Prioritisation of methods for assessing alcohol use in emergency room settings: findings from a qualitative study

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Key Messages:

- This study investigated four groups of stakeholders' views on what is deemed the type of alcohol information useful to inform a validation study of alcohol diagnostics for injury-related trauma.
- Despite the huge burden alcohol places on the healthcare system and its significant role in injury causation and mortality, currently robust alcohol assessment in emergency rooms is lacking.
- Stakeholders acknowledge that quantified blood alcohol levels would not change acute management.
- There is a need to validate the efficacy of selected diagnostic tools in public hospital settings.

ABSTRACT

Limited alcohol-related injury data in hospital settings globally underscores the need for routine monitoring to inform policy formulation for injury prevention, especially in addressing violence and road traffic injuries. COVID-19, and the related alcohol sales bans in South Africa in 2020-2021 brought the impact of alcohol on trauma presenting to health facilities into sharp focus and highlighted the absence of practical, cost-effective and accurate alcohol diagnostic tools in emergency rooms. This qualitative study aims to identify valuable alcohol-related information for stakeholders to inform a validation study of alcohol diagnostics for injury-related trauma. We conducted five virtual Focus Group Discussions (FGDs) with four groups of stakeholders: clinicians (n=9), academics (n=4), hospital and other operational staff (n=6) and policymakers (n=4). FGDs were audio recorded and transcribed verbatim. Coding and thematic analyses were conducted using NVivo version 12. Results highlighted the belief that alcohol places a burden on the healthcare system and plays a significant role in injury causation and mortality. Currently, robust alcohol assessment in emergency rooms is lacking. Despite acknowledging that quantified blood alcohol levels would not change acute clinical management, there was consensus regarding the need-to-know patients' alcohol usage to inform long-term management and broader public health objectives.

Findings support plans to validate the efficacy of selected alcohol diagnostic tools in public hospital settings and to further test their feasibility and utility at a national level.

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INTRODUCTION

The harmful use of alcohol resulted in 2.6 million deaths (4.7% of all deaths) in 2019 worldwide and accounted for 4.6% of all disability-adjusted life years lost (DALYs) (World Health Organization, 2024). Unintentional injuries, digestive diseases, AUDs, and communicable diseases were the leading contributors to the burden of disease and injury caused by alcohol, responsible for 28.5%, 16.7%, 16.6% and 10.2% of all alcohol-attributable DALYs, respectively (World Health Organization, 2024). In South Africa, alcohol consumption has been identified as the fifth leading risk factor for death and disability (Bradshaw et al., 2022). Studies in sub-Saharan Africa emphasize the significant impact of alcohol on injury and violence (Greene, Kane, & Tol, 2017; Liebenberg, du Toit-Prinsloo, Saayman, & Steenkamp, 2020; Meel, 2006; Staton et al., 2018). The need for better screening and intervention tools for alcohol-related injuries is therefore critical for healthcare systems, public health planning, and policy interventions.

Despite the clear link between alcohol and injury, routine monitoring of alcohol-related trauma in emergency settings remains limited in South Africa. Studies linking forensic chemistry laboratory test

results to national mortality surveillance studies have highlighted alcohol as a contributing factor to injury deaths since the early 2000s (R Matzopoulos, 2005; Matzopoulos R et al., 2013; M Prinsloo et al., 2021; Roomaney RA et al., 2023). However, alcohol is not routinely assessed in non-fatally injured patients who present to hospital settings, and thus, the true prevalence of alcohol-related injuries cannot be tracked over time. Reasons for this include the difficulty of assessing blood alcohol concentration (BAC) based on the time lapsed after the incident (Flynn & Wells, 2013; WHO, 2007) and the lack of appropriate alcohol diagnostic tools in the emergency settings to accurately assess patients for their use of alcohol (WHO, 2007).

While past research has demonstrated the feasibility of alcohol screening and brief interventions in emergency settings (Myers, Stein, Mtukushe, & Sorsdahl, 2012; Sorsdahl et al., 2014), studies highlight significant barriers to their successful implementation. Sorsdahl et al. (2014) identified concerns among healthcare providers regarding staff shortages, the need for specialized training, and socio-demographic factors affecting intervention uptake. Similarly, Myers et al. (2012) examined the feasibility of a peer-led screening and brief intervention (SBI) program in Cape Town emergency services, finding that while such interventions were acceptable, they required better integration into existing hospital structures and additional training for peer counselors. These findings underscore the importance of context-specific intervention strategies that align with healthcare system capacities and resource constraints.

