

# Patient experiences of alcohol specialist nurse interventions in a general hospital, and onwards care pathways

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## Abstract

**Aims:** To provide insight into patient experiences of a general hospital-based alcohol specialist nurse intervention during alcohol detoxification, experiences of alcohol specialist nurse hospital-based follow-up appointments (Pathway A) as well as the experiences of patients who did not have access to this additional help post detoxification (Pathway B).

**Design:** A longitudinal qualitative study.

**Methods:** A thematic analysis of semi-structured interviews (2016–2017) with 24 patient participants ( $N = 12$  in each pathway; purposive selection) 1–4 weeks post-detoxification and at 3 and 6 months, to identify patient experiences of these interventions.

**Results:** Participants gave accounts of how ‘empathic’ and ‘straight talking’ interactions with alcohol specialist nurses during detoxification helped them to ‘open up’ and orient towards change. After detoxification follow-up, outpatient appointments in the hospital setting were seen as supporting change in early recovery and engagement with a wider range of services. Those with no access to nurse follow-up described experiencing a ‘void’ in available help. Participants in both groups described barriers to engagement with community alcohol services, peer groups and access to help for mild-moderate mental health problems.

**Conclusion:** Patient accounts indicate alcohol specialist nurse interventions during and after unplanned detoxification in a hospital setting can help orient patients towards change and support early recovery.

**Impact:** Providing alcohol specialist nurse interventions in general hospitals offers one route to initiating recovery in alcohol-dependent patients. This has potential to improve the lives of those affected and to reduce related demands on hospital services, but further research is needed.

## KEYWORDS

advanced practice, alcohol specialist nurse, alcohol treatment, alcoholism, care pathways, clinical nurse specialist, nurse interventions, nurse–patient relationships, nursing, patient perspectives

## 1 | INTRODUCTION

The misuse of alcohol is estimated to account for 5.1% of global burden of disease and 3 million deaths annually, with a causal relationship between alcohol misuse and mental health problems, and severe social impacts such as family breakdown and job losses (World Health Organization, 2020). The prevalence of alcohol-use disorders is estimated to be 5.1% globally and is the highest in high-income countries (Rehm & Shield, 2019). Alcohol dependence refers to physical or psychological dependence on alcohol, where the individual has loss of control over their alcohol use, despite experiencing significant harm (World Health Organization, 2010). A range of serious health harms are associated with alcohol dependence, including physical withdrawal, liver disease, cardiovascular disease and injury, and these conditions contribute to frequent use of hospital services (Westwood et al., 2017; World Health Organization, 2018). Pryce et al. (2017) estimated the prevalence of alcohol dependence to be 1.4% of the adult population in England (mild 0.77%, moderate 0.41%, severe 0.25%). Moderate to severe dependence can indicate an increase likelihood of need for specialist alcohol treatment (NICE, 2015). It is estimated that only 20% of those in need are accessing alcohol specialist treatment (Alcohol Concern, 2018).

Acute hospital admissions in the alcohol dependent patient group provide a potential opportunity to engage people in treatment who do not usually access alcohol services (Mdege et al., 2013; Public Health England, 2014). In the United Kingdom, alcohol specialist nurse teams have been developed in some hospitals to provide detoxification, brief and extended interventions, and referral to specialist services. In this study, semi-structured qualitative interviews were used to understand patient experiences of accessing alcohol specialist nurse detoxification and follow-up interventions in a general hospital and identify barriers to engagement in wider networks of support.

### 1.1 | Background

People with moderate to severe alcohol dependence typically need medically assisted alcohol detoxification in order to stop drinking (NICE, 2010); when this group of people is admitted to hospital, a medical detoxification becomes a necessary part of treatment. Detoxification from alcohol usually lasts seven days and can lead to longer hospital stays than otherwise necessary. The aforementioned Alcohol Specialist Nurse Services (ASNS), located in some UK hospitals, support patients to complete detoxification as outpatients by attending the hospital daily, and they have been shown to significantly reduce occupied bed days (Moriarty, 2014). There has been limited research on patient outcomes for ASNS interventions (Cobain et al., 2011; Ryder et al., 2010) with one randomized controlled trial (Owens et al., 2016) and no published papers of patient experiences of using ASNS. It is particularly important to understand the needs of patients using such detoxification services in the hospital from their own perspective.

