



Health Development Agency

Manual for the Fast Alcohol
Screening Test (FAST)

Fast screening for alcohol problems

*Health Development Agency and
University of Wales College of Medicine*

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About the HDA

The Health Development Agency (HDA) is an NHS special health authority, established to support and enhance national efforts to improve health in England, with a particular focus on reducing health inequalities. In partnership with others, it gathers evidence of what works, advises on putting health into practice, and develops the skills of all those working to improve people's health.

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Background

Excessive alcohol consumption is a major risk factor for physical, social and mental health problems. In the UK alcohol accounts for 80% of deaths from liver cirrhosis and is associated with increased levels of cancer and hypertension, as well as cardiovascular disease. Starting with low levels of intake there is a steadily increasing risk of harmful social consequences, such as assaults or family distress, as levels of alcohol consumption increase (Raistrick et al., 1999). Quick and routine screening for alcohol-related problems within a wide range of health and social service settings has, therefore, become an important focus for research during the last decade.

Twenty-five years ago the main focus of research workers and practitioners was severe alcohol dependence or alcoholism. It is only in recent years that there has been an attempt to broaden the base to include hazardous and harmful drinking as well as dependence (Institute of Medicine, 1990). This change is reflected in the screening instruments that were developed then, compared to those that have been developed more recently:

- The CAGE questionnaire (Mayfield et al., 1974 – CAGE stands for Cut down, Annoyed, Guilty, Eye opener) includes items such as guilt related to heavy drinking and taking alcohol first thing in the morning. There is no attempt to assess risky levels of consumption.
- The AUDIT (Alcohol Use Disorders Identification Test) questionnaire, on the other hand, includes questions about the quantity and frequency of alcohol consumption. It assesses hazardous and harmful as well as dependent drinking (Babor et al., 1989).

The AUDIT questionnaire is proving to be very useful in many community and hospital settings. It consists of just ten questions and usually takes less than two minutes

to complete. AUDIT was developed in a World Health Organization study (Saunders et al., 1993) and validated across six countries. The questionnaire has proved to be an excellent screening test for all types of alcohol misuse, ie hazardous drinking, harmful drinking and dependence.

Hazardous drinking refers to a pattern of drinking that is associated with a high risk of psychological or physical problems in the future. Harmful drinkers are already experiencing these problems. The dependent drinker is experiencing symptoms of dependence including impaired control or a subjective experience of compulsion to drink. The term alcohol misuse will be used to cover all these categories.

The need for the Fast Alcohol Screening Test

The AUDIT questionnaire is a very useful and robust screening test. But there is an urgent need for an even shorter questionnaire that screens for hazardous drinking as well as harmful drinking and dependence. This need is particularly strong in accident and emergency departments and other medical settings where time pressure is a major factor (Hodgson et al., 2002b; John et al., 2002). Furthermore, there is a need for tests that can be scored in seconds. A questionnaire such as AUDIT requires extra resources to score thousands of tests a year if it is administered routinely.

Brief alcohol interventions as short as five minutes have been shown to be effective in reducing alcohol consumption within primary care settings (Poikolainen, 1999; Wilk et al., 1997). If alcohol misuse could be identified in less than 15 seconds, on average, then screening leading to a brief intervention is more likely to be a routine component for medical, mental health and social services.

Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

- 1 MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

- 2 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

- 3 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

- 4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

Construction of the FAST questionnaire

The development and validation of the FAST questionnaire involved over 3,000 patients in a range of busy medical settings and almost 100 nurses administering a number of measures (Hodgson et al., 2002a, 2002b). Since most users of this manual will mainly be interested in administering and scoring the FAST questionnaire, the details of the development work are described in a later section.

Test procedures

Administration

A copy of the FAST questionnaire is shown opposite. It consists of just four items. Administration of the FAST questionnaire is a very straightforward procedure. The questionnaire can either be self-completed or administered by a health professional.

