Role of nurses in alcohol screening and treatment interventions

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Abstract
Alcohol consumption can be a positive factor in many people’s social lives, but for some individuals it may cause associated harm to their health. Alcohol consumption can also place a burden on healthcare services. This article explores the trends of alcohol use, primarily in the UK, and outlines the related health effects. The author reviews the screening and brief interventions that non-specialist nurses can use, in partnership with patients, where they have concerns regarding patients’ alcohol use and its potentially harmful health effects.

Aims and intended learning outcomes
This article aims to provide information regarding alcohol use and its related harmful health effects. It discusses the burden that alcohol-related morbidity places on healthcare services, and outlines screening and brief interventions that can be delivered by non-specialist nurses. After reading this article and completing the time out activities you should be able to:

» Understand recent trends of alcohol use and related harmful health effects.
» Explain how to assess an individual’s alcohol intake and understand the process for screening people for alcohol-use disorders.
» Outline a brief intervention for people with alcohol-use disorders.
» Describe the treatment options and services available for people with alcohol-use disorders.
» Outline the aspects of care for people with alcohol-use disorders.

Introduction
Alcohol continues to be widely consumed by people across the world (World Health Organization (WHO) 2014a). It is consumed from youth through to old age, and in many social situations (Babor et al 2010). Societal use of alcohol is affected by culture, economics and social norms (Babor et al 2010), while for individuals, their experience of drinking alcohol will evoke various feelings. Some people may find the experience of drinking alcohol relaxing, sociable and enjoyable, while others may have had regretful, sorrowful or isolating experiences.

The WHO (2014a) stated that harmful use of alcohol is one of the world’s leading risk factors for disease, disability and death, and results in approximately 3.3 million deaths each year, or 6% of all deaths. While there is wide variation in the rates of alcohol consumption and alcohol-related harm between countries around the world, the burden remains significant in most countries (WHO 2014a). In the WHO European Region, rates of alcohol consumption and alcohol-attributed deaths are the highest in the world (WHO 2014a), while in 2010, the UK ranked 20th of 45 European countries that provided data on the average quantity of alcohol consumed per adult (WHO 2014b).

Nurses in all healthcare settings will encounter people whose health has been affected by alcohol use, and therefore require up-to-date knowledge to be able to provide effective support, care and treatment options.
**Trends in alcohol use**

A 2016 national survey of UK adults aged 16 years and above found that 57% drank alcohol during the week before the survey (Office for National Statistics (ONS) 2017). Using data from a 2014 national survey, Public Health England (PHE) (2016a) estimated that more than ten million adults – 25% of all adults – in England are drinking at a level that increases the risk of harm to their health. This includes 1.9 million adults – 4% of all adults – who are drinking at high-risk or very high-risk levels. The levels of alcohol risk are defined in Table 1.

Overall, the average consumption per person and the prevalence of people reporting alcohol use in the week before they were surveyed have consistently declined in the UK since a peak in 2003 (ONS 2017). In addition, alcohol use has declined among young people aged 11-15 years, and they have an increasingly negative attitude towards alcohol (Health and Social Care Information Centre 2015). However, the incidence of alcohol-related health harms, such as hospital admissions and liver disease, has increased over the same period. One reason for this is that high-risk and very high-risk drinkers, who comprise 4% of the adult population, consume more than one third of the total alcohol consumed (PHE 2016a). If increasing risk, high-risk and very high-risk drinkers are combined, they total 25% of the adult population, but consume more than three quarters of the total alcohol consumed (PHE 2016a). Thus, it is important to note that while the average quantity and frequency of alcohol consumption is declining on a population level in England, there is a subpopulation of more than ten million increasing risk, high-risk and very high-risk drinkers who consume the majority of the total alcohol intake, resulting in an increasing number of alcohol-related health harms.

