Managing patients with alcohol problems in the general hospital

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Alcohol and medical in-patients

- Many medical in-patients drink excessively
- This is expensive to the NHS.
- Brief counselling works
- Can we implement a service?
Alcohol-related admissions

- 12% A & E attenders alcohol-related problems; c. 50% of head injuries
- **20-25% of men** admitted to general medical wards consume in excess of sensible limits.
- Most not admitted for alcohol-related diseases - unrecognised

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Alcohol - can the NHS afford it?

- Estimates of cost to NHS of excessive alcohol consumption
  - £41 m - direct in-patient; £120m alcohol-related
  - £188-392m of hospital costs
  - £500m

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Randomised controlled trial of brief intervention (Chick et al bmj 1985)

- 4 medical wards - screened 731 men (18-65 years) - 22% > 50 units + no previous Rx

- 78 counselled by nurse specialist on ward (x 1) & 78 controls
Alcohol - Brief interventions

- **Assessment** / feedback of intake

- Give **information** re hazardous drinking (50 men / 35 women)

- Clear advice - verbal, written to stop / cut down + details of local services

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Brief interventions (contd.)

- Responsibility lies with patient
- Menu of options
- Empathy
- Self-efficacy for change
Randomised controlled trials of brief interventions

- General hospital in-patients: 20-60% reduction of amount consumed per week
- Overall reduction from brief interventions - 20% more than controls

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<table>
<thead>
<tr>
<th>Study</th>
<th>Brief Int</th>
<th>Control</th>
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<tbody>
<tr>
<td>Chick (1985)</td>
<td>64%</td>
<td>49%</td>
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<td>Anti-poika (1988)</td>
<td>58%</td>
<td>+11%</td>
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<td>Heather (1996)</td>
<td>40%</td>
<td>30%</td>
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<td>Watson (1999)</td>
<td>46%</td>
<td>33%</td>
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Stage of considering stopping
Rumpf et al Gen Hosp Psychiat 1999

- 118 alcohol-dependent patients in general hospital
- 50 alcohol-dependent persons in general population
Contemplating stopping alcohol

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Problem

- We know many medical in-patients drink excessively & this is expensive to the NHS.
- We know brief counselling works
- Why can’t we make this successful treatment happen routinely?
Royal College of Physicians Reports

- 1987 A great and growing evil
- 1995 Alcohol and the young
- 1995 Alcohol & the heart: sensible drinking reaffirmed
- 2001 Alcohol - can the NHS afford it?
Royal College of Physicians Reports 1987

- A great and growing evil; the medical consequences of alcohol abuse

- recommended that “every patient seen in hospital should be asked about his/ her alcohol intake as a matter of routine… and the answers recorded”

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Royal College of Physicians Reports 2001

Alcohol - can the NHS afford it?

Recommends a coherent alcohol strategy for hospitals

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Successful hospital alcohol strategy

- **Screening** strategy for early detection
- **Brief intervention** for coincidental hazardous drinkers
- **Widely available protocols** for pharmacotherapy of detoxification
- **Good links** with specialist services

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Successful hospital alcohol strategy

- Provision of general staff training and support
  - a) to assess need for referral
  - b) make referral to support services (local knowledge)
- Service support from senior medical, psychiatric and nursing staff

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Detox

Assess dependence

Recog → unrec.

Screening strategy

brief intervention

Links to:

local support
Rx facilities

* Training of staff

*Support from senior medical, psych. & nursing staff

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Unrecognised heavy drinkers in general hospital

- Admission may not be directly alcohol-related but help offered at an early stage can reduce the potential future burden

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Manchester project - Aims

- Development and Implement Fund:
- Repeat Chick’s project
- Establish a brief intervention for medical in-patients using a (nurse) alcohol counsellor

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3 questions

- Can we implement a brief intervention

- 2 counselling sessions > 1?