Retrospective accounts of recovery from alcohol dependence have been the focus of qualitative studies; those who consider themselves to be 'in recovery' frequently describe a crisis event (such as a health crisis) as a turning point towards change, often influenced by family members or health professionals (Christensen & Elmeland, 2015; DePue et al., 2014; Orford et al., 2006; Roper et al., 2013). Unplanned hospital detoxification episodes potentially provide an opportunity for ASNS to support early recovery after an unplanned detoxification; further investigation of the role of ASNS in this respect is paramount.

## 2 | THE STUDY

### 2.1 | Intervention

An ASNS in a UK acute District General Hospital screened hospital patients to identify likely alcohol dependence (Westwood et al., 2017) and provided detoxification to inpatients and outpatients with a medical need to stop drinking. The nurses observed poor uptake of community alcohol services after detoxification and, based on patient consultation, developed a follow-up service in the hospital, commissioned for half of their patient group who reside within a city area (Pathway A). Those in this pathway could have follow-up outpatient appointments with the ASNS, initially weekly for a month, and subsequently less frequent appointments; the length of follow-up was typically a month but could last for up to a year if needed. The outpatient sessions focused on monitoring health and orientation towards recovery; patients were encouraged to engage with a range of local services according to need such as peer support groups or mental health services, and nurses liaised with GPs to prescribe anti-craving medication. People who lived in the surrounding mainly urban areas did not have access to these outpatient appointments after detoxification but were encouraged to engage with community alcohol services directly after detoxification (Pathway B). Services provided locally varied according to area, but typically included assessment, group support, access to counselling and structured treatment, according to need.

### 2.2 | Aims

The aim of this study was to understand patient experiences of detoxification in a general hospital supported by this ASNS, as well as to compare the experiences of patients following Pathways A and B after detoxification.

### 2.3 | Design

This was a longitudinal qualitative study drawing on Thematic Analysis, an approach suited to understanding people's experiences of events over time (Braun & Clarke, 2013; Grossoehme &

Lipstein, 2016). This is appropriate as recovery from alcohol dependence is generally understood to be a long-term process requiring sustained efforts (White & Kurtz, 2005). Semi-structured interviews were conducted within 1 month of detoxification and at 3 and 6 months post-detoxification. Interviews were carried out by LD between July 2016 and December 2017; LD has a background as a psychiatric nurse and counsellor working in the addictions field and was undertaking a PhD (Dorey, 2019).

## 2.4 | Sample/participants

Participants were recruited within 1–4 weeks after detoxification with the ASNS in a general hospital. Patients were identified by the alcohol specialist nurses. A purposive sampling strategy was aimed at participants with a range of co-morbid conditions and characteristics (e.g. liver disease, alcohol poisoning and alcohol-related mental disorders), but excluding those who expressed an intention to return to drinking following detoxification. Sampling was completed when the number of interviews and the quality of data were sufficient to identify patterns in the data and tell a rich story (Braun & Clarke, 2013).

## 2.5 | Data collection

The interviews were conducted on the hospital site within 2–4 weeks of detoxification, and participants were invited back at 3 and 6 months. Participants could be accompanied by a family member of friend, but the majority were interviewed alone. Contextual information was collected directly from participants for demographics (age, gender, marital status, employment) and health issues (self-reported physical and mental health conditions, number of prior detoxification episodes in the hospital). With patient consent, their notes were accessed for Alcohol Use Disorder Identification Test (AUDIT) scores as recorded by nurses at initial assessment; this is a well-established screening tool with good reliability and internal

consistency (Reinert & Allen, 2002). A score over 20 suggests likely dependence and higher scores have been shown to indicate more severe dependence (Donovan et al., 2006). Participants also completed the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) at initial interviews. This is a validated and reliable instrument designed to assess readiness for change in people with alcohol abuse issues (Miller & Tonigan, 1996); high scores for the construct 'taking action' (36 and over are high and 39–40 very high) indicate active changes are being made.

