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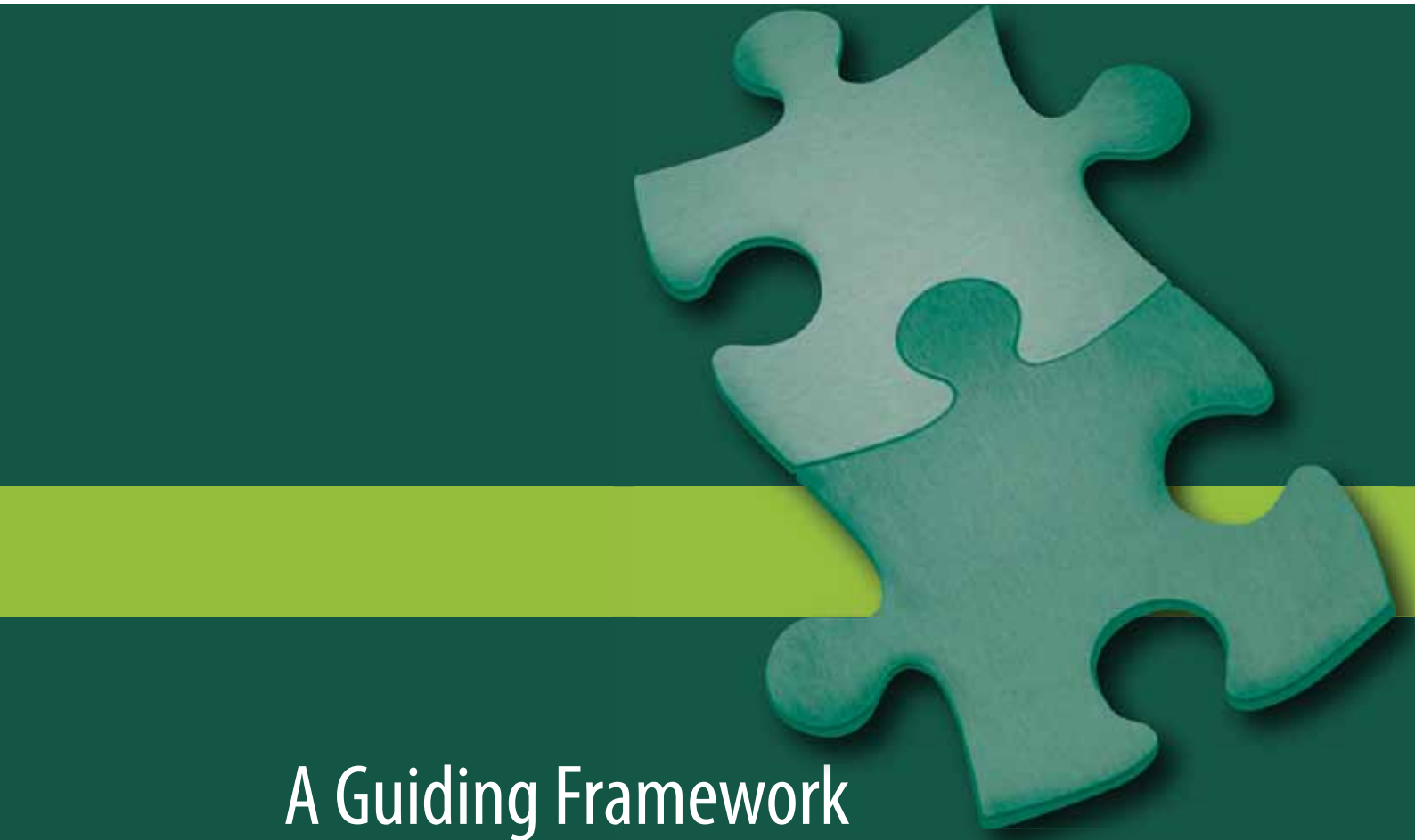
Health Service Executive



A Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use

For Nurses and Midwives in Acute, Primary and Community Care Settings

Office of the
Nursing & Midwifery
Services Director

Foreword

This guiding framework supports the development and evaluation of education and training in screening and brief intervention utilising a step by step skills based approach. The framework was developed in partnership with the Office of the Nursing and Midwifery Services Director (ONMSD), Nursing and Midwifery Planning and Development Unit (NMPDU), Centres of Nursing and Midwifery Education, Substance Misuse Services, Acute Hospitals, Health Promotion Service, Social Inclusion Service, Integrated Services Directorate, healthcare professionals and educators with expertise in Screening and Brief Intervention. We are grateful to the health service organisations whose education, practice development and clinical staff, involved in screening and brief intervention, gave of their time, expertise and educational material, which in turn facilitated the development of this framework.

A major challenge for the Health Service Executive and its staff is to respond effectively to common chronic conditions or risk behaviours in whichever settings they can be identified. Problem alcohol use has emerged as a considerable burden on individual health and the social fabric in Ireland. Health services have been identified as appropriate settings in which to detect and offer an intervention in relation to problem alcohol use. In order for this to happen, staff training is essential. This guiding framework provides a template for such training and we commend those who have prepared it. With it, the prospects for comprehensively addressing problem alcohol use in Ireland are enhanced.

Screening and brief Intervention carried out by nurses and midwives will support the health service in providing an accessible, effective, timely and efficient service to those experiencing alcohol related problems. This will in turn enhance the patient/service user journey within the health service leading to increased awareness of the consequences of excessive alcohol use and enhanced engagement with appropriate services when required.

It is with great pleasure that we introduce this *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use.* We believe that this will make a significant input to delivery of services to people experiencing alcohol related problems, leading to more comprehensive integrated services and contributing to improved outcomes.

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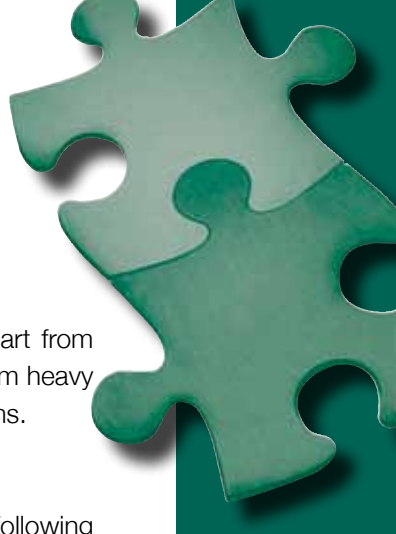

Glossary of Terms

Alcohol

Alcohol is a sedative/hypnotic drug which depresses the central nervous system. Apart from social effects of use, alcohol intoxication may result in poisoning or even death; long-term heavy use may result in dependence or in a wide variety of physical and psychological problems.

Alcohol Dependence

Alcohol dependence can be said to exist in a person experiencing three or more of the following in a same twelve-month period:

- Strong desire or sense of compulsion to take the substance;
- Impaired capacity to control substance-taking behaviour in terms of onset, termination, or levels of use;
- Physiological withdrawal state when substance use is reduced or stopped, or use of the substance to relieve or avoid withdrawal symptoms;
- Evidence of tolerance to the effects of the substance;
- Other pleasures or interests being given up or reduced because of the substance use;
- Persistent substance use despite clear evidence of harmful consequences (WHO, 2007).

Alcohol-Related Harm

Alcohol-related harm indicates any of the range of adverse effects of drinking alcohol experienced by the drinker or by other people. This definition is used interchangeably with alcohol related problem, alcohol problem, drinking problem (Hvalkof and Anderson, 1995).

