ALCOHOL RESEARCH UK

The 3rd National Emergency Department Survey of Alcohol Identification and Intervention Activity

Dr Bob Patton

January 2016

AUTHOR DETAILS

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ACKNOWLEDGEMENTS

We are grateful to Ms Ghiselle Green for help in preparing the final report, and to Professor Robin Touquet and Dr Fiona Wisniacki for commenting on earlier versions. This study would not have been possible without the endorsement of the Royal College of Emergency Medicine and the assistance of Dr Clifford Mann (President RCEM).

This report was funded by Alcohol Research UK. Alcohol Research UK is an independent charity working to reduce alcohol-related harm through ensuring policy and practice can be developed on the basis of reliable, research-based evidence.
www.alcoholresearchuk.org

Opinions and recommendations expressed in this report are those of the authors.

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EXECUTIVE SUMMARY

The results of the 2015 National Emergency Department survey of alcohol identification and brief advice activity indicate that, in comparison to the previous 2011 survey (Patton and O'Hara, 2013), the number of Emergency Departments informing patients' GPs about alcohol-related attendance, routinely asking questions about alcohol use (in adults) and having access to Alcohol Health Worker or Clinical Nurse Specialist services have all significantly increased. The provision of training on alcohol screening and brief advice, and the use of a formal alcohol screening tool have also demonstrated modest increases.

Nearly half of all departments are now implementing strategies to tackle re-attenders. Improved communication with GPs highlights a move towards multidisciplinary care and integration across primary and secondary care services. While routine questioning about alcohol use is fairly high among adults (aged 18-65 years), the limited routine questioning among under 18's marks room for improvement, particularly since those aged 15-24 years provide the greatest volume of A&E attendances (Currie et al., 2015).

BACKGROUND

Alcohol misuse in the UK remains associated with a high level of morbidity and mortality. The latest figures from the HSCIC indicate that alcohol-related deaths have increased by 10% since 2003 (1% from 2012), with 18% of all males and 13% of all females drinking at a level leading to an increased rate of harm (HSCIC, 2015). 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 (Drummond et al., 2005, Crawford et al., 2004a). The most recent systematic review and meta-analyses conclude that alcohol identification and brief advice (IBA) in the ED remains an effective and cost effective method to reduce levels of alcohol consumption and alcohol-related harm (Schmidt et al., 2015, Woolard et al., 2011). However, research has shown that there is no evidence that longer and more complex interventions are more efficacious than simpler and shorter interventions in both primary health care (Kaner et al., 2013), and in ED settings (Schmidt et al., 2015). Given the fast-paced setting of an ED and the lack of evidence that more complex interventions are superior, these findings complement recommendations from the SIPS ED study, which suggest screening followed by simple clinical feedback and information is likely to be the most efficacious form of IBA in the ED (Drummond et al., 2014).

The most recent UK Alcohol Strategy (2012) indicated that local councils would have access to a public health grant to facilitate implementation of alcohol IBA and funding for alcohol liaison nurses in Emergency Departments (HMSO, 2012). In the same year the government also launched the "Change4Life" alcohol social marketing campaign "Choose less booze"; a dedicated website providing information on units, tips on reducing consumption and a drink tracker app (Health, 2012). To date no formal evaluation of the impact or effectiveness of this campaign has been undertaken.

In 2013, NHS England produced a document focusing on what needed to be done to improve ED performance (England, 2013), it identified that among frequent attenders many suffered from addictions and/or mental illness, and that the implementation of both an alcohol strategy and psychiatric input would be beneficial in reducing costs, attendances, and re-admissions. Recent research has supported embedding mental health into care plans for frequent attenders, showing significant decreases in ED attendances following the involvement of psychiatrists into care planning and management (Ng et al., 2015).

The latest guidelines by NICE (2010) "Preventing the development of hazardous and harmful drinking", and SIGN (2004) "The management of harmful drinking and alcohol dependence in primary care", continue [1] to recommend the use of screening tools and the delivery of brief advice in the ED to reduce levels of consumption and harm (Nice, 2010, SIGN, 2004).

