

The 2nd National Emergency Department survey of Alcohol Identification and Intervention activity

Final report to the funders: Alcohol Research UK

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Background

Alcohol use in the UK remains 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 10 years, with 37% of all males and 29% of all females consuming in excess of the DH recommended units on one or more occasion per week [1]. Previous research has found that up to 70% of all Emergency Department (ED) admissions at peak times 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 consumption [2,3]

In 2007 “Safe Sensible Social” [4] was published, this was an update to the Alcohol Strategy for England [5] that further endorsed the application of screening and brief interventions to identify and intervene with problematic alcohol users presenting to the ED. A survey by Owens et al in 2005 [6] 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. A subsequent survey of all EDs in England in 2006 [7] found that although there was awareness that alcohol consumption represented a very real issue to departments, most had not adopted formal screening methods and therefore there existed the very real possibility that many patients who might benefit from help or advice were missed.

Two systematic reviews [8,9] have concluded that alcohol identification and brief advice (IBA) in the ED is an effective and cost effective method to reduce levels of alcohol consumption and alcohol related harm. This finding has been translated into UK alcohol policy guidelines by the Department of Health [10,11], both of which

recommend that EDs adopt alcohol IBA strategies, although at this time there are no specific instructions to do so. The recent NICE guidelines [¹²] “Preventing the development of hazardous and harmful drinking” also commend the use of screening tools and the delivery of brief advice in the ED.

To determine the extent to which the continuing recommendations for the provision of alcohol screening and brief advice have been adopted by EDs, a survey of all English EDs was undertaken. This survey followed up on the previous National Survey [⁷], with more specific questions regarding access to training on screening and brief interventions and additional questions regarding alcohol IBA activity targeting the under 18 year olds (to help support an ongoing NIHR programme SIPS Jr [¹³]).

Methodology

This was a cross sectional survey targeting all 187 consultant led Emergency Departments in England (Minor Injury Units and specialist trauma centres were excluded).

A set of survey questions were developed, based upon the previous national survey, and in conjunction with the Section of Alcohol Research at the National Addiction Centre. A copy of the questionnaire is found in Appendix 3. Copies of the questionnaire were printed out for delivery via royal mail, and in addition a version was made available on the internet via the *Survey Monkey* service¹. Anonymity of responses was preserved by utilising an Identity Number, which also facilitated the collation of responses to allow regional identification and to enable appropriate follow-up activity for non-responders.

Prior to the commencement of the survey, support for and endorsement of the survey was sought and obtained from the College of Emergency Medicine (CEM). The CEM was able to provide contact address for all English EDs, however it was not possible to obtain the names of the lead clinicians for each department. The researcher augmented the CEM database with telephone contact details for each department.

Advice was sought from the local NHS Research Ethics Committee, who determined that this survey counted as an example of Clinical Service Audit, and as such ethical clearances were not required to proceed. A copy of the correspondence with the Chair of the REC is found in Appendix 1.

¹ www.surveymonkey.com

In the first instance, a copy of the (pre-numbered) questionnaire was sent to the “Lead Clinician” of each ED. This was accompanied by a covering letter, signed by the ex-president of the CEM and the lead researcher) encouraging participation in the survey². Each questionnaire (one side of A4) also contained a return address, a link to the online version of the survey and details to allow the return of completed materials via electronic methods (Email, web and fax).

Two weeks after the initial mail-shot, non-responding departments were initially contacted via telephone and email details for the Lead Consultants secretary were obtained. An Email version of the cover letter and questionnaire (personalised where possible) were then sent to each secretary who had agreed to forward the materials on to an appropriate consultant. In the small number of instances where Email details were not provided, copies of the survey materials were faxed to the ED.

Two weeks after the initial email contact, a second wave of emails was sent to remaining non-responders, and two weeks after that a final round of telephone and email contacts was undertaken. Data collection was occurred between November 2011 and January 2012, over a total of eight weeks. Once the survey was closed, data from all paper returns were entered into an SPSS database and merged with the data from the web-based responses. All data was then analysed.