For the purpose of routine screening, it is advisable to administer the questionnaire in conditions where distractions are kept to a minimum.

The purpose of the questionnaire is to assess alcohol misuse through routine screening in a variety of clinical contexts, although this will not be possible with individuals who are in pain, distressed or have other obvious cognitive limitations; or with individuals who are intoxicated.

Average administration time is less than 20 seconds.

In the case of self-completion, a staff member should be available to address any problems and should check that all questions have been answered. Patients should be asked to circle the appropriate response for each question. If more than one response has been made for an individual question, staff should clarify the correct response with the patient.

For frequently asked questions (FAQs) relating to the administration and use of this test, see p5 of this manual.

Scoring the FAST questionnaire

Scoring is quick and can be completed with just a glance at the pattern of responses as follows:

Score questions 1, 2 and 3 as follows:	Score question 4 as follows:
Never = 0	No = 0
Less than monthly = 1	Yes, on one occasion = 2
Monthly = 2	Yes, on more than one occasion = 4
Weekly = 3	
Daily or almost daily = 4	

Stage 1

The first stage only involves question 1.

If the response to question 1 is **Never** then the patient is not misusing alcohol.

If the response to question 1 is **Weekly** or **Daily** or **almost daily** then the patient is a hazardous, harmful or dependent drinker.

Over 50% of people will be classified using just this one question.

Only consider questions 2, 3 and 4 if the response to question 1 is **Less than monthly** or **Monthly**.

Stage 2

If the response to question 1 is **Less than monthly** or **Monthly** then each of the four questions is scored 0 to 4. These are then added together, resulting in a total score between 0 and 16. The person is misusing alcohol if the total score for all four questions is 3 or more.

In summary:

Score questions 1 to 3: 0, 1, 2, 3, 4

Score question 4: 0, 2, 4

The minimum score is 0

The maximum score is 16

The score for hazardous drinking is 3 or more.

A PHOTOCOPIABLE VERSION OF THE FAST QUESTIONNAIRE AND A SCORING KEY ARE INCLUDED IN THE BACK OF THIS MANUAL.

Reliability

The reliability of the FAST questionnaire was calculated in two ways.

First, *Cronbach's alpha* provided a measure of the strength of the inter-correlations between the four items (Pedhazur and Schmelkin, 1991). This demonstrated good reliability (alpha = 0.77).

Second, a measure of test–retest reliability demonstrated high reliability when retesting was completed one week after the first test.

Test–retest reliability is greater than 0.8.

Applications

The FAST questionnaire has been shown to be valid and useful across a range of medical services. The development work has involved, primarily, busy medical settings such as A&E departments, primary care settings and out-patient departments. It has been successfully used in a maxillo-facial clinic and a fracture clinic.

A screening test is not a diagnostic instrument. In some situations the FAST questionnaire will be just a first step and will be followed by a further interview if a patient is screened positive. A diagnostic interview is not usually required if a brief intervention or a health promotion initiative follows the screening.

The most appropriate use of the FAST questionnaire is to initiate a very brief intervention in hazardous drinkers. The following example of an intervention within an A&E department gives an idea of the way in which such a brief interaction could be structured.

Empathise and develop a non-confrontational style

'What happened? How did you get this injury?'
'We ask quite a few questions about the causes of accidents because we want to work out how to prevent them. Could you tell me about your injury?'

Initiate discussion about excessive alcohol use as a risk factor

'For many A&E patients alcohol was one of the reasons they were injured. Do you think alcohol could have played a part in your injury?'

Give feedback about level of consumption

'Some of your friends probably do drink as much as you but you do drink more than is recommended and more than average.'

Discuss the benefits of reduced consumption

'Do you think your life would improve in any way if you cut down on your drinking?'

'Would you be in more control?'

'Would you be healthier?'

Discuss intentions and commitment

'Do you plan to drink less in the future?'

