

## **Routine alcohol screening and brief interventions in general hospital in-patient wards: Acceptability and barriers**

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### **Abstract**

**Aims:** To explore the acceptability and barriers to the introduction of nurse-led routine screening and brief interventions (SBI) for alcohol misuse on general in-patient hospital wards.

**Methods:** Screening was introduced on an in-patient ward at three general hospitals. Screening rates, numbers of referrals to alcohol liaison nurses (ALNs), brief interventions conducted and patients' access to specialist alcohol services at follow-up were measured. Semi-structured qualitative interviews were conducted to explore staff/patient attitudes.

**Findings:** Screening rates ranged from 17.7% to 36.6% in the three wards. The highest rates of screening and positive screening scores were recorded on a gastrointestinal (GI) ward. Attitudes of staff and patients towards the SBI process were generally positive; however, a number of current barriers to its implementation were identified.

**Conclusions:** In order for the SBI approach to be incorporated into routine procedures in in-patient medical settings it may be necessary to provide ongoing support and training from specialist alcohol workers, and to have mechanisms that ensure the screen remains part of routine nursing documentation.

### **Introduction**

A stepped-care approach to alcohol misuse (Sobell & Sobell, 2000) proposes that initial interventions should be as minimal and unrestrictive as possible, with increases in intensity and duration only if initial interventions are unsuccessful.

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In accordance with this model, early identification and brief interventions for individuals drinking at hazardous/harmful levels are now being implemented in a variety of settings including educational institutions (Bendtsen, Johansson, & Akerlind, 2006; Marlatt et al., 1998), the Internet (Copeland & Martin, 2004; Saitz et al., 2004), the workplace (Richmond, Kehoe, Heather, & Wodal, 2000), and general medical settings.

General medical services are a particularly relevant context for the adoption of screening and brief interventions for alcohol misuse (SBI), and there is considerable evidence to indicate that this can lead to reductions in alcohol consumption (Babor & Grant, 1992; Crawford et al., 2004; Moyer, Finney, Swearingen, & Vergun, 2002; Ockene, Adams, Hurley, Wheeler, & Herbert, 1999; Poikolainen, 1999; Wilk, Jensen, & Havighurst, 1997; Wright, Moran, Meyrick, O'Connor, & Touquet, 1998). Many studies concerning SBI in medical settings to date have focused on primary care and accident and emergency (A&E) departments. However, general in-patient hospital wards have been relatively overlooked as another potential setting for the adoption of SBI, despite recommendations from a number of sources that this opportunity be utilized (Cabinet Office, 2004; National Treatment Agency for Substance Misuse, 2005; Royal College of Physicians, 2001).

At any one time, there is likely to be a high representation of individuals with alcohol-related problems in general medical or surgical in-patient beds (Department of Health, 2001), with around one in eight bed days in the NHS due to alcohol-related diseases (Department of Health, 2005). Alcohol-related in-patient hospital stays are said to constitute approximately 33% of the financial burden of alcohol on the NHS (Cabinet Office, 2003). A recent review of screening studies in general hospitals (Roche, Freeman, & Skinner, 2005) also reported that average prevalence rates of alcohol misuse were comparable for A&E departments and general in-patient wards (15.6% and 16.5%, respectively). Incorporating SBI into routine procedures on in-patient wards as well as A&E departments may therefore be a beneficial strategy. There may, indeed, be some advantages in conducting SBI on general in-patient wards; patients remain on the wards for longer and tend to be more medically stable in this setting, thus providing more opportunities for screening to be conducted.

There have been a number of research studies concerning SBI on general in-patient wards, and the findings indicate that the effectiveness of this is still uncertain. A recent review (Emmen, Schippers, Bleijenberg, & Wollersheim, 2004) identified eight controlled trials involving opportunistic brief interventions (BIs) conducted in general hospitals (although many more were rejected for methodological reasons). Outcomes were inconsistent, with only one study, which was an out-patient study, showing significant reductions of alcohol consumption in the intervention group (Maheswaran, Beever, & Beever, 1992), although other studies have found improvements in other outcome variables such as reductions in alcohol-related problems (e.g. Chick, Lloyd, & Crombie, 1985). A study by McManus, Hipkins, Haddad, Guthrie, and Creed (2003) reported that alcohol consumption was reduced at follow-up by 63–68% for in-patients on

acute medical wards who received brief interventions compared with a 7% reduction only for patients not receiving the intervention, although a more recent study (Saitz et al., 2007) failed to find benefit of adding a brief intervention to usual care on medical wards.

