

This entry is our account of a study selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the UK. Unless indicated otherwise, permission is given to distribute this entry or incorporate passages in other documents as long as the source is acknowledged including the web address <http://findings.org.uk>. The original study was not published by Findings; click on the [Title](#) to obtain copies. Free reprints may also be available from the authors – click [Request reprint](#) to send or adapt the pre-prepared e-mail message. Links to source documents are in [blue](#). Hover mouse over [orange](#) text for explanatory notes. The Summary is intended to convey the findings and views expressed in the study. Below are some comments from Drug and Alcohol Findings.

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► [Routine alcohol screening and brief interventions in general hospital in-patient wards: acceptability and barriers.](#)



Groves P., Pick S., Davis P. et al.

Drugs: Education, Prevention and Policy: 2010, 17(1), p. 55–71.

[Request reprint](#) using your default e-mail program or write to Dr Groves at paramabandhu.groves@candi.nhs.uk

At three London hospitals 4% of inpatients completed a brief alcohol intervention after being screened for hazardous drinking by ward staff. Staff were positive and on one ward nearly half the patients were screened and one in ten counselled, but the overall results are unlikely to dent the public health burden imposed by risky drinking.

Summary Around one in eight bed-days in the British national health service are due to alcohol-related diseases. At any one time, general medical or surgical inpatient beds are likely to be occupied by problems drinkers, making them in theory promising places in which to identify and counsel these patients. A key question, however, is to what extent (without the aid of researchers or specialist alcohol workers) ward nurses or doctors are willing and able to screen for risky drinking patients as part of their routine practice. Other issues are which wards are most suitable this work, how best to respond to positive screens, which procedures are acceptable to staff and patients, and what may prevent their successful implementation.

The featured study explored these issues in three inner-London general hospital inpatient wards where trained staff had been asked to use the four questions in the [FAST](#) (Fast Alcohol Screening Test) screening test to identify hazardous drinkers. Two of the wards specialised in gastro-intestinal complaints and infectious diseases respectively while the third was a short-stay medical admissions unit for patients admitted from the accident and emergency unit. Staff on these wards were encouraged to screen all new admissions and were fully responsible for the process, with the exception that at two of the wards a researcher or the hospital's alcohol liaison nurse added the screening test to patients' files, effectively prompting staff to ask the questions. Ward staff were asked to give an alcohol advice booklet to positive screen patients and offer referral to the hospital's

alcohol liaison nurse.

After receiving referrals, alcohol liaison nurses conducted 20–40-minute brief interventions on the wards based on motivational interviewing principles. The protocol had been devised for the study and staff had been trained in its use.

Patient files were audited to assess the degree to which staff had implemented these procedures, and 15 ward nurses and 11 patients who had participated in a brief intervention were interviewed to gain their views on the process.

Main findings

During the one or two months of the audit, of 509 adult admissions in total, on the gastro-intestinal ward 37% of patients were screened, 18% on the infectious diseases ward, and 29% on the medical admissions unit. Of these patients, 43%, 20% and 20% respectively tested positive. Two-thirds of positive screen patients were referred to the alcohol liaison nurse and all but a few completed a brief intervention, resulting in 22 completions of whom five patients were known to have subsequently attended a specialist alcohol service. Over two-thirds of patients who screened positive were provided with advice booklets on the gastro-intestinal ward compared with half on the infectious diseases ward and two fifths on the medical admissions unit.

Almost all the nurses interviewed felt that screening was useful. Most accepted responsibility for this task and none denied it was part of their role. Nearly all said they would be happy to continue. Many felt the medical admissions unit was the most appropriate location. Nearly all felt the FAST was quick and easy to administer and none felt screening had significantly affected their other duties.

Implementation would, some felt, have been aided by more publicity to raise staff awareness of the alcohol liaison nurse and to remind staff to screen and refer patients. Impediments to screening included patients being too sick, not fitting the profile of people the nurse thought might be a hazardous drinker, and adverse patient reactions including refusal to answer, secrecy, defensiveness and intimidation. Other barriers included time constraints, copious paperwork, repetition of the same questions during a patient's stay, lack of staff motivation, concerns about the nurses' own drinking, and not remembering the screening tool.

Patients too generally found the FAST acceptable, the screening process useful, and the brief intervention beneficial, particularly as a means of obtaining contact details or referrals to specialist services.

