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The Health Promotion Alcohol Project in the Flinders Medical Centre, South Australia

Alex Ask, Steve Allsop, Charlotte de Crespigny, Joseph de Luca & Julie Watkinson

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Recent estimates show that a significant number of Australians drink alcohol at hazardous and harmful levels, and that many hospital admissions are related to alcohol use. Despite the effectiveness of alcohol assessments and brief interventions, hospital staff often do not assess, recognise and intervene with alcohol-related problems. An alcohol health promotion project was conducted in the Flinders Medical Centre of South Australia (FMC). The health promotion was a multifaceted project and comprised several programs that aimed to address a number of related alcohol issues.

METHODS:

Several programs were conducted at FMC during the health promotion project. Program 1 entailed a number of general health promotion strategies within FMC. Transmitted messages included information on standard drinks, low risk alcohol use and drink driving risks. A variety of media were used to transmit these messages, such as in-house television, newsletter articles, pamphlets and foyer displays. Apart from these general strategies, two specific programs were conducted under this project. Program 2 entailed a series of training sessions across five wards for medical and nursing staff on alcohol assessment, intervention and withdrawal and intoxication management. A total of 105 nurses completed the four-session program. Pre- and post-training questionnaires were administered to participants as a means of assessing changes in knowledge, attitudes and practice. The Clinical Nurse Consultant (CNC) from each pilot ward completed a questionnaire. Ninety-six case notes were audited following the training to monitor the nature and extent of alcohol-related assessments and interventions performed by nurses. Program 3 was the development and implementation of a workplace alcohol/drug policy by Occupational Health and Safety unit staff. The policy was evaluated using a set of criteria outlined in a major review of Australian policy documents.

RESULTS:

Analysis of pre- and post-training questionnaires showed that after training nurses had a higher level of knowledge about issues related to alcohol, exhibited a more positive attitude towards the assessment and treatment of patients with alcohol-related problems, and were more likely to intervene. These findings, however, are tentative because the changes across the scales were small and there was a poor response rate from participants on the post-training questionnaire. An analysis of case notes showed that staff frequently failed to complete the alcohol assessment forms. Despite these points, other sets of data showed positive indications of change. Reports from CNCs were generally positive about the training program, and there were a total of 44 referrals to the alcohol/drug counselling service in FMC from the wards involved in the training program. The social work staff reported that such referrals were more appropriate since the training. In addition, the number of alcohol-related assaults fell markedly during the health promotion project. An analysis of the workplace alcohol and drug policy developed by FMC showed that the document was of a high utility. The general promotion strategies were widely seen by staff, visitors and patients, although no formal evaluation was conducted on this particular program.

CONCLUSIONS:

The health promotion of low risk alcohol use by FMC raised the awareness of staff, patients and visitors about alcohol issues. Among the positive outcomes of the project included changes in organisational structure, policies and clinical practice.

SO WHAT?

Despite the limitations, there is great scope for developing alcohol health promotion projects in the hospital setting.

KEY WORDS:

alcohol, harmful and hazardous use, brief interventions, hospital.

Introduction

Hospitals, Hazardous and Harmful Drinking Assessment, and Brief Interventions

Despite the National Health and Medical Research Council's guidelines on low risk drinking,¹ the prevalence of hazardous and harmful drinking in Australia remains significant. For example, the National Drug Strategy Household Survey showed that 79% of males and 69% of females were consuming alcohol at a hazardous or harmful level at least once in the preceding year, and 8% of male and 5% of female current drinkers had consumed alcohol at very harmful levels 2 weeks before the survey.² Similar data have been reported elsewhere.³ Hazardous and harmful drinking is particularly prevalent among young men and women.⁴

Consistent with the suggestion that significant numbers of Australians consume alcohol at unsafe levels is the estimation that 20–40% of general hospital admissions involve people who have an alcohol-related problem even though the presenting problem may not be directly related to alcohol (e.g. injuries), with a small proportion experiencing alcohol dependency (i.e. most are hazardous or harmful drinkers).^{5,6} Hospital staff (e.g. doctors, nurses) have been consistently cited in both Australian and overseas literature as professional groups who may benefit from training to identify and respond to alcohol-related harm.^{7,8,9,10,11} However, nursing staff and medical practitioners are often unsupported, unable or reluctant to identify alcohol-related harm.¹² This point was first acknowledged more than a decade ago¹³ and later recognised in guidelines on quality assurance¹⁴ that concluded:

