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Building on Harrington-Dobinson and Blows: Effective interventions for patients with alcohol-related problems

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Abstract

Harrington-Dobinson and Blows recently provided a three-part series of papers on alcohol, its consequences for health and wellbeing, and the role of the nurse. Their third paper outlined the health education and health promotion role of the nurse. They outlined basic principles for nursing practice in relation to the patient with alcohol dependence in the acute general hospital. We believe that much more can – and must – be said in relation to the vital issue of nurses’ clinical interventions for alcohol. We therefore build on their third paper by outlining in more concrete terms how nurses in all settings can effectively intervene with patients. We introduce the current evidence-based guidelines in this area and use the ‘consensus model’ contained within them to describe the process of effective alcohol intervention. Using dialogue examples to illustrate the research, we introduce the literature on brief interventions and motivational interviewing to a nursing audience.

Key words: Alcoholism, Alcohol Abuse, Alcohol Drinking, Motivational Interviewing, Health Promotion, Health Behavior

Key points:

- Nurses know that the interpersonal relationship is central to nursing outcomes.
- Effective alcohol interventions also depend on interpersonal relationship skills.
- Nurses are proven to be effective in using brief intervention strategies to improve patients’ health and wellbeing around alcohol
- Incorporating the lessons of motivational interviewing offers additional benefits for both nurses and patients

- Nurses have a huge potential to benefit patients across the full spectrum of severity of alcohol use disorders

Alcohol – what do nurses need to know?

The BJN recently published a series of articles giving an overview of alcohol (Harrington-Dobinson and Blows 2006), its relation to health and wellbeing (Harrington-Dobinson and Blows 2007), and how nurses can helpfully respond to the alcohol dependent patient in the acute general hospital (Harrington-Dobinson and Blows 2007). We believe that there is a huge potential for nurses in all clinical settings to intervene effectively across the full spectrum of alcohol use disorders. We believe that further development of Harrington-Dobinson and Blows (2007b) is warranted.

Harrington-Dobinson and Blows (2007a) usefully define hazardous, harmful, and dependent drinking. These concepts are useful in communicating the range of severity of patterns of alcohol use and their attendant problems. Nurses come into contact with patients whose drinking spans the hazardous-harmful-dependent spectrum. The majority of alcohol-related harm is actually experienced amongst hazardous and harmful drinkers, an example of the preventive paradox (Poikolainen, Paljärvi et al. 2007). The incidence of a wide range of alcohol-related health conditions increases from as little as three units of alcohol per day (Corrao, Bagnardi et al. 1999), hence the level of current recommendations about low-risk drinking (Box 1).

A number of policy and practice guidelines have now been published that nurses in all settings can use to guide their clinical work (Babor and Higgins-Biddle 2001; Scottish Executive 2002; SIGN 2003; National Treatment Agency for Substance Misuse 2006). These guidelines represent the consensus view of expert authorities regarding

the current research literature. They are important because – in a similar manner to other healthcare professionals – nurses often report lacking the knowledge and skills to intervene effectively (Lock, Kaner et al. 2002). This is not to underestimate the importance of also having organisational structures that supportive clinical practice in place (Skinner, Roche et al. 2005).

In simplified terms, the consensus model holds that:

- all hazardous and harmful drinkers warrant an opportunistic brief intervention (BI) with follow-up enquiry as to progress
- some harmful drinkers warrant structured brief treatments such as *Motivational Enhancement Therapy* (MET)
- some dependent drinkers will respond well to structured brief treatments such as MET
- some harmful and dependent drinkers – such as those with serious comorbid health conditions (such as serious liver disease, or psychological problems), and those with serious, problematic social circumstances, warrant specialist referral and treatment
- certain pharmacological treatments are a useful addition to psychosocial interventions

We shall use this model to outline how nurses can use psychosocial interventions to effectively intervene with the patient whose alcohol use puts them at risk of, or has already caused, negative consequences. Harrington-Dobinson and Blows (2007b) highlight the role that communication skills play in effective nursing interventions. Interpersonal communication is the core component of effective alcohol interventions.

Indeed, *all* psychotherapeutic techniques are inherently, “highly specialised therapeutic relationship *skills*” (Fraser and Solovey 2007) (p.108, emphasis in original).