In many previous studies, the research team or specialist alcohol workers have contributed to some extent in the screening process. However, permanent incorporation of SBI into routine ward procedures would require the nursing or medical staff to complete the screening independently. A key question is to what extent the ward nurses or doctors are willing and able to *independently* carry out alcohol screening with patients on general hospital wards? It is also unclear which types of in-patient hospital wards are most suitable for this process. Second, if screening is completed and a positive score obtained, are appropriate interventions then provided? Finally, it is essential to explore how acceptable these procedures are to the staff and patients involved and what are the barriers that may prevent successful implementation.

The aim of this study, therefore, was to explore these issues on in-patient wards of different specialities in three inner-London general hospitals. By assessing the rate of screenings completed on the wards and what interventions these led to, we wanted to establish whether a SBI system could be successfully incorporated into routine ward procedures. We also sought to investigate the attitudes of both the staff and patients towards this process, in order to gain a greater insight into factors that may affect the success of this approach.

## **Methods**

### *Design*

An audit was conducted on three specified wards after the introduction of the FAST (Fast Alcohol Screening Test; Hodgson, Alwyn, John, Thom, & Smith, 2002) screening tool. Qualitative data were collected using semi-structured interviews with staff and patients to explore attitudes to the SBI process.

### *Setting*

Three wards from three different London general hospitals participated in the study. Routine screening for alcohol misuse was introduced on a gastro-intestinal (GI) ward, an infectious diseases (ID) ward, and in a medical admissions unit (MAU). The MAU was a short-stay ward where patients were admitted directly from accident and emergency for initial investigations and treatment. The FAST audit was conducted for two months on the GI ward and the ID ward. Due to greater admission rates on the MAU, data were collected for one month only there.

### *Participants*

Participants consisted of all new admissions to the wards over 18 years of age. Patients recruited to take part in the post-discharge follow-up were an

opportunity sample of 15 patients pooled from the three wards. These patients met the following criteria:

- screening had been carried out during the patient's hospital stay;
- a positive score on the FAST had been obtained;
- the patient was referred to the ALN;
- a brief intervention was provided by the ALN; and
- the patient gave informed consent to take part in the follow-up component of the study.

### *Intervention*

The FAST alcohol screening test (Hodgson et al., 2002) was used as the standard tool for screening on the wards. The FAST was selected due to its brevity, specificity and sensitivity (Hodgson et al., 2003). A score of 3 or more is FAST positive, indicating hazardous or more problematic drinking. Nursing staff at each site were provided with training from the Alcohol Liaison Nurses (ALNs) before data collection. This training included guidance on the use of the FAST, the rationale for the study, and general information on alcohol misuse. Staff members were also asked for their opinions on how the study would be implemented on the wards.

Ward staff were encouraged to screen all new admissions using the FAST. For those scoring positively, they were also asked to provide an advice booklet (Health Education Authority, 1997) and an offer of a referral to the hospital ALN. At all sites, the ALN and the researcher checked patient files daily to collect completed screening tools. BIs were carried out on the hospital wards by the ALNs. The BI followed a manualized protocol-based procedure written specifically for this study (available on request). This is based on the principles of planned brief motivational interviewing (MI) described by Miller (Miller & Sanchez, 1994) and included additional techniques common to MI (Miller & Rollnick, 2002). The specific techniques were asking the patient about the pros and cons of drinking and not drinking together with the patient rating the importance of reducing consumption and their confidence in being able to do this. The ratings were followed up by key questions designed to evoke change talk and enhance self-efficacy. Other elements of the BI were giving feedback on the patient's alcohol consumption, emphasizing both realistic optimism that change is possible and personal responsibility for this change, offering advice and using reflective listening as the predominant style (Miller & Rollnick, 2002). The BI sessions lasted from 20 to 40 minutes and were held on the ward in as confidential a setting as possible. The staff attended bespoke BI and MI training and received supervision from an appropriately accredited MI therapist.