A topic guide, developed in line with study aims (Figure 1), informed the semi-structured interviews. For the main part of the interview (approximately 40 min) participants were asked about the changes they were making, or that they and others had noticed happening, towards their recovery (e.g. What changes have you noticed since detoxification? Can you give an example of behaving or thinking differently? Who was present, where were you, what were you feeling? What factors supported and hindered you?).

## 2.6 | Ethical considerations

This study received ethical approval from NHS ethics and Health Research Authority (Reference 16/SC/0278).

Those patients who agreed to be contacted for the research study were then approached by the researcher to provide written and oral information (using a Patient Information Sheet) addressing the study purpose, researcher's professional background, what taking part would entail, confidentiality and data security. Participants were advised that interviews could bring up emotions and they were encouraged to identify sources of support prior to the interview. Informed consent was obtained.

## 2.7 | Data analysis

Interview audio data were transcribed and analysed according to the framework described by Braun and Clarke (2013). Complete coding

Questions focused on the following areas during semi-structured interviews (after consent and background information were collected):

- a. Positive changes noticed by participant or participant's family and friends since detoxification or the last research meeting.
- b. Changes deliberately made or attempted by the participant. Probe for specific examples of behaving or thinking differently, asking for details such as who was present, where were they, what feelings were they experiencing.
- c. Changes the participant has been considering but hasn't acted upon yet.
- d. What or who the participant sees as having helped implement the changes? Probe for examples of specific situations.
- e. What or who the participant sees as having been obstacles to implement the changes? Probe for examples of specific situations.

FIGURE 1 Interview topic guide

identified overlapping categories of 'factors or behaviours supporting/hindering recovery', 'sources of support' and 'process of change' (Figure 2); codes were compared for two groups following different pathways. Themes highlighted where the actions of support services influenced the person's process of change; this is consistent with a pragmatic philosophy where action and its influence on existence is the central focus of analysis (Goldkuhl, 2004). The longitudinal approach allowed themes identified in the analysis of the first interviews to be tracked over time.

## 2.8 | Rigour

During analysis, a 15-point checklist for good thematic analysis was followed (Braun & Clarke, 2013). Coding and initial analysis were carried out by one researcher and themes were discussed by all the authors; three people with lived experience of alcohol dependency provided feedback on the preliminary findings.

## 3 | FINDINGS

Table 1 provides details of the sample characteristics, and Table 2 gives individual participant characteristics. A total of 24 participants (just over half of those referred to the study, with 2 being accompanied by a partner or friend) took part in the interviews within 1–2 weeks following detoxification or as soon after as possible; half of the participants ( $N = 12$ ) had access to ongoing outpatient

appointments with the ASNS (Pathway A) and half did not (Pathway B). Half of the participants attended additional research interviews at 3 ( $N = 4$  Pathway A;  $N = 4$  Pathway B) and/or 6 months ( $N = 6$  Pathway A;  $N = 6$  Pathway B). Participants were male and female, mostly aged 40–59 (71%), and the majority were unemployed or retired (63%). AUDIT scores were high (median 40; IQR 35–40) suggesting a high level of alcohol dependence. Nineteen of the participants scored high or very high for the SOCRATES 'Taking Action' category, suggesting a high degree of readiness for change within the group who were interviewed. Mental health issues were commonly reported alongside alcohol dependence, and liver disease was known to be present in a smaller number of cases (17%); a wide range of other co-morbid physical health conditions were also reported in line with the purposive sampling aims.

