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Alcohol: signs of improvement. The 2nd National Emergency Department survey of Alcohol Identification and Intervention activity

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Abstract

- **objectives** – To conduct a survey of current alcohol identification and brief advice activity in English Emergency Departments, and to compare the results to the previous survey conducted in 2007.
- **methodology** – Cross sectional survey of all 187 Emergency Departments in England
- **results** – Significant increases ($p < 0.001$) in the proportion of departments routinely asking about alcohol, using a screening questionnaire, offering help / advice for alcohol problems and having access to Alcohol Health Workers or Clinical Nurse Specialists. More than half of all departments indicated that they had an “alcohol champion”, and this was significantly associated with access to training on both identification and provision of brief advice ($p < 0.001$). Departments that routinely asked questions were the most likely to use a formal screening tool ($P < 0.05$) and the Paddington Alcohol Test was the most frequently used measure (40.5%).
- **conclusions** – There have been significant improvements in ED alcohol identification and brief advice activity since 2007 in line with the recommendations of the Royal College of Physicians, Department of Health and NICE guidelines. English EDs are beginning to maximise the likelihood of identifying patients who may benefit from further help or advice about their alcohol consumption, and are able to offer access to specialist staff who can provide appropriate interventions

Background

Alcohol use in the UK remains associated with a high level of morbidity and mortality. The latest figures from the ONS indicate that alcohol related deaths have more than doubled over the last 10 years, with 37% of all males and 29% of all females consuming in excess of the DH recommended units on one or more occasion per week[1]. Previous research has found that up to 70% of all Emergency Department (ED) admissions at peak times are associated with alcohol misuse[2]. It is apparent that this is an ideal location to both detect hazardous drinkers and to offer help and advice to reduce their consumption[3].

In 2007 “Safe Sensible Social”[4] was published. This was an update to the Alcohol Strategy for England[5] that further endorsed the application of screening and brief interventions to identify and intervene with problematic alcohol users presenting to the ED. A survey by Owens et al in 2005[6] examined the impact of the strategy in general hospital settings, concluding that most did not have appropriate services to deal with patients presenting with alcohol related problems, and highlighting the lack of specific funding to provide such services. A subsequent survey of all EDs in England in 2006[7] found that although there was awareness that alcohol consumption represented a very real issue to departments, most had not adopted formal screening methods and therefore there existed the very real possibility that many patients who might benefit from help or advice were missed.

Two systematic reviews[8;9] have concluded that alcohol identification and brief advice (IBA) in the ED is an effective and cost effective method to reduce levels of alcohol consumption and alcohol related harm. This finding has been translated into UK alcohol policy guidelines by the Department of Health[10;11], both of which recommend that EDs adopt alcohol IBA strategies, although at this time there are no specific instructions to do so.

The recent NICE guidelines[12] “Preventing the development of hazardous and harmful drinking” also commend the use of screening tools and the delivery of brief advice in the ED.

To determine the extent to which the continuing recommendations for the provision of alcohol screening and brief advice have been adopted by EDs, a survey of all English EDs was undertaken. This survey followed up on the previous National Survey[7], with more specific questions regarding access to training on screening and brief interventions.

Methodology

This was a cross sectional survey targeting all 187 consultant led Emergency Departments in England (Minor Injury Units and specialist trauma centres were excluded). A set of survey questions based upon the previous national survey was developed and made available in both print and online versions. Anonymity of respondents was preserved by utilising an Identity Number.

Prior to the commencement of the survey, support for and endorsement of the survey was sought and obtained from the College of Emergency Medicine (CEM). The CEM was able to provide contact address for all English EDs, however it was not possible to obtain the names of the lead clinicians for each department. The researcher augmented the CEM database with telephone contact details for each department.

Advice was sought from the local NHS Research Ethics Committee, who determined that this survey counted as an example of Clinical Service Audit, and as such ethical clearances were not required to proceed.

In the first instance, a questionnaire was sent to the “Lead Clinician” of each ED. Each questionnaire also contained a return address, a link to the online version of the survey and details to allow the return of completed materials via electronic methods. Two weeks after the initial mail-shot, non-responding departments were sent an Email version of the cover letter and questionnaire. Two weeks after the initial email contact, a second wave of emails was sent to remaining non-responders, and two weeks after that a final round of telephone and email contacts was undertaken. Data collection occurred over a total of eight weeks. Once the survey was closed data were entered into SPSS and then analysed.

Results

A total of 153 departments (of 187 contacted) responded to the survey (81.8% response rate). The proportion of participating departments varied by region, with between 72.0% - 90.3% returning completed questionnaires. Table 1 shows a comparison of the current and previous survey findings. There was a significant reduction (-17.9%) in participating departments compared to the previous national survey, however over 80% of EDs did complete the questionnaire. There have been significant increases in routine questioning about alcohol consumption (+35.0%), the use of a formal alcohol screening questionnaire (+49.6%), the provision of help / advice about alcohol problems (+22.1%) and access to Alcohol Health Workers (AHW) or Clinical Nurse Specialists (CNS) (+54.9%).