² See appendix 2 for further details

Results

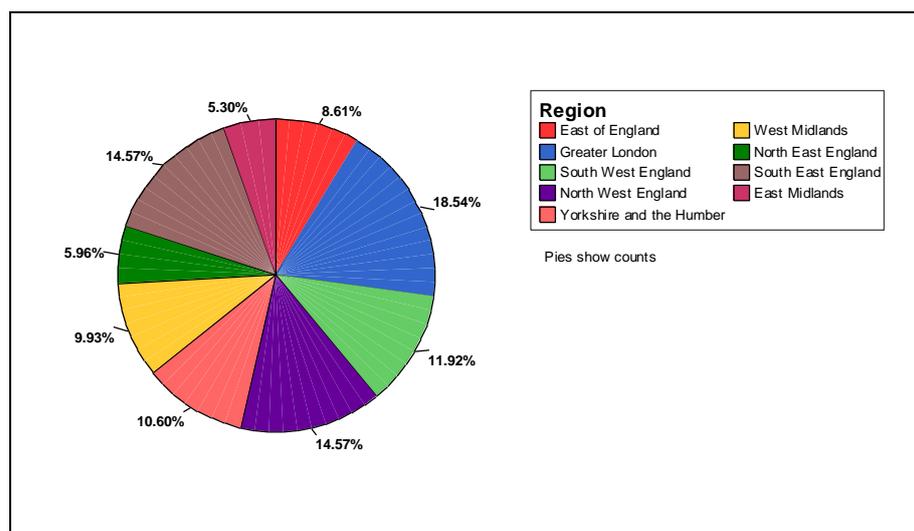
Participating departments

A total of 151 departments (of 187 contacted) responded to the survey (81% response rate). The proportion of participating departments varied by region, with between 72.0% - 90.3% returning completed questionnaires.

Proportion of respondents by Region

	Frequency	Study Percent	Percent of Regional EDs
East of England	13	8.6	72.2
Greater London	28	18.5	90.3
South West England	18	11.9	72.0
North West England	22	14.6	81.5
Yorkshire and the Humber	16	10.6	88.9
West Midlands	15	9.9	75.0
North East England	9	6.0	81.8
South East England	22	14.6	84.6
East Midlands	8	5.3	72.7
Total	151	100.0	

Regional distribution of participating departments



Changes in Alcohol IBA activity 2006 – 2011

There was a significant *reduction* (-17.9%) in the proportion of participating departments; however over 80% of English EDs did complete the questionnaire.

There have been a significant *increases* in routine questioning about alcohol consumption (+35.0%), the use of a formal alcohol screening questionnaire (+49.6%), the provision of help / advice about alcohol problems (+22.1%) and access to AHS / CNS (+54.9%).

Comparison of survey findings 2006 vs. 2011

	2006 (N = 189)	2011 (N = 151)	Difference in Proportions
Response Rate	98.9 %	81.0%	-17.9 *
Routinely ask about alcohol	12.7%	47.7%	+35.0 *
Use a formal screening tool	2.1%	51.7%	+49.6 *
Measure blood alcohol as required	52.7%	56.4%	+3.7
Record alcohol related attendance	69.7%	70.5%	+0.8
Offer help / advice for alcohol problems	73.9%	96.0%	+22.1 *
Have access to an AHW or CNS	16.9%	71.8%	+54.9 *

* p<0.001

Training

Almost two thirds of departments (63.6%) offered staff access to training on alcohol screening, with just over half (57.0%) providing some form of brief advice training. Most training was provided within the department (68.5%), with online (15.0%) and external agencies (10.5%) providing the rest.

Access to training on alcohol screening

		Frequency	Percent
Valid	NO	55	36.4
	YES	96	63.6
	Total	151	100.0

Access to training on brief advice

		Frequency	Percent
Valid	NO	65	43.0
	YES	86	57.0
	Total	151	100.0

Type of training provision

		Frequency	Percent
Valid	Online	13	15.0
	Internal	59	68.5
	External	9	10.5
	Other	5	6.0
Total		86	100.0

Alcohol Champions

More than half of all departments (57.6%) indicated that their ED had an “alcohol champion” – that is a specific member of staff who took responsibility for alcohol issues. There is a significant association between the presence of a champion and access to training on screening ($\chi^2=36.64$, $df=1$, $p<0.001$) and brief advice ($\chi^2=29.93$, $df=1$, $p<0.001$).

Access to screening training and presence of alcohol champion

			alc_champ		Total
			NO	YES	NO
screen_train	NO	Count	41	14	55
		% within screen_train	74.5%	25.5%	100.0%
	YES	Count	23	73	96
		% within screen_train	24.0%	76.0%	100.0%
Total		Count	64	87	151
		% within screen_train	42.4%	57.6%	100.0%

Access to brief advice training and presence of alcohol champion

			alc_champ		Total
			NO	YES	NO
adv_train	NO	Count	44	21	65
		% within adv_train	67.7%	32.3%	100.0%
	YES	Count	20	66	86
		% within adv_train	23.3%	76.7%	100.0%
Total		Count	64	87	151
		% within adv_train	42.4%	57.6%	100.0%

Alcohol screening

Almost every department (98.7%) indicated that they asked adult patients about their alcohol consumption. Of these, almost half asked such questions routinely (47.7%), and used a standardised screening tool (51.7%).