'We are giving out booklets which give information about alcohol – would you like one? Do you think you might read it?'

Application summary

The above steps and suggested questions can be summarised by the acronym, BRIEF:

Benefits – the client should be aware of the benefits of sensible drinking

Risk factor – exploration of the substance (ie alcohol) as a risk factor in the client's current situation can raise awareness

Intentions – clarify the client's future intentions

Empathise – the practitioner should empathise and retain a non-judgemental attitude

Feedback – the practitioner should give the client feedback on their levels of consumption.

Right time, right place, right person

A brief intervention such as this can be given at the same time as other medical procedures, adding little to the time involved. The aim of the intervention is to raise awareness and motivation to change while facilitating decision-making. Lengthy discussion should be discouraged though specialist referral may be one possible future option. A few words given at the right time by the right person can have a significant influence. Health professionals have status and credibility. A nurse or doctor may be the right person to carry out this activity, and immediately after a health worry or an injury may well be the right time.

Frequently asked questions

The FAST questionnaire covers a whole year. What if I am interested in just a six-month period?

The FAST questionnaire covers a whole year to ensure that short-term fluctuations do not predominate. Nevertheless, sometimes the focus is on short-term fluctuations and then the questionnaire can be modified to cover a three-month or a six-month period depending on the question that is being asked.

What if a person reports that they have been drinking heavily for most of the last year but for the last three months they have been drinking sensibly?

If a research project involves counting the number of hazardous drinkers during the previous year then this person would be counted as a hazardous drinker. If the screening were part of a health promotion intervention, then it would be appropriate to acknowledge the fact that drinking has changed and their motivation to continue drinking sensibly could be reinforced.

Can we trust the report of a person who misuses alcohol?

Research studies tend to support the view that patients give accurate subjective reports of alcohol use if they are in a situation where they are being helped. They may attempt to give a good impression (faking good) in other contexts, for example if they are applying for a job. The health practitioner should emphasise the confidentiality of the questionnaire and also that it is just part of a health assessment, the aim of which is to help the patient.

Why use the FAST questionnaire rather than CAGE?

The CAGE questionnaire is a frequently used screening instrument that has been well researched. It is very useful if the aim is to identify severely dependent drinkers. It is not a useful questionnaire if the aim is also to identify hazardous drinkers.

Is the FAST questionnaire useful for young people as well as older people, and for women as well as men?

The questionnaire can be used from the age of 16 and also for women. It is not quite as good for women and the under-25s but the reduction in accuracy is only slight.

Can the FAST questionnaire be used in non-medical settings such as probation, social services or in surveys of the general population?

There is no reason why not but further research needs to be encouraged in these, and other, diverse situations.

To what extent can the FAST questionnaire be used across different cultures?

The FAST questionnaire was derived from the AUDIT tool, which was validated across several cultures. Further work needs to be carried out on the FAST questionnaire in a variety of cultures but there is no reason to believe that it will be more culturally bound than the AUDIT questionnaire.

Development of the FAST questionnaire

The development of the FAST questionnaire was based on the belief that the AUDIT questionnaire is an excellent screening instrument but that in busy settings not all of the items are required.

Evidence supporting the value of the AUDIT questionnaire

A solid body of evidence has demonstrated that the sensitivity and specificity of the AUDIT questionnaire are high for criteria that define current hazardous use.

Saunders et al. (1993) demonstrated that for those diagnosed as having harmful or hazardous use, 92% had an AUDIT score of 8 or more. For those with non-hazardous consumption, 94% had a score of less than 8.

Since its development a number of independent studies have shown that the AUDIT questionnaire is a reliable and valid screening instrument (Barry et al., 1993; Isaacson et al., 1994; Schmidt et al., 1995; Bohn et al., 1995; Volk et al., 1997; Allen et al., 1997; Bradley et al., 1998). It should be emphasised that, unlike most other alcohol screening tests, the AUDIT questionnaire was specifically designed to identify current hazardous alcohol consumption (as well as, at higher scores, suggesting harmful or dependent use). Mackenzie et al. (1996) compared sensitivities and specificities of the AUDIT, CAGE and the Brief Michigan Alcoholism Screening Test (MAST). Sensitivities for the identification of weekly drinking over recommended limits were 93%, 79% and 35% respectively.