The authors' conclusions

Staff and patients in these general inpatient settings were positive about alcohol screening and brief intervention and the FAST test appeared to be appropriate for this type of setting. However, staff faced several barriers to its routine and widespread implementation, resulting in modest screening rates.

That the gastro-intestinal ward screened the highest proportion of patients might have been due to the high prevalence of alcohol-related problems in this patient group, raising the awareness and motivation of staff. It seems that many staff would be more willing to screen if this was incorporated (along with other lifestyle screens) into a standard

admission pack or nursing documentation, reducing the need for nurses to independently remember to ask the alcohol questions, and perhaps also reducing awkwardness or adverse patient reactions and avoiding certain types of patients being missed out.

Especially given high staff turnover, ongoing and repeated input and support from specialist alcohol workers seems a prerequisite for the success of this approach in this setting, but would place a substantial burden on those workers which may be difficult to reconcile with their direct patient-contact roles.

While patients were generally appreciative, it should be acknowledged that this was a convenience sample biased towards heavy and dependent drinkers. Also the assistance provided to staff on two of the wards meant the study might not reflect what would happen if screening was left entirely to ward staff.

FINDINGS The study illustrates that even with engaged and positive staff and the relative time and 'space' available on an inpatient ward, intervention rates can be low. Overall 4% of all adult admissions completed a brief intervention. On the gastro-intestinal ward this rose to 10%. With its high throughput of patients sourced mainly from the emergency department, the medical admissions unit should (as many staff felt) have been an ideal location for alcohol screening and intervention, yet just 3% of adult admissions completed a brief intervention.

Encouragingly, all but a few patients referred for alcohol counselling attended and completed the process, in other studies a stage where drop-out has been high. Possibly this was because on two of the wards positive screen patients average a score of 9 out of 16 on FAST, indicative of drinking which has already caused problems apparent to the patient and/or others. The upshot was that relatively problematic drinkers were seen by the alcohol liaison nurse who thought over 70% warranted being directed to specialist alcohol services. Instead of the referral stage, the biggest loss to the process was at the screening stage when over two-thirds of admissions were not screened. This was possibly the main reason that the process acted more as a way of identifying drinkers in need of specialist treatment than a public health measure tackling low-level but pervasive hazardous drinking.

A [synthesis of studies](#) of brief interventions for risky drinkers admitted to general hospital wards found that even when intervention occurred, the consumption-reduction benefits were inconsistent. On the other hand, such interventions *can* reduce drinking, and in some studies substantially reduced risk or harm, sometimes when overall consumption was unaffected. What accounted for this patchy record was unclear, but may have been related to whether the patient's admission was due to a drink-related condition, the implications of which the intervention could build on.

Alcohol screening and brief intervention policy in Britain focuses more on primary care and accident and emergency departments than general hospitals, though hospital wards and, by implication, those like gastro-intestinal wards most likely to see heavy drinkers, are among the sites where investing health resources in such work has been legitimised by Britain's [National Institute for Health and Clinical Excellence](#) (NICE). Its [guidance](#) insists that health service commissioners and managers "must" provide the required training, resources and time to implement these programmes.

Progress certainly is being made. For example, in 2010 a [survey](#) of alcohol leads in

London-based multi-agency alcohol strategy partnerships found that most partnerships had commissioned alcohol liaison nurses in their hospitals. However, these were inadequately supported by hospital staff (in terms of screening and referrals) and were not well supported by alcohol services outside the hospital. They tended to spend most of their time working with dependent as opposed to harmful/hazardous drinkers, effectively becoming a specialist treatment resource rather than a public health resource addressing the bulk of risky drinking and alcohol-related harm. To an extent this was also found in [eight case studies](#) of alcohol health worker posts across England, where at only one hospital did the majority of client work concern identification and brief advice as opposed to medical work with problem drinkers such as detoxification. However, at several sites the aim was that ward staff trained by the workers would handle identification and brief advice. Though valuable in its own right, the competing demands of delivering specialist alcohol treatment services is bound to erode the focus on the public health role of widespread brief intervention.

Practical guidance on alcohol brief interventions (but not necessarily specifically in respect of hospital inpatients) is available from a [UK web site](#) developed by leading researchers, and in guides from the [American College of Surgeons](#) and from the [American Public Health Association](#).

Thanks for their comments on this entry in draft to Adrian Brown of the St George's Healthcare NHS Trust in London. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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