There was a significant association between these two variables, suggesting that departments that routinely asked questions were more likely to use alcohol screening tools ($\chi^2=4.29$, $df=1$, $p<0.05$)

Cross tabulation of Routinely Ask Questions and Use of a Screening Tool

			Use screening tool		Total
			NO	YES	NO
Routine ask	NO	Count	44	34	78
		% within routine ask	56.4%	43.6%	100.0%
	YES	Count	28	43	71
		% within routine ask	39.4%	60.6%	100.0%
Total		Count	72	77	149
		% within routine ask	48.3%	51.7%	100.0%

Screening tools

The Paddington Alcohol Test was the most frequently used screening tool (40.5%), with the AUDIT-C (23.0%) and FAST (14.9%) also accounting for most screening activity.

Alcohol screening tools

		Frequency	Percent	Valid Percent
Valid	PAT	30	19.9	40.5
	SASQ	3	2.0	4.1
	FAST	11	7.3	14.9
	AUDIT	6	4.0	8.1
	AUDIT-C	17	11.3	23.0
	Other	4	2.6	5.4
	CAGE	3	2.0	4.1
	Total	74	49.0	100.0
Missing	System	77	51.0	
Total		151	100.0	

Blood Alcohol Measurement

In general, most departments measure blood alcohol “as required” (55.7%), and the service is available 24/7 (94.3%). Four in ten departments did not ever measure blood alcohol (43.6%).

Blood alcohol measurement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	65	43.0	43.6	43.6
	As required	83	55.0	55.7	99.3
	Routinely	1	.7	.7	100.0
	Total	149	98.7	100.0	
Missing	System	2	1.3		
Total		151	100.0		

Blood alcohol measurement and service availability *

			Service availability		Total
			24/7	mon-fri 9 - 5	24/7
Blood Alcohol	Routinely	Count	1	0	1
		% within blood alcohol	100.0%	.0%	100.0%
	As required	Count	49	3	52
		% within blood alcohol	94.2%	5.8%	100.0%
Total		Count	50	3	53
		% within blood alcohol	94.3%	5.7%	100.0%

* Please note only 53 of the 84 departments that indicated they measured blood alcohol responded

Of those departments that routinely used alcohol questionnaires, only a fifth (18.6%) indicated that they measured blood alcohol levels if a patient was unable to complete the screening tool.

Recording alcohol related attendances

About two thirds (70.5%) of all EDs recorded an alcohol related attendance in the patients notes, with three quarters (74.8%) informing the patients GP about such attendances. There is a significant association between these two variables, with departments that record attendances more likely to also inform patient's GPs of an alcohol related attendance ($\chi^2=10.27$, $df=1$, $p=0.001$)

			gp_informed		Total
			NO	YES	
alc_recorded_notes	NO	Count	19	25	44
		% within alc_recorded_notes	43.2%	56.8%	100.0%
	YES	Count	19	86	105
		% within alc_recorded_notes	18.1%	81.9%	100.0%
Total		Count	38	111	149
		% within alc_recorded_notes	25.5%	74.5%	100.0%

Alcohol Interventions

Every department offers help or advice for patients who might have an alcohol problem (100.0%). The help / advice provided by about half (53.0%) of all department was a referral to their own “in house” specialist team, with about a quarter (28.5%) referring patients to an external agency. Some department staff provided an intervention themselves as either a leaflet (19.2%) or “Brief Advice” (6.0%).

Help / advice offered

	frequency	percentage
Leaflets	29	19.2
Brief Advice	9	6.0
Referral external	43	28.5
Referral internal	80	53.0

The majority of departments had access to either Alcohol Health Workers or Clinical Nurse Specialists (71.8%) – most of these were based on-site (74.8%).

Young people - Screening

Three quarters (76.7%) of departments had a separate area for patients under 18 years old. Most did ask young people about their alcohol consumption (82.0%) but few did so routinely (8.9%).

About one in seven departments (14.6%) use an alcohol screening tool, and of these the PAT (29.4%), FAST (23.5%) and AUDIT-C (23.5%) were the most common.

Alcohol screening tool used on under 18's

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	PAT	5	3.3	29.4	29.4
	FAST	4	2.6	23.5	52.9
	AUDIT	3	2.0	17.6	70.6
	AUDIT-C	4	2.6	23.5	94.1
	Other	1	.7	5.9	100.0
	Total		17	11.3	100.0
Missing	System	134	88.7		
Total		151	100.0		

Young people - Alcohol Related Attendances

Intoxication was the most frequently cited reason for a young person's alcohol related ED attendance (55.6%). Evenings (46.4%) and weekends (45.0%) were the most likely times for young people to present to the ED with an alcohol related presentation.