[1] It should be noted that the NICE guideline is due for review in 2017 and that the SIGN guideline was withdrawn in February 2015 as it was over 10 years old.

In 2013 the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) produced a report entitled "Measuring the Units" (Ncepod, 2013). This report presented a number of recommendations on how alcohol-related liver disease could be prevented, including:

- All patients should be screened for alcohol misuse.
- Patients presenting to acute services with a history of harmful drinking should be referred to alcohol support services for a comprehensive assessment.
- Each acute hospital should have a 7-day Alcohol Specialist Nurse Service.
- Every acute hospital should have a consultant led multidisciplinary alcohol care team.

While this report was not aimed at Emergency Department practitioners, there is a good deal of synergy between these recommendations and those proposed following the publication of our previous ED IBA survey report (Patton, 2012).

The Royal College of Emergency Medicine (RCEM) has recently published an alcohol 'toolkit' (RCEM, 2015). This specifically calls for the creation of local 'Alcohol Champions' to lead on training and development of staff and to facilitate IBA and the creation of alcohol care teams (with alcohol nurse specialists), as well as guidance on the management of frequent attenders to the ED.

To determine the extent to which the continuing recommendations for the provision of alcohol IBA have been adopted by EDs, a new survey of all English EDs was undertaken, following up on the previous National Surveys (Patton, 2012, Patton et al., 2007), with an additional focus on older drinkers and frequent alcohol-related ED attendees.

METHODOLOGY

This was a cross sectional survey targeting all 180 consultant-led Emergency Departments in England (Minor Injury Units, children's hospitals and specialist trauma centres were excluded).

A set of survey questions were developed, based upon the previous national survey (Patton, 2012), and in conjunction with the Section of Alcohol Research at the National Addiction Centre. In addition to the questions covered in the 2011 survey, we asked additional questions about patients aged 65+ and about assertive outreach service and frequent alcohol-related attendees. A copy of the questionnaire is found in Appendix 3.

The survey was made available on the internet via the *Survey Monkey* portal[2]. Survey respondents were not required to provide their names, however the name of their hospital was requested to help track participation. In line with our previous National Survey this study was classed as Audit and therefore NHS ethical approval was not required.

Prior to the commencement of the survey, support for and endorsement of the survey was sought and obtained from the Royal College of Emergency Medicine (RCEM). The RCEM was able to provide contact address for all English EDs and, where possible, the contact email for the clinical lead was also provided. Where an email address was not available the researcher sought contact details from the relevant medical secretaries in each department.

In the first instance, an email describing the study together with a link to the online survey was sent to the "Lead Clinician" of each ED, or other identified ED consultant. This was accompanied by a covering letter, signed by the current president of the RCEM, the RCEM alcohol lead and the lead researcher encouraging participation in the survey[3].

One week after the initial email, non-responding departments were sent a reminder email together with the covering letter and link to the survey website. If it was indicated that the contact was unavailable (annual leave etc.) then additional consultant contact details were obtained either from the internet or from the appropriate medical secretary. Two weeks after the initial email invitation was sent, the contact details for all non-responding departments were confirmed by contacting the appropriate medical secretaries and again a copy of the cover letter and survey link were sent. Two weeks later a final copy of the invitation and survey link was emailed to departments who had not yet participated. Over the eight week period each department received up to four reminders to participate.

Data collection occurred between August 2015 and October 2015, over a total of eight weeks. Once the survey was closed, data were entered into an SPSS database. All data was then analysed.

[2] www.surveymonkey.com
[3] See Appendix 2 for further details

RESULTS

Participating departments

A total of 147 departments (of 180 contacted) responded to the survey (81.6% response rate).

Table 1: Proportion of respondents by Region

	Number	Percentage
East of England	16	10.9
Greater London	24	16.3
South West England	18	11.9
North West England	25	17.0
Yorkshire and the Humber	17	11.6
West Midlands	14	9.5
North East England	11	7.5
South East England	19	12.9
East Midlands	6	4.1

Changes in Alcohol IBA activity 2011 – 2015

There was no change in the proportion of participating departments, with over 80% of English EDs completing the survey.