Daepfen et al. (2000) provided further evidence of high sensitivity and specificity against an interview diagnosis of alcohol dependence (91.7% and 90.2% respectively), though low sensitivity for their diagnosis of 'at-risk drinking' based on consumption only. Similar results were obtained when the AUDIT items were incorporated into a

general health risk screening questionnaire. The AUDIT's test-retest reliability over a six-week interval was assessed in this study and was 0.88.

The AUDIT items have also been incorporated into a general population telephone survey (Ivis et al., 2000). In this study it was demonstrated that changes in item ordering had no discernible effect on AUDIT scores.

Outline of the development work on the FAST questionnaire

The development of FAST involved the following:

Step 1. AUDIT questionnaires were completed by 666 patients from two A&E departments in London, one inner city, the other suburban. The data were subjected to a principal components analysis in order to identify the three highest loading items on the first component.

Step 2. The aim was to identify one question that would serve as a first filter. This was achieved by asking whether any of the three highest loading questions could identify more than 50% of participants as either true positives or true negatives with few false positives or false negatives ('positive' meaning scoring 8 or more on the 10 item AUDIT).

Step 3. To develop a second filter the other two highest loading questions were combined with each of the other seven AUDIT questions to identify the combination with the best sensitivity and specificity.

Step 4. The data for both filters were combined so that the sensitivity and specificity of the test as a whole could be calculated.

Step 5. To ascertain whether this two-stage screening test performs well in a range of settings, 100 AUDIT questionnaires were completed by an opportunistic sample of patients in each of the following NHS services: a dental hospital which follows up patients who have had maxillo-facial injuries as well as a fracture clinic and a primary care health centre.

Step 6. A larger study was also completed to check out the sensitivity and specificity of the FAST questionnaire when administered by nurses in A&E departments. A total of 62 nurses and four A&E departments were involved in the study.

Step 7. The last step involved fine-tuning. Could any of the questions be slightly modified to improve sensitivity or specificity? Could the percentage of participants identified as positive or negative by the first screening item be increased? This was investigated in a further sample recruited from the waiting rooms of two A&E departments, at an inner-city hospital and in a market town in south Wales.

Results of the development work

Step 1. AUDIT questionnaires were completed by 666 patients from A&E departments (53% were male and 76% were older than 24 years). All of these questionnaires included a definition of one drink as '1/2 pint of beer or 1 glass of wine or 1 single spirits'. The AUDIT data were subjected to a principal components analysis in order to identify the three best items that represent the whole scale. These three defining questions are:

AUDIT Q3: *How often do you have six or more drinks on one occasion?*

AUDIT Q5: *How often during the last year have you been unable to remember what happened the night before because you had been drinking?*

AUDIT Q8: *How often during the last year have you failed to do what was normally expected of you because of drinking?*

As a first step this was very encouraging, especially since the three items covered hazardous, harmful and dependent drinking respectively.

Step 2. AUDIT question 3 was the best item. This question is:

<i>How often do you have six or more drinks on one occasion?</i>				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

This item turned out to be particularly useful since it served as the best first filter in identifying those who were and were not hazardous drinkers. It could be used as a filter in the following way.

If the response is **Never** (score = 0) then there is no hazardous use. If the response is **Weekly** or **Daily** or

almost daily (score = 3 or 4) then there is probably hazardous use. Using the AUDIT tool as the measure of hazardous drinking, this one question successfully classified 66% of patients as either hazardous or non-hazardous drinkers. Only the 34% of patients who responded **Less than monthly** or **Monthly** to this question needed to be asked further questions.