Alcohol related presentations among under 18's *

		frequency	Total % (n=151)	Valid % (n=131)
Presentation	Intoxication	84	55.6	64.1
	Assault	39	25.8	29.8
	DSH	31	20.5	23.7
	Collapse	42	27.8	32.1
	Head Injury	28	18.5	21.4
	Fall	19	12.6	14.5
Occasion	Other	37	24.5	28.2
	Holidays	11	7.3	8.4
	Evenings	70	46.4	53.4
	Weekends	68	45.0	51.9

** Of the 131 departments that responded to this question, many provided multiple reasons thus this table adds to more than 100%*

Regional variations

As the ANARP report noted variation in the availability / capacity of alcohol services sub-analysis of the data was undertaken at a regional level. A summary table of all regional variation is found in appendix 4.

Training - Screening

Departments in the East of England, North West England and the Yorkshire & the Humber regions had below average rates of training in alcohol screening.

Regional variation in training on alcohol screening

			screen_train	
			NO	YES
Region	East of England	Count	7	6
		% within Region	53.8%	46.2%
	Greater London	Count	9	19
		% within Region	32.1%	67.9%
	South West England	Count	5	13
		% within Region	27.8%	72.2%
	North West England	Count	9	13
		% within Region	40.9%	59.1%
	Yorkshire and the Humber	Count	8	8
		% within Region	50.0%	50.0%
	West Midlands	Count	4	11
		% within Region	26.7%	73.3%
	North East England	Count	3	6
		% within Region	33.3%	66.7%
	South East England	Count	8	14
		% within Region	36.4%	63.6%
	East Midlands	Count	2	6
		% within Region	25.0%	75.0%
Total		Count	55	96
		% within Region	36.4%	63.6%

Training – Brief Advice

Departments in the East of England, South West England, South East England and the East Midlands had below average levels of training in brief advice for alcohol problems.

Regional variation in the provision of training on brief advice for alcohol problems

			adv_train	
			NO	YES
Region	East of England	Count	9	4
		% within Region	69.2%	30.8%
	Greater London	Count	11	17
		% within Region	39.3%	60.7%
	South West England	Count	8	10
		% within Region	44.4%	55.6%
	North West England	Count	9	13
		% within Region	40.9%	59.1%
	Yorkshire and the Humber	Count	6	10
		% within Region	37.5%	62.5%
	West Midlands	Count	4	11
		% within Region	26.7%	73.3%
	North East England	Count	3	6
		% within Region	33.3%	66.7%
	South East England	Count	11	11
		% within Region	50.0%	50.0%
	East Midlands	Count	4	4
		% within Region	50.0%	50.0%
Total		Count	65	86
		% within Region	43.0%	57.0%

Routine questioning

Departments in the East of England, Greater London, South West England and the West Midlands have below average rates of routine questioning about alcohol consumption.

Regional variation in routine questioning about alcohol consumption

			Routinely asked	
			NO	YES
Region	East of England	Count	8	5
		% within Region	61.5%	38.5%
	Greater London	Count	15	13
		% within Region	53.6%	46.4%
	South West England	Count	11	6
		% within Region	64.7%	35.3%
	North West England	Count	8	14
		% within Region	36.4%	63.6%
	Yorkshire and the Humber	Count	12	4
		% within Region	75.0%	25.0%
	West Midlands	Count	8	6
		% within Region	57.1%	42.9%
	North East England	Count	3	6
		% within Region	33.3%	66.7%
	South East England	Count	9	13
		% within Region	40.9%	59.1%
	East Midlands	Count	4	4
		% within Region	50.0%	50.0%
Total		Count	78	71
		% within Region	52.3%	47.7%

Access to AHW/CNS

Departments based in Greater London, Yorkshire & Humber, North East England and South East England had below average levels of access to AHW/CNS overall.

Regional access to AHW/CNS

			Access to AHW/CNS	
			NO	YES
Region	East of England	Count	1	12
		% within Region	7.7%	92.3%
	Greater London	Count	11	17
		% within Region	39.3%	60.7%
	South West England	Count	4	14
		% within Region	22.2%	77.8%
	North West England	Count	5	17
		% within Region	22.7%	77.3%
	Yorkshire and the Humber	Count	6	9
		% within Region	40.0%	60.0%
	West Midlands	Count	3	12
		% within Region	20.0%	80.0%
	North East England	Count	3	6
		% within Region	33.3%	66.7%
	South East England	Count	9	12
		% within Region	42.9%	57.1%
	East Midlands	Count	0	8
		% within Region	.0%	100.0%
Total		Count	42	107
		% within Region	28.2%	71.8%

Alcohol champions

Departments located in the East of England, West Midlands and South East England had below average presence of Alcohol Champions.