Getting started: asking about drinking

Questions about drinking are routinely asked by nurses during global assessment. Questions are also asked when specific concerns arise regarding the possible contribution of alcohol to the patient’s condition. Key questions contained in validated alcohol screening tools include ‘how much’ and ‘how often’, for both ‘average drinking days’ and ‘heaviest drinking days’. Tools, such as the Fast Alcohol Screening Test (FAST), can be incorporated into global assessment documentation, and can be downloaded from the web address in box 2.

Nurse: Would it be okay for me to ask you some questions about your use of alcohol?

Patient: Oh, right, not too much really...

N: Don’t worry, I’m not going to give you ‘the lecture’. I’m interested because it might be relevant to your condition.

P: Okay then...

N: **How much** would you drink **on an average day**?

P: Not much, I mean, probably three or four pints in an evening...

N: So, about three or four pints of, what, beer? On a typical day?

P: Yes, lager, and maybe a nightcap too...

N: And what would that be?

P: a whisky...a ‘good’ measure!

N: So, we’re roughly talking about, um, what, around eight units on an average day I think.

P: Mmmm...

N: And **how often** would this kind of average day happen, **in a week**, say?

P: Oh, probably about four, no, five days a week, some days a bit more, some a bit less, you know...

N: And **on the days when you drink heaviest, how much** would you drink on those days?

P: With friends, like? Oh, easy seven, eight pints and a few nips...

N: And **how often** do these heaviest days happen? Once a week, less often?

P: Usually a Saturday, most Saturdays

N: So, probably about, say, eighteen units maybe.

P: Okay.

N: Adding that up, that's about, somewhere between 50 and 70 units a week, that kind of area

P: Is that a lot?

N: Well, I think we should make a mental note to come back to it. It's something we could usefully look at in a bit more detail, if that's okay...

P: yes, of course

N: moving on just now, can I ask you about...

In this example, the nurse has established that the patient is clearly exceeding daily and weekly recommended limits. This patient would warrant further assessment and (at least) a brief intervention. The next task is therefore to negotiate this onto the clinical agenda (Rollnick, Mason et al. 1999). This might occur following straight on from a global assessment, or after specific 'stand alone' questioning regarding the patient's drinking. Equally, the clinical agenda that is negotiated at the beginning of every clinical encounter could be an opportunity to refer back to screening information gathered during an earlier assessment.

Nurse: We gathered a lot of information from our assessment of your condition, and we've already discussed the nature of your illness and the medical treatments that are being recommended to you. There are some other areas that I would like to talk a bit more about, if that was okay, but before I mention them I wonder if there's any specific issues that you want us to look at?

Patient: Well, mainly it was about the treatment side of things...which you've covered

N: We can always come back to anything that occurs to you at any time, so don't be afraid to ask questions. Some of the areas I'd like to talk more about are, things like, how you manage at home by yourself at the moment, your smoking...

P: oh [rolls eyes and laughs/groans]

N: I know! Don't worry, we're not going to talk about anything you're not happy to discuss...you're in charge here. Also, maybe, how to manage your pain, and I'd also like to talk a bit more about the ins and outs of alcohol for you just now...is there any area I've mentioned that you feel we should talk about first?

P: I don't want to waste your time, what do you think we need to talk about?

N: No, it's okay; I wonder, might we look at your drinking a bit more?

P: I don't have a drink problem...

N: I wouldn't dream of saying that you do! From your initial answers I would like to discuss it a bit more, to see if there's any advice I could offer, particularly in relation to your health?

P: No, it's okay, I don't mind you asking, go ahead...

This negotiation is a potentially delicate business (Rapley, May et al. 2006). Harrington-Dobinson and Blows (2007b) establish the need for the nurse to "show warmth, genuine interest in the client's welfare, empathic understanding and must demonstrate active listening...It will convey to the client that [he] is worthy of the nurse's time and commitment" (p.108). The nurse in the example above uses these skills to guide the direction of the discussion, while avoiding labelling the patient and explicitly acknowledging and respecting the patient's right to self-determination (Miller and Rollnick 2002).

Exploring drinking further (aka delivering a brief intervention)

Dealing with “yes, but...”