'Binge Drinking'

The term 'binge drinking' has been used to describe a lot of drinking on one occasion and historically this has been described as consuming seven or more standard drinks per drinking occasion for men and five or more standard drinks per drinking occasion for women. However, the term 'binge drinking' and others are being appraised within Ireland and internationally.

'Harmful Drinking'

'Harmful drinking' is defined as a pattern of alcohol use which is already causing damage to health. It arises following a long period of hazardous use. The damage may be physical (e.g. hepatitis-inflammation of the liver) or mental (e.g. depressed mood secondary to alcohol intake). Harmful use commonly has social consequences (HRB, 2010).

'High Risk' or 'Hazardous Drinking'

'High Risk' or 'Hazardous Drinking' is defined as a pattern of alcohol use that increases the risk of harmful consequences for the drinker. Such consequences include impact on mental and physical health functioning, relationships, behaviour and self esteem. The term describes drinking over the recommended limits by a person with no apparent alcohol-related health problems (HRB, 2010).

Identification and Brief Advice

Commonly refers to the delivery of "simple brief advice" following identification of "at risk drinking".

'Low Risk' or Moderate Drinking

'Low risk' or moderate drinking is described as drinking that does not cause harm to the drinker

or society. Drinking in moderation means not exceeding the recommended weekly limits and spreading the quantity out through the week with two-three alcohol free days. Consumption should not exceed fourteen standard drinks for females and twenty-one standard drinks for males per week.

Screening and Brief Interventions

Screening for alcohol use identifies whether patients' drinking places them and others at risk and hence warrants an appropriate intervention.

Standard drink

A standard drink in Ireland is ten grams of pure alcohol.

Abbreviations

CNME	Centre of Nursing and Midwifery Education
CPD	Continuing Professional Development
ED	Emergency Department
HSE	Health Service Executive
IBA	Identification and Brief Advice
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Director
SBI	Screening and Brief Interventions
TCD	Trinity College Dublin

SECTION 1
THE FRAMEWORK

Introduction

As part of the Programme for Government 2007-2012, the Government agreed to "provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking". The purpose of early intervention programmes is to detect high risk and harmful drinking in individuals, before or shortly after the early signs of alcohol related problems. This action led to the decision by the Health Service Executive (HSE) former Population Health Directorate to designate "Towards a Framework for Implementing Evidence Based Alcohol Interventions" as one of its transformation projects. The implementation of this project is supported by a Project Manager from the Health Promotion Service Dublin Mid-Leinster. The aim of this project is to help establish routine screening, data collection and appropriate interventions emanating from the acute hospital sector. The initial focus is on screening and brief intervention (SBI) in emergency departments for harmful and hazardous alcohol use. Screening occurs on a daily basis in health care settings. It is a process by which members of a defined population, who do not necessarily perceive they are at risk of disease, are screened to identify those likely to benefit from appropriate intervention. An alcohol brief intervention is described as a short, evidence based, structured conversation about alcohol consumption with a service user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm (Scottish Government, 2007).

Rationale for the Framework

National Policy

Irish policy and strategy documents have recommended the use of screening and brief intervention among other interventions as a response to alcohol and substance misuse.

Policy/Strategy Document	Recommendations
The second report of the Strategic Task Force on Alcohol (Government of Ireland, 2004)	Advocates the use of brief interventions across a range of health care settings including primary care, community services and general hospitals.
Programme for Government 2011-2016	The Government supports the principles and objectives of the National Drugs Strategy. The first step in implementing a successful strategy will be to outline key priorities for short-term implementation, underpinned by a realistic timeframe and targets.
Expert Group on the Formulation of Mental Health Policy (Government of Ireland 2006, a: Government of Ireland 2006, b)	Recommended that Continuing Professional Development (CPD) should be directed towards improving services as a primary goal and should have the welfare of service users as the ultimate objective. Mental health policy and legislation provides for all clients having access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans.
Interim National Drugs Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009)	Notes that the general hospital setting (emergency departments in particular) is a key area to deliver interventions designed to address both psychological and social harms associated with problem substance use. The steering group mention that training of trainers within the general hospital setting, particularly nurses and allied health professionals, is necessary in order to provide adequate SBI for all substances of abuse including nicotine, alcohol and drugs.

International Policy

Policy/Strategy Document	Recommendations
The EU Strategy on Alcohol (2007)	Expressly states the aim to increase EU citizen's awareness of the impact of harmful and hazardous alcohol consumption on health, especially the impact of alcohol on the foetus, on under-age drinkers, on working and on driving performance.
The WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010)	Calls on governments of the WHO 194 member states to take active policy measures to combat alcohol-related harm. These measures include supporting initiatives for SBI for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of child-bearing age.

Alcohol Related Harm

Alcohol is ranked as the eighth leading cause of death globally and is a causal factor in more than 60 major types of diseases and injuries and results in approximately 2.5 million deaths a year (WHO, 2011). The burden of alcohol related harm is widespread in Ireland and includes harm experienced by the drinker but also harm experienced by people other than the drinker (harm to others). The harm from alcohol is linked to a range of health and social problems and the burden of harm to the drinker can be seen in hospitals, on the streets, on the roads and in families. Among the alcohol related harms are high risk drinking linked to suicide, sexually transmitted infections, alcohol related cancers, cardiovascular disorders and chronic illnesses and diseases (Hope, 2008).

- Alcohol related harm is evident in persons presenting with injuries to emergency departments, among service users in hospital, in treatment services and in alcohol related mortality. Drunkenness and public disorder, alcohol related road accidents and self reported negative consequences experienced by drinkers are all indicators of alcohol related harm. Since 1995 alcohol-related morbidity and mortality have increased in line with increased consumption and harmful drinking patterns (Mongan et al, 2007).
- There is clear and conclusive evidence both nationally and internationally that the problems from increased alcohol consumption levels are reflected in both admissions to general hospitals (Royal College of Physicians, 2001; Hearne et al, 2002; Molyneux et al, 2006 and Hope, 2008) and attendances at emergency departments (Charalambous, 2002; Hope et al, 2005 and Hope, 2008). Hope et al (2005) proposed that between 20% and 50% of all presentations to emergency departments in Ireland are alcohol related, with the figure rising to over 80% at peak weekend periods.
- An Irish study involving 2,500 patients in six major acute hospitals, found that over one in four (28%) of all injury attendances in the emergency departments were alcohol related. The patient profile showed that three-quarters of those in attendance with alcohol related injuries were male and almost half were in the 18-29 age group (Hope et al, 2005).
- The best estimate of the cost to the healthcare system of alcohol related illnesses in Ireland in 2007 were €1,200 million. (Byrne, 2010).
- An estimated 10% of Irish hospital bed-days are due to the harmful effects of alcohol over the time period 2000-2004 (Martin et al, 2011).
- Irish hospital bed-days attributed to alcohol comprise 13% and 7% of all bed-days in men and women respectively. In men, the proportion of total hospital bed-days that are attributable

to alcohol increased from 7% in 15-19 year olds to a peak of 18% in 50-54 year olds and decreased to 10% by 80 years of age. In women, the proportion of total hospital bed-days that are attributable to alcohol is 5% or less in those under 40 years, and between 8% and 10% in those over 40 years (Martin et al, 2011).

- Over the period 2000-2004, the cost of Irish hospital bed-days attributable to the negative effects of alcohol was €953,126,381. The costs of bed-days due to alcohol were nearly twice as high in men as women (€618,927,425 in men compared with €334,198,956 in women). This represented 15% of total hospital costs for that time period (Martin et al, 2011).
- Over the period 1999-2005, the Coombe Women's Hospital study reported that 63% of women reported alcohol use during pregnancy. Over two thirds of all pregnant women under 18 year olds reported drinking alcohol during pregnancy. The highest percentage category reporting drinking over 10 units per week was the 18-24 year olds. 7.1% of all pregnant women admitted drinking more than six units of alcohol per week. 58% of pregnant women were aware of the potential harmful effects of alcohol in pregnancy and 11% had been advised about the hazards of alcohol by a doctor (Barry et al, 2006).