Regional distribution of Alcohol Champions

			Alcohol Champion	
			NO	YES
Region	East of England	Count	10	3
		% within Region	76.9%	23.1%
	Greater London	Count	9	19
		% within Region	32.1%	67.9%
	South West England	Count	6	12
		% within Region	33.3%	66.7%
	North West England	Count	6	16
		% within Region	27.3%	72.7%
	Yorkshire and the Humber	Count	6	10
		% within Region	37.5%	62.5%
	West Midlands	Count	12	3
		% within Region	80.0%	20.0%
	North East England	Count	3	6
		% within Region	33.3%	66.7%
	South East England	Count	10	12
		% within Region	45.5%	54.5%
	East Midlands	Count	2	6
		% within Region	25.0%	75.0%
Total		Count	64	87
		% within Region	42.4%	57.6%

Blood Alcohol measurement

Departments in Greater London, Yorkshire & the Humber and the West Midlands have below average levels of Blood Alcohol measurement.

Regional variation on Blood Alcohol measurement

			Blood alcohol measured	
			Never	As required
Region	East of England	Count	5	8
		% within Region	38.5%	61.5%
	Greater London	Count	16	12
		% within Region	57.1%	42.9%
	South West England	Count	6	12
		% within Region	33.3%	66.7%
	North West England	Count	7	14
		% within Region	31.8%	63.6%
	Yorkshire and the Humber	Count	12	3
		% within Region	80.0%	20.0%
	West Midlands	Count	9	6
		% within Region	60.0%	40.0%
	North East England	Count	1	8
		% within Region	11.1%	88.9%
	South East England	Count	8	13
		% within Region	38.1%	61.9%
	East Midlands	Count	1	7
		% within Region	12.5%	87.5%
Total		Count	65	83
		% within Region	43.6%	55.7%

Discussion

This cross sectional survey of current alcohol IBA activity had a response rate of over 80%. Although this represented a decrease on the previous national survey [7] the broadly equal regional variation in response rates suggests that our sample is representative of all English EDs. Reasons for the reduction in response rates are unclear, however it is worth noting that the previous survey consisted of five simple questions and was administered by a full time research assistant.

The increases in alcohol IBA activity over the last five years are very encouraging. In particular departmental access to AHW / CNS staff has changed from 17% to 72%, and this is in line with the recommendations of the RCP [14] and DH [10]. Routine questioning, specifically with the use of a formal alcohol screening tool also significantly increased, again this is in line with the NICE guidelines for good practice [12]. We have not observed any significant change in the proportion of departments that measure blood alcohol as required (just over half do), or in the recording of an alcohol related attendance in the patients notes (over two thirds).

The preliminary results from the SIPS trailblazer research programme [15] clearly indicate that the presence of an alcohol champion is an important factor in the successful implementation of IBA activity into routine practice. This survey found that over half of all English EDs are able to identify a specific person who takes a lead on alcohol issues. We have found that the presence of an alcohol champion is significantly associated with an increased likelihood of training in both alcohol screening and in delivering brief advice, and suggest that as more departments move towards the 'appointment' of such a person, that current levels of screening (and the

use of a formal screening tool) will increase proportionately. We also suggest that the current level of brief advice (about 6% of all departments currently offer this) would also be set to rise should additional alcohol champions be identified.

While almost 100% of departments (ever) ask about alcohol consumption, just under half do on a routine basis. From our data we are unable to determine whether this is an artefact of targeted versus universal screening, however we know that the use of formal screening tools is more likely in departments that routinely ask questions about alcohol consumption, which suggests that those departments that ask such questions occasionally or as required may not effectively identify patients who may benefit from further help or advice about their drinking.

Departments currently use a variety of screening tools, with the Paddington Alcohol Test [^{16,17}] cited as the most commonly used measure, and this is in line with the recent NICE guidance [¹²]. In our opinion the choice of screening tool remains secondary to the actual use of such measures, and while the PAT is currently the measure of choice, individual departments should be able to choose whatever screening tool works best for their staff and patients.

The proportion of departments who measure Blood Alcohol Concentration as required has not changed over the last five years. Recent research by Touquet and colleagues [¹⁸] suggests that BAC should be obtained from patients who are unable to complete a screening questionnaire, however at this time less than one in five departments who routinely use a formal screening tool collect BAC data from such patients. We recommend that departments consider the use of BAC in cases where information

about alcohol consumption is otherwise unavailable, as this can provide important information that could enable better clinical management.

Although every department sets out to offer to help to patients who they believe have an alcohol problem, the issues around identification of such patients remains an issue. Having identified an alcohol related attendance; most departments record this in the notes, with the majority also informing the patients GP of this. This sharing of information is a vital component in the continuity of care, and may contribute towards the recent “making every contact count” guidance [19]. We suggest that every department who identifies problematic levels of alcohol consumption make reference to this in the patients’ record and also notify their GP who can then offer further appropriate help and advice as and when the opportunity occurs.

