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A national study of acute care Alcohol Health Workers

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Key findings

- 45 out of the 48 hospitals responding to the survey had at least one dedicated AHW
- AHW services are frequently precarious, with limited management support, short-term funding and a lack of ownership from key agencies
- Over time, AHWs tended to migrate up the alcohol problem gradient, working with dependent drinkers rather than undertaking or encouraging identification and brief advice
- Given the complex and multifaceted nature of their work, it was difficult for AHWs to demonstrate their effectiveness through routine data collection. There is an urgent need for more sophisticated outcome evaluations in this field.

Research team

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Background

AHWs are specialist staff working in hospital – usually nurses – who identify and work with patients drinking at levels that may impact or have already impacted their health. While a range of policy documents, including the Government's Alcohol Strategy (in England) recommend the expansion of AHW provision and it is clear that there has been a rapid spread of such posts across the acute care sector, there has been very little recent research exploring their nature and coverage. This research aimed to address this gap and consisted of a telephone survey of 115 hospitals (of which 48 responded) and more detailed qualitative work in four hospitals.

Findings

AHW provision can be characterised as precarious for a number of reasons. First, they are relatively new and many are still responding to initial problems and finding their place within the hospital. Second, partnership funding was the most common funding arrangement (36% of services surveyed) and this could lead to a lack of clear ownership of the service. This was particularly problematic when Acute Trusts had no financial involvement. Third, funding was short-term and insecure. Fourth, some AHWs were poorly managed and felt invisible and isolated.

While 94% of responding hospitals had a dedicated AHW, hospitals without an AHW may have been less likely to respond and so this may be an overestimate. Services included in the survey represented considerable variation. The number of AHWs per hospital varied between 0.6 and 6 FTE. While the number of AHWs was correlated with the number of alcohol-related hospital admissions, it was by no means a complete explanation. The majority of services were available between 9am and 5pm on week days, although some services covered evenings (38%) and weekends (42%).

AHWs covered a range of roles, including screening and brief interventions, liaison with outside agencies, education, detoxification, protocol and care pathway development, follow-up and discharge planning, and management of 'frequent fliers' (patients who are repeatedly admitted to hospital). However, there

was variation in how AHWs spent their time across these tasks. There was a tendency for AHWs to migrate up the alcohol problem ladder, focusing increasingly on dependent drinkers. 71% of the patients seen by AHWs were dependent drinkers.

It was hard for AHWs to monitor their work effectively. While screening figures could be relatively easily collected, the complex work done with dependent drinkers was harder to measure. Measuring outcomes was very difficult for all aspects of their work.

Implications

The precarious nature of AHW services raises questions about whether, and how, these services could be given a firmer footing. The Government's Alcohol Strategy simply 'encourages' all hospitals to employ Alcohol Liaison Nurses, but this may not be encouragement enough if a minimum national service is to be developed. Given strong financial pressures and the immediacy of ill-health and disease, the more preventive role played by AHWs may require financial incentives from the centre.

The variability in provision raises questions about standardisation. Of course, local services need to reflect local needs. However, the considerable variation in AHW provision does not simply reflect local needs: it is likely to reflect the presence or absence of local champions and the degree to which alcohol is taken seriously by commissioners. There may be worth in drawing up minimum requirements for AHW teams – or alcohol teams – in hospitals.

An important issue here is the strength of the evidence base. If AHWs convincingly were shown to decrease admissions and save money, the argument for a properly resourced service is greatly strengthened. While the multi-faceted nature of their role and the frequently delayed nature of their impact makes outcome evaluation challenging, nonetheless this should be a priority for future research.

More immediately, there seems to be a clear need for better management and peer support. There is a worrying tendency for AHWs to feel undervalued and isolated in their posts. It may be that this is partly a consequence of the cross-cutting nature of the role, which is largely peripatetic. However, proper ownership of AHW services by NHS hospital trusts, with attendant management would be likely to go some way towards improving this situation.

Conclusion

There are clear indications, not just from the present study (Thom et al., 2013), that the extent of AHW provision has greatly increased in recent times, reflecting the rising saliency of alcohol as a pressing health issue. However, the evidence from this study suggests that provision is variable and precarious. The time seems to be ripe for a proper review of the AHW function and how it can be properly supported and integrated within the hospital setting. However, it is difficult to make a strong case for AHW provision when the evidence-base is weak. Evaluating multi-faceted services such as those provided by AHWs is challenging but there is a pressing need for more outcomes research in this field.

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References

Thom B, MacGregor S, Godfrey C, et al. (2013) The Alcohol Improvement Programme: Evaluation of an Initiative to Address Alcohol-Related Health Harm in England. *Alcohol and Alcoholism*.

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