

# 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?



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## 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

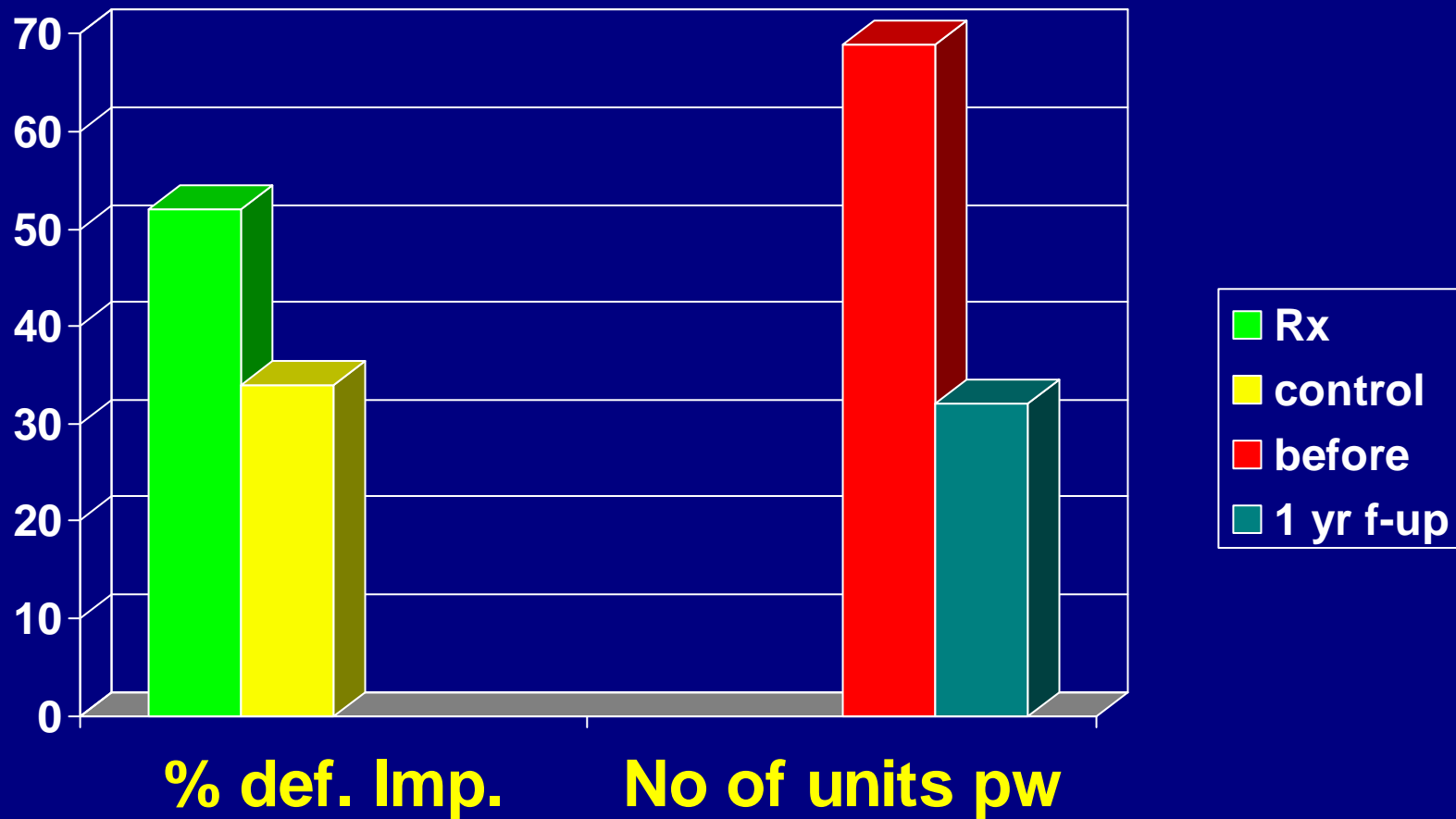
# Alcohol - can the NHS afford it?

