Understanding hospital-based alcohol services and aftercare

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ABSTRACT Foster, J., Heather, N. (2005) Improving hospital-based alcohol services and aftercare. Nursing Times; 101: 35, 32–35. Many patients are admitted to general hospitals with conditions that are alcohol related but they may be unaware that their drinking has contributed to their admission. A general hospital provides an excellent opportunity for health promotion, advice and referral to specialist services. This article looks at the importance of asking patients questions relating to their alcohol consumption as well as introducing hospital and community-based alcohol support services.

Research has shown that many patients come into hospital with alcohol problems that remain unrecognised throughout their admission because both nurses and doctors are reluctant to ask questions concerning the alcohol consumption of their patients (Canning et al, 1999). This is because health professionals are not using the appropriate screening tools and integrating them into practice. There are various facilities open to the patient with an identifiable alcohol problem:

- The liaison nurse/clinical specialist;
- Specialist clinics/general practice;
- Community alcohol and drug teams;
- Intensive counselling;
- Drop-ins;
- Rehabilitation units;
- Self-help groups;
- Support for carers and families such as Al-Anon and Al-Ateen.

Hospital-based services

Liaison nurse/Clinical specialist
Mental health liaison nurses are becoming increasingly common but unfortunately many areas of the country do not have alcohol/substance abuse liaison nurses. Where they exist the usual model is that the alcohol/substance abuse liaison nurse is linked to an A&E team. How this role operates in practice is generally down to what is negotiated between the liaison nurse and the nursing team.

The role is generally to assess patients with a substance misuse problem in an A&E setting. Two points should be borne in mind when calling upon the liaison nurse:

- What is the best time for her or him to be based in a A&E – there is little point in the nurse being there when there are no patients to be seen,
- No matter how experienced someone is, it is virtually impossible to accurately assess an intoxicated patient.

Clinical nurse specialists (CNS) can be a valuable resource. They can provide advice to a nursing and medical team on how to manage a patient with alcohol problems in a ward setting, in particular with issues concerning safe detoxification from alcohol (Foster, 2004).

Once the patient’s condition has been stabilised...
the specialist can work with the patient to suggest the types of help available on leaving hospital.

Stopping drinking in an inpatient setting is comparatively easy. The major challenge for the patient is continuing to abstain after discharge. Often this requires lifestyle changes that are very difficult to make. Relationships with friends and family may have to be re-negotiated as interactions may have revolved around alcohol in the past.

One of the key tasks for nurses is to find out who the clinical specialist is and the support they can offer. Such a person should be seen as an integral part of the nursing team as many hospital admissions are alcohol related even if alcohol is not the primary cause for admission.

Specialist clinics
A hospital admission may be the first time a patient has received an extensive range of physical examinations and tests. These may reveal a number of physical/psychological problems that could at least in part be related to prolonged drinking and would benefit from specialist medical supervision. It is also possible that by using the CNS some of the underlying problems may also become apparent. Depending upon local protocols the CNS/LN may be able to refer directly to a medical specialist.

Alcohol is a depressant and one of the effects of prolonged drinking is that the patient can present with the appearance of being depressed or anxious. However, before suggesting referral to psychiatric services a period of four to five days should be allowed to elapse.

During the first four to five days of being alcohol free the patient could still be suffering from the ‘psychological vegetative symptoms inherent to alcoholism which are erroneously interpreted as positive indicators of depressive illness’ (Clark et al, 1993). Davidson (1995) found that depression scores returned to normative levels between 10 and 21 days of abstinence. Allan (1995) after reviewing the literature drew similar conclusions concerning anxiety.

Most clinics do not provide a joint assessment of mental and physical health but for those trusts considering developing such an initiative Glass-Crome et al (1994) provide a good template.

The key task for the nurse should be the utilisation of all available services to provide a comprehensive assessment of the patient and communicate with them in terms that are easy to understand and non-judgemental. It has been shown that one of the major factors in enhancing motivation for behavioural change is to present patients with the information and leave them with the space to consider the best options open to them. Table 1 summarises some of the types of additional help that are available in a hospital setting.