Every department offers help or advice to patients who they have identified as having problematic consumption of alcohol. In line with DH guidelines [10,11] most departments provide a referral to a specialist worker or service, with the majority of these being based on-site, and there is good evidence that such referrals can reduce levels of consumption and associated alcohol related problems and subsequent hospital attendances [20]. At this time very few departments (6%) provide brief advice to patients. Reasons for this are unclear, however such short focused advice sessions may be as effective as more intensive interventions, and we would anticipate an increase in their provision as further guidance on alcohol IBA is published (following the SIPS trailblazer programme [21]). It is likely that brief advice at the time of the identification of problematic alcohol use has a beneficial impact upon patients’ drinking behaviours, and as such we would suggest that all departments adopt this

approach in addition to the onward referral of patients to specialist services as required.

In addition to alcohol IBA for adult patients, this survey also examined provision for the under 18s. This was in support of an ongoing programme of work exploring the best ways to identify and intervene with young people presenting to the ED who may have alcohol problems [13]. Although most departments have a separate (paediatric) area and do ask young people about their alcohol consumption, few do so as a matter of routine, or use specific alcohol screening tools. Guidance around the prevention and reduction of alcohol use among children and young people was published by NICE in 2007 [22], which highlighted the need to identify alcohol intake and provide appropriate interventions to reduce harm. Clearly the departmental integration of an alcohol IBA programme that specifically targets these vulnerable young people would go some way towards addressing this issue.

Our findings that that (in the opinion of the clinicians who completed the questionnaire) intoxication, particularly in the evenings and at weekends, was the most prevalent alcohol related presenting condition for young people is unsurprising. What remains unclear is the proportion of young people presenting to the ED who are misusing alcohol, but whose presentation is not necessarily related to alcohol consumption. The ongoing SIPS Jr [13] research programme sets out to clarify the extent of such presentations.

This survey highlights considerable regional variation in the provision of training, IBA activity, AHW/CNS access, measurement of BAC levels and the presence of an

alcohol “champion”. However, it is not possible to compare the findings of the previous and current survey at a regional level, as the regional definitions employed are not compatible. The 2004 Alcohol Needs Assessment Research Project (ANARP) [23] used the same regional definitions as our survey, and found that those areas that demonstrated the highest levels of both hazardous/harmful drinking and alcohol dependence also had the lowest number of specialist treatment agencies, concluding that the areas of highest need also had the lowest capacity to provide treatment. The conclusions from the data gathered in this survey are less clear; ANARP identified both the North East and North West regions as having the greatest proportion of hazardous and harmful drinkers, this survey shows that they now have above average levels of alcohol IBA activity. While we cannot demonstrate that current levels of provision are related to or as a consequence of, the earlier ANAP findings, it is encouraging to note that regions that were characterised as less able to meet the treatment / intervention needs of the population, now show elevated levels of actions (at least in the ED setting) that will reduce alcohol related harms.

Summary

The results of the 2011 National Emergency Department survey of alcohol identification and brief advice activity show that, compared to the earlier 2006 survey, levels of screening, provision of help / advice and access to AHW / CNS services have all increased significantly. Departments are beginning to identify local alcohol “champions”, and this is associated with an increase in the provision of training in both identification and brief intervention. The increased use of formal alcohol screening measures, often applied routinely, suggests that English EDs are beginning to maximise the likelihood of identifying those patients who may benefit from further help or advice about their alcohol consumption. The four fold increase in access to specialist services for such patients should serve to also ensure that those who require help are exposed to interventions that are both effective and cost effective. To conclude; alcohol no longer represents a missed opportunity in the ED, departments are to be commended upon their progress towards the integration of alcohol IBA into routine practice; this increased focus upon alcohol affords a chance to instigate change for the betterment of the patient, the department and the wider health service.