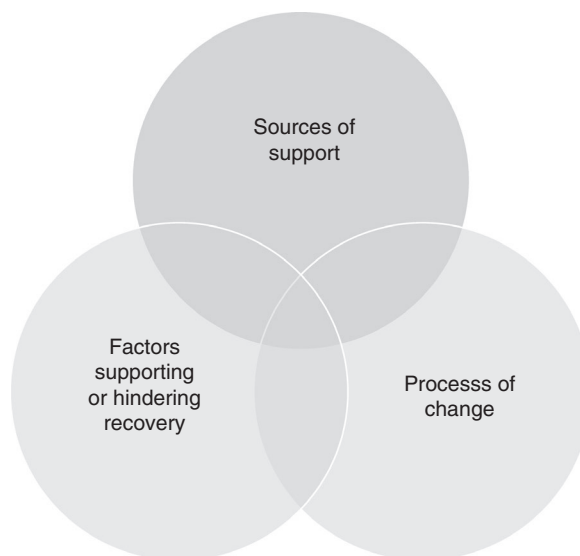
The majority of participants were admitted to hospital after a medical emergency caused by alcohol poisoning, severe alcohol withdrawal syndrome or deliberate overdose. Three patients were not in an acute medical crisis, but referred to the ASNS by an outpatient clinic because of advancing liver disease in one case, and the need to stop drinking before an operation for cancer in two cases.

Several participants described their experiences of the physical, mental or social crisis leading to admission:

I was really scared for myself, I kind of knew, my nose was bleeding like fairly consistently on and off throughout the day and I knew it was getting worse and worse and worse, something was going on. (P22)

Factors supporting recovery:  
Straight talking  
Caring  
Non-judgemental, accepting  
Empathy and understanding  
Connecting  
Decent advice  
You're doing good  
I can open up to you  
Referral to other services  
Offered helpful sayings  
Feedback about physical health

Factors hindering recovery:  
We know better than you  
Difficult to get appointment  
Judgements about me  
Put off by talk of higher power  
Unprofessional attitude  
Access to therapy denied  
Meeting persons not similar to me  
Contact with people with active addiction  
Didn't address underlying issues



Sources of support:  
Alcoholics Anonymous  
Alcohol Specialist Nurse Service  
Community alcohol service  
Individual therapy  
Family and friends  
Mental health services  
Structured day programme  
Social services  
Residential treatment  
GP

Process of change:  
Physical health got really bad  
Drinking got really bad  
I don't want to die early  
Someone to open up to  
Admitting I have a problem  
Aware of the consequences  
Taking responsibility for change  
Repeating helpful sayings

**FIGURE 2** Examples of the codes that were identified from the first interviews. Following the coding within these broad categories, initial themes were developed from the areas of overlap

TABLE 1 Sample characteristics

Demographic characteristics	Number (N = 24)	Percentage	Pathway A (N = 12)	Pathway B (N = 12)
Gender				
Male	13	54.2%	7	6
Female	11	45.8%	5	6
Age				
25–34	2	8.3%	2	0
35–44	6	25.0%	3	3
45–54	12	50.0%	5	7
55–64	3	12.5%	2	1
65–74	1	4.2%	0	1
Employment				
Employed	10	41.7%	4	6
Unemployed	12	50.0%	7	5
Retired	2	8.3%	1	1
Relationship status				
Single	6	25.0%	2	4
Married or in partnership	15	54.2%	9	7
Widowed	2	8.3%	1	1
Prior detoxification episodes in the same general hospital				
0	13	54.2%	6	7
<6	6	25.0%	5	1
>6	5	20.8%	1	4

I hit her and I got arrested, she moved out the house with our four children for 4 weeks and I carried on drinking for three or four days to a dangerous state. (P15)

it's just them thoughts (suicidal thoughts) ... I did stop myself, I did ring up the ambulance ... so the paramedics came and basically I was quite an emotional wreck, that's when I wanted to get the help, because ... I just don't want to live my life like that. (P04)

For some participants, this was the first time they had wanted to change their drinking, while for others it was a chance to get back on track with their recovery, often after periods of recovery and periods of relapse. While the crisis itself appeared to play a role in motivating patients to change, most patients went on to describe the impact of their experiences with the Alcohol Specialist Nurses and other support services, which are presented in three themes: 'straight talking care', 'filling the gap after detoxification' and 'barriers to community based recovery support'.