The urgency of addressing alcohol-related injuries has been further amplified by the COVID-19 pandemic. Alcohol sales bans during lockdowns in South Africa provided a unique natural experiment, demonstrating a marked decline in alcohol-related trauma cases (Chu et al., 2022; Navsaria et al., 2020). This period highlighted both the significant role of alcohol in driving trauma-related admissions and the gaps in existing healthcare responses to alcohol-related harms. As valuable as *ad hoc* local research studies of alcohol-related trauma have been in the past, routine monitoring of the alcohol-relatedness of trauma is crucial to informing appropriate policy formulation towards the prevention of violence and road

traffic injuries, to reduce the burden of injury nationally. Routine monitoring would also be of value in measuring the impact of alcohol policy interventions in society more broadly.

This qualitative study, therefore, aimed to determine the type of alcohol information deemed useful for different stakeholders (such as policy, operational, clinical and academic stakeholders) as a formative step to undertaking a validation study of alcohol diagnostics for injury-related trauma. Understanding stakeholder needs is deemed crucial in designing effective monitoring systems and policies to mitigate the harmful impacts of alcohol on public health, as it will be difficult and inadvisable to consider implementing measures to monitor alcohol-related trauma without their inputs (Sauerborn, Nitayarumphong, & Gerhardus, 1999; Segarra-Oña, Peiró-Signes, & Verma, 2020). Furthermore, this study sought to unpack key themes, particularly in relation to the burden of alcohol-related injuries, current assessment practices, and the feasibility of policy interventions. Through this, the study aims to provide insight into the structural and operational challenges faced by healthcare facilities in addressing alcohol-related trauma, the attitudes of healthcare professionals toward alcohol screening and interventions, and the broader policy implications for reducing alcohol-related harm in South Africa.

METHODS

Setting and recruitment

This qualitative study is presented in line with COnsolidated criteria for REporting Qualitative research (COREQ) guidance (Tong, Sainsbury, & Craig, 2007). The Applying Research to Policy and Practice for Health (ARCH) stakeholder mapping tool was used to guide the mapping process (Mtika, Wicox, & Feune De Colombi, 2021) to identify stakeholders to participate in Focus Group Discussions (FGDs). We started by making a list of stakeholders in the trauma/injury prevention and alcohol policy fields according to four categories: academic, clinical, operational and policy stakeholders [REF removed for anonymous review – to be added upon acceptance]. Snowballing techniques from the initial core group were used to identify additional stakeholders. Stakeholders were then placed in a power-interest matrix

based on the information outlined in the mapping (Mtika et al., 2021) in order to categorize South African trauma and injury stakeholders according to their role in the professional landscape. This was to understand methods of engagement, and to lay out the proposed engagement strategy for the invited stakeholders throughout the project. Academic experts invited to participate in interviews included researchers from various universities and research institutes and relevant epidemiologists. Clinical experts invited to participate included clinicians, nurses and hospital managers. Operational experts invited to participate included traffic officials, emergency medical services (EMS), forensic pathology services (FPS), South African Police Services (SAPS) and fire and rescue services. Finally, policy experts invited to participate in interviews included individuals from the local government, the Department of Health, the Department of Community Safety and the Department of the Premier's Office.

Procedures

FGDs were conducted virtually via Teams (to accommodate experts in different regions) in English by XXX, who was assisted by XX, who are both female. Participants were purposively selected based on their expertise in clinical care, policy, research, or hospital operations, ensuring a broad representation of viewpoints. Snowball sampling was further used to identify additional key informants, maximizing the inclusion of relevant perspectives. This approach was essential to capturing the multi-sectoral insights necessary for understanding alcohol-related injury surveillance needs. XXX is a senior researcher with extensive qualitative research experience, specifically with the facilitation of FGDs. Prior to the FGDs, participants were asked to provide informed consent. A topic guide was used to facilitate the discussion using open ended questions for example: "What are current practices locally and internationally for measuring alcohol intoxication in injury? How does alcohol impact the day-to-day management of injured patients?" FGDs lasted up to 60 minutes and took place between June and July 2022. Interviews were audio recorded and transcribed verbatim.

