individual and societal levels, which affect the magnitude and patterns of consumption and can increase the risk of alcohol use disorders and other alcohol-related problems in drinkers and others.
Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining differences in vulnerability between societies, historical trends in alcohol consumption and alcohol-related harm.

Age

Children, adolescents and elderly people are typically more vulnerable to alcohol-related harm from a given volume of alcohol than other age groups.

Early initiation of alcohol use (before 14 years of age) is a predictor of impaired health status because it is associated with increased risk of alcohol dependence and abuse at later ages, alcohol-related motor vehicle accidents, and other unintentional injuries. At least part of the excess risk among young people is related to the fact that, typically, a greater proportion of the total alcohol is consumed during heavy drinking episodes. Also, young people appear to be less risk-averse and may engage in more reckless behaviour while drunk.

While alcohol consumption generally declines with age, older drinkers typically consume alcohol more frequently than other age groups. Also, as people grow older, their bodies are typically less able to handle the same levels and patterns of alcohol consumption as when they were younger, leading to a high burden from unintentional injuries, such as alcohol-related falls.

Gender

Harmful use of alcohol is the leading risk factor for death in males aged 15–59 years, yet there is evidence that women may be more vulnerable to alcohol-related harm from a given level of alcohol use or a particular drinking pattern. The vulnerability of females to alcohol-related harm is a major public health concern because alcohol use among women has been increasing steadily in line with economic development and changing gender roles and because it can have severe health and social consequences for newborns.

There is a higher burden of alcohol-related disease among men than women because men are less often abstainers, drink more frequently and in larger quantities.

However, the same level of alcohol consumption leads to more pronounced outcomes for women because women typically have lower bodyweight, smaller liver capacity to metabolise alcohol and a higher proportion of body fat, so achieve higher blood alcohol concentrations than men.

Women are also affected by interpersonal violence and risky sexual behaviour as a result of the drinking problems and drinking behaviour of male partners.

Women who drink during pregnancy may increase the risk of fetal alcohol spectrum disorder and other preventable health conditions in their newborns.

Familial Risk Factors

A family history of alcohol use disorders is considered a major vulnerability factor for both genetic and environmental reasons.

Multiple genes influence alcohol use initiation, metabolism and reinforcing properties in different ways, contributing to the increased susceptibility to toxic, psychoactive and dependence-producing properties of alcohol in some vulnerable groups and individuals.

Parental alcohol use disorders have been found to negatively affect the family situation during childhood. Parents with alcohol use disorders display particular patterns of alcohol consumption and thereby increase the likelihood that their children will develop drinking patterns associated with high risk of alcohol use disorders when they are introduced to alcohol. Heavy drinking by parents affects family functioning, the parent–child relationship and parenting practices, which in turn affects child development adversely. The mistreatment of children, including sexual abuse, physical abuse and neglect, may also lead to childhood psychopathology and later to problem drinking.

2.3 Socioeconomic Status[1]

Surveys and mortality studies, particularly from the developed world, suggest that there are more drinkers, more drinking occasions and more drinkers with low-risk drinking patterns in higher socioeconomic groups, while abstainers are more common in the poorest social groups. However, people with lower socioeconomic status (SES) appear to be more vulnerable to tangible problems and consequences of alcohol consumption. For example, manual workers seem more vulnerable to severe alcohol-related health outcomes, including mortality, than non-manual workers for a given pattern of drinking.

One explanation for the potentially greater vulnerability among lower SES groups is that they are less able to avoid adverse consequences of their behaviour due to a lack of resources. For example, individuals with higher SES may be more able to choose safer environments in which to drink, purchase social or spatial buffering of their behaviour and have better access to high-quality health care services.
A second explanation could be that individuals in lower SES groups have a less extensive support network, i.e., fewer factors or persons to motivate them to address alcohol problems before severe consequences occur.
A third, contested, explanation that has been proposed in the past is that of an “all or nothing” pattern of behaviour in lower SES groups, i.e. poor people drink less often, but when they drink, they drink a lot.

3. Guidelines on Alcohol Use

In August 2016, the UK Chief Medical Officers issued guidelines and recommendations on regular drinking, single episodes of drinking and on pregnancy and drinking[2].

Weekly Drinking Guideline

This applies to adults who drink regularly or frequently i.e. most weeks

The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Single Occasion Drinking Episodes

This applies to drinking on any single occasion (not regular drinking, which is covered by the weekly guideline)

The Chief Medical Officers' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level is to reduce them by:

- limiting the total amount of alcohol you drink on any single occasion
- drinking more slowly, drinking with food, and alternating with water
- planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.

The sorts of things that are more likely to happen if you do not understand and judge correctly the risks of drinking too much on a single occasion can include:

- accidents resulting in injury, causing death in some cases
- misjudging risky situations, and
- losing self-control (e.g. engaging in unprotected sex).

Some groups of people are more likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion for example those at risk of falls, those on medication that may interact with alcohol or where it may exacerbate pre-existing physical and mental health problems.

[2] UK Chief Medical Officers' Low Risk Drinking Guidelines, August 2016

If you are a regular weekly drinker and you wish to keep both your short- and long term health risks from drinking low, this single episode drinking advice is also relevant for you.

Pregnancy and drinking

The Chief Medical Officers' guideline is that:

If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

4. Classification of drinking behaviours

The most common classifications of alcohol consumption are based on quantity. The World Health Organisation and the National Institute of Health & Care Excellence (NICE) refer to classifications as follows:

Table 1: Classification of Drinking Behaviours[3]

RISK			Men	Women
1	**Lower risk** This level of drinking means that in most circumstances you have a low risk of causing yourself future harm.	**Sensible drinking** Drinking within the recommended limits.	No more than 3-4 units a day on a regular* basis	No more than 2-3 units a day on a regular* basis
2	**Increasing risk** Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.	**Hazardous drinking** A pattern of alcohol consumption that increases risk of harm.	More than 3-4 units a day on a regular* basis	More than 2-3 units a day on a regular* basis
3	**Higher risk** This level of drinking has the greatest risk of health problems.	**Harmful drinking** A pattern of alcohol consumption that is causing mental and physical damage.	More than 50 units per week (or more than 8 units per day) on a regular* basis	More than 35 units per week (or more than 6 units per day) on a regular* basis

*Regular in this context means drinking at this sort of level every day or most days of the week; whilst for weekly drinking, it refers to the amounts drunk most weeks of the year.

[3] Adapted from Gravesham County NHS. http://www.gravesham.gov.uk/__data/assets/pdf_file/0007/62359/Units_Poster.pdf last accessed 16/09/14

4.1 Binge drinking

The new guidelines allow estimates to be made of the amounts of alcohol likely to be harmful when consumed on a single drinking day.

Table 2 Risks in a Single Drinking Day

Amount of Alcohol in One Day	Risk
Up to 4.67 units	This value is a third of the recommended weekly limit. This is the value you would drink if you drank 14 units spread evenly over three days.
More than 4.67 and up to 7 units	Evidence in the new guidelines suggests that the risk of accident or injury increases when drinking this amount of units over 3 to 6 hours.
More than 7 and up to 14 units	Up to the level that men and women are advised not to regularly drink in a week.
More than 14 units	The equivalent of drinking more than the low risk guidelines recommend for regular drinking in a week, in one day.

Source: Opinions & Lifestyle Survey 2016

4.2 Dependence

Drinkers can also be classified by their addiction to alcohol, known as dependence. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

- **Mild dependence:**
  May crave an alcoholic drink when it is not available or find it difficult to stop drinking.
- **Moderate dependence:**
  Likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.
- **Severe dependence:**
  May have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

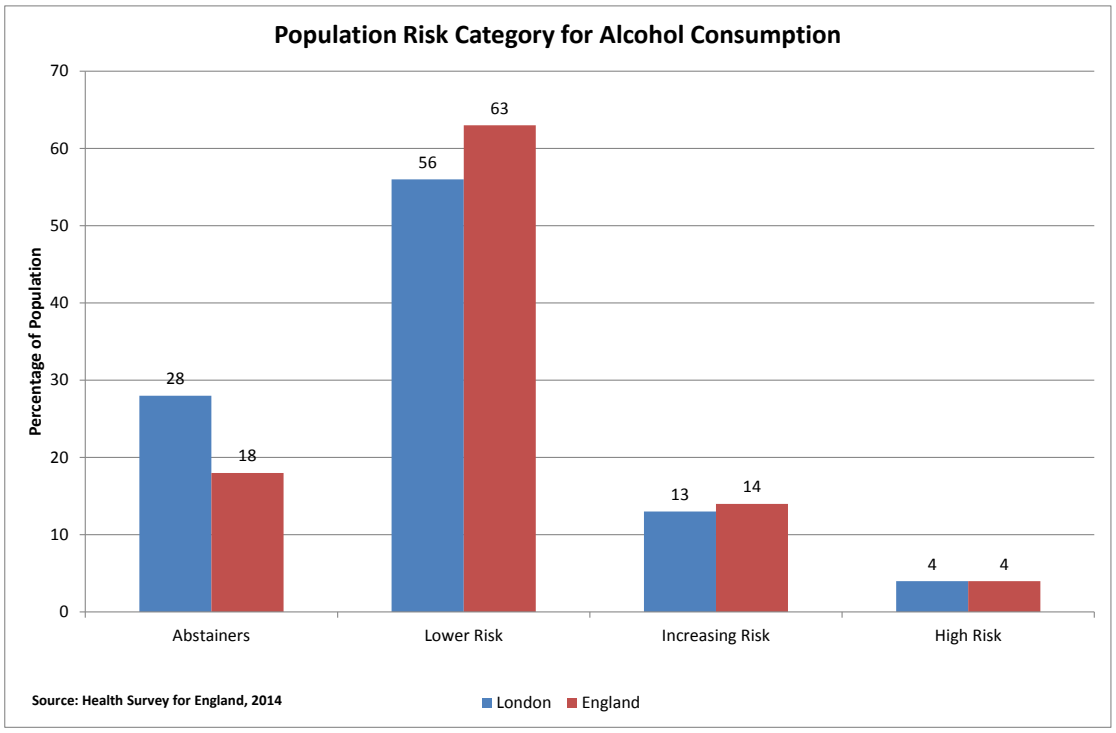
Abstainers are considered to be people who have reported not consuming alcohol in the previous 12 months. This may include people who have once been dependent on alcohol but are no longer consuming it.

5. Alcohol Consumption in Bromley

Obtaining reliable information about drinking behaviour is difficult, and social surveys consistently record lower levels of consumption than would be expected from the data on alcohol sales. However, a range of data sources which are available locally were extracted and analysed to understand patterns and trends in alcohol consumption in the Bromley population.

People in Bromley are not thought to drink any more than the average for London or England. In 2012 an estimated 73.6% of all drinkers in Bromley were in the lower risk category and drinking within the recommended levels, compared to 73.4% for London. There were 19.5% of drinkers at increasing risk, and a further 6.9% at high risk, which was no different to the London average. Figure 1 shows the most recent estimates of people consuming alcohol regionally and nationally.

Figure 1: Health Survey for England Estimates of Alcohol Consumption 2014



* Abstainers include people who may have had harmful or dependent drinking patterns in the past but may have stopped drinking since. They are not included in the estimation of lower risk drinkers.

Data collected from GP systems in June 2016 shows that of the 274,935 people aged 16 years and over registered with Bromley GPs, 42.2% have been asked about their alcohol consumption within the last three years. As this proportion is quite low, it is not possible to draw definite conclusions about alcohol consumption in the population. It should also be noted that information on the volume of alcohol consumption alone will not identify all those at risk, as some patterns of consumption e.g. heavy episodic drinking cause harm at lower levels of consumption.

The following data relates to those who have a record of their alcohol consumption within the last three years:
Almost 13% of people in Bromley reported drinking above the recommended weekly limit, with more men than women exceeding the recommendations (21.3% vs 6.3%). This is lower than Health Survey for England estimates for London.