### 3.1 | Theme 1—Straight talking care

Participant accounts suggested that a non-judgmental approach mattered. This participant had presented to the service a number of times:

I would imagine that they see a lot of their people time and time again and it must be hard to think, oh for Christ sake we've been here before and now we're here again, and there was none of that ... you feel that they care for you. (P14)

For the following participant, it was the first time admitting to an alcohol problem, and an affirming, almost light-hearted approach from the nurses led to a sense of relief:

I just said, look I'm an alcoholic I've got a problem and they all virtually congratulated me on saying it, and it was a bit of a weight off my shoulders cos I was always embarrassed, I don't want to be known as an alcoholic and stuff. (P15)

This highlights the social stigma attached to being considered by others as an alcoholic and how, in the context of the nurse's congratulatory response, opening up is not experienced as shaming.

Several participants felt that the experience of being cared for had influenced their desire to change: *I felt more like people cared, they wanted to make this right as I did (P13)*. Some participants emphasized the caring approach they experienced went alongside a directness:

She's very down to the point, very straight, but very nice with it. Not nice enough that she'd go, oh it's

TABLE 2 Participant characteristics

ID	Pathway	Gender	Age group	Employment	Relationship	AUDIT	Physical health issues <sup>a</sup>	Mental health issues <sup>b</sup>
P1	B	M	35–44	Unemployed	Single	40	3	Y
P2	B	F	45–54	Unemployed	Single	40	1	Y
P3	B	F	35–44	Employed	Married	36	0	Y
P4	A	M	25–34	Unemployed	Partner	40	0	Y
P5	B	M	45–54	Employed	Partner	28	4	N
P6	A	F	45–54	Unemployed	Single	40	0	Y
P7	A	M	45–54	Unemployed	Single	23	1	N
P8	B	F	45–54	Unemployed	Partner	32	1	Y
P9	A	M	55–64	Retired	Partner	40	3	N
P10	A	M	45–50	Unemployed	Partner	32	1	N
P11	A	M	35–44	Employed	Partner	36	0	Y
P12	B	M	45–54	Employed	Single	38	0	N
P13	B	M	35–44	Employed	Single	29	0	Y
P14	B	F	55–64	Retired	Married	35	2	N
P15	A	M	35–40	Employed	Partner	38	0	Y
P16	A	F	55–64	Employed	Married	40	0	N
P17	A	F	45–54	Unemployed	Widowed	40	1	Y
P18	B	M	45–54	Employed	Married	36	1	Y
P19	B	M	65–74	Unemployed	Married	24	1	Y
P20	A	F	25–34	Employed	Boyfriend	40	0	Y
P21	A	F	45–54	Unemployed	Married	35	2	Y
P22	A	M	35–44	Unemployed	Partner	40	0	N
P23	B	F	45–54	Unemployed	Widowed	40	0	N
P24	B	F	45–54	Employed	Separated	40	0	N

<sup>a</sup>Self-disclosed mental health issues- yes or no.

<sup>b</sup>Number of self-disclosed physical health issues.

ok everything is going to be all-right, no that's not (nurse's name). She is direct. (P25)

This approach was often used when giving feedback and advice regarding health concerns related to drinking. For a few, this could be bad news about the seriousness of their situation; it may have progressed beyond a point where stopping drinking could reverse the health condition. However, many participants described receiving feedback about their physical health to be a helpful motivator for change, typically involving results of tests indicating liver damage. For example:

I was brought in and one of the alcohol nurses came up and said with the blood tests they had done ... it was extremely high; they said would you like help to stop, and I said I'd love some help to stop, I'd love to live a normal life again and not rely on it. (P21)

Another aspect, commonly spoken about, was the importance of not being rushed: *they don't seem like they're in a rush to get you out*

(P17); and *you never felt rushed for time* (P14). Having time available and feeling cared for created the context in which participants could talk about the challenges facing them:

You can open up to them and talk to them as if you're talking to someone that you've known for years. (P17)

Another participant found that being able to open up to the nurse allowed him to admit to himself his own part in his problem, and to see there was support available.

