Brief interventions for alcohol problems in hospital settings

Learning objectives

Each week Nursing Times publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Know the extent of the alcohol misuse problem in general hospitals;
- Understand techniques for screening people who misuse alcohol in the general hospital setting;
- Be familiar with the essential stages of brief intervention in alcohol misuse;
- Understand how screening and brief interventions can be implemented.

REFERENCES


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Many patients present to general hospitals with alcohol-related problems, but most of them are not identified as such. This article summarises the evidence base for screening and brief interventions delivered by nurses in general hospital medical/surgical wards and A&E departments. It also suggests how screening and brief interventions can operate in these environments.

Many patients who pass through general hospitals have problems with the misuse of alcohol, but the majority are not identified. However, screening and brief instruction tools have been developed that could be applied in general hospitals, including in A&E and on medical/surgical wards.

General hospital setting

The general hospital ward provides an important opportunity for screening and brief interventions in alcohol misuse – in some ways better than other settings in which brief interventions have been deployed, such as primary health care. This is mainly because patients have time to fill in a screening questionnaire or answer questions about their drinking, and to receive advice if their drinking is harmful. In addition, the patient’s concern about their medical problems represents a ‘teachable moment’ that increases prospects of successful intervention.

There is lots of evidence that many types of hospital ward contain large numbers of patients drinking at levels that are hazardous or harmful to their health. Estimates range between 25 per cent and 40 per cent of acute, unselected medical admissions (Royal College of Physicians, 2001).

There is also evidence that most alcohol misusers in general hospitals go undetected and receive no advice about their drinking (Canning et al, 1999). Part of the problem may be that many patients are admitted with illnesses that are not typically associated with alcohol consumption or show no classic signs of alcohol dependence.

Brief interventions are not aimed at people with significant alcohol dependence, who probably need more intensive treatment. Furthermore, they should not be restricted to cases where there is an obvious connection between drinking and ill health – like other medical settings, the general hospital represents an opportunity to detect excessive drinkers and offer advice or help.

Nurses are more cost-effective than doctors in screening for excessive drinking. The Royal College of Physicians (2001) recommended that nurses ask patients to complete an alcohol-screening questionnaire, perhaps combined with questions on other lifestyle behaviours, as part of the routine admissions procedure.

With regard to the effectiveness of brief intervention, a study by Chick et al (1985) randomised heavy-drinking men identified on the wards of an Edinburgh hospital to either a single session of counselling from a nurse lasting up to one hour or routine medical care only. At 12 months both groups reported a reduction in alcohol consumption and there was no statistically significant difference between the groups. However, counselled patients showed improved outcome on a composite measure encompassing alcohol-related problems, level of consumption and the results of blood tests or a relative’s report.

A&E departments

Carrying out screening for hazardous and harmful consumption among the users of A&E services is difficult but by no means impossible (Huntly et al,
2001). Green et al (1993) found that almost half the patients they identified as having an alcohol problem accepted an invitation to return to the department for advice on drinking the following day.

In a recent UK study, Crawford et al (2004) randomised alcohol misusers attending A&E to receive either an information leaflet (control condition) or a leaflet plus an appointment with an alcohol health worker. The appointment was scheduled to last about 30 minutes and consisted of a non-confrontational and patient-centred discussion of current and previous drinking. At a six-month follow-up, patients who had received the brief intervention were drinking at significantly lower levels than those in the control group. In addition, those receiving the intervention made an average of 0.5 fewer visits to the A&E department over the following 12 months, indicating a reduced demand for A&E services following brief intervention.

Brief interventions can cut down the workload of A&E departments and may be especially useful in reducing alcohol-related harm among young male patients whom it may be difficult to recruit for intervention elsewhere.

**Primary care**

Strenuous attempts have been made over the years to persuade primary health care professionals to incorporate SBIs into their routine practice, but these efforts have so far met with little success. A survey of GPs in the Midlands, for example, led to an estimate that as many as 98 per cent of hazardous and harmful drinkers presenting to primary health care may be missed (Kaner et al, 1999). There are several obstacles to implementation, including lack of time for this work and lack of suitable reimbursement.