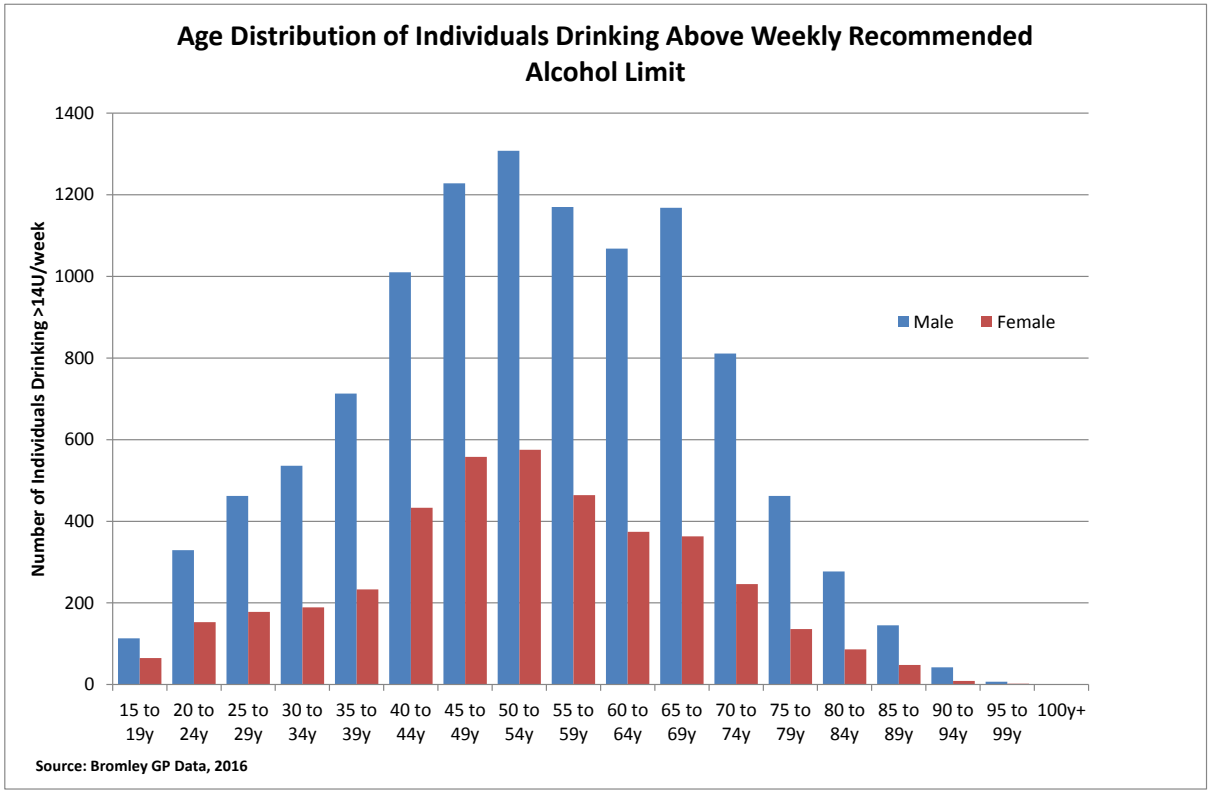
Table 3 Alcohol Consumption in Bromley

No. of Units Weekly	Persons	Male	Female
Zero	33%	25.1%	39.7%
Up to 14 units	53.9%	53.7%	54%
Over 14 units	12.9%	21.3%	6.3%

Source: Bromley GP Data, 2016

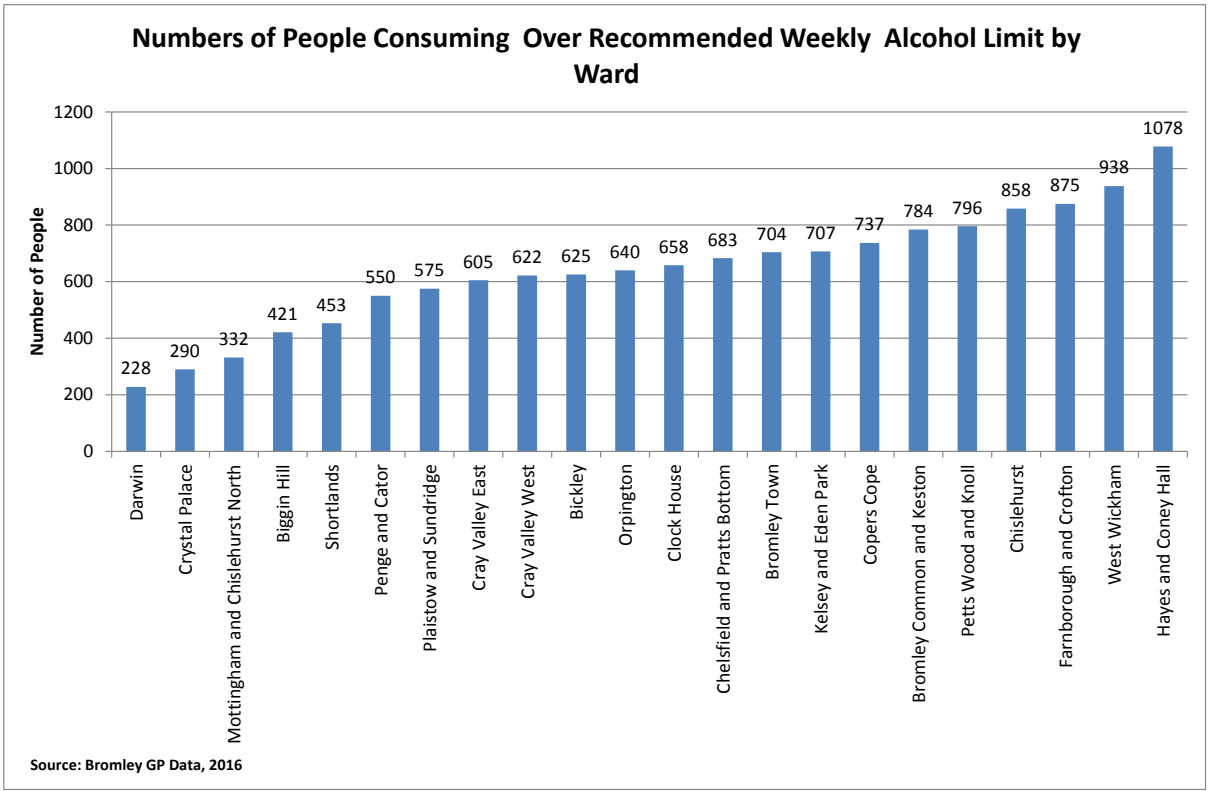
The numbers of men and women drinking above the recommended limit of 14 units per week rises with age to a peak at age 50 to 54 years, and declines again thereafter.

Figure 2 Age Distribution of Alcohol Consumption in Bromley, 2016



The numbers of people drinking above the recommended weekly limits varies with ward of residence, Hayes & Coney Hall ward having the highest number, and Darwin having the lowest number.

Figure 3: Harmful Alcohol Consumption in Bromley by Ward, 2016



Patients registered with Bromley GPs who are aged between 40 and 74 years and do not have existing cardiovascular disease are eligible for an NHS Health Check every five years. As part of the NHS Health Check, patients complete a short questionnaire relating to their alcohol consumption, the Audit C questionnaire (see Appendix).

In 2015-16, of the 6,868 people who had an NHS Health Check, 95% completed the Audit C questionnaire. 736 of these (10.7%) had a score of 8 or more, indicating an increasing risk from their volume and pattern of alcohol consumption (16.1% of men and 7.1% of women). This level is slightly lower overall and particularly for men than that expected for this age group compared to the reported consumption in the GP data.

5.1 Prevalence of binge drinking

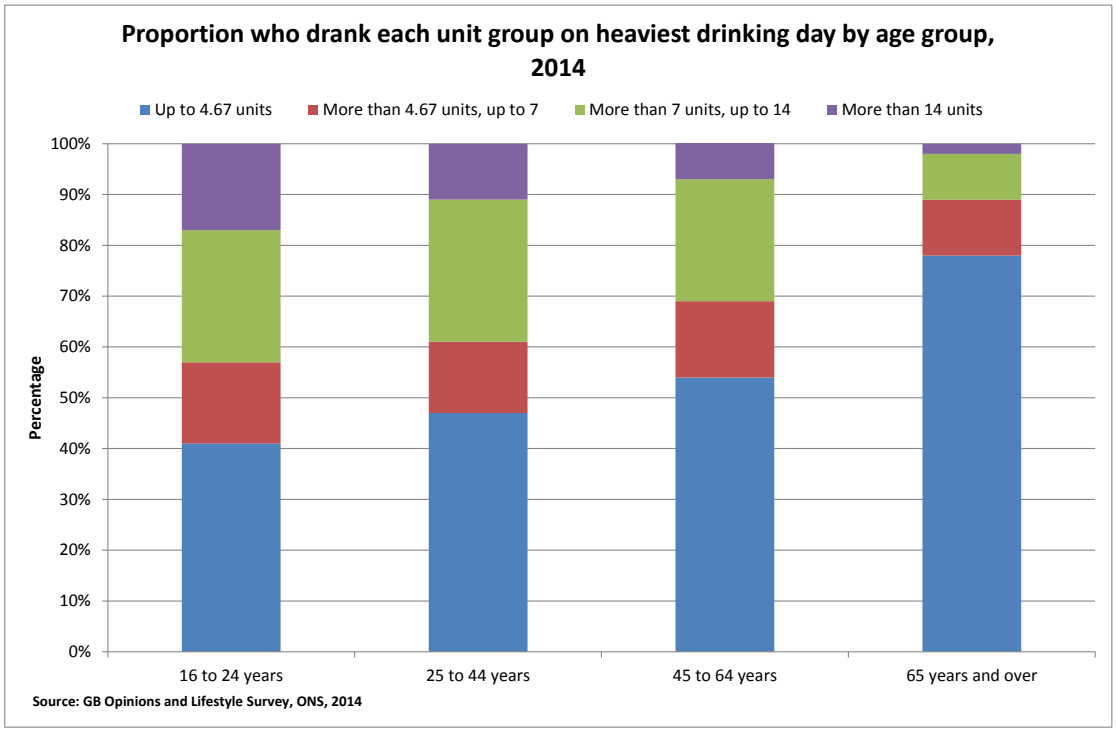
In 2014, the GB Opinions and Lifestyle Survey found that 58% of the population had drunk alcohol in the week before being interviewed.

Of these, 45% drank more than 4.67 units on their heaviest drinking day (i.e. over a third of the weekly limit) and 9% drank more than the recommended weekly amount of 14 units in one day.

Although young people were less likely to have consumed alcohol (48% of those aged 16 to 24 years as compared with 66% of those aged 45 to 64 years), they were more likely to consume more than the recommended weekly limit in one day (17% of 16 to 24 year olds as compared with 2% of those aged 65 years and over).

There are no recent local Bromley estimates for the level of binge drinking available.

Figure 4 National Estimates for Alcohol Consumption on a Single Drinking Day



6. Impact on Health & Wellbeing

The Chief Medical Officer's Alcohol Guidelines published in 2016 state that drinking any level of alcohol regularly carries a health risk for everyone.

An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the 3rd leading risk factor for death and disability after smoking and obesity.

Among the conditions for which alcohol is a causal factor are:

- Mouth, throat, stomach, liver and breast cancers
- Cirrhosis of the liver
- Heart disease
- Depression
- Stroke
- Pancreatitis

The lifetime risk of cancer increases with increasing alcohol consumption, as illustrated in the table below:

Table 4 Alcohol Consumption and Cancer Risk

Weekly Alcohol Consumption (Units)	Lifetime Risk (per 1000)	
	Breast Cancer	Bowel Cancer
35+	206	115
14	126	64
0	109	64

Alcohol misuse is also associated with mental health problems. A number of large epidemiological surveys demonstrate the high prevalence of co-morbidity in those attending mental health services and both drug and alcohol treatment services.
An estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year.
There is a strong association between alcohol misuse and suicide. The National confidential inquiry into suicide and homicide by people with mental illness found that there was a history of alcohol misuse in 45% of suicides among the patient population during period 2002 to 2011.

6.1 Alcohol Related Mortality

Excessive alcohol consumption is a major cause of preventable premature death. Liver disease is one of the leading causes of death in England and people are dying from it at younger ages. Alcohol accounts for over a third of all cases of liver disease. Most liver disease is preventable.
Liver disease has more than doubled since 1980 and is the only major killer disease on the increase during that period in the UK [4].

National

In England, in 2014 there were 22,966 alcohol-related deaths. Males accounted for a larger proportion of all alcohol-related deaths than women in England (66% in 2014). Between 2012 and 2014, the rate of deaths related to chronic liver disease in England was 15.21 per 100,000 population, and the rate of alcohol-related cancer deaths was 38.04 per 100,000 population.

Local

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013.
The alcohol-related mortality rate for men and women in Bromley is lower than the national levels, but the rate for women is slightly higher than the London regional

[4] PHE, Health Matters: harmful drinking and alcohol dependence, January 2016

rate. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.
Between 2012 and 2014, the rate of deaths related to chronic liver disease in Bromley was 10.00 per 100,000 population, and the rate of alcohol-related cancer deaths was 34.3 per 100,000 population.
Figures 5 and 6 show the trend in alcohol-related deaths in Bromley, London and England by gender.

