Alcohol misuse: Positive response. Alcohol Health Work for every acute hospital saves money and reduces repeat attendances

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Westminster Primary Care Trust (PCT) in London, UK now funds Alcohol Health Work (AHW) from a full-time clinical nurse specialist (CNS) in alcohol treatment, who works solely at St Mary’s Hospital, Paddington, London, UK. This came about in response to the evidence presented by our randomised controlled trial published in the Lancet in 2004 titled 'Screening and referral for brief intervention of alcohol misusing patients in an emergency department: a pragmatic randomised controlled trial'. During this trial, CNS from the local community alcohol service visited St Mary’s Hospital on only three mornings a week. Even so, we were able to show that for every two referrals made for BI, there was one less ED re-attendance over the next 12 months. This was irrespective of whether the patient actually attended their appointment.

ED staff routinely recorded the required pragmatic baseline data. Researchers only collected the 6 and 12 month follow-up data from the 599 alcohol misusing patients, who had been randomized to receive either brief advice (BA), or BA plus an appointment with the CNS for BI. It was judged unethical to have a ‘no treatment’ control arm in the study, as our ED had been providing services for alcohol misuse since 1987 (Public Health White Paper, Chapter 6, ‘A health promoting NHS’, p. 148, 16.11.04, DOH. http://www.dh.gov.uk/assetRoot/04/09/47/64/04094764.pdf). One of this Editorial’s authors (AB) is a full-time CNS in alcohol treatment now based within our ED and already 100 patients a month are being referred, with 60 actually attending for BI. Referrals are accepted from the whole of St Mary’s Hospital. In 2003 it was reported that there were 21 such posts in the UK, some only part-time. Evidence from both the UK and the USA demonstrate the cost savings.

The problem of alcohol misuse, wherein in the UK up to 40% of ED attendances are associated with alcohol (Alcohol Harm Reduction Strategy for England, March 2004, http://www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp), is the same for all the ED worldwide, occurring wherever alcohol is readily available and cheap, as evidenced for instance in Australia by Watt et al. and Tjipto et al. in this issue of Emergency Medicine Australasia.

The ED are medical ‘places of safety’ for patients suffering unexpected events. The top 10 presenting ED conditions associated with alcohol misuse are fall, collapse, head injury, assault, accident, unwell, non-specific gastrointestinal problems, psychiatric, cardiac and repeat attender. ‘Focused Selective Screening’ when combined with education, audit and feedback is achievable pragmatically using the Paddington Alcohol Test (PAT) (see Figs 1,2). The PAT is considered non-judgemental with the word ‘routine’ used in the introduction, and only quantity and frequency questions being asked, as opposed to those on behaviour, such as the CAGE questionnaire (Cut down/Annoyed you/Guilty/Eye-opener). The process of BA is started by asking ‘Do you feel your attendance here is related to alcohol?’ If the patient is PAT-positive, advice is
given, ‘We advise you that this drinking is harming your health.’ The introduction of the latter resulted in a 20% increase in uptake of the offer of an appointment for AHW. Therefore, the PAT is an evolving clinical tool guiding the BA, that is often given by staff with no specialist knowledge (see Fig. 2).

This work has now been made easier by increased resources aimed at EDs meeting mandatory Government set targets, such as that 98% of patients should pass through the ED in under 4 h. Therefore, patients are more likely to be grateful, and are more receptive to staff introducing their ‘agendas’ to improve health and reduce re-attendance, with the patient’s own ‘agenda’ having been attended to first. Rollnick and Heather have delineated how patients may be successfully encouraged to change. Brief advice structured by the PAT focuses on the relationship between ED attendance and the prior consumption of alcohol (see Figs 1, 2).

ED staff must, however, have specific training in recognizing and managing alcohol misuse. A majority themselves drink alcohol; appropriate staff attitudes

Figure 1. The Paddington Alcohol Test (PAT) 2005.
including empathy and volition, are vital.\textsuperscript{17} Drunken patients are not easy to assess clinically;\textsuperscript{18,19} and even drunkenness itself is difficult to classify.\textsuperscript{20} Occasional binge drinkers need to develop insight, even if they refuse the offer of a next-day appointment for AHW. Patients may indeed be sober on ED attendance; however, the superficially sober may have developed tolerance.\textsuperscript{21} The dependent drinker, often of no fixed abode (NFA) that constitute 10\% of referrals for AHW, must also be managed professionally and appropriately, especially to prevent medical emergencies such as Wernicke’s encephalopathy.\textsuperscript{22,23}

Management of the drunken patient is facilitated by the use of ‘Clinical Decision Units’ or 24 h short-stay wards, where patients remain under the care of ED staff, as well as by medical Admission/Observation wards. Our full-time CNS in alcohol treatment visits both daily. For the patient who is not alert and orientated, knowledge of the blood alcohol level not only may assist immediate management of, for instance, the drunken head injury,\textsuperscript{21,24} but also flags up the need for the later application of the PAT.

Referral for AHW is appropriate from a wide spectrum of ED presentations. These may range from the multiply injured patient in the resuscitation room, to the sober patient with a minor injury; also for the full spectrum of alcohol misuse from the occasional binge drinker to the dependent drinker. The most productive

Figure 2. How to use the Paddington Alcohol Test (PAT).
and rewarding work is to detect alcohol misuse early in a patient’s drinking career, when it is so much easier to change. The ED gives an opportunity to make use of ‘The Teachable Moment’, whose half-life is 48 h,

hence the importance of the next working-day appointment.

The CNS in alcohol treatment educates, performs audit and gives feedback to staff (see Fig. 3). A hospital Consultant of any acute speciality provides clinical leadership. Education and training of doctors and nurses results in ‘Focused Selective Screening’. Patients are offered an appointment with the CNS where appropriate. The AHW model shows how effective this work is

(see Fig. 4). Success generates success.

The UK Alcohol Treatment Trial (UKATT) study showed cost savings for alcohol misuse of five times the expenditure on health, social and criminal justice services. Gentilello in the USA showed savings of US$3.81 for every US$1.00 spent on screening and intervention. Everybody benefits, even appreciating that different health-care systems have different structures and funding opportunities. Australasian EDs and hospitals need to be responding too. The information provided in the present Editorial and summarized in the Figures is one proven, cost-effective way to respond.

Competing interests

None declared.

References