A project entitled ‘Integrating health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals’ daily work’ (or ‘Primary health care European project on alcohol’ for short) has been funded by the European Union as part of the community action programme on public health. It began at the start of 2002 and is due to be completed in the summer of 2005. A total of 16 countries in the EU are taking part in the project, together with Eurocare and the World Health Organization regional office for Europe.

The project’s general aim is to develop and apply country-wide strategies for widespread, routine and enduring implementation of SBI for hazardous and harmful drinkers throughout the primary health care systems of participating countries.

The alcohol strategy for England is currently being developed and will be presented to the Department of Health and other interested parties later this year.

**Implementation in the general hospital setting**

**Screening**

Alcohol misuse frequently remains unrecognised in a general hospital setting (Canning et al, 1999). Other research has showed that many nurses feel that it is not within their role to ask questions concerning alcohol consumption (Lockhart, 1997). One possible way to get round this is for nurses to consider questions concerning alcohol consumption as part of general lifestyle enquiries alongside issues such as diet, exercise, sleep patterns, medication and smoking (Proctor, 2003). Proctor has stressed that these can be carried out in an opportunistic manner.

However, this is still unsystematic and the authors recommend that general hospitals introduce the routine implementation of a screening tool in their patient assessment, such as:

- **AUDIT** (Alcohol Use Disorders Identification Test), developed by the World Health Organization (Saunders et al, 1993) to identify risky or hazardous drinking. It contains 10 items, takes about two

**TABLE 1. ITEMS AND SCORING OF THE AUDIT-C SCREENING TOOL**

<table>
<thead>
<tr>
<th>1. How often do you have a drink containing alcohol?</th>
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<tbody>
<tr>
<td>Never</td>
</tr>
<tr>
<td>(0)</td>
</tr>
<tr>
<td>2. How many standard drinks containing alcohol do you have on a typical day drinking?</td>
</tr>
<tr>
<td>1 or 2</td>
</tr>
<tr>
<td>(0)</td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>(0)</td>
</tr>
</tbody>
</table>

Numbers in brackets indicate score that can be applied.

**REFERENCES**


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
Guided reflection

Use the following points to write a reflection for your PREP portfolio:

- Outline your area of work and why this article is relevant;
- Summarise the main points the article makes about implementing brief interventions for alcohol misuse;
- Identify how knowledge of brief interventions has informed your recent practice;
- Identify a new piece of information you have learnt about brief interventions in alcohol misuse;
- Outline how you intend to follow up what you have learnt.

minutes to complete and one minute to score. AUDIT is regarded as the gold standard for screening and research purposes, though a number of shorter questionnaires exist that may be easier to use in busy general hospital settings;
- AUDIT-C (Bush et al, 1998) is a shorter version of AUDIT (Table 1, p39). The cut-off score for identifying risky or hazardous drinking is five. It can be administered verbally or self-administered. Completion takes less than one minute;
- FAST (Fast Alcohol Screening Test) (Hodgson et al, 2002) has been approved by the Health Development Agency and can be self-completed or administered by a health professional. It takes under 20 seconds to administer (Table 2, p40). A score of three or more is indicative of hazardous drinking. A manual has been developed that provides guidance for implementation (Health Development Agency and University of Wales College of Medicine, 2002);
- PAT (Paddington Alcohol Test) (Smith et al, 1996). This is a screening tool devised by the A&E department at St Mary’s Hospital in Paddington, London, and is designed for use in an A&E setting. It lists a set of triggers that indicate the presence of alcohol-related difficulties (Table 3, p41). A number of questions are then asked concerning the patient’s drinking that are accompanied by a series of treatment/information options according to the patient’s replies.

Both of the AUDIT versions were designed for administration in primary health care settings, but the FAST and PAT tools have been designed for use in other medical settings. PAT can be used in A&E and the list of triggers that should initiate a further investigation of alcohol-related behaviour is particularly useful. It would be good practice if similar lists could be drafted for each medical setting, for example medical and surgical wards.