There have been significant *increases* in routine questioning about alcohol consumption (+15.9%), informing patients' GPs about alcohol-related attendance (+10.2%) and access to AHW / CNS (+13.4%). Modest increases were also found in access to brief advice training (+9.7%) and use of formal screening tools (Adults, +9.7%).

Table 2: Comparison of survey findings 2011 vs. 2015

	2011 (N = 151)	2015 (N = 147)	Difference in Proportions
Survey Response Rate	81.0%	81.6%	0.6%
Access to training on screening	63.6%	70.1%	6.5%
Access to training on brief advice	57.0%	66.7%	9.7%
Identified alcohol Champion	57.6%	59.2%	1.6%
Routinely ask about alcohol (Adults)	47.7%	63.6%	15.9%*
Use a formal screening tool (Adults)	51.7%	61.4%	9.7%
Ask about alcohol (Young People)	82.0%	83.8%	1.8%
Routinely ask about alcohol (Young People)	8.9%	11.6%	2.7%
Use a formal screening tool (Young People)	14.6%	15.0%	0.4%
Measure blood alcohol as required	55.7%	61.5%	5.8%
Record alcohol-related attendance	70.5%	75.4%	4.9%
Inform patients GP of alcohol related attendance	74.8%	85.0%	10.2%*
Offer help / advice for alcohol problems	100.0%	97.7%	-2.3%
Have access to an AHW or CNS	71.8%	85.2%	13.4%*

Training

Three quarters of all departments offered Alcohol Awareness training (82.4%). Over two thirds of departments (72.5%) offered staff access to training on alcohol screening, with most (69.0%) providing some form of brief advice training. About half of all training was provided by the Alcohol Liaison Service (52.3%), with eLearning (13.5%) and departmental induction (12.6%) providing the rest. "Other training" accounted for 21.6% of responses.

Alcohol Champions

Almost two thirds of departments (61.7%) 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 (χ^2=25.59, df=1, p<0.001) and brief advice (χ^2=24.17, df=1, p<0.001).

Table 3: Access to screening training and presence of alcohol champion

			Does your department have an "alcohol champion" - someone who leads on alcohol issues?	
			No	**Yes**
Do any staff have access to training on alcohol screening?	**No**	Count	28	11
		% within Does your department have an "alcohol champion" - someone who leads on alcohol issues?	51.9%	12.6%
	Yes	Count	26	76
		% within Does your department have an "alcohol champion" - someone who leads on alcohol issues?	48.1%	87.4%

Table 4: Access to brief advice training and presence of alcohol champion

			Does your department have an "alcohol champion" - someone who leads on alcohol issues?	
			No	**Yes**
Do any staff have access to training on brief advice about alcohol?	**No**	Count	30	14
		% within Does your department have an "alcohol champion" - someone who leads on alcohol issues?	55.6%	16.1%
	Yes	Count	24	73
		% within Does your department have an "alcohol champion" - someone who leads on alcohol issues?	44.4%	83.9%

Adults – Screening (aged 18-64 years)

Every department (100.0%) indicated that they had ever asked adult patients about their alcohol consumption. Of these, almost two thirds asked such questions routinely (63.6%), and used a standardised screening tool (61.4%).

The AUDIT-C and the Paddington Alcohol Test (PAT) were the most frequently used screening tools (33.7% and 31.4% respectively), accounting for almost two thirds of screening activity. Since 2011 PAT use has fallen by 9.1% while AUDIT-C has increased by 10.7%. Use of the CAGE has increased significantly from 4.1% to 18.6% (Z=-2.82)

Table 5: Alcohol screening tools 2011 vs 2015

		2011 % (n=74)	**2015 % (n=86)**	**Change %**
	AUDIT	8.1	3.5	-4.6
	AUDIT-C	23.0	33.7	10.7
	CAGE	4.1	18.6	14.5*
	FAST	14.9	5.8	-9.1
	PAT	40.5	31.4	-9.1
	SASQ	4.1	4.7	0.6
	Other	5.4	2.3	-3.1

Young people – Screening (aged <18)

Three quarters (80.1%) of departments had a separate area for patients under 18 years old. Most did ask young people about their alcohol consumption (83.8%) but few did so routinely (11.6%).