**TABLE 1. Levels of alcohol risk**

<table>
<thead>
<tr>
<th>Alcohol health risk</th>
<th>Definition</th>
<th>Estimated percentage of adults in England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>Men and women who do not regularly drink more than 14 units per week</td>
<td>59%</td>
</tr>
<tr>
<td>Increasing risk</td>
<td>Men who drink more than 14 units and up to 50 units per week, and women who drink more than 14 units and up to 35 units per week</td>
<td>21%</td>
</tr>
<tr>
<td>High risk</td>
<td>Men who regularly drink more than 50-75 units per week and women who regularly drink more than 35-75 units per week</td>
<td>3%</td>
</tr>
<tr>
<td>Very high or extreme risk</td>
<td>Men and women who regularly drink more than 75 units per week</td>
<td>1%</td>
</tr>
<tr>
<td>Dependent drinking</td>
<td>People who experience three or more alcohol-related symptoms during a 12-month period. Alcohol-related symptoms as defined by the World Health Organization (2010a) include: › Craving or compulsion › Loss of control › Withdrawal symptoms › Tolerance › Neglect of other interests › Continued use despite awareness of harm</td>
<td>1%</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>Men who exceed eight units in one day and women who exceed six units in one day</td>
<td>17%</td>
</tr>
</tbody>
</table>

(Department of Health 2016, Public Health England 2016a, NHS Digital 2017a)

**Health risks associated with alcohol use**

As a result of the toxic biochemical effect of alcohol, it can affect almost every organ in the body, and is noted as a causal factor in more than 60 medical conditions, including some cancers, cardiovascular conditions, depression and liver disease (PHE 2016b). In a broad measure of the burden of alcohol-related harm in England, it was estimated that there were 1.1 million alcohol-related hospital admissions in 2015-16, which was a 4% increase on the previous year. This represents 7% of all hospital admissions in England (NHS Digital 2017b) at a cost of £3.5 billion to the NHS (PHE 2016b).

Most patients with alcohol-related health harms were male (61%), and older adults (45% were aged 55-74 years), and half of alcohol-related hospital admissions were for cardiovascular disease (NHS Digital 2017b). For hospital admissions that were wholly attributable to alcohol use, the primary causes were intoxication, withdrawal symptoms and alcohol-related cirrhosis (NHS Digital 2017b). Alcohol-related hospital admissions have doubled over the past ten years, driven by partially attributable chronic conditions, such as cardiovascular disease, cancer and unintentional injuries (PHE 2017a).

In terms of mortality, there was a 10% increase in the number of alcohol-related deaths from 2005 to 2015; in 2015 this totalled 6,813 deaths, which accounted for 1.4% of all deaths in England (NHS Digital 2017b). Of these deaths, 65% were male and 65% were caused by alcoholic liver disease (NHS Digital 2017b). Significantly, the average age of alcohol-related death was 54.3 years in 2014, compared with an average age of death from all causes of 77.6 years (PHE 2016a). Furthermore, it was estimated that there were 167,000 years of working life lost in 2015 because of alcohol use, which accounts for 16% of all working years lost that year in England (PHE 2016a).

Despite the fact that there were more than ten million increasing
risk, high-risk and very high-risk drinkers in England in 2016 (PHE 2016a), including 0.5 million dependent drinkers, the number of people who accessed treatment for an alcohol-use disorder only was 80,454 in 2016-17 (PHE 2017b). Thus, considering the overall number of people with alcohol-use disorders and alcohol-related health harms, there appears to be a low number of people accessing specialist alcohol treatment services. Healthcare practitioners, including nurses, have an important role in screening, intervening and referring people to specialist alcohol treatment services, if patients are amenable to the process. Among individuals exiting alcohol treatment services, 62% successfully completed treatment free from dependence in 2015-16 in England (PHE 2017b).

It is important for non-specialist nurses to have heightened awareness of individuals who are at increased risk of alcohol-related ill health, and to be able to have non-judgemental and collaborative conversations with people about their alcohol use. This article will discuss some of the tools that can be used to guide such conversations.