Figure 5: Alcohol-related deaths. Directly Standardised Rate - Males

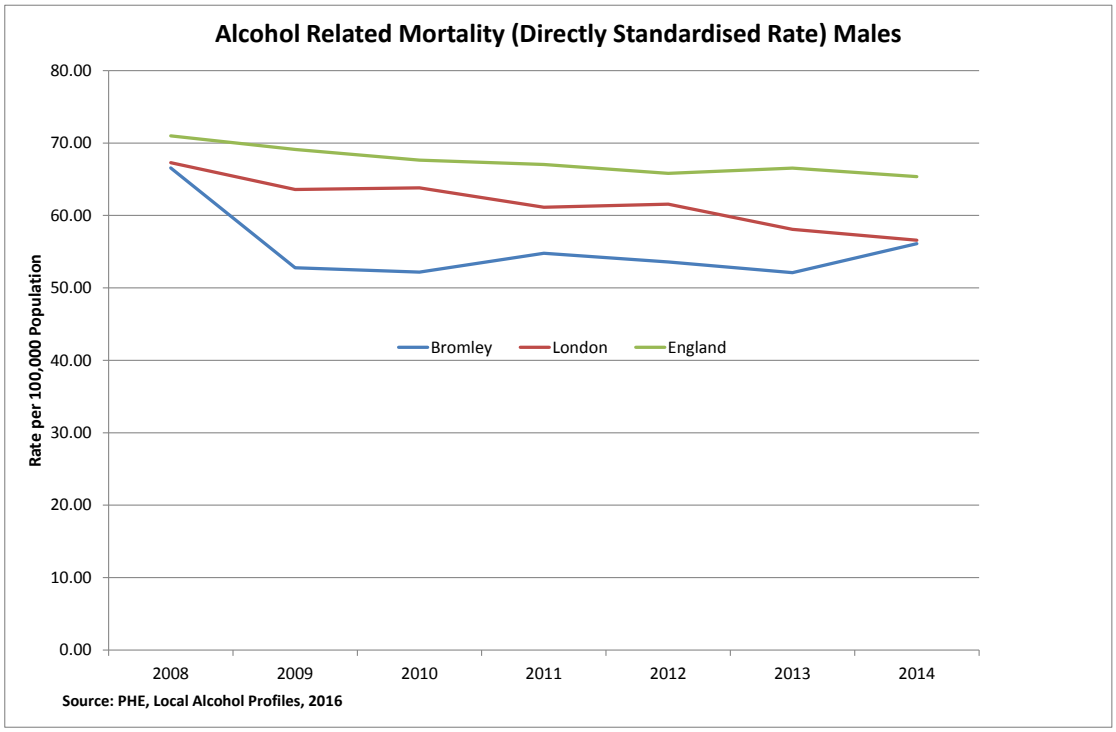
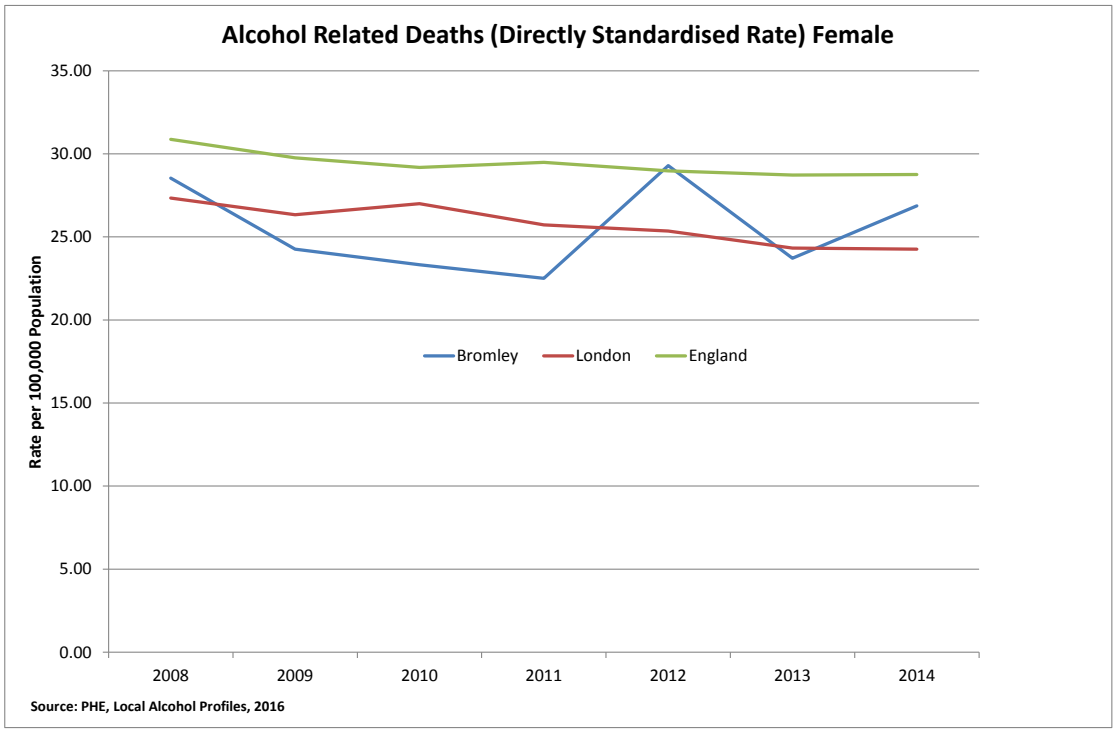


Figure 6: Alcohol-related deaths. Directly Standardised Rated - Females



6.2 Hospital Admissions - burden of ill-health due to alcohol[5]

Alcohol-related hospital admissions can be due to regular alcohol use that is above lower-risk levels and are most likely to involve increasing-risk drinkers, dependent drinkers and binge drinkers.

Alcohol dependence can be a long-term condition, which may involve relapses even after good quality treatment. Dependent individuals also experience many health problems and are frequent users of health services.

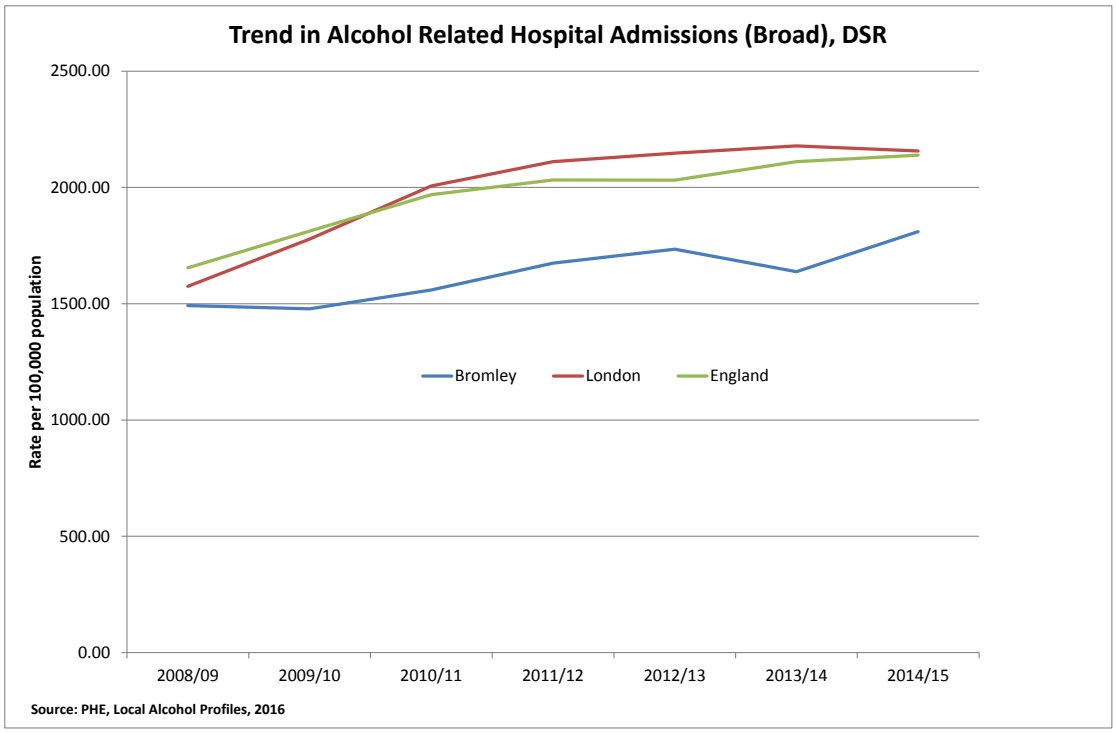
Health conditions in which alcohol plays a causative role can be classified as either "alcohol-specific" or "alcohol-related". For alcohol-specific conditions, alcohol is causally implicated in all cases e.g. alcohol poisoning or alcoholic liver disease. Alcohol-related conditions include all alcohol-specific conditions plus those where alcohol is causally implicated in some, but not all cases, e.g. high blood pressure, various cancers and falls.

There are two types of measure for alcohol-related admissions. The broad measure is an indication of the totality of alcohol health harm in the local adult population. The narrow measure shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause. The narrow measure is more responsive to change resulting from local action on alcohol.

[5] PHE, JSNA Support Pack 2016

The rate of alcohol-related hospital admissions whilst increasing at national, regional and local levels, remains lower in Bromley than for London and England as shown in figure 7 below.

Figure 7: Alcohol-related NHS hospital admissions 2008/09 to 2014/15



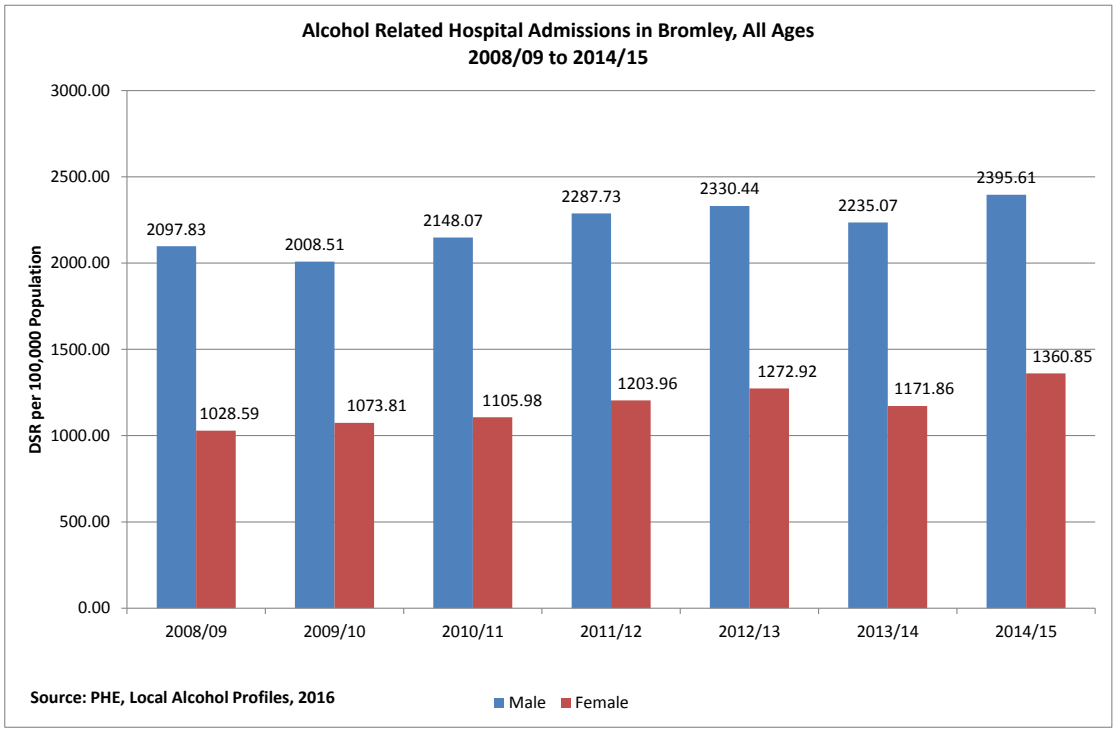
In 2014/15, there were an estimated 1,085,830 hospital admissions in England where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code (the broad measure).

Nationally, more males than females are admitted to hospital with alcohol-related conditions.

The hospital admission rate for males is almost twice the rate for females in Bromley. The rates are shown in Figure 8.

