



This one-off report provides statistics on a Defence initiative to introduce an alcohol screening tool (the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)) and brief advice (an Alcohol Brief Intervention) for all UK Armed Forces Personnel attending routine dental inspections from 1 June 2016. This report includes data collected between 1 June 2016 and 31 May 2017.

Key Findings

ALCOHOL USAGE IN THE UK ARMED FORCES

1 June 2016 - 31 May 2017

ALCOHOL SCREENING TOOL



74% (n = 109,459) of Regular UK Armed Forces personnel had completed a questionnaire (AUDIT-C). (1% declined)



This is the first large scale use of the AUDIT-C questionnaire in a military population

RISK CATEGORIES

61% scored 5+ indicating that they may potentially be at increasing risk or above of alcohol related harm

(ranging from poor mood, accidents and reduced fitness, to possible long-term illness)

You would score in this category if you drank:



3 glasses of wine twice a week

OR



4 pints of beer on one occasion in the month

2% scored 10+ indicating that they may potentially be at increasing or higher risk and should be advised to see their GP

You would score in this category if you drank:



3 pints of beer 5 times a week

ALCOHOL ADVICE



80% of personnel who scored 1+ had been given an alcohol advice leaflet



63% of personnel who scored 5+ had been given advice about reducing their drinking (alcohol brief intervention)

Alcohol brief intervention: a short, evidence based structured conversation about alcohol consumption with a patient that seeks, in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their alcohol consumption and risk and/or their risk of harm. (NHS Scotland)

Alcohol advice leaflet: describes what a unit of alcohol is, and the government recommended 'safe' limits for alcohol consumption. It describes what binge drinking is and the risks it can lead to in terms of behaviour and health. The benefits of reducing alcohol consumption are presented. (See Annex A)

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Background quality report: <https://www.gov.uk/government/statistics/alcohol-usage-in-the-uk-armed-forces-1-june-2016-to-31-may-2017>

Would you like to be added to our **contact list**, so that we can inform you about updates to these statistics and consult you if we are thinking of making changes? You can subscribe to updates by emailing DefStrat-Stat-WDS-Pubs@mod.uk

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Introduction

Within MOD there is a desire to establish a through-life process that creates a healthy culture, fosters wellbeing and mitigates risks to health for all its employees. As such it is important for the Armed Forces to take responsibility for their own health, with the MOD supporting them in making informed, healthy choices through education, leadership and service provision. This includes encouraging personnel to adopt a lifestyle which optimises their health and wellbeing, including a sensible approach to alcohol.

Previous evidence published in academic literature indicates that alcohol misuse within the UK Armed Forces (AF) population is higher than in the UK general population^{1,2}, with estimates of increased risk drinking levels within the Armed Forces ranging from 39%³ to 67%¹ of the military population. There is a tradition of alcohol consumption in the Armed Forces and drinking in moderation, as in wider society, is still considered to be a significant part of bonding and unit cohesion. An institute of Employment Studies report on Alcohol in the Armed Forces⁴ identified a requirement to introduce interventions to reduce the impact of excessive alcohol consumption in Armed Forces personnel. The recommendations support the use of alcohol screening tools, the provision of education and training for practitioners and an agreed protocol of care.

National Institute of Clinical Excellence (NICE) guidance on alcohol recommends that healthcare professionals ask patients about alcohol consumption and that brief interventions (short, structured advice) and/or signposting to support services are delivered⁵. Public Health England⁷ and NICE⁵ recommend the use of alcohol screening tools and Alcohol Brief Interventions (ABI) as tools to help reduce levels of alcohol misuse, and therefore reduce the risk of adverse health outcomes.

In accordance with NICE guidelines⁶, UK Armed Forces personnel should attend a dental inspection at a frequency of between 6 and 24 months, based on an individual's assessed oral disease risk. Therefore dental teams are in a unique position to implement a screening tool and provide brief advice and support patients as they have regular contact with patients during dental check-ups. The role of dentists to deliver this type of intervention has been recommended by Public Health England and the Department of Health⁷.

