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### ► [Brief interventions in dependent drinkers: a comparative prospective analysis in two hospitals.](#)

Cobain K., Owens L., Kolamunnage-Dona R. et al. [Request reprint](#)  
**Alcohol and Alcoholism: 2011, 46(4), p. 434–440.**

*In the north of England just a few (and often just one) counselling sessions by a specialist nurse had a remarkable impact on dependent drinkers seeking medical care at an accident and emergency department.*

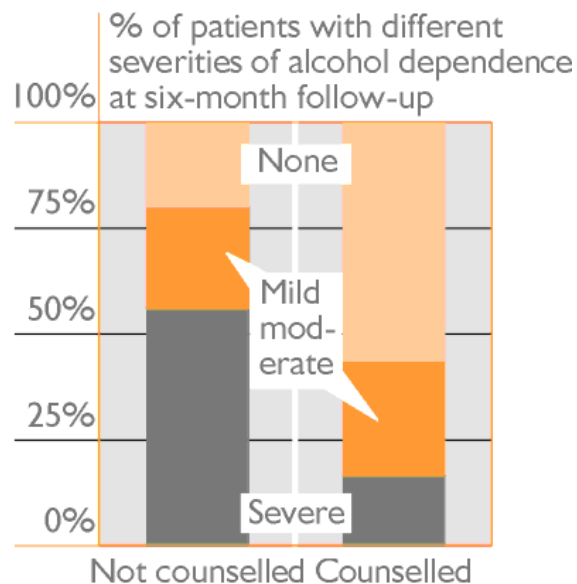
**Summary** Unusually this study in England's north west region assessed the impact of relatively brief advice, not on adult drinkers selected to be at risk from their drinking, but those likely already to be dependent. As with studies of non-dependent drinkers, despite their heavy drinking they were not seeking treatment for drink problems but attending a hospital accident and emergency department for some other reason.

Patients whose attendance was thought to be related to drinking were referred for assessment to specialist hospital or research nurses by emergency department triage staff in two hospitals in neighbouring cities. The assessments included the [AUDIT questionnaire](#) and for patients who scored as possibly dependent, the [Severity of Alcohol Dependence Questionnaire](#). Patients indicated by both to possibly be at least mildly dependent were asked to join the study.

In Liverpool the assessments were done by specialist alcohol nurses who immediately engaged possibly dependent patients in about 20 minutes of advice based on the [FRAMES model](#), prioritising exploration of patients' perceptions of the link between their drinking and their hospital attendance. At the nurses' and patients' discretion, further sessions could be arranged. In practice, of the 100 patients recruited to the study, 46 attended typically four further sessions. In the other hospital in nearby Warrington, the same referral and research recruitment procedures operated, but instead patients were referred to a nurse who was part of the research team who did not offer any alcohol-related advice. Again, 100 patients were recruited at this site to act as a [control](#) group against which to benchmark any improvements associated with counselling.

At both sites most patients were daily drinkers who consumed on average about 27 UK units (216g) of alcohol a day, tested as severely dependent, and were taking alcohol withdrawal medication. Typically they were single, unemployed white men in their mid-40s suffering from gastrointestinal or cardiovascular complaints. Six months later research nurses were able to reassess about half the patients to evaluate changes in their drinking and drink-related problems since they joined the study.

## Main findings



Six months later the general picture was (despite some reductions) of continued severe drinking and drink-related problems in the control group, but substantial remission among patients who had been counselled by specialist alcohol nurses. The controls were still drinking on average 23 units (184g) of alcohol on nearly six days a week, while counselled patients had cut back to nearly four days a week and eight units (64g). These averages reflected the fact that none of the controls but 39% of the counselled patients had stopped drinking altogether. Also, just 17% of the counselled patients scored as severely dependent on the Severity of Alcohol Dependence Questionnaire compared to 56% of the controls ► *chart*. The greater reductions in drinking days and intensity and in scores on the two alcohol problem questionnaires were all highly statistically significant.

Not statistically significant but almost so was the difference in the times patients returned to accident and emergency departments – about 90 times among the 50 control patients but only 34 times (or 36 extrapolated to 50 patients) among those counselled.

## The authors' conclusions

The study demonstrates that treatment can be accepted and effective among dependent drinkers who have not come seeking treatment for their drinking. Generally it has not been ethically acceptable to deny treatment to dependent drinkers who are seeking it, complicating the evaluation of whether treatment works. In contrast, because patients were not seeking or expecting treatment, this study was able to compare structured treatment with no specific treatment. It showed that treatment is effective, and that even severely dependent patients can substantially benefit from relatively brief treatment. The patients in this study were usually medically ill; providing alcohol treatment in a general hospital offers a way to reach them even if they do not present to alcohol treatment clinics, and may reduce their need for further medical care.

