▶ Randomized controlled trial of a brief intervention for unhealthy alcohol use in hospitalized Taiwanese men.

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Addiction: 2011, 106, p. 928–940.

Even dependent drinkers among Taiwanese hospital patients substantially cut back their drinking after being identified and offered brief advice, findings from a study which provides one of the most convincing demonstrations yet that brief intervention can work in this setting.

Summary Many general hospital patients in Taiwan abuse or are dependent on alcohol but only 15% are identified by their treating physicians. Only one previous study has investigated brief advice for such patients, finding greater remission in the severity of alcohol problems among patients offered brief advice.

To add to this evidence base, at medical or surgical wards in a medical centre in Taiwan, the featured study recruited consecutively admitted male inpatients who reported to researchers that were drinking more than 14 drinks or 168g of alcohol per week. Of the 3669 men admitted, 717 were heavy drinkers of whom 616 joined the study. They averaged 41 years of age and about a third were unemployed. Based on their responses to the researchers, about half in each group met criteria for alcohol dependence.

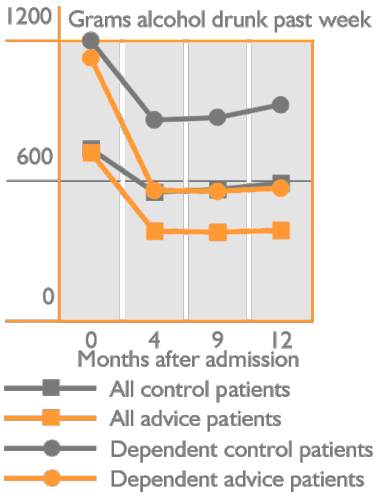
The patients were randomly allocated to a control group which received usual treatment, or to receive brief advice on their drinking from specially trained social workers who were supervised in an attempt to ensure they followed the programme's manual.

Advice was intended to be delivered over two weekly 30-minute sessions. It was based on motivational interviewing principles and associated strategies allied with a self-help booklet/diary which the social worker reviewed with participants and encouraged them to use as a reference for cutting back or stopping drinking. Because hospital stays were short, the first session started as soon as the patient's condition allowed, the second either during the same hospital stay or after discharge. At the second session the social worker asked the participant if he had read the booklet and if he had any questions, and additional opportunities were provided for patients to plan their course of action. An optional third booster session was provided for drinkers with alcohol use disorders, who were referred to specialised care.

Researchers followed up patients over the phone four, nine and 12 months later. Of the 616 patients, 83% completed the first follow-up and 77% the final; 76% completed all three. Heavier drinkers were less likely to be recontacted. The assumption was made that missing patients were drinking as per their last assessment. From the first follow-up more of the patients offered advice could be followed up – 87% v. 79%.

Main findings

On all three main measures of drinking (amount over past week; days of drinking in past week; days of drinking at least 60g alcohol in one day in the past week) both the control group and those offered brief advice cut back in the year after they were admitted to the wards. But on all three, reductions were significantly greater among patients offered brief advice. This was the case among patients as a whole and just those who met criteria for alcohol dependence. For example, when missing values were predicted from those known, before admission the patients were on average drinking about 732g of alcohol a week. In the control group this had fallen 12 months later to 591g but in the those offered advice to 389g ▶ *chart*. In no case did the extra reductions wane significantly over the follow-up period. Results were similar when a different questionnaire was used to assess drinking over the past three months.



These extra drinking reductions among the advice patients were not reflected in extra remission in the number of alcohol-related problems experienced over the past three months at each follow-up point. Even among the advice group these remained at about the same level. Nor did the advice group spend relatively fewer days in hospital or make fewer visits to emergency departments. Though still very few did, significantly more of the alcohol-dependent or alcohol-abusing patients in the advice group (8% v. 2% of controls) had by the end of the 12 months received specialised treatment for their drinking problems.

Of the 308 patients offered brief advice, 289 received at least one session and 213 two. Just 52 opted to attend a third session, including just one patient who met criteria for abuse but not dependence, but about a third of the dependent patients. Patients who attended more sessions made greater reductions in the days they drank and in heavy-drinking days but not in total consumption.

The authors' conclusions

In this study a brief intervention was associated with sustained reductions in drinking among men hospitalised in Taiwan up to a year after the intervention, offering strong support for the value of routine alcohol problem screening and brief advice as integral components of inpatient care in general hospitals.

It was particularly encouraging that patients with alcohol use disorders, including alcohol dependence, also benefited from brief advice by cutting their drinking, and were more likely than control patients to seek specialised treatment. It seems that the adaptation of motivational interviewing and the use of booster sessions may be helpful for men with unhealthy alcohol use, including those dependent.

Results in respect of alcohol-related problems and use of hospital services may have been negative because a year is too short to determine whether changes in drinking persist and reverse the adverse physical, psychological and social effects of unhealthy drinking.

The results of this study may however not be generalisable to Chinese living in other areas [Editor's note: or presumably to other countries]. However, within Taiwan, the fact that our study included men admitted to medical and surgical wards with the entire spectrum of unhealthy alcohol use (including dependence) suggests the results would probably be applicable to most general hospital settings.