References

Reference List

- (1) NHS Information Centre. Statistics on Alcohol: England 2011. London, The Health and Social Care Information Centre. 2011
- (2) Drummond D, Phillips T, Coulton S, Barnaby B, Keating S, Sabri R et al. National prevalence survey of alcohol-related attendances at accident and emergency departments in England. *Alcoholism: Clinical and Experimental Research* 2005; 29(5):36A.
- (3) Crawford M, Patton R, Touquet R, Drummond D, Byford S, Barrett B et al. Screening and referral for brief intervention of alcohol misusing patients in an Accident and Emergency Department: A pragmatic randomised controlled trial. *The Lancet* 2004; 364:1334-1339.
- (4) Department of Health. Safe. Sensible. Social. The next steps in the National Alcohol Strategy. London. 2007
- (5) Strategy Unit. Alcohol Harm Reduction Strategy For England. London, The Cabinet Office. 2004
- (6) Owens L, Gilmore IT, Pirmohamed M. How do NHS general hospitals in England deal with patients with alcohol-related problems? A questionnaire survey. *Alcohol & Alcoholism* 40[5], 409-412. 2005
- (7) Patton R, Strang J, Birtles C, Crawford M. Alcohol: a missed opportunity. A survey of all accident and emergency departments in England. *Emergency Medicine Journal* 2007; 24:529-531.
- (8) Kaner EFS, Dickinson HO, Beyer F, Pienaar E, Schlesinger C, Campbell F et al. The effectiveness of brief alcohol interventions in primary care settings: A systematic review. *Drug and alcohol review* 2009; 28(3):301-323.
- (9) Nilsen P, Baird J, Mello MJ, Nirenberg T, Woolard R, Bendtsen P et al. A systematic review of emergency care brief alcohol interventions for injury patients. *J Subst Abuse Treat* 2008; 35(2):184-201.
- (10) Department of Health. Reducing alcohol harm: Health Services in England for Alcohol Misuse. London, HMSO. 2008
- (11) Department of Health. Signs for Improvement. Commissioning interventions to reduce alcohol related harm. London, HMSO. 2010
- (12) NICE. Alcohol Use Disorder: Preventing the development of hazardous and harmful drinking. National Health Service. 2010
- (13) SIPS Junior. www.sipsjr.net, 2012
- (14) Royal College of Physicians. Alcohol - can the NHS afford it? London. 2001

- (15) Deluca P, Drummond C, Coulton S, Perryman K, Bland M, Cassidy P et al. Challenges and Solutions in Implementing Screening and Brief Interventions for Hazardous Alcohol Use in Accident and Emergency Departments. *Alcoholism-Clinical and Experimental Research* 2010; 34(6):294A.
- (16) Patton R, Touquet R. The Paddington Alcohol Test. *British Journal of General Practice* 2002; 52(474):59.
- (17) Patton R, Hilton C, Crawford M, Touquet R. The Paddington Alcohol Test: A Short Report. *Alcohol & Alcoholism* 2004; 39(3):266-268.
- (18) Touquet R, Csipke E, Holloway P, Brown A, Patel T, Seddon AJ et al. Resuscitation room blood alcohol concentrations: one-year cohort study. *Emergency Medicine Journal* 2008; 25(11):752-756.
- (19) NHS Futures. The NHS's role in the public health: A report from the NHS Future Forum. London. 2012
- (20) Crawford M, Patton R, Touquet R, Drummond C, Byford S, Barrett B et al. Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: a pragmatic randomised control led trial. *Lancet* 2004; 364(9442):1334-1339.
- (21) SIPS: Alcohol Screening and Brief Intervention Trailblazers. www.sips.iop.kcl.ac.uk , 2007
- (22) NICE. PH4: Interventions to reduce substance misuse among vulnerable young people. London. 2007
- (23) Drummond D. Alcohol Needs Assessment Research Project. London, Department of Health. 2006

Appendix 1: Ethical Clearance

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Patton, Robert

From: Bailey Charis [Charis.Bailey@eoe.nhs.uk]
Sent: 25 August 2011 17:04
To: Patton, Robert
Subject: RE: Ethics committee application - Chairs opinion requested

Dear Bob

The Chair of the London - Camberwell St Giles Research Ethics committee has reviewed your proposal and his view is that this project can be regarded as service evaluation and therefore does not require ethical review.

I hope this helps and wish you luck with your project.

With very kind regards
Charis

Charis Bailey | Committee Co-ordinator

National Research Ethics Service (NRES)
National Patient Safety Agency
Direct line: 01223 597509
Mobile: 07919 890 312
Fax: 01223 597645 |
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Victoria House, Capital Park, Fulbourn, Cambridge, CB21 5XB

www.nres.nhs.uk

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From: Patton, Robert [mailto:robert.patton@kcl.ac.uk]
Sent: 25 August 2011 15:22
To: Bailey Charis
Subject: Ethics committee application - Chairs opinion requested
Importance: High

Dear Charis

Following on from our phone call, I have attached the funding proposal as discussed. This is a National survey (a follow up to work undertaken 5 years ago, which did not require ethical approval) examining the current practice of Emergency Departments in England regarding screening and intervening with patients presenting with alcohol related conditions. No Patient / identifiable data is requested, we are interested in ascertaining the number of departments that currently screen for alcohol misuse and what interventions may be offered.

I would be grateful for a decision from the chair of the REC as to whether or not this can be classified as a service evaluation or audit, and if so that it would not require a full ethical approval application to be made.

I look forward to hearing from you.

