Drug Facts: Alcohol

AKA: *booze, bevvie, juice, sauce*, alcopops, beer, wines, spirits. There are numerous forms of alcohol. The alcohol found in alcoholic beverages is ethyl alcohol (ethanol). Other forms include methyl alcohol (methanol) which is highly toxic.

Source: Alcohol is produced as yeast metabolizes sugar. Grains, fruit or vegetables are fermented and the resulting liquid drunk, or the alcohol extracted by distillation for further processing.

Alcohol is sold via licensed outlets such as supermarkets, off licenses and bars.it is also brewed at home and in custodial settings.

Appearance: Ethanol is a clear liquid with a distinctive smell. Vodka is effectively ethanol further diluted with water and no other additives. Other drinks will contain colour and flavour from the original source material, the brewing and fermenting process or added after fermentation. For example wine colour comes from the skin of grapes, the colour of whiskey is from the material through which it is filtered and barrels used for fermentation and alcopops are the result of sugar, colour and flavours added post-fermentation.

Costs: Alcoholic drinks range in price from under £1 for cheap lagers through to many thousands for expensive wine. In Scotland a “minimum unit price” of 50p per unit was introduced to address the provision of super strength lagers and ciders.

Strength: Alcohol strength is measured as ABV (alcohol by volume), the percentage of alcohol in a drink. A 1litre bottle (1000ml) at 40% ABV contains 400ml of ethanol and 600ml of water and other additives.

The older term “proof” is no longer used in the UK. It was based on the fact that drinks of around 50% ABV would ignite and burn away. This was the Proof – that the drinks had an ABV of 50% or more. This would be referred to as 100 proof. Drinks with less than 50% would not ignite – underproof.

One litre bottle = 1000ml
ABV = 40%

60% water etc 600ml

40% alcohol = 400ml
One unit = 10ml
400ml = 40 units

Alcohol is also counted in UNITS. A UNIT of alcohol is 10ml of pure ethanol or 7g. Some drink producers state the number of units on the packaging but this is not always the case.

When trying to calculate units there are a number of tools and apps such as “Drink Wheel,” and Unit Counter tools to help.

The easiest way to work out the units in a drink is:

volume (in litres) x strength (the ABV:
e.g. a bottle of wine: 0 75 (litres) x 13 (ABV) = 9.75 units

In practice the number of units quoted in a drink is an approximate figure based on the approximate size of the drink and the ABV, usually rounded up. The figures below look at the most common drinks. Where a person is pouring or mixing their own drinks, it becomes much harder to accurately count units

Product	ABV(%)	Volume	Units (approx)
Wine	12%	Standard Glass (125mls)	1.5 Units
	13%	Bottle (750mls)	10 Units
Spirits	37.5%	25ml (small single)	.9 Unit
	40%	35ml (large single)	1.4 Units
Alcopops	5.5%	275ml	1.5 Units
Beer	3% 5% 9%	1 Pint 1 Pint 440ml can	2 Units 2.8 Units 4 Units
Cider	5% 8.5%	1 Pint 275ml bottle 2 litre bottle	2.8 Units 2.3 Units 17 Units

Purity: Professionally produced drinks are not simply alcohol + flavour. They can contain a number of other chemicals some of which may be psychoactive and others which could cause adverse reactions. Some people are, for example, intolerant of tannins found in some wines and spirits, and the congeners which give dark spirits their flavour and colour can be unpleasant too.

Chemicals such as GHB naturally occur in some wines.

Illicitly produced alcohol may contain more dangerous contaminants. Illicity brewed and bootleg alcohol may contain dangerously high levels of methanol which breaks down to form the toxin formaldehyde. Buying bootleg alcohol or badly-made hooch can be dangerous and potentially life-threatening.

Safe(r) Drinking Limits:

There aren't really any safe drinking levels and medical consensus is that for most of the population all alcohol use is damaging, and the safest approach is simply not to drink.

However levels of drinking are associated with different levels of risk and the Government guidance is for those who do drink to reduce risk by drinking at levels associated with a lower level of harm.

In the past drinking levels were presented as number of units per week with different levels for men and women. This saw people who may have been drinking within the "safe" weekly levels but were drinking harmful amounts over a small number of days. To address the safer level guidance is presented in terms of units per day and per week. Medical evidence no longer supports the different levels for men and women so this difference has been removed from the guidance.

