

Towards a Framework for Implementing Evidence Based Alcohol Interventions

A Health Service Executive Report



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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What is this Project trying to do?

The aim of this project is to help establish routine screening, data collection and appropriate interventions emanating from the acute hospital sector. The initial focus is on screening and brief intervention (SBI) in emergency departments for harmful and hazardous alcohol use. Mechanisms for the dissemination of appropriate evidence and information to relevant Health Service Executive (HSE) personnel will be established. With a comprehensive distribution strategy, it will be possible to assist the development of evidence based interventions within the acute hospital sector. This project will provide a framework for the appropriate response to problem alcohol use emanating from the acute hospital sector.

Background to the Project

As part of the Programme for Government 2007-2012, the Government agreed to: "Provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking". The purpose of early intervention programmes is to detect high risk and harmful drinking in individuals, before or shortly after the early signs of alcohol related problems. This action led to the decision by the HSE former Population Health Directorate to designate "Towards a Framework for Implementing Evidence based Alcohol Interventions" as one of its transformation projects.

Policy Context

National Policy	
Irish policy and strategy documents have recommended the use of screening and brief intervention as a response to alcohol and substance misuse.	
The Second report of the Strategic Task Force on Alcohol (Government of Ireland, 2004)	Advocates the use of brief interventions across a range of health care settings including primary care, community services and general hospitals.
Programme for Government 2011-2016	The Government support the principles and objectives of the National Drugs Strategy. The first step in implementing a successful strategy will be to outline key priorities for short-term implementation, underpinned by a realistic timeframe and targets
Interim National Drugs Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009)	Notes that the general hospital setting (emergency departments in particular) is a key area to deliver interventions designed to address both psychological and social harms associated with problem substance use. The steering group mention that training of trainers within the general hospital setting, particularly nurses and allied health professionals, is necessary in order to provide adequate screening and brief interventions for all substances of abuse including nicotine, alcohol and drugs.

International Policy	
The (2007) EU Strategy on Alcohol	Expressly states the aim to increase EU citizens awareness of the impact of harmful and hazardous alcohol consumption on health, especially the impact of alcohol on the foetus, on under-age drinkers, on working and on driving performance
The WHO (2010) Global Strategy to Reduce the harmful use of alcohol.	Calls on governments of the WHO 194 member states to take active policy measures to combat alcohol-related harm. These measures include supporting initiatives for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of child-bearing age.

Why is the Health Service Executive trying to reduce people's drinking?

Alcohol is ranked as the eighth leading cause of death globally and is a causal factor in more than sixty major types of diseases and injuries and results in approximately 2.5 million deaths a year (WHO, 2011). While hazardous and harmful alcohol use is a global phenomenon, Europe has the highest proportion of drinkers and the highest levels of alcohol consumption per head of the population in the world, with total alcohol consumption averaging 11 litres of pure alcohol a year per adult (Anderson et al, 2006). Ireland still continues to rank amongst the highest consumers of alcohol in Europe, with the average Irish adult drinking 11.3 litres of pure alcohol in 2009 (OECD, 2011).

The burden of alcohol related harm is widespread in Ireland and includes harms experienced by the drinker but also harms experienced by people other than the drinker (harm to others). The burden of alcohol harm to the drinker can be seen: in hospitals, on the streets, on the roads, in families and in lost and damaged lives in every community. Among the alcohol related harms are high risk drinking linked to suicide, sexually transmitted infections and acute cardiac events from concomitant alcohol and cocaine consumption.

- Alcohol related harms are evident in persons presenting with injuries to emergency departments, among patients in hospital, in treatment services and in alcohol related mortality. Drunkenness and public disorder, alcohol related road accidents and self reported negative consequences experienced by drinkers are all indicators of alcohol related harm. Since 1995 alcohol- related morbidity and mortality have increased in line with increased consumption and harmful drinking patterns (Mongan et al, 2007).
- There is clear and conclusive evidence that the problems from consumption levels are reflected in both admissions to general hospitals (Royal College of Physicians 2001; Hearne et al 2002; Molyneux et al, 2006 and Hope, 2008) and attendances at Emergency Departments (Charalambous, 2002, Hope et al, 2005 and Hope, 2008). Hope et al (2005) proposed that between 20% and 50% of all presentations to emergency departments in Ireland are alcohol related, with the figure rising to over 80% at peak weekend periods.
- A national study involving 2,500 patients in six major acute hospitals across Ireland, found that over one in four (28%) of all injury attendances in the emergency departments were alcohol related. The patient profile showed that three-quarters of those in attendance with alcohol related injuries were male and almost half were in the 18-29 age group (Hope et al, 2005).