### *Qualitative interviews*

All interviews were carried out by the same interviewer (SP). Interviews followed a predetermined but flexible interview schedule. Recordings were transcribed

as soon as possible after each interview. Analyses of the transcripts were carried out by SP, based on methods described in the 'FRAMEWORK' approach (Ritchie & Spencer, 1994). A subsample of transcripts was checked by two other independent raters (RC & MF) for consistency.

## Results

### Quantitative findings

Demographic characteristics of all patients admitted to the wards, screened and scoring positive on the FAST can be found in Table I. Quantitative outcome data for each site can be found in Table II.

### Screening

Over a third of patients were screened on the GI ward, less than a third on the MAU, and less than two-fifths on the ID ward. The mean FAST score of all patients screened was highest on the GI ward and lowest for the ID ward. Two-fifth of patients scored positive on the FAST on the GI ward, as oppose to one-fifth for the MAU and the ID ward. The mean FAST scores for patients who screened positive were greater for the GI ward and the MAU, and considerably lower for the ID ward.

Patients who were screened on this GI ward were in hospital for significantly longer than those who were not screened ( $t = 2.919, p = 0.004$ ). However, this was not the case for the MAU or the ID ward. There were non-significant trends for more men than women to be screened on the GI ward ( $\chi^2 = 3.088, p = 0.079$ ) and the MAU ( $\chi^2 = 3.018, p = 0.082$ ), however there were no significant gender differences on the ID ward. The age of patients did not differ significantly between those screened or not screened at any of the sites. The proportion of screened patients classified as White British or non-White British also did not differ significantly on any of the wards.

Table I. Demographic characteristics: All patients.

	GI ward	ID ward	Medical admissions unit
<i>Total admissions</i>			
Mean age (SD)	57.4 (17.4)	50.1 years (18.7)	54.03 (22.1)
Gender	77 male (57.5%) 57 female (42.5%)	51 Male (45.1%) 62 Female (54.9%)	98 Male (37.4%) 164 Female (62.6%)
<i>Patients screened</i>			
Mean age (SD)	56 (17.04)	47.2 (20.7)	55.3 (21.1)
Gender	33 Male (67.3%) 16 Female (32.7%)	7 male (35%) 13 Female (65%)	35 Male (45.5%) 42 Female (54.5)
<i>FAST positives</i>			
Mean age (SD)	46.10 (10.5)	42.5 (26.4)	47.4 (16.1)
Gender	18 Male (85.7%) 3 Female (14.3%)	1 Male (25%) 3 Female (75%)	12 Male (80%) 3 Female (20%)

Table II. SBI results: Frequencies, means, and percentages of outcome variables for the GI & ID wards (2 months) and the MAU (1 month).

	GI ward	ID ward	Medical admissions unit
Total admissions recorded	134	113	262
Mean in-patient stay ( <i>SD</i> )	9.1 (12.5)	13.7 (15.9)	3.6 (2.9)
Patients screened (% all admissions)	49 (36.6%)	20 (17.7%)	77 (29.4%)
Mean in-patient stay ( <i>SD</i> )	13.1 (16.05)	13 (14.7)	3.7 (2.3)
Mean FAST score ( <i>SD</i> )	4.2 (5.35)	0.95 (1.8)	1.9 (4.3)
FAST positives (% patients screened)	21 (42.9%)	4 (20%)	15 (19.5%)
Mean in-patient stay ( <i>SD</i> )	10.1 (14.5)	3.7 (2.7)	3.3 (1.5)
Mean FAST score ( <i>SD</i> )	9.2 (4.6)	4.2 (1.3)	9.1 (5.5)
Advice booklets provided (% positive screens)	15 (71.4%)	2 (50%)	6 (40%)
ALN Referrals (% positive screens)	15 (71.4%)	0 (0%)	11 (73.3%)
Brief interventions completed (% patients referred)	13 (75%)	0 (0%)	9 (81.8%)
Referrals to new specialist services (% patients who received a BI)	7 (62.4%)	0 (0%)	8 (88.9%)
New specialist services accessed (% patients referred to specialists)	3 (42.9%)	0 (0%)	2 (75%)

*Referrals and brief interventions*

More than two-thirds of patients who screened positive were provided with advice booklets on the GI ward compared with half on the ID ward and two-fifths on the MAU. Almost three-quarters of patients who screened positive were referred to the ALNs from the GI ward and the MAU. No successful referrals were made to the ALN at the ID ward, due to the extremely low numbers of positive scores.