**TIME OUT 2**

Reflect on your clinical area and consider the patients you encounter. There may be patients whom you consider to be clearly affected by their alcohol use. What common presentations might you encounter? Consider the patients where this may not be obvious, for example people with hypertension, cancer or depression. Which of these individuals might benefit from a guiding conversation about their alcohol use?

**Alcohol-use disorders**

When considering alcohol-related health harms that healthcare practitioners might encounter in primary and secondary care, the International Statistical Classification of Diseases-10 Classification of Mental and Behavioural Disorders (ICD-10) (WHO 2010a) is widely used to stratify a patient’s alcohol-use disorder. In the ICD-10, there are two types of alcohol-use disorder (WHO 2010a):

- Harmful use of alcohol – a pattern of alcohol use that is causing physical and/or mental damage to health.
- Alcohol dependence – this is diagnosed when at least three of the following criteria have been present together at some time during the previous year:
  - A strong desire or sense of compulsion to consume alcohol.
  - Difficulties in controlling alcohol-taking behaviour.
  - Evidence of tolerance to alcohol.
  - A physiological withdrawal syndrome.
  - Progressive neglect of alternative pleasures or interests as a result of alcohol use.
  - Persistent use of alcohol despite clear evidence of harmful consequences.

A diagnosis of an alcohol-use disorder is a component of a comprehensive assessment that includes aetiology, severity and functioning, and contributes to a management plan, which is central to guiding patients to make informed decisions about their care (Caddock and Mynors-Wallis 2014).

**Alcohol units**

When discussing alcohol use with a patient, it is important for healthcare practitioners to understand how alcohol units are measured and calculated, because this will affect the accuracy and reliability of the screening. It is important to consider that measures of alcohol vary internationally. In the UK, alcohol is measured in units, and one unit of alcohol is 10mL or 8g of pure alcohol (NHS Choices 2018). The number of units of alcohol is calculated as follows:

\[
\text{Volume of liquid (mL) \times \frac{\text{Strength of alcohol (alcohol by volume %)}}{1,000}}
\]

The number of units in common alcoholic drinks can be identified via websites such as: www.drinkaware.co.uk

**TIME OUT 3**

Calculate the units of alcohol in the following common alcoholic drinks:

- One 568mL pint of 5% beer
- One standard 175mL glass of 14% wine

**Key points**

- While the average quantity and frequency of alcohol consumption is declining on a population level in England, there is a subpopulation of more than ten million increasing risk, high-risk and very high-risk drinkers who consume the majority of the total alcohol intake, resulting in an increasing number of alcohol-related health harms.

- Nurses in many settings are well-placed to screen patients regarding their alcohol use. There are several opportunities for screening, such as on admission to inpatient settings or initial assessments in general practice or outpatient clinics.

- Brief interventions are intended to be delivered by non-specialist healthcare practitioners as ‘short conversations aiming in a non-confrontational way to motivate individuals to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm’ (The Scottish Government 2013). There have been major reports that collectively support the efficacy and cost-effectiveness of brief interventions provided to increasing risk, high-risk and very high-risk drinkers.

**National guidelines**

After an extensive review of the evidence, the Department of Health (2016) produced the updated UK Chief Medical Officers’ Low Risk Drinking Guidelines. The guidelines were adjusted in response to evidence that the level of risk for alcohol-related harm is similar for men and women, and that alcohol use increases the risk of various illnesses, including cancers. The weekly drinking recommendations are summarised in Box 1. When discussing alcohol use with patients, it may be useful to refer to national guidelines such as these.
Screening for alcohol use