So the current drink levels for men and women are:

2-3 units a day or less:	14-21 units/week	no significant risks
3-5 units per day:	21-35 units/week	moderate risk
5+ per day	35+/week	high risk

Patterns of use: Both constant drinking and binge drinking are unhealthy. It is safer to aim for at least two alcohol-free days per week; a person who is finding it difficult to achieve this may want to seek assistance to moderate their drinking.

Binge drinking (more than eight units for men and six units for women is a UK interpretation) is associated with heart and circulatory problems such as high blood pressure.

The Liver and Units of Alcohol:

Ethanol is broken down by the liver in several stages using enzymes.

Ethanol >>> *alcohol dehydrogenase (ADH)* >>> acetaldehyde
acetaldehyde >>> *aldehyde dehydrogenase (ALDH)* >>> acetic acid

Acetaldehyde is highly toxic and responsible for some of the unpleasant symptoms during and after drinking. Some people can't produce the enzyme ALDH so can't break down acetaldehyde making them "alcohol intolerant."

The liver of an average healthy male can remove approximately one unit of alcohol from the blood stream. While this alcohol is being metabolised, the rest remains in circulation. This means that if, between 8 and 12pm a person drank two bottles of wine, it would take at least twenty hours for all the alcohol to be metabolised out. By the time we factor in the time for alcohol to be absorbed, when drinking commenced and ended and a reduction in liver enzymes needed to break down alcohol the length of time will in practice be longer for a lot of people.

Drinkers may well have excessive levels of alcohol in the blood-stream the day after a heavy nights drinking.

Women, people with impaired liver function and people of small build will generally metabolise alcohol more slowly, get drunk faster and sober up more slowly. Women may also find that tolerance to alcohol decreases during just prior to the start of menstruation.

Methods of Use: Alcohol is usually drunk; it is also eaten and used in cooking. When heated, most alcohol is evaporated away; however, alcohol can be eaten in cold products such as jelly.

Alcohol is also sometimes used in other ways such as via snorting it, injecting it or attempting to absorb it via the eye. These methods are invariable painful, and while young people may attempt to snort alcohol or eyeball it, such efforts are rarely pursued. Recently, companies have tried to promote 'alcohol with oxygen' a machine that allows alcohol to be breathed in via a face mask and absorbed in the lungs. Such a method means that alcohol initially bypasses the stomach and the liver, so

gets intoxicated more quickly. However, such equipment in bars falls foul of licensing laws and so has not become more widespread.

Alcohol can be absorbed through other mucous membranes – such as an alcohol enema – but this is (a) not that common (b) messy (c) can cause overdose.

Injecting alcohol is quite unusual. It is most often injectors habituated on injecting processes who may attempt this painful activity.

Effects: Onset of alcohol will depend on the strength of the drink, previous food intake, other substances used and the user's general build and metabolism.

Alcohol is primarily a depressant drug - making the person drowsier and moving them towards sleep and unconsciousness. It does this by mimicking the brain chemical **GABA,** which reduces electrical signals in the brain and body.

However, early on it can act as a euphoriant, elevating levels of the brain chemicals serotonin and dopamine. This makes the person more animated, lively and talkative. As more alcohol is taken in, the depressant effects can become more marked as reactions and muscular control are impeded.

At higher doses, the drinker may become drowsier, with slurred speech, difficulty standing and stupor. Finally, the person may become unconscious.

People experience a wide range of different moods when drinking; some people describe feeling happier, while others become less happy and more withdrawn; others may become aggressive. To some extent, alcohol may act as a mood amplifier, exacerbating a mood or state that was already there. Others would argue that alcohol reveals underlying personality traits, and the rest argue that different drinks affect people in different ways.

Alcohol can also cause nausea, vomiting, excessive urination, impaired memory and judgement.

Many alcohol users will be familiar with the 'hangover' which is a symptom of excessive alcohol use. The symptoms tend to include nausea, aches in the lower back, headaches, sensitivity to light and sound and a general sense of feeling unwell. These symptoms result from high levels of dehydration, brain chemistry adjusting to absence of alcohol, irritation of stomach, swelling of the liver and removal of toxins from the blood.

Health Implications: There is no commonly used drug which is more toxic to more parts of the body than alcohol. Excessive use of alcohol can have a devastating impact on health.