It is clear that dealing with this significant issue makes good sense from both health and economic perspectives. In this context, it is notable that hospital attendances may provide "teachable moments" (Watson, 1999) offering opportunities to provide SBI for hazardous and harmful alcohol use which may help motivate patients to change their drinking behaviours (D'onofrio et al, 2002).

Value of Education / Training

The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with hazardous and harmful alcohol use (Allen, 1998; D'onofrio et al, 2002; Herring & Thom, 1999; Anderson et al, 2001 and Goodall et al, 2008). These brief psychological interventions aim to investigate a potential problem and motivate individuals to do something about their substance abuse, either by natural, client directed means (self-change) or by seeking additional substance misuse treatment (Health Research Board, 2006). There are a number of easily administered screening tools (Hearne et al, 2002) and brief intervention models (Miller and Sanchez, 1993) available to facilitate the delivery of SBI. There is an increasing need for continuing education to develop and renew knowledge and skills amongst health professionals in brief intervention (Martinez and Murphy-Parker, 2003). A study by Kelleher et al (2009) identified an urgent need for further in-service training programmes and the development of standard guidelines for the identification and management of substance using patients who present in the ED.

D'onofrio et al (2002) have highlighted the value of education and continuing professional development inputs for health care staff in this context, suggesting that they contribute to the development of knowledge and clinical practice. Conversely the lack of knowledge and skills of frontline healthcare staff in dealing with people who present with alcohol-related problems reflects negatively on their confidence and willingness to provide appropriate care for this client group (Rayner et al, 2005 and Indig et al, 2008). Role adequacy (feeling knowledgeable about one's work) and role legitimacy (believing that one has the right to address certain client issues) have long been key theoretical constructs regarding explanations why various helping professionals are reluctant to address alcohol/drug misuse problems with clients. In order to be effective, practitioners need:

1. *Role adequacy* - accurate knowledge and skills;
2. *Role legitimacy* - belief that this is a valid intervention and that the professional is ideally placed to deliver the intervention;
3. *Role support* - comfortable and acceptable ways to raise the issue as well as access and follow up support for patients. Practitioners need support to learn these skills through training (Anderson et al, 1987 & 2004).

There are a number of studies that support the effectiveness of Screening and Brief Intervention, the most important of which are outlined in Table 1.

Table 1: The Evidence for Screening and Brief Intervention

Brief intervention is amongst the most effective of psychosocial treatments across a range of health related behaviours.	Hester and Miller (2003) Miller and Rollnick (2002)
The utility of brief intervention has been demonstrated with a range of mental health problems including: depression, deliberate self harm, anxiety disorder, alcohol and substance misuse disorders.	Lang (2003); Wilhelm et al. (2007); Roy-Byrne et al. (2009) and Hester and Miller (2003).
A substantial body of literature exists which supports the use of brief intervention across a range of health care settings, including emergency departments, primary care and mental health.	Roy-Byrne et al. (2009); Irish College of General Practitioners (2007); Wilhelm et al. (2007); Sommers et al. (2006); Crawford et al, (2004); Lang (2003); Scottish Intercollegiate Guidelines Network (2003); Babor and Higgins-Biddle (2001).
It is calculated that one in every eight patients who receives a brief intervention for alcohol use is likely to benefit in terms of reduced health risks, compared with one in every twenty people who receive brief advice to stop smoking.	The Scottish Intercollegiate Guidelines Network (2003)
Risky drinkers who receive brief advice are twice as likely to moderate their drinking six-twelve months after an intervention when compared to drinkers receiving no intervention	Wilk et al (1997)
Several reviews of the literature have placed SBI at the pinnacle of efficacious treatments for hazardous and harmful alcohol use.	Bien et al (1993). Project M.A.T.C.H. (1997). Wilk et al, (1997). Miller & Wilbourne, (2002).
Fifty-six controlled trials have shown the value of SBI.	Moyer et al (2002)

A Cochrane Collaboration review of the effectiveness of brief interventions for hazardous and harmful alcohol use found a positive impact on alcohol consumption, mortality, morbidity, alcohol related injuries, alcohol related social consequences, use of health care resources and laboratory indicators of harmful alcohol use.	Kaner E., Beyer, F., Dickinson, H., Pienaar, E., Campbell, F., Schlesinger, C., Heather, N., Saunders, J. and Bernand B. (2007)
The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with hazardous and harmful alcohol use.	Allen (1998). D'onofrio et al (2002). Herring & Thom (1999). Anderson et al (2001) Goodall et al (2008)
A trial conducted in the United Kingdom primary care practices reported that providing brief interventions for alcohol misuse resulted in cost savings of five times the expenditure on health, social and criminal justice services.	The UK Alcohol Treatment Trial (2005b)
An American study examined direct injury medical costs and savings associated with routine provision of SBI to patients presenting at trauma centres. An estimated 27% of all injured adult patients were candidates for a brief alcohol intervention. The net cost savings of the intervention was $89 per patient screened, or $330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of $3.81 for every $1.00 spent on SBI.	Gentilello et al (2005).
Although studies on the use of SBI in the ED are in their infancy, they have a demonstrated efficacy not only to reduce alcohol consumption but also to impact positively on the psychosocial consequences of high risk drinking.	Smith et al (2003) Bazargan-Hejazi et al (2005) Walton et al (2008) Crawford et al, (2004)
There is extensive and consistent evidence that brief advice in health care settings reduces alcohol-related harm. There is consistent evidence that organisational factors can increase the implementation of brief advice programmes and that brief interventions are cost-effective.	WHO, 2009
Five systematic reviews with meta-analysis specifically focused on the effectiveness of brief interventions in primary health care concluded that brief interventions delivered in primary care settings are effective in reducing alcohol consumption and health related consequences of excessive alcohol use.	Kahan et al (1995) Poikolainen, (1999) Ballesteros et al. (2004) Whitlock et al. (2004) Bertholet et al. (2005)
A study of brief intervention for alcohol use in pregnant women found that women who received a brief intervention were five times more likely to report abstinence after intervention compared with women in the assessment-only group.	O'Connor and Whaley (2007)

Please see Appendix I for specific evidence supporting Screening and Brief Intervention in the emergency department, acute hospital, primary care and antenatal healthcare settings.

Scope of the Framework

The framework applies to:

- Nurses and Midwives employed in both the adult and children's setting in the HSE who wish to undertake screening and brief intervention skills;
- Allied Health and Social Care Professionals who offer screening and brief intervention to service users presenting with problem alcohol use to all healthcare settings;
- Integrated Services Directorate/Primary Care Teams.

Core Principles

The core principles guiding the Screening and Brief Intervention Framework are defined as follows:

- **Patient centeredness**: that SBI is organised, located and accessed in ways that take greater account of the needs and preferences of service users. It encourages shared decision-making where service users are facilitated to have greater responsibility for their own health through the provision of non judgemental advice and information.
- **Maximising benefit to service users**: effectiveness and efficiency in the delivery of SBI based on good governance and leadership, data management and evidence-based practice.
- **Quality**: evidence-based standards are developed collaboratively by the interdisciplinary team, the standards are audited and that continuous improvement is valued.
- **Safety**: service user protection is paramount and of the highest priority and is achieved through the identification and management of potential risks.
- **Inter-disciplinary collaboration**: co-operation and communication between nurses and other members of the multidisciplinary team. Approaching service development with collective wisdom, attained through consultation and collaboration, achieves more refined and complete outcomes of care for service users.
- **Consistency**: a coherent and collective approach within each health care setting to the introduction of SBI underpinned by the implementation framework. It is anticipated that this will be achieved through the building of partnerships and networks across and within the whole health service to support integrated and cohesive care pathways.
- **Sustainability**: the introduction of SBI is planned in a way that the service will continue to grow and be imbedded in the health system over a period of time, especially after the specific implementation project ends.