Nurses in many settings are well-placed to screen patients regarding their alcohol use. There are several opportunities for screening, such as on admission to inpatient settings or initial assessments in general practice or outpatient clinics. The aim of screening patients regarding their alcohol use is to identify and stratify low risk, increasing risk, high-risk, very high-risk and dependent drinkers. The WHO developed the gold standard Alcohol Use Disorder Identification Tool (AUDIT) (Babor et al 1989). This is a 10-item screening tool that assesses alcohol consumption, drinking behaviours and alcohol-related issues. This was subsequently refined to three questions, creating the AUDIT alcohol consumption questions (AUDIT-C) (Bush et al 1998), shown in Figure 1. The AUDIT-C is commonly used in primary care and hospital settings because of its brevity, sensitivity and specificity (Bradley et al 2007, National Institute for Health and Care Excellence (NICE) 2010).

The three AUDIT-C (Bush et al 1998) screening questions are scored by the healthcare practitioner, with a score of five or more screening positive for higher-risk drinking. For people who screen positive, the remaining AUDIT questions can be completed to differentiate increasing risk, high-risk, very high-risk and dependent drinking patterns. Using these screening questions can assist in identifying alcohol use disorders and is the first step of an intervention about alcohol use with patients.

BOX 1. UK Chief Medical Officers’ recommendations for low risk weekly drinking

These recommendations apply to adults who drink regularly or frequently - that is, most weeks. The Chief Medical Officers’ guidelines for men and women are:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units per 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 three or more days. If you have one or two heavy drinking episodes per week, you increase your risk of death from long-term illness and from accidents and injuries
- The risk of developing a range of health conditions, including cancers of the mouth, throat and breast, increases the more you drink on a regular basis
- If you wish to reduce the amount you drink, one way is to have several drink-free days per week

(Department of Health 2016)

Brief interventions

Brief interventions are intended to be delivered by non-specialist healthcare practitioners as ‘short conversations aiming in a non-confrontational way to motivate individuals to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm’ (The Scottish Government 2013). There have been major reports that collectively support the efficacy and cost-effectiveness of brief interventions provided to increasing risk, high-risk and very high-risk drinkers (Raistrick et al 2006, NICE 2010, WHO 2010b, Kaner et al 2018). The supporting research demonstrates that individuals who have engaged with brief interventions are more likely to be drinking less alcohol over a 12-month period compared with control subjects (Raistrick et al 2006, NICE 2010, WHO 2010b, Kaner et al 2018).

In practice, healthcare practitioners engage the patient, introduce the topic and ask permission to complete an alcohol screen. For example: ‘It can be surprising how even small quantities of alcohol can affect a person’s health. Would it be okay to discuss your alcohol use and consider if this may be relevant for you?’ or ‘We routinely ask everyone who attends some general lifestyle questions, including questions about alcohol. Is it okay if I ask you about that?’

If the patient consents, the healthcare practitioner should complete the screening questions. If the patient is an increasing risk, high-risk or very high-risk drinker the healthcare practitioner should follow the screening with a brief intervention. A brief intervention is not targeted at dependent drinkers, who instead should be referred to local specialist alcohol services. In its simplest form, a brief intervention comprises (PHE 2017c):

- Asking the patient the AUDIT-C questions and scoring their answers.
- Providing personalised feedback to the patient about their AUDIT-C score and health risk, as shown in Figure 1.
- Providing information about harm and the benefit of reducing alcohol intake to patients who drink above low-risk levels but are not dependent on alcohol. This information can be given verbally, in writing and through websites or mobile phone applications.

Healthcare practitioners can access free online training in screening and brief interventions via a PHE learning package at: www.alcohollearningcentre.org.uk/eLearning/IBA

Discussing alcohol use with patients

Nurses are well placed to collaborate with patients and potentially influence behaviour change. The non-judgemental and collaborative style of conversation used to provide a brief intervention is complemented by motivational interviewing (WHO 2017).

