

The SAOR Model

Screening and Brief Intervention (SBI) for Alcohol Misuse

in the

Emergency Department & Acute Care Settings

James O'Shea and Paul Goff May 2009 ©

Foreword

I am very pleased to publish 'The SAOR Model of Screening and Brief Intervention for Alcohol Misuse in the Emergency Department & Acute Care Settings'. This publication details an innovative model for the delivery of Screening and Brief Intervention (SBI) to people with hazardous/harmful alcohol use who present to acute hospital settings.

The World Health Organization (WHO) has identified alcohol use as a leading cause of mortality and disability, ranking it in the top five risk factors for disease burden. In Ireland it is suggested that that between 20% and 50% of all presentations to Emergency Departments (ED's) are alcohol related, with the figure rising to over 80% at peak weekend periods.

The second report of Strategic Task Force on Alcohol (2004) advocates the use of SBI across a range of health care settings including primary care, community services and general hospitals. It is well recognised that nurses and other health care professionals can play a central role in the delivery of these interventions.

The SAOR model provides an evidence-based practical step by step guide to the delivery of SBI for hazardous/harmful alcohol use in acute care settings. It incorporates all the key components of SBI including the common elements of screening, assessment, intervention and referral. This model has been utilised in a comprehensive training and development programme for Emergency Nurses here in the south-east of Ireland. It is anticipated that it will now contribute to the development of both regional and national training programmes on SBI for hazardous/harmful alcohol use in Emergency Departments and Acute Care settings.

I would like to take this opportunity to thank the authors for their creativity and innovation in designing this model of SBI which will contribute to the development of evidence based practice well into the future.

TONY BARDEN,
Regional Drug Co-ordinator.

Acknowledgements

The authors would like to acknowledge the support received in the preparation of this publication from the following:

- Mr. Tony Barden, Regional Drug Co-ordinator, HSE South, Waterford
- Mr. Pat O'Neill, Substance Co-ordinator, Waterford Substance Misuse Team
- Management and staff of the HSE National Addiction Training Programme
- Management and staff of Waterford Regional Hospital

Table of Contents

Introduction.....	5
Background and Context.....	6
Screening and Brief Interventions	8
Effectiveness of SBI	10
SBI in the Emergency Department	10
Contemporary Models of Care.....	12
Discussion and Rationale.....	15
The Model.....	18
Guide for Practice	21
Conclusion	31
Bibliography	33

Screening and Brief Intervention (SBI) for Alcohol Problems in the Emergency Department & Acute Care Settings: A Model for Practice

Introduction

This paper details an innovative model for the delivery of Screening and Brief Intervention (SBI) to people with alcohol related problems who present to acute hospital settings. The model has emerged from the authors (i) clinical practice as substance misuse liaison specialists in an acute hospital setting and (ii) extensive experience of training Nurses and other frontline health care professionals in the delivery of SBI for alcohol problems. This paper reviews relevant contemporary literature in order to set both background and context. Current models of SBI are presented. The rationale for the proposed model and a comprehensive guide for practice are outlined.

SAOR, the Irish word for “free” is used as an acronym to facilitate Nurses and other clinical staff in remembering the key components of SBI. The four principle aspects of the intervention are (i) **S**upport, (ii) **A**sk and assess, (iii) **O**ffer assistance and (iv) **R**efer.

Background and Context

The World Health Organization (WHO) has identified alcohol use as a leading cause of mortality and disability and ranked it in the top five risk factors for disease burden (WHO, 2002). While alcohol misuse is a global phenomenon the European Union (EU) is the highest ranked region in the world for alcohol consumption, drinking two and half times more pure alcohol than the international average (WHO, 2004). Although global alcohol consumption has decreased since the mid-1980's Ireland's consumption increased by 17% between 1996 and 2007 (Health Research Board, 2007). The second report of the Strategic Taskforce on Alcohol (Government of Ireland, 2004) has noted that Ireland ranks amongst the highest consumers of alcohol in the world, with the highest levels of binge drinking in Europe. These findings are supported by the work of Anderson and Baumberg (2006) which indicates that Ireland spends between 3 and 10 times higher proportions of income on alcohol than our European counterparts. They also note that our young people top the European league for binge drinking.