¹ Fear NT, Iversen A, Meltzer H, Workman L, Hull L, Greenberg N, et al. Patterns of drinking in the UK Armed Forces. *Addiction*. 2007;102(11):1749-59

² Henderson A, Langston V, Greenberg N. Alcohol misuse in the Royal Navy. *Occupational medicine*. 2009;59(1):25-31

³ Field PR - Service Evaluation of an alcohol screening tool (AUDIT-C) and the delivery of alcohol brief interventions within Defence Dental Centres : Masters in Public Health Dissertation 2014

⁴ Tamkin P. Alcohol and the Armed Forces. Defence Human Capability Science and Technology Centre: Institute of Employment Studies (DHCSTC), 2013

⁵ NICE 2015. Oral health promotion: general dental practice. <https://www.nice.org.uk/guidance/ng30>

⁶ NICE Clinical Guideline 19 – Recall Intervals Between Routine Dental Examinations – October 04

⁷ Delivering better oral health: an evidence-based toolkit for prevention

<https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

Introduction Cont.

A MOD alcohol screening tool and alcohol brief advice initiative was implemented on the 1 June 2016 across Defence Primary Healthcare (DPHC) dental centres as part of routine dental inspections. Screening is implemented by use of a World Health Organisation developed questionnaire (the AUDIT-C). Questions are delivered by trained dental centre staff and accompanied by brief advice (Alcohol Brief Intervention) if required and signposting of personnel to support services where appropriate. The overall goals of screening and providing brief advice to patients includes raising awareness of drinking guidelines and offering them feedback on how their drinking may adversely affect their oral and general health.

This report is a one-off publication; published in response to requests for information from the media, external academic institutions and the general public about alcohol use by UK Armed Forces personnel. The report also contributes to the MODs commitment to release information where possible. It focuses on the introduction of AUDIT-C at scale in the UK Armed Forces population; this represents one aspect of Defence's broader population approach to promoting sensible drinking in the UK Armed Forces.

Background - AUDIT-C

The Alcohol Use Disorders Identification Test (AUDIT) is a tool developed by the World Health Organization (WHO) as a 10 question screen to assist in identifying potentially increased risk drinking. The Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) was developed as a shortened three question version of the AUDIT intended for rapid use in a clinical environment to help identify patients whose alcohol use may potentially place them at increased risk⁸. The AUDIT-C has been used in a wide range of primary care settings and populations but this is the first time it has been used at scale in a military population.

The AUDIT-C consists of the following questions scored on a scale of 0-4. Patients are invited to complete the questions at the dental centre when attending for a dental inspection; they are free to refuse to do so.

Questions	Scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Each of the scores from the three questions were added together to produce a score on a scale of 0-12⁹.

- A score of 0 indicates non-drinkers and no risk of harm from alcohol.
- A score of 1-4 indicates that the patient is at a lower risk of harm from alcohol.
- A score of five or more indicates that the patient is potentially at increasing or higher risk from alcohol-related problems.
- If the patient has a score of 10 or more they should be given the brief intervention, but also advised on the importance of seeking further advice from their GP or a local alcohol support service.

Data collection templates have been introduced in the electronic dental patient record to allow recording of the AUDIT-C screening tool scores and interventions given. Information in this publication has utilised coded data from these templates. Please note that the clinician may also record the content or outcome of a consultation in free text within the patient record which will not be available for central analysis.

⁸ AUDIT The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care Second Edition, Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders, Maristela G. Monteiro World Health Organization.
http://www.alcohollearningcentre.org.uk/library/WHO_-_AUDIT.pdf

⁹ Delivering better oral health: an evidence-based toolkit for prevention
<https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

Background - AUDIT-C Cont.

Example alcohol consumption and AUDIT-C risk categories:



1 glass of wine 3 times a week



3 – Potentially at lower risk



3 glasses of wine twice a week



5 – Potentially at increasing or higher risk



4 pints of beer on one occasion in the month



6 – Potentially at increasing or higher risk



3 pints of beer, 5 times a week



10 – Potentially higher risk individuals who should be advised to see their GP

One unit is 10ml of pure alcohol. As alcoholic drinks come in different strengths and sizes, units are a way to tell how strong your drink is. The number in the glass represents the units of alcohol in the drink.

Limitations of AUDIT-C

The AUDIT-C is not a diagnostic tool. It does not give a measure of absolute or relative risk. It is a brief screen that can be used to help identify individuals who might be at potential risk from their drinking and may benefit from advice or signposting to support services. Personnel with higher scores may not have experienced any actual harm or ill health from their drinking behaviour.

The AUDIT-C scores do not represent sequential stepped increases in alcohol consumption or risk, e.g. a score of 4 does not signify drinking twice as much, or being at twice as much risk of harm as a score of 2.