The greater drinking reductions among patients at the hospital offering counselling were due to the greater abstinence rate – 39% v. 0%. It seems likely that their medical conditions would have mandated advice to abstain for 8 in 10 patients and that this was the advice given by the specialist nurses, advice often well responded to. From previous research, it seems likely that planned follow-up counselling augmented the impact of the evaluated intervention.

Though striking, the results have emerged from a study in which patients were not randomly allocated and attended different hospitals. On the assessed variables, the patients seemed similar but there may have been remaining differences between them and between how they were treated at the hospitals which contributed to the findings. Moreover, the research nurse who conducted the follow-up assessments was not always 'blinded' to whether patients had been counselled. Despite its general brevity, it is a moot point whether the open-ended treatment could be called a 'brief intervention'. Half the patients could not be followed up, potentially biasing the findings.

## **FINDINGS**

These impressive results are weakened somewhat by the low follow-up rate. But even if we assume bad outcomes (severe alcohol dependence, death or imprisonment) in all patients not followed up, at most 60% of the counselled patients met these fates compared to 88% not counselled. Similarly, assuming continued drinking among patients not re-assessed, the abstinence rate would be 19% among counselled patients but zero among those not counselled. Yet on average these patients drank at least as much as those at specialist alcohol clinics in the [UKATT trial](#) in England and Wales, who were seeking treatment and offered what was intended to be a **full course** of psychosocial therapy in addition to medical treatments like detoxification and anti-relapse medications. In [that study](#), 12 months after starting treatment a **minimum of 12%** of patients had sustained abstinence over the past three months, compared to 19% at six months (over an unspecified period) in the featured study.

Despite its successes, for most patients the intervention was not enough. If abstinence is the yardstick of success, 8 in 10 could **not be shown** to have achieved it; if not being severely dependent was the yardstick, the corresponding proportion was 6 in 10. Whether more extended or intensive intervention would have been accepted by the patients and helped reduce the failure rate is unclear. The main limitation on delivering it might have been staying in touch with the patients. Few were homeless, yet two letters and two phone calls were unable to recall half for follow-up assessments.

As the authors speculated, it could be that the nurses and perhaps ward staff were in a position in most cases to credibly counsel abstinence on medical grounds, helping bolster the results. Few patients were there because of injuries which could be avoided by continuing to drink but taking greater care to avoid getting drunk in dangerous situations. Instead, most seemed to be suffering from chronic conditions which would be aggravated by continued drinking. They were also generally the **type of people research suggests** are most receptive to abstinence as a goal of treatment and least able to sustain non-problem drinking.

Among the issues raised by the study are whether extended treatment is always required before dependent patients – especially those with the disadvantages shared by most of the study's sample – can attain non-dependent drinking or abstinence. Along with **other**

[research](#), it clearly indicates that this is not the case for many patients. More generally, added benefits from longer versus shorter treatments (as opposed to [post-treatment aftercare](#)) has yet to be adequately established. Another issue is whether brief interventions will only benefit non-dependent patients. Again this study along with [other research](#) strongly suggests this is not always (but sometimes) the case. What makes the difference may be whether the patient makes (or can be led to make) a link between their drinking and the medical misfortune which led them to the emergency department. These issues are explored in greater detail in the [background notes](#).

Perhaps the most serious of the limitations acknowledged by the authors is that the hospitals may have differed not just in the availability of specialist alcohol counselling, but in how drinking was addressed by other medical staff. With counsellors available to handle the aftermath, in Liverpool they may have been more willing to expose the need for counselling by assessing and discussing alcohol problems with their patients. A hospital which hosts four specialist alcohol nurses is likely to have a different and perhaps more serious attitude to drinking than one which hosts none. But even if this were the case, it would not affect the strength of the intervention's impact, just relocate a greater part of that intervention to usual medical staff.

### British studies

In 2008 an [audit](#) of alcohol health service provision in England found that advice-giving at accident and emergency departments was rare. Commissioners have [reportedly found](#) it hard to persuade staff to undertake this work.

The best researched example is the programme at St. Mary's hospital in London, which uses trained and motivated (performance feedback is important) emergency unit staff to screen suspected heavy drinkers or patients with complaints linked to heavy drinking. Doctors explain to positive screen patients that drinking is damaging their health and offer an appointment with an on-site health worker, typically the same or the next working day. In these circumstances, two-thirds of patients attend for advice. Offering this service [was found](#) to reduce later drinking and return visits to the department.

[Further analysis](#) based on the same study found that total public service costs and productivity losses over the following 12 months were roughly equivalent whether or not the intervention was offered, but that offering it was the most cost-effective option for reducing drinking. [Another study](#) at the unit demonstrated the (at least temporary) feasibility of tasking reception staff to hand out screening questionnaires to all adult ambulant patients, and the willingness of over half the patients to fill in and return the forms.