Alcohol-related harm could directly affect the user or other people indirectly affected. Harm takes place in the short, medium and long term.

Short term risks:

Risk taking behaviour: because alcohol disinhibits it can lead to impaired decision making This could lead to other risky behaviours including episodes of unplanned drug taking, unsafe sex, fights, offending or other risk taking. It also increase the risk of lapse for people endeavouring to abstain from drug use.

Alcohol poisoning: Drinking too much can also lead to alcohol poisoning, which can be fatal, and according to the National Drugs Helpline, over 1,000 people under the age of 15 are admitted to hospital each year with alcoholic poisoning and all require emergency treatment.

The risks of dangerous alcohol overdose is increased by mixing alcohol with other drugs. Key risks come from mixing alcohol with stimulants (such as cocaine) which allow people to drink larger amounts in the short term, but leave the person dangerously intoxicated once stimulants have worn off. The combination forms a new psychoactive compound ***cocaethylene*** which is longer acting than cocaine, but more liver and cardio-toxic.

The other key risks come from mixing alcohol with sedating drugs, especially opiates and benzodiazepines. The combined effect of alcohol with these drugs significantly increases the risk of fatality.

Binge drinking can also lead to irregular heartbeat and acute pancreatitis.

Medium term:

Excessive alcohol use in the medium term is associated with:

- Gastro-intestinal problems: gastritis, IBD, stomach ulcers
- High blood pressure, weight gain,
- Skin problems
- Fatty liver or inflamed liver (alcoholic hepatitis)
- Kidney and bladder damage
- depression

Long term

Long term excessive alcohol use is associated with significant damage to many organs:

- Cancers of the mouth, throat, stomach and bowel
- Pancreatic diseases
- Cirrhosis of the liver and liver cancer
- Oesophageal varices (varicosed veins in the throat, which can burst)
- Neurological damage
- Muscle damage
- Stroke
- Heart disease
- Organic brain damage

Alcohol is directly associated with between 50-70,000 deaths per year.

Alcohol and pregnancy: Alcohol use during pregnancy can damage the foetus and this leads to a range of physical and developmental issues referred to by the umbrella term Foetal Alcohol Spectrum Disorder.

For managed, women who are non-dependent drinkers who are pregnant or seeking to become pregnant, the (conflicted) advice is to abstain from alcohol or limit it to one to two units per week to minimise risk of harm.

For women with alcohol problems including dependency, discussion about effective contraception is important. Heavy alcohol use can mask early indicators of pregnancy but once a pregnancy is identified it is important to support engagement with alcohol and midwifery services so risks can be minimised.

Indirect risks: Alcohol is also a key factor in many social and industrial accidents, road traffic accidents and homicides. It is a significant aggravating factor in assaults and domestic violence and a feature of much offending.

Alcohol and Mental Health:

Alcohol has a complex relationship with mental wellbeing.

Alcohol and depression: In the short-term alcohol elevates dopamine and serotonin and so can alleviate symptoms of depression. Some people may end up using alcohol to self-medicate for existing low mood.

As alcohol mimics GABA it can increase relaxation and drowsiness and so gets used to reduce anxiety and help with sleep.

With longer term and heavier use, alcohol will start to damage stomach and guts which can inhibit the production of serotonin and dopamine. These brain chemicals are being used up faster than they can be replenished and diet may suffer as money is spent on alcohol rather than quality food. These factors can result in lower levels of dopamine and serotonin causing or increasing depression.

The risk is now that alcohol use will be used in the first instance to help the person feel happier (which won't work as alcohol can't replace the missing dopamine/serotonin) and then just to blank out the low mood.

In other words early drinking may have been to feel better and later drinking is just not to feel. Or early drinking was for pleasure and later drinking to avoid "displeasure."

Too frequently antidepressants are prescribed to people drinking excessively and experiencing depression in the hope or mistaken belief that these will alleviate depression and therefore positively impact on alcohol use. In truth, beyond placebo effect such an intervention is unlikely to be effective. Cessation of alcohol, healing of the gastro-intestinal track, diet improvement and other holistic interventions will be essential at which point antidepressants could be a useful adjunct.

Alcohol and anxiety: Alcohol was also mimicking the effects of GABA and with excessive drinking the brain starts to adapt, over-producing GABA's "opposite

number" Glutamate, and producing less GABA. These higher levels of glutamate and lower levels of GABA can increase anxiety and stress and so again, alcohol use which have once been to help manage anxiety now increases to manage the anxiety resulting from excess alcohol use.