The AUDIT-C does not discriminate between occasional binge drinkers, who may be at risk of accidental injury, and regular heavy drinkers who could be at risk from more widespread impacts on health. It is possible to drink within the Chief Medical Officer's Low Risk Drinking Guidelines¹⁰ which advise not to regularly drink more than 14 units a week and yet still achieve an AUDIT-C score that indicates potentially increasing or higher risk from alcohol-related problems.

The AUDIT-C is open to response bias as the screening tool involved self-reported responses and therefore could be influenced by cognitive biases. The responses of personnel may not always be accurate or truthful.

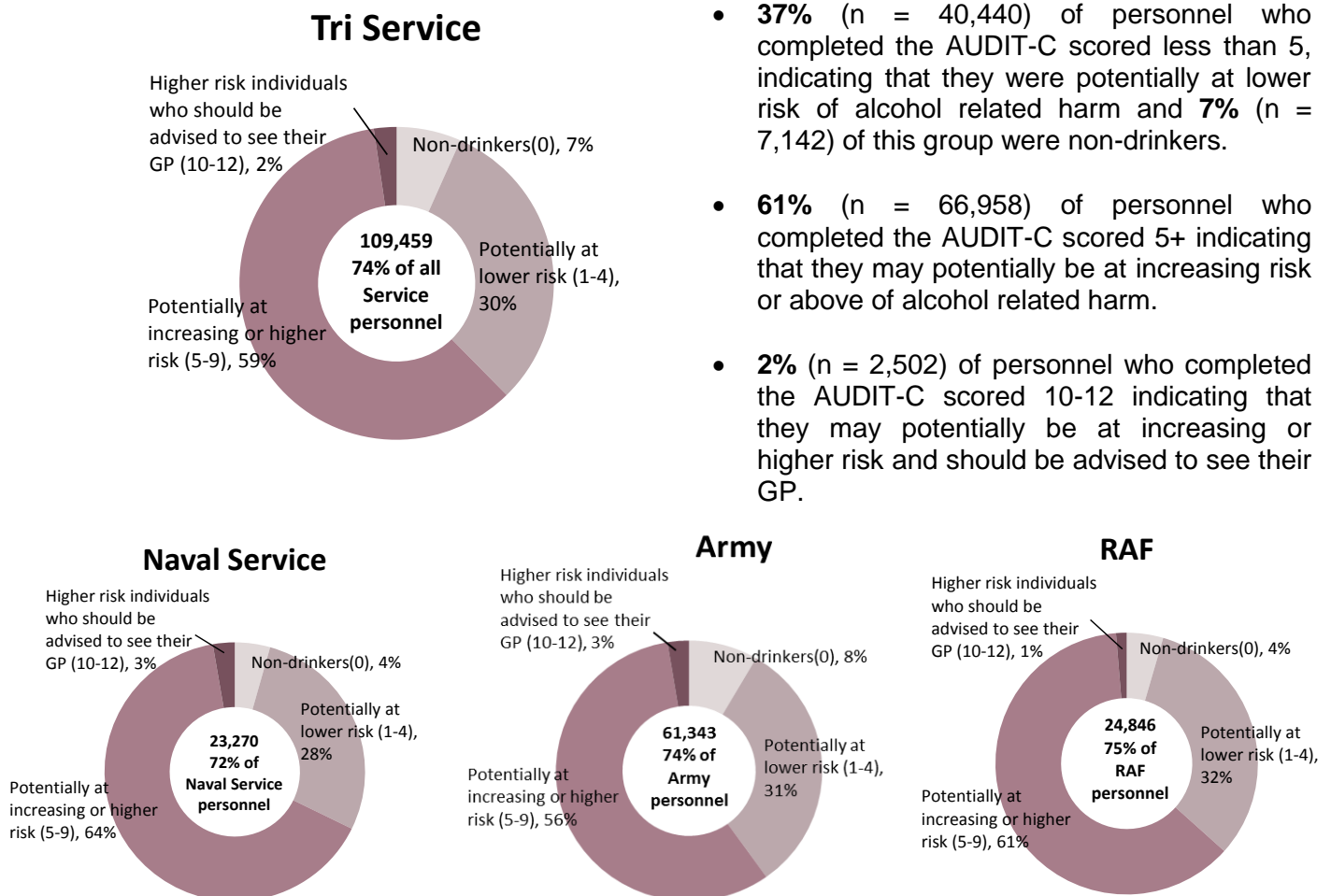
¹⁰ DH 2016. Alcohol consumption: advice on low risk drinking. <https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking>

Main Findings – AUDIT-C Risk Categories

Figure 1: Regular UK Armed Forces personnel, AUDIT-C risk of alcohol related harm category^{1,2}, by service, percentages of personnel completing AUDIT-C

Personnel serving as at 1 June 2017

Completed AUDIT-C between 1 June 2016 and 31 May 2017



Source: DMICP & JPA

¹Percentages may not add up to 100%, this is due to rounding and personnel being given the AUDIT-C but not having all three question scores entered correctly (2%, n=2,061).