A therapeutic nihilism has developed among general health care workers with regard to intervening to reduce excessive drinking. This phenomenon may be partly related to the stereotype of "alcoholism" as a chronic, relapsing

problem, but it is also likely to be due to an uncertainty regarding appropriate methods for intervention. Brief and early interventions provide a partial answer to this question, because they focus on excessive drinkers who are more likely to alter drinking patterns in the face of a clear health warning, compared with dependent drinkers. (p.137)

Given the effectiveness of brief interventions for many hazardous drinkers,¹⁵ their appropriateness for alcohol-related hospital admissions and the directive of the National Drug Strategic Plan to "increase the numbers of generalist health care and welfare workers who directly intervene with any patient drinking at hazardous or harmful levels" (p. 11),¹⁶ exposure to alcohol and other drug training for hospital staff should be commonplace.

Alcohol Health Promotion

The South Australian Health Commission (SAHC) under the Primary Health Care Initiatives Program, provided funds for 1995–96 to improve the health and well-being of South Australians.¹⁷ A primary strategy of the program was to promote "more integrated and continuous quality care for people who are already ill as well as increasing the emphasis on health promotion and illness prevention in the health system" (p.2).

The Drug and Alcohol Services Council (DASC), the Flinders Medical Centre (FMC) and the National Centre for Education and Training on Addiction (NCETA) received funding under the Primary Health Care Initiatives Program to conduct a health promotion alcohol project. FMC is a large acute hospital with a workforce exceeding 3000 people. It has substantial contact with the public (e.g. nearly 40,000 new patients each year) and is linked with other local hospitals, community and mental health services, general practitioners, community nurses and specialised health programs in the

southern region of Adelaide. It is also linked to the Faculty of Health Sciences at Flinders University of South Australia.

Historical Developments

For some time prior to the formation of the first committee, FMC nursing staff liaised with DASC nursing education staff to identify issues and develop a strategic plan. Discussions suggested that an advisory committee should be formed that was multidisciplinary, containing key professional groups such as medical practitioners, nurses, social workers, hospital administrators and health promotion and occupational health personnel.

The Alcohol Project Advisory Committee (comprising 12 individuals) was the first organised group of the project, and was established in April 1995. Over several meetings, the Advisory Committee established that there were a number of major issues with respect to the management of alcohol-related problems at FMC. These issues were:

- inconsistent and often absent assessment on alcohol use for all adult patients;
- inconsistent alcohol withdrawal identification and management by medical and nursing staff;
- limited coordination of alcohol-related treatment efforts by medical and nursing staff;
- approximately 40% of violence response call outs and 50% of nursing staff assaults were related to alcohol intoxication or withdrawal;
- inconsistencies in the level of intervention offered to hazardous or harmful drinkers;
- ineffective follow-up and/or referral of patients, either within the hospital or beyond;
- lack of up-to-date health promotion materials, clinical resources, protocols, policies and guidelines;

- lack of staff training; and
- outdated workplace policy on alcohol/drugs and serving practices in the staff bar.

The Advisory Committee established a Clinical Reference Group (comprising 22 individuals) who identified key wards or functional areas and facilitated the training of nurses, social workers and medical doctors and the evaluation of the program. DASC/NCETA nursing education staff coordinated the training and evaluation program, and medical staff from DASC contributed to training. The Clinical Reference Group first met in January 1996. When the Clinical Reference Group was firmly established, the Advisory Committee was dissolved. The Health Promotion Unit became responsible for health promoting strategies such as reviewing and issuing standardised (and current) resource and information folders to each pilot ward, setting up displays promoting safe alcohol use, assisting project staff in obtaining funding from FMC volunteers, and screening low risk alcohol use messages on the in-house television. The Alcohol Project Reference Group (comprising senior nurses, health promotion staff, social workers and the DASC/FMC team) guided the training content and delivery for ward nursing staff and social workers. The FMC Nursing Service Education Division coordinated the overall training program.