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

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

- 4 medical wards - screened 731 men (18-65years) - **22% > 50 units + no previous Rx**
- **78 counselled** by nurse specialist on ward (x 1) & **78 controls**

# Results - 1 year follow-up



# 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



# Brief interventions (contd.)

- Responsibility lies with patient
- Menu of options
- Empathy
- Self-efficacy for change



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# 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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# % reduction

**Brief Int. Control**

**Chick (1985)** 64% 49% \*\*

**Anti-poika(1988)** 58% +11% \*\*

**Heather (1996)** 40% 30%

**Watson (1999)** 46% 33%



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# Stage of considering stopping

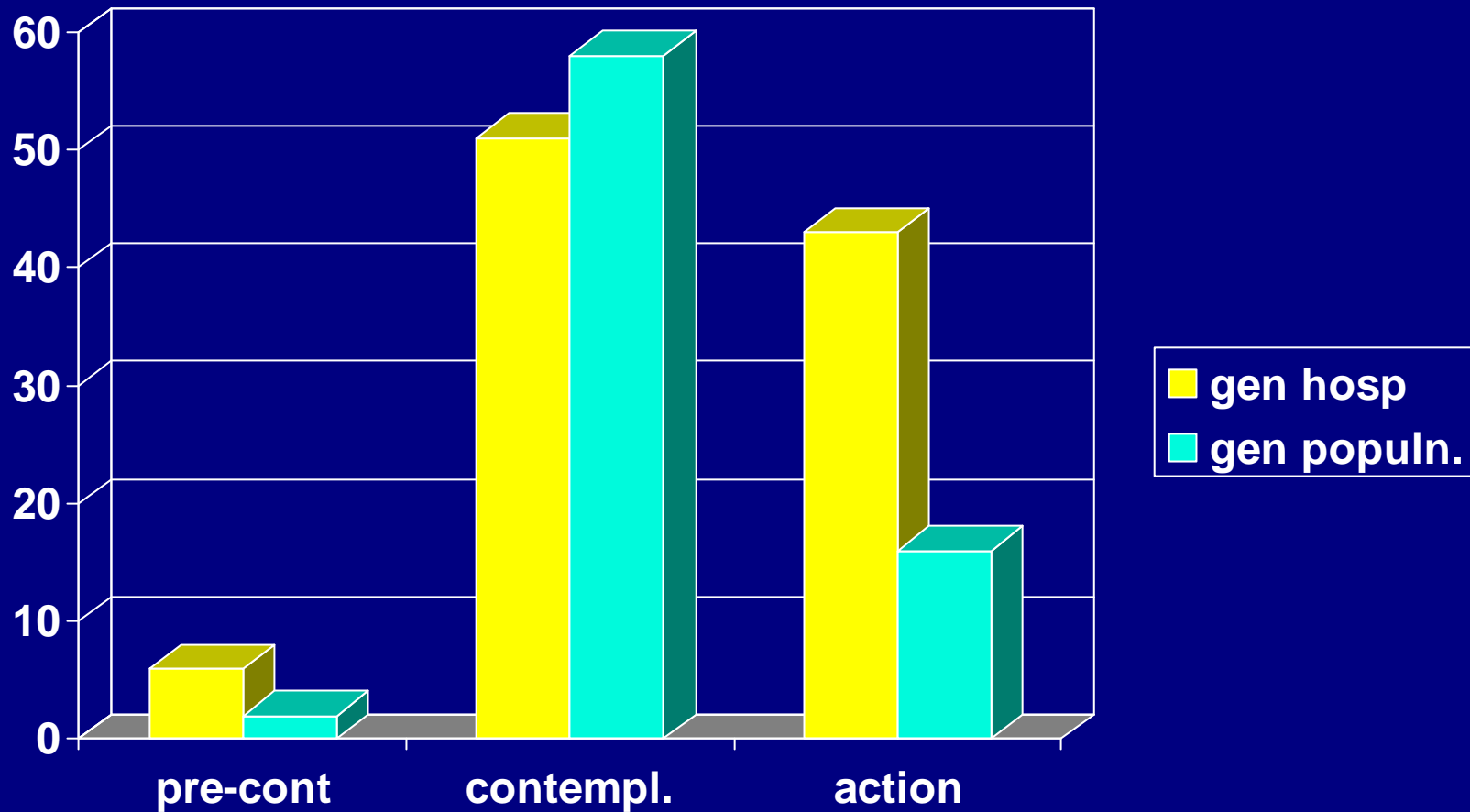
Rumpf et al *Gen Hosp Psychiat* 1999

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



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# Contemplating stopping alcohol



# 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?



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# 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?