Aim of the Screening and Brief Intervention Framework

The aim of this framework is to provide a standardised approach for the education and training of nurses, midwives and allied health and social care professionals who undertake screening and brief intervention. The framework supports safe, quality and effective care for service users, who access healthcare across the HSE and promotes the effective management of problem alcohol use in acute, primary and community care settings.

Purpose

To promote excellence though evidence based practice amongst nurses, midwives and allied health and social care professionals who offer screening and brief intervention to service users presenting with problem alcohol use to acute, primary and community care settings.

Framework for Implementation

Planning the delivery and implementation of the Screening and Brief Intervention Education Programme will be structured as follows:

Step1: Collaborative Working

Developing a collaborative working arrangement between the Centre of Nursing and Midwifery Education (CNME), the Acute Hospital and the local Substance Misuse Service. This may take the form of a working group where the key stakeholders can plan the implementation of the education programme and integration of the learning into practice in a structured and systematic manner. These working groups and their function will inevitably vary in their structure and function depending on existing local collaborations and working arrangements.

Step 2: Programme Delivery

The programme will be coordinated by the Centre of Nursing and Midwifery Education with expert input from the local Substance Misuse and Health Promotion Service as required. The alcohol/substance misuse liaison nurse or counsellor for the acute hospital is well placed to offer this expert input. In the absence of such a role within the hospital, another clinician from the substance misuse team may be utilised.

Step 3: Integration of Learning

The Centre of Nursing and Midwifery Education supported by the local Substance Misuse Service will offer updates for staff who have completed the programme based on locally identified learning needs. The local Substance Misuse Service will offer advice and support to staff who are delivering SBI within the acute hospital in order to maximise learning transfer and skills development.

Step 4: Evaluation and Audit

Each healthcare provider introducing this initiative will make a commitment to implement monitor, audit and evaluate the education programme. Each course will be evaluated via end of course evaluation including feedback from participants and course tutors.

Project Governance

This project was initiated under the former HSE Population Health Directorate and forms part of the HSE Transformation Programme 4.8 '*Towards a Framework for Implementing Evidence Based Alcohol Interventions'*. Governance structures will include:

Education Programme

- Responsibility for delivery of the Education Programme will rest with Centres of Nursing and Midwifery Education. The primary target audience will be nurses and midwives; however the programme can be made available to other health professionals at the discretion of the Director of each participating CNME.
- Centres of Nursing and Midwifery Education participating in the programme will report activity on the education programme as part of the annual report to their Board of Management and provide attendance figures to the ONMSD as required.
- Centres of Nursing and Midwifery Education will carry out course evaluations in line with their normal course evaluation processes (see Appendix V for sample course evaluation form)
- Centres of Nursing and Midwifery Education will establish a collaborative working group at

local level to support course delivery. This group will be comprised of an educator from the CNME, a representative from the local substance misuse team and representatives from the service areas targeted by the education programme

Implementation of Screening and Brief Intervention in Health Care Settings

- Oversight of the implementation of screening and brief intervention in health care settings will rest with the screening working group of the HSE National Transformation Programme "*Towards a Framework for Implementing Evidence Based Alcohol Interventions*". This group, in addition to its existing membership, will have a nominated representative from the Directors of Centre of Nursing and Midwifery Education Group.
- This group will agree implementation strategies in line with the forthcoming National Substance Misuse Strategy.

SECTION 2
EDUCATION PROGRAMME

Introduction

This education programme introduces a structured model of SBI for problem alcohol use. The programme presents the SAOR (**S**upport, **A**sk and **A**ssess, **O**ffer assistance and **R**efer) model for screening and brief intervention for alcohol in the emergency department & acute care settings (O'Shea and Goff, 2009). The model has emerged from and is consistent with contemporary international models of evidence based practice for dealing with problem alcohol use. It offers a training model which provides a foundation of knowledge, skills and understanding designed to enhance participants existing professional repertoire.

SAOR Model for Screening and Brief Intervention for Alcohol in the Emergency Department and Acute Care Settings.

The SAOR model incorporates all the key components of SBI including the common elements of screening, assessment, intervention and referral. In addition, it emphasises three critical components of:

- accentuating the relationship building aspect of SBI;
- sequencing the intervention in a logical and user friendly manner and
- providing a flexible step by step guide for healthcare practitioners.

Accentuating the Relationship Building Aspect of SBI

SAOR accentuates the support and relationship building aspect of SBI by focusing on the development of a robust therapeutic alliance. Lock (2004) concluded that the development of a therapeutic relationship is critical in obtaining a positive outcome from SBI. The development of this relationship in the SAOR model is achieved utilising a person-centred approach. The support aspect of the intervention is achieved by ensuring openness, empathy and supporting self-efficacy, all of which are pivotal in the delivery of a meaningful SBI. The importance of support and relationship building has its foundations in the work of Rogers' (1961) who championed empathy, realness and unconditional positive regard in the therapeutic relationship. This work has been advanced by the development of Motivational Interviewing techniques by psychologists William Miller and Stephen Rollnick (Miller and Rollnick, 1991, Miller and Rollnick, 2002). Providing support and fostering a good working relationship can elicit true information, help to determine the service users willingness to change and construct a realistic and achievable change strategy.

Sequencing the Intervention in a Logical and User Friendly Manner

The SAOR model sequences the intervention in a logical and user friendly manner which is congruent with busy acute hospital settings. This is achieved by facilitating the development of a supportive alliance with the service user, asking the appropriate questions, delivering a credible brief intervention and making appropriate referrals.

Providing a Flexible Step by Step Guide for Practitioners in Acute Hospital Settings

The SAOR acronym offers a four step model for the delivery of SBI which guides practitioners through brief intervention in a flexible and adaptable manner. The intervention is designed to be delivered as part of a brief therapeutic conversation between the practitioner and service user which can be integrated with other medical and nursing interventions rather than creating an extra and excessive work load. The model also offers a framework for more in depth intervention depending on the time available and skills level of the practitioner. Thus, the intervention can be delivered in time frames ranging from five minutes up to one hour.

The Model

The key components of the SAOR model are outlined below.

Support

The support aspect of the intervention is guided by the work of Rogers (1961), Miller and Rollnick (1991, 2002) and Lock (2004) which places a strong emphasis on the therapeutic alliance. This aspect of the intervention sets the scene by developing a positive therapeutic relationship with the service user. This is achieved by emphasising and accentuating the support aspect of the encounter. Key components of this process include:

- ensuring an open and friendly style of communication;
- communicating a non-judgemental acceptance and understanding of the service users' circumstances through the use of accurate empathy;
- supporting the service users' self efficacy or belief in his/her ability to change current drinking behaviours.