² An additional 1,150 personnel declined to complete the AUDIT-C. Additional personnel have been given the AUDIT-C but have since left Service.

The percentage of personnel scoring 5+ was significantly higher in the Naval Service (67%, n = 15,580) than in the Army (59%, (n = 35,912) and RAF (62%, n = 15,466). The World Health Organisation recognized that sea men were one of the higher risk groups for alcohol consumption¹¹. These findings are consistent with the AUDIT-C scores for the Naval Service in MOD.

For statistics by demographics split by Service please see the supplementary figures of this report.

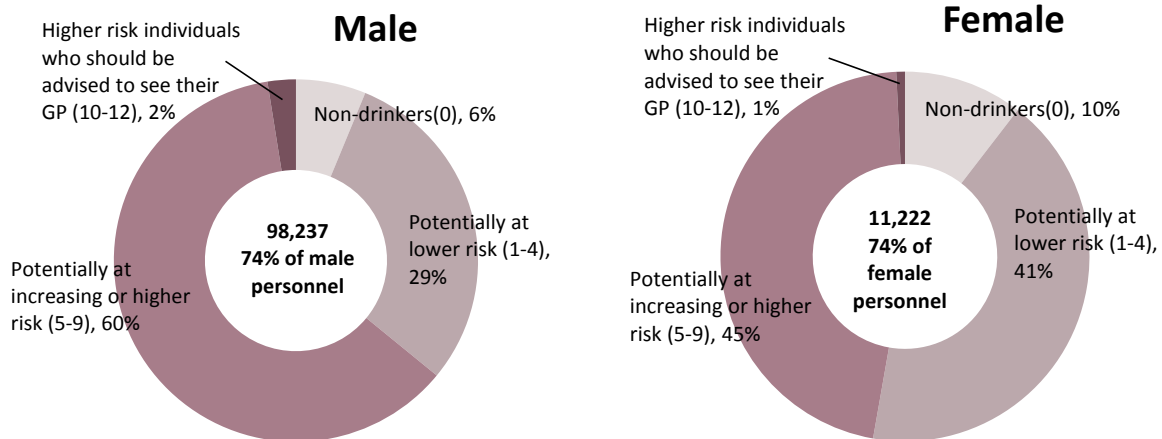
¹¹ AUDIT The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care Second Edition, Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders, Maristela G. Monteiro World Health Organization.
<http://www.alcohollearningcentre.org.uk/library/WHO - AUDIT.pdf>

Main Findings – AUDIT-C Risk Categories Cont.

Figure 2: Regular UK Armed Forces personnel, AUDIT-C risk of alcohol related harm category¹, by gender, percentages of personnel completing AUDIT-C

Personnel serving as at 1 June 2017

Completed AUDIT-C between 1 June 2016 and 31 May 2017



Source: DMICP & JPA

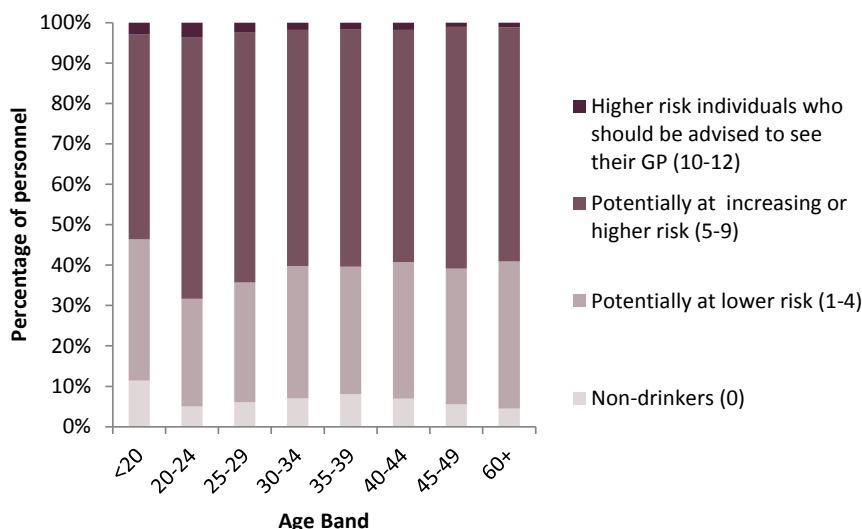
¹ Percentages may not add up to 100%, this is due to rounding and personnel being given the AUDIT-C but not having all three question scores entered correctly