Table 1: Comparison of survey findings 2006 vs. 2011

| | 2006 (N = 189) | 2011 (N = 151) | Difference in Proportions |
|---|--------------------------|--------------------------|----------------------------------|
| Response Rate | 98.9 % | 81.0% | -17.9 * |
| Routinely ask about alcohol | 12.7% | 47.7% | +35.0 * |
| Use a formal screening tool | 2.1% | 51.7% | +49.6 * |
| Measure blood alcohol as required | 52.7% | 56.4% | +3.7 |
| Record alcohol related attendance | 69.7% | 70.5% | +0.8 |
| Offer help / advice for alcohol problems | 73.9% | 96.0% | +22.1 * |
| Have access to an AHW or CNS | 16.9% | 71.8% | +54.9 * |

* p<0.001

A sensitivity analysis, based on the conservative assumption that non-responding departments were not engaging in any of the specified identification and intervention activities, indicated that although there was still an increase in the number of departments offering help or advice for alcohol problems, this was no longer statistically significant (+4.4%). All other reported differences remained unchanged.

Almost two thirds of departments (63.6%) offered staff access to training on alcohol screening, with just over half (57.0%) providing some form of brief advice training. Most

training was provided within the department (68.5%), with online (15.0%) and external agencies (10.5%) providing the rest.

More than half of all departments (57.6%) indicated that their ED had an “alcohol champion” – that is a specific member of staff who took responsibility for alcohol issues. There was a significant association between the presence of a champion and access to training on screening ($\chi^2=36.64$, $df=1$, $p<0.001$) and brief advice ($\chi^2=29.93$, $df=1$, $p<0.001$).

Almost every department (98.7%) indicated that they asked adult patients about their alcohol consumption. Of these, almost half asked such questions routinely (47.7%), and used a standardised screening tool (51.7%). There was a significant association between these two variables, suggesting that departments that routinely asked questions were more likely to use alcohol screening tools ($\chi^2=4.29$, $df=1$, $p<0.05$). The Paddington Alcohol Test was the most frequently used screening tool (40.5%), with the AUDIT-C (23.0%) and FAST (14.9%) also accounting for most screening activity.

In general, most departments measure blood alcohol “as required” (55.7%), and the service is available 24/7 (94.3%). Four in ten departments did not ever measure blood alcohol (43.6%). Of those departments that routinely used alcohol questionnaires, only a fifth (18.6%) indicated that they measured blood alcohol levels if a patient was unable to complete the screening tool.

About two thirds (70.5%) of all EDs recorded an alcohol related attendance in the patients notes, with three quarters (74.8%) informing the patients GP about such attendances. There is a significant association between these two variables, with departments that record attendances more likely to also inform patients GPs of an alcohol related attendance ($\chi^2=10.27$, $df=1$, $p=0.001$).

Every department offers some sort of help or advice (i.e. leaflets, advice or specialist referrals) for patients who might have an alcohol problem (100.0%). The help / advice provided by about half (53.0%) of all departments was a referral to their own “in house” specialist team, with about a quarter (28.5%) referring patients to an external agency. Some department staff also provided an intervention themselves as either a leaflet (19.2%) or “Brief Advice” (1-2 minutes of structured advice about their level of alcohol consumption) (6.0%). The majority of departments had access to AHW / CNS (71.8%) – most of these were based on-site (74.8%).

Table 2: Regional variation in survey responses

| | | Alcohol Champion (%) | Screening Training (%) | Advice Training (%) | Routine Questioning (%) | Access AHW / CNS (%) | BAC Measured (%) |
|-----------------------|-----------------------------------|-------------------------------------|---------------------------------------|------------------------------------|--|-------------------------------------|---------------------------------|
| English Region | East of England | 23.1 | 46.2 | 30.8 | 38.5 | 92.3 | 61.5 |
| | Greater London | 67.9 | 67.9 | 60.7 | 46.4 | 80.7 | 42.9 |
| | South West England | 66.7 | 72.2 | 55.6 | 35.3 | 77.8 | 66.7 |
| | North West England | 72.7 | 59.1 | 59.1 | 63.6 | 77.3 | 63.6 |
| | Yorkshire & The Humber | 62.5 | 50.0 | 62.5 | 25.0 | 80.0 | 20.0 |
| | West Midlands | 20.0 | 73.3 | 73.3 | 42.9 | 80.0 | 40.0 |
| | North East England | 66.7 | 66.7 | 66.7 | 66.7 | 66.7 | 88.9 |
| | South East England | 54.5 | 83.6 | 50.0 | 59.1 | 57.1 | 61.9 |
| East Midlands | 25.0 | 75.0 | 50.0 | 50.0 | 100.0 | 87.5 | |

Discussion

This cross sectional survey of current alcohol IBA activity had a response rate of over 80%. Although this represented a decrease on the previous national survey[10] the broadly equal regional variation in response rates (see Table 2) suggests that our sample is representative of all English EDs.