Alcohol and psychosis: Alcohol causes dopamine and serotonin levels to go up and can interfere with anti-psychotic medications so drinking for people with a psychotic disorder can cause more symptoms, disengagement from medication and disinhibited behaviour which increases risk of people acting on impulse.

This also applies where people are having suicidal thoughts. Alcohol can worsen depression, increasing risk of suicidal thoughts. And alcohol can disinhibit, increasing the risk that the person will act on these thoughts.

Heavy long term use of alcohol can cause alcohol-induced psychosis, a state of delusion, panic and disordered thinking which increased with alcohol consumption and should start to reduce as alcohol use is reduced.

Long term excessive drinking can cause organic brain damage under the umbrella term "Alcohol-related Brain Damage." This can include dementia, impulsive behaviours, memory and balance problems. The most commonly referred to diagnoses are Wernicke's Encephalopathy and Korsakoff's Psychosis.

Alcohol and Dependency:

Alcohol use can lead to physical and psychological dependency. Alcohol dependency is often not assessed properly as there are some common erroneous assumptions such as that dependent drinkers will go into withdrawal without a drink, or that they will be drinking in the morning or drinking daily. Not all dependent drinkers are physically dependent. The clinical definition of **Alcohol Use Disorder** was revised in DSM V (the Diagnostic and Statistical Manual used extensively by American Psychiatrists) and changed from having separate "alcohol misuse" and "alcohol dependency" categories. You can read more about how it changed here here: https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-use-disorder-comparison-between-dsm

Rather than just thinking about physical dependency we are looking at a collection of indicators including:

- Difficulty with control
- Evidence of harm (physical, psychological, social, situational)
- Escalation
- Physical withdrawal symptoms
- Psychological withdrawal symptoms
- Alcohol as a priority
- Individual or others expressing concern

UK Clinicians will often use a short standardised screening tool such as **AUDIT** https://auditscreen.org/ to assess for alcohol dependency but failure to interpret AUDIT correctly or an unwillingness for a person to answer questions openly can mean problematic or dependent drinking can go unidentified.

Using a drink-diary and unit counting to build motivation and to identify dependency issues:

Drink diaries are tools used to help assess, monitor and promote change in drinking behaviours. They are sometimes derided as being of no use with heavy drinkers and only really useful with moderate and excessive drinkers who can control their drinking but a well completed drink diary can be a very useful tool in all aspects of drink management.

There are simple drink diaries, paper versions, online ones and apps. However there are some specific things that we should be looking for in a good drink diary:

Date	What I drank	How much (units)	Time/Place who with	How I felt before	How I felt during	How I felt after	Other notes

Drink diary and the cycle of change:

Lots of people starting to engage with a service are at best contemplative about addressing their drinking. Many aren't seriously contemplating change – they may have been referred by someone else and don't see their drink as a problem.

- A willingness to start to complete a drink diary is a very first step to exploring the issue of "*do I drink too much*." Which is the start of a journey towards contemplation.
- Some people will already subconsciously be aware that they are drinking a lot; by noting it down and adding it up they can make this much more concrete – the "*wow, that's a lot and I didn't think it was that much*" can help recognise unhealthy drinking
- In terms of pros and cons work the before/during/after sections can help unpick some of the conflicted feelings around alcohol. I may say I help to drink with low mood but I can see from my diary that I am often low after drinking which helps me revisit pros and cons of drinking.

The language of drinking pathology is deeply unhelpful and creates barriers to change. We talk variously about:
- alcohol dependency
- alcohol use disorder
- alcohol addiction
- alcoholism

Each of these have different meanings from professionals, people who drink and wider society. And they each bring with them their own barriers. So people may for example say "*I'm not an alcoholic*." This is in part because the term is laden with social meaning (down and out, strong lager, drinking in the park, red nose), treatment meanings (12 steps, higher powers, addiction, disease) and consequential meaning (can never have another drink.) So the person may refuse the label and in turn refuse to acknowledge the issue.

So rather than using these labels less confrontational approaches can help.
For example a workers could ask "*on a spectrum from healthy to very unhealthy, where would you put your relationship with alcohol over the last year.*" A person may find it easier to acknowledge that they have an "*unhealthy relationship with alcohol*" as it's not got the same baggage attached to it as some of the other terms.