Three-quarters (the GI ward) or more (the MAU) of BIs were completed with patients who were referred. Of the patients who had received brief interventions most from the MAU and over half from the GI ward and the MAU were referred to external specialist alcohol services. For the GI ward, over two-fifths of those who were referred were found to have accessed new specialist services at the time of follow-up; whereas only a quarter of those referred from the MAU went on to do this.

*Qualitative findings*

Eleven patients and fifteen nurses participated in the qualitative interviews. Nurses were selected from a variety of grades in order to reflect the target population. Demographic characteristics for the staff and patient samples can be found in Tables III and IV, respectively.

*Staff interviews*

*Attitudes to alcohol misuse.* Most staff members described both positive and negative attitudes to alcohol misuse. In terms of positive attitudes, some nurses had thought about possible causes of alcohol misuse, felt sympathy for patients who had alcohol-related problems, and expressed a commitment to their duty-of-care, regardless of patients’ lifestyles or habits.

You talk to them, and you learn more about them and you learn why they are like it . . . (N11)

[W]e’re here to look after patients in general, whatever they have, alcohol abusers, drug abusers, whatever. (N8)

Table III. Demographic characteristics: Staff sample.

	Staff sample
<i>N</i>	15
Mean age ( <i>SD</i> )	31.9 (6.4)
Ward	7 GI (46.7%) 3 ID (20%) 5 MAU (33.3%)
Nursing grade	1 H (6.7%) 1 G (6.7%) 2 F (13.3%) 8 E (53.3%) 2 D (13.3%) 1 Healthcare Assistant (6.7%)
Mean months of employment ( <i>SD</i> )	38.7 (28.1)
Gender	2 Male (20%) 12 Female (80%)

Table IV. Demographic characteristics: Patient sample (interviews).

	Patient sample
<i>N</i>	11
Mean age ( <i>SD</i> )	43.5 (5.5)
Mean days on ward ( <i>SD</i> )	5.4 (4.4)
Gender	10 Male (90.9%) 1 Female (9.1%)
Mean FAST score ( <i>SD</i> )	10.3 (3.7)

Possible reasons for alcohol misuse suggested were educational background, adverse life events, medical conditions, upbringing and social factors. Most nurses also felt happy to work with patients who misuse alcohol, although one nurse stressed the importance of this being supported by a specialist service.

Negative attitudes included having experienced abuse and aggression, fear and intimidation, frustration, reduced motivation and negative expectations about working with individuals who misuse alcohol. This was particularly relating to patients who are repeatedly admitted for alcohol-related reasons or who self-discharge prematurely.

But it's just because they're really hard work sometimes . . . they can argue with you and do silly things like, pull out their venflon, and abscond and then come back four hours later, and just take up so much of your time. (N11)

[B]ecause sometimes, you know, they just come, if they're very ill, then after detoxing, they start to leave the ward, or self-discharge, I think, it's like they're just wasting your time . . . sometimes it's really irritating, you're giving the best for them, and they just self-discharge, sometimes they are aggressive to the staff. (N3)

*Attitudes to screening for alcohol misuse.* Almost all of the nurses interviewed felt that screening for alcohol misuse was a useful activity. Reasons given included the educational value for patients, providing an opportunity to discuss alcohol, facilitating referrals to the ALN, improving general quality of care, and highlighting the issue for other professionals. Some nurses also stated that they thought the screening was particularly useful for identifying people who wouldn't be expected to misuse alcohol. Some of the staff gave the condition that screening would only be useful if the patients are honest about their alcohol consumption.