(The nurse) just sat me in the chair and went right ... just spit it out, what's going on here ... and I felt comfortable for the first time ever to just sit there and spill, ... I got to talk about it properly and I got to realise that there was a real web of help out there, and it was there for you ... that is the only time I've really thought I can crack this now ... and that's only because I've had people who've helped me break that shell open. (P13)

Opening up to the nurses could also be important to those with a number of past periods of recovery in order to identify and explore some underlying psychological factors that had contributed to relapses.

Having met them and feeling like I can talk to you, you get where I'm coming from, I talked really candidly to (the nurse) about some of the challenges at work, how do I handle that ... kind of it felt like a bit of a tipping point. (P3)

### 3.2 | Theme 2—Filling the gap after detoxification

Most participants wanted access to professional support after detoxification to continue abstinence from alcohol. One exception was where a participant had severe liver failure and was ambivalent about change; another patient felt she had the necessary support from her family, and a third felt able himself to limit his heavy binge drinking. The hospital was seen as an acceptable place to come for help with alcohol dependence, often because it was not a specialist service for addictions: *coming to the hospital, it's a multitude of different things people are coming for (P11)*. For those who were working, it could also be easier to ask employers for time to attend hospital rather than an addiction service.

The nurses gave various pieces of advice, *just different little things (P10)*, such as advice to take it *day by day (P4)*. An example from another participant: *She said I need to be humble ... I took it in my head, I need to be humble (P18)*. The support of the nurses could often bridge a gap immediately after detoxification when participants felt they most needed it, and this could lead to engagement with other relevant services.

They offer a good support network, giving you all the information... all the numbers at your fingertips so you can reach out and pick up the phone. (P21)

The ASNS Pathway A also provided easy access to support if needed between sessions or after follow-up appointments had ended: *just as you leave, you think there might be other problems, just call, we are here (P11)*. This meant that when a person relapsed they could access assistance early:

I went in and I was straight down the line, I said, look, I failed ... so at the moment I'm feeling very embarrassed, very raw, and a kind of inner anger with myself, that's the truth. (P9)

The opportunity to access the ASNS post detoxification was valued by patients in Pathway A:

I still can't imagine how I would have got through that period if I hadn't had the appointments here to come back and see them. (P3, 3 months)

The experiences of participants in Pathway A of feeling supported after detoxification were in contrast to those of participants who could not access the ASNS post detoxification; they often perceived help as scarce or not available to them:

There seemed to be this huge gaping hole that what do you do ... when I really needed the help I did feel it wasn't there for someone who was ill ... I felt a little bit redundant I couldn't go anywhere. (P24)

Apart from seeing (Social worker's name), no there's still nothing else ... I was still in my flat, ... you can't go to (community alcohol and drug service's name), I can't access here (ASNS) unless I'm an inpatient which isn't much fun. (P1, 3 months)

### 3.3 | Theme 3—Barriers to community based recovery support

Just over half the participants in both pathways who returned for follow-up appointments at 3 and 6 months ( $N = 4$  Pathway A;  $N = 3$  Pathway B) described a wider network of support beyond the ASNS intervention, and some had family support; however, there was no pattern related to the pathways in this respect. One study participant engaged in counselling and group work in community alcohol services, one attended a structured day programme, one had cognitive behavioural therapy through work, one had self-funded residential treatment and several engaged with and found benefit from peer groups ( $N = 6$ ), usually alcoholic anonymous (AA;  $N = 5$ ).