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# 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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# 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

# 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”



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**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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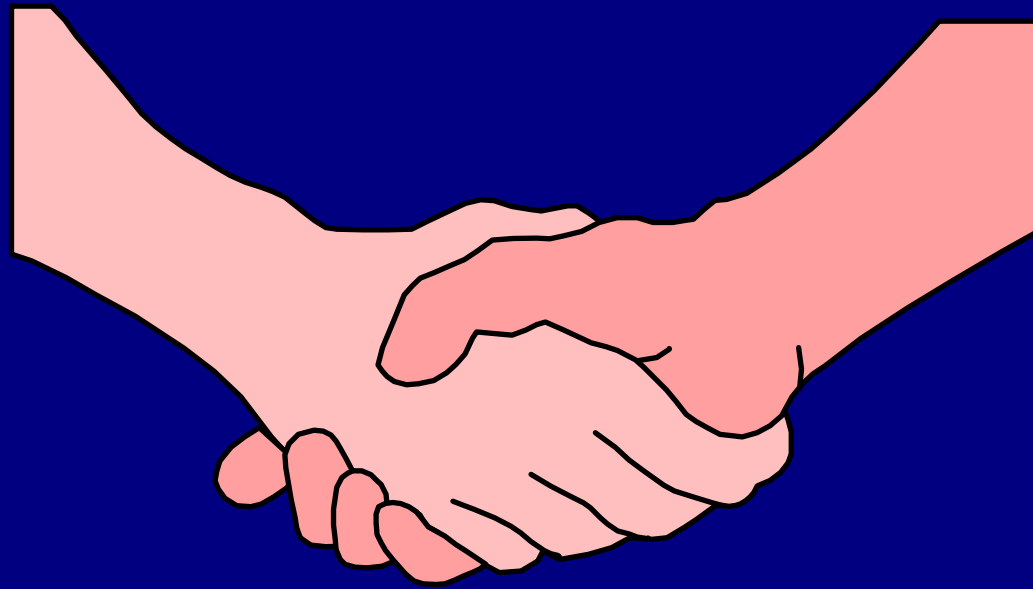
# Training of nurses

- 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



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# 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.**

