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Brief contact and written advice as effective as a longer talk for heavy drinking hospital patients

In Scotland, handing heavy drinking medical inpatients a guide to sensible drinking led to declines in consumption as great as more extended advice, seemingly demonstrating the impact of being professionally identified as a risky drinker and the suggestion (even if conveyed by a minimal intervention) that you should consider cutting back.

FINDINGS Over six months the featured study[1] recruited 215 adult patients from among the 2307 admitted as inpatients to 16 wards in a general hospital. Steps were taken to exclude patients known to have serious drinking problems. Among the 819 not excluded for these or other reasons, screening tests identified 215 who had drunk excessively over the past week. In two-week blocks (to reduce 'cross-contamination' between patients), they were allocated to one of three alcohol advice options.

About a third (the control group) were left to the wards' usual care. Another third met a mental health nurse who handed them a written guide to sensible drinking.[2] The same nurse engaged the remaining third in a roughly 20-minute discussion[3] intended to bolster confidence in their abilities to control drinking and to lead them to the point where they set their own change goals.

Six months later 172 of the 215 were reinterviewed. Typically men in their 40s, before being admitted half had drunk at least 35 UK units of alcohol in the past week. Those allocated to either intervention had on average cut their weekly drinking by 14 or 15 UK units. Compared to assessment and normal care, both interventions had led to a further reduction of 10 units a week, highly unlikely to have occurred by chance. However, the interventions still left the patients drinking heavily; on average they still consumed perhaps about 30 units a week.

IN CONTEXT There are some concerns over the reliability of the findings (notably, many control group patients could not be reinterviewed), but none threaten the conclusion that the interventions led to equivalent drinking reductions relative to screening, research assessment and normal care only.

Accepting this, a key question becomes why such a well structured brief intervention, delivered by an apparently highly skilled interventionist, to patients in the relatively conducive (the very ill were excluded) environment of an inpatient ward, had no greater

effect than handing them an alcohol advice booklet.

Since the same interventionist handed over the booklet, one possibility is that this entailed some discussion which, though presumably shorter, drew on the same skills and content as the longer intervention. Another is that this mistakenly targeted confidence in ability to cut down when this was not the decisive obstacle, or perhaps muddied the water[4] by asking patients to rehearse what for them were the benefits of drinking and by not giving clear advice.

Given other studies (detailed in the background notes), perhaps the most likely explanation is that being identified as a risky drinker and professionally advised (as the offer of the booklet would probably have been interpreted) to consider cutting down, was sufficient to trigger such drinking reductions as there were going to be. The limits of what can be achieved by unsought advice in situations where drinking is neither implicated in the patient's condition, nor a natural topic for clinicians to raise, are typically quite low. Compared to assessment only, often no significant impact is observed,[5] even after fully fledged brief interventions.

A recent analysis[6] pooled results from studies of written advice on drinking accompanied by at most one face-to-face discussion with patients identified by screening. The whole package of screening, assessment and intervention led to substantial drinking reductions, but there were major falls too after just screening and assessment, leaving a small (but still statistically significant) extra benefit from intervention. Its magnitude varied across studies, suggesting that even modest extra benefit was not guaranteed. Where this had been tested, sometimes very brief interventions were just as effective as longer ones.

Focusing on the UK, the picture is similar. Two studies of non-emergency hospital patients tested fully fledged brief interventions against a minimal intervention based on handing over an advice booklet with[7] or without[8] a warning about the patient's drinking. In the first, relative to assessment only, both interventions led patients to cut drinking by on average 2–3 UK units a day. In the second, neither intervention significantly improved on assessment only; all the groups reduced their drinking to roughly the same degree.

Beyond the UK, studies have also found more extended brief interventions offer no advantage over briefer ones.[9] [10] [11] The exception was an Australian study[12] of psychiatric inpatients which found greater reductions in drinking after a 45 minute intervention than after handing over a booklet. In the context of substantial falls in both groups, the difference was modest, and did not translate in to fewer hospital admissions over the next five years.[13] Similarly, at GP practices,[14] more extended interventions have led to only slight and statistically non-significant extra reductions in drinking.

A second key issue is whether *any* form of brief intervention, longer or shorter, is likely to reduce drinking in the non-emergency hospital setting. Compared to merely being assessed, one UK study[7] found modest extra reductions, two[8] found[15] none, and in another,[16] the gains were questionable.

All these studies concerned the general run of patients. Two further UK studies concerned patients whose complaints meant that being talked to about drinking might have seemed

a natural part of their medical care. Compared to assessment only, both found substantial drinking reductions after intervention. The most convincing study[17] concerned young male outpatients with facial injuries after drinking. The second,[18] of patients with high blood pressure, trialed a four-session intervention rather than the more usual one-off, compared it to perverse advice to *carry on* drinking, and the follow-up period was just eight weeks.

With the featured study, this work seems to show that in hospital patients, drinking reductions of the order of two or three UK units a day can be achieved by screening and brief intervention. However, none of the UK studies showed that longer and more sophisticated interventions were any more effective than being identified as a heavy drinker and given very brief advice and/or an advice booklet. On this issue of whether more is better, evidence from elsewhere is also unconvincing.

PRACTICE IMPLICATIONS Among hospital patients, screening for risky drinking and, if indicated, offering very brief advice reinforced by written material seems a worthwhile preventive intervention, but there is no convincing case for more extended (if still brief) intervention. Gains might be greater in clinics or wards whose specialism makes enquiring about drinking integral to the core business of responding to the patient's complaint, but even on general wards, the proportion of heavy drinkers seems sufficient to justify screening and intervention. In the featured study, even after eliminating known problem drinkers, over a quarter of patients screened as excessive drinkers. Similarly, in the general wards of a London hospital,[19] 28% of screened patients had a current substance misuse problem, for three quarters involving alcohol.

Screening and intervention is likely at best to lead to modest reductions but enough, in a few studies which looked at this issue, to reduce the future load on health services. The rate of alcohol-related hospital admissions is an optional local indicator[20] for English health authorities, relating to the national ambition[21] to reduce that rate. Conceivably, hospital based screening and brief intervention could contribute to that objective as well as to national priorities to curb alcohol-related violence and disorder and to prevent or mitigate alcohol-related[22]chronic diseases such as cancer, mental illness, heart disease and diabetes.

These gains are potential rather than certain, but the cost of attempting to secure them is also low because the simplest, quickest and least costly interventions seem as effective as the more sophisticated and extensive. Given this, such programmes might be considered a worthwhile investment[6] in public health terms and to provide an opportunity to identify individuals who need further treatment.

Current alcohol screening policy in England[23] and Scotland[24] focuses more on primary care and accident and emergency departments than general hospitals, but the Department of Health's programme of improvement[25] for alcohol misuse interventions saw hospitals as one of the sites for such work, particularly clinics dealing with complaints often related to drinking.

Though aimed at other medical settings, practical guidance is available from a UK web

site[26] developed by leading researchers and an officially published US guide[27] from the American College of Surgeons.

Thanks for their comments on this entry in draft to Aisha Holloway of the University of Nottingham, Robert Patton of the National Addiction Centre, and Eileen Kaner of Newcastle University's Institute of Health and Society. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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Last revised 01 November 2008

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