The main objectives of the FMC alcohol project included:

- raising the awareness, confidence, knowledge, and skills of clinical staff in assessing, preventing and responding to alcohol-related problems among patients and the southern region community;
- increasing the number of adult patients who receive effective assessment and intervention in the range of alcohol-related problems;
- improving the assessment and management of alcohol intoxication and withdrawal;

- improving continuity of patient care through the improved policies, plans and procedures of the health care team; and
- improving patient, visitor and staff awareness of low-risk drinking; and increasing the number of health promotion strategies targeted towards staff, patients and visitors on low-risk alcohol use.

Methodology

General Health Promotion Strategies

A number of general strategies were employed within FMC as a means of promoting low risk alcohol use among patients, visitors and staff. Several media were utilised to disseminate health information. The health promotion strategies included the following:

- promulgation of general information on alcohol through FMC in-house television stations and the hospital's monthly newspaper;
- written and pictorial information, presented on display panels in the general foyer of the hospital, on drink driving, standard drinks and alcohol harm-reduction;
- placement of an updated alcohol information package for patients and visitors in each pilot ward;
- temporary abandonment of "Happy Hour" in the staff/student bar in order to discourage excessive and binge drinking, with low-alcohol content drinks reduced in price so that a greater price difference existed between these types of drinks and high-alcohol content drinks; and
- messages on low-risk harm reduction strategies placed on staff payslips during Christmas and New Year.

Evaluation of the strategies was conducted by interviewing various informants (i.e. staff, patients and visitors) from FMC. Apart from these general strategies, two specific programs conducted in the hospital

were related to this project: training of health professionals and workplace alcohol/drug policy.

Training Health Professionals on Alcohol

Following presentation to all senior nursing staff and colleagues, a range of seminars were offered to all nursing staff and other health professionals (e.g. social workers, medical practitioners) to raise awareness of and engage participants in the project. These seminars were advertised in the FMC staff newsletter on a monthly basis. Five wards were involved in the training program. The clinical nurse consultant (CNC) of each pilot ward was consulted and informed of the program's goals and content. Seventeen training programs were conducted between June 1996 and April 1997. All pilot wards had the four-part program repeated at least three times over that timeframe. A total of 105 nurses from these wards completed the training program, as well as a smaller number of social workers and medical practitioners. Night staff were provided videos and written materials in order to participate in the program. In addition to this process, resources such as alcohol assessment forms were identified for staff who were trained in their implementation.

The training program was developed through consultation with the Reference Group. The training program comprised knowledge sessions and a skill component during the last session in which staff were assessed on performance. The four sessions, which ran for 45 minutes each, covered topics such as general information about alcohol use, models of alcohol/drug problems,^{18,19,20} alcohol use screening and assessment methods,²¹ brief interventions,²² withdrawal management²³ and referral strategies. The skills component session involved patient assessment of drinking patterns, administration and scoring of the Alcohol Use Disorders Identification Test (AUDIT),²¹ and implementing a brief intervention at

the time of assessment.

A pre- and post-test instrument was utilised during the training program based on an instrument developed in NSW (Bill Goodin, University of Sydney). The first section of the survey requested general information about nursing experience and qualifications, and any previous alcohol/drug training. The second section contained questions about clinical aspects of nursing (e.g. availability of clinical guidelines, frequency of consultation with clinical manuals for alcohol-related problems). The third section was a series of 12 items comprising a scale that assessed attitudes towards alcohol assessment and treatment in an acute care setting (ATTITUDE). The range of scores on ATTITUDE is 12–60. Each item (e.g. "I have a responsibility to identify patients with alcohol-related problems") is rated on a five-point scale where "1" means "strongly disagree" and "5" means "strongly agree". The fourth section was a series of 13 items comprising a scale (BEHAVIOURS) of the respondent's behaviour towards patients with alcohol problems (i.e. do they conduct brief interviews with patients, encourage patients to discuss problems, discuss the consequences of alcohol use, and provide referral to specialist drug services?). The range of scores on BEHAVIOURS is 13–65. Each item is rated on a five-point scale where "1" means "never" and "5" means "always". The final section was a series of 19 items on the respondent's knowledge of alcohol (KNOWLEDGE). The range of scores on KNOWLEDGE is 0–19. A point is accrued on this scale when an item is correctly answered.