- A US study found that people who present to emergency departments are one and a half to three times more likely to be high risk drinkers than their counterparts who present in primary care settings (Cherpitel, 1999).
- The best estimate of the cost to the healthcare system of alcohol related illnesses in Ireland in 2007 were €1,200 million. (Byrne, 2010).
- An estimated 10% of bed-days in Ireland are due to the harmful effects of alcohol over the time period 2000-2004. (Martin et al, 2011)
- Bed-days attributed to alcohol comprise 13% and 7% of all bed-days in men and women respectively. In men the proportion of total hospital bed-days that are attributable to alcohol, increased from 7% in 15-19 year olds to a peak of 18% in 50-54 year olds and decreased to 10% by 80 years of age. In women, the proportion of total hospital bed-days that are attributable to alcohol is 5% or less in those under 40 years, and between 8% and 10% in those over 40 years. (Martin et al, 2011)
- Over the period 2000-2004, the cost of bed-days attributable to the negative effects of alcohol was €953,126,381. The costs of bed-days due to alcohol were nearly twice as high in men as women (€618,927,425 in men compared with €334,198,956 in women). This represented 15% of total hospital costs for that time period. (Martin et al, 2011)
- Over the period 1999-2005, the Coombe Women's Hospital study reported that 63% of women reported alcohol use during pregnancy. Over two thirds of all pregnant women under 18 year olds reported drinking alcohol during pregnancy. The highest percentage category reporting drinking over 10 units per week was the 18-24 year olds. 7.1% of all pregnant women admitted drinking more than 6 units of alcohol per week. 58% of pregnant women were aware of the potential harmful effects of alcohol in pregnancy and 11% had been advised about the hazards of alcohol by a doctor. (Barry et al, 2007)

How can we respond?

It is clear that dealing with this significant issue makes good sense from both health and economic perspectives. In this context, it is notable that hospital attendances may provide “teachable moments” (Watson, 1999) offering opportunities to provide SBI for hazardous and harmful alcohol use which may help motivate patients to change their drinking behaviours (D'onofrio et al, 2002). The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with hazardous and harmful alcohol use (Allen, 1998, D'onofrio et al, 2002, Herring & Thom, 1999, Anderson et al, 2001, Goodall et al, 2008). These brief psychological interventions aim to investigate a

potential problem and motivate individuals to do something about their substance abuse, either by natural, client directed means or by seeking additional substance misuse treatment (Health Research Board, 2006). There are a number of easily administered screening tools (Hearne et al, 2002) and brief intervention models (Miller & Sanchez, 1993) available to facilitate the delivery of SBI.

What is Screening?

Screening occurs on a daily basis in health care settings. It is a process by which members of a defined population, who do not necessarily perceive they are at risk of disease, are examined to identify those likely to benefit from appropriate intervention. Screening for hazardous and harmful alcohol use is conducted in acute care settings to identify those patients who drink at hazardous levels, those who are beginning to experience alcohol-related problems and those who are showing signs of alcohol dependence (Babor and Higgins-Biddle, 2001).

Hazardous drinking is described as a pattern of alcohol consumption that places individuals at risk for adverse health events (Saunders et al, 1993). Harmful drinking can be described as a pattern of use that is already causing damage to health. It arises following a long period of hazardous use. The damage may be physical (e.g. hepatitis-inflammation of the liver) or mental (e.g. depressed mood secondary to alcohol intake). Harmful use commonly has social consequences (HRB, 2007). Alcohol dependence is described as a syndrome that includes a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value (WHO, 1992).

Screening is completed through the use of validated screening tools and laboratory tests. Many screening tools are available with varying levels of sensitivity, validity and acceptability across a range of settings. Screening questionnaires are often seen to be superior and more sensitive than laboratory tests for the detection heavy or problem drinking (Yersin et al, 1995; Hoeksema et al, 1993). Laboratory results can however provide objective evidence of problem drinking which is helpful to confirm screening results and raise doubts for patients who deny any drinking problem. Positive results from screening signal the need for brief interventions aiming to ameliorate alcohol related problems and improve health related outcomes.

What is a Brief Intervention?