Data Analysis

NVivo version 12 software was used to manage the qualitative data. Data were analysed thematically using the Braun and Clarke approach (Braun & Clarke, 2006). We combined a deductive approach to coding based on the research questions with an inductive approach to allow for the identification of emergent themes. XX conducted the initial process of familiarization through a review of transcripts and coding. XX and XX discussed the initial framework and individually coded the first two transcripts. Following this, they discussed refining codes and themes. Coding then continued independently for all transcripts. Any coding disagreements were resolved through discussion and consultation with XXX. The number of FGDs and participants was determined based on qualitative research principles, particularly the concept of thematic saturation. Recurrent themes emerged across discussions, indicating that additional FGDs were unlikely to provide new insights. The diversity of stakeholders strengthened the validity of the findings by capturing a broad range of perspectives on alcohol-related injury surveillance. This ensured a comprehensive understanding of the topic while maintaining analytical rigor. The inclusion of perspectives from different stakeholder groups ensures that the findings are relevant for clinical practice, public health policy, and future research into alcohol diagnostics in emergency settings.

Ethical approval

The study was approved by the South African Medical Research Council's (SAMRC) ethics committee (EC005-2/2022) and further approval from the Western Cape Health Department (WCDoH) (WC_202204_041) to conduct research with healthcare professionals was granted.

RESULTS

Sample characteristics

We conducted five virtual FGDs with twenty-three participants (14 male, nine female) across four groups of stakeholders as described above, including clinical experts (n=9), academic experts (n=4), hospital and other operational experts (n=6) and policy experts (n=4). Clinical experts included forensic pathologists, head of emergency, trauma and other medical departments as well as surgeons. Academic experts were represented by lecturers and professors specializing in public health, trauma and medicine. Operational

experts included managers, chief operating officers, and head of compliance related to alcohol use and overall health. Policy-making experts included directors and other senior figures from alcohol advocacy organisations and alcohol regulatory bodies.

Three major themes were identified: burden of alcohol-related injuries, assessment practices, and actionable intelligence, assessment, policy and practice.

Burden of alcohol-related injuries

Alcohol's role in injury causation and mortality

Among the experts there was unanimous agreement of alcohol's role in injury causation. They highlighted the high level of burden of alcohol-related injuries, particularly for road traffic injuries and crime, gender-based violence and child abuse and how the burden was concentrated during the busiest times of the week; during the weekend and at night and thus had major strain on the nursing and medical staff.

> *"And, how that does affect us is in the utilisation of all the distribution of staff where now you are getting the surge of weekends on top of all the other stuff that you normally have which comes in drips and drabs during the week." [Clinical expert P7]*

> *"It's probably the most avoidable reason to present to acute care facility for emergency care." [Operational expert P4]*

Impact of availability of alcohol on the trauma burden

Experts went on to share how the incidence of alcohol-related injuries had plummeted during the alcohol ban during COVID 19 lockdowns. The lockdowns and related alcohol sales bans, however, had an impact

on the production of homebrews which impacted trauma as well and resulted in a change in the type of trauma cases seen where there was a reduction in road traffic fatalities but an increase in sharp injuries.

> *"The difference was that people didn't drink in bars. You got six people sleeping in a room and they're locked in because of curfew... Who stabbed you? My friend. Do you want the cops involved? No, I will go and stab him when we come back. So the number of alcohol driven stab wounds went up dramatically…." [Clinical expert P4]*

Burden on hospital resources and patient management

Participants described their experience of the management of patients admitted to the hospital with alcohol-related injuries. Specifically, alcohol intoxication was seen to alter patients' physiological responses, complicating clinical assessment and influencing their reactions to medications. This added complexity often necessitated additional tests and interventions, further straining hospital staff and resources.

> *"Because of the alcohol, the difference between a head injury and intoxication is not easy, which means you end up using a lot more resources. They stay in the department for longer." [Academic expert P1]*

They commented that alcohol affects the level of understanding needed for the medical team to obtain the correct information for better management of the patient, such as a good medical history, or being able to assess cognitive functioning (whether related to an injury or due to intoxication). Additionally, the violence and aggression portrayed by intoxicated patients at point of care, results in staff burnout, impacts retention of staff and requires additional staff and hospital resources.

"So I think that's also an aspect…we get the violent side coming out of the patient that's intoxicated, it makes everything more difficult. And then…the clinicians could be left to maybe look in terms of just sedation medication to calm the patient so that they can get on the job." [Policy expert P4]

Experts highlighted significant challenges in referring and following u with patients due to the lack of a standardized care pathway or brief intervention within hospital settings. They emphasized that many patients, once sober, no longer view their alcohol use as a pressing concern, making it difficult to ensure engagement with support services. One participant noted:

"When they are sober, for them, it's not such a big issue anymore and therefore actually following up or acting on that referral is not something that they want to do. So how do you insource it, whether it's the hospital social worker or you actually have SANCA[1] or the AA[2] stationed within this?" [Policy expert P1]

The high rates of relapse among patients with alcohol dependence further complicate long-term follow-up. However, experts acknowledged that even brief interventions, such as a short conversation about alcohol use, could make a meaningful difference in encouraging patients to seek support.