Motivational interviewing is defined as ‘a collaborative conversation style for strengthening a person’s own motivation and commitment to change’ (Miller and Rollnick 2013). When undertaking motivational interviewing, Miller and Rollnick (2013) emphasised the importance of engaging the patient in a dialogue to explore their thoughts and feelings about alcohol use and any reasons they may have for changing their drinking patterns. It is important to avoid confrontation, judgement or criticism during the conversation, and instead to focus on the patient’s own motivations and goals for change.
of patient autonomy in the process of change, and that healthcare practitioners can guide patients through a conversation that aims to explore the person’s own reasons for change. It is important that this conversation is conducted in a non-judgemental and non-discriminatory manner, which should be in line with nurses’ professional standards and code of conduct, and is a partnership approach where the patient’s views are respected.

Miller and Rollnick (2013) outlined the core communication skills required in motivational interviewing, including:

» Asking open questions – these cannot be answered with ‘yes’ or ‘no’ and are intended to elicit longer, more detailed answers. For example, ‘Could you explain how you feel about your alcohol use?’

» Affirming – recognising and commenting on the patient’s strengths, abilities, good intentions and efforts. For example, ‘You have good insight about your situation’.

» Reflective listening – making statements that reflect the patient’s meaning and demonstrate empathy and engagement. For example, ‘You seem to be concerned about the effect of alcohol on your health’.

» Summarising – giving several condensed reflections about what a person has been saying. For example, ‘You said that you still enjoy drinking alcohol and that you also feel you’ve been drinking too much recently. You would like to cut down your alcohol use as you recognise this may be a risk to your health. Have I missed anything?’

In the context of a brief intervention, if the conversation has explored any concerns the patient has regarding their alcohol use, it is important to follow this up by offering treatment options and ongoing support. Other aids to promote information retention and processing, such as leaflets or links to websites and mobile phone applications about alcohol units, alcohol-related health risks or specialist alcohol treatment services, can support patients to reflect on the conversation and decide whether they wish to make any further plans for treatment.

### Treatment options for alcohol-use disorders

#### Alcohol withdrawal

Some people who stop consuming alcohol abruptly will experience alcohol withdrawal syndrome (NICE 2017). Patients who are dependent on alcohol and are admitted to any inpatient setting are at particular risk of alcohol withdrawal and should be assessed for any symptoms of this. Potential symptoms include generalised hyperactivity, anxiety, tremor, sweating, nausea, retching, tachycardia, hypertension and mild pyrexia (NICE 2017). Some patients may experience seizures, and one uncommon effect of withdrawal is delirium tremens, which is characterised by severe alcoholic withdrawal symptoms and profound confusion, delusions and hallucinations (NICE 2017). Severe withdrawal symptoms, in particular seizures and delirium tremens, can be life-threatening. The risk of death is reduced for patients who receive adequate pharmacological treatment and medical support (Trevisan et al 1998).

NICE (2017) guidelines consider the revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) (Sullivan et al 1989) to be the most appropriate tool to measure alcohol withdrawal symptoms. This scale measures ten symptoms of alcohol withdrawal, with each item being rated numerically by the healthcare practitioner. The scoring can be repeated as often as necessary; in practice it is recommended that this is undertaken every two hours and should take less than two minutes (Sullivan et al 1989). The total score provides an indicator of mild, moderate or severe withdrawal symptoms, and this guides the healthcare practitioner on the pharmacotherapy required to treat the symptoms.

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Typically, the recommended pharmacological treatment includes benzodiazepines, which have significant evidence of managing withdrawal symptoms, alongside vitamin B supplementation as prophylaxis for alcohol-related brain disorders, and supportive care (NICE 2017). Patients who experience alcohol-related withdrawal symptoms in inpatient settings should be referred to specialist alcohol treatment services, where available.

Alcohol care teams
In inpatient settings, it is recommended that there is an alcohol care team or alcohol liaison service to provide comprehensive and specialist care for patients with alcohol-use disorders (PHE 2014). From a patient perspective, the role of the alcohol care team is to provide specialist alcohol assessment and counselling, contribute to multidisciplinary care, assist in alcohol withdrawal management, liaise with community alcohol services and other involved agencies, liaise with relatives of patients, refer to specialist alcohol services, and contribute to discharge planning (PHE 2014).