All nursing participants completed the questionnaire before the training program began, thus providing baseline data. While staff completed all training sessions, a large number of survey questionnaires ($n=74$) were not returned. This may have been due to staff changes, ward restructuring and/or a "natural" non-response rate. Limitations therefore

exist regarding the interpretation of these results. Each CNC of the pilot wards was given a short evaluation questionnaire at the completion of the training program, and their feedback was included in the evaluation data. While other health professionals (e.g. social workers, medical practitioners) completed the training program, evaluation data are not available for these groups.

Case notes were randomly selected across the pilot wards for the purpose of auditing the compliance of nursing staff to complete the alcohol screening tool (i.e. MR250), and monitoring whether appropriate assessments and interventions were performed after the training program. A total of ninety-six case notes were audited.

Alcohol and Other Drugs Workplace Policy

The Occupational Health and Safety Unit of FMC developed a comprehensive workplace alcohol and drug policy during the health promotion project. The policy was developed through consultation with FMC, NCETA and DASC, and informed by information from a paper produced by the Western Australian Chamber of Mines and Energy.²⁴ The development of the policy was driven by FMC staff, who recognised that this is an important issue, and by changes in recent years in the domain of alcohol/drug issues in the workplace. Current occupational health and safety legislation supports the development of formal alcohol/drug policies in Australian workplaces.²⁵ Moreover, the Australian workplace has been suggested as a productive avenue to reduce the harmful effects of alcohol in the community.

FMC workplace alcohol/drug policy was assessed by the current authors using a set of criteria outlined in a major review of Australian policy documents.²⁵ General criteria include whether the document:

- is supported by empirical evidence;

- is internally consistent;
- is easily interpreted; and
- adheres to principles of social justice.

Policy development criteria include whether there is:

- evidence of consultation with all parties influenced by the document;
- articulation of the purpose and goal of the document; and
- identification of the policy-maker's authority.

Implementation criteria are:

- evidence of achievable goals;
- resources allocated to implementing the policy effectively;
- strategic planning;
- outline of specific programs; and
- an evaluation of the policy.

Policy documents are categorised as having high utility (i.e. could be applied beyond the workplace it was devised and implemented for) if they adhere to three or more of these criteria.

Limitations of the Methodology

It is important to note that there was a lack of independence between program instigators and evaluators. All but the first author were involved in the design, implementation and evaluation of the program. The first author was only involved in the evaluation. Potential evaluator bias should therefore be considered in data interpretation.

Results

Training Health Professionals on Alcohol

Questionnaire Data From Nurses

Pre-training questionnaire

It is relevant to note that some data were not available from all participants. All participants completed a pre-test questionnaire ($n=105$). The mean (SD) number of years for working in the particular clinical area at the time of the alcohol project was 3.5 (3.6) with a

range of 1–14 years. The majority of participants were registered nurses ($n=65$) or enrolled nurses ($n=25$), and seven participants were CNCs.

One hundred and two participants said they had consulted a nursing manual in the past, but only 35 participants (34%) had ever consulted a clinical nursing manual on alcohol problems. Of those 35 participants, nine participants (26%) had consulted the manual in the month prior to the questionnaire, 16 (46%) had consulted the manual in the past 6 months (but not in the previous month), and 10 (28%) had consulted a manual but more than 6 months prior to the questionnaire. Thirty-four of the 35 participants indicated that the manual was useful in dealing with the alcohol problem. Thirty-eight participants reported having alcohol procedures in their current workplace, 14 participants indicated that they did not have procedures, and 49 participants did not know or could not recall.

