



A drop of advice

Effective brief interventions on alcohol can depend on knowing when to grab the moment and which questions to ask.

Dr Malcolm Thomas suggests how to make the most of an opportunity

This article is aimed at professionals and staff who are not alcohol specialists – that is, those who are not seeing patients referred for an alcohol problem, who have relatively short periods of time with clients in which to talk about alcohol, and whose patients or clients include some who might be drinking above sensible levels. They might be doctors in general practice or A&E, health visitors, drug workers, probation officers, arrest referral officers, social workers or others.

For every adult dependent drinker, there are around nine other adults drinking above levels regarded as medically sensible. Because they are not dependent on alcohol, these people can choose to cut down what they drink – and by cutting down, they can reduce their immediate and future risk of alcohol-related harms.

There is now good evidence that we can do something useful to prompt this, at acceptable cost. That 'something' is to identify drinkers at increased risk, and offer them a well-crafted conversation, backed up by appropriate reading matter.

The National Audit Office reported that 10.5m adults in England drink at

levels described as 'hazardous' or 'harmful' – though only 1.1m of these show significant symptoms of dependence on alcohol.

Alcohol-related hospital admissions are approaching 1m a year and are still rising. While this figure may in some part be due to greater awareness and recording by doctors and nurses, it is likely that it also represents a real trend.

Since around a quarter of adults are at increased risk, all of us working in the fields of health, social welfare, education or criminal justice are in regular contact with people in the 'at risk' group. We are in an ideal position to help identify them, to stratify their level of risk, and to offer a short conversation.

Evidence on what to do has been best developed for a general medical practice setting – however, the principles are appropriate for anyone offering a professional service to the public. A large UK study – the screening and intervention programme for sensible drinking (SIPS) – has been investigating the impact of alcohol screening and brief interventions in general medical practice, in A&E and in criminal justice settings. This is scheduled to report its first results in October.

This is a very active field of research and there is an international network of researchers and educators in brief interventions called INEBRIA. Research is being conducted in other settings, such as the proposed Scottish project I recently learned about which will examine the impact of brief interventions given by dentists.

For GPs and many other frontline staff, time is short so the conversations will only happen if they can be done quickly. Fortunately, the evidence shows that we can be effective in a short period of time – just three to five minutes. Indeed, spending extended periods of time appears to produce little or no extra benefit and cannot be recommended as an effective use of time in these settings.

If you can do as well they did in the research, then you should find about one person in nine responds with a medically useful reduction in their consumption, maintained for six to 12 months. And that is a good enough result for three to five minutes of professional time per patient or client.

The important caveat is this: you do need to know what you are doing. Based on my organisation EPI's extensive training experience, we know that an easy trap is to resort to traditional advice-giving mode. Researchers call this 'business as usual' – we call it finger-wagging.

The way to avoid this is to use the best materials and to be trained in how to use them in a time-efficient way. There are three steps: first, identification of 'at risk' drinkers; then diagnosing motivation, followed by matching the conversation to the motivation.

It should be easy to identify 'at risk' drinkers. If all drinkers knew how much alcohol was in their drinks, and how much they drank, then we could just ask something like 'how many units do you drink, on average, per week?'. As I am sure you have already discovered, this often fails to deliver the goods.

Patients often don't know the strength of their drinks, or how much they consume. They may kid themselves. They may lie to us. They may drink irregularly, with binges and gaps.

So it turns out that the best approach is to use a questionnaire. The gold standard in community settings is the alcohol use disorder identification test (AUDIT). However, this contains ten questions, so it may be too long for some settings, such as GP surgeries and A&E departments.

A number of shortened versions exist, the best of which are around 90 per cent accurate when measured against the whole questionnaire. The two shortest, called FAST and AUDIT-C, are widely used in the UK, and examples of them can be found at www.alcohollearningcentre.org.uk/

A workable strategy is to use FAST or AUDIT-C on all of your patients/clients. For anyone that scores 'positive' on your short questionnaire, you then proceed to a full AUDIT questionnaire. The outcome is a verdict that your patient/client is drinking at levels that are in one of these four categories: sensible, hazardous, harmful, or possibly dependent.

This approach has recently been incentivised for GP surgeries. Earlier in 2009, a new national additional service was launched. This pays GP practices to ask all new patients about their drinking, using the above approach (proceeding to a brief intervention if appropriate – see below).

Brief interventions are consistent with the 'cycle of change' model. So when

diagnosing motivation, we need to know which of the following stages most reflects the patient or client's thinking: Precontemplation, contemplation, or planning/preparing for action.

This can be done simply by doing something that many professionals find difficult – and that is by keeping your mouth shut! It works like this: after calculating the AUDIT score and finding which category the drinker belongs to, the professional should make a clear statement, pointing to the questionnaire total at the same time. For example: 'Your score is 12, and as you can see, that indicates hazardous drinking...' [pause]

This pause is the key. You may need to keep quiet for a few seconds. It is vital that your patient/client responds in their own words, because this is how to establish their thinking in relation to the Cycle of Change.

Typical responses include:

- 'Aye, so you say. Load of rubbish if you ask me.' (Precontemplator)
- 'Hazardous? Really? I'm a bit surprised.' (Contemplator)
- 'Funny you should say that, I have been thinking maybe I drink a bit too much.' (Possibly in preparation/planning stage.)

You now have maybe two minutes left to have complete a conversation, for the brief intervention to be effective. This needs targeting. For clients/patients who are interested, you need some material that has been designed to be discussed. Perhaps the best researched is the Structured Brief Intervention (SBI) Sheet. This is not likely to be the final word and it is worth keeping your ears open for new developments – for instance the SBI sheet is not ideal for younger or binge drinkers. The SBI sheet and other useful resources can be found at www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement

Also note that the SBI sheet has been designed to be used during a professional discussion – it is not the most suitable self-read material. The NHS 'units' leaflets are better for this purpose (see www.units.nhs.uk) – and many organisations have produced their own advice sheets that work well for the patient/client to take away.

The actual conversation then needs tailoring to your diagnosis of the patient/client's stage on the 'cycle of change'. Consider the following for suggestions:

Precontemplators should be offered some self help material (if they would like it), together with an open invitation – 'If you change your mind, I'd be happy to talk'.

Contemplators should be offered some factual information and invited to respond. The SBI sheet lists social, psychological and physical harms that can be brought on by alcohol, and has a graph of the proportions of the public who are sensible/hazardous/harmful/dependent drinkers. Show your patient/client the list and the graph and ask something like, 'How does that seem to you?'

Preparers/planners are best offered a conversation focused on cutting down, ie what limits to set and how to go about it. The SBI sheet gives an opportunity to set a target and make a detailed plan, listing ideally three or four steps the drinker will take to bring about a reduction in his or her consumption.

You do not see the patient/client again just to talk about drinking. To reiterate an earlier point, the evidence shows this is unlikely to make much – or indeed any – difference. On the other hand, letting the drinker know that you are interested is in order. In our training, we recommend a variant of, 'When I next see you, I'd be pleased to answer questions and hear how you are getting on.'

The evidence shows that very brief interventions for alcohol can be effective. However, they can also be a waste of time. The key to success is good material and knowing how to weave it into an effective and efficient conversation. An instructive demonstration can be found at the Alcohol Learning Centre (www.alcohollearningcentre.org.uk/)

If this is going to become a regular part of your role, we would recommend that you seek good quality training, to help you save time and increase your effectiveness.

You may have a local organisation that can offer this, and there are national providers (such as EPI).

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