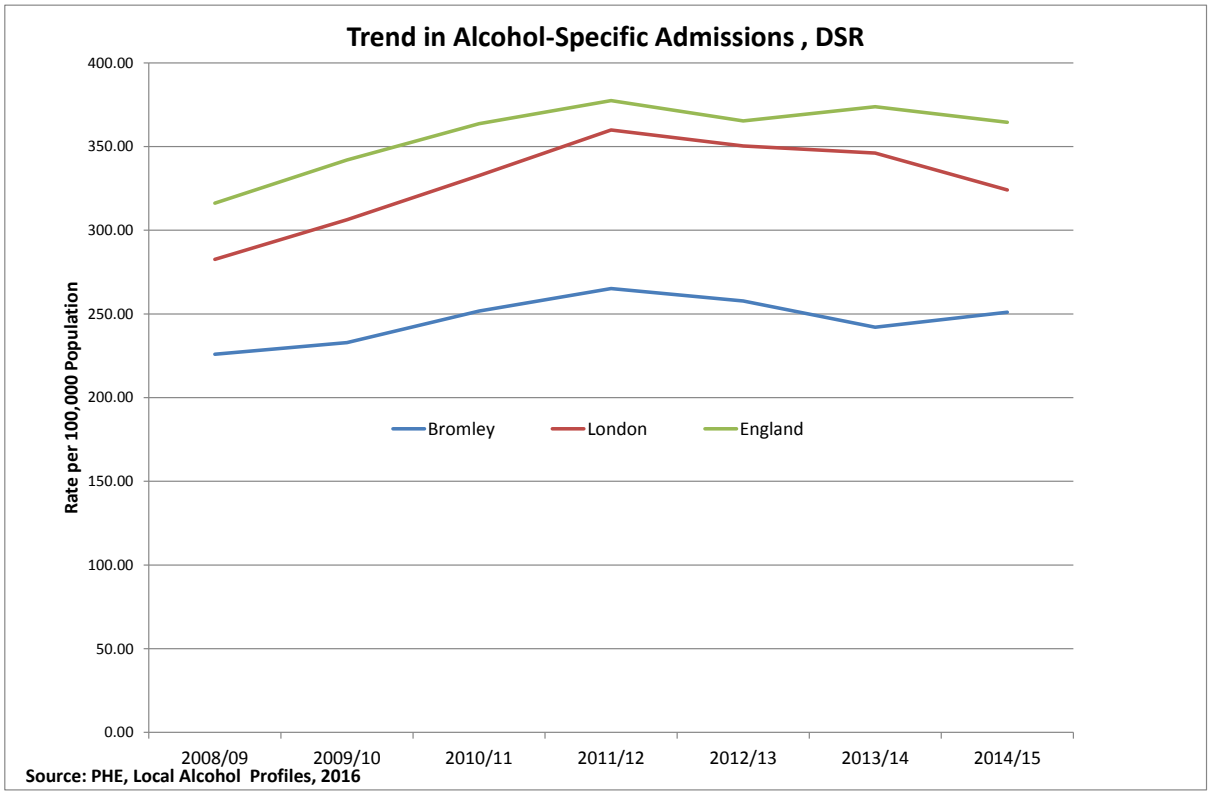
In 2014-15, nearly half of the alcohol-related hospital admissions nationally were for cardiovascular disease, and 19% were for mental and behavioural disorders due to alcohol.

Figure 8: Alcohol-related hospital admissions for men and women in Bromley 2008/09 - 2014/15



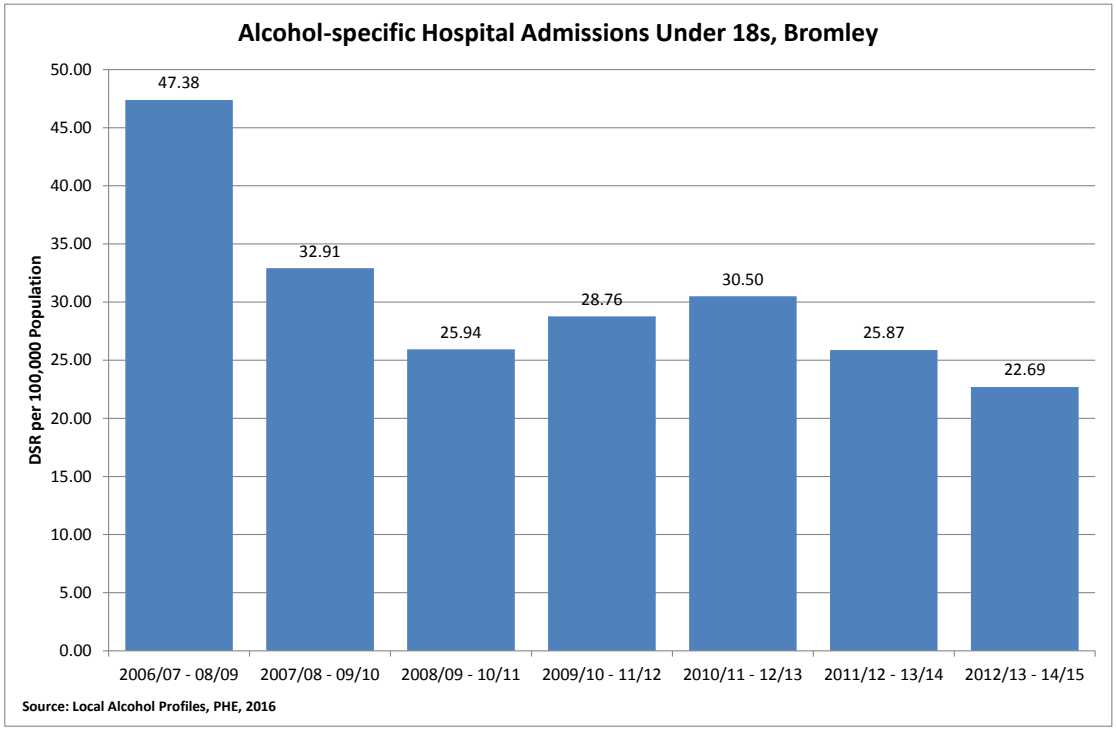
Alcohol-specific hospital admissions have been lower in Bromley than in London and England over the last seven years, but overall, there has been an increase in the rate of admissions over this period.

Figure 9 Trend in Alcohol Specific Admissions



The alcohol-specific admission rate for under 18 year olds in Bromley has been gradually decreasing over the last two years, and is comparable with the rate for London (23.73 per 100,000), but significantly lower than the rate for England (36.61 per 100,000 population).

Figure 10: Alcohol-specific hospital admissions for young people in Bromley 2006/07 to 2014/15



7. Socioeconomic Impact[1]

In addition to harm to the physical (e.g., liver disease) and/or mental health (e.g., episodes of depressive disorder) of the drinkers, alcohol consumption is often associated with socioeconomic consequences.

Alcohol is typically a valued commodity, which means that drinking usually uses resources which would otherwise be available for other purposes. Where earnings are low, heavy drinking may further impoverish the drinker, the drinker's family, or a whole community, thus increasing health or social harm.

Intoxication, dependence or alcohol withdrawal states can result in poor performance in major social roles – in functioning at work, in parenting, in relationship and friendship roles. Both the drinker and others may be affected by the consequences, such as job or productivity loss, break-up and dysfunction in family life, including domestic violence. This in turn can result in harm to physical or mental health.

The reputational drinking history of an individual, i.e., how the pattern of drinking is interpreted by others, is crucial in social judgements, both those made in the moment and in the longer term. There is a clear tendency in many cultures to marginalize and

socially exclude habitually intoxicated persons and their families, even more so than "dirty or unkempt" persons.

Marginalisation related to alcohol use can affect health status through diminished access to good health care. Studies on health services show that the care given is likely to be inferior, or the access to health care worsened, if the patient is seen as a run-down drinker or a similarly degraded status.

Harm to Other Individuals
In addition to harm to the drinker from their alcohol consumption, there are also harms to others by various means:

- **Injury** to other individuals can be intentional, e.g., assault or homicide, or unintentional, e.g., a traffic crash, workplace accident or scalding of a child.
- **Neglect or abuse** can affect, for example, a child, a partner or a person in the drinker's care.
- **Default on social role** can involve the drinker's role as a family member, as a friend and/or as a worker.
- **Property damage** can involve damage, for example, to clothing, a car or a building.
- **Toxic effects** on other individuals include most notably fetal alcohol syndrome (FAS) and preterm birth complications.
- **Loss of amenity or peace of mind** can influence family members (including children), friends, co-workers and strangers, who may, for example, be kept awake or frightened by the actions of the drinker.

Harm to Society at Large
The harmful use of alcohol results in a significant health, social and economic burden on society at large through:

- The increased burden of disease
- Social and economic costs

5.9% of all deaths and 5.1 % of the global burden of disease and injury in 2012, as measured in DALYs (Disability Adjusted Life Years), is attributable to alcohol. Beyond the population-level burden of diseases and injuries, it is important to note that harmful use of alcohol kills or disables people at a relatively young age, resulting in the loss of many years of life to death and disability.
There are three major categories of alcohol-attributable social and economic costs.

1. Direct economic costs of alcohol consumption. Direct costs encompass costs for multiple types of health-care services, such as hospitalisations, ambulatory care, nursing home care, prescription medicines or home health care. Direct costs also include significant costs in the justice sector caused, for example,

by damage to property from vehicle crashes and arrests for being “drunk and disorderly” as well as increased crime. Depending on the society, many of the direct costs are borne by governments.

2. Indirect costs. Indirect costs result, for example, from lost productivity due to absenteeism, unemployment, decreased output, reduced earnings potential and lost working years due to premature pension or death. These indirect costs are typically borne by society at large, because the alcohol-attributable loss in workforce productivity can affect the economic viability of an entire community.
3. Intangible costs. Intangible costs are the costs assigned to pain and suffering, and more generally to a diminished quality of life. Such intangible costs are borne by the drinkers, as well as their families and potentially by other individuals linked to the drinker.

8. Treatment and Management of Alcohol Misuse

The management of alcohol misuse at a population level falls into three categories:

- **Primary Prevention** which seeks to prevent the onset of disease. This takes place when the individual is still in good health, before there are any signs and symptoms of disease. It is chiefly concerned with maintaining a healthy lifestyle and avoiding adverse environmental influences. In this case primary prevention is concerned with preventing harmful alcohol use.

- **Secondary Prevention** aims to halt the progression of a disease once it is established. It takes place when the individual has developed early indicators of the development of disease. Lifestyle changes can still have a beneficial effect at this stage. In this case secondary prevention is concerned with identifying harmful alcohol use and harm reduction in individuals who are not yet alcohol dependent.

- **Tertiary Prevention** is concerned with the rehabilitation of people with an established disease to minimise residual disabilities and complications. In this case, tertiary prevention is concerned with managing individuals who are dependent on alcohol.

Management of the physical consequences of harmful alcohol use is not considered here, as this is in the NHS domain and management is not specifically related to alcohol.

8.1 Primary Prevention

Population approaches help reduce the aggregate level of alcohol consumed and therefore lower the whole population’s risk of alcohol related harm.

Population approaches can help by creating an environment that supports lower risk drinking. Examples of population approaches include those that seek to control the availability of alcohol through pricing, licensing controls, and preventing under age sales.
International evidence suggests that making it less easy to buy alcohol, (by reducing the number of outlets selling it in a given area and the days and hours when it can be sold), is an effective way of reducing alcohol related harm. The research base also supports the use of local crime and related trauma data to map the extent of alcohol related problems before developing or reviewing a licensing policy. The Council is responsible under the Licensing Act 2003 for granting licences for the retail sale/supply of alcohol in the borough. If an area is saturated with licensed premises, and the evidence suggests that additional premises may affect the licensing objectives, the Council can then adopt a cumulative impact policy which can be used to limit the number of new premises. The Council has identified two Cumulative Impact Areas (Bromley and Beckenham Town Centres), however, the policy can only be considered where there are relevant representations made against an application. If no one objects to an application, then the Council must grant it.

In addition, effective interventions on preventing under age sales, sales to people who are intoxicated or proxy sales (that is, illegal purchases for someone who is under-age or intoxicated) have been effective in reducing harm, in particular to young people. Ensuring that action is taken against premises that regularly sell alcohol to people who are under age, intoxicated or making illegal purchases for others is important in reducing harm. NICE and other studies support undertaking test purchases (using mystery shoppers) to ensure compliance with the law on under age sales.

Supporting people in understanding how much alcohol they are drinking is key to promoting sensible drinking as the social norm.

Primary prevention strategies include national programmes such as Change for Life, which highlight safe levels of alcohol consumption, the harms of drinking and suggest alternatives and tracking devices.
More locally, Bromley Changes (the Young Person's Substance Misuse Service) offers an annual session at each of Bromley's secondary schools for 13 to 15 year olds talking about safe levels of drinking, the journey of alcohol through the body, and the effects of alcohol.
For nine secondary schools, there is also a monthly drop in session, where pupils can ask for information about issues relating to alcohol.
During the week of 17th to 23rd November – Alcohol Awareness Week, assemblies are offered at schools for pupils aged 14 to 16 years.

The Licensing Act 2003 covers retail sales and the supply of alcohol, the provision of various forms of entertainment and the provision of late night refreshment.

There are four statutory objectives which must be addressed when any licensing functions are undertaken. The licensing objectives are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance and
- the protection of children from harm.

There is currently no public health objective in the Act, but since April 2013, the Director of Public Health has been designated a Responsible Authority and as such is entitled to make representations to the licensing authority. Within Bromley's Statement of Licensing Policy, there is a section on Public Health. However, at present, the role of Public Health information in relation to licensing decisions in Bromley is unclear.

