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Alcohol: a missed opportunity – A survey of all accident & emergency departments in England

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DRAFT

Aim: To determine the extent to which the recommendations of the Alcohol Harm Reduction Strategy for England and the “Choosing Health” white paper for the provision of Screening and Brief Interventions for hazardous and harmful drinkers have been adopted by Accident and Emergency Departments.

Method: telephone / postal survey of all 191 Type 1 departments in England. The survey was part larger study investigating the impact of the changes in the licensing act (2004) on alcohol related attendances.

Results: (98.9% response rate) Four departments use formal screening tools and 24 ask general questions about consumption. Blood alcohol levels were measured as required by 100 departments. No departments routinely measure blood alcohol, and 84 departments *never* assess blood alcohol levels. Alcohol related attendances were formally recorded by 131 departments. Access to an alcohol health worker (AHW) or clinical nurse specialist (CNS) was reported by 32 departments.

Discussion: Although departments may be willing to address hazardous alcohol consumption the low numbers of departments utilising formal screening tools suggests that patients who may benefit from help or advice remain undetected.

Alcohol use in the UK is 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 15 years ¹, with 23% of all males and 9% of all females consuming at least double the DH recommended units on one or more occasion per week ². The Prime Ministers Strategy Unit ³ have estimated that alcohol misuse costs the NHS £1.6 billion / year, with Accident & Emergency Departments (AEDs) attendances accounting for one

third of the total. Considering that up to 70% of all AED admissions at peak times⁴ are associated with alcohol misuse, it is apparent that this is an ideal location to both detect hazardous drinkers and to offer help and advice to reduce their consumption⁵⁻⁷.

It is now two years since the publication of the first UK alcohol harm reduction strategy. A survey by Owens et al (2005)⁸ 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. To determine the extent to which the recommendations for the provision of alcohol screening and brief interventions have been adopted by AEDs, we have undertaken a survey of departments in England.

METHODS

As part of a larger study investigating the impact of the changes in the licensing act (2004) on alcohol related attendances to AEDs⁹ the researchers made contact with the lead consultants of all 191 Type 1 AEDs in England.

Survey design

The questionnaire consisted of five items:

- Do you ask patients about their drinking or screen for hazardous drinking?
- Do you measure blood/alcohol level (routinely/ as necessary/ never)?
- Do you record alcohol related attendances in the notes?

- Do you offer advice or treatment to people with alcohol problems?
- Do you have access to an alcohol health worker or nurse specialist?

Procedure

This study was endorsed by both the British Association of Emergency Medicine and the College of Emergency Medicine. During March 2006 the brief questionnaire was posted to each lead consultant. A second wave of questionnaires was sent during April 2006. One month later all remaining non-respondents were contacted by telephone.

Data Analysis

The data from the survey is presented descriptively.

RESULTS

Responses were received from 189 departments (98.9% response rate). For the assessment of regional variation departments were determined to be located in Northern (31.6%), Midlands (15.3%), South West (11.1%) or South East (42.0%) areas.

The results of the survey are summarised in table 1. Only 4 departments admitted to using a formal screening tool to identify hazardous drinkers (2.1%), however 24 (12.7%) did ask general questions about consumption. Blood alcohol levels were measured as required by 100 departments (52.7%). No departments routinely measure blood alcohol, and 84 departments *never* assess blood alcohol levels (44.4%). Alcohol related attendances were formally recorded by 131 departments (69.7%), with 21 (10.1%)

actually annotating the patients' electronic record. Most departments offered advice on alcohol problems (73.9%), however less than half of all departments offered treatment (44.4%). Access to an alcohol health worker (AHW) or clinical nurse specialist (CNS) was reported by 32 departments (16.9%).

Table 2 shows a breakdown of departmental responses by geographic region (South East, South West, Midlands and Northern). There was a significant difference in the proportions of departments in each area that were asking general questions about alcohol consumption ($\chi^2=15.2$, $df=6$, $p<0.05$), however no other significant differences were identified.

Table 1. Survey responses

	N	%
Departments using a formal alcohol screening tool	4	2.1
Departments asking questions about consumption	24	12.7
Departments requesting blood/alcohol levels as required	100	52.7
Departments offering advice on alcohol problems	139	73.9
Departments offering treatment for alcohol problems	84	44.4
Departments with access to an AHW / CNS	32	16.9

Table 2. Responses by region (proportion)

	South East	South West	Midlands	North
Departments asking questions about consumption	2.7	0.0	23.1	11.1
Departments requesting blood/alcohol levels as required	58.8	50.0	44.8	53.3
Departments offering advice on alcohol problems	74.7	76.0	75.9	71.7
Departments offering treatment for alcohol problems	41.3	52.4	44.8	45.0
Departments with access to an AHW / CNS	12.5	14.3	24.1	20.0

DISCUSSION

This study has a response rate of almost 99%, the largest response rate of any survey of English AEDs. In order to achieve this rate, survey questions were kept to a minimum. This meant that detailed data on the management of alcohol problems in the departments was not collected; nonetheless this study provides an important snapshot of current practice.

The number of departments requesting blood alcohol levels, recording alcohol related attendances and offering advice on alcohol related problems is encouraging. However this data must be critically reviewed in the context of an AED culture where very few departments actually employ formal screening procedures to identify hazardous and harmful drinkers. It is likely that in the absence of such formal procedures that AED staff will rely upon their judgement or intuition to identify those patients who they believe may benefit from advice or treatment, which we know to be less reliable than formal screening¹⁰.

The measurement of blood alcohol levels occurs in about half of all departments as required. Such measures may be useful in the detection of hazardous or harmful levels of alcohol consumption among those patients who are either unable or unwilling to complete a verbal assessment¹¹⁻¹³. The substantial minority of departments that do not assess blood alcohol levels further reduce their likelihood of identifying alcohol misusing patients.

The ANARP survey (2004) ¹⁴ identified the Northern region of England (North East, North West and Yorkshire) as having the largest proportion of hazardous and harmful drinkers. Despite this only 11% of departments the Northern region are asking questions about alcohol consumption. Clearly there are regional inconsistencies in the way that departments identify and address alcohol related problems; however reasons for this remain uncertain.

The results of this survey suggest that English AEDs are aware of the role that alcohol plays in the aetiology of admissions and that they are willing to address alcohol issues as part of their package of clinical care. The low numbers of departments asking specific questions about alcohol consumption and its relationship to a patient's reason for attendance and those who do not undertake assessment of blood alcohol levels as required, are of concern. Presentation to the AED is a teachable moment ¹⁵. Simply asking questions about consumption can act as an intervention and reduce levels of alcohol consumption ¹⁶. Why do AEDs continue to treat the consequences of alcohol misuse without addressing the underlying cause? Clinicians may be unwilling to identify hazardous drinkers as they do not believe that they are able to offer an effective intervention themselves, or offer access to appropriate local services (such as an Alcohol Health Worker or Clinical Nurse Specialist) ^{17,18}. There is some evidence to suggest that clinicians own patterns of alcohol consumption may encourage a state of clinical inertia

The current DoH *trailblazer* projects²¹ should provide definitive recommendations as to the most appropriate methods of screening and intervention. Prior to the dissemination of the results in 2009, we recommended that all AEDs consider formal methods of identifying hazardous drinkers such as the Single Alcohol Screening Question²² or Paddington Alcohol Test²³.

Competing Interests: None declared.

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