Definitions of brief interventions and their implementation in practice are diverse across the literature. Ali, Miller and McCormack (1992) described them as any intervention that involves a minimum of professional time in an attempt to facilitate a patient's awareness of the need to change their alcohol use, requiring a total of between five minutes and two hours to administer. Bein, Miller, and Tonigan (1993) further develop this definition suggesting that brief interventions are (i) generally restricted to four sessions or less (ii) designed to be conducted by health care workers who do not specialise in addictions treatment and (iii) utilised with less dependent drinkers. Moyer and Finney (2005) have argued that simply providing feedback is in itself a brief intervention, as it may be enough to encourage those at risk to reduce their alcohol intake. Therefore brief interventions can be represented on a continuum of care that responds to an individual's needs, starting at raising the issue of alcohol misuse through to more in-depth intervention taking from four sessions and up to two hours.

Do Screening and Brief Interventions work?

The Evidence for Screening and Brief Intervention

Brief intervention is amongst the most effective of psychosocial treatments across a range of health related behaviours.	Hester and Miller (2003) Miller and Rollnick (2002)
The utility of brief intervention has been demonstrated with a range of mental health problems including: depression, deliberate self harm, anxiety disorder and alcohol and substance misuse disorders.	Lang (2003). Wilhelm et al. (2007). Roy-Byrne et al. (2009). Hester and Miller (2003).
A substantial body of literature exists which supports the use of brief intervention across a range of health care settings, including emergency departments, primary care and mental health	Roy-Byrne et al. (2009). Irish College of General Practitioners (2007). Wilhelm et al. (2007). Sommers et al. (2006) Crawford et al, (2004). Lang (2003). Scottish Intercollegiate Guidelines Network (2003). Babor and Higgins-Biddle (2001).

<p>It is calculated that one in every eight patients who receive a brief intervention for alcohol use is likely to benefit in terms of reduced health risks, compared with one in every twenty people who receive brief advice to stop smoking.</p>	<p>The Scottish Intercollegiate Guidelines Network (2003).</p>
<p>Risky drinkers who receive brief advice are twice as likely to moderate their drinking 6-12 months after an intervention when compared to drinkers receiving no intervention</p>	<p>Wilk et al (1997)</p>
<p>Several reviews of the literature have placed SBI at the pinnacle of efficacious treatments for hazardous and harmful alcohol use</p>	<p>Bien et al (1993). Project M.A.T.C.H. (1997). Wilk, Jensen and Havighurst, (1997). Miller & Wilbourne, (2002).</p>
<p>56 controlled trials have shown the value of SBI.</p>	<p>Moyer et al (2002)</p>
<p>A Cochrane Collaboration review of the effectiveness of brief interventions for hazardous and harmful alcohol use found a positive impact on alcohol consumption, mortality, morbidity, alcohol related injuries, alcohol related social consequences, use of health care resources and laboratory indicators of harmful alcohol use.</p>	<p>Kaner E., Beyer, F., Dickinson, H., Pienaar, E., Campbell, F., Schlesinger, C., Heather, N., Saunders, J. and Bernard B. (2007)</p>
<p>The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with hazardous and harmful alcohol use</p>	<p>Allen (1998). D'onofrio et al (2002). Herring & Thom (1999). Anderson et al (2001) Goodall et al (2008)</p>
<p>These brief psychological interventions aim to investigate a potential problem and motivate individuals to do something about their substance abuse, either by natural, client directed means or by seeking additional substance misuse treatment</p>	<p>Health Research Board (2006).</p>

<p>A trial conducted in UK primary care practices reported that providing brief interventions for alcohol misuse gave cost savings of five times the expenditure on health, social and criminal justice services. This has frequently been summarised as every £1 spent on evidence based alcohol treatment results in a net saving of £5 to the public sector.</p>	<p>The UK Alcohol Treatment Trial (2005b) Raistrick et al (2006)</p>
<p>A US study examined direct injury medical costs and savings associated with routine provision of SBI to patients presenting at trauma centres. An estimated 27% of all injured adult patients were candidates for a brief alcohol intervention. The net cost savings of the intervention was \$89 per patient screened, or \$330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of \$3.81 for every \$1.00 spent on SBI.</p>	<p>Gentillio et al (2005).</p>
<p>Although studies on the use of SBI in the ED are in their infancy, they have a demonstrated efficacy not only to reduce alcohol consumption but also to impact positively on the psychosocial consequences of high risk drinking</p>	<p>Smith et al (2003) Bazargan-Hejazi et al, (2005). Walton et al (2008). Crawford et al, (2004)</p>
<p>There is extensive and consistent evidence that brief advice in health care settings reduces alcohol -related harm. There is consistent evidence that organisational factors can increase the implementation of brief advice programmes and that brief interventions are cost-effective.</p>	<p>WHO, 2009</p>

What are the potential benefits of implementing Screening and Brief Interventions?