Table 5 Licenced Premises in Bromley

Year	Number of licenced premises	Number of licenced Clubs	No of 24hr licences
2009	815	90	4
2012	839	81	5
2013	731	81	5
2014	712	97	5
2016	774	77	10

Source: Bromley DCMS/Home Office Returns

In Bromley three alcohol exclusion zones have been established, in Beckenham Town Centre, Bromley Town Centre and in Penge. Within an alcohol exclusion zone it is an offence under the Criminal Justice and Police Act 2001 to consume alcohol in 'public' - any open space other than that which forms part of licensed premises. These zones have been established primarily to reduce problems relating to alcohol crime and disorder, but also serve a primary prevention function.
The police collect information about violent crime/drunkenness incidents related to the night-time economy (between 8 pm and 5 am) on Beckenham and Bromley High Streets and on East Street in Bromley.
There is quite a lot of variation in the incident figures from month to month (Figures 11 to 13) because of the small numbers involved, however, these stay largely within the control limits (set at +/- 2 standard deviations).

Figure 11

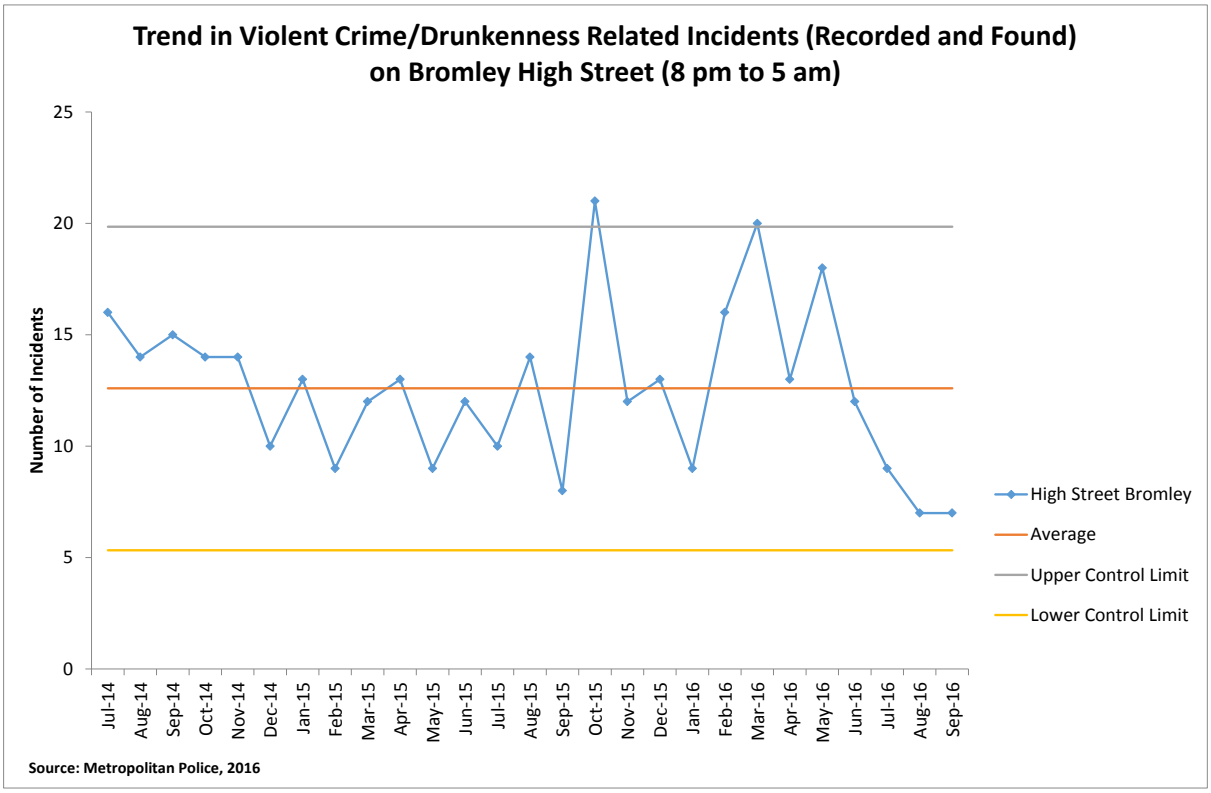


Figure 12

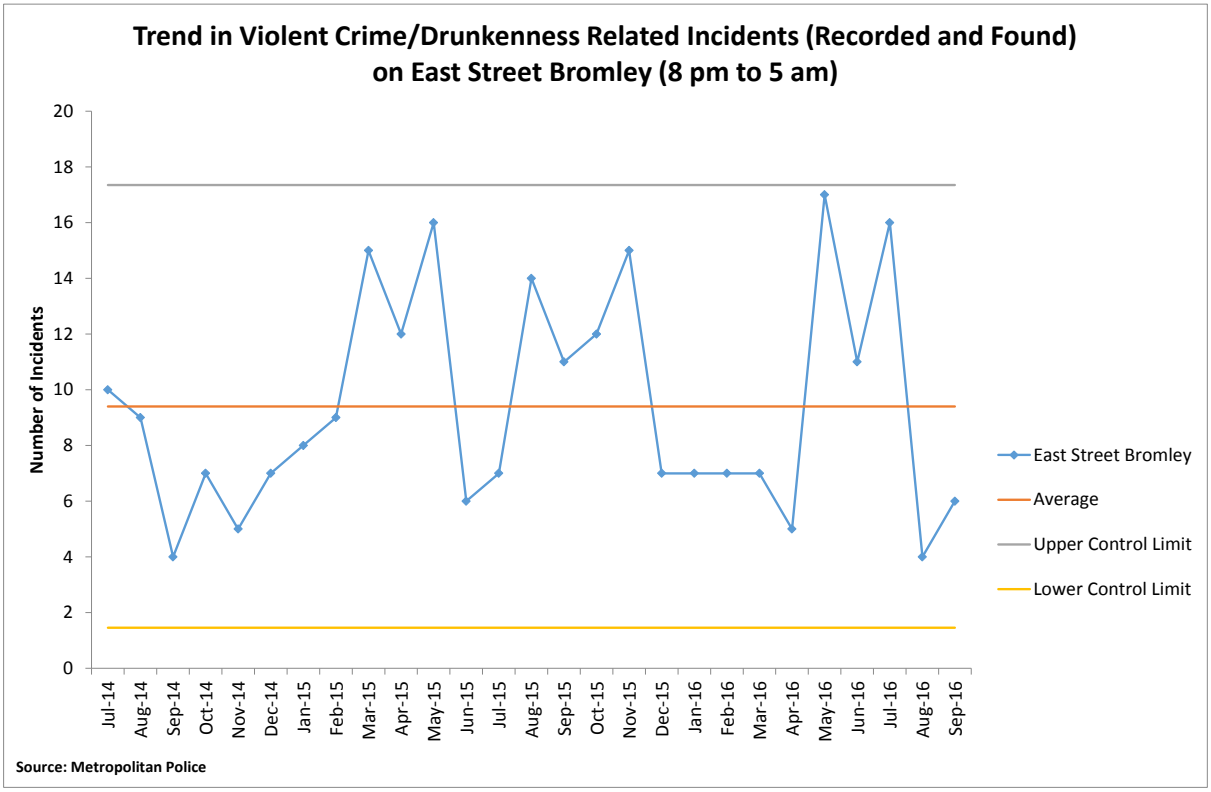
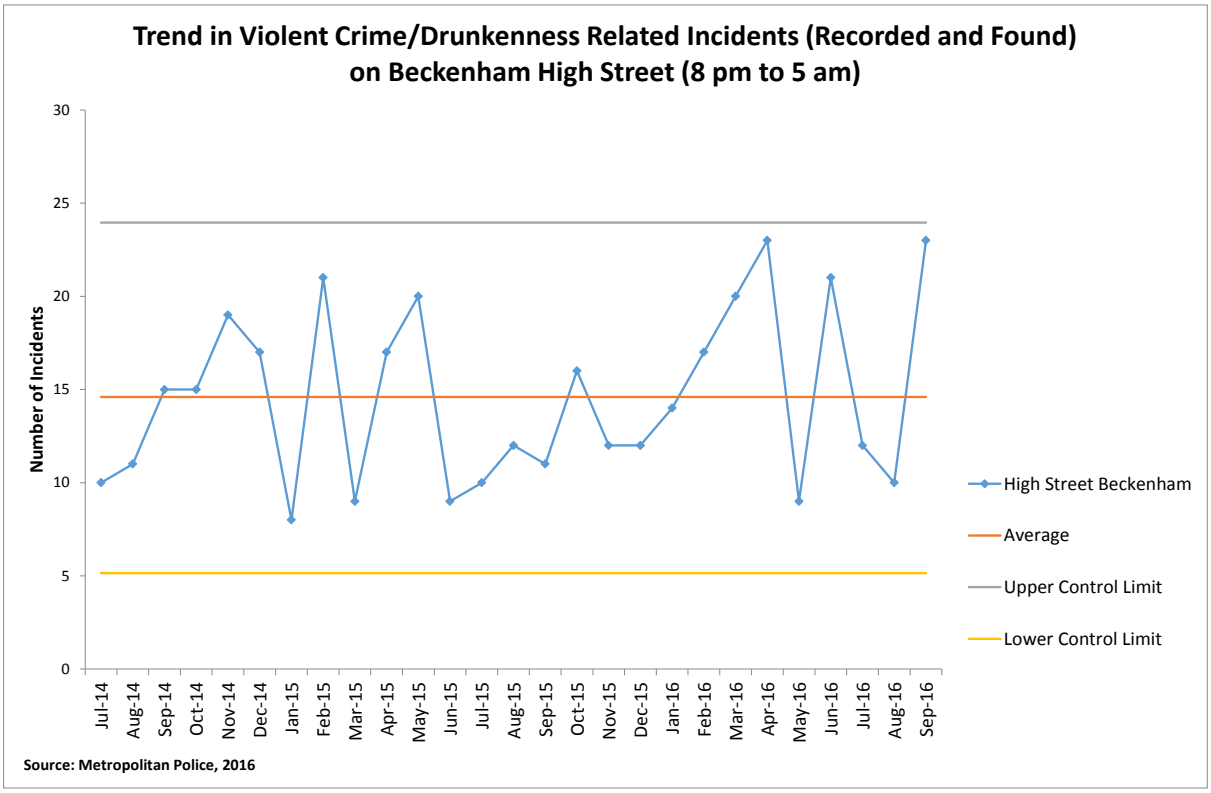


Figure 13



Trading Standards have a role to play in the primary prevention of alcohol misuse by enforcing the law and restricting alcohol sales.
It is against the law:

- To sell alcohol to someone under 18 anywhere.
- For an adult to buy or attempt to buy alcohol on behalf of someone under 18.
- For someone under 18 to buy alcohol, attempt to buy alcohol or to be sold alcohol.

Trading Standards carry out test purchases using under age volunteers, often police cadets. Premises targeted are those where we have received an allegation of under age sales, or as a result of visits by officers who have carried out a risk assessment of the management of the business. In some cases, a previous visit with an 18 year old volunteer would have been conducted to test whether or not the business was complying with voluntary age verification systems, for example Challenge 25, where we would expect the business to ask for proof of age.
Compliance levels for alcohol test purchasing are as follows:

In 2015-16 the proportion of premises who refused the sale was 85%. This compares to previous years where the compliance level was 88% in 2014-15, 70% in 2013-14 and 77% in 2012-13.

8.2 Secondary Prevention

Secondary prevention includes screening of individuals to detect whether their consumption of alcohol is at a harmful level, and giving brief advice.
This takes place in Primary Care as part of the NHS Health Checks for people aged between 40 and 74 years, and also at the Princess Royal University Hospital (PRUH) as part of the Health Promoting Hospital Local Incentive Scheme commissioned by the CCG.
All patients admitted to participating wards at the PRUH should be screened using the FAST Questionnaire (see Appendix) offered a brief intervention and referral to the Bromley Drug and Alcohol Service as appropriate. This scheme (part of the Health Promoting Hospital Incentive Scheme commissioned by the CCG) started in 2014-15 and each year more wards are enrolled onto the scheme, and currently 10 wards are participating.

Table 6 Alcohol Screening Results at the PRUH

Time Period	No. of Admissions	Screened	FAST Score >3	Brief Advice
Q1 2015-16	2736	82.7%	4.7%	99.1%
Q2 2015-16	3713	81.1%	4.9%	99.3%
Q3 2015-16	3923	86.2%	6.3%	90.6%
Q4 2015-16	3909	85.8%	5.0%	78.7%
Q1 2016-17	3986	90.5%	5.5%	76.0%
Q2 2016-17	3780	84.0%	6.3%	37.7%

The level of screening is high, but there are a lower than expected proportion of FAST scores above 3 (compared to alcohol consumption levels in the general population). Work is ongoing to support this initiative, as performance is affected by staff turnover. From 2018-19, alcohol screening in hospitals will be part of a National CQUIN.
In parallel with this, work has been ongoing to strengthen awareness of alcohol services and of referral pathways amongst hospital staff.

Harm reduction interventions by the Specialist Substance Misuse Service for both adults and young people are considered in the section on tertiary prevention.