I think the alcohol screening tool is a useful tool, and I think it is a way of highlighting awareness for patients, and I think sometimes, the patient might think that they're just drinking normally and what they're doing has no effect on their health. I think . . . it's a teaching mechanism really for patients. It is useful, because if they weren't aware of the quantity to drink or how drink is affecting them, I think it could have a positive effect. (N1)

I think it picks up people who you don't think would have an alcohol problem, and they do and then they maybe want help. So then we can access the ALN. (N8)

The majority of the staff accepted responsibility for alcohol screening and none rejected it being part of their role. Nearly all of the nurses stated that they would be happy to continue screening for alcohol misuse. Some of the nurses stated that

they usually ask patients about alcohol anyway. Many of the staff felt that the medical admissions unit was the most appropriate location for the screening to be carried out, although there were some exceptions.

The majority of the staff felt happy with how the SBI process was implemented on the wards, and felt confident that they knew how the process worked. Generally, the staff seemed to feel as though there had been adequate training to complete the screening tool and make a referral to the ALN. However, it was suggested that awareness of the alcohol liaison service throughout the hospital wards may have been limited, and that publicising this service could be beneficial. The nurses seemed to feel that ongoing promotion and reminders about the service and the screening process would increase the likelihood that this would be adopted.

Unless [the ALN] came back and did some sort of teaching around it, you know, keep reinforcing it, give it a couple of months and then go over it again . . . just keep going on about it and suddenly it'll click in to place. It's the same as the benchmarks, you know, you can bang on about them, and it keeps going on and on and on, and then suddenly they're all done. It just takes a while to get through. (N8)

*Facilitating factors for screening.* Some factors that were said to facilitate the screening process were: explaining the reasons for screening to patients, asking patients who are well-known to the staff, screening when the ward is quiet (e.g. during night shifts), doing several screening tools together in an admission pack or documentation booklet, and presenting the tool in a salient way (e.g. using brightly coloured paper).

I find if you do it all at the same time as the admission, then it's all part of the same thing really, it's much easier then. You don't have to think about it, to come back to it. Then it's actually quite quick. (N12)

I think having it on the yellow sheets that they were on before, it's on the white sheets now, because we had to photocopy it, when it was on the yellow sheet it kind of made it more identifiable. If it's white it can get forgotten. (N9)

A few nurses stressed the importance of ensuring that staff members understand the rationale behind the screening process in order to motivate them to complete it. It was also suggested that regular reminders about the screening would be beneficial.

*Barriers to screening.* Importantly, many of the nurses also mentioned potential barriers to carrying out alcohol screening for new admissions. These barriers could be classified into those relating to the patients and those relating to the staff and hospital. Patient barriers included being too unwell, demographic characteristics, and adverse patient reactions. Some of the demographic characteristics that were said to have affected screening for alcohol were age, sex, ethnic background and religion. More specifically, it seemed that some nurses were more reluctant to screen older patients, females, and Muslim patients.

On the whole, we kind of knew who to ask, and who wouldn't take part in the screening . . . Partly from doing the admission, a classic example is if somebody knew a patient was a Muslim, there's no point in asking them to do the screening because they don't

drink. But for somebody who has a history of being an alcoholic, then I always made sure that I did do a screening, if they agreed. Some of them actually wanted to do it anyway, to help them get an idea of what could help them. (N10)

The adverse patient reactions mentioned were refusals to answer, secrecy, defensiveness and intimidation. A few nurses felt that adverse reactions were often due to patients wishing to continue drinking at the same level and not wanting any intervention.

And if they are drinking and they know that they are drinking more than they should be, then they're not going to... when I've gone round we've had a few people who've declined to answer, and you know fully well that they are here for that reason, but they, you know, are too embarrassed or ashamed. (N4)

Yeah, ... some can be defensive. Especially if they aren't drinkers, it's almost like you're implying you know, is there a problem there? But the majority of the patients who do have drink-related problems kind of will answer, they will either have been in contact with alcohol services or, they're not shy about saying it. (N9)

Barriers relating to the staff/hospital were time constraints, the large amount of paperwork involved in modern nursing, repetition of the same questions during a patient's stay, lack of staff motivation, concerns about nurses' own use of alcohol, and not remembering the screening tool.