About one in seven departments (15%) use an alcohol screening tool, and of these the PAT (26.7%) and AUDIT-C (53.3%) were the most common. Since 2011 there has been a significant decrease in the use of the FAST tool in adolescent screening. While there was a considerable increase in the use of AUDIT-C, due to low numbers of departments actually using screening tools, this change was not statistically significant.

Table 6: Alcohol screening tool used for under 18's

		2011 % (N=17)	2015 % (N=15)	Change %
	PAT	29.4	26.7	-2.7
	FAST	23.5	-	-23.5*
	AUDIT	17.6	6.7	-10.9
	AUDIT-C	23.5	53.3	29.8
	Other	5.9	13.3	7.4

Older Adults – Screening (aged 65+)

The 2015 survey contained an additional section on older drinkers. Most departments did ask older people (aged 65+) about their alcohol consumption (94.9%), with about half doing so as a matter of routine (52.7%).

About half of all departments (51.2%) used an alcohol screening tool on this age group, and of these the AUDIT-C (35.4%), PAT (21.5%) and CAGE (21.5%) were the most common.

Table 7: Alcohol screening tool used for over 65s

		2015 % (N=15)
	PAT	21.5
	FAST	4.6
	AUDIT	6.2
	AUDIT-C	35.4
	CAGE	21.5
	SASQ	6.2
	Other	2.0

Blood Alcohol Measurement

In general, most departments measure blood alcohol "as required" (61.5%), and the service is available 24/7 (95.8%). Four in ten departments did not ever measure blood alcohol (37.7%).

Of those departments that routinely used alcohol questionnaires, less than one fifth (16.7%) indicated that they measured blood alcohol levels if a patient was unable to complete the screening tool (due to injury or unconsciousness).

Recording alcohol related attendances

About three quarters (75.4%) of all departments recorded an alcohol-related attendance in the patients' notes, and of these almost all (90.4%) informed the patient's GP about such attendances. There is a significant association between these two variables, with departments that record attendances more likely to also inform patients' GPs of an alcohol-related attendance (χ^2=8.76, df=1, p=0.003)

Table 8: Recording of alcohol-related attendances and informing GPs

			Are alcohol related attendances recorded in the patients' notes?	
			No	**Yes**
If a patient presents with an alcohol related condition do you inform their GP?	**No**	Count	10	9
		% within Are alcohol related attendances recorded in the patients' notes?	31.3%	9.6%
	Yes	Count	22	85
		% within Are alcohol related attendances recorded in the patients' notes?	68.8%	90.4%

Alcohol Interventions

Almost every department offers help or advice for patients who might have an alcohol problem (97.3%). The help / advice provided by about half (51.60%) of all departments was a referral to their own "in house" specialist team, with about a quarter (27.4%) referring patients to an external agency. Some department staff provided an intervention themselves as either a leaflet (12.1%) or "Brief Advice" (8.9%). There were no significant changes between 2011-2015.

The majority of departments had access to either Alcohol Health Workers or Clinical Nurse Specialists (85.2%) – most of these were based on-site (79.6%). The numbers of AHW and CNS varied between departments (Median= 1, range 0-6), with a significant increase in the numbers of departments that had access to either an AHW or a CNS since the 2011 survey (+13.4%, $p<0.05$).

Eighty five percent of departments inform the patient's GP if they have an alcohol-related attendance (a significant increase of 10.2% since 2011, $p<0.05$).

Table 9: Help / advice offered

	2011 %	**2015 %**	**Change %**
Leaflets	16.5	12.1	-4.4
Brief Advice	6.0	8.9	2.9
Referral external	26.5	27.4	-0.9
Referral internal	51.0	51.6	0.6

Frequent attendance for alcohol-related problems

We defined Assertive Outreach (AO) as a service that delivered intensive, comprehensive treatment and care in the community. Forty percent of participating departments indicated that they provided an assertive outreach service for patients who attended due to alcohol-related problems.