As with negotiating the agenda, discussions about a patient’s drinking are paved with potential pitfalls (Miller and Rollnick 2002). Harrington-Dobinson and Blows (2007b) identify that people drink alcohol because they expect it will have positive benefits for them (e.g. that it will increase their self-confidence, or help them ‘cope’ with problems). Attempts to explore behaviour change with patients can easily provoke explanations of these benefits as justification for maintaining the status quo. The more forcefully we argue the case for change, the more strongly the patient argues the case against it (Miller and Rollnick 2002). Forceful attempts to ‘make’ the patient see why they should change actually risks producing the *opposite* result. (The seminal work exploring this in the clinical setting is William Miller and Stephen Rollnick’s *motivational interviewing* (Miller and Rollnick 1991).)

We perhaps best recognise this *resistance* to our efforts at persuasion by the phrase, “yes, but...”, where the patient explains why our concerns are unfounded, or why change is not practical, or why the risks are worth running. This is a normal, human reaction. None of us want to look incompetent or foolish. On being advised that our behaviour is risky, our instinct is to explain ourselves in a way that defends our competence and responsibility (Leffingwell, Neumann et al. 2007). Even when we *would* like to change our behaviour, it’s normal for us to have doubts and reservations about doing so (Miller and Rollnick 2002). As much as we might see the risks that might be minimised and the benefits that might accrue, we also know of the anxiety produced by even *thinking* of change, of the feeling of dread at being at the bottom of a large Sisyphean hill, of the fear of failing (perhaps yet again) despite all our best efforts. The last thing we need is for someone in authority to ride roughshod over

those worries, pushing them aside in an attempt to persuade us about what we already know!

Nurse: Could you start by telling me how alcohol fits into an average day for you? [open question]

Patient: I don't really bother with drink much, too much else to do!

N: Drink's not the first thing on your mind. [reflective listening – stated as a *statement* not a question]

P: No, it's not. I like a few beers of an evening, while watching telly, you know.

N: It helps you relax. [reflective listening statement]

P: Yes, after all day at work you need to unwind, don't you?

N: I seem to remember you'd have three or four beers in an evening?

P: Yes, that's right.

N: Have you ever had cause for concern about your alcohol intake?

P: Not really...probably only when I get a real hangover, that's when everyone says 'never again', isn't it!

N: When it's made you ill you might have second thoughts about drinking so much.

P: Yes, but you have to relax every now and again don't you, everyone needs that. [resistance]

N: Alcohol helps you relax *and* makes you unwell if you drink too much.

P: Yes, but life's too short to worry about it

N: So, drinking is an important part of how you relax. You don't really have much cause for concern about your alcohol consumption. [reflection statements]

P: Well, my doc says it's why I get my stomach pains, she gives me the lecture to quit drinking

N: Well, I'm certainly not here to lecture you! What do you think about your stomach pains?

P: Oh they're bad alright, crippled at times with it. The medicine helps a bit, but...

This nurse is avoiding argument, power-struggles, and attempts at direct persuasion, all of which would be obstacles to developing a meaningful discussion with the patient about their drinking (Miller and Rollnick 2002). High level communication skills, such as empathy, acceptance, egalitarianism, warmth, and genuineness, are required to avoid such therapeutic cul-de-sacs (Moyers, Miller et al. 2005;

Harrington-Dobinson and Blows 2007). An opening strategy can be to encourage the patient to talk about how drinking fits into an average day (Miller and Rollnick 2002). Encourage the patient to elaborate on any concerns or worries they have about their alcohol use, or of any related problems they feel they experience. Asking about ‘the 4 L’s’ can guide this process: Liver relates to all health related concerns or problems, Lover relates to relationship issues, Livelihood relates to employment and finance, and Law relates to matters legal. Reflective listening demonstrates empathy and is to be favoured over multiple questioning (Miller and Rollnick 2002). *Resistance* should not be challenged by argument, rather it should be reflected empathically to demonstrate understanding of the patient’s experience. The approach is one of exploration *alongside* the patient, rather than a confrontation by a nurse intent on persuasion. The goal is for *the patient* to have verbalised the case for change, facilitated by sensitive exploration by the nurse (Miller and Rollnick 2002).

Nurse: So, if I can just check my understanding of things so far. You value your beers in the evening because they help you to relax. Most of the time this doesn’t cause you great concern. Sometimes you do get bad hangovers and think ‘never again’, and your doctor attributes your stomach problems to your drinking. You like drinking the way you do and at the same time you don’t like being crippled by your stomach pains. [summarise the patient’s ambivalence]

Patient: Sounds about right I guess...

Additional components that can be added to the discussion

Research trials into brief interventions have typically incorporated components such as individualised feedback on assessment information, comparison with local

population drinking norms, health education about alcohol-related risks, and clear recommendations to reduce or stop drinking (Babor and Higgins-Biddle 2001).