Well, it made the admission process slightly longer, I mean admission is... there are so many bits of paper to be filled in, so you do actually, when you're half way through admission and you're half way through your pile of paper you think, 'Oh, I've still got all these sheets to go, and I should be off washing somebody or giving somebody some drugs or something'. (N10) But it's when you talk to people who kind of probably, clearly do drink too much according to guidelines, but you look at it and you think yeah, you probably don't actually drink that much outside of what me and my friends drink of a weekend and things. And you think you know, it's a bit difficult to know where you stand, you know, this isn't really good enough, yet knowing full well I probably do the same thing. (N12)

*Feedback on the FAST.* Some specific feedback on the FAST screening tool was also provided. Nearly all of the staff agreed that the FAST was quick and easy to administer. None of the nurses felt that carrying out the screening had significantly affected how they carried out their other duties. Some nurses expressed concerns about the accuracy of the FAST and suspicions that some patients were not completely truthful when answering the questions.

No, I mean even though it's another piece of paper to fill in, but it's hardly a lengthy assessment tool. It's quick, tick box and... obviously if they say yes to the questions it becomes more lengthy because then you're referring them on. But if it's a simple no, then no, it didn't really add that much time. It's only filling in a name, hospital number and asking one or two questions, it's not much. (N9)

[S]ometimes I doubt this one. Because some of the patients are not honest themselves. You ask them, they say, 'Oh I never drink', when in fact they have drink... So you don't know. (N7)

#### *Patient interviews*

*Feedback on the FAST.* Patients generally found the FAST acceptable. However, a few patients suggested possible limitations of the tool, including questionable appropriateness for some types of patients (binge-drinkers), concerns about the accuracy of the tool, and lack of specificity.

[I]t's very difficult for me to give them an accurate answer because it's more designed for a person who drinks all year round, and I'm more of a binge-drinker, I drink for a couple of weeks and then I might not drink for months . . . so it was quite difficult and how accurate mine was I don't know . . . . (P1)

*Attitudes to the screening process.* Most of the patients felt that the screening process was useful. On the whole, patients felt comfortable about being screened while on the wards. Some stated that they had nothing to hide regarding their alcohol use, and recognized the importance of answering the questions as honestly as possible. Most of the patients interviewed were familiar with providing information regarding their alcohol consumption. A few patients suggested that it would be more suitable for the screening or intervention to be completed after discharge from the hospital.

I felt quite comfortable, I've got nothing to hide . . . I have come to terms with my alcoholism, you know, so I am finally addressing it. So, yeah no, I was fine. (P2)

I mean I'm here because . . . well if I'm getting any help it would be stupid of me to start trying to be difficult. (P3)

A small group of patients stated that they would have preferred the screening to have been conducted in a private room. None of the patients had experienced alcohol screening by general nurses before.

Well, I suppose I would have preferred it if it could be a bit more discreet, people in the bed next to you can hear what you are talking about . . . and they might be in for other reasons, other medical reasons, and you're being asked questions about your drinking, which a lot of people can hear. (P1)

*Feedback on the BIs.* Some patients found the advice booklet useful, particularly the advice on how to reduce alcohol intake. However, many of the patients found the booklet quite limited, either because they had seen the booklet before, or they were already familiar with the information provided.

And that's the problem with most of the booklets, they always tell you the obvious. (P8)

In contrast, most of the patients felt that having a session with an ALN was beneficial, particularly as a means to obtaining contact details or referrals to specialist organizations. Some of the patients particularly appreciated the individualized attention given by ALNs. There were a few patients, however, who found the session with the ALN less useful, primarily because they felt it would be more appropriate outside of the hospital setting.