Community alcohol services
There are several community support options for people who require assistance with reducing or ceasing their alcohol use. Community alcohol services commonly offer:
- Assessment and engagement.
- Counselling and group support, for example harm reduction, relapse prevention and abstinence support.
- Peer recovery support services – these involve people in recovery who are trained to provide support and assist others to initiate and maintain recovery.
- Support with social issues, such as housing, finances, parenting, work and occupational training.
- Pharmacotherapy, for example medicines that aid relapse prevention.
- Community detoxification – medically-assisted alcohol withdrawal.
- Onward referral to specialist alcohol inpatient services such as inpatient detoxification or residential rehabilitation.

Peer recovery support is an essential component of alcohol treatment services. It involves empathic support through shared experiences, and increases a person’s ‘recovery capital’ (the resources necessary to begin and maintain recovery) (Substance Abuse and Mental Health Services Administration 2017). The largest peer recovery support service worldwide is Alcoholics Anonymous, often known as ‘AA’, which offers support to people who want to stop drinking by sharing experiences with each other; the primary purpose is to stay sober and support others to achieve sobriety (Alcoholics Anonymous 2018).

There is evidence that supports the effectiveness of specialist alcohol treatment services; however, aside from peer recovery support, specialist alcohol treatment services are expensive to implement and maintain (Babor et al 2010). Furthermore, the benefits of these services are limited to the small proportion of the population that engages with treatment (Babor et al 2010).

Reduction of the burden of alcohol-use disorders
For non-specialist nurses, screening, brief interventions and treatments for alcohol-use disorders are the most tangible components of the policies available to reduce alcohol-related harm. Governments are best placed to review and implement a combination of alcohol policies for their population. The strongest evidence is for policies that restrict the affordability, availability and accessibility of alcohol, as well as drink-driving deterrence (Babor et al 2010). The evidence suggests that these are highly cost-effective interventions that are feasible to implement and have a significant effect on reducing the burden of alcohol-related harm (WHO 2013). With favourable political will, and a high level of commitment, planning and community action, it will be possible to reduce the burden of alcohol-related health harms.

Conclusion
The WHO European Region has the highest per capita alcohol consumption and alcohol-related harms in the world. In the UK, there has been a decline in the per capita consumption of alcohol by adults over the past decade; however, there has been a rise in alcohol-related health harms during the same period. These harms mainly occur in increasing risk, high-risk and very high-risk drinkers, who comprise 25% of the adult population in England (PHE 2016a).

Nurses are well-placed to provide screening and brief interventions to drinkers at risk of related health harms. Screening for alcohol use can be enhanced by having an awareness of higher-risk populations, alcohol units and national guidelines, and being familiar with a specific screening tool. A brief intervention, which involves a short conversation with a patient who has screened positive for increasing risk, high-risk or very high-risk drinking, can lead to reductions in alcohol use. The brief intervention should be a non-confrontational, empathic conversation that motivates the individual to think about their drinking behaviour, potential health harms and the benefits of reducing alcohol intake. Nurses should also refer people dependent on alcohol to specialist treatment services.

Overarching the work of healthcare staff, it is the responsibility of governments to create policies to alleviate the burden of alcohol-related harm; collectively it is possible to reduce this burden.

TIME OUT 6
Identify the services available in your local area for patients with alcohol-use disorders that you could refer them to. If you have not done so already, contact these services and enquire what support they can offer to patients. What methods of referral does the service accept?

TIME OUT 7
Consider how the nurse’s role in alcohol screening and treatment interventions relates to The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing and Midwifery Council 2015) or, for non-UK readers, the requirements of your regulatory body.