There is clear and conclusive evidence that these problems 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 (ED's) (Charalambous 2002, Hope et al 2005 and Hope 2008). Hope et al (2005) proposed that between 20% and 50% of all presentations to ED's in Ireland are alcohol related, with the figure rising to over 80% at peak weekend periods.

Recent Irish policy and strategy documents have recommended the use of SBI as a response to this increasing problem. The second report of 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. Cullen (2005), in a report on the development of drug and alcohol services in the south east of Ireland, endorsed these recommendations and suggested the expansion of education and training for health and social care professionals on screening and brief interventions for alcohol problems.

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 screening and brief intervention for alcohol misuse which may help motivate patients to change their drinking behaviours (D’onofrio et al, 2002).

The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with alcohol related problems (Allen, 1998, D’onofrio et al, 2002, Herring & Thom, 1999, Anderson et al, 2001, 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 or by seeking additional substance misuse treatment (Health Research Board, 2006). There are a number of easily administered screening tools (Hearn et al, 2002) and brief intervention models (Miller & 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). 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; Indig et al, 2008).

Screening and Brief Interventions

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 examined to identify those likely to benefit from appropriate intervention. Screening for alcohol misuse is conducted in ED's to identify those patients who drink at hazardous levels, those who are beginning to experience alcohol-related problems and those who are showing signs of alcohol dependence (Babor and Higgins-Biddle, 2000).

Hazardous drinking is described as a pattern of alcohol consumption that places individuals at risk for adverse health events (Saunders et al, 1993). Alcohol dependence is described as a syndrome that includes a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value (WHO, 1992).

Screening is completed through the use of validated screening tools and laboratory tests. Many screening tools are available with varying levels of sensitivity, validity and

acceptability across a range of settings. Screening questionnaires are often seen to be superior and more sensitive than laboratory tests for the detection heavy or problem drinking (Yersin et al, 1995: Hoeksema et al, 1993). Laboratory results can however provide objective evidence of problem drinking which is helpful to confirm screening results and raise doubts for patients who deny any drinking problem. Positive results from screening signal the need for Brief Interventions aiming to ameliorate alcohol related problems and improve health related outcomes.

Definitions of brief interventions and their implementation in practice are diverse across the literature. Ali, Miller and McCormack (1992) described them as any intervention that involves a minimum of professional time in an attempt to change alcohol use, requiring a total of between five minutes and two hours to administer. Bein, Miller, and Tonigan (1993) further develop this definition suggesting that brief interventions are (i) generally restricted to four sessions or less (ii) designed to be conducted by health care workers who do not specialise in addictions treatment and (iii) utilised with less dependent drinkers. Moyer and Finney (2005) have argued that simply providing feedback is in itself a brief intervention, as it may be enough to encourage those at risk to reduce their alcohol intake. Therefore brief interventions can be represented on a continuum of care that responds to an individuals needs, starting at raising the issue of alcohol misuse through to more in-depth intervention taking from four sessions and up to two hours.

Miller and Sanchez (1993) proposed a framework, FRAMES, for the delivery of Brief Intervention (BI) which was based on motivational interviewing techniques. Fleming and Baier Manwell (1999) built upon this work identifying five key components for the

delivery of effective brief interventions. These included: Assessment and Feedback, Negotiation and Goal Setting, Behavioural Modification Techniques, Self-Help-Directed Bibliotherapy and Follow-up and Reinforcement. Resnick (2003) developed a framework, ETOH, for the implementation of BI with an aged population. Despite the variations in the style and content of delivery of these frameworks, all advocate the use of a patient-centred, non-confrontational, supportive approach to effect change in drinking behaviours.