Ask and Assess

All major contemporary models of care for hazardous and harmful alcohol use in frontline healthcare settings emphasise the need for appropriate screening and assessment (Babor & Higgins – Biddle, 2001; SIGN, 2003; NIAAA, 2005; Anderson, 2006). The next key element of the SAOR is congruent with these models focusing on objective assessment of the extent of the service users' alcohol use and related problems and exploring commitment to change. The principal elements of this assessment phase include:

- asking about the service users alcohol use;
- eliciting the service users concerns about drinking;
- establishing the service users expectations of the consultation;
- carrying out a screening assessment utilising an evidence based screening tool;
- assessing for evidence of withdrawal symptoms;
- exploring the service users broader psychosocial and health status;
- gauging readiness to change current drinking behaviours.

Offer Assistance

The third phase synthesises the principal aspects of contemporary models of care (Bien, Miller & Tonigan, 1993; Miller & Sanchez, 1993; Babor & Higgins – Biddle, 2001; SIGN, 2003; Resnick, 2003; NIAAA, 2005; Anderson, 2006) locating them within a user friendly framework which offers non threatening, non judgemental concrete assistance to the service user. This includes the key elements of:

- advising the service user about his/her drinking;
- clearly assigning responsibility for change to the service user;
- outlining a menu of options for change;
- agreeing collaborative goals for changing drinking behaviour.

Refer

The final aspect of the intervention is congruent with the above models aiming to ensure a cohesive and integrated care pathway by making an appropriate referral. This involves:

- discussing treatment options with the service user;
- making a referral to appropriate services if required;
- ensuring appropriate follow up care.

Table 2 summarises the key components of the SAOR model. See Appendix II for a comprehensive guide for practice.

Table 2: SAOR Model of Screening and Brief Intervention (SBI) for Problem Alcohol Use in the ED and Acute care Settings

S
SUPPORT
Ensure an open and friendly style of communication
Express empathy
Support self efficacy
A
ASK & ASSESS
Ask about alcohol use
Elicit the service users' concerns about drinking
Establish the service users' expectations of the consultation
Screen and assess for alcohol problems
Assess for withdrawals
Explore the context
Gauge readiness to change
O
OFFER ASSISTANCE
(The Four A's)
Advise and give feedback
Assign responsibility
Allow for a menu of options.
Agree goals
R
REFER
Discuss treatment options with the service user
Make referral to appropriate services if required
Ensure that there is appropriate follow up care

Core Requirements

All HSE SBI education and training programmes shall incorporate the following core requirements:

- Approval by An Bord Altranais (Category One).
- Based on SAOR model of training for SBI.
- Explicit aims and learning outcomes for the programme.
- Agreed mechanisms for recording and reporting attendance of participants at SBI education and training.
- Provision of support for course participants.

The need for Continuing Professional Development (CPD) for nurses is well documented in the Irish context. An Bord Altranais (Irish Nursing Board) states that:

> *"Continuing professional development following registration is essential for nurses and midwives if they are to acquire new knowledge and competence that will enable them to practice effectively in an ever-changing health care system"* (ABA, 2000:22).

In addition, nurses are required to maintain continuing competence as part of their Code of Professional Conduct (ABA, 2000). Within this context the board has outlined a framework for continuing professional education (ABA, 1997). The National Council for the professional development of Nursing and Midwifery (NCNM) provides guidance on the CPD needs of nurses and midwives in Ireland (NCNM, 2004). In 2009, the HSE also published "*The Education and Development of Health and Social Care Professionals in the Health Services*". This strategy document focuses on the twelve Health and Social Care Professions (H&SCP) named in the Health and Social Care Professionals Act, 2005. It sets out key aims and areas of focus in relation to the education and development of these professionals until 2014.

The overall purpose of this document is to support the improvement of services to service users through focusing on the development of Health and Social Care Professionals (as presently included in the provisions of the Health and Social Care Professionals Act, 2005) within the HSE in terms of education and training.

Programme Rationale

The rationale for this programme is to provide nurses, midwives and allied health and social care professionals with the knowledge skills and attitudes that will enable them to deliver effective SBI.

Programme Philosophy

The philosophy underpinning this education programme is to promote excellence through evidence based practice amongst nurses, midwives and allied health and social care professionals who offer SBI to service users presenting with problem alcohol use.
Integration of theory and practice is a cornerstone of this educational approach, ensuring learning transfer to participants day to day work environments and promoting excellence in the delivery of care. Close liaison with Directors of Nursing and other Service Managers should ensure that the programme is aligned with individual participant's learning needs and closely stitched into service developments.

This course is designed to offer *just in time learning* (timely learning that can be immediately integrated into practice) to participants facing the challenges of a rapidly changing health system

as well as actively supporting service developments which form an integral part of the HSE's service development.

Programme Aims

To prepare nurses, midwives and allied health and social care professionals to implement SBI as an effective intervention for problem alcohol use.

Learning Outcomes

On completion of this course, participants should be able to:

- identify hazardous and harmful alcohol users who present to healthcare settings with alcohol related problems;
- Discuss contemporary models of Screening & Brief Intervention;
- Utilise the SAOR model of Screening & Brief Intervention;
- Apply Screening and brief Intervention Strategies to their practice with problem alcohol users.

Teaching and Learning Strategies

The teaching and learning strategies are designed to support the course learning outcomes and include theoretical input, interactive group-work, experiential learning, role plays (skills practice), DVD observation and reflection.

Syllabus/Indicative Content

The key course content which emerges from the course learning outcomes is outlined below:

- Evidence for the effectiveness of SBI for problem alcohol use.
- Alcohol related presentations to healthcare settings.
- Contemporary models of SBI for problem alcohol use.
- Overview of the SAOR model of intervention for problem alcohol use.
- Establishing a supportive working relationship with the service users.
- Asking about alcohol use and screening for alcohol related problems.
- Delivering a structured brief intervention based upon the SAOR model.
- Developing appropriate care pathways for service users and arranging appropriate follow up.
- Accessing useful links and reference materials for further reading and research.

Target Audience

The primary target audience is nurses, midwives and allied health and social care professionals who offer SBI to service users presenting with problem alcohol use to healthcare settings.

Pre Requisites/Entry Criteria

The following entry criteria apply:
Qualification and/or experience in health or social care field (e.g. registered nurse or registered midwife, registered psychologist, professionally qualified social worker, occupational therapist, medical practitioner and other relevant healthcare workers).

Programme Structure and Delivery

The current context in both the education/training and service provision sectors require innovative, creative and flexible approaches for the delivery of programmes. Centres of Nursing and Midwifery Education in consultation with local services will select the most appropriate mode of delivery for their service area. This 6 hour course can be delivered as a one day programme or as a series of onsite workshops.

Participant Assessment

While there is no formal assessment process, all participants are expected to demonstrate full attendance at the programme (confirmed by sign in sheet).
A Brief Intervention Competency Framework (Appendix IV) is available as a guide for participants, who are encouraged to utilise it as part of the development of their skills in Brief Intervention. This is offered as a resource rather than part of formal assessment.

Certification/Accreditation

Participants who complete the programme will receive a *Certificate of Attendance,* which confirms (i) hours of attendance, (ii) mode of delivery and (iii) ABA Category 1 Approval (for Registered nurses and midwives only).

Programme Evaluation

The course evaluation includes:

(i) *Participant feedback via an end of course evaluation*: A course evaluation questionnaire (See Appendix V) will be completed by each participant on completion of the programme. All questionnaires are reviewed by the course team.

(ii) *Facilitator feedback:* Facilitators meet with the Centre of Nursing and Midwifery Education to discuss course delivery and participants progress on an ongoing basis.

(iii) *Consultation with Service Providers:* Feedback will be sought from Senior Clinicians and Managers. The Centre of Nursing and Midwifery Education will meet with the above personnel to evaluate learning transfer and the impact of the programme on service delivery on an ongoing basis.