The cost of investing in routine screening and appropriate interventions, employing an alcohol liaison nurse and investing time and resources are outweighed by the following benefits:

- A reduction in alcohol related attendances to the emergency department.
- A staff base confident in dealing with alcohol related attendances.
- A reduction in associated costs to acute care settings.
- A reduction in bed occupancy.
- A reduction in alcohol consumption and chronic addiction and an increase in health gains.
- Prevention and reduction of the following:
 - Premature deaths and disabilities. The harmful use of alcohol is listed as the third leading risk factor for premature deaths and disabilities in the world. (WHO, 2009).
 - Stroke.
 - Unsafe sexual practices.
 - Cancers causally related to alcohol consumption.
 - Prenatal alcohol exposure and associated effects.
 - Reduction in liver and other chronic illnesses and diseases associated with alcohol.
 - Reduction in alcohol related injuries.
- Ludbrook et al (2002) used simulated costs of a UK programme in 1999/2000 prices, their study suggested that the cost per life year gained would be in the region of £2,600, factoring in reduced health and legal costs meant that brief interventions would yield savings of around £2,000 per life year.
- Kunz et al. (2004) randomised 294 individuals to brief intervention or control treatment in an ED in a poor, multi-ethnic inner city area. Evidence from this pilot study indicated that screening and brief intervention was relatively low in cost and potentially cost-effective.
- Gentillio et al (2005) examined direct injury medical costs and savings associated with routine provision of SBI to patients presenting at trauma centres in the USA. The net cost savings of the intervention was \$89 per patient screened, or \$330 for each patient offered an intervention. This was driven by future health care costs outweighing the cost of the intervention and screening. The benefit in reduced health expenditures resulted in savings of \$3.81 for every \$1.00 spent on screening and intervention.

- According to Touquet and Brown (2009), there are financial implications to employing alcohol nurse specialists but the benefits far outweigh the cost. They believe that every hospital needs an “alcohol czar”- a senior clinician who will provide leadership and advice to ensure that the teachable moment is utilised at every ED visit.
- The UK Royal College of Physicians (2001) undertook an economic analysis of having an alcohol liaison nurse in a general hospital and suggested that the post saved ten times more in reducing repeat admissions than its cost (15 fewer admissions or readmissions per month).
- Crawford et al, (2004) found that for every two referrals by ED staff to an alcohol health worker, there is one less re-attendance during the following twelve months.
- The Alcohol Ready Reckoner (2011) calculates the cost and benefits of employing a fulltime Alcohol Health Worker in Paddington hospital ED with non-dependent drinkers. One Nurse could prevent 37 hospital admissions and 550 ED attendances a year at a net saving of £67,000 to the NHS having allowed for estimated salary costs of £60,000. The real benefit comes in the form of improved health status of the population and could just as informatively be expressed in terms of Quality Adjusted Life Years.
- The Department of Health (2009) in the UK commissioned a review of the effectiveness and cost-effectiveness of public health interventions with the potential to achieve eight objectives, one of which was preventing dangerous drinking. The report found reliable evidence for the cost-effectiveness of brief interventions for high risk drinkers in terms of public sector savings.

Feasibility test within Acute Hospital Emergency Departments.

The initial focus of the project was to test feasibility of SBI within emergency departments. In February, 2008 a mapping exercise was undertaken with all acute hospitals nationally. The results of this exercise showed the level of response to alcohol related attendances and helped to identify acute hospitals where significant interventions were already in place. A national meeting with persons interested in alcohol in the acute hospital setting took place in June, 2008 followed by multi-disciplinary meetings with staff in Letterkenny General Hospital, Cavan General Hospital, Naas General Hospital, Cork University Hospital and Waterford Regional Hospital. Further meetings took place with staff from Beaumont Hospital and AMNCH, Tallaght in the first quarter of 2009.