The increases in alcohol IBA activity over the last five years are very encouraging. In particular departmental access to AHW / CNS staff has changed from 17% to 72%, and this is in line with the recommendations of the Royal College of Physicians[13] and Department of Health[10]; these specialist staff provide Brief Intervention (20 minutes of assessment and advice, as compared to the 1-2 minutes of Brief Advice provided by ED practitioners). Routine questioning, specifically with the use of a formal alcohol screening tool also significantly increased, again this is in line with the NICE guidelines for good practice[12].

The preliminary results from the SIPS trailblazer research programme[14] clearly indicate that the presence of an “alcohol champion” is an important factor in the successful implementation of IBA activity into routine practice; this survey found that over half of all English EDs are able to identify one. We have found that the presence of an alcohol champion is significantly associated with an increased likelihood of training in both screening and in delivering brief advice, and suggest that as more departments move towards the ‘appointment’ of such a person, that current levels of screening (and the use of a formal screening tool) will increase proportionately. We also suggest that the current level of brief advice (about 6% of all departments currently offer this) would also be set to rise should additional alcohol champions be identified.

Departments currently use a variety of screening tools, with the Paddington Alcohol Test[15;16] cited as the most commonly used measure, and this is in line with the recent NICE guidance[12]. In our opinion the choice of screening tool remains secondary to the actual use of such measures, and while the PAT is currently the measure of choice (perhaps due to its speed of administration or accuracy [15,17] , individual departments should be able to choose whatever screening tool works best for their staff and patients.

The proportion of departments who measure Blood Alcohol Concentration (BAC) as required has not changed over the last five years. Recent research by Touquet and colleagues[18] suggests that BAC should be obtained from patients who are unable to complete a screening questionnaire, however at this time less than one in five departments who routinely use a formal screening tool collect BAC data from such patients. We recommend that departments consider the use of BAC in cases when it is inappropriate or not possible to use a screening questionnaire, as this can provide important information that could enable better clinical management.

Although every department sets out to offer help to patients who they believe have an alcohol problem, the identification of such patients remains an issue. Having identified an alcohol related attendance; most departments record this in the notes, with the majority also informing the patients GP of this. This sharing of information is a vital component in the continuity of care, and may contribute towards the recent “making every contact count” guidance[19]. We suggest that every department who identifies problematic levels of alcohol consumption make reference to this in the patients’ record and also notify their GPs who can then offer further appropriate help and advice as and when the opportunity occurs.

Every department offers help or advice to patients who they have identified as having problematic consumption of alcohol. In line with DH guidelines most departments provide a referral to a specialist worker or service, with the majority of these being based on-site, and there is good evidence that such referrals can reduce levels of consumption and associated alcohol related problems and subsequent hospital attendances[20]. At this time very few departments (6%) provide brief advice to patients. Reasons for this are unclear, however such short focused advice sessions may be as effective as more intensive interventions, and we would anticipate an increase in their provision as further guidance on alcohol IBA is published (following the SIPS trailblazer programme[14]). It is likely that brief advice at the time of the identification of problematic alcohol use has a beneficial impact upon patients' drinking behaviours, and as such we would suggest that all departments adopt this approach in addition to the onward referral of patients to specialist services as required.

The results of this survey of alcohol identification and brief advice activity show that, compared to the earlier 2006 survey, levels of screening, provision of help / advice and access to AHW / CNS services have all increased significantly. Departments are beginning to identify local alcohol "champions", and this is associated with an increase in the provision of training in both identification and brief intervention. The increased use of formal alcohol screening measures, often applied routinely, suggests that English EDs are beginning to maximise the likelihood of identifying those patients who may benefit from further help or advice about their alcohol consumption. The four fold increase in access to specialist services for such patients should serve to also ensure that those who require help are exposed to interventions that are both effective and cost effective. To conclude; alcohol no longer represents a missed opportunity in the ED. Departments are to be commended upon their

progress towards the integration of alcohol IBA into routine practice; this increased focus upon alcohol affords a chance to instigate change for the betterment of the patient, the department and the wider health service.

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Details of Contributors

RP conceived and designed the study, analysed (using SPSS) and interpreted the data. POH and RP collected data and prepared the results for publication.

All authors had full access to all of the data (including statistical reports and tables) in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis.

Competing Interests Statement

All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare that (1) RP received support from Alcohol Research UK for the submitted work; (2) RP and POH have no relationships with any companies that might have an interest in the submitted work in the previous 3 years; (3) their spouses, partners, or children have no financial relationships that may be relevant to the submitted work; and (4) RP and POH have no non-financial interests that may be relevant to the submitted work.

Ethical approval

No ethical approval was required for this study as it was a Service Evaluation, and this was confirmed in a personal communication from the Chair of the London - Camberwell St Giles Research Ethics Committee (dated 25/08/2011).

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Data sharing

No additional data available

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