## 6.1 Emergency patients benefit from minimal alcohol intervention

**Findings** Patients screened for alcohol problems in a Swedish emergency surgical ward responded well to a simple brief intervention; outcomes were not improved by professional counselling.

563 out of 697 inpatient admissions agreed to participate in a study of 'alcohol and health' and were screened for alcohol problems using standard tests. 186 screened positive and while still on the ward received one of two face-to-face interventions. Both included an immediate assessment of the patient's drinking and of their readiness to change, plus brief feedback of the assessed risks. With screening, this averaged under half an hour. Randomly selected patients then also received professional counselling lasting one to two-and-a-half hours to explore their concerns, compare their intake to safer drinking limits and population norms, and to offer further counselling and brain function tests. Six and twelve months later nearly three-quarters were reassessed. About 30% were now drinking on *more* days, twice as many as had done the opposite. However, as a whole they were drinking 13–16% less alcohol and over 70% had reduced the number of times on which they had drunk enough to become intoxicated. Outcomes were not further improved by counselling or if the brief intervention was done by alcohol specialists rather than ward staff.

**In context** The featured study confirms previous studies in hospitals which found alcohol intake substantially reduced after little if anything more than assessment. Many (but not all) also found that additional brief intervention created no further reduction in use levels, though several found extra reductions in alcohol-related problems or in the proportion drinking to excess. Probably due to difficulties in getting ward staff to take on these roles, most studies which demonstrated such benefits used special staff to conduct screening and/or intervention.

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Implementation of brief interventions is obstructed by lack of convincing evidence of cost effectiveness in routine practice, and ward staff remain reluctant to 'intrude' into their patients' drinking. In the nature of the intervention, staff do not see the benefits, most evident in public health terms rather than individual recovery from illness. Specialist staff improve identification rates but at extra cost.

In the featured study alcohol specialists conducted most of the interventions and the research context probably meant interventions by ward staff were of high quality. Whether they would have been able to handle the entire caseload and perform as well is unclear. The longer intervention might have performed better if it had focused on enhancing motivation. These factors probably improved outcomes from the briefer intervention and depressed those from the longer. Without a no intervention control group, it is impossible to say to what degree the interventions were responsible for the improvements. The prospect of being reassessed after being told that your drinking was harmful might have been an added incentive for moderation.

**Practice implications** Studies of screening and brief intervention based on hospital readmission rates or similar data would avoid contamination by research interviews which in themselves could have an impact. Such studies could easily and cheaply be mounted and demonstrate cost-savings directly relevant to the health funders which will need to fund the interventions.

Where alcohol-related risk is common (as in accident and emergency departments and trauma wards) there is a case for specialist alcohol intervention staff. In other settings a few hours of training can equip doctors and nurses to conduct brief assessment and feedback which may significantly reduce risks. To maximise uptake, screening, assessment and intervention should be conducted as one while the patient remains in hospital. A non-confrontational motivational interviewing approach is most appropriate. If a follow-up check (eg, by telephone) can be factored in, outcomes can be monitored and are likely to be improved. Severely or moderately dependent patients should be referred to treatment and proactively followed up to improve treatment uptake.

**Featured studies** Forsberg L., *et al*. "Brief interventions for risk consumption of alcohol at an emergency surgical ward." *Addictive Behaviors*: 2000, 25(3), p. 471–475. Copies: apply Alcohol Concern.

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