13/10/2011

Appendix 2: Survey endorsement letter

**Institute of
Psychiatry**

at The Maudsley

Addictions Department
Box PO48
National Addiction Centre
4 Windsor Walk
London
SE5 8EB

Dr Robert Patton
Visiting Lecturer in Addictions
robert.patton@kcl.ac.uk
02078480449
07963538284

KING'S
College
LONDON

Dear Colleague

The National Addiction Centre is currently conducting an assessment of alcohol screening and brief intervention activity in all Emergency Departments in England. A researcher, Dr Bob Patton, will be collecting anonymous information directly from each department. This survey is a five year follow-up to one undertaken in 2006* which achieved a 98% response rate, and with your help we hope to do even better this time.

We are writing to you today to strongly encourage you to participate in this study. *Why is it important for you to participate? Because this is an important issue.* Collecting reliable data about alcohol screening and brief intervention activity will help us to better plan future service provision and identify additional training needs. I want to emphasise that your participation in this study is voluntary and will not affect your department in any way.

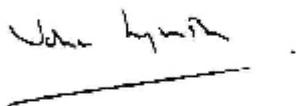
Please be assured that all information collected will be kept strictly confidential, and that the National Addiction Centre will not release any information that can be linked to your department.

We would be grateful if you could pass this information on to the person in your team best able to answer the enclosed questions.

Thank you in advance for your participation in this very important effort!

Yours sincerely,

Dr John Heyworth, Past President CEM



Dr Robert Patton, Research Consultant



* Patton R, Strang J, Birtles C & Crawford MJ, 2007, Alcohol: a missed opportunity. Results of a survey of all AEDs in England. *Emergency Medical Journal*, 24; 529-531

Appendix 3: NEDS questionnaire

The National Emergency Department Alcohol Identification and Brief Advice Survey: 5 year follow-up

Thank you for agreeing to participate in this survey. You can complete this form and send it by fax, post or email (address below), or you can complete it online at the following link:

<https://www.surveymonkey.com/s/NEDS2011>

Hospital Name:	
Thinking about your department,	
Do any staff have access to training on alcohol screening?	YES /NO
Do any staff have access to training on brief advice for alcohol use?	YES /NO
If YES, please tell us what training is available: _____	
Does your department have an "alcohol champion" – someone who takes a lead on alcohol issues?	YES /NO
Thinking about your ED patients,	
Are adult patients ever asked about their alcohol consumption?	YES /NO
Are adult patients routinely asked about their alcohol consumption?	YES /NO
Does your department use an alcohol screening questionnaire?	YES /NO
If YES, please tell us which one: _____	
If a patient is unable to complete a questionnaire do you measure blood alcohol?	YES /NO
Thinking about your patients aged 11 - 17 years,	
Does your department have a separate Paediatric area?	YES /NO
Are these patients ever asked about their alcohol consumption?	YES /NO
Are these patients routinely asked about their alcohol consumption?	YES /NO
Do you use an alcohol screening questionnaire for these patients?	YES /NO
If YES, please tell us which one: _____	
What presenting conditions are associated with alcohol misuse for these patients? _____	

Are there any typical days / times that these patients may present to the department as a result of their alcohol consumption? _____	

For ALL patients,	
Is blood alcohol measured:	routinely [] as required [] Never []
If blood alcohol is measured, is this facility available:	24/7 [] Monday – Friday 9 – 5 []
Are alcohol related attendances recorded in the patient's notes?	YES /NO
Does your department offer help or advice to patients who may have an alcohol problem?	YES /NO
If YES, please tell us what: _____	
Does your department have access to Alcohol Health Workers or Clinical Nurse Specialists?	YES /NO
If YES, how many:	AHW [] CNS []
If YES, are they based on site?	YES /NO
If a patient presents with an alcohol related condition, do you inform their GP?	YES /NO

Please return completed questionnaires to:
 Dr Robert Patton, National Addiction Centre, 4 Windsor Walk, London, SE5 8BB
 Email: robert.patton@kcl.ac.uk
 Fax: 020 7848 0818

Appendix 4: Overall regional variation

		Alcohol Champion	Screening training	Advice training	Routine questioning	Access AHW / CNS	BAC measured
		%	%	%	%	%	%
Region	East of England	23.1	46.2	30.8	38.5	92.3	61.5
	Greater London	67.9	67.9	60.7	46.4	60.7	42.9
	South West England	66.7	72.2	55.6	35.3	77.8	66.7
	North West England	72.7	59.1	59.1	63.6	77.3	63.6
	Yorkshire and the Humber	62.5	50.0	62.5	25.0	60.0	20.0
	West Midlands	20.0	73.3	73.3	42.9	80.0	40.0
	North East England	66.7	66.7	66.7	66.7	66.7	88.9
	South East England	54.5	63.6	50.0	59.1	57.1	61.9
	East Midlands	25.0	75.0	50.0	50.0	100.0	87.5