Males reported higher AUDIT-C scores than females with significantly more male personnel scoring 5+ (63%, n = 61,770) compared to female personnel (46%, n = 5,188). This reflects gender differences consistently reported across non-military populations¹².

Figure 3: Regular UK Armed Forces personnel, AUDIT-C risk of alcohol related harm category¹, by age band¹, percentages of personnel completing AUDIT-C

Personnel serving as at 1 June 2017

Completed AUDIT-C between 1 June 2016 and 31 May 2017



Source: DMICP & JPA

¹ Age as at 1 June 2017. Please note that this may be different from when the AUDIT- took place.

The 20-24 age group contained the largest proportion of personnel who scored 5+ (67%, n = 14,133). There was a reduction in the proportion of personnel who scored 5+ with increasing age.

¹² Wilsnack RW, Wilsnack SC, Kristjanson AF, Vogeltanz-Holm ND, Gmel G. Gender and alcohol consumption: Patterns from the multinational GENACIS Project. *Addiction*. 2009;104(9):1487-1500.

Main Findings – AUDIT-C Risk Categories Cont.

Figure 4: Regular UK Armed Forces personnel, by Service, gender, rank, age band¹ and ethnicity, percentages of personnel scoring 5+ on the AUDIT-C

Personnel serving as at 1 June 2017

Completed AUDIT-C between 1 June 2016 and 31 May 2017

		Percentage of Regular UK Armed Forces personnel scoring 5+	
		n	%
Number of Regular UK Armed Forces personnel Scoring 5+		66,958	61.2
Service			
	Naval Service ⁺	15,580	67.0
	Army	35,912	58.5
	RAF	15,466	62.2
Gender			
	Male*	61,770	62.9
	Female	5,188	46.2
Rank			
	Officer*	11,593	63.0
	Other Rank	55,365	60.8
Training status			
	Trained ^{2*}	61,026	62.1
	Untrained ³	5,932	52.7
Age			
	Aged <20	3,255	52.7
	Aged 20-24 ⁺	14,133	67.1
	Aged 25-29 ⁺	16,773	63.1
	Aged 30-34	12,231	59.1
	Aged 35-39	9,733	59.2
	Aged 40-44	5,441	58.2
	Aged 45-49	3,427	59.8
	Aged 50+	1,965	58.0
Ethnicity			
	White*	63,536	64.7
	BAME ⁴	2,869	25.5

Source: DMICP & JPA

+ Groups found to be at a significantly higher than average risk using a z-test for a single proportion at a 95% confidence level

*Groups found to be at a significantly higher using a z-test for proportions at a 95% confidence level

¹ Demographic category as at 1 June 2017. Please note that this may be different from when the AUDIT-C took place.

² Trained (RN/RM & RAF) and Trade Trained (Army) (which comprises military personnel who have completed 'Phase 1' and 'Phase 2' training) personnel

³ Phase 1 and Phase 2 trainees

⁴ BAME represents Black, Asian and Minority Ethnic personnel

In men and women generally, heavy drinking is more common in young single individuals¹³. The levels of alcohol consumption reported in the UK Armed Forces may reflect the consequences of a young, single and predominantly male population, living, working and socialising in close proximity, and operating in demanding and stressful situations. Similar patterns of increased alcohol consumption have been reported in allied 'high risk' professions of the police and fire fighters¹³.

¹³ Fear et al. Patterns of drinking in the UK Armed Forces. *Addiction*. 2007;102(11):1749-59

Main Findings – AUDIT-C Risk Categories Cont.