Among other policy drivers, the recent national focus on reducing alcohol-related hospital admissions, and recognition of hospital-based alcohol specialists as a priority by the Department of Health, has helped stimulate emergency department brief intervention initiatives, some of which have been reported on. For example, in implementation terms, a [major programme in Manchester](#) started in late 2006 was a limited success – generally accepted by staff and patients, but at some sites falling well below anticipated screening rates, and only a few of the patients offered this attended for more extended alcohol advice from a specialist nurse. However, experience at the hospitals showed that screening rates could be improved by feeding back to and rewarding staff, and making the recording of screening decisions and results mandatory. [A report](#) on the early months of operation at one of the sites reveals how few patients were counselled beyond any

advice given during screening: of about 27,000 people screened over 10 months, just 99 – a tiny fraction of the anticipated at-need population.

That a successful screening and intervention programme can take over a year to develop was the implication of a [report](#) on a project in a Basingstoke hospital. The targeted 100 interventions per month across the hospital including the emergency department materialised in the first year as just 42 involving 20 people per month.

The featured study's model of a specialist nurse to whom patients can be referred for brief advice is common in the UK. It relieves general hospital staff of this burden and encourages screening because this does not entail the 'risk' that the clinician will have to engage in counselling positive-screen patients. However, commonly such nurses have multiple roles. When the national charity Alcohol Concern [investigated this model](#) at eight locations in England, it found that often screening and brief intervention had entirely or largely given way to managing dependent patients through detoxification and treatment.

The [Scottish drive](#) to implement alcohol brief interventions in emergency care and other settings from April 2008 seems to have been most successful in GPs' surgeries. In the three health board areas where these figures were known, 17%, 8% and not more than 7% of interventions were delivered in emergency departments. If these kind of figures applied nationally, these departments accounted for perhaps 11% of the 174,205 alcohol brief interventions recorded over the three years, or about 6400 a year – just over 6% of the [estimated](#) 100,000 alcohol-related attendances per year to Scottish emergency departments. Why this might be was revealed by staff interviews conducted as part of a [national evaluation](#). Resistance from staff (feeling that this was not their business and detracted from core activities and objectives) and time pressures sometimes led (contrary to the preferred option in [guidance](#)) to intervention being by appointment some time after screening rather than immediate, and this in turn reduced attendance. Screening rates probably too suffered from inadequate buy-in by staff, but might have suffered more had they had to cater for the possibility that a positive screen would mean they had to spend more precious minutes counselling the patient.

For more on emergency department brief intervention initiatives run [this search](#) on the Alcohol Learning Centre site.

### The UK policy climate

In England directors of public health are [expected](#) to include alcohol brief interventions among attempts to address the population-wide determinants of ill health. This policy is in line with [recommendations](#) from Britain's National Institute for Health and Clinical Excellence (NICE), which in 2010 saw screening and brief interventions targeted at risky drinkers as an effective way to prevent drinking problems, though one less important at a population level than policy changes affecting the price and availability of alcohol. Among the sites NICE envisaged for this work were emergency departments, and the recommended approach was the [FRAMES model](#) trialled in the featured study. However, the guidance acknowledged that (in contrast to primary care) research on emergency department interventions was scarce and the barriers to implementation were considerable.

In Scotland [national policy](#) prioritises screening and brief intervention in primary care,

antenatal care, and accident and emergency departments, backed by a health service target for 2008/09–2010/11 to deliver 149,449 brief interventions across the three years supported by dedicated funding. Set [in the context](#) of what was in any event 111,200 primary care consultations for alcohol misuse in a single year in 2006/07, this target of around 50,000 a year across all three priority settings may seem to lack ambition. It was [set on the basis](#) that 19% of adult patients would present to these services with conditions possibly related to drinking, that all would be screened for excessive drinking and a fifth would screen positive. The target was to actually counsel three quarters of these at-need patients. In the event, the target [was exceeded](#); over the three-year period 174,205 alcohol brief interventions were recorded across the three priority settings.

The [Welsh substance misuse strategy](#) recognises the potential value of brief alcohol interventions in accident and emergency departments, but its action plan made no commitment to their expansion; neither did the strategy for [Northern Ireland](#).

In the UK advice on brief interventions [is available](#) from the Alcohol Learning Centre, while for Scotland [specific guidance](#) has been published for emergency department staff. US guidance is available on the [SBIRT](#) method trialled nationally and on emergency department alcohol screening and intervention [in general](#).

*This draft entry is currently subject to consultation and correction by the study authors and other experts.*

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