The response towards the project was positive in all hospitals and there was an acceptance among all staff that alcohol is a problem for emergency departments. Staff felt that alcohol was by far the main drug problem encountered in their work and in some areas staff cited an increase in poly drug use, particularly cocaine and alcohol use. All agreed that there was value in screening and delivering brief interventions particularly as some staff felt that alcohol was becoming an increasing problem in emergency departments. The issue of detoxification was raised during all hospital meetings and the need for a National strategy was highlighted. This would guide management and outline how alcohol should be managed in the acute hospital. Some hospitals have developed detoxification policies and others have yet to do so, this was felt by staff to be a gap which they wanted addressed. While hospitals have alcohol policies, no hospitals have yet written a policy on how to address hazardous and harmful alcohol use, which are the main focus of this project.

The M-SASQ (modified-single alcohol screening question) screening tool was selected for use within the hospital emergency departments. This is a single question screening tool, which uses question 3 from the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT screening tool is considered the gold standard of screening tools internationally, however it contains ten questions and is considered time consuming to administer. The SIPS (*Screening and Intervention Programme for Sensible Drinking*) programme in the UK developed the M-SASQ screening tool from the original Single Alcohol Screening Question (SASQ) (Williams & Vinson, 2001; Canagasaby & Vinson, 2005) The tool was modified and adapted to Ireland's standard drinks (1 drink= 10g of ethanol). Testing in the SIPS pilot study, showed M-SASQ has a higher sensitivity and specificity than the original SASQ (Sensitivity 91.8; Specificity 70.8; AUC 0.929) when compared to the gold standard AUDIT during a pilot study within this wider SIPS programme.

The SIPS programme was commissioned by the Department of Health to support the National Alcohol Harm Reduction Strategy for England and to develop more information about the most effective methods of targeted screening and brief interventions. Various screening tools are being tested across three settings, one of them being the emergency department. Preliminary results showed that the M-SASQ screening tool was proving to be the most effective screening tool within the emergency department setting in the UK. The SIPS study showed that M-SASQ was found to be the most efficient screening tool in emergency department settings, in terms of the number of positives identified for the numbers approached.

A training programme was offered to all participating hospitals and the SAOR model of training for screening and brief intervention for alcohol in the emergency department & acute care settings was selected (O'Shea & Goff, 2009). The SAOR acronym (**S**upport, **A**sk and **A**ssess, **O**ffer assistance and **R**efer) offers a four step model for the delivery of SBI which guides practitioners in the emergency department and other acute hospital settings through brief intervention in a flexible and adaptable manner. The intervention is designed to be delivered as part of a brief therapeutic conversation between the practitioner and patient which can be integrated with other medical and nursing interventions rather than creating an extra and excessive work load. The model also offers a framework for more in depth intervention depending on the time available and skills level of the practitioner. Thus the intervention can be delivered in time frames ranging from five minutes up to one hour. A draft training manual and resources were prepared for hospitals delivering training.

While the aim of the project was to screen everyone attending the emergency department, it was acknowledged at the outset by the project team that there are certain circumstances where this is not feasible for staff. Examples given were; patients drunk on arrival in the emergency department, seriously ill patients, refusal to co-operate, confused or agitated patients, nursing home/residential care unit patients and patients detained under the Mental Health Act, 2001. At all times screening was left to the discretion of staff in the individual hospitals and patients could also decline to be screened. As screening for alcohol use was likely to identify some patients requiring referrals to specialist services, local alcohol and addiction services were informed of the project prior to the commencement. A localised media campaign accompanied the rollout of the project in the participating hospitals and included press releases, interviews with local media and posters displayed in waiting rooms. The aim of the media campaign was to inform the general public that this project was taking place in selected hospitals and if they attended the emergency department in their local area they would be asked about their alcohol use.

Staff displayed a positive attitude and willingness to participate in the project and committed to the project despite the barriers they encountered within their work environment. Emergency departments are by their very nature busy environments and at the time of the screening and brief intervention rollout there were additional strains placed on resources with the H1N1 virus and severe winter weather resulting in an increase in emergency department attendances. The identification of a local “champion” at each site was vital to the roll out of SBI within the emergency department. In some cases the alcohol liaison nurses and liaison psychiatrists fulfilled this role providing invaluable information on existing alcohol interventions within the hospital and acting as a liaison between the project team and relevant staff within the hospital. In other cases the “champion” role was fulfilled through a combination of support from the local addiction services, psychiatric liaison service and the health promoting hospital co-ordinator or emergency department nurse manager. This led to a co-ordinated effort within the emergency department. The value of the work provided by alcohol liaison nurses and other services cannot be underestimated.