In previous research increased alcohol consumption in Armed Forces personnel has been linked to: being young and single, being of more junior rank and being of white ethnicity¹⁴. This pattern is reflected in the MOD AUDIT-C data:

- The percentage of personnel scoring 5+ was higher in white personnel (65%, n= 63,536) compared to Black, Asian and Minority Ethnic (BAME) personnel (26%, n= 2,869).
- The percentage of age 20-24 (67%, n = 14,133) and 25-29 (63%, n = 16,773) personnel scoring 5+ was significantly higher than in other age groups.

The percentage of personnel scoring 5+ was significantly higher in Army officers (61%, n = 5,173) compared to Army rank personnel (58%, n = 30,739). However, this pattern was not seen in Naval Service and RAF personnel. It is possible that other ranks may be more affected by response bias than officers which may lead to less accurate responses.

The percentage of personnel scoring 5+ was significantly higher in trained personnel (62%, n = 61,026) compared to untrained personnel (52%, n = 5,932). This pattern was seen in Naval Service and Army personnel but not in RAF personnel.

¹⁴ Fear et al. Patterns of drinking in the UK Armed Forces. *Addiction*. 2007;102(11):1749-59

Main Findings – Alcohol Brief Interventions

An Alcohol Brief Intervention (ABI) is a short, evidence-based, structured conversation about alcohol consumption with a patient that seeks to motivate and support the individual to consider reducing their consumption¹⁵.

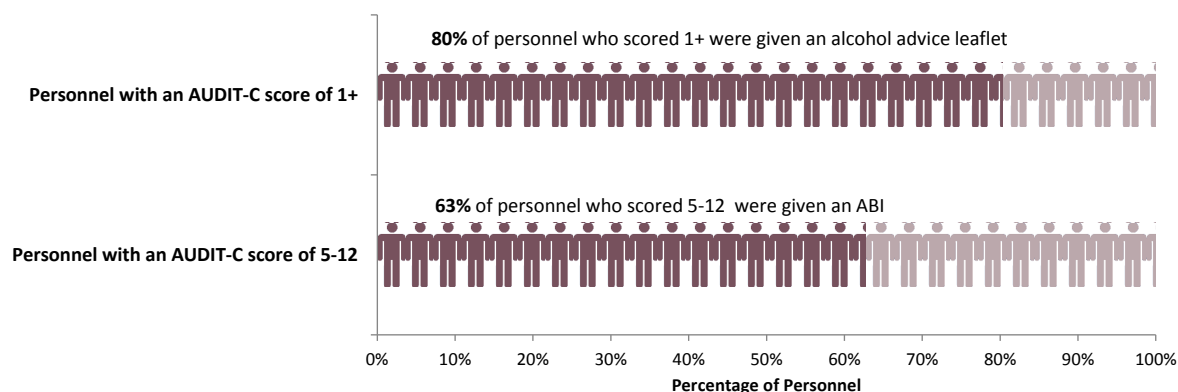
In accordance with Public Health England guidance for dental teams¹⁶, Defence dentists use the self-reported AUDIT-C scores to indicate whether the individual should be offered further advice or signposting based on their AUDIT-C score:

- **Score 0:** No risk, no further action.
- **Score 1 - 4:** Feedback that the patient is potentially at a lower risk of harm from alcohol. Provision of a patient information leaflet (Annex A).
- **Score 5 - 9:** Feedback that the patient is potentially at increasing or higher risk from alcohol-related harm. Provision of ABI and a patient information leaflet.
- **Score 10 - 12** ABI, leaflet and offer of referral to local medical facility to be seen by the General Medical Practitioner to discuss alcohol consumption.

Figure 5: Regular UK Armed Forces personnel, by score and Alcohol Brief Intervention, percentages of personnel

Personnel serving as at 1 June 2017

Completed AUDIT-C between 1 June 2016 and 31 May 2017



Source: DMICP & JPA

Of the personnel who scored 1+, **80%** (n = 80,662) were given an alcohol advice leaflet. Of personnel who scored 5-12, **63%** (n = 42,074) were given an Alcohol Brief Intervention (ABI). 1% (n = 780) of personnel who scored 5-12 declined the ABI.

There were **217** personnel who scored 10-12 that had a referral to their GP recorded in their medical record. An additional 2,285 personnel scored 10-12 but did not have any details of whether they accepted or declined a referral coded in their dental record. The referral to see a medical professional is undertaken with the informed consent of the patient. Any individual for whom a referral is recommended remains free to decline.