Post-training questionnaire

Seventy-four of the 105 participants who attended the training program did not complete the post-training questionnaire. Thirty-one participants completed both pre- and post-training questionnaires. The mean (SD) number of years that this sub-sample had been working in the particular clinical area was 3.1 (2.7) with a range of 1–10 years. The majority of participants were nursing staff: 18 were registered nurses and six were CNCs. It is noted that the characteristics of the post-questionnaire sample are approximately the same as the pre-questionnaire sample. However, the response rate was so low as to invite substantial caution in interpreting data. Therefore, these data are offered in summary and interpretation is necessarily tentative. All respondents indicated that they had consulted a nursing manual in the past, and more than 50% ($n=18$) had consulted a manual for an alcohol problem. The majority

TABLE 1. Impact of training on KNOWLEDGE, ATTITUDES and BEHAVIOUR scores.

	Pre-training Mean (SD)	Post-training Mean (SD)		
KNOWLEDGE	12.8 (3.3)	15.4 (2.3)	$t(30)=-4.4$	$p<0.001$
ATTITUDES	27.1 (2.0)	28.1 (2.3)	$t(25)=-1.8$	$p=0.08$
BEHAVIOUR	41.5 (5.4)	43.6 (6.3)	$t(22)=-2.0$	$p<0.06$

reported that they found the manual useful. Without sufficient data for formal analysis, the conclusion is that these data are consistent with improvement.

An internal reliability analysis was conducted on the knowledge, attitudes and behaviour scales. These indicated that the BEHAVIOURS and KNOWLEDGE scales had reasonable internal consistency with alpha coefficients of 0.66 and 0.76, respectively. Three items were deleted from ATTITUDE in order to increase the alpha coefficient to a reasonable level of 0.54. All scales had good statistical qualities because the means were in the middle of their respective scales. Mean (SD) ratings for BEHAVIOURS, KNOWLEDGE and ATTITUDE were 40 (5.2), 11.4 (3.7) and 35.8 (3.0), respectively.

A series of related samples t tests were conducted using pre- and post-questionnaire scores across these scales. Results are summarised in Table 1. Many participants did not complete the scales at the post-training stage so a number of cases were lost for each t test.

These results are indicative of an increase in knowledge, some change in attitudes (more positive towards patients with alcohol-related problems) and an increase in alcohol-related information being provided to patients subsequent to the training program. However, the only significant change was in knowledge. In addition, the low response rates and mean increases for the scales implies caution. Conclusive statements about the precise effects of the training program on the knowledge, attitudes and behaviour of nurses should not be made.

CNC Interviews

A questionnaire administered to CNCs at the completion of the training program supported the findings of the questionnaire. All six CNCs thought there was a greater sense of team approach to managing patients with alcohol problems after the training program. They reported that nursing staff applied more appropriate responses to patients with alcohol-related problems, were more effective in conducting assessments and interventions, and there was greater consideration of the contributing factor of alcohol use in medical problems of patients. However, one CNC reported that some nursing staff indicated that the alcohol assessments were time-consuming and added to their existing paperwork.

Random Audit of Case Notes

The following percentages summarise the findings from the random case note audits:

- 56% of case notes contained an MR250;
- 7% showed records of weekly alcohol consumption;
- 20% contained a record of standard drinks per day;
- 18% contained an AUDIT score;
- 22% had an alcohol diagnosis; and
- 2% made suggestions for an intervention.

These data show that the ward clerks placed the MR250 in a relatively high number of case notes (56%), but comparatively few were completed by staff. Nursing staff were responsible for administering the AUDIT, while medical staff were

responsible for conducting the alcohol diagnosis and proposing an intervention. While few case notes contained an alcohol diagnosis, still fewer recommended an intervention. These findings are disappointing because the MR250 (and related tools) are relatively simple in content and structure.