### TABLE 2. COMMUNITY SERVICES FOR PATIENTS WITH ALCOHOL PROBLEMS

These services are likely to vary depending on local provision but could include the following:

- Community alcohol and drug services;
- Supervision by a consultant psychiatrist;
- Support in the event of slipping/relapsing to heavy drinking;
- Intensive counselling services;
- Longer-term counselling provided through voluntary organisations;
- Drop-in centres;
- Unstructured day-support – tea/coffees and snacks provided;
- Rehabilitation units;
- Medium to long-term (3–6 months typically) treatment regimes dependent upon the philosophy of individual projects;
- Structured activities such as group work, individual support and domestic tasks.

### Community based services

#### Community alcohol and drug teams

These are usually provided by NHS mental health trusts although some are provided by voluntary sector. The precise service these offer is dependent upon local arraignments and it is not uncommon for these to be linked to local probation services. Nowadays community alcohol teams are rare and most facilities are shared with drug users. This reflects an increasing trend towards polydrug use, which means the use of many drugs including alcohol.

Often the CNS and LN have close links with these teams and provide guidance on the services offered and how they can be accessed. A typical service configuration would be a 6–12-week day programme, short-term counselling based on the principles of motivation interviewing (Miller and Rollnick, 2002) and follow-up appointments provided by a psychiatrist. One of the main services these can offer is to provide a link in the event of relapse. The problem drinker can then be seen with a view to stopping or reducing drinking to prevent the need for detoxification. It may be necessary to detoxify the patient. Community alcohol/drug services can assess the best way of achieving this goal.

Detoxification should take place in the community (Foster et al, 2001) or in a residential facility.

### REFERENCES


For related articles on this subject and links to relevant websites see www.nursingtimes.net


Guided reflection

Use the following points to write a reflection for your PREP portfolio:

- Write about how alcohol problems can impact on your place of work;
- Outline the main points the article makes about services for people with alcohol problems;
- Identify a fresh piece of information you have learnt about alcohol services;
- How will you use this information in the care of patients in your area;
- Outline how you intend to follow up what you have learnt.

Community alcohol and drug teams are gatekeepers for most statutory sector residential detoxification and treatment services.

Intensive counselling
Community drug and alcohol teams tend to offer short-term interventions. They do not usually provide intensive counselling. The majority of alcohol services in the UK are run by the voluntary sector and intensive alcohol-focused counselling is almost exclusively provided in this manner. A number of texts describe the processes of ‘person-centred dialogue’ (Bryant Jeffries, 2003).

Services that operate in this way do not as a rule insist on a period of abstinence before assessment and will continue to see the patient in the event of a relapse, viewing this as a learning opportunity. Some of these services may be free, however, it is likely that a referral to social services will be required to approve funding. This process will be described in greater depth in the section concerning residential rehabilitation.

It may be relevant to consider referral to local statutory sector psychotherapy services, though these facilities often insist on a period of long-term alcohol and drug abstinence (more than six months is not uncommon).

Drop-in centres
One of the key difficulties facing someone with alcohol problems is filling time that used to be spent drinking – local drop-in centres can be useful in this area. Once more these are almost exclusively provided by the voluntary sector. In the experience of the author most of these are aimed at chronic drinkers and many are linked to homelessness services. As such, although drinking within the premises is discouraged (and usually forbidden) many of the people present will have been drinking recently. Often meals and sandwiches are provided. One of the key roles drop-in centres can provide is referral to other support services, including referral to detoxification services or local authority funding if required.

Rehabilitation units
Many people with alcohol problems feel that they need a prolonged period away from the situation that led to their problematic drinking in order to take stock of their various options. Rehabilitation units can provide this. Typically a three-month programme is offered including group and individual work and the expectation that the patient will contribute to a number of household tasks.

Rehabilitation units are usually ‘dry’ houses, which means abstinence is a prerequisite. There may be some provision for relapses but the general rule is that in the event of drinking the patient will be asked to leave.

Virtually all rehabilitation units are provided by the voluntary sector and many operate on the Minnesota model of treatment (Cook, 1988). This was originally formulated and based on the first four steps of Alcoholics Anonymous (see section on self-help groups below).

In order to access rehabilitation treatment the patient will have to be assessed by an alcohol and drug worker employed or commissioned through social services. This individual will also have to approve funding. The CNS or LN should be able to provide details of the named person for the local area. Very little is known about how local authority funding operates. This is an important omission as potentially large sums of money are involved. Foster et al (2003) provide what is to date the only published data in this area.