One of the other key challenges is lots of people come in to contact with services at a point where they may want to drink differently but aren't currently looking at stopping completely. Abstinence is a huge and challenging step. We live in an alcohol-suffused society where the ability to drink, drink happily and drink "responsibly" are part of the social norms. Stopping drinking is to drop out from a huge part of UK social culture and is a threatening step to contemplate.

As a stepping stone we may want to explore managed drinking and control first. In doing so we might also help the person identify that, actually, they need to stop drinking.

A motivational conversation could look like this:

A is the person who drinks; B is the person offering support.

A: I don't have a problem with my drinking; it's under control
B: *OK, but humour me. Let's complete this drink diary for a couple of weeks…*
[a couple of weeks later]
B: *well done for doing the diary. So on average you're drinking 100 units a week*.
A: yes that was a bit of a shock. I thought maybe I was drinking a lot but I didn't know how much.
B: *so if you think 100 units a week is a bit too much what would a more healthy pattern of drinking look like to you?*
A: maybe 50 units a week?
B: *So we're agreed that 100 units a week is not that healthy and if we could get it down to 50 that would be less damaging?*
A: yes
B: *so it's May now; when would you like to have it down to 50?*
A: maybe by the end of the summer?
B: *OK, so let's talk about how we get there…*

This conversation uses elements of motivational interviewing and establishing a SMART target. Importantly it's A's target of 50, not B's. B doesn't state that it's unhealthy to drink at 100 units per week but reinforces and amplifies A's own statements about this.
The drop from 100 to 50 still leaves risk of alcohol related harm BUT it needs to be A's target so they own it. At the end we have a specific time-bound target to work towards.

B can then explore alcohol management strategies to get this target. This is the journey from precontemplation to action.

It could be successful and result in a drop in alcohol consumption. This can

demonstrate the capacity for self-management and control. And if A do a journey from 100 to 50 they can also see that they can do 50 to 25. A has the capacity to be a managed drinker and through engagement with B has developed the motivation and tools to achieve this.

Alternatively the attempt may not work and there's no reduction in alcohol use. This approach may be attempted a few times, with different approaches and targets. But it can help the person come to terms that despite their best efforts they struggle to manage their alcohol use and abstaining may be the best option for them.

We might then need to explore cessation strategies.

Alcohol dependency and withdrawal:

Dependency on alcohol is far more than the physical aspects of withdrawal. It includes the drivers for drinking, the perceived benefits of drinking, social and ritual aspects of alcohol use, fears or withdrawing, practical difficulties in withdrawing, and learning to live without alcohol.

Cues and Craving: Alcohol is (especially early on) a dopaminergic drug giving feelings of reward and euphoria. So regular drinking builds up an association with alcohol being a reward. The associated cues (time of day, places, people, tastes, moods) cause dopamine release leading to anticipation and craving and motivating the person towards drinking which in turn causes further dopamine release and reward.

As dopamine levels drop the urge to redose will kick in, encouraging further drinking.

Simultaneously alcohol is mimicking the effects of GABA reducing activity in decision-making areas of the brain. This means that my determination to only have one drink is undermined by two things: my dopamine-induced craving for another drink and my disinhibition from reduced activity in the Prefrontal Cortex making it less likely I'll say no to the second drink.

This is part of alcohol dependency – about the triggers and cues and disinhibition that lead to unmoderated drinking.

Tolerance and neuro-adaptation: Regular use leads to tolerance where more alcohol is required to achieve intoxication. This leads to changes in brain chemistry and changes to structures in the brain.
With regular and frequent drinking:
- the brain makes less GABA as alcohol is doing the job of GABA
- the brain makes more Gutamate (GABA's opposite number) to try and get brain activity back to normal.