Referrals

Despite the low compliance among nursing staff to complete the MR250, referrals from the pilot wards suggested that nurses were making relevant referrals. A counselling service became operational on 28 April until September 1997 as part of an independent project by NCETA/DASC. Some 9 hours of counselling referral service was provided each week during this period. Data on the number of referrals to the counselling service provided additional information indicative of the effectiveness of the training. During the period 6 May to 22 August 1997 there were 44 referrals to the counselling service from the pilot wards and the Emergency Department. It should be noted that while a number of referrals were related to alcohol, there were also consultations based on other drugs such as heroin, psychostimulants, benzodiazepines and marijuana. This implies a need to enhance staff capacity to respond to drugs other than alcohol. The Social Work Department reported that referrals were more appropriate from the pilot wards subsequent to the training.

Alcohol-related Violence

A case note analysis of staff assaults by patients was conducted as a method of demonstrating the influence of staff training on the management of alcohol-related incidents within the FMC. An analysis of case notes showed a significant reduction in the number of alcohol-related assaults. From October 1993 to September 1995 there were 61 recorded assaults within FMC, and 40% were related to alcohol

intoxication or withdrawal. In comparison, from October 1995 to September 1997 the number of total assaults fell to 41, of which only 4% were related to alcohol. The majority of incidents are now due to cognitive impairment and acute confusion. Thus, while there was a substantial fall in alcohol-related assaults, non-alcohol-related assaults appeared stable (a slight increase). Reports from the Violence Management Team (VMT), which responds to calls-outs in the hospital, suggested that the significant reduction in alcohol-related assaults was largely a result of better management of alcohol-related incidents by staff in a particular ward who were involved in the health promotion training program.

However, it would be unsound to solely attribute the reduction in alcohol-related assaults to the FMC Alcohol Project, given that other factors may have contributed to these data. For example, the new Emergency Department facility, which is less crowded and promotes better visibility of patients, may have also caused a reduction in alcohol-related assaults. Despite these other factors, the trend in assault data and reports from the VMT suggest that the health promotion project may have contributed to the prevention and better management of alcohol-related violence within the hospital.

Alcohol and Drug Workplace Policy

An analysis of the FMC's policy on alcohol and other drugs (AOD) in the workplace showed that the document was reliably produced given the citation of key references and consultation with professionals from leading alcohol/drug agencies (e.g. NCETA, DASC). However, the background section, containing statements about the rationale of the policy, had no citations of relevant empirical evidence (5.27.2). This criticism is overlooked given the paucity of Australian research on workplace alcohol/drug issues.²⁵

There is clear articulation of definitions of different types of drugs

in the document, which is particularly important in the health industry, where some drugs are often kept at work (5.27.1). The policy distinguishes between critical concepts such as "harmful" and "hazardous" drug use (5.27.1), and reference is made to the *South Australian Occupational Health, Safety and Welfare Act, 1986* (5.27.2).

Adherence to principles of social justice is evident in the document. The provision of an employee assistance program (EAP) is outlined (5.27.5). Strategies for responding to alcohol/drug-impaired employees are clearly stated, with managers and supervisors encouraged to refer employees to the EAP (5.27.6), and appropriate practices are discussed (e.g. providing a taxi home for alcohol/drug-impaired employees).

It is clearly written that all parties who may be influenced by the policy were considered (see 5.27.1), and the aim of the policy is clearly outlined:

Employees of FMC have a responsibility to the community to ensure appropriate use of AOD in regard to the workplace, and this responsibility is also extended to ensure that employee's work performance and the safety of others whilst at work, is not comprised due to the inappropriate use of AOD. (5.27.2)

However, it is not stated whether these parties contributed to the formulation of the policy.

Implementation issues are well covered in the policy. The roles and responsibilities of all parties influenced by the policy are outlined in detail (5.27.4). For example, the Chief Executive Officer is identified as the individual responsible for the allocation of adequate resources to implement the policy. The implementation of the policy is said to be the responsibility of the Occupational Health and Safety Committee (5.27.5).

An additional aspect of the policy is a

code of practice for FMC workplace social functions (5.27.9). The guidelines cover issues such as the availability of food and non-alcoholic and low alcohol beverages, provision of safe transport, responsible drinking role of management, and the conduct of organisers and participants. The guidelines also cover the FMC social bar. Guidelines include responsible serving practices, promotion of safe drink driving through the dissemination of information in the bar area, and the price reduction of low alcohol and non-alcoholic beverages. A number of these principles were observed to be in practice (e.g. changes in the provision of cut-price alcohol as promotional activities).