Finally, the impact of alcohol and alcohol-related trauma across multiple hospital services was raised. Beyond straining the emergency department, these cases affect medical, surgical, psychiatric, and trauma care, often requiring input from various specialties throughout a patient's hospital stay. This broad-reaching burden amplifies the strain on hospital resources, as the effects of alcohol are not limited to a single discipline but extend across the entire healthcare system.

[1] South African National Council on Alcoholism and Drug Dependence
[2] Alcoholics Anonymous

Assessment practices

Methods of data collection and challenges related to alcohol assessment and measurement

The experts felt that there were several challenges to testing in the emergency room. Firstly, they shared their concerns about the accuracy of tools used for testing alcohol and for example raising the issue of calibration of testing devices, charging of devices and the accuracy needed for medical versus legal proceedings.

> *"I think it really is around the intent of, you know, for why it's being done. So, if it's done, obviously for medical legal purposes, then it would be, it would need to be validated methodology. But if it's done in terms of the clinical management of the patient, then the approach might be different." [Clinical expert P3]*

There were mixed feelings about the availability of time to conduct alcohol testing. Furthermore, it is extremely difficult to get a breath test from a very drunk, uncooperative, belligerent patient; that it takes extra time out of the busy schedules of doctors and nurses. Even if a test takes only a minute or two, with the number of patients coming in, the additional burden adds up.

> *"You could introduce loads of policy… including simple things like you mustn't write L and R you must write left and right and it takes two seconds to do. But that's one of ten other things that they've got to do that take another two seconds for every single patient they do. And people don't have time, and then they don't do it." [Academic expert P1]*

Finally, experts were also concerned about the ethics of getting consent from a drunk patient. They spoke about being able to distinguish between ethical testing and patient consent being provided under duress

and what that would mean for how policies and legislations are formed, for example around road traffic accidents and sentencing guidelines.

Utility of diagnostic tools

Most clinicians felt that knowing a patient's exact blood alcohol level in the acute phase was unnecessary, as they could typically determine intoxication based on behavior and the smell of alcohol. Additionally, documentation of alcohol levels was seen as impractical, with some noting that the system was not designed to record such information efficiently, making formal documentation uncommon. .

> *the system is just not geared to document and record that in a practical way. And so that's why they don't document it. So why would I document it? You know, I could smell it. [Operational expert 6]*

Experts also reported that blood alcohol results had little influence on immediate patient management, as regular tests and assessments were conducted regardless of suspected intoxication. One expert emphasized that in most emergency cases, this information was not critical to clinical decision-making, describing it as *"a nice to know, inconsequential in your clinical pathway."* However, there was greater interest in identifying patients with long-term alcohol problems, as this information could have important implications for their overall recovery and long-term care planning.

Stakeholders therefore spoke to the usefulness of the data, but more in terms of the societal impact such data would have in terms of being able to provide numbers, and being able to create a benchmark.

> *"So I agree with [Academic expert P3], it's really important to know, but not for any clinical purpose, which is really interesting and we want to know this stuff from I guess we're talking*

about from a health system point of view. They actually have no clinical impact. But it does have some much wider societal and policy impacts of all those sorts of things." [Academic expert P1]

Actionable intelligence, assessment, policy and practice

Feasibility of policies

Experts raised concerns about whether the health system is geared up for implementation of such monitoring as well as the feasibility of policies connecting alcohol with injury. However, they recognized the need for change in policy where testing was concerned. They raised concerns about resource allocation or a lack of resources and the lack of infrastructure in government hospitals as well as the ability to use technology correctly should the technology be available. One stakeholder suggested that instead of rolling out testing across all hospitals, to have sentinel sites. However, some indicated doubt that even with the data, the evidence does not create action.

"Well, I think the idea of, you know, sentinel sites at different levels might be useful, but it is kind of a costly business to organize. And, you know, I think he's absolutely right. We know what the problem is. There's enough evidence out there. It's not good… We're not doing the right thing, and I'm not sure evidence will create political will or whatever you call it. So that's a different problem." [Academic expert P3]

Sustainability of alcohol testing

Participants raised further concerns about the sustainability of alcohol testing in an emergency setting with specific mention of cost implications and the issue of varying resources. The consideration of the cost burden associated with the purchase and maintenance of the diagnostic tools, as well as the cost of the analysis was brought to attention. What was shared was the concern of the cost related to testing every trauma patient versus conducting prior screening, to provide eligibility for testing to possibly reduce the burden of cost onto the public hospitals.