8.3 Tertiary Prevention

Tertiary prevention is the management of individuals who are dependent on alcohol. This management is delivered by the specialist substance misuse provider.
Included in this section is information on harm reduction for non-dependent drinkers, as this is also delivered by the specialist service.

The main aim of treatment is to move a client from a position of problematic drugs and/or alcohol misuse, with possible poor physical health status, chaotic lifestyle and

criminality to a position of stability, improved health and well-being, employment and positive engagement with the community.
This may be achieved through:

- harm reduction – reducing the alcohol consumption to achieve “controlled drinking” i.e. reducing alcohol consumption to a moderate level.
- Abstinence oriented treatments using a range of interventions including community or inpatient detoxification, medication, psychosocial interventions and residential rehabilitation.

Treatments are more effective if given in combination. However, it should be understood that dependency is a chronic illness for which there is no cure. Abstinence is a lifelong battle.

8.3.1 Treatment in Bromley

Bromley Drug and Alcohol Service provides services at different levels based on the level of dependency determined at initial assessment, as shown in the Alcohol Model Pathway diagram.

Beyond brief intervention, each level includes:

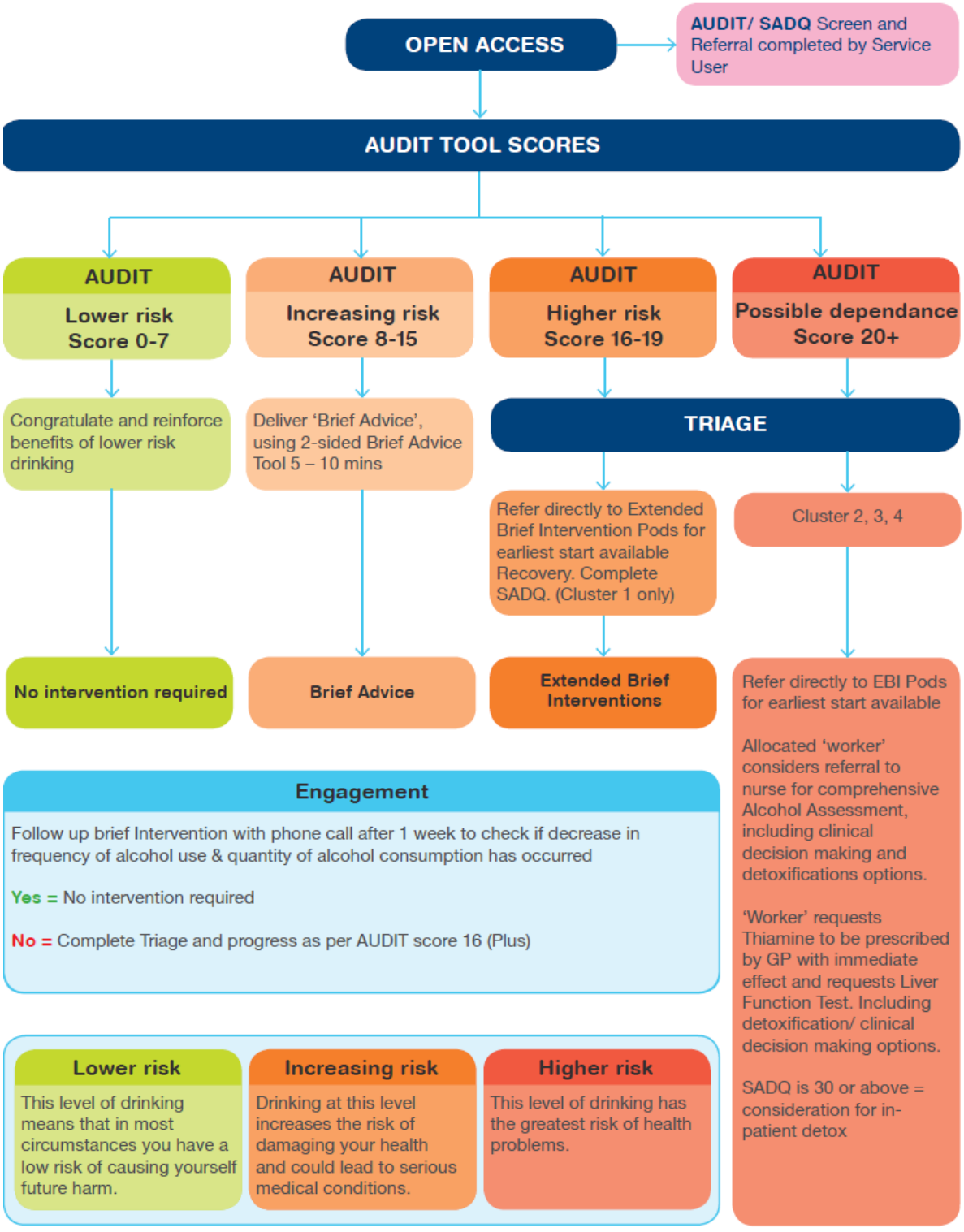
- Assessment/Engagement
- Extended Brief Intervention Pods (groups)
- Care Planning/Care Co-ordination and case management
- Withdrawal management
- Psychosocial interventions
- Pharmacotherapy
- Aftercare/Reintegration/Recovery

The length of treatment is determined by the level of dependency:

- Harmful/Mild Dependence 12 weeks
- Moderate Dependence 24 weeks
- Severe Dependence (without complex needs) approx. 12 months
- Moderate/Severe Dependence (with complex needs) at least 12 months

In addition, for complex patients who require it, there is spot purchasing from specialist providers for inpatient detoxification (for patients for whom there are medical risks) and for residential rehabilitation (where there is a need for complete separation from established patterns of behaviour and social networks).

CGL Alcohol Model Pathway

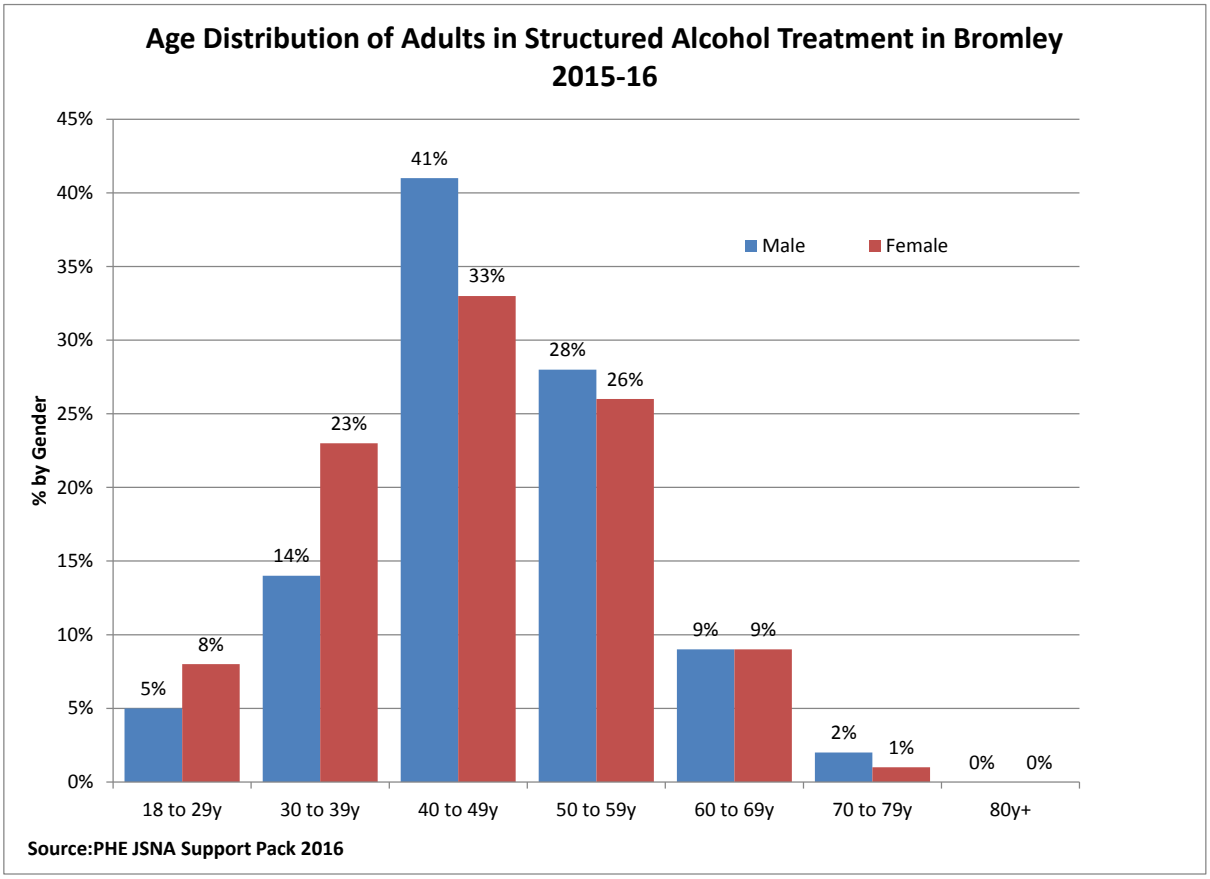


8.3.2 Adults Attending Structured Alcohol Treatment Services in Bromley

Evidence shows that, when individuals are engaged in treatment, they consume less alcohol, improve their health, manage their lives better and cause less harm to themselves, those close to them and to the wider community.

During 2015-16, 238 adults were engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.

Figure 14: Age of Individuals Receiving Alcohol Treatment



The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar, although more females than males under the age of 40 years present for alcohol treatment.

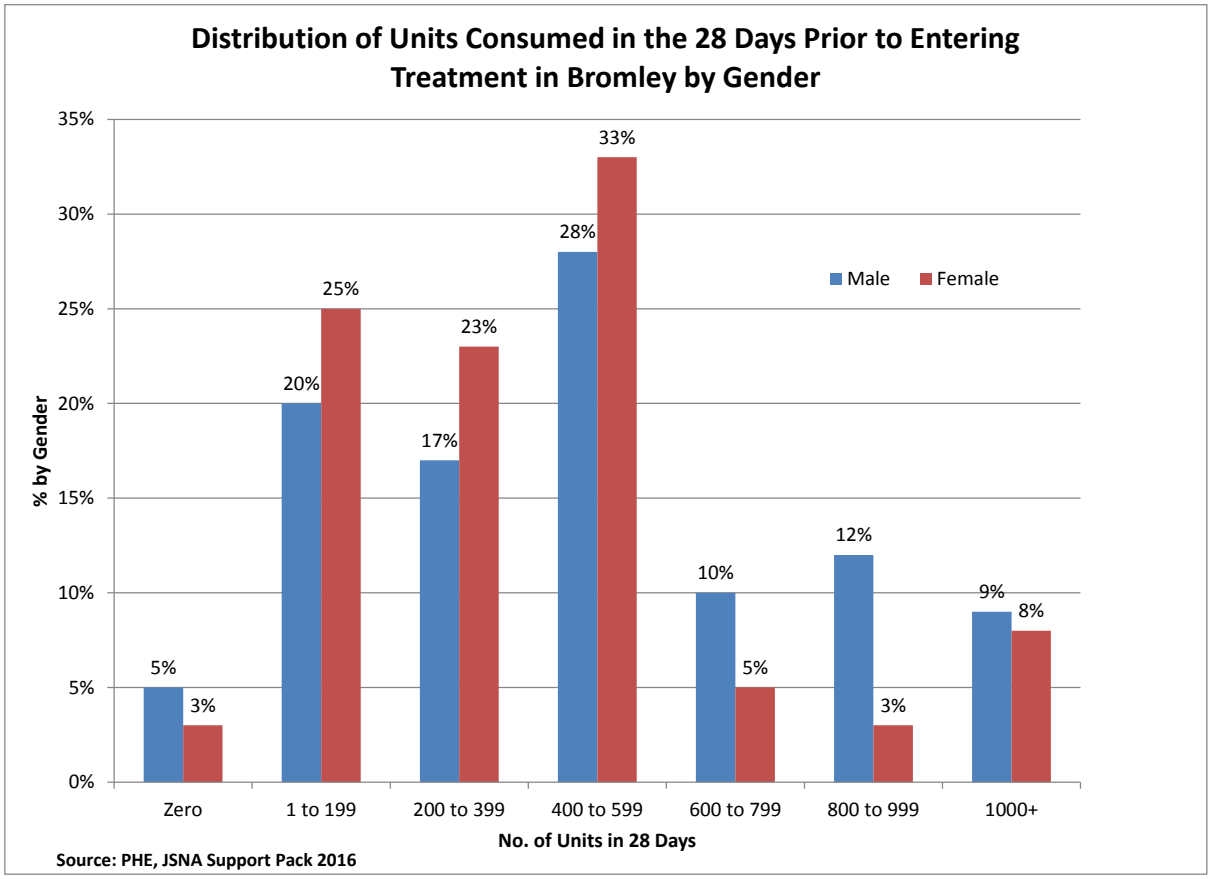
Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.