Individualised feedback on assessment data

One useful option is to ask the patient to complete the World Health Organisation's (WHO) *Alcohol Use Disorder Identification Test* (AUDIT) (box 2). This 10-item questionnaire scores out of forty and assists in determining hazardous, harmful or dependent drinking status (box 3). AUDIT has a higher sensitivity and specificity than CAGE for harmful and dependent drinking (Saunders, Olaf et al. 1993), and has a particularly high sensitivity and specificity for hazardous and harmful drinking (Saunders, Olaf et al. 1993). Patients suspected of suffering from alcohol dependence can also be asked to complete the *Severity of Alcohol Dependence Questionnaire* (SADQ) (box 4).

Comparative feedback on local population norms

Where the patient's weekly alcohol consumption has been calculated, this can be compared to population drinking norms reported in surveys such as the General Household Survey (National Statistics 2002). Alternatively, AUDIT or SADQ scores can be compared to scores in surveys such as the Psychiatric Morbidity Study (Singleton, Bumpstead et al. 2001). The point of this comparison is to identify that the majority of the population do not drink in a hazardous, harmful or dependent manner (Leffingwell, Neumann et al. 2007).

A discussion of alcohol-related risks

The WHO BI treatment manual by Babor and Higgins-Biddle (2001) (box 2) provides a useful graphic highlighting the range of risks associated with alcohol consumption that is above recommended limits. Such graphics can be useful to direct the discussion to the relationship between alcohol and the patient's condition and/or symptoms, and to discuss potential future risks posed by their alcohol consumption.

Asking about importance and confidence

It can be useful to ask the patient to self-rate importance and confidence. Together these give an indication of readiness to change (Miller and Rollnick 2002).

A clear recommendation

It can be empowering to ask the patient's permission before delivering advice about their drinking (Rollnick, Mason et al. 1999). Patients who are hazardous or harmful drinkers, or suffering from low alcohol dependence on SADQ, warrant a clear recommendation to reduce to daily and weekly recommended limits. Patients suffering from moderate or severe alcohol dependence, those with alcohol-related organ damage, and those with significant comorbid psychiatric disorders should be recommended to abstain from alcohol (SIGN 2003).

Nurse: Okay, we've worked out your questionnaire scores. Would it be okay to run these past you?

Patient: Of course.

Nurse: On the AUDIT you score 14 out of 40. We can see from this table [Singleton et al, 2001] that for men in their early fifties like yourself, roughly one in four men would have a similar score to yourself; three in four don't drink as much as you do.

Patient: That can't be right. Everyone I know drinks like me.

Nurse: That figure doesn't seem right to you.

Patient: No way that's right.

Nurse: You think *more* people drink the same way you do.

Patient: ...I don't know...I suppose I did

Nurse: Would it be okay if I give you some information about alcohol-related harm?

Patient: Maybe you better

Nurse: You'll see in this picture [Babor and Higgins-Biddle, 2001] there's a chap in the middle with a whole range of nasty conditions around him. Alcohol can cause all of these things or make them worse or more difficult to treat.

Patient: Look at that...

Nurse: The thing is, that anything over the daily recommended amount, of three or four units of alcohol a day – that's only two beers – increases anyone's risks of any of these conditions. You'll see there why your doctor has been warning you about your stomach: "*severe inflammation of the stomach*"

Patient: Can it get better?

Nurse: The good news is that nearly all of these conditions get better if you cut back, although some of them require people to stop drinking.

Patient: I couldn't do that!

Nurse: Hold on, no-one's saying that yet: it's up to you what to do here. Would it be okay for me to offer you some advice about this?

Patient: Go on then...

Nurse: I wonder, how important is it, given what you've heard, for you to think about changing your drinking?

Patient: Um, it's important, but I can't just give up.

Nurse: Can you put it between 1 and 10, if 1 was it wasn't important to change at all and 10 was that changing your drinking was the most important thing in your life just now

Patient: Well, it is important, probably, about 8

Nurse: And it's that important only because of your stomach? [exploring other reasons for change that the patient might have]

Patient: Well, and the hangovers, and to get the doc off my back, and to stop being so sick in the mornings, to feel healthier, you know?

Nurse: And how confident are you that you can change? Same idea, 1 is you have no confidence and 10 is you are full of confidence?