Nevertheless, the majority of participants described barriers to access further support after detoxification. Most participants were reluctant to attend community alcohol and drug services, and described past and recent difficulties accessing these services. This included the difficulty of getting to speak to someone in a service or not being called back:

I went for an assessment, and they said I would be allocated a keyworker ... I was never contacted again. (P5)

A number of participants also described negative experiences when they attended a community service, such as experiencing aggression from people drinking outside a service building or group sessions being dominated by those actively drinking: *I didn't enjoy the meetings, a lot of them were still drunk (P21)*; it was often felt that services were offering help to those who were still drinking but not to those who had stopped drinking.

Conversely, another common barrier to finding help was that participants mainly perceived services to be oriented around people who had lost employment, relationships and/or housing. One participant described how she had been perceived as doing well by the worker she met, based, it seemed, on her appearance:

I'd turned up in my suit and he said, look, you're looking well together, you know, you've done your hair, your makeup, you're dressed for work, you are doing ok. (P3)

Furthermore, several participants reported that they did not to meet the criteria for community mental health services, as their problems were not severe enough, and several participants had been turned down for psychological therapy. One patient reported that she was advised she needed to stay 6 months sober before she could access psychological help. She was also refused counselling, having been advised that she should *not delve into her past* (P21). Her frustration was evident in the following quote:

I'm sure the counselling would have done me a lot of good, that would have really helped me, it would have taken the pressure off my family as well, they wouldn't have to keep watching me go downhill and pick myself up again by myself. (P21, 6 months)

For several participants, there were barriers to taking part in peer led groups, such as concern about confidentiality for one participant, and social anxiety for others: *I'm a bit anxious of being in a group* (P4). Furthermore, during the study period, several participants attended peer or service led groups to find that some members of the group had been drinking; this was often considered unhelpful when trying to be abstinent:

It did get me thinking of alcohol again, which was the last thing I needed, especially when I was, to be honest, well, I was thinking about it anyway. (P1, 3 months)

Many participants spoke about their difficulty with fitting into the approach of some group meetings, such as controlled drinking groups or AA. This was stated as a barrier, and some felt quite confused by the advice they had received, feeling pressure to conform rather than make their own decisions:

It just defines you as one thing and you become like sheep, basically. If it's not their way, it's the highway, you are told, you leave and you die, and all these kind of awful things. (P6)

## 4 | DISCUSSION

This study was successful in recruiting a group of patients who accessed a general hospital for alcohol detoxification because of urgent medical need rather than a planned detoxification following help-seeking in the community. Participants in both pathways identified ASNS contact at the point of crisis and detoxification as facilitating an important turning point in their recovery.

Participants in Pathway A benefitted from an extended hospital intervention and usually sought to engage in a wider network of support. Those in Pathway B (without specialist nurse follow-up) faced a discontinuity of care once they left the hospital, potentially leading to worse health outcomes. In the context of struggling UK alcohol treatment provision (Roberts et al., 2020), both groups experienced barriers to accessing specialist alcohol and mental health treatments.

Some studies suggest there is low motivation for specialist alcohol treatment in patients attending hospital emergency department and outpatient services. In a qualitative study, Parkman et al. (2017) found that only a third ( $N = 30$ ) of patients frequently using London-based emergency departments wanted help from alcohol specialist services, while most were looking for broader psychosocial support ( $N = 30$ ). A recent pilot study of alcohol dependent patients attending outpatients in Australia ( $N = 10$ ) found these participants described little interest in change or help-seeking (Johnson et al., 2018). However, the group of dependent drinkers in this study were motivated towards change and gaining help from specialist alcohol services as well as seeking a wider network of psychosocial support. This finding may partially relate to the higher severity of alcohol problems in the selected group.

The findings in this study suggest that the experience of a crisis being met with the caring and straight talking intervention from the ASNs influenced the patients' openness to change. The potential for nurse interventions to make timely use of the 'teachable moment' has been recognized previously (Williams et al., 2005) as well as the positive effect of on the nurse-patient relationship of an authentic caring approach during acute medical care (Bove et al., 2019). This study also supports earlier findings that people in recovery from alcohol dependence describe interactions with professionals during a medical crisis as influencing change (Orford et al., 2006; Roper et al., 2013; Wing, 1995). A common element in the literature is that a turning point involved opening up to trusted others (DePue et al., 2014; Orford et al., 2006) who might be family, professionals or peers in recovery; this could only take place when the interpersonal interaction was perceived as non-judgemental, which meant that the stigma preventing disclosure could be overcome (Dyson, 2007). The accounts of study participants who came to this point of willingness to open up and accept help to change were often striking examples of how a turning point could be reached in the context of a medical crisis.