The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse, this is lower than the national figure of 20%.

Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. There is no direct correlation between regular consumption levels and dependence, but the levels of alcohol consumed by individuals in the 28 days prior to entering treatment may give some indication of the severity of dependency and potential harm among the treatment population.

Although the majority of adults cite using alcohol in the month prior to treatment, 7% nationally (and 5% locally) cite no alcohol use. This may be because they have been referred to treatment directly from the criminal justice system or they may be in treatment to maintain abstinence and prevent relapse.

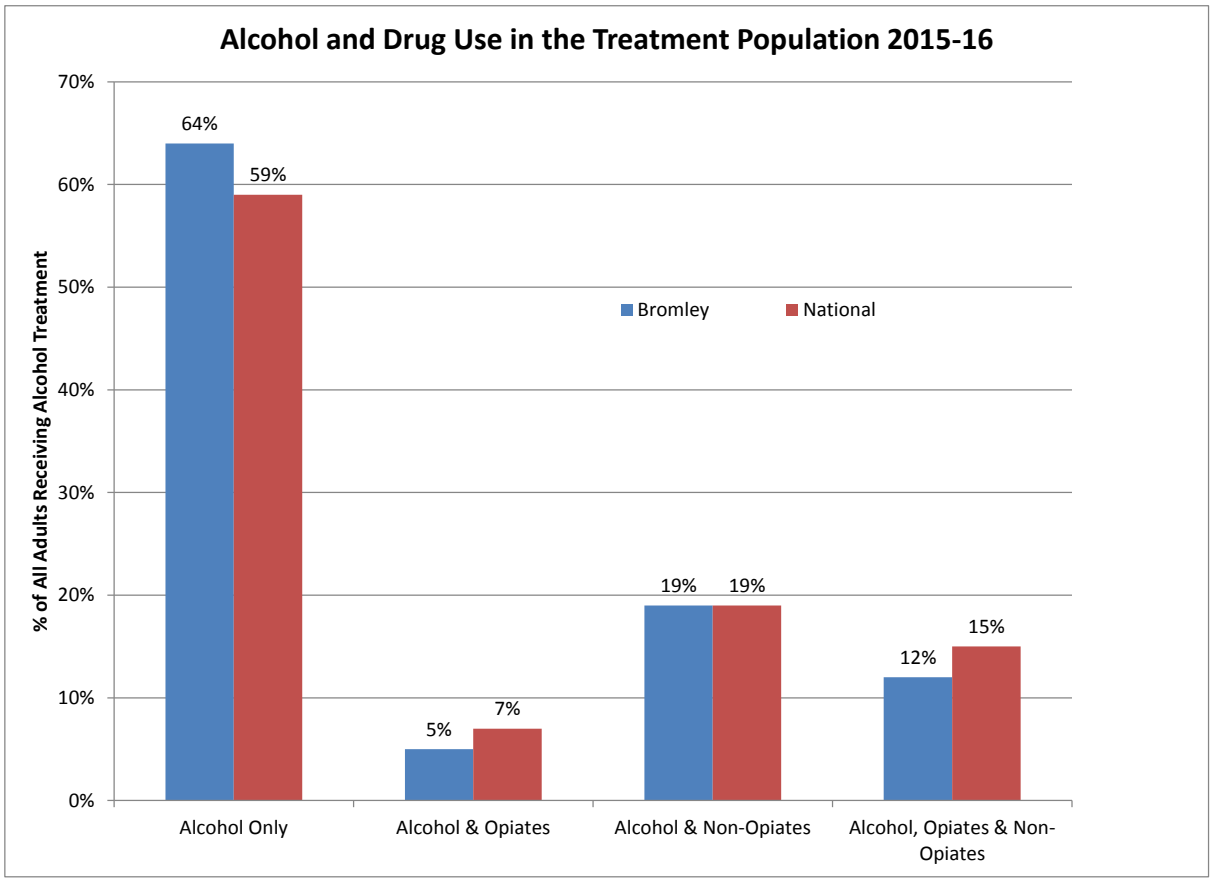
Figure 15: Alcohol Consumption Levels Prior to Treatment



In the chart above, it can be seen that a greater proportion of men than women were consuming above 600 units in the 28 day period, however, it should be remembered that women suffer harm at lower alcohol consumption levels than men.

In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.
The proportion of adults in alcohol treatment also using opiates is lower for Bromley than nationally. The most commonly cited additional drugs were crack (12%), cocaine (15%) and cannabis (11%).

Figure 16: Additional Substance Use



Recovery from alcohol dependence relies to some extent on the social, physical and financial assets of the individual; so called recovery capital.

Improving job outcomes is key to sustaining recovery. In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.

A safe, stable home environment also enables people to sustain their recovery. In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Figure 17: Employment Status

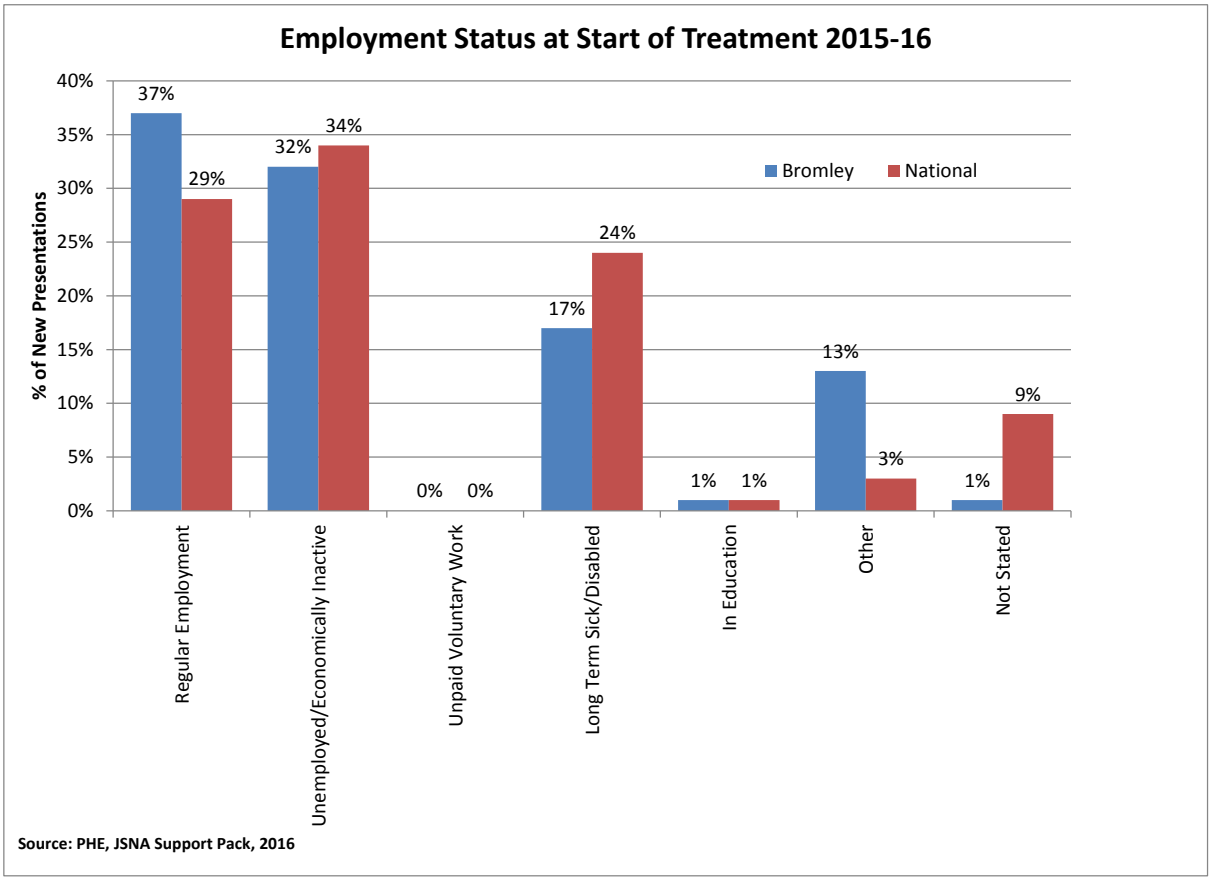
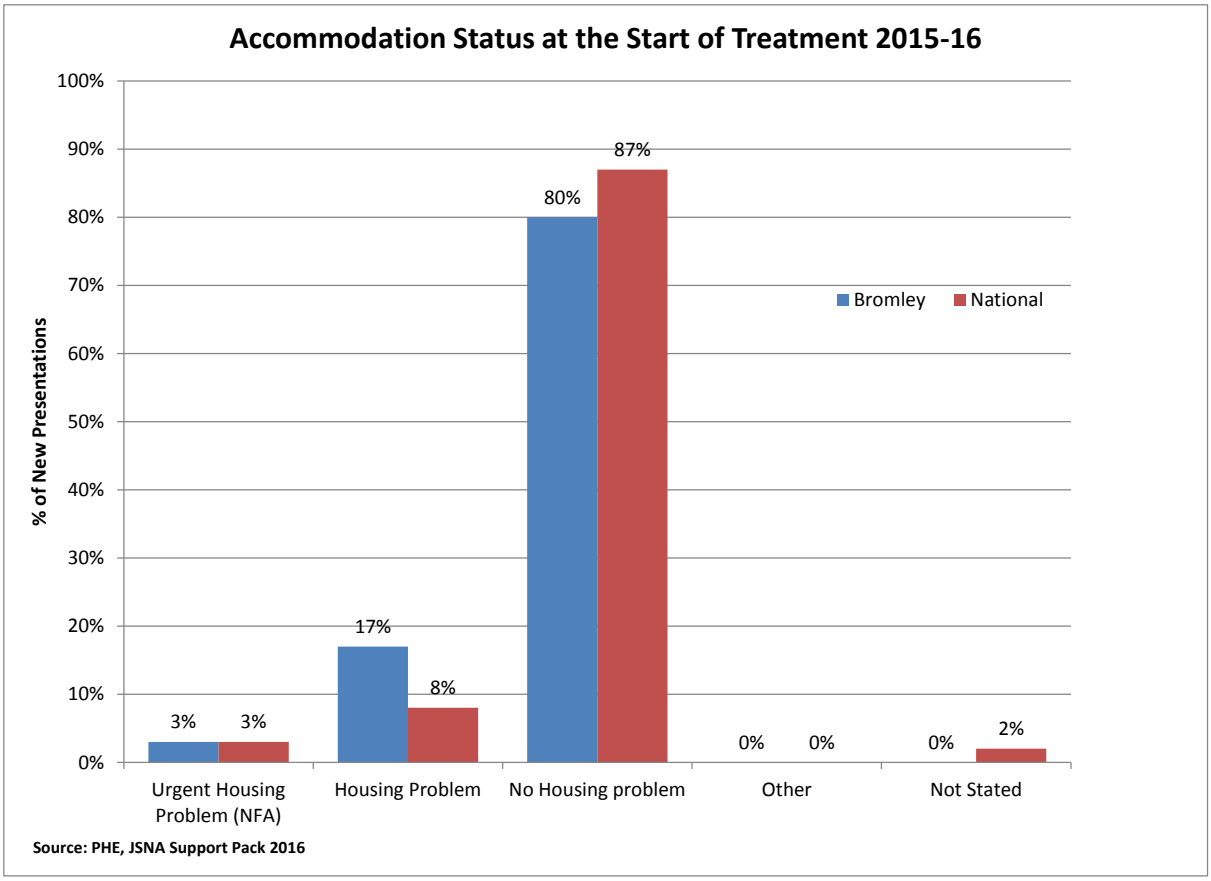


Figure 18: Housing Status



8.3.3. Adults in Non-Structured Treatment

The alcohol treatment service provides support not only for those who are dependent on alcohol, but also for individuals who have harmful levels of drinking and need support to reduce their alcohol consumption (i.e. harm reduction).

Those whose level of drinking places them at higher risk are offered an extended brief intervention over a course of twelve weeks.

Between July 2015 and June 2016, there were 74 individuals drinking at higher risk levels who received support from the service.

Of these 64.9% were male and two thirds were between 35 and 54 years of age. Many of this group have stable backgrounds, i.e. stable housing (75.7%), a stable employment situation (44.6%), and no identified safeguarding issues (51.4%). Referrals are mainly from the GP (37.8%) or self-referrals (31.1%).