Table 10: Assertive outreach service for patients who attend the ED due to alcohol-related problems

		Frequency	%	Valid %	Cumulative %
Valid	No	77	52.4	60.2	60.2
	Yes	51	34.7	39.8	100.0
	Total	128	87.1	100.0	
Missing	System	19	12.9		
Total		147	100.0		

Forty percent of departments also offered a programme that aimed to reduce alcohol-related attendances.

Table 11: Do you have a programme which aims to reduce alcohol-related attendances to the department?

		Frequency	%	Valid %	Cumulative %
Valid	No	79	53.7	60.3	60.3
	Yes	52	35.4	39.7	100.0
	Total	131	89.1	100.0	
Missing	System	16	10.9		
Total		147	100.0		

There was a significant association between departments offering assertive outreach programmes and those that had a programme to reduce alcohol-related attendances ($x2 = 5.33$, $df=1$, $p=0.021$).

DISCUSSION

This 3rd National Emergency Department survey of alcohol identification and intervention activity had an excellent response rate of over 81%, maintaining the levels achieved by the previous national surveys (Patton and O'Hara, 2013, Patton et al., 2007). Changes in alcohol IBA activity over the last four years remain positive, with significant increases in routine questioning about alcohol consumption, the number of GPs being informed of patients alcohol related attendances, and departments access to Alcohol Health Worker and/or Clinical Nurse Specialist services, together with modest increases in the provision of training on alcohol screening and brief advice and the use of a formal alcohol screening tool for adult attendees.

The observed increase in the routine questioning of patients regarding their drinking is encouraging, given that this has been a consistent recommendation in all relevant reports and guidelines published or updated over the last 5 years (Ncepod, 2013, RCEM, 2015, Nice, 2010, Nice, 2011, PHE, 2014) as well as reviews of the literature on alcohol IBA (O'Donnell et al., 2014, Mitchell et al., 2013, Pilowsky and Wu, 2013, Jones, 2011). With about two thirds of EDs now routinely questioning adult patients about their consumption (most using a formal tool), there is still room for improvement, but this is now a much more accepted component of routine patient care.

The number of GPs who are being informed about alcohol-related attendance has improved from 75% to 85%. This supports the NCEPOD (2013) recommendation of multidisciplinary care teams that are integrated across primary and secondary care settings (Ncepod, 2013). The recent SIPS ED RCT (Drummond et al., 2014) concludes that while the ED is an appropriate location for screening and simple feedback, that primary care may be a more appropriate setting for more in depth interventions. Thus any increased potential for GPs to become involved in the wider implementation of alcohol IBA is a welcome improvement and could lead to a more multidisciplinary approach to case management, development of care plans and improved awareness of alcohol issues.

There has been a significant increase (up 13.4%) in the number of departments that have access to either Alcohol Health Worker or Clinical Nurse Specialist based alcohol care teams. This is encouraging as this follows the recent RCEM guidance. There is good evidence that access to these teams can help reduce levels of consumption and harm (PHE, 2014).

Building upon the previous surveys and given the recent focus (RCEM, 2015) on tackling re-attenders, current strategies regarding frequent attenders were assessed. It is promising to note that 40% of departments are offering Assertive Outreach services and have programmes to reduce ED re-attendances.

While there has been little change in the proportion of EDs who identified an 'Alcohol Champion', we note that the presence of a senior staff member who takes responsibility of dealing with alcohol issues is significantly associated with access to IBA training. There remains scope for more Champions to be created, and this ought to further increase alcohol IBA activity.

Departments currently use a variety of screening tools, with the AUDIT-C (Bush et al., 1998) and Paddington Alcohol Test (Patton et al., 2004) reported as the most commonly used measures, and this remains in line with the recent NICE and RCEM guidance (Nice, 2010, RCEM, 2015). Our opinion remains that the choice of actual screening tool remains secondary to the use of these measures, and that individual departments should be able to choose whatever screening tool works best for their staff and patients.