Further research is needed into the outcomes for the groups receiving ASNS interventions as the prior research has been limited to geographical comparisons (Cobain et al., 2011; Dorey, 2019) and one trial with low statistical power (Owens et al., 2016). Cobain et al. (2011) compared outcomes for an alcohol specialist nurse hospital-based intervention in the north of England with treatment as usual at another UK hospital, finding significant improvement in dependence for the intervention group. Their approach was described as a brief intervention using FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy (Hester & Miller, 1989). Owens et al. (2016) carried



out a randomized trial of a six session extended brief intervention delivers by ASNs, recruiting from accident and emergency departments; they found no significant difference for any outcome. They also observed that both groups improved and hypothesized that the initial assessment received by both groups could have influenced change; the findings of the current study would support this view that the greatest impact of the intervention was during the crisis.

The extended ASNS intervention studied in this paper also overlaps with Brief Interventions, but went further in orienting patients towards early recovery strategies, providing health interventions, initiating prescribing, and actively supporting patients to engage with other services. The patients clearly valued being able to access ongoing follow-up appointments in the hospital. The quality of the relationship with the nurses, combined with the neutrality of the hospital setting, appeared to influence further engagement. There was a contrast between the experiences of those who were offered follow-up by the nurses in the hospital and those who were not.

Alcohol Specialist Nurse Services interventions delivered in an acute medical hospital setting can facilitate the initiation of change in those with alcohol dependence, but there is also a need for adequate services and support networks to sustain recovery. Only well integrated hospital and community recovery services are likely to achieve positive outcomes in this group, such as reduced dependence maintained over time. The provision of services that bring those who are still actively drinking or cutting down into contact with those who are in early abstinence may need to be reconsidered. For many of these patients mild to moderate mental health issues were fuelling a cycle of repeated relapses; the barriers to accessing psychological therapy for mental health issues in this group need to be overcome, as is well recognized (Alcohol Concern, 2018).

#### 4.1 | Limitations

There was a significant drop out of participants from follow-up research appointments; the reason was not known for all cases, but for those who were in contact relapse or illness were the reasons given. However, the amount of data collected (considering both number and depth of interviews) was sufficient to tell a rich story, and to allow repeating patterns in the data to be identified and followed over time; this is consistent with Braun and Clarke's (2013) approach. Similarity to findings in other research studies (e.g., Orford et al., 2006) enhances the trustworthiness of the findings. This study recruited the more motivated participants who engaged with ASNSs during and after detoxification, and excluded patients who had no intention to change their drinking after discharge; this should be taken into account when considering relevance to other contexts. Possible barriers to community engagement identified in this study relate to the available services in this context, and may exhibit similarities or differences in other contexts.

## 5 | CONCLUSION

The findings of this study support previous findings that change for people who are alcohol dependent can follow a crisis. They also provide insight into how this process can be facilitated by alcohol specialist nurses who are well placed to engage and influence patients at a time of medical crisis. Hospital based follow-up with an ASNS was acceptable to study participants who often did not engage in community alcohol services.

It would be recommended to evaluate the impact of both brief and extended ASN interventions. An appropriate outcome to focus on, alongside alcohol dependence outcomes, would be the level of engagement in specialist treatment and other supports; however, these need to be available and appropriate to an abstinence seeking group, and also the tools to measure this might need to be developed.

#### CONFLICT OF INTEREST

No conflicts of interest have been declared by the authors.

#### AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE\*): (1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

#### PEER REVIEW

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#### DATA AVAILABILITY STATEMENT

Research data are not shared.

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