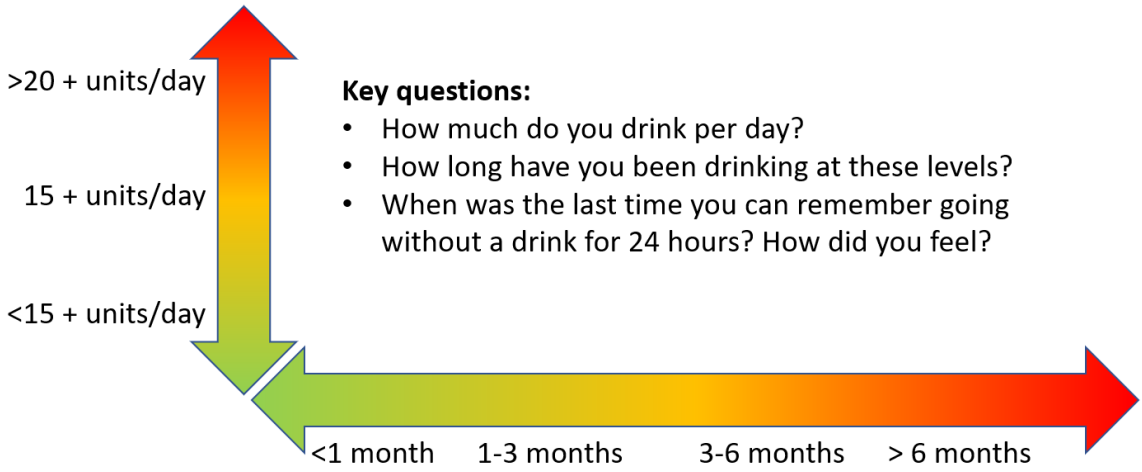
As a result of this more alcohol is needed to achieve intoxication and keep the excess Glutamate in check.

In response the brain continues to adapt, less GABA production and less GABA

receptors and more Glutamate production and increased sensitivity to Glutamate.

At this point the person needs large amounts of alcohol to avoid the symptoms of all this excess glutamate.

For people drinking at a rate of 10 units or less per day there's plenty of time for all the alcohol to clear from the body and the brain chemistry to get back to normal. But as alcohol use increases there's less and less time for the body to detox each day. At the 15-unit mark there's barely enough time for all the alcohol to clear and brain chemistry to rebalance. And if we consume more than 20 units then there's always alcohol in the body and the brain can not get back to normal before more alcohol arrives.



Again, this is one of the areas where a good drink diary is helpful. It can help to establish who is likely to be at risk of physical withdrawal symptoms.

For people at the lower end of the risk spectrum (lower levels of use for shorter periods of time) with good physical and mental health, motivated and with support, it is feasible to stop alcohol abruptly and with no withdrawal risks.

Alcohol Withdrawal:

Where there is a risk of physical dependency on alcohol then stopping suddenly can be dangerous leading to significant physical and psychological risks. This an include seizures, convulsions, hallucinations and psychosis. It can be distressing and has the potential to cause permanent harm or be fatal.

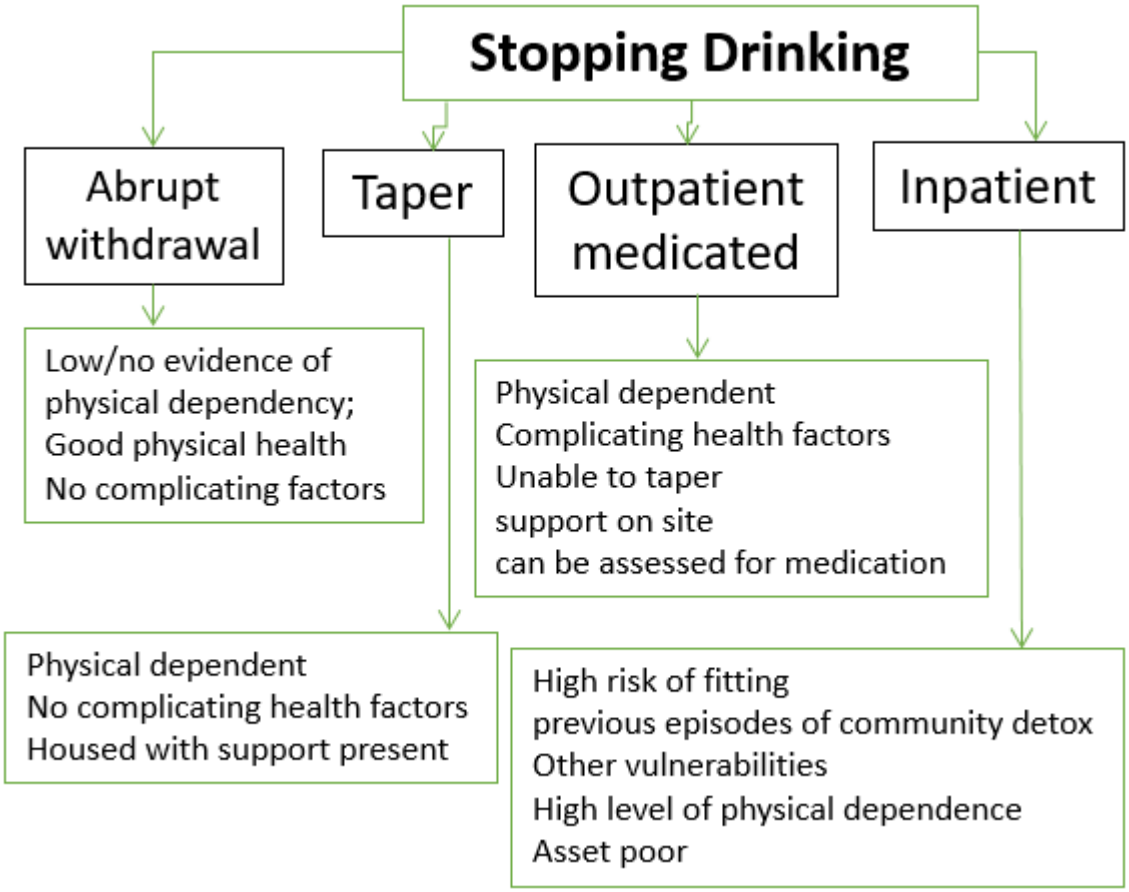
Risk of withdrawal is increased if the person has underlying health issues that could be worsened by withdrawal (mental illness, convulsions) or has experienced withdrawal symptoms in the past (a process known as "kindling" where the likelihood of severe symptoms appears to increase if there has been previous bad withdrawals.