Venues

The programme will be organised and coordinated by local Centres of Nursing and Midwifery Education supported by specialists from the local substance misuse services. Specific venues will be decided at local level and be congruent with service and participant needs.

Education Facilities and Resources

Facilities

A full range of educational facilities are available at Centres of Nursing and Midwifery Education and associated outreach/onsite venues. This includes tutorial/class rooms, AV equipment and IT resources. Participants (HSE staff) also have access to the HSE regional libraries as well as access to libraries in local hospitals.

Resources

The course will be coordinated by the local Centre of Nursing and Midwifery Education and facilitated by experienced clinicians, therapists and educators. The teaching team will have the support of nurse managers, clinical staff and the local substance misuse services.

Useful Reading and Resources

Babor, T.F. and Higgins – Biddle, J.C. (2001) *Brief Intervention for Hazardous and Harmful Drinking; A Manual for Use in Primary Care.* Geneva: World Health Organisation.

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Please see Appendix III for a list of supporting documentation.

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APPENDICES

Appendix I

Evidence for Screening and Brief Intervention in the emergency department, acute hospital, primary care and antenatal healthcare settings.

Screening and Brief Intervention and the Emergency Department

- People who present to the ED are one and a half to three times more likely to be high risk drinkers than their counterparts who present in primary care settings (Cherpitel, 1999).
- This provides an ideal opportunity for the delivery of SBI. Many of these patients are young adults engaged in harmful and hazardous use of alcohol who are more receptive to changing risky behaviours whilst in crisis (D'Onofrio et al, 2002).
- Adolescents and young adults in Ireland have particularly high rates of 'binge drinking' (Hibell et al, 2004). International literature identifies this age group as being at particularly high risk of trauma and injury (NIAAA, 2005) which inevitably leads to presentations at ED.
- Walton et al (2010) found a decrease in the prevalence of self-reported aggression and alcohol consequences, following a brief intervention to adolescents identified in the ED with self-reported alcohol use. SBI can reduce the average number of drinking days per month and frequency of high-volume drinking ('binge drinking') when delivered to adolescents aged 13-17 years following an alcohol-related presentation to the ED (Spirito et al, 2004).
- Although studies on the use of SBI in the ED are in their infancy, they have a demonstrated efficacy not only to reduce alcohol consumption but also to impact positively on the psychosocial consequences of high risk drinking (Smith et al, 2003: Bazargan-Hejazi et al, 2005).
- This has been demonstrated by Walton et al (2008) in their study of 575 at-risk drinkers who attended an ED following injury. They concluded that participants who received advice about their drinking had significantly lower levels of average weekly alcohol consumption and less frequent heavy drinking episodes from baseline to twelve-month follow-up when compared with those who did not receive advice.
- Previously Crawford et al (2004) investigated the experiences of 599 patients who attended an ED with alcohol related problems over a twelve month period. They concluded that at six month follow-up the SBI group had lower levels of alcohol consumption and reduced re-attendance when compared to a control group.
- A review of literature focusing on trials that are applicable to real-world settings found that at risk drinkers who received a brief intervention reduced their consumption of alcohol by an average of 41g per week more than controls and that these results were consistent across all trials, suggesting they are widely applicable (Kaner et al, 2007).
- Trauma patients are at high risk of future injury, (Poole et al, 1993) with the risk further increased among hazardous drinkers (Rivara et al, 1993). Previous SBI trials among trauma patients have been effective in reducing problem drinking behaviour and injury recurrence. In a twelve month follow of patients in a trauma centre SBI study, the intervention group had decreased their weekly alcohol consumption significantly more (by 21.8 drinks) than the control group (by 6.7 drinks) (Gentilello et al, 1999).

Screening and Brief Intervention and the Acute Hospital

- In one major acute hospital in Ireland, the prevalence of problematic drinking behaviour (hazardous alcohol use and dependency) among in-patients was reported at 28% (Hearne et al, 2002).
- In the UK, it is estimated that up to one-third of men admitted to medical and surgical wards have alcohol related problems (UK Alcohol Forum, 1997). A study in two Glasgow hospitals reported

that almost one fifth of acute medical admissions misused alcohol (Cameron et al, 2006).

- In Ireland, alcohol related hospital discharges increased by 92% between 1995 and 2004, the largest increase was observed among discharges with alcohol related liver disease, which increased by 147% between 1995 and 2004 (Mongan et al, 2009).
- One study found that among inpatients reporting unhealthy alcohol use, those not dependent on alcohol and those reporting low levels of problem perception; alcohol-attributable illness may serve as a strong catalyst for changes in drinking. As such, alcohol-attributable illnesses could become a focus of hospital-based brief interventions (Williams et al, 2010).
- Chick et al (1985) recommended that screening for alcohol problems should become a routine part of nursing assessment and medical history so that advice can be given before irreversible physical or psychosocial problems have developed.
- Alcohol consumption and use of health services can decrease when clinicians implement SBI into routine visits among those who are nondependent drinkers (Fleming et al, 1997a).
- Data extracted from two studies included in a Cochrane review, indicated that alcohol consumption could be reduced at one year follow up for people who received brief interventions as inpatients. These people drank significantly less alcohol per week than those in the control groups (McQueen et al, 2009).
- Alcohol related problems are common among inpatients in general hospitals. Admission to hospital as an inpatient provides an opportunity to access hazardous and harmful alcohol users when they may have time for an intervention and also can be made aware of any links between their admission and alcohol.

Screening and Brief Intervention in Primary Care Settings

- The public health impact of widespread implementation of brief interventions in primary healthcare is potentially very large (Raistrick, et al, 2006)
- A systematic review with meta-analysis specifically focused on the effectiveness of brief interventions in primary healthcare, found that brief interventions are effective in reducing consumption among both men and women at six and twelve months following intervention (Bertholet et al, 2004).
- Research has established the effectiveness of brief interventions in decreasing alcohol consumption among both male and female primary care patients, and among older and younger adults. (Whitlock et al , 2004)
- Results from the ICGP led Alcohol Aware Practice Pilot Study (2006) revealed that at least one-third of patients in primary care have some form of alcohol problem. One third of these patients with alcohol problems do extremely well and one third make “some improvement” with intervention at primary care level.
- Studies of treatment interventions for hazardous and harmful drinkers in primary care settings demonstrate that brief interventions may effectively decrease alcohol consumption, improve liver function (among patients with previously elevated liver enzyme levels) and decrease the use of certain health services. (Wilk et al, 1997, Bien et al, 1993, Fleming et al, 1997)
- Prevention of excessive alcohol use by implementing alcohol SBI in a GP setting appears to be cost-effective, with mean incremental costs of €5,400 per Quality Adjusted Life Year (QALY) gained. (Tariq, 2009)
- Rubio et al, (2010) demonstrated that significant and durable reductions in binge drinking to safer levels can be achieved with screening and brief physician-delivered counselling in men and women who “binge drink”, with accompanying reductions in overall drinking. The study also showed that SBI could be delivered during a routine primary care visit.
- The UK Department of Health (2009) provided estimates for the average PCT (population 350,000) and calculated that for every £91,611 invested in identification and advice for hazardous or harmful drinkers, there would be a saving of £393,927 in return on investment.