¹⁵ NHS Education for Scotland. 2010. Delivery of Alcohol brief Interventions: A Competency Framework. http://www.nes.scot.nhs.uk/media/3125/Delivery_of_Alcohol_brief_Interventions_spring_2010.pdf

¹⁶ Delivering better oral health: an evidence-based toolkit for prevention <https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

Methodology

This section provides a brief summary of the methodology and data sources; more detailed information is available in the background quality report for this bulletin.

The analysis provided in this publication is based on personnel serving as at 1 June 2017 who have completed an AUDIT-C between 1 June 2016 and 31 May 2017. Personnel who completed an AUDIT-C but left Service before 1 June 2017 have not been included in this report.

Both trained and untrained Regular UK Armed Forces personnel have been included. Reservists may receive dental care when they mobilise for deployment but they majority of their dental care is delivered by the NHS, therefore Reservist personnel have been excluded from this report.

Where personnel have been given the AUDIT-C more than once in between 1 June 2016 and 31 May 2017, only the latest entry in the medical record has been included.

AUDIT-C screening tools completed at all types of dental appointment have been included. The majority (97%) were carried out at dental inspections.

In accordance with NICE guidelines¹⁷, UK Armed Forces personnel should attend a dental inspection at a frequency of between 6 and 24 months, based on an individual's assessed oral disease risk. There are two possible reasons why 100% of personnel did not complete the AUDIT-C in the 12 month period: Personnel on a recall frequency of greater than 12 months would not have attended a routine dental inspection. Personnel may be overdue for their routine dental inspection if they were unable to attend their appointment.

It is possible that not all personnel who had a dental appointment between 1 June 2016 and 31 May 2017 were offered the AUDIT-C. Due to staff turnover and the use of locum staff there may have been occasions when the dentist carrying out the appointment did not know that they should have offered the AUDIT-C or may not have yet had the training to deliver the programme.

Coded data was searched for using the Dental AUDIT-C template. Information entered as free text in the patient record is not available in the data warehouse and is not included in this publication. Only templates filled in by dental staff have been included in this publication.

Dentists are able to enter inconsistent data on the templates and are able to omit data items. The AUDIT-C scores have been validated resulting in 4% of scores being corrected and 3% of risk categories being changed. Defence Dental Services are addressing the accuracy of template use through training. See the background quality report for further information on data validation. Personnel with incorrect scores entered have been counted as having completed the AUDIT-C and may have received alcohol brief interventions. However, the interventions are not included this report as the patient cannot be put in a potential risk category.

There are also initiatives led by the Chain of Command to deliver Alcohol Brief Intervention (ABIs) by non-clinical personnel. It is not currently possible to measure how many of these ABIs have been delivered as there is no requirement to capture the information on a central reporting system.

¹⁷ NICE Clinical Guideline 19 – Recall Intervals Between Routine Dental Examinations – October 04

Glossary

Alcohol Brief Intervention

An Alcohol Brief Intervention (ABI) is a short, evidence-based, structured conversation about alcohol consumption with a patient that seeks to motivate and support the individual to consider reducing their consumption.

Alcohol related harm

At the individual level, alcohol consumption has multiple short, medium and long term negative health effects, ranging from poor mood, anxiety, accidents and injury, weight gain and reduced fitness, to possible long-term effects of increased cardiovascular disease, diabetes and cancer risks. It is a major cause of breakdown in relationships, trauma, hospitalization, prolonged disability and early death¹⁸.

Alcohol Use Disorders Identification Test (AUDIT-C)

A 3 question self-reported alcohol screening tool recommended for use by the WHO that can help identify individuals who may be at increased risk from their drinking habits.

Binge drinking

Consuming more than eight units of alcohol in a single session for men, and more than six units for women¹⁹.

Black, Asian and Minority Ethnic (BAME)

Now the widely used terminology, as a collective descriptor for non-white citizens (including those of mixed ethnic origin), across Whitehall, other public sector bodies and the third sector, as well as among Civil Service race staff networks and their cross-Whitehall umbrella body, the Civil Service Race Forum.

Defence Medical Information Capability Programme (DMICP)

The MOD electronic primary healthcare patient record.

Joint Personnel Administration (JPA)

The personnel administration system used by the UK Armed Forces. It is the single authoritative source for personnel demographic information.

Regular UK Armed Forces personnel

Full time Service personnel, including Nursing Services, but excluding FTRS, Gurkhas, Naval activated Reservists, mobilised Reservists, Military Provost Guarding Service (MPGS) and Non Regular Permanent Service (NRPS). Unless otherwise stated, includes trained and untrained personnel.