For people who cannot stop abruptly options are:

- Stop by tapering of alcohol
- Stop alcohol and manage symptoms in the community or on a ward with medication

Tapering is where the person reduces their alcohol consumption by around 25% a week until they can stop completely. It is best for people living in the community with professional or peer support and is not suitable for people with underlying health conditions or living without support.

Medicated detoxes usually involve the benzodiazepine chlordiazepoxide (Librium) which is used to reduce withdrawal symptoms such as convulsions, panic and insomnia. It is dangerous if used with alcohol so the person needs to stop drinking and then start using Librium as withdrawal symptoms start to emerge. Should drinking resume then they need to step away using Librium which could otherwise cause a fatal overdose. In the community people detoxing with Librium should be housed with support on site to manage a lapse while prescribed.



Post-acute withdrawal: The brain can take a long time to get back to "normal" after the acute detox period. With glutamate levels too high and GABA levels still low the person may continue to experience anxiety and jitters for weeks or months after.

The drug **Acamprosate** is often prescribed to help manage these symptoms alongside psycho-social interventions.

As discussed earlier, alcohol will have caused low levels of dopamine and serotonin and once the person is sober they are likely not just to experience low mood but be much more aware of their low mood and other emotions that were previously being blocked by alcohol.

There may, for some people, be a role for anti-depressant prescribing if very low mood is jeopardising recovery. But this should be alongside other psychosocial and holistic interventions so that antidepressants can be a short term intervention to help promote and sustain change.

A smaller number of people are prescribed the opiate blocker **naltrexone**. Research evidence has shown that it inhibits dopamine release when drinking and so makes alcohol use less rewarding. This can help reduce the severity and extent of lapses.

Another drug used to help reduce early lapse is disulfiram (**Antabuse)** which prevents acetaldehyde being broken down in the liver. This causes levels of acetaldehyde to spike rapidly after drinking alcohol and this causes adverse symptoms including nausea.

Sustaining change:

Withdrawal from alcohol can be physically and mentally difficult; given its high social acceptance, remains a hard drug to avoid in daily life. It can cause serious physical symptoms in withdrawal.

In order to initiate and sustain a range of interventions can be useful including counselling, therapy, trauma work, and group work can be useful.

A key source of support for people looking to address their alcohol use is AA (Alcoholics Anonymous).

Whatever route to sustaining change people find works for them, it is essential that people are offering support recognise that there is no “one size fits all” and the key may be to explore a range of interventions that finds the one that works for this individual.

Screening:

Standard screening tools such as AUDIT are routinely used in alcohol services and there are additionally “12 questions” which are in the Alcohol Change “Blue Light Toolkit” which are useful.