Screening and Brief Intervention and Antenatal Healthcare Settings

- A study of postnatal women in the Rotunda Hospital (Dublin) in 2003 found that alcohol was consumed by 89% of the women, with 10% reporting binge drinking during pregnancy (McMillan et al, 2006).
- A study of women who attended the Coombe Women's Hospital (Dublin) found that almost twothirds (63%) of the 43,318 women surveyed said they drank alcohol during their pregnancy. Alcohol consumption, particularly in the first three months of pregnancy, can lead to disorders in how the brain develops in the womb. The study found that one in ten women reported drinking more than six units of alcohol per week in pregnancy and that this pattern was more pronounced in younger women (Barry et al, 2006).
- O'Connor and Whaley's (2007) study reported that newborns whose mothers received brief intervention had higher birth weights and birth lengths, and foetal mortality rates were three times lower (0.9%) compared with newborns in the assessment-only (2.9%) group.
- Manwell et al (2000) conducted a forty-eight month follow-up study of a trial for early alcohol treatment (Project TrEAT) focused on women of childbearing age. The intervention consisted of two fifteen minute, physician-delivered counselling visits that included advice, education, and contracting by using a scripted workbook. The trial found a significant treatment effect in reducing both seven day alcohol use and binge drinking episodes over the forty-eight month follow-up period. Women in the experimental group who became pregnant during the follow-up period had the most dramatic decreases in alcohol use.
- Chang et al (2000) conducted a study of 123 pregnant women who screened positive for alcohol use and received a brief intervention in the 16th week of gestation. Women who expressed clear drinking goals were found to be more likely to abstain or reduce consumption than those who did not.
- The Growing up in Ireland study (2010), a major national study tracking the lives of 11,100 nine-month olds, has found that 20% of women drank while pregnant "Drinking alcohol at some stage in pregnancy was highest for mothers with a degree level education (26%). Mothers with the highest education were more likely to drink at any stage of pregnancy, in all three trimesters…than their peers with the lowest education". One in ten women had no intention of ever becoming pregnant and 14% of infants lived in lone parent families.
- Motivation for making health behaviour changes is generally high during pregnancy (Higgins et al, 1995).

Appendix II
Guide for Practice *(Based upon the work of O'Shea & Goff, 2009)*

SUPPORT: Key Components

1 **Ensure an open & friendly style of communication**
2 **Express empathy**
3 **Support self efficacy**

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
1 Ensure an open & friendly style of communication	• Be respectful • Seek service users permission to discuss alcohol use • Avoid a confrontational approach • Establish a rapport	"Good morning, my name is…I work here in the hospital as a …" "Good morning Mrs/Mr …..how are you today?" "Do you mind if we take a few minutes to discuss your drinking"
2 Communicate acceptance & understanding of the service users circumstances (empathy)	• Let the service user know that you are trying to understand his/her difficulties and where they are "coming from" • Avoid being judgemental • Listen attentively and reflect your understanding back to the service user in a sensitive manner	"So your drinking had been helping you to cope with the stress at work" "You are feeling very low this morning" "You are finding this hospital visit particularly difficult"
3 Support and reinforce the service users belief in his/her ability to change (support self efficacy)	• Help service user to believe that he/she can make positive changes in drinking behaviours • Demonstrate your confidence in the service users ability to change • Be enthusiastic and engender enthusiasm in the service user	"You have said that you are worried about your drinking, what can we do to help you" "You have said that you stopped drinking for six months last year. That is a long period, you did very well" "We can assist you with some practical things to help you have a look at your drinking" "I am aware that you find this a bit daunting but people do successfully stop drinking all the time"

ASK AND ASSESS: Key Components

1. **Ask about the service users alcohol use**
2. **Elicit the service users concerns about drinking**
3. **Establish the service users expectations of the consultation**
4. **Screen & assess for alcohol problems**
5. **Assess for withdrawals**
6. **Explore the context**
7. **Gauge readiness to change**

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
1 Ask about the service users alcohol use	• Identify quantity (how much) & frequency (how often) of drinking • Explore the drinking patterns • Observe for evidence of 'binge drinking'	"Do you take a drink" "Can you tell me how many drinks you would have over a week" "How many days of the week do you have a drink" "How much would you generally take on one drinking session"
2 Elicit the service users concerns about drinking	• Encourage the service user to talk about his/her drinking & any concerns that he/she has about it	"Can you tell me a bit about your drinking" "Can you tell me what concerns you about your drinking" "So you are worried that your drinking is getting a bit out of hand"
3 Establish the service users expectations of the consultation	• Encourage the service user to articulate his/her expectations of the consultation • Let the service user tell you what he/she wishes to do (if anything) about drinking	"How do you think we can help you with your drinking?" "Can you tell me what changes you would like to make regarding your drinking" "What kind of an outcome do you expect from our discussion here today"

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
4 Screen & assess for alcohol problems	• Assess for evidence of alcohol related problems • Use evidence-based screening tools to screen for problem alcohol use	Helper should utilize screening questionnaires as per local guidelines, prompt questions may include: "Do you mind if I ask you a few more questions about your drinking?" "I have a short questionnaire here which helps us to get a clearer picture of your drinking. Do you mind answering a few more short questions?"
5 Assess for withdrawals	• Assess for evidence of withdrawal symptoms • Use a standard assessment tool such as CIWA-Ar (as per local guidelines)	"Sometimes people experience withdrawal symptoms when they have been drinking heavily for a while, have you ever experienced sweating or shakes when you stop drinking" "Have you ever had strange or unusual experiences when you are coming off drink" "Have you ever experienced DT's when you were coming off drink" "We have a short questionnaire here which helps us to assess your risk of developing withdrawal symptoms. Do you mind answering a few short questions?"

ASK AND ASSESS: Key Components Continued

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
6 Explore the context	Gain an understanding of lifestyle and issues related to drinking including: • Age • Gender • Work/ School • Family & other support networks • Mental Health • Physical health & alcohol related injuries	"Can we take a few minutes to look at other aspects of your life" "Can you tell me a little bit about how drinking fits into your life" "How does your drinking impact on other areas of your life such as your family, your work and friendships" "How would you describe the effects of drinking on your mental health" "Have you ever had an accident or injury following drinking"
7 Gauge readiness to change	• Assess the service users interest in and commitment to changing his/her drinking behaviour	"You have said that you are worried about your drinking, can you tell me what changes you would like to make" On a scale of 1-10 how ready are you to make a change in your drinking" "People differ a lot in their commitment to changing their drinking, how ready would you say that you are to change"

OFFER ASSISTANCE – THE FOUR A's: Key Components

1 **Advise and give feedback**

2 **Assign responsibility**

3 **Allow for a menu of options**

4 **Agree goals**

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
1 Advise the service user and give feedback	• Give the service user clear & explicit advice regarding the risks of current behaviour. This may be verbal, written or both • Give personalised, non – judgmental, accurate feedback on results of screening, medical investigations, consequences & complications of use • Make clear recommendations in a non threatening & empathic manner • Express concern at hazards & personal risks of current drinking behaviours • Compare use to safe consumption limits • Make a connection between alcohol use and hospital attendance where appropriate	"We know that drinking at these levels can have a serious impact on your health" "The results of your blood tests show us that your liver has been damaged by your drinking" "If you continue to drink at these levels your health is likely to be severely damaged" "What connection would you make between your current health problems and your drinking" " From looking at your medical chart I see that you had been drinking prior to your three previous attendances at the ED" "Here is a short information leaflet on the effects of alcohol on your body. Would you like to have a read of it and we can discuss it tomorrow"