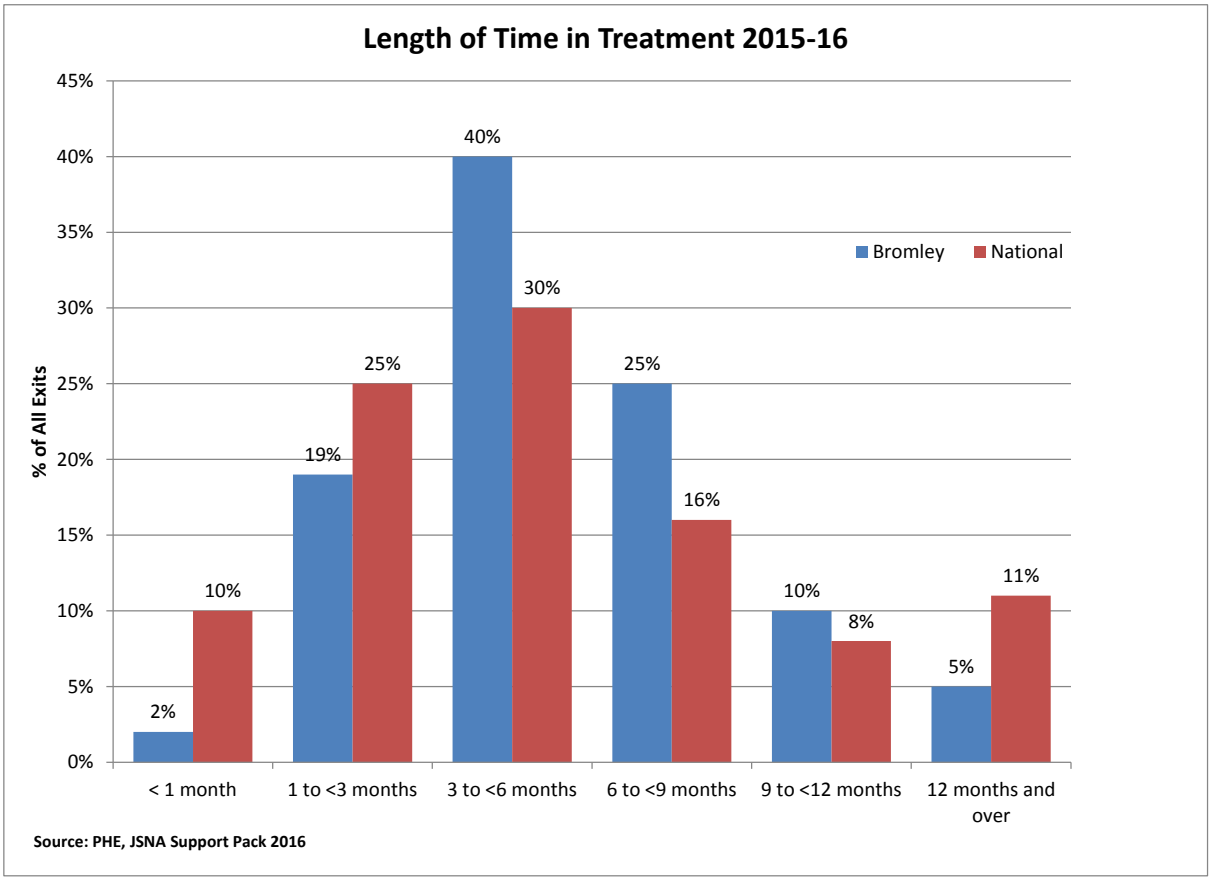
9. Treatment Outcomes in Adults

NICE Guidelines suggest that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months, while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.

The length of a typical treatment period is around six months, although nationally 11% of clients remained in treatment for at least a year. Retaining individuals for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of individuals in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

In Bromley, a higher proportion of individuals than nationally are retained in treatment for over three months, and a lower proportion are retained beyond 12 months.

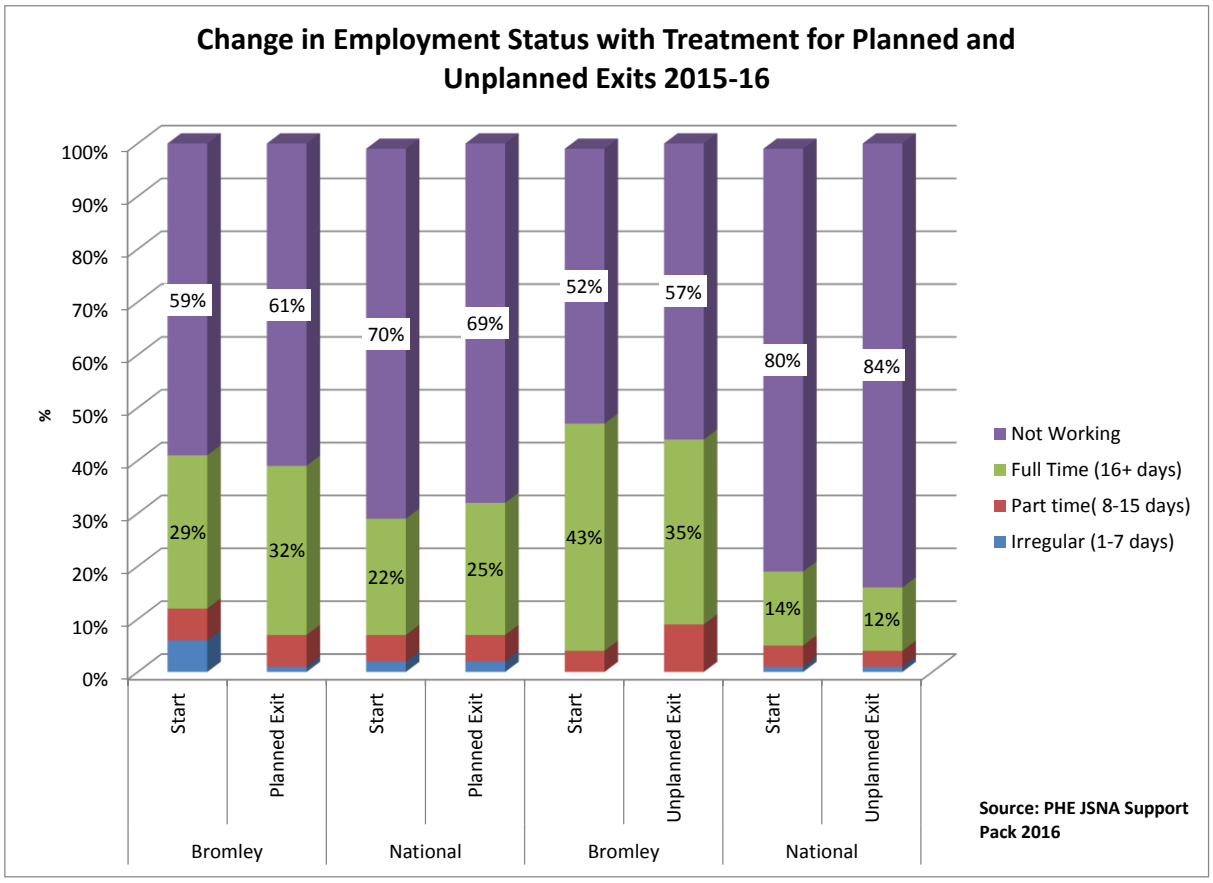
Figure 19: Length of Time in Treatment



The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within six months.
In the calendar year 2015, 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

For those still in treatment, there are a number of indicators at six month review which are predictors of continued recovery. These are rates of abstinence from alcohol, and changes in average days use, secure housing at planned exit and employment status at planned and unplanned exit.
In 2015-16, 65% of individuals reported abstinence at planned exit, as compared with 48% nationally.
There was a reduction in average drinking days from 21.7 days to 11.7 days in Bromley, compared with from 20.6 days to 12.4 days nationally.
A lower proportion of individuals (78%) no longer reported a housing need in Bromley than nationally (84%).
Although there was an improvement in the proportion of individuals working fulltime at planned treatment exit as compared with at start of treatment, there was also an increase in the percentage not working at all in Bromley. For unplanned exits, the employment status worsened between start and exit both in Bromley and nationally.

Figure 20: Change in Employment Status



10. Young People

Young people are more prone to harmful health effects from alcohol use, and misuse of alcohol can have a major impact on their education, and their long-term chances in life.

Official data for the year 2015-16 relating to alcohol and substance misuse treatment in young people is not yet available, although the numbers appear to be much lower than would be expected.

Of the 35 young people aged between 13 and 17 years treated in the Young People's Substance Misuse Service during 2015-16, 23 (65.7%) reported alcohol use in combination with other substances (34 of the 35 reported cannabis use).

Since the current Young Person's service was awarded the contract in December 2015, there has been a great deal of work to establish referral pathways to the service from children's social care, the acute hospital trust, youth offending services and mental health services, thus increasing access for young people.

11. Strategic Review

Bromley has been identified by Public Health England as a priority partnership which would benefit from support to address alcohol harm.

It was agreed at a meeting with the Head of the London Alcohol and Drugs Team that Bromley would complete Public Health England's Alcohol CLeaR Assessment Tool.

CLeaR is an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective collaborative working. It allows partnerships to **C**hallenge services, provide **Lea**dership and examine **R**esults (CLeaR).
The areas to be considered are summarised in Table 7.

Table 7 CLeaR Domains

	Domain	**Content of Sub-sections**
1	Setting the Context	Defining local priorities
2.	Leadership	Vision and governance
		Planning and commissioning
		Partnership
3.	Challenge services	Communications and social marketing
		Primary prevention (reducing availability)
		Secondary prevention (targeting those at risk)
		Tertiary prevention (treatment provision)
4.	Results	Nationally reported data
		Locally collected intelligence
		Progress against local alcohol objectives

The CLeaR tool was launched on 16th September; therefore this strategic review is just starting. It will involve discussions with all the partners involved in the prevention and management of alcohol misuse: community safety partnership representatives, licensing, trading standards, planning, housing, the clinical commissioning group, the substance misuse treatment provider, an elected member with responsibility for the alcohol, licensing, and/or community safety portfolios, representatives from primary care and the Kings College Hospital NHS Foundation trust and Oxleas NHS Foundation trust. The process will include a wider consultation with adult and children's social care, Jobcentre Plus, third sector agencies working with vulnerable groups, housing providers, schools and colleges and service users.

What this means for residents and children in Bromley

Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories. Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.

The rate of alcohol-related hospital admissions has been increasing at national, regional and local levels, but remains lower in Bromley than for London and England. The hospital admission rate for males (2,396 per 100,000 population) is almost twice the rate for females (1,361 per 100,000 population) in Bromley.
The alcohol-specific admission rate for under 18 year olds in Bromley (22.7 per 100,000 population) has been gradually decreasing over the last two years, and is comparable with the rate for London, but significantly lower than the rate for England.

Availability of alcohol in Bromley is controlled through the Licensing Act 2003 and the Council's Licensing Policy; however, this is only relevant where objections to an application are made. If no objections are made, then the Council must grant the licence. Trading Standards work to ensure that alcohol is not sold or available to under 18 year olds. There is also a programme of education on alcohol for 13 to 15 year olds.

Screening and advice on alcohol use are delivered in both primary care (for new patients and at NHS Health Checks) and secondary care (PRUH).

During 2015-16, there were 238 adults engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.

The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar.

Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.

The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse.

In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.

In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.

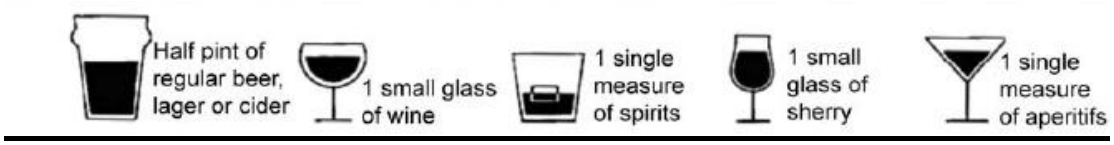
In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Bromley had a lower proportion of successful treatment completers in 2015 than the national value. 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

Fewer than expected young people have accessed the Young person's Substance Misuse Service in the last year. Of those who access the service, the majority are cannabis users, with 66% additionally using alcohol.

A strategic review of alcohol services is currently underway. Prevention, early identification and intervention will be the focus, particularly in the highest risk group (aged 40 to 69 years). There will also be an emphasis on strengthening the referral pathways.

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.

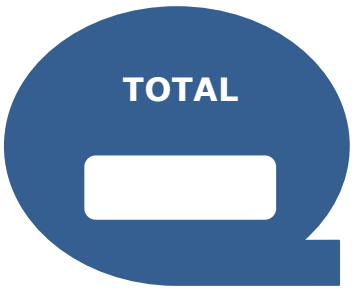
Score from AUDIT- C (other side)

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

TOTAL Score equals

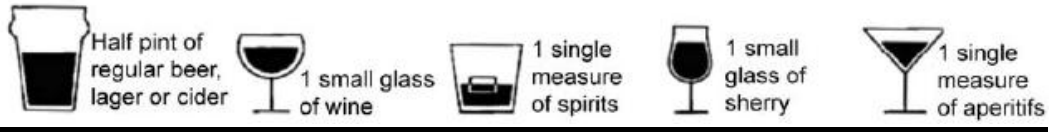


AUDIT C Score (above) +

Score of remaining questions

FAST Questionnaire

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

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