Step 3. Having classified 66% of patients as hazardous or non-hazardous drinkers using just one question, the next step is to explore how the other 34% can be sorted using AUDIT questions 5 and 8 and possibly one other. The details of this analysis are given in Hodgson et al. (2002b). The best second filter turned out to be AUDIT questions 5, 8 and 10 so that the four-item questionnaire is:

AUDIT Q3: *How often do you have six or more drinks on one occasion?*

AUDIT Q5: *How often during the last year have you been unable to remember what happened the night before because you had been drinking?*

AUDIT Q8: *How often during the last year have you failed to do what was normally expected of you because of drinking?*

AUDIT Q10: *In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?*

Step 4. We now have a two-stage questionnaire with AUDIT question 3 identifying 66% of A&E patients as either hazardous or non-hazardous drinkers, and questions 5, 8 and 10 sorting the rest.

When both stages are combined the overall sensitivity of the test is 91% and the overall specificity is 93%, using the full AUDIT score as the 'gold standard'. Sensitivity refers to the accuracy with which the test identifies people who are hazardous drinkers. Specificity refers to the accuracy with which a test identifies those who are not hazardous drinkers.

Step 5. The next question to ask is whether this two-stage screening test performs as well in other settings. Approximately 100 AUDIT questionnaires were completed by an opportunistic sample of patients in each of three other medical settings. The resulting sensitivity and specificity indices are displayed in Table 1.

It was concluded that these four questions have good sensitivity and specificity across a range of settings, when

Setting	Sensitivity(%)	Specificity(%)
Fracture clinic (57% male: 60%>25)	94	89
Primary care (40% male: 74%>25)	91	95
Dental hospital (59% male: 58%>25)	97	91

Table 1: Sensitivity and specificity of the FAST questionnaire across four medical settings using AUDIT greater than or equal to 8 as the gold standard

predicting hazardous drinking using AUDIT as the gold standard. Furthermore, across all settings the first filter (AUDIT question 3) categorised over 50% of patients into hazardous or non-hazardous drinkers with accuracy above 95%.

Step 6. A larger study was also completed to check the sensitivity and specificity of the FAST questionnaire when used in different A&E departments. A total of 62 nurses were involved in the study. They were volunteers from four A&E departments in London, Southampton, Bristol and Cardiff. All patients seen by triage nurses for the duration of the study were recruited if they gave informed consent and were not ruled out by the following exclusion criteria: inability to read English; severe intoxication whether by alcohol or other drugs; and excessive pain or confusion.

A total of 2,185 patients completed questionnaires at four centres, London (n=503), Southampton (n=852), Bristol (n=270) and Cardiff (n=560). The following summary of the study compares FAST and CAGE as predictors of AUDIT as the gold standard. Table 2 shows the sensitivity and specificity of the instruments for the whole sample of over 2,000 patients.

FAST	
Sensitivity	93%
Specificity	88%
CAGE	
Sensitivity	40%
Specificity	98%

Table 2: Sensitivity and specificity of FAST and CAGE relative to AUDIT as the gold standard

These results indicate that the CAGE test only identifies 40% of hazardous drinkers. This is not surprising since the CAGE test was designed to identify severe dependence rather than hazardous drinking.

Table 3 displays the sensitivity and specificity indices for men and women, for the young and those over 25 as well as the different A&E departments.

	FAST		CAGE	
	Sensitivity	Specificity	Sensitivity	Specificity
Male	94	86	40	96
Female	89	90	41	99
Age<25	88	82	34	98
Age>25	97	89	45	98
Bristol	91	87	46	95
Cardiff	96	82	37	96
London	90	82	55	98
S'hampton	92	95	31	99

Table 3: Sensitivity and specificity (%) for FAST and CAGE by age, gender and locality

The above results indicate that the FAST questionnaire has high sensitivity and specificity when compared to AUDIT as the gold standard. The CAGE tool has low sensitivity but very high specificity. The specificity of the FAST questionnaire differed to some extent between centres and its sensitivity differed significantly between younger and older age groups. Nevertheless the sensitivity and specificity of the FAST questionnaire were high in all localities, in men and women, and in both age groups.