"But I just wanted to comment on the issue of resources... that we're not just talking about the actual instrument we're talking about the administration of it and the complexity of that and the resources you require to administer those tests in terms of persons." [Policy expert P3]

"There's a marginal cost to that and there's an opportunity cost to that and those are the kinds of things we must weigh up." [Operational expert P3]

By determining the value added of the testing, taking into consideration the time taken to obtain results was also seen as a negative component to point of care testing. One of the stakeholders from the Clinician stakeholder group thought that providing an external group of service providers to conduct testing in facilities would be a more feasible option; however, a comment from another stakeholder about costing suggested the need for funds to rather be placed in other areas. It was noted by a few stakeholders the importance of identifying resources in facilities and being reminded throughout the focus group discussions about resources being limited across public health facilities.

Emerging themes

Safety of healthcare providers

Stakeholders felt that healthcare workers would be at risk of danger by conducting alcohol testing. Patients may feel as though they are being victimised or marginalised because of being tested for alcohol or may be fearful of possible legal implications and may act out as a result. This was raised as a particular concern for healthcare providers working in more rural and smaller outlying areas.

"when people know you're taking tests for alcohol, it can make the situation a little bit tricky… sometimes people can feel very unsafe…in big major trauma centres where you have lots of people there and probably security, it's not such an issue…. But when you're in some other

environments… difficult working environments for the healthcare providers, and especially I'm thinking of nurses… they go back into the community." [Clinical expert P1]

Impact of other drugs in addition to alcohol

Some stakeholders noted that recreational drugs contribute to trauma cases just as much as alcohol, placing a significant strain on healthcare facilities. They also highlighted that alcohol use is often accompanied by drug use, further complicating patient management and resource allocation, particularly in certain geographic areas where both substances are prevalent

Stigma

Finally, stakeholders highlighted the issue of stigma, particularly in cases where victims of violence are treated in the trauma unit while the perpetrator's alcohol use goes undocumented. This was especially concerning in cases of gender-based violence and violence against children, where key information about alcohol use is often missing. For instance, if a victim had been drinking, that detail might be recorded, but there would be no equivalent record of whether the perpetrator was intoxicated. The discussion also underscored the sensitivity required when considering alcohol testing in victims of gender-based violence, as it risks further stigmatization and could hinder efforts to fully understand the role of alcohol in these incidents.

"Maybe it's something to think about because we are missing a big portion of the burden of disease." [Academic expert P3]

DISCUSSION

Findings highlight the multifaceted impact of alcohol-related injuries on healthcare systems, patient management, assessment practices, and policy considerations. Alcohol increases the burden of injury in

trauma facilities, by patients who present with intentional and unintentional injuries, both as victims and/or perpetrators. Experts unanimously agree on alcohol's significant role in causing injuries, particularly in road traffic crashes, crime, gender-based violence (GBV), and child abuse. Like studies conducted elsewhere (Cholerzyńska, Zasada, Kłosiewicz, Konieczka, & Mazur, 2023; Parkinson et al., 2016; Verelst, Moonen, Desruelles, & Gillet, 2012; Young et al., 2004), the burden is higher during weekends and nights. Alcohol-related injuries impose a substantial burden on healthcare systems worldwide, particularly evident in the strain placed on medical staff and resources. The concentration of these injuries during weekends and nights exacerbates the challenges faced by emergency departments (Parkinson et al., 2016), leading to increased workload and potential burnout among healthcare providers. The need for adequate staffing and resources to handle the surge in alcohol-related cases during peak times was discussed, highlighting the importance of strategic resource allocation and workforce management.