FINDINGS The study is a convincing demonstration that in the Taiwanese context brief advice while in hospital leads heavy-drinking surgical and medical patients to cut back, justifying attempts to identify such patients through screening. At the four-month follow up the advice patients had on average reduced their drinking per week by 151g more than control patients, well over twice the average 69g difference at the six-month follow-up in similar studies. That figure was calculated in a meta-analytic synthesis of findings from studies of brief interventions for risky drinkers identified among hospital inpatients. However, it included a Finnish study which recorded a much greater

difference than the others but which featured several follow-up advice sessions, taking it beyond the scope of what is normally considered a 'brief' intervention. Also, the people assessing the outcomes knew who had been allocated to the brief intervention. Excluding this study meant the gap fell a statistically non-significant 54g and by 12 months to 34g, again a possibly chance finding. In general findings from studies were inconsistent, and in the UK generally negative. Just two of six UK studies recorded statistically significant extra drinking reductions and neither was methodologically convincing.

In the featured study perhaps the greatest interest is the finding of substantial extra drinking reductions among men who met criteria for alcohol dependence. At the final follow-up dependent advice patients were on average drinking 558g of alcohol a week less than they had been before being hospitalised compared to 275g among patients not offered brief advice. It seems that this extra reduction amounting to 35 UK units was not largely due to specialist treatment. In Britain too, a more extended advice intervention among dependent drinkers identified at an emergency department appears to have led to a substantial reduction in drinking and a substantial remission in the severity of dependence. Such studies conflict with the usual assumption that dependent drinkers do not profit from brief advice and require fully fledged treatment. Other research too 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 visit the hospital.

One methodological issue in the featured study is that significantly more advice than control patients could be followed up. Together with the fact that the heaviest drinkers were least likely to be followed up, it means that the practice of replacing missing assessments with the previous values will have biased the results in favour of the brief intervention. However, a subsidiary analysis avoided this risk by including just the patients who completed all follow-up assessments. It too generally found statistically significant extra drinking reductions among advice versus control patients. While the non-impact on alcohol-related problems is disappointing, it seems that the relevant measure counted whether such problems had occurred in different domains, taking no account of their frequency or severity. In respect of further hospital care, among presumably quite severely ill patients on average hospitalised for several days, the impact of drinking reductions over a year is likely to have been swamped by the progress they made or did not make in the remission of their medical problems. In so far as these were related to the chronic effects of heavy drinking, a year of curbed drinking might not yet have had a noticeable impact.

Policy and practice in the UK

Alcohol screening and brief intervention policy in Britain focuses more on primary care and accident and emergency departments than general hospitals, though hospital wards and especially those most likely to see heavy drinkers, are among the sites where investing health resources in such work has been legitimised by Britain's National Institute for Health and Clinical Excellence (NICE). Its guidance insists that health service commissioners and managers "must" provide the required training, resources and time to implement these programmes.

Reflecting this advice, the 2012 national alcohol strategy called for programmes to identify hazardous drinkers in NHS services. Accident and emergency departments and hospitals in general were encouraged to check for and offer brief advice about hazardous drinking, in the case of hospitals by employing alcohol liaison nurses who will also manage patients with alcohol problems, liaise with community alcohol and other specialist services, and support other healthcare workers in the hospital.

Even before this strategy was released, progress was being made along these lines. For example, in 2010 a survey of alcohol leads in London-based multi-agency alcohol strategy partnerships found that most partnerships had commissioned alcohol liaison nurses in their hospitals. However, these were inadequately supported by hospital staff (in terms of screening and referrals) and were not well supported by alcohol services outside the hospital. They tended to spend most of their time working with dependent as opposed to harmful/hazardous drinkers, effectively becoming a specialist treatment resource rather than a public health resource addressing the bulk of risky drinking and alcohol-related harm. To an extent this was also found in eight case studies of alcohol health worker posts across England, where at only one hospital did the majority of client work concern identification and brief advice as opposed to medical work with problem drinkers such as detoxification. However, at several sites the aim was that ward staff trained by the workers would handle identification and brief advice.

Though valuable in its own right, the competing demands of delivering specialist alcohol treatment services is bound to shift the focus from the public health role of widespread brief intervention, and in practice it seems very few patients not obviously dependent may be offered advice. For example, on three inner-London general hospital inpatient wards, despite being encouraged to screen all new admissions for risky drinking, staff screened under a third, meaning that just 4% of all adult admissions completed a brief intervention. Generally they were the most obviously problematic drinkers in need of specialist treatment, confounding hopes that screening would act as a public health measure tackling low-level but pervasive hazardous drinking.

Practical guidance on alcohol brief interventions (but not necessarily specifically in respect of hospital inpatients) is available from a Public Health England's e-learning centre and in guides from the American College of Surgeons and from the American Public Health Association.

Run this search on the Findings site for more studies of brief alcohol interventions with hospital patients.

Last revised 27 June 2013. First uploaded 24 June 2013