The questions below can help generic workers and drug/alcohol workers identify issues relating to alcohol related risk and harm.

Screen for	Explore
Is use stable or escalating	Marker for situation deteriorating or tolerance building
What brings your drinking episodes to an end?	Looks at do you control it, someone else has an influence or only stops because you are stopped from drinking by lack of money, health, arrest etc
Do you use alcohol with other substances	OD risk, education re cocaine/alcohol & benzos or opiates + alcohol

Have you done things when you've been drinking that have shocked you or you've been distressed by when you were sober	Looks at risks in relation to disinhibited behaviour
Where are you drinking?	Looks at dangerous drinking environments or risky company when drinking?
Could you be pregnant? How effectively are you using contraception?	Look at issues around pregnancy and safe sex.
Have you found yourself gaining weight	Alcohol is calorific and can contribute to weight gain
When did you last have blood pressure checked?	Heavy drinking can contribute to weight gain
Do you find yourself with stomach pains or burning in stomach?	Heavy drinking can cause and worsen stomach problems
Have you had your liver function checked	If not can identify symptoms of fatty liver or early evidence of inflamed liver
Do you find you are getting bruises	Could be a marker for liver problems, vitamin deficiency or possibly abuse
Have you noticed any yellowing of eyes or skin	Marker for liver problems
Do you find yourself getting more itchy skin	Marker for liver problems but could also be a marker for neglect
Have you found that your poo is more greasy or your urine has got darker in colour	Markers for liver problems
Have you found yourself being sick? was there any blood in it? Was it clotted (like coffee grinds) or fresh?	Marker for gastritis clotted blood in vomit is a marker for stomach ulcers. fresh blood could be a marker for bursting oesophageal varices
Do you find yourself with symptoms like heartburn or reflux	Could be hiatus hernia or damage to pyloric sphincter muscle
Have you found blood on your poo	Marker for intestinal bleeding – could be colitis or indicator of bowel cancer
Any evidence of swelling to the belly	Indicator of ascites – fluid from liver accumulating in the abdomen
Have you been falling more	Balance problems could be a sign of brain damage or possible numbness at extremities
Have you suddenly started to lose weight	Could be that the liver is struggling to synthesis glucose and person is burning fat and muscle as a result (ketosis)
Is there a smell of acetone on breath?	Indicator of ketosis and marker of serious malnutrition/liver problems
Any smell of urine or faeces?	Marker for incontinence or possible neglect
Have you found it harder to remember people's names, recent conversations or things you meant to do?	Start to screen for possible memory deficits which could be early indicators for brain damage
How well do you think you are coping at the moment?	Screening for low mood, very poor mental health
Apart from this conversation where else can you go for support about your drinking	Looking at strategies for support and reduce isolation

LEGAL STATUS: Alcohol is covered by licensing laws and other regulations as follows:

- Under 5: It is illegal to give alcohol to a child under five years old in any circumstances excepting on the orders of a doctor.
- 5+: It is legal for children over the age of five to drink alcohol on private premises, such as in the home.
- 14+: Young people between the ages of fourteen and seventeen may be in a bar during opening hours but may not buy, be bought or drink alcohol on the premises.
- 16+: Young people sixteen and seventeen years of age may buy or be bought certain drinks in licensed premises but only in a separate eating area and only for consumption with a meal. The permitted drinks in England and Wales are beer, cider and perry. In Scotland, they may also purchase and consume wine with the meal.
- Under 18: It is illegal for any person under eighteen years of age to buy any alcohol from an off licence, attempt to buy alcohol or for someone else to buy it in order to supply it to someone under the age of 18.
- Confiscation of Alcohol (young Persons) Act 1997:
- Empowers police to require under 18-s to hand over alcohol in a public place. Failure to do so (without reasonable cause) and give name and address when requested summary offence and carries power of arrest.

Other

- Local by-laws re. Public drinking; many areas prohibit this and this can lead to a fine.
- Drunk and disorderly, Drink driving, Drunk in charge of a vehicle.

OTHER INFORMATION: Alcohol is a widely used drug. Its legality and social acceptability mean that we don't always talk about it as much as we could or should. However, it is one of the most important drugs that we need to engage with, causing huge levels of harm to individuals and wider society. Informed, high quality interventions around alcohol are a critical aspect of any drugs work.