[V]ery very good feedback [from the ALN] . . . yeah the feedback has been fantastic . . . she's going to get in touch with my key worker and all sorts of stuff . . . of all the associations to do with alcoholism that I've dealt with, this is by far the finest and the easiest to deal with. I want to change my life. But I'll change it my way. And I like the approach that your particular association does for that, you're actually looking at the needs of the individual, as opposed to the group ideal, you know? I think that the intervention is really really good . . . . (P2)

*Perceived attitudes of medical staff to alcohol misuse.* Most patients had been asked about their alcohol consumption by doctors at some point. The attitudes of doctors to alcohol misuse were generally perceived as quite negative. Descriptions of hospital doctors' interventions for alcohol misuse were usually very brief,

dismissive and/or didactic. Some patients felt reluctant to go to general hospitals when experiencing alcohol-related illness, due to concerns about the stigma they felt was associated with this. In some cases, patients had previously been refused admission to general hospitals for this reason. In addition, two patients felt that GPs also held negative attitudes, were too busy and were unlikely to help with alcohol-related issues.

But I find that sometimes, there's always one or two that are OK, but most of the doctors are like, it's your own fault sort of thing, tough luck. Basically, not very sympathetic. (P9)

The attitudes and practices of the general nurses tended to be viewed as positive and non-judgemental. However, some patients felt that discussions about alcohol misuse were best left to a specialist worker, either because the general nurses were so busy that they should focus on other aspects of care, or because of a lack of knowledge and training in this area. Many patients appreciated the presence of a specialist alcohol worker in the hospital and felt that there should be more of these professionals in general hospitals.

In all honesty, a lot of the nurses are . . . I mean the nurse who asked me these questions didn't have a clue when it comes to alcohol. Probably doesn't drink at all. I mean I'm not faulting her as a nurse at all, but what I'm saying is that she doesn't know anything about alcohol. . . . (P1)

## **Discussion**

The principle aim of this study was to explore the acceptability and barriers to introducing a screening-based stepped-care approach to managing alcohol misuse in general hospital in-patient settings. The modest screening rates observed on the wards suggest that barriers may significantly impede the adoption of alcohol screening by general in-patient ward staff. Despite the positive attitudes to screening expressed by the staff, and the overall acceptability of the process to the patients, there were difficulties with implementation on general in-patient wards. The findings of this study highlighted some of the factors that facilitate involvement in the SBI process, and some of the current barriers to the process being carried out routinely.

The highest screening rate observed was on the GI ward, which could be explained by a number of factors. Alcohol-related GI disorders constitute a large proportion of the workload of GI specialists in general hospitals (British Society of Gastroenterology, 2006). The percentage of positive scores and the average FAST score were higher on the GI ward than the other wards studied, suggesting that alcohol misuse was more common in this setting. As a result of the prevalence of alcohol-related problems in this patient group, GI nursing staff may be particularly aware of and attentive to this issue, instigating more engagement with a developing alcohol service on the ward. Staff on this GI ward had also been familiar with the FAST and an alcohol liaison worker for some time prior to the commencement of the study. The staff on the GI ward had also been relatively stable over time; therefore many of the nurses had received training from the ALN and were familiar with patients who reattend to the ward for alcohol-related

reasons. Therefore, both familiarity with the process and greater perceived relevance are factors that could promote uptake of screening on these wards.

Patient factors also seemed to affect the screening process to some extent. On the GI ward, the average length of hospital stay was longer for patients who were screened than those who weren't. Staff would have had more opportunities to engage in the screening with patients with longer stays. The nurses may also have felt that the screening was more relevant for those with more severe medical conditions. However, many of the long-stay patients on this ward may have been patients detoxifying from alcohol; and so the nurses may simply have been more inclined to screen this group.

Gender also appeared to influence screening to some extent. Male patients tended to be screened more than female patients on both the GI ward and the MAU. The interviews with staff indicated that this could be due to either greater discomfort in broaching the subject with females, or being influenced by the greater prevalence of alcohol problems among men. Ethnicity was not found to significantly affect whether screening took place in this study, however, due to the small number of participants screened from some non-White British ethnic backgrounds, it was only possible to compare White British patients to non-White British patients as a group. Future research with more participants in each category may allow a more detailed exploration of this issue.

In general it seemed that the screening process was acceptable to both staff and patients, with an overall consensus that it was a useful process. Many of the staff members also expressed positive attitudes to working with patients who misuse alcohol and were happy to be involved in the SBI process. All of the nurses agreed that the FAST was easy and quick to use, and so this tool appears to be appropriate for this type of setting.

