Summary Points

1. The effects of alcohol abuse in society are clearly documented and require a public health response in terms of prevention and education.

2. Harmful effects of alcohol are seen in general hospitals and emergency departments and constitute a major proportion of workload. Many other patients present at risk of alcohol related problems because of hazardous drinking patterns – this provides an unique opportunity to detect and intervene.

3. Alcohol abuse is so common that all medical and nursing personnel need to be able to evaluate and briefly intervene in patients.

4. Education & training in brief interventions can be provided by liaison psychiatry (or local addiction specialists) for basic intervention.

5. In hospital initiatives such as development of a clinical nurse specialist post in alcohol problems can lead to culture change through education and training and offer more intensive treatment and/or coordination of follow up care in the community.

6. Community services for alcohol have little or no coordination and negligible capacity to integrate with acute hospitals. This serves to undermine the identification of alcohol problems as specialist services are largely unavailable (contrast with drug services).
**Background**

Alcohol is a major contributor to attendances at Emergency Departments (EDs), particularly at nights and weekends. This is consistent with the pre-eminence of alcohol as a contributor to harm at every level of Irish society (Hope 08). The strategic taskforce in alcohol (2004) outlines the scope of this problem and the range of measures necessary to address it. It proposes action at a number of levels - legal, educational, social and health amongst others. This is in recognition that isolated interventions are unlikely to be effective in tackling a complex problem that is embedded in Irish Society. It requires integrated measures to bring about systemic or even the necessary cultural change.

The burden of alcohol abuse in the EDs of Irish hospitals is high and at least consistent with international figures. The statistics in relation to EDs are well known with 30% of ED costs attributable to alcohol (Chief Medical Officer, 2010). Alcohol related problems range from physical injury, medical emergencies associated with the long-term effects of alcohol dependency to the psychosocial consequences of alcohol misuse. Current practice is that alcohol problems will be referred to psychiatry and/or social work, depending on the nature of the issues that arise with the alcohol abuse. However, if there is no conspicuous problem as a result of alcohol, there is little screening or brief advice or intervention done as a routine, due to underdevelopment and inadequate resourcing of such services.

Effective healthcare interventions for alcohol and its harm need to be coordinated. EDs (and general hospitals) cannot serve as the site of definitive interventions for complex alcohol problems but rather serve to identify, assess, stabilise and link with appropriate services for ongoing care. That said, the emergency setting is uniquely placed to contribute to ‘alcohol care’. It is a point of contact for people who otherwise have little to do with health services. Injuries or trauma as a consequence of alcohol abuse, provide an opportunity to link the consumption of alcohol with its adverse consequences, what has been called “a teachable moment”. These reasons constitute a compelling argument to use the ED for specific alcohol related interventions. However, such interventions must be feasible or deliverable in busy 24 hour environments. They have to be effective and crucially, be a component of the response of the healthcare system rather than an isolated measure.

**Evidence for Interventions**

During the 1990s, the role of brief interventions (BIs) in effectively reducing alcohol consumption was clearly established (Bien et al 1993). A meta-analysis by Wilks et al (1997) demonstrated that the combined odds ratio was almost two to one in favour of brief alcohol interventions over no intervention. The role of BIs in general practice has been clearly established (Kaner et al) and is showing promise in the general hospital environment (McQueen et al 2009).

The past decade has seen a significant number of studies examining the efficacy of BIs for alcohol problems in the ED. Outcome measures include reductions in consumption, binges and injuries. This latter point of reducing injuries has been the subject of a systematic review and meta-analysis (Havard et al 2008) which concluded that BIs do reduce alcohol-related injuries. However, it should be noted that the systematic review of 13 studies failed to reveal a significant effect of BIs on alcohol consumption. The meta-analysis was based on three of the 13 studies, two of which were limited to young people, one
in the thirteen to seventeen year age group. In the study of Monti et al (1999) looking at a group of older adolescents, there is a very marked discrepancy between the intensity of the interventions. It compared structured motivational interviewing with a few minutes of feedback. Studies in groups of such limited age spans are not necessarily representative and probably not generalisable to the general population attending EDs. The other study cited as demonstrating a reduction in alcohol related injury is that of Longabaugh et al (2001). In this study, while there was a reduction in alcohol related injuries overall, there was no decrease in alcohol related injuries requiring medical intervention, i.e. there was no change in more severe injuries and neither was there any reduction in alcohol consumption between the active intervention and comparison group. A review by this group in 2008, while reporting positive effects on a range of measures in the ED, did highlight the heterogeneity of the methodologies & outcomes (Nilsen et al, 2008)

It is a recurrent theme that in many of the BI studies, significant reductions are seen in both the intervention and comparison / control groups. There is difficulty in then demonstrating the effectiveness of BIs while the comparison groups have improved in all measures of alcohol abuse also. This suggests that there is something about the studies in general which may be effective in reducing alcohol related harm. A common element of many of the studies is the extent of the assessment. It has been suggested that thirty to forty minutes of assessment, of itself, constitutes an intervention (Bernstein and Bernstein 2008). This is on the basis that time spent enquiring about alcohol consumption and the potential consequences of it will lead to an increase in reflection and awareness of alcohol abuse. Given that this takes place in the Emergency Department in close temporal proximity often to harmful consequences of alcohol abuse, people may make the link themselves to modify their alcohol intake.