There has been a modest increase in the number of departments that routinely ask patients <18 years about their drinking, however only about one in six are currently asked about their alcohol consumption. Given that the latest reports suggest that the greatest proportion of overall ED attendances are from patients aged 15-24 years (Currie et al., 2015), departments need to increase screening activity for this population. We know that alcohol IBA for young people is effective (Patton et al., 2014), and the ongoing SIPS JR ED RCTs should provide useful recommendations on how best to reduce alcohol consumption and related harm among under 18s presenting to Emergency Departments (Deluca et al., 2015).

Most departments ask older patients (aged 65+) about their drinking, although only half do so routinely. Since one in five older people are estimated to drink at above the previous recommended guidelines (Rao et al., 2015), increased screening of this vulnerable population is required, particularly given their increased sensitivity to alcohol and potential complications due to concomitant medications (Immonen et al., 2011, Holahan et al., 2010).

The proportion of departments who measure Blood Alcohol Concentration as required has slightly increased since 2012. Research by Touquet and colleagues (Touquet et al., 2008, Csipke et al., 2007) suggests that BAC should be obtained from patients who are unable to complete a screening questionnaire. We again suggest 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.

Almost every department offers help or advice to patients who they have identified as having problematic consumption of alcohol. In line with recent guidelines (Nice, 2010, RCEM, 2015) most departments continue to 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 are both effective and cost effective, and can reduce levels of consumption and associated alcohol-related problems and subsequent hospital attendances (Barrett et al., 2006, Crawford et al., 2004b). Very few departments (8.9%) themselves provide brief advice to patients, which may be a reflection of continued pressure to meet 4 hour waiting time targets.

Appendix 1: Ethical Clearance

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
Email: charis.bailey@eoe.nhs.uk

Victoria House, Capital Park, Fulbourn, Cambridge, CB21 5XB

www.nres.nhs.uk

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

The Royal College of Emergency Medicine

Patron: HRH Princess Royal
7-9 Bream's Buildings
London
EC4A 1DT

Tel +44 (0)207 404 1999
Fax +44 (0)207 067 1267
www.rcem.ac.uk

Dear Consultant

We are emailing to ask you to take part in an online study on assessment of alcohol screening and brief intervention activity in all Emergency Departments in England. Dr Bob Patton will be collecting anonymous information directly from each department. This survey is a follow-up to ones undertaken in 2006* and 2011** which achieved a 78% response rate, and with your help we hope to do even better this time. This is very timely following the launch of the 'RCEM Alcohol Toolkit'.

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. 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 any reports or academic papers will not contain 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 questions

Click here to access the online survey, or type https://www.surveymonkey.com/r/EDIBA into your web browser.

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

Yours sincerely,

Dr Clifford Mann, President RCEM

Dr Robert Patton, Research Consultant

Dr Fiona Wisniacki
Alcohol Co-Lead RCEM

* *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

** *Patton R* & O'Hara P, 2013, Alcohol: signs of improvement. The 2nd National Emergency Department survey of Alcohol Identification and Intervention activity. *Emergency Medical Journal*, 30:492–495

Appendix 3: NEDS questionnaire

Thank you for agreeing to take part in the 3rd National Emergency Department Alcohol Identification and Brief Advice Survey (2015)

If you have any questions about this survey you can contact me at the following address:

r.patton@surrey.ac.uk

***1. Please tell us your ID number or hospital name - it's on the covering letter we sent you, and on the paper version of the questionnaire.**

***2. In which Government Office Region is your department located?**

Thinking about your department,

***3. Do any staff have access to training on alcohol awareness?**

- YES
- NO

***4. Do any staff have access to training on alcohol screening?**

- YES
- No

***5. Do any staff have access to training on brief advice about alcohol?**

- YES
- NO

***6. Please tell us what training is available (if none, please type 'none')**

***7. Does your department have an "alcohol champion" - someone who leads on alcohol issues?**

- YES
- NO

8. We would like to develop a database of ED based alcohol champions. If you would like to be included in this database, please provide contact details (Name, Address, email, telephone)