However, it is clear that there are a number of changes that could be made to increase the likelihood that these findings can be extrapolated to routine practice. It seems that many of the staff would be more willing to conduct alcohol screening if it was incorporated into a standard admission pack or nursing documentation, along with other lifestyle screens. This could lead to a number of benefits; it would reduce the necessity for nurses to independently remember this screen and could also reduce awkwardness or adverse patient reactions, as it would be seen as a routine procedure and would be administered to all patients. In addition, this could reduce the number of patients being missed as a result of nurses' preconceptions (e.g. that certain patients are not likely to misuse alcohol). This may also avoid repetition of alcohol-related questions, as the information would remain in the patients' files from the start to the end of their hospital stay.

Many nurses seemed to agree that a medical admissions unit is the most appropriate setting for screening, and so it would be beneficial to introduce this procedure in these wards. The provision of regular training and feedback to staff throughout the hospitals could increase both the motivation and skills necessary for them to be part of the screening process. As staff turnover can be high, it would be important that this input from specialist alcohol workers should be ongoing and responsive to staffing changes. However, this ongoing training and

support for staff would place a substantial workload on specialist hospital alcohol workers, which may be difficult to reconcile with the provision of brief interventions and patient care. As some hospitals do not have specialist alcohol workers, and some have only one, it seems that numbers of such professionals would need to increase in general hospitals in order to give full support to the development of such strategies.

Some limitations to the current study should be noted. The ID ward and the MAU had both undergone significant staffing and structural changes prior to the commencement of this study, which may have affected the outcome. There were ward closures and movement that may have affected the motivation of staff to engage in a new process during this time period. In addition, patients being admitted to the ID ward, during the data-collection period, were increasingly from other specialities. The change in emphasis on this ward may have affected the degree to which staff felt that screening for alcohol misuse was relevant to their patients' care, as increasing numbers of older patients were admitted.

There was also a possible bias in the patient sample recruited to the study. Many of the patients recruited were already known to local alcohol services and some were admitted due to alcohol-related illnesses/accidents. The mean FAST score for the interviews and follow-up samples were 10.3 and 11.5, respectively, which indicate harmful–dependent alcohol use. This may have affected the responses provided in the qualitative interviews as well as the likelihood that they would access new specialist services. The research literature indicates that brief interventions are most useful for individuals drinking in the hazardous–harmful ranges, and so the interventions conducted during this study may have been less effective due to the nature of the sample. For example, the finding that some of the patients were already familiar with the information presented in the advice booklet could be due to being given similar material in the past. In future research it would be important to ensure that the nurses do not concentrate their screening solely on alcohol-dependent patients, and that participants recruited are from a broader range of drinkers. The failure to find a benefit in the study by Saitz et al. (2007) may have been due to the over representation of alcohol-dependent patients (three-quarters of the participants).

During the study, the ALNs and the researcher were present on the wards only during regular working hours, therefore patients who were admitted and discharged quickly on evenings or weekends may not have been included. This is particularly likely to be the case for the MAU, which had the highest admission rate of the three sites. As a result, the figures presented in this report should not be interpreted as the exact numbers of patients admitted and screened at these sites.

There were also some limits to the generalizability of this study due to some degree of involvement of the research staff in the screening process. Prior to data collection, ward staff were consulted about how the SBI process should be implemented on the wards and at two of the three sites, it was agreed that the research worker or ALN would add the screening tool to patients' files shortly after they were admitted. It is therefore a question whether or not these

findings would generalize to situations in which nurses would need to remember to administer the tool. Indeed if the FAST was part of the admission pack/standard documentation, it might be the case that this rate of screening could continue.

It can be concluded that although attitudes and feelings towards the SBI process are positive among staff and patients in general in-patient settings, there are a number of barriers to the routine implementation of this. It seems that ongoing input and support from specialist alcohol workers is a prerequisite for the success of this approach in this setting. Further research may seek to explore the rate of screening conducted by ward staff if the screening tool is incorporated into routine documentation; or on medical admissions wards only; and ways to ensure that not just the most dependent drinkers who might benefit least from BIs are selectively screened.

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