TIME OUT 8
Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account
Alcohol screening and treatment
TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Which World Health Organization region has the highest alcohol consumption?
   a) Western Pacific region  [ ]
   b) European region  [ ]
   c) South-East Asia region  [ ]
   d) Eastern Mediterranean region  [ ]

2. How many units of alcohol would a man classified as drinking at a 'high-risk' level consume per week?
   a) Up to 14 units  [ ]
   b) 14-50 units  [ ]
   c) 50-75 units  [ ]
   d) More than 75 units  [ ]

3. Which statement is true?
   a) Alcohol use has declined but the incidence of alcohol-related health harms has increased in the UK  [ ]
   b) Young people have an increasingly positive attitude towards alcohol  [ ]
   c) Alcohol use has increased but the incidence of alcohol-related health harms has declined in the UK  [ ]
   d) The majority of the UK population are high-risk or very high-risk drinkers  [ ]

4. Alcohol use has been noted as a causal factor in which of the following conditions?
   a) Cardiovascular conditions  [ ]
   b) Depression  [ ]
   c) Liver disease  [ ]
   d) All of the above  [ ]

5. The two types of alcohol-use disorder in the International Statistical Classification of Diseases-10 Classification of Mental and Behavioural Disorders (ICD-10) are:
   a) Binge drinking and addiction  [ ]
   b) Harmful use of alcohol and alcohol dependence  [ ]
   c) Tolerance and intolerance of alcohol  [ ]
   d) Continual and intermittent drinking  [ ]

6. How are the number of units of alcohol calculated?
   a) Volume of liquid (mL) divided by strength of alcohol (alcohol by volume %), divided by 1,000  [ ]
   b) Number of grams of pure alcohol divided by strength of alcohol (alcohol by volume %), multiplied by 1,000  [ ]
   c) Volume of liquid (mL) multiplied by strength of alcohol (alcohol by volume %), divided by 1,000  [ ]
   d) Number of grams of pure alcohol multiplied by strength of alcohol (alcohol by volume %), divided by 1,000  [ ]

7. The Department of Health low-risk weekly drinking guidelines recommend:
   a) Drinking more than 14 units of alcohol per week  [ ]
   b) Focusing drinking on one day per week  [ ]
   c) Having no drink-free days each week  [ ]
   d) Spreading drinking evenly over three or more days  [ ]

8. What does a brief intervention entail?
   a) Using the Alcohol Use Disorder Identification Tool (AUDIT) and scoring the patient’s answers  [ ]
   b) Providing personalised feedback to the patient about their AUDIT-C score and health risk  [ ]
   c) Providing information about alcohol-related harms and the benefits of reducing alcohol consumption to patients who drink above low-risk levels, but are not dependent on alcohol  [ ]
   d) All of the above  [ ]

9. Peer recovery support services provide:
   a) Empathic support through shared experiences  [ ]
   b) Medicines that aid relapse prevention  [ ]
   c) Onward referral to specialist alcohol inpatient services such as inpatient detoxification or residential rehabilitation  [ ]
   d) Medically-assisted alcohol withdrawal  [ ]

10. Which group of medicines is recommended in the pharmacological management of alcohol withdrawal symptoms?
   a) Tricyclic antidepressants  [ ]
   b) Statins  [ ]
   c) Benzodiazepines  [ ]
   d) Beta blockers  [ ]

This activity has taken me minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent  [ ] Good  [ ] Satisfactory  [ ] Unsatisfactory  [ ] Poor  [ ]

As a result of this I intend to:  

How to complete this quiz
This multiple-choice quiz will help you to test your knowledge. It comprises ten questions that are broadly linked to the CPD article. There is one correct answer to each question.

» You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.

» You might like to read the article before trying the questions.

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This multiple-choice quiz was compiled by Alex Bainbridge

The answers to this multiple-choice quiz are:

1. d 2. d 3. a 4. d 5. b 6. c