

Screening and Intervention Programme for Sensible Drinking (SIPS)

Screening Tools

1. Modified-Single Alcohol Screening Question (M-SASQ)

[Access M-SASQ](#)

Finding time to screen for alcohol problems in a busy clinical setting is challenging and this has been the primary reason for developing and including a single item screening test in SIPS.

We developed this screening tool from the original Single Alcohol Screening Question (SASQ) (Williams & Vinson, 2001; Canagasaby & Vinson, 2005) which asks “When was the last time you had more than X drinks in one day?” Where X = 4 for women and 5 for men, with any time in the past 3 months considered a positive screen (1 drink = 14g ethanol – USA definition). This tool has been modified and adapted to the UK’s standard drinks (1 drink = 8g ethanol) and validated during our pilot research. The new question asks “How often do you have X or more standard drinks on one occasion?” where X = 6 for women and 8 for men, with monthly or more frequently considered a positive screen (M-SASQ). We have tested it in our pilot study, and it has shown a higher sensitivity and specificity than the original SASQ (Sensitivity 91.8; Specificity 70.8; AUC 0.929) when compared to the gold standard Alcohol Use Disorders Identification Test (AUDIT) during a pilot study within this wider SIPS programme. This new question is identical to the first item of the FAST questionnaire, which was also found to identify >50% of hazardous and harmful drinkers (Hodgson et al., 2002).

The original SASQ has also undergone validity testing in primary care settings and has shown a high level of sensitivity and specificity for alcohol use disorders, although lower than FAST (Williams & Vinson, 2001; Canagasaby & Vinson, 2005). However, it is still unclear which of the two tools is most effective in identifying cases of hazardous and harmful drinking in routine primary care as well as other settings.

2. Fast Alcohol Screening Test (FAST)

[Access FAST](#)

The FAST Alcohol Screening Test (Hodgson et al., 2002) is a 4-item screening test developed for busy clinical settings using the Alcohol Use Disorder Identification Test (AUDIT, Saunders et al. 1993) as the gold Standard.

The FAST questionnaire is a two-stage screening test that is quick to administer since >50% of patients are identified by using just the first question. These four questions are taken from the AUDIT.

FAST has undergone validity testing in primary care and has been found to be of high sensitivity and specificity (Hodgson et al., 2002) and performs well in comparison to the currently recognized ‘gold standard’ the Alcohol Use Disorders Identification Test or AUDIT (Saunders et al. 1993) across a range of settings. We are aware from our pilot work that shorter screening instruments are more likely to be adopted in the typical clinical setting than the longer AUDIT therefore we will compare FAST to the even shorter single item test (M-SASQ) described above. Moreover, the FAST has been used mainly 5 in a research screening context to establish prevalence rather than as a clinical tool.

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3. SIPS Paddington Alcohol Test (SIPS-PAT)

Access SIPS-PAT

The original Paddington Alcohol Test (PAT, Patton et al 2004) has also been modified to fit with our research protocol. Although we retained the original top 10 presenting conditions, which are used to target patients, we reduced and simplified the following 4 questions down to 2 questions. Question 1, asks “Do you feel your attendance here is related to your drinking?” if the answer is Yes, then the patient is considered SIPS-PAT positive; if the answer is No, a further question is asked. Question 2, asks “How often do you have X or more standard drinks on one occasion?” where X = 6 for women and 8 for men, with monthly or weekly or daily considered a positive screen. This latter question is identical to the M-SASQ and to the first question of FAST.

The original PAT has undergone validity testing in AED settings as a targeted screening tool and has been found to be of high sensitivity and specificity (Patton et al., 2004). However, it is unclear which approach is most effective in identifying cases in the typical AED setting. Or more specifically, whether universal tools like the M-SASQ or FAST are more likely to be adopted by busy AED staff compared to PAT that is a targeted screening tool which is applied in cases with presenting conditions commonly associated with alcohol misuse. Moreover, PAT has been studied exclusively at St Mary’s Hospital, London where it is embedded in the standard clinical assessment process.

4. Alcohol Use Disorder Identification Test - AUDIT (standard and extended versions)

Access AUDIT

The AUDIT is considered the gold standard test for screening for alcohol use disorders and it is widely used internationally. In SIPS we use the AUDIT questionnaire as an outcome measure, but not as a screening tool. The AUDIT was developed by the World Health Organization (WHO) (Saunders et al 1993) as a simple method of screening for excessive drinking and to assist in brief assessment. It is used to detect alcohol problems experienced within the last year (in SIPS we changed the time frame from the standard past 12 months to the past 6 months to bring it in line with the 6 month follow-up period). It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

It focuses on identifying the preliminary signs of hazardous drinking and mild dependence. There are several versions available (e.g. self completion, online, clinician completed, as well as the shorter version; AUDIT-C). The version we have used is the Extended AUDIT. This is based on the standard version which contains 10 questions on quantity and frequency of alcohol consumption, drinking behavior and alcohol-related problems and takes approximately a few minutes to complete and score. It is scored on a point 6 system ranging from 0 to 40 where a score of more than eight indicates an alcohol problem. More specifically, a score of 0-7 identifies sensible drinking, 8-15 hazardous, 16-19 harmful and 20+ dependence.

The extended version differs from the standard AUDIT only for the first two questions, which have an extra item in the response scale. That is in question 1 there is an additional “6 or more times a week” option, and in question 2 there is the option “none” .