- Feasibility of training nurses to detect problem drinking

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Subjects

- Only concerned with people who were not recognised as having an alcohol problem, including alcohol-related illness

- i.e. excluded recognised heavy drinkers with alc-related disease
Phase 1 - screening - no counselling

- 6 mths follow-up “before”

phase 2 - 1 session counselling

- 6 mths follow-up “after”

phase 3 - 2 sessions counselling

- 6 mths follow-up “after”
Phase 1 - screening only (counsellor)

- 6 mths follow-up “before”

Phase 2 - screening + 1 session counselling (c + nurses)

- 6 mths follow-up

Phase 3 - 2 sessions counselling (nurses)

- 6 mths follow-up

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Training of nurses

- To approach patient, ask questions
- With patient - complete drinking diary for 1 week
- If units >50m / 35f, refer to counsellor

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Counselling

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Counselling

- c. 1 hour
- stages of change model
- booklet - coping with craving, cutting down, stages of change, units of alcohol, recommended limits

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Training of nurses

- **Formal**: group or 1-to-1, increasing nurses’ understanding
  - importance of screening,
  - recording in case notes,
  - skills in responding to person with drinking problem
  - knowledge of local services
Training of nurses

- Informal: Alcohol Counsellor frequently on wards
- Advice, support,
- Specific teaching
- See patients quickly

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Results

- During phases 1 & 2 screened 1360 consecutive patients - 177 (13%) drank more than 50/35 units cut-off
- = 19.6% men and 4.8% women
Phases 1 & 2

During screening phases 1 & 2: all eligible patients recruited: (52 ineligible - lived outside Manchester, admitted for DSH, alcohol-related disease)

------ 125 entered (80 in phase 1 “before” and 45 in phase 2)
Phases 3

- Nurses screened patients as part of routine admission procedure - 45 referred to nurse counsellor during phase 3

- Same no (45) as during phase 2 while screening occurred.
Follow-up

● 78% followed-up
  (10% refused, 6% died, 6% changed address)

● Interviewed by researcher blind to counselling/previous intake

● Drinking diary for week.
Median no. of units per week

- Before 6 mths f-up
- 6 mths f-up

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<th>No counsel.</th>
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<th>2 Sessions</th>
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<td>n</td>
<td>80</td>
<td>45</td>
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3 questions

- Can we implement a brief intervention
  - YES

- 2 counselling sessions > 1?
  - NO

- Feasibility of training nurses
  - YES
Outcome

- **Commissioners**: Not in priorities for new money - support but only within existing contract w Trust

- **Trust**: support but can’t do within existing budget - need new money from commissioners
Organisational barriers (RCP 2001)

- Separate Mental health & acute Trusts and separate alcohol services
- Who pays for alcohol counsellor - “Acute Trust but (s)he must link to MH Trust to avoid isolation”

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Organisational barriers (RCP 2001)

- **Steering group:**
  - manager from acute trust,
  - liaison psychiatry,
  - substance misuse service
- **Physician**

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Staff attitudes

- Drs & nurses reluctant to raise alcohol consumption with patients even when they feel it is an important part of problem:
  - lack of time, -ve personal attitude,
  - unable to help, not within their remit

- Routine

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Staff attitudes

- Delegate to most junior member of team.
- But not trained / unskilled - anxiety, lack of support from senior colleagues.
- Ambivalence - heavy drinking medical student culture
- Senior Physician must take the lead
Staff attitudes - London teaching hospital

- Physicians spend c 3 hours per week on alcohol-related problems
- Alcohol-dependent “aggressive,... frustrating,... treatment is futile”  Little internal support
Staff attitudes

- Negative attitudes
- stem from pre-clinical days
- Stigma - patients delay Rx, ..
  Alcohol consumption as cause of admission not discussed..
  if it was, authoritarian approaches were used

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Staff attitudes (RCP 2001)

- National lead - whom?
- We need a change in culture in secondary care - move beyond treating presenting alcohol-related diseases to tackling the underlying alcohol-related problem and assume a wider role in health promotion.
Staff attitudes

- Who will take the lead?