Availability of alcohol brings the impact of alcohol on injury and trauma into sharp focus. It has been suggested that the COVID-19 crisis for instance provided an opportunity to address dysfunctional societal relationships with alcohol and implement evidence-based policies to reduce the burden on healthcare services (Stockwell et al., 2021). In South Africa, significantly fewer trauma cases presented to emergency centres during the COVID-19 alcohol ban compared to periods where alcohol sales were only restricted or where partial bans were in place (Chu et al., 2022; Navsaria et al., 2020; van Hoving, van Koningsbruggen, de Man, & Hendrikse, 2021) drawing attention to the harms of alcohol consumption and the potential for policy reform related to availability (Bartlett, Lesch, Golder, & McCambridge, 2023; Richard Matzopoulos, Walls, Cook, & London, 2020). In the current study, experts discussed the observed changes in injury patterns during the alcohol bans, such as a decrease in road traffic fatalities but an increase in sharp injuries and alcohol-driven violence. This underscores the complex interplay between alcohol availability, behaviours, and injury outcomes. Understanding these dynamics is crucial for implementing alcohol control measures (Kilian et al., 2023; Stockwell et al., 2021). Moreover, the shift

towards homebrews during bans (Theron et al., 2023) as indicated in the current study, highlights the need for targeted interventions to address emerging trends in alcohol consumption and related harms. This further points to the fact that alcohol prohibition as a mechanism to reduce consumption may dwindle over time and is therefore not necessarily a solution. An effective policy to reduce alcohol harm requires a range of measures (WHO, 2019) that reduce not only supply but also demand for drinking and treatment of drinkers. Similar to studies which have drawn attention to the importance of targeted policies for specific causes of injury (Cherpitel, Witbrodt, Ye, & Korcha, 2018), understanding the intent and type of injuries, when alcohol-related injuries are most likely to be seen, where injuries are taking place and where interventions should be focused were highlighted.

Findings demonstrate the significant challenges faced by healthcare professionals in managing patients who are intoxicated, particularly in terms of clinical assessments and the overall management of their care. Experts spoke about the lack of sufficient support and referral systems in the hospital setting, which further exacerbates these challenges. Alcohol consumption places a huge burden on clinical assessments of patients and overall management of intoxicated patients (Sarkar, Bhatia, & Dhawan, 2023) with limited support and referral in hospital settings. Alcohol consumption places a burden on resources such as additional testing which overburdens staff resources and impacts other hospital services (beyond emergency medicine). Intoxicated patients may display violence and aggression, leading to staff burnout and additional resource needs. Further challenges with assessment practices include the accuracy of alcohol testing tools, time constraints, and obtaining consent from intoxicated patients, particularly in light of the evidence that intoxicated emergency department patients mostly do not possess the capacity to provide informed consent to research (Martel et al., 2017).

Our findings indicate that clinicians rely more on behavioural cues than specific alcohol test results. They stated that knowing the exact BAC at presentation would not change clinical management and CT scans would still be given. However, it has been argued that accurate and objective measurement of both acute

and medium-term (up to four weeks using a biomarker such as phosphatidylethanol (PEth) test) alcohol consumption in emergency department presentations is essential for informing targeted public health prevention and control strategies (Cameron et al., 2023). By implementing these measures, healthcare systems can better manage the immediate and long-term effects of alcohol use, ultimately reducing the burden on emergency departments and improving overall public health outcomes with stronger upstream policies. The current study also demonstrated that there is a greater interest in knowing alcohol status from a follow-up and long-term management point of view (other than as part of routine assessment).

Policy responses to alcohol-related injuries face numerous challenges, ranging from resource constraints to ethical dilemmas and political will. While there is a recognition of the need for policy changes to improve alcohol testing and intervention strategies, the feasibility of implementation remains a concern. Experts pointed out the importance of considering cost implications, infrastructure requirements, and the potential impact on healthcare providers' safety and well-being. Moreover, similar to studies that have highlighted stigma as a potential barrier to alcohol testing at the point of care for trauma patients (Gargaritano, Murphy, Auyeung, & Doyle, 2020; Lau et al., 2023) addressing stigma associated with alcohol-related injuries, particularly in cases of violence and victimization, requires sensitive and inclusive approaches that prioritize patient dignity and support.

Findings from this study should be considered in light of its limitations. The expert stakeholders interviewed were identified from known contacts within the field. However, by using the ARCH stakeholder mapping tool to identify stakeholders, we believe we were able to include appropriate individuals who will continue to engage in a manner that can contribute to successful research uptake. Secondly, there may have been social desirability bias particularly from experts invested in seeing the implementation and use of diagnostic tools in public hospital settings.

CONCLUSION

Despite these limitations, it was evident that there was consensus about the need for some type of understanding of alcohol use, which would be useful from a broader public health approach to the issue. Overall, findings highlight the complex challenges associated with alcohol-related injuries, from patient management to policy implementation, and emphasize the need for comprehensive approaches to address these issues effectively and support plans to validate the efficacy of selected alcohol diagnostic tools in public hospital settings (M. Prinsloo et al., 2023) and to further test their feasibility and utility at a national level.

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