The evidence suggests that universal screening in primary care is unacceptable to practitioners and patients and that screening should be confined to clinics where alcohol misusers are more likely to be detected, and to consultations, such as general health checks, where patients find questions about their drinking acceptable (Heather et al, 2004).

Whether universal screening is effective on
medical or surgical wards remains to be investigated. Some health care teams may feel that the AUDIT or AUDIT-C best suits their needs, so the final decision should be left with the ward team. However, it should become routine practice to use screening tools for alcohol misuse.

**Readiness to change**

An effective framework for nurses to consider when facilitating changes in drinking behaviour is the one developed by Prochaska and DiClemente (1983). This is known as the stages-of-change model and the nurse assists the patient through the stages:

- **Pre-contemplation.** At this point the patient has no intention of changing his or her behaviour or acknowledging that it needs to change. The nurse can provide information or encourage him or her to question their behaviour, with the aim of moving them to the second stage and entering the ‘cycle’;
- **Contemplation.** The patient is thinking about changing but has not changed his/her behaviour;
- **Preparation.** At this point the patient is intending to take action in the immediate future, usually within the next month;
- **Action.** The patient is changing their behaviour;
- **Maintenance.** The behaviour change has now been maintained over a period of time and the patient is working towards preventing relapse;
- **Established change.** The change has become established and they are able to leave the cycle.

Relapse has also been inserted into the model. Any behavioural change is rarely achieved without relapse. The stages-of-change model considers relapses as opportunities to learn (for example, how the patient has placed themselves in a high-risk situation) and not as failures, leading to guilt, remorse and lowered self-esteem. Following relapse, the patient can enter at any point in the change cycle.

**Components of brief intervention**

Miller and Sanchez (1994) outline the essential components of brief intervention using the acronym FRAMES. First, the nurse should provide feedback on the patient’s personal risk, then she or he should emphasise the patient’s responsibility to change. The third component is to provide advice on behavioural change, which the nurse does by providing a menu of options. There are two other essential components that can be seen as the principles underlying the delivery of SBI. These are to deliver the counselling in an empathetic manner and to encourage self-efficacy.

**Suggested implementation in an A&E setting**

There is good evidence as to the efficacy of SBI in this setting, but what is the best way to integrate it into nursing practice?

First, information leaflets should be prominently displayed. There is little point in attempting SBI with intoxicated patients. However, if they are accompanied by someone who is not intoxicated, it may be worth providing them with leaflets concerning levels of hazardous drinking and offering a follow-up appointment the following day (Green et al, 1993).

The Paddington Alcohol Test (PAT) is an excellent screening tool in this setting and it should be used if any of the triggers shown in Table 3 are present. The patient’s reply will guide the various intervention options. Alcohol-related problems are highly prevalent in an A&E setting and designing hospital policies so this can be seen as an opportunity for behavioural change rather than merely crisis management, and discharge should be a main priority.

**Suggested implementation in a medical/surgical ward setting**

To date there has been little research into SBI in this setting, although medical and surgical wards provide an excellent opportunity for a thorough assessment followed by a ‘teachable moment’. The patient is often admitted for a number of days and the effects of intoxication are no longer present, so coherent thinking and reflection is possible. Every patient should be screened using FAST and be given SBI if they score three or more. Ward policies should address the question of what form SBI should take.

Various physical tests, in particular liver function tests, could be used to provide evidence of some health-related problems that have at least in part been caused by drinking. However, it may be many years before damage shows up in liver functioning tests and appropriate SBI can be used to intervene.

**REFERENCES**


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**TABLE 3. PADDINGTON ALCOHOL TEST: TRIGGERS INDICATING MISUSE**

- Fall – trip or facial injury
- Collapse, in particular fits
- Head and facial Injury
- Assault
- Non-specific gastrointestinal problems
- Unwell
- Psychiatric difficulties, including overdose
- Cardiac, including palpitations
- Self-neglect
- Repeat attender