Given that FMC policy adheres to many of the criteria outlined in the methodology section, it was categorised as a high utility document that could serve as a model alcohol/drugs policy for organisations that wish to devise and implement such a policy. Despite having a high utility, provisions for the continued evaluation of the policy are strongly encouraged.

Discussion

A health promotion alcohol project with a number of related programs within FMC was associated with positive changes in the hospital. For example, an evaluation of nurse training on assessment and intervention was indicative that staff were more knowledgeable about alcohol, possessed greater awareness of alcohol issues, and had a more positive attitude towards alcohol-related cases. Awareness of services and utilisation of resources also rose as a consequence of the training program. A major limitation of these data, however, was the poor response rate at the post-training stage from both medical staff and nurses, which makes it difficult to formulate precise estimations of the effects of training on participants. Furthermore, a shortcoming of the evaluation was the inability to follow up participants several months after

in order to assess the long-term impact of the program. Overseas research has highlighted the value of follow-up evaluations. One study showed that nurses had a greater inclination to respond to alcohol- or drug-related problems directly after a training program, but then showed a reduction in their inclination to intervene with the same problems when interviewed 3 months later.²⁶ Kennedy (1997) also reported evidence that short training courses for nurses (i.e. of 3 hours duration) had only negligible effects on participants' knowledge and attitudes during 3- and 6-month follow-up surveys.²⁷

There was mixed compliance among medical and nursing staff in assessing and responding to alcohol-related problems, as suggested by an audit of case notes. It is beyond the scope of this report to specifically identify the factors that contributed to low adherence. Organisational factors (e.g. whether or not assessment of alcohol problems was perceived as a component of unit policy), professional factors (e.g. perceived legitimacy or level of skill to intervene) and resource factors (e.g. job and time demands in the unit) may all have variously contributed. Clearly some staff believed that even the apparently simple assessment tools added to work demands, and there were differences among medical and nursing staff in adherence to assessment and intervention guidelines. Each of these observations has implications for the design of interventions that are employed in a hospital setting.

The rationale underlying the general health promotion of alcohol was based on the facts that FMC has a large workforce and a high number of the community (i.e. patients and visitors) are in the hospital each year. Health promotion messages were transmitted through the in-house patient television, newspaper, display panels, payslip messages and information packages. Although no formal evaluation was conducted regarding the reach of these

strategies, interviews with staff, patients and visitors indicate that the information was widely seen. However, it must be emphasised that the effectiveness of health promotion strategies lie in their propensity to show change in behaviour (e.g. low risk alcohol use within the National Health and Medical Research Council's guidelines). Demonstrating that health promotion information has been widely received suggests little about the influence of this information on drinking behaviour *per se* (not to mention subsequent effects on public health). The challenge of future health promotion entails developing reliable and valid measures of the cognitive, behavioural and health effects of information based on low-risk drinking.

Conclusions

The FMC health promotion alcohol project raised awareness among staff, patients and visitors about alcohol-related issues in the hospital. A number of related programs were established to address these issues, with positive effects flowing across key areas of the hospital. While the evaluations were not ideal, the tentative findings should not deter future work using a primary health care approach for health promotion in a hospital in order to reduce alcohol-related harm.

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Authors

Alex Ask
National Centre for Education and Training on Addiction (NCETA)

Steve Allsop
Next Stop Specialist Drug and Alcohol Services, Western Australia

Charlotte de Crespigny
School of Nursing
Flinders University of South Australia

Joseph de Luca
Drug and Alcohol Services Council,
South Australia

Julie Watkinson
Flinders Medical Centre, South
Australia

Correspondence

Alex Ask
Department of Public Health
Flinders University of South Australia
GPO Box 2100
Adelaide, SA 5042.
Phone: 0411 772 586
Fax: (08) 8204 5693
E-mail: alex.ask@flinders.edu.au

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