Patient: I've no confidence I could stop. To cut down, I'd say about 5.

Nurse: Why is your confidence that high to cut down, I'm interested in where your confidence comes from? [going with the patient's preference to 'cut down']

Patient: Well, I've done it before. Got so sick I had no choice, and I managed, went a couple of weeks without drinking in fact. So getting it down should be okay.

Nurse: [tentatively] Sounds like you're about ready to make a plan here?

Following a relatively brief discussion the nurse in the example has 'walked with the patient' to the point of thinking about a behavioural plan. Behavioural components of a brief intervention have been described elsewhere (Holloway, Watson et al. 2006).

What to do next

Depending on the setting, some nurses may only have a single contact with a patient. For many hazardous and harmful drinkers a single brief intervention will be enough to be effective (Ballesteros, Duffy et al. 2004). It is not necessarily the case that more than one session produces better outcomes than a single session (Ballesteros, Duffy et al. 2004). Certainly, if the opportunity presents (e.g. in primary care) it is good practice to enquire as to progress. Patients willing to discuss their drinking prefer to do so on more than one occasion, even if this doesn't influence immediate outcomes (PAPER REF HERE).

Hazardous drinkers do not routinely warrant more than a single session, with an additional follow-up enquiry as to progress. If subsequently they re-present with

developing or developed alcohol-related harm(s) then the discussion process can and should be repeated.

Harmful drinkers generally warrant a single session, with follow-up enquiry as to progress. Those who fail to progress, or who present with significant social or health harms, or whose harmful drinking is occurring amidst a complex background of social or health complications, usually warrant encouragement to discuss matters with a specialist alcohol counsellor.

It is not usually expected that the kind of brief intervention approach outlined above will help those with alcohol dependence to change (Moyer, Finney et al. 2002), although it can be used to 'talk about whether the patient needs to talk about' their drinking with a specialist alcohol counsellor.

For those who remain reluctant to speak to a specialist alcohol counsellor, there are online resources that can be of assistance (box 2).

Of note, the manualised form of motivational interviewing – Motivational Enhancement Therapy (MET) (Miller, Zweben et al. 1992) – has been demonstrated to have similar efficacy in randomised trials as more intensive forms of alcohol interventions (Project MATCH Research Group 1997; UKATT Research Team 2005). In principle, there is no reason why trained and supported nurses could not provide this treatment in a variety of settings (Tober, Godfrey et al. 2005).

Conclusion

There is much that nurses in all settings can do to help patients whose health and wellbeing is being threatened by their use of alcohol. Nurses have the potential to effectively intervene with patients across the spectrum of alcohol-related behaviour and consequences. There is a wealth of guidance and information available, and training and supervision in brief interventions, motivational interviewing (and associated health behaviour change counselling) and cognitive-behavioural techniques hold great potential.

Box 1 Recommended limits

Daily recommended limits:

- No more than 4 units per day for men
- No more than 3 units per day for women

Weekly recommended limits:

- No more than 21 units per week for men
- No more than 14 units per week for men

Two alcohol-free days per week are also recommended

Source: (Erens and Moody 2005)

Box 2 Further resources

Brief intervention guidelines

- http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf
- <http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>
- <http://www.sign.ac.uk/pdf/sign74.pdf>

Screening and assessment tools (e.g. FAST, AUDIT, SADQ)

- <http://www.clintemplate.org/groups/9/>

Alcohol-related websites for patients

- www.alcoholhelpcenter.net
- www.downyourdrink.net
- http://www.knowyourlimits.gov.uk/pdf/DH_Drinking_25+.pdf
- <http://www.patient.co.uk/showdoc/23068675/>

Alcohol-related websites for nurses

- www.nursingcouncilonalcohol.org
- http://www.prodigy.nhs.uk/alcohol_problem_drinking

Printed resources

- 'So you want to cut down your drinking' Available from NHS Health Scotland, Woodburn House, Canaan Lane, Edinburgh EH10 4SG

Box 3 Interpreting AUDIT scores

Score	Category
0 – 7	Low risk drinking
8 – 15	Hazardous drinking
16 – 19	Harmful drinking
20+	Dependent drinking

Box 4 Interpreting SADQ scores

Score	Category
0	No alcohol dependence
1 – 15	Low alcohol dependence
16 – 30	Moderate alcohol dependence
31+	Severe alcohol dependence

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