Time involved and cost of implementing the FAST questionnaire

Table 4 displays the mean time taken to administer each of the screening tests as well as the cost per year if 50,000 patients are routinely screened by nurses at a cost to the NHS of £9.60 per hour (E grade nurse in UK, 2000 salary). These data were collected in just one of the A&E departments.

	Mean time (seconds)	Cost per 50,000 patients
FAST	12.52	£1,669
CAGE	14.37	£1,916
AUDIT	78	£10,400

Table 4: Mean time taken to administer each test and cost of routinely screening

Step 7. One of the strengths of the FAST questionnaire is that just one question successfully identifies hazardous and non-hazardous use for over 50% of most samples. Although the question 'How often do you have six or more drinks on one occasion?' was a good first filter, there were some doubts about face validity. Shepherd et al. (1990) found that a cut-off of 8 units of alcohol on one occasion differentiated male A&E patients with an alcohol-related injury, from a friend or relative who accompanied them to the trauma clinic. The next step was, therefore, to consider using 'How often do you have eight or more drinks on one occasion?' as the first filter for men. It is universally recognised that women face hazardous consequences at lower levels of consumption than men and so the six drinks question could be retained for them.

The next study compared the eight drink version of the FAST questionnaire with the six drink version. This was accomplished by administering the AUDIT with the new 'eight drinks' question inserted either before or after question 3. Attendees at two A&E departments were recruited, 58% male, and 69% aged over 25.

Although there were very few differences between the two versions of FAST there were, in fact, good reasons for keeping six drinks for women and eight drinks for men. For women the correlations (Spearman rho) between the AUDIT score and scores for the two versions of the test strongly favoured the six drink version (Spearman rho = .745 for the six drink version and .587 for the eight drink version).

The main advantage of the 'eight drinks' version was the use of this question as a first filter for men. In this particular sample the 'six drinks' question alone identified 56% of the men as hazardous or non-hazardous drinkers, whereas the 'eight drinks' question identified 63%. Since the aim of this investigation is to develop a quick alcohol-

screening test, the ability to screen out over 60% of a male sample with just one question is a major benefit. The 'six drinks' filter identified 58% of women so that, for men and women combined, the first FAST question identified 61% as hazardous or non-hazardous drinkers, with an accuracy of 95%.

Finally, a minor modification was made to the question: 'Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?' In the AUDIT questionnaire this particular question is not confined to the previous year and can therefore result in false positives if the concern occurred a few years ago.

Other brief alcohol screening tests

There are now several very brief alcohol screening instruments in existence. One of them is a shortened version of the AUDIT tool proposed by Piccinelli et al. (1997). They recommend using five items, only two of which are included in the FAST questionnaire. The short AUDIT and FAST questionnaires are strongly correlated (0.92 in the A&E data) but the main strength of FAST is the use of one item as a first filter. The range of instruments include the CAGE (Mayfield et al., 1974), the TWEAK (Russell et al., 1991), the brief MAST (Pokorny et al., 1972), the RAPS (Cherpitel 2000), the five-shot test (Seppa et al., 1998) and the PAT (Smith et al., 1996). Soderstrom et al. (1998) use the first two AUDIT questions to assess quantity and frequency of alcohol consumption and the TICS (Brown et al., 1997) attempts to assess both alcohol and drug misuse. Further work is now needed to explore which of these is the most useful and cost-effective instrument for which client groups and for what purpose.

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Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

- 1 MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

- 2 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

- 3 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

- 4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

FAST scoring key

For the following questions please circle the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

- 1 MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

- 2 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

- 3 How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

- 4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one occasion