Characteristics of the patients studied are of importance also. Those with full blown alcohol dependence syndrome may reduce their alcohol intake but by levels which are clinically of little value and statistically insignificant. In contrast, those who are drinking at levels considered hazardous or indeed harmful do benefit in many studies from active intervention. A more meaningful outcome for the alcohol dependent group would be engagement with an alcohol treatment programme and research needs to occur examining this question. Project Assert (Bernstein et al 1997) went some way to addressing this issue, though in a US population.

In the U.S. the National Institute for Health (NIH) advocates the adoption of screening and brief intervention in the ED. This was primarily based on the academic ED Screening, Brief intervention and Referral for Treatment programme (SBIRT, 2007). This was a project involving four academic centres in the United States. It demonstrated the efficacy of a brief intervention delivered by Emergency Department personnel trained in brief negotiated interviews in reducing harmful and hazardous consumption. The efficacy of this study is impressive. The brief negotiated interview was delivered by ED staff that had just been trained in the week or so before recruitment of approximately forty patients at each centre. The patients were screened and recruited (including payment) by research support staff and once identified, received brief negotiated interview. The comparison was with a group identified by the research assistants who received only a written list of local referral sources. This does show the that BI is significantly better than just being given a list of alcohol related resources in patients systematically screened, identified and brought to the attention of ED staff of academic centres, involved in a research project and trained in the four weeks prior to seeing the patients. Problems with the generalisability – clinical effectiveness rather than efficacy - of this to the routine workings of a busy ED are clear.
**Issues that Arise**

There are significant impediments to doing anything with alcohol in hospitals and in EDs. The incorrect assumption that people who present with alcohol related harm are alcoholics is part of a clinical dichotomisation of patients into normal drinkers or alcoholics. As alcoholics are notoriously evasive and will minimise and deny the extent of their problems, their treatment is (rightly) seen as a specialist area and beyond the competence of all but specialists in addiction. This is all the more apparent late at night and in the midst of an already stretched clinical service – staff will generally prioritise people who actually want help rather than evade it. These factors may all conspire to undermine any therapeutic optimism and lead to a pragmatic decision to deal with the presenting problem and leave the alcohol problem for the specialists.

However, there are plenty of patients requiring help who will cooperate and do want it. The evidence cited above suggests that brief advice or interventions do work to reduce alcohol related harm. Put simply there is a general reduction in alcohol intake and related harm seen in the ED with most intervention studies. The components of effective interventions with hazardous / harmful drinkers in the E.D. are based on sound clinical practice. Clinicians need to be aware of the effectiveness of brief interventions, the components of which are taking a history, reflecting on the effect of the drinking with the patient and advising accordingly. If the assessing clinician identifies a need for further intervention, ready access to such agencies should be available.

Liaison psychiatry (general hospital psychiatry) takes a lead in the training and education of staff in the ED (and throughout the general hospitals) on how to approach alcohol problems with ongoing educational programmes. Comorbidity of alcohol problems and mental illness are very common and such patients with complex needs require expertise in the evaluation and management of both. Different initiatives such as development of a short video for staff training and development of an alcohol liaison nurse specialist have been useful and are being evaluated currently. While these initiatives are improving the situation for people with alcohol problems and their families, there is a conspicuous lack of community and residential specialist alcohol services when problems are identified. Community services for alcohol are poorly integrated with hospitals such that patient outcome is not known when referred. That is not due to unwillingness to collaborate with hospitals but a lack of infrastructure to coordinate activities.

**Conclusions**

To significantly address the problem of alcohol will need a public health approach consisting of preventative and educational approaches. In relation to identification and treatment, alcohol problems are rife within the hospital system and EDs in particular. This requires as a minimum a capacity of all health professionals dealing with patients to be able to identify and advise in relation to alcohol problems. Currently, there are significant impediments to addressing the needs of both symptomatic and asymptomatic patients in the hospital system. These include what might be termed a “therapeutic nihilism” based on a perceived deficit in skills to approach an alcohol problem and a lack of agencies to refer to once a problem is identified. Liaison psychiatry can provide a lead in training & education of staff thus empowering incorporation of the components of BIs into routine clinical practice. Development of community treatment facilities properly integrated with the HSE would further promote the identification & intervention of alcohol problems.
References


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McQueen J, Howe TE, Allan L, Mains D. Brief interventions for heavy alcohol users admitted to general hospital wards. The Cochrane Library 2009, issue 3


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**Glossary**

**Brief Intervention**: A time limited intervention focusing on changing behaviour. They can range from five to ten minutes of information to two to three sessions of motivational interviewing or counselling (Cochrane Review, 2009).

**Liaison Psychiatry**: Psychiatry practised in the general hospital (as opposed to the community). Deals with presentations to the Emergency Department and psychiatric/psychological issues that may arise in the course of medical/surgical treatments.