Thinking about your adult ED patients (aged 18-64);

***9. Are adult patients ever asked about their alcohol consumption?**

- YES
- NO

***10. Are adult patients routinely asked about their alcohol consumption?**

- YES
- NO

***11. Does your department use an alcohol screening questionnaire?**

- YES
- NO

***12. Please tell us which screening questionnaire is used:**

***13. If a patient was unable to complete a questionnaire (because of injury or they are unconscious) do you measure blood alcohol?**

- YES
- NO

Thinking about your patients aged 65 and older ;

***14. Are these patients ever asked about their alcohol consumption?**

- YES
- NO

***15. Are these patients (aged 65+) ROUTINELY asked about their alcohol consumption?**

- YES
- NO

***16. Do you use an alcohol screening questionnaire on patients aged 65+ years?**

- YES
- NO

***17. Please tell us which screening questionnaire is used:**

Thinking about your patients aged 11 - 17 years;

***18. Does your department have a separate Pediatric area?**

- YES
- NO

***19. Are these patients ever asked about their alcohol consumption?**

- YES
- NO

***20. Are these patients ROUTINELY asked about their alcohol consumption?**

- YES
- NO

***21. Do you use an alcohol screening questionnaire on patients aged 11 - 17 years?**

- YES
- NO

***22. Please tell us which screening questionnaire is used:**

***23. Which presenting conditions are associated with alcohol misuse for patients aged 11 -17 years?**

***24. Are there any typical days / times that patients aged 11 -17 years may present to the department as a consequence of their alcohol consumption?**

Thinking again about ALL your ED patients,

***25. Is blood / breath alcohol measured?**

- Routinely
- As required
- Never

26. If Blood alcohol is measured, is this facility

- 24/7
- mon-fri 9 - 5

***27. Are alcohol related attendances recorded in the patients' notes?**

- YES
- NO

The following questions are all about any help or advice about alcohol that your department may offer patients

***28. Does your department offer help or advice to patients who may have an alcohol problem?**

- YES
- NO

***29. Please tell us what help or advice your department offers patients who may have an alcohol problem:**

***30. Assertive outreach can be defined as a service that delivers intensive, comprehensive, treatment and care in the community. This may involve:**
- an emphasis on home visits or contact based primarily in other community places
- a low patient to staff ratio
- an interdisciplinary team involving professionals such as psychiatrists, social workers, nurses, occupational therapists and peer support specialists
- patient-led treatment
- support with things other than alcohol dependence such as shopping, budgeting, cooking, cleaning, help finding suitable education, employment or training, finding and keeping accommodation
- working with patients on a time-unlimited basis, as long as they demonstrate the need for this type of professional help

Do you offer an assertive outreach service for patients who attend the ED due to alcohol related problems?

- ○ YES
- ○ NO

***31. Do you have a programme which aims to reduce alcohol related attendances to the department?**

- ○ YES
- ○ NO

***32. Does this programme specifically target alcohol related frequent attenders to the department?**

- ○ YES
- ○ NO

***33. Please tell about the programme you offer to reduce alcohol related attendances**

***34. Are you aware of any local services that offer support to alcohol related frequent attenders?**

- YES
- NO

35. Please tell us which services offer this support

***36. Is your department able to offer alcohol screening and brief advice to all patients?**

- YES
- NO

***37. Does your department have access to Alcohol Health Workers or Clinical Nurse Specialists?**

- YES
- NO

***38. How many:**

Alcohol Health Workers

Clinical Nurse Specialists

***39. Are they based on site?**

- YES
- NO

***40. If a patient presents with an alcohol related condition do you inform their GP?**

- YES
- NO

41. Would your department be interested in taking part in research on alcohol screening and advice?

- YES
- NO

42. Do you currently have access to data on alcohol related attendances to your department?

- YES
- NO

43. Would you be willing to share the data as part of a wider research programme?

- YES
- NO

44. Please tell us your email or address so we can contact you about future studies

That's all the questions we have for you today. Thank you for participating in the National Emergency Department Alcohol Identification and Brief Advice Survey 2015

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