Effectiveness of SBI

A substantial body of literature exists which supports the use of SBI across a range of settings, including Emergency Departments (Crawford et al, 2004; Sommers et al, 2006), Primary Care (Babor and Higgins-Biddle, 2001; Scottish Intercollegiate Guidelines Network, 2003; Irish College of General Practitioners, 2007) and Third Level Colleges (Borsari and Carey, 2000; Walters and Neighbors, 2005). Indeed several reviews of the literature have placed SBI at the pinnacle of efficacious treatments for alcohol misuse (Bien et al, 1993; Project M.A.T.C.H., 1997; Wilk, Jensen and Havighurst, 1997; Miller & Wilbourne, 2002). For the purposes of this paper we will focus primarily on the efficacy of SBI in ED's.

SBI in the Emergency Department

People who present to ED's are one and a half to three times more likely to misuse alcohol than their counterparts who present to primary care settings (Cheripitel, 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 (National Institute on Alcohol and Alcoholism, 2005) which inevitably leads to presentations at ED's. 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 alcohol misuse (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 12-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 12 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. It is clear from this substantial body of literature that the delivery of SBI within the ED is efficacious in the treatment of varying degrees of alcohol misuse.

Contemporary Models of Care

A range of systematic models for the delivery of SBI to clients experiencing alcohol related problems are documented across the literature. Four such models are outlined in setting the context for this paper.

(i) The World Health Organisation (Babor & Higgins – Biddle, 2001)

advocates a comprehensive approach to screening and intervention (Babor & Higgins – Biddle, 2001). Screening is seen as the first step in this process, providing a simple way to identify people whose drinking may pose a risk to their health. The WHO describes a process whereby health care workers utilise a systematic screening tool followed by a brief intervention which addresses levels or zones of risk. Interventions are matched to the client's level of risk. They may include; (i) alcohol education, (ii) simple advice, (iii) advice plus brief counselling and monitoring and (iv) referral to specialist services.

(ii) The Scottish Intercollegiate Guidelines Network (SIGN 2003)

endorse the use of the F.R.A.M.E.S. model (Bein, Miller & Tonigan, 1993). This involves giving **F**eedback, emphasising personal **R**esponsibility for change, giving **A**dvice, offering a **M**enu of alternatives, being **E**mpathic and supporting **S**elf efficacy. The SIGN guidelines advocate a structured model for screening and brief intervention.

(iii) The U.S. Department of Health and Human Services (NIAAA, 2005)

also advocate a structured and systematic approach to screening and brief intervention for alcohol related problems

(iv)The Irish College of General Practitioners (Anderson, 2006) propose the double AA approach which consists of four steps of asking, assessing, assisting and arranging.

Table 1 summarises the intervention frameworks outlined in these contemporary models.

Table 1; Contemporary Models of SBI for Alcohol Problems

<p>World Health Organisation (Babor & Higgins – Biddle, 2001)</p>
<ul style="list-style-type: none"> • Risk level zone 1; Alcohol education • Risk level zone 2; Simple advice • Risk level zone 3; Simple advice, brief counselling and continued monitoring • Risk level zone 4; Referral to specialist services for diagnostic evaluation and treatment
<p>Scottish Intercollegiate Guidelines Network (SIGN 2003)</p>
<ul style="list-style-type: none"> • Assessing the patients concerns regarding alcohol • Eliciting and recording relevant information on quantity, frequency and alcohol related health and social problems • Considering the use of screening tools such as F.A.S.T. or C.A.G.E. and biological markers • Delivering a brief intervention • Agreeing goals
<p>U.S. Department of Health and Human Services (NIAAA 2005)</p>
<ul style="list-style-type: none"> • Asking about alcohol use and screening • Utilising diagnostic tools such as DSMIV to establish evidence of alcohol dependence syndrome • Advising and assisting the patient which includes giving feedback, gauging readiness to change and agreeing an action plan • Providing a follow up session, review and support.
<p>Irish College of General Practitioners (Anderson, 2006)</p>
<ul style="list-style-type: none"> • Asking about amounts, frequency and patterns of use plus the AUDIT C. • Assessment using the CAGE and/or AUDIT, taking collateral history and assessing mental state and readiness to change • Assisting the patient by giving feedback, prescribing appropriate medications and delivery of a brief intervention • Arranging follow up appointments, tests and links with the family.