Response bias

The tendency of a person to answer questions on a survey untruthfully or misleadingly. For example, they may feel pressure to give answers that are socially acceptable.

Trained

Trained in this report are those that have completed training or artificer candidacy for Naval Service and those that have completed both Phase 1 and 2 training for Army and RAF.

Trade Trained

Following public announcement and public consultation the definition of Army Trained Strength has changed. From 1 October 2016, UK Regular Forces and Gurkha personnel in the Army who have completed Phase 1 training (basic Service training) but not Phase 2 training (trade training), are now considered Trained personnel. This change will enable the Army to meet the SDSR 15 commitment to improve support to UK resilience. Previously, only personnel who had completed Phase 2 training were considered trained. This change does not affect the Royal Navy/Royal Marines (RN/RM) or the Royal Air Force (RAF).

This report however considers trade trained personnel only as trained. Personnel currently completing Phase 1 and Phase 2 training are included as untrained.

¹⁸ AUDIT The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care Second Edition, Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders, Maristela G. Monteiro World Health Organization.

http://www.alcohollearningcentre.org.uk/library/WHO_-_AUDIT.pdf

¹⁹ <http://www.nhs.uk/livewell/alcohol/pages/bingedrinking.aspx>

Further Information

Other Publications

For Statistical information on mental health among the UK Armed Forces including medical discharges for psychoactive substance abuse (of which disorders due to alcohol) please see: <https://www.gov.uk/government/statistics/uk-armed-forces-mental-health-annual-statistics-financial-year-201617>

Contact Us

Defence Statistics welcome feedback on our statistical products. If you have any comments or questions about this publication or about our statistics in general, you can contact us as follows:

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Email: DefStrat-Stat-Health-PQ-FOI@mod.uk

If you require information which is not available within this or other available publications, you may wish to submit a Request for Information under the Freedom of Information Act 2000 to the Ministry of Defence. For more information, see:

<https://www.gov.uk/make-a-freedom-of-information-request/the-freedom-of-information-act>

Other contact points within Defence Statistics are:

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Army Manpower	01264 886175	DefStrat-Stat-Army-Hd@mod.uk
RAF Manpower	01494 496822	DefStrat-Stat-Air-Hd@mod.uk
Tri-Service Manpower	020 7807 8896	DefStrat-Stat-Tri-Hd@mod.uk
Civilian Manpower	020 7218 1359	DefStrat-Stat-Civ-Hd@mod.uk
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For Press Office, please call: 020 721 83253

Annex A – Alcohol Advice Leaflet

No matter how much you drink, you need to know the following to manage your risk...



NOTHING can speed up the process of alcohol leaving your body - not coffee, sleep, food, medication.

1 unit takes one hour to leave your body/8 units takes 8 hours

New Government Alcohol Guidelines for Men & Women

You shouldn't regularly drink more than

14 units a week

This means you should not drink more than this amount of wine...



...OR this amount of lager or ale



...OR this amount of cider



...OR this amount of spirits



Binge drinking

When you have lost control, you are more likely to:

- Make poor decisions - less likely to notice danger
- Take risks (getting into fights, unsafe sex)
- Leave your friends behind - making them and you more vulnerable
- Receive disciplinary action
- Drink drive - including the next morning
- Be unsafe at work the next day - don't drink the night before important/safety critical duties!

Why bother to change...

Once you start to cut down you will feel the benefits quickly.

Health

- Sleep better
- Lose weight
- Better physical shape and levels of fitness
- Reduced risks of injuries and accidents
- Less likely to suffer with depression and anxiety

Family

- Improved relationships with partners, children and colleagues
- Less likely to get into arguments
- More likely to have a positive influence on children

Other benefits

- More money
- Less likely to end up involved in disciplinary issues that can affect your military career
- Less likely to find yourself in vulnerable situations

Want more help?

- Speak to your GP and get the support you need to reduce drinking
- Speak to your friends, family or chain of command - don't do it alone
- Visit www.drinkaware.co.uk to gain more information and support
- Search and use the 'One You' drinking app to track your drinks

National helpline

- Call the confidential National Drinkline phoneline **0300 123 1110 - Mon - Fri 9am - 8pm, weekends 11am - 4pm**. Information and self-help materials, help to callers worried about their own drinking, support to the family and friends of people who are drinking, advice to callers on where to go for help