Staff expressed considerable concern regarding time constraints for delivering screening and brief interventions. Staff felt that alcohol is a sensitive issue for a lot of patients and the emergency department environment is not always conducive to delivering a brief intervention. The need for privacy was referred to, along with delivering a worthwhile intervention. There was a perceived benefit from having a dedicated member of staff to provide information and support and who has allocated time to provide an intervention. The existence of an alcohol liaison nurse meant that staff had already been exposed to alcohol awareness training and in some cases brief intervention training. In the absence of an alcohol liaison nurse, other services such as local drug and alcohol services or health promotion hospital co-ordinators provided training support to hospitals. Where alcohol awareness training had been provided, staff reported that they were more comfortable asking about alcohol use. Training is essential for staff to feel competent and confident in delivering screening and brief interventions. During discussions with staff at hospital visits, several barriers to training were highlighted, in particular the release of staff to attend training and the length of training courses. Flexible options for training delivery are now required; in practice onsite and e-learning programmes are the only practical options for emergency department staff. The SAOR model of training provided an appropriate training tool for introducing SBI to the emergency department and verbal feedback from the hospitals was positive. The accompanying resources for the training manual were welcomed by the hospitals to add to their existing resources and promote the SBI project to patients.

The single item M-SASQ screening tool proved popular with staff and as envisaged, staff reported that the screening tool itself was the best option for a busy emergency department. Administering a longer screening tool was not deemed practical in an emergency department but staff felt that this might be possible in other hospital wards or in a self-administered computerised test based in the emergency department. Overall, staff reported that the M-SASQ screening tool was user friendly and quick and easy to administer. They also felt that a single item question could be more easily included in standard patient documentation, both paper and electronic. The inclusion of screening questions in emergency department and patient documentation would help with the recording of data and follow up with the patient. Proposals have been put forward in some of the hospitals to have alcohol documentation included in the standard patient documentation.

Results:

Four hospital learning sites; Waterford Regional Hospital, Letterkenny General Hospital, Naas General Hospital and Cork University Hospital began screening and brief intervention between December 2009 and February 2010.

	Waterford R.H Total Number screened=381	Letterkenny G.H Total Number screened=337	Naas G.H Total Number screened=170	Cork U.H Total Number screened=56*	Total 944
No further intervention	46% (n=177)	60% (n=202)	41% (n=70)	19% (n=11)	49% (n=460)
Brief advice	41% (n=157)	30% (n=101)	33% (n=56)	56% (n=31)	36% (n=345)
Referral to specialist services	11% (n=41)	3.5% (n=12)	12.5% (n=21)	16% (n=9)	9% (n=83)
Declined to take part	2% (n=6)	6.5% (n=22)	13.5% (n=23)	9% (n=5)	6% (n=56)

*Cork University hospital screened patients in the Clinical Decisions Unit and not in the main Emergency Department hence the numbers screened are lower than the other hospitals.

The results show that there was good co-operation from the public with only 6% declining to be screened. The screening tool detected 36% requiring brief advice and 9% required referral to specialist services. In total 49% required no further intervention.

Recommendations

Policy:

- There should be a policy for addressing hazardous and harmful alcohol use in all acute hospitals.
- One of the existing frontline staff should be dedicated as an alcohol liaison nurse for each hospital. The alcohol liaison nurse will provide support to nursing and medical staff to enable them to deliver screening and brief interventions and will act as a resource to improve hospital management of problem and dependent drinkers.
- The M-SASQ single item screening question should be included in standard patient documentation.
- There should be a written detoxification protocol and appropriate services for acute hospitals.
- Screening and brief intervention should be extended beyond the emergency department to the wider hospital.

Service Provision:

- There should be a clear referral pathway to drug and alcohol services and primary care teams for patients requiring a referral from the emergency department after screening.
- Consideration should be given to the inclusion of general drugs screening (instrument based) within acute hospitals.

ICT:

- There is a need to have improved electronic data collection to capture patients who have received a brief intervention and a referral to specialist services.
- The M-SASQ single item screening question should be included in electronic patient records.
- An evidence based self- assessment tool should be provided within hospital waiting rooms and on the HSE and www.drugs.ie website.

Training:

- Multi-disciplinary training should be provided in Screening and Brief Intervention (SBI) at all stages of career development, beginning in student training.
- An e-learning programme should be developed for the SAOR model of training.

National:

- A public education campaign should be devised for alcohol related harms and new standard drinks information.
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- Appropriate standardised alcohol information should be available to health professionals.
- The findings of this report should be sent to the National Group examining the incorporation of alcohol into the National Substance Misuse Strategy.

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