OFFER ASSISTANCE – THE FOUR A's: Key Components Continued

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
	• Give advice and/or information leaflets on how to stop or cut down on drinking. • Give positive constructive feedback on improvements in functioning and/or drinking behaviours since the last consultation • Avoid being overly prescriptive or dogmatic	"You have made major improvements since your last visit. You have cut down dramatically on your drinking and your overall health appears to have improved considerably"
2 Assign responsibility	• Locus of control for change must rest within the client • Clarify roles & responsibilities • Service user is responsible for making any changes • Helper is responsible for supporting the service users in making changes • The service user, not the helper, will have to make the changes	"We have a range of services available locally which can support you in changing your drinking patterns" "While we can help you to deal with your drinking the changes that you make will be your choice" "We can provide a range of supports, however you will need to put in the work at making changes"

3 Allow for a menu of options	• Make service user aware that there are a range of alternative change options available
	• Options will vary depending upon his/her level of alcohol use, physical & psychosocial circumstances. They may include:
	  • Making no change
	  • Cutting down
	  • Abstaining from alcohol
		"Given that your drinking falls within the hazardous use category there are a range of options available to you at this point"
		
		"People choose a broad range of options when changing there drinking patterns. They may include cutting down or giving up drinking for a period of time"
		
		"There are several ways to change your drinking……What do you think might suit you best"

OFFER ASSISTANCE – THE FOUR A's: Key Components Continued

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
4 Agree Goals	• Agree realistic & achievable drinking goals with the patient • Ensure that they are collaborative rather that imposed goals	"I hear you say that you want to cut down to drinking two nights per week, that you want to reduce your consumption to three drinks on each occasion & that you want to keep a record of your overall consumption. Have I got that right" "So we are agreed that your drinking has been a major problem for the past ten years, you want to attend your GP for a detox and go back to see your addiction counsellor" "So you plan to stop drinking for three months to see how you manage without alcohol, is that right?"

REFER: Key Components

1	**Discuss treatment options with the service user**
2	**Make a referral to appropriate services if required**
3	**Ensure that there is appropriate follow up care**

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users

1 Discuss treatment options with the service user	• Discuss treatment & intervention options:
	  • Evidence of dependence – refer to specialist addiction service for comprehensive assessment and intervention
	  • Lower risk & hazardous use – deliver brief intervention & advice or refer to hospital substance misuse liaison service
	  • Evidence of self harm or mental health problems – refer to mental health services & ensure safe environment
	• Ensure that the service user is actively involved in choosing a treatment option
		"Your drinking appears to fall within the hazardous use category. Avoiding 'binge drinking' and reducing your overall consumption is going to be important if you wish to avoid health complications"
		
		"Given that your drinking problems go back a long time & you have had treatment in the past, I suggest that you need to attend a specialist alcohol service"
		
		"From the range of treatment options that we have discussed which do you think would suit you best"
		
		"This is a list of local alcohol services, can we take a few minutes to discuss the various options"
		
		"There are many organisations in the local area who provide confidential advice & support about drinking"

Key Objective	Actions/Strategies	Sample Questions, Comments & Reflections to Services Users
2 Make a referral to appropriate services if required	• Provide the service user with a list of local addiction services including contact names, telephone numbers & an e-mail/web address where available • Make a direct referral to the appropriate service to ensure continuity of care • Refer to mental health services & ensure safe environment in cases of self harm and dual diagnosis	"This is a list of the local alcohol treatment services. Given what you have told me I think that the first one would best meet your needs" "I can telephone the alcohol service & get an appointment for you if you wish" "I am giving you a referral letter for the alcohol treatment service. Would you like to use the phone in the office to get an appointment"
3 Ensure that there is appropriate follow up care	• Provide service users GP with a summary of the hospital treatment episode highlighting concerns regarding drinking • Contact alcohol treatment service to which service user was referred to ensure continuity of care (with service users consent) • Ensure that service user is re-screened on next hospital attendance • Ensure integrated care pathway	"It may be helpful if you discuss your drinking with your GP on your next visit. He/She will be in a position to provide you with ongoing advice and support" "We find it useful to link with the alcohol service when we make a referral. Would that be ok with you?" "I will put a brief note of our discussion on your chart to ensure that staff check in to see how you are doing on your next hospital visit"

Appendix III

Supporting Documentation

The following electronic supporting documentation is available:

- Training PowerPoint presentation (available upon request)
- *Organising & Delivering an Education Session: A Resource Pack for Healthcare Professionals (2009)* developed by the Centre of Nurse Education & Nursing and Midwifery Planning Development Unit, HSE South.
- A Guide to planning the Implementation of Screening and Brief Intervention in Acute Care Settings.

Please email ruth.armstrong@hse.ie stating which copies you wish to obtain.

Appendix IV

Brief Intervention - Competency Framework

Competency Area 1 – Supporting the Client

- Ensures an open and friendly style of communication with the client.
- Expresses empathy, demonstrating an understanding for the client's current circumstances.
- Supports self efficacy by encouraging the client to believe in his/ her ability to make a change in drinking behaviour.

Competency Area 2- Screening and Assessment

- Asks client about his/her alcohol use.
- Elicit the clients concerns about his/her drinking.
- Clearly establish the client's expectations of the consultation.
- Carries out a screening assessment for problem alcohol use utilizing evidence based screening tool.
- Assesses for withdrawal symptoms utilizing an evidence based assessment tool.
- Explores broader contextual factors which may contribute to or be impacted by problem drinking.
- Gauges the client's readiness to change drinking behaviour.
- Gauges the client's confidence to make a change in drinking behaviour.

Competency Area 3 – Offering Advice and Assistance

- Provides client with objective advice and feedback regarding drinking and its consequences.
- Clearly assigns responsibility for behaviour change to the client.
- Offers the client a menu of change options from which to choose.
- Agrees clear goals with the client which are ***SMART***
  - ***S***pecific
  - ***M***easurable
  - ***A***ttainable
  - ***R***ealistic
  - ***T***ime framed

Competency Area 4 – Making a Referral

- Discusses treatment options with the client.
- Makes referral to appropriate services if required.
- Ensures that there is appropriate follow up care for the client.

James O'Shea and Paul Goff May 2011

Appendix V

Course Evaluation Form

Course Title: **Brief Intervention for Problem Alcohol Use in Acute, Primary and Community Care Settings**

Course Date:

Course Venue:

Satisfaction Rating;
Please rate the following statements using the Scale below by circling the statement that best reflects your opinion of the course

1 Strongly disagree	**2** Disagree	**3** Neither agree nor disagree (neutral)	**4** Agree Agree	**5** Strongly Agree

1 - Course content was appropriate to my learning needs	1	2	3	4	5
2 - Course met the stated learning outcomes	1	2	3	4	5
3 - Mode of delivery of course was useful and engaging	1	2	3	4	5
4 - Information was well organised and sequenced	1	2	3	4	5
5 - Course written materials were useful	1	2	3	4	5
6 - Course was relevant to my practice,	1	2	3	4	5
7 - Course prompted me to think reflectively	1	2	3	4	5
8 - Course duration was sufficient	1	2	3	4	5
9 - Training room was conducive to learning	1	2	3	4	5
10 - I will use course learning in my practice	1	2	3	4	5

Other Comments

Name _____(optional)

Appendix VI

Programme Development Team

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Appendix VII

Stakeholders

Office of Nursing and Midwifery Services Director

Nursing and Midwifery Planning and Development Unit

Centres of Nursing and Midwifery Education

Substance Misuse Services

Acute Hospitals

Health Promotion Service

Social Inclusion Service - the HSE Social Inclusion Department works to reduce the impact of health inequalities by addressing the needs of socially excluded groups through a comprehensive, intersectoral approach and involvement in a range of statutory led and associated community and voluntary sector initiatives

Integrated Services Directorate

Healthcare professionals and educators with expertise in Screening and Brief Intervention

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Further copies of this framework can
be downloaded from www.hse.ie/go/alcohol

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