This research group interviewed funders from 10 randomly selected London boroughs. They found that people in charge of funding often had minimal training and that the only factor consistently associated with a positive funding decision was whether the patient had mental health problems – in particular evidence of a recent suicide attempt or self-harm. Table 2 (p33) summarises the community-based support services available to the patient with alcohol problems.

Self-help services

Self-help groups
The main self-help option open to the patient with alcohol problems is Alcoholics Anonymous (AA) (Emrick, 2001). Most of the research concerning AA has come from the US – very little is written about AA in the UK. In the author’s experience there is a degree of resistance to using AA in the alcohol treatment community because it is based upon the goal of abstinence and is believed to have spiritual and religious connotations. However, AA is not affiliated to any religious organisation.
alcohol can place enormous stress on family members (Velleman, 1993). As problems worsen the drinking parent becomes increasingly unreliable and the family has to adapt to these changes. Often the drinking parent becomes increasingly marginalised within the family.

After stopping drinking one of the major tasks facing the drinking parent is to re-establish a role within the family. Many relationships break up at this point. In the author’s experience there is little support available to family members. Fortunately this situation is beginning to change, mainly driven by the National Society for the Prevention of Cruelty to Children and the Alcohol Recovery Project.

However, services specifically aimed at the parents and children of people with alcohol problems are still uncommon. The nurse in the general hospital setting may also be in contact with family members who may benefit from support. Her main task should be to establish whether such a facility exists in the area so that such information can become a shared ward resource.

However, it is still unlikely that such facilities will be available. In this case there are two other organisations that are part of AA that may be of assistance. Al-Anon is an organisation where families and friends of problems drinkers can meet (whether the drinking partner is drinking or not) to share their experiences and provide mutual support. There are approximately 1,000 Al-Anon groups that meet in the UK and Eire. There are further contact details available on the www.al-anonuk.org.uk website.

The other organisation that the general hospital nurse may find helpful is Al-Ateen. This is a similar organisation to Al-anon but it is aimed at young people aged 12–20. The meetings are sponsored (assisted) by two adult Al-Anon members. The aim is to allow young people to focus on their own needs rather than being preoccupied with coping with the drinking behaviour of those around them. Table 3 summarises the self-help organisations able to assist patients with alcohol problems and family members.

**Conclusion**

This article has described the various types of help available to the patient with alcohol problems admitted to a general hospital setting and some support networks that could be utilised by family members. In order to access some of these services various gatekeeping procedures have to be followed. The author recommends that nurses familiarise themselves with the help available in their area and provide information on the ward. Most hospitals have senior nurses able to provide advice for the ward and they should be seen as part of the nursing team.

### Table 3. Self-help Services for Patients with Alcohol Problems

<table>
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<tr>
<th>Organisation</th>
<th>Description</th>
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| **Alcoholics Anonymous** | - Regular nationwide meetings for patients with alcohol problems  
- Chance to gain support from other patients with alcohol problems |
| **Al-Anon**       | - Meetings for families and friends of problems drinkers to share their experiences and provide mutual support |
| **Al-Ateen**      | - Meetings for young people aged 12–20                                      |

The author has spoken to a number of patients attending AA meetings and who were clearly benefiting from the experience. Among the reasons they put forward were that by attending AA meetings regularly they were reminded about their goals and were able to spend time in the company of people who had similar aims. This is important as one of the greatest problems facing the patient with alcohol problems is social isolation and loneliness (Akerlind and Hornquist, 1990).

It is difficult to talk about these issues in A&E due to the often chaotic nature of the area and it is not advisable to talk about such issues to anyone who has been drinking no matter how settled they may appear to be. Patients are often accompanied by family or friends who may have alcohol problems themselves. Details of local AA telephone numbers should be on public display.

For those nurses working in settings where the patient is likely to stay longer such as medical or surgical wards there are greater opportunities. AA meetings are not for everyone but there are great benefits available for those who want to involve themselves in the AA culture. As a minimum the ward should have posters available setting out AA contact details and a booklet outlining the times of local meetings. Details of these can be found on the www.aa-uk.org.uk website.

Nurses can also attend an open AA meeting and find out how they operate. With sufficient warning most meetings welcome this. The website provides a contact for most meetings. A distinction is made between open and closed meetings.

**The family members**

It is estimated that more than 92,000 children in the UK are living in a family where a parent has an alcohol problem (Alcohol Concern, 1997). Living with a parent or partner who has a problem with

### References


