Brief motivational counselling does not reduce alcohol consumption in people with high alcohol intake

Scott H Stewart

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Brief motivational counselling does not reduce alcohol consumption in hospitalised patients with high alcohol intake


Q Does a brief motivational counselling session improve alcohol outcomes in hospitalised patients with unhealthy alcohol use?

METHODS

Design: Randomised controlled trial.

Allocation: Concealed.

Blinding: Unblinded.

Follow-up period: Twelve months.

Setting: Patient recruitment from an urban teaching hospital with out-patient follow-up; Massachusetts, USA; time period not stated.

Patients: 341 medical in-patients (≥18 years) with unhealthy alcohol intake over the past month (men: >14 standard drinks/week or ≥5 drinks/occasion; women and those aged ≥66 years: >11 standard drinks/week or ≥4 drinks/occasion). Drinking habits were initially assessed using the Alcohol Use Disorders Identification Test (AUDIT). In the first 7 months, patients with AUDIT score ≥8 were asked additional questions (drinking-days per week; drinks per day; maximum drinks per occasion) to determine eligibility; subsequently, any patient who drank in past 12 months was asked these questions, regardless of AUDIT score. Exclusions: fewer than two contacts to assist with follow-up; planning to move from area within next year; Mini-Mental State score <21.

Intervention: Brief motivational counselling or usual care. Counselling consisted of a single, 30-min session with feedback, discussion and development of an action plan, conducted by counselling and clinical psychology students. Usual care consisted of being informed of screening results, referral to specialist if requested, and opportunity to discuss condition with a physician.

Outcomes: Any alcohol assistance at 3 months (for example, out-patient or residential treatment, mutual-help groups, or employee assistance programmes; assessed using Treatment Services Review and Form 90) in participants with alcohol dependence; and change in mean number of drinks per day in all participants.

Patient follow-up: 80% at 3 months; 84% at 12 months.

MAIN RESULTS

There was no significant difference between motivational counselling and usual care in the proportion receiving alcohol assistance at 3 months (204 of 341 randomised patients assessed (55% of counselling group; 65% of controls): adjusted absolute risk for receiving assistance: 49% with counselling vs 44% with usual care; adjusted difference: ±8%, 95% CI –8% to +19%, p = 0.55).

CONCLUSIONS

A single brief session of motivational counselling does not reduce alcohol consumption by 12 months, or the need for assistance for alcohol dependence at 3 months compared to usual care.

NOTES

See http://ebmh.bmj.com/supplemental for Notes.

Commentary

Problem drinking and its associated consequences are common in the general hospital.1 While heavy drinking often causes disease or complicates management, generalisable methods for integrating alcohol treatment with in-patient medical care are lacking. Saitz and colleagues addressed this gap in standards of care through their trial of brief motivational intervention (BMI) during medical hospitalisation. BMI was conducted by trained counsellors, with goals of reducing consumption for heavy drinkers and facilitating post-hospitalisation alcohol treatment for those with dependence. The comparison was screening, feedback on screening results, and advice that drinking could be discussed with the physician. Encouragingly, despite a high prevalence of dependence, overall consumption had dropped at 12 months and 45% of the alcohol dependent group reported seeking help within three months. However, outcomes were similar in the BMI and control conditions.

Despite the absence of clear benefit from BMI, these findings contribute to patient care. First, with screening and physician advice, reductions in drinking and some involvement in alcohol treatment were common. While hospitalisation and illness may independently affect these outcomes, screening and advice (including drinking reduction for hazardous drinkers or abstinence and referral for dependence) could be considered a minimum intervention, as it is brief and may have important benefits. Secondly, while it is possible that characteristics of this study sample limited the benefits of BMI (for example, prevalent alcohol dependence, mental health comorbidities, low economic resources), general hospitals should consider other methods for assisting medical patients with alcohol problems. As the investigators concluded, additional research is required to develop effective and generalisable methods for this purpose.

Importantly, results cannot be extrapolated to other hospital services such as emergency departments, where screening and brief intervention programmes appear effective.2 This may be due to a relatively lower severity of alcohol involvement on average.

Scott H Stewart, MD

Center for Drug and Alcohol Programs, Medical University of South Carolina, Charleston, SC, USA

Competing interests: None.