Discussion and Rationale

The models of SBI outlined above contain the common elements of screening, assessment, intervention and referral. The proposed SAOR model has emerged from a critique of contemporary models in light of our clinical practice and experience of teaching SBI skills to nurses and other frontline health care professionals. Based upon that experience within acute hospital settings we have concluded that contemporary models are often deficient in four ways; (i) They frequently fail to lend themselves to application in busy emergency departments and acute hospital settings, (ii) No single model adequately incorporates the key elements of relationship building, screening and assessment, offering assistance and ensuring integrated care pathways within the acute hospital system, (iii) They are not sufficiently user friendly and often sequenced in a manner which hospital staff find both cumbersome and difficult to apply and (iv) they do not adequately emphasise the importance of building a strong therapeutic alliance with the patient.

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:

- (i) Accentuating the relationship building aspect of SBI,
- (ii) Sequencing the intervention in a logical and user friendly manner and
- (iii) Providing a flexible step by step guide for practitioners in acute hospital settings.

These key components are outlined below:

- (i) SAOR accentuates the support and relationship building aspect of SBI by focusing on the development of a robust therapeutic alliance. Having extensive experience in the delivery of SBI in acute care settings we support Lock's (2004) conclusion 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 Rollinck (Miller and Rollinick, 1991, Miller and Rollinick 2002). We contend that providing support and fostering a good working relationship can elicit true information, help to determine the patient's willingness to change and construct a realistic and achievable change strategy.
- (ii) 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 patient, asking the appropriate questions, delivering a credible brief intervention and making appropriate referrals.

(iii)The SAOR acronym offers a four step model for the delivery of SBI which guides practitioners in the ED and other acute hospital settings 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 patient 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 patient. This is achieved by emphasising and accentuating the support aspect of the encounter. Key components of this process include:

- (i) ensuring an open and friendly style of communication
- (ii) Communicating a non-judgemental acceptance and understanding of the patients circumstances through the use accurate empathy
- (iii) Supporting the patients self efficacy or belief in his/her ability to change current drinking behaviours.

Ask and Assess

All major contemporary models of care for alcohol misuse 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 patients alcohol related problems and exploring commitment to change. The principal elements of this assessment phase include:

- (i) Asking about the patients alcohol use
- (ii) Eliciting the patients concerns about drinking
- (iii) Establishing the patients expectations of the consultation
- (iv) Carrying out a screening assessment utilizing an evidence based

screening tool

- (v) Assessing for evidence of withdrawal symptoms
- (vi) Exploring the patients broader psychosocial and health status
- (vii) Gauging readiness to change current drinking behaviours.

Offer Assistance

The third phase synthesises the principal aspects of contemporary models of care (Bein, Miller & Tonigan, 1993; Miller & Sanchez, 1993; Baer and Manswell, 1999; 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 patient. This includes the key elements of:

- (i) advising the patient about his/her drinking
- (ii) Clearly assigning responsibility for change to the patient
- (iii) Outlining a menu of options for change
- (iv) 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:

- (i) Discussing treatment options with the patient
- (ii) Making a referral to appropriate services if required
- (iii) Ensuring appropriate follow up care.

Table 2 below summarises the key components of the SAOR model. This is accompanied by a comprehensive guide for practice for the delivery of SBI in the ED and acute hospital settings.