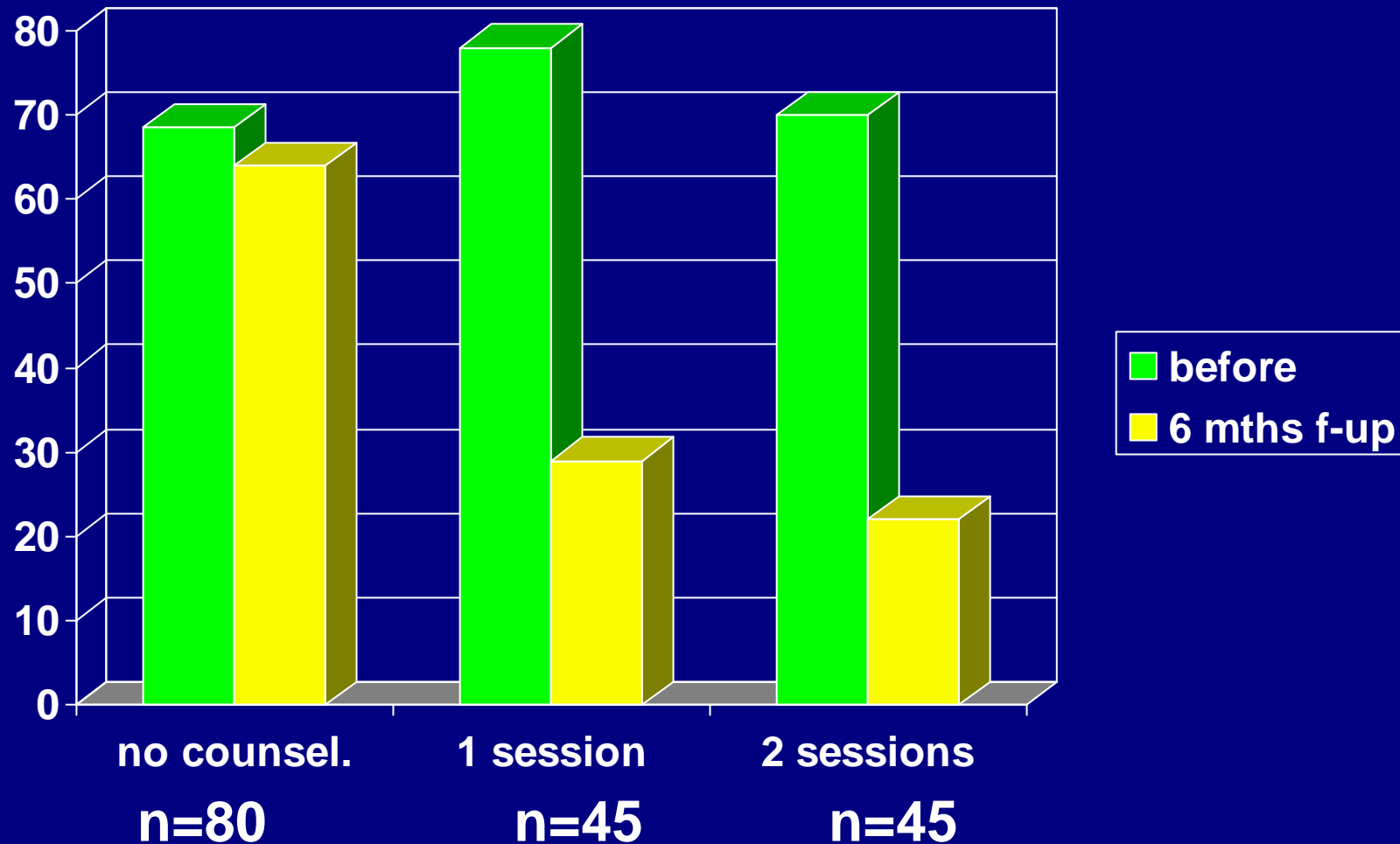
# Follow-up

- **78% followed-up**  
(10% refused, 6% died, 6% changed address)
- **Interviewed by researcher blind to counselling/previous intake**
- **Drinking diary for week.**



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# Median no. of units per week



# 3 questions

- Can we implement a brief intervention
- YES
- 2 counselling sessions > 1 ?
- NO
- Feasibility of training nurses
- YES



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# 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**



# 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



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# 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

# 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.



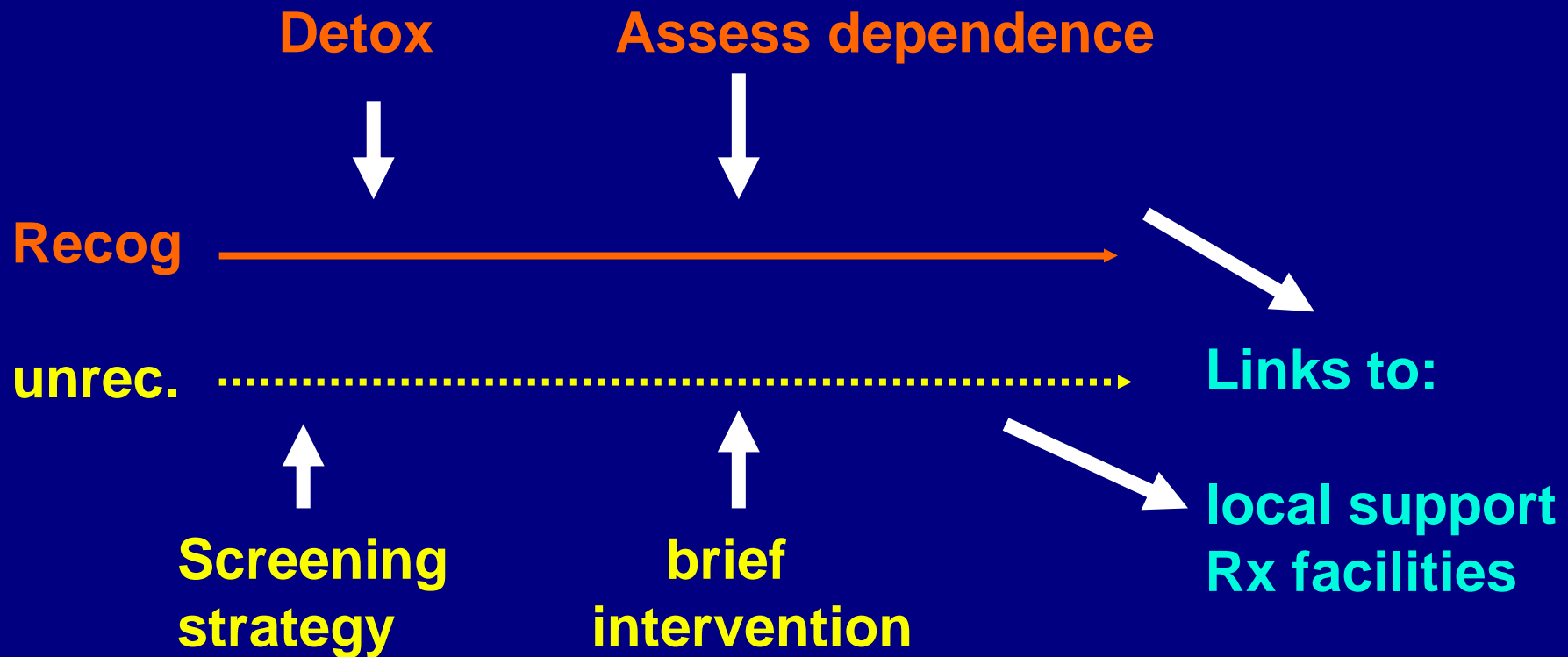
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# Staff attitudes

- Who will take the lead?



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**\*Support from senior medical,  
psych. & nursing staff**



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