Table 2; SAOR Model of Screening and Brief Intervention (SBI) for Alcohol Problems in the ED and Acute Care Settings

S	SUPPORT	<ol style="list-style-type: none"> 1. Ensure an open and friendly style of communication 2. Express Empathy 3. Support self efficacy
A	ASK & ASSESS	<ol style="list-style-type: none"> 1. Ask about alcohol use 2. Elicit the patients concerns about drinking 3. Establish the patients expectations of the consultation 4. Screen and assess for alcohol problems 5. Assess for withdrawals 6. Explore the context 7. Gauge readiness to Change
O	OFFER ASSISTANCE (The Four A's)	<ol style="list-style-type: none"> 1. Advise and give feedback 2. Assign responsibility 3. Allow for a menu of options. 4. Agree goals
R	REFER	<ol style="list-style-type: none"> 1. Discuss treatment options with the patient 2. Make referral to appropriate services if required 3. Ensure that there is appropriate follow up care

Guide for Practice

SUPPORT

KEY Components

1. Ensure an open & friendly style of communication

2. Express empathy

3. Support self efficacy

Key Objectives	Actions/Strategies	Sample Questions, Comments & Reflections to Patient
1. Ensure an open & friendly style of communication	<ul style="list-style-type: none"> • Be respectful • Seek patients permission to discuss alcohol use • Avoid a confrontational approach • Establish a rapport 	<ul style="list-style-type: none"> • “Good morning my name is.... I work here in the hospital as a..” • “Good morning Mrs..... how are you today” • “Do you mind if we take a few minutes to discuss your drinking”
2. Communicate acceptance & understanding of the patients circumstances (empathy)	<ul style="list-style-type: none"> • Let patient 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 patient in a sensitive manner 	<ul style="list-style-type: none"> • “So your drinking has 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 patients belief in his/her ability to change (support self efficacy)	<ul style="list-style-type: none"> • Help patient to believe that he/she can make positive changes in drinking behaviours • Demonstrate your confidence in the patients ability to change 	<ul style="list-style-type: none"> • “ 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

	<ul style="list-style-type: none">• Be enthusiastic & engender enthusiasm in the patient	<p>practical things to help you have a look at your drinking”</p> <ul style="list-style-type: none">• “There are many organisations in the local area who provide advice & support about 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 patients Alcohol use

2. Elicit the patients concerns about drinking

3. Establish the patients expectations of the consultation

4. Screen & assess for alcohol problems

5. Assess for withdrawals

6. Explore the context

7. Gauge readiness to change

Key Objectives	Actions/Strategies	Sample Questions, Comments & Reflections to Patient
1. Ask about the patients alcohol use	<ul style="list-style-type: none"> • Identify quantity (how much) & frequency (how often) of drinking • Explore drinking patterns • Observe for evidence of binge drinking 	<ul style="list-style-type: none"> • “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 patients concerns about drinking	<ul style="list-style-type: none"> • Encourage the patient to talk about his/her drinking & any concerns that he/she has about it 	<ul style="list-style-type: none"> • “ 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 patients expectations of the consultation	<ul style="list-style-type: none"> • Encourage the patient to articulate his/her expectations of the consultation • Let the patient tell you what he/she wishes to do’ if anything about 	<ul style="list-style-type: none"> • “How do you think we can help you with your drinking?” • “ What kind of an outcome do you expect from our discussion here today”

	drinking	
--	----------	--

Key Objectives	Actions/Strategies	Sample Questions, Comments & Reflections to Patient
4. Screen & assess for alcohol problems	<ul style="list-style-type: none"> • Assess for evidence of alcohol related problems • Use standard screening tools such as the RAPS4QF1 	<ul style="list-style-type: none"> • “Do you mind if I ask you a few more questions about your drinking” RAP4SQF1 • During the last year have you had a feeling of guilt or remorse after drinking? (Remorse) • During the last year has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (Amnesia/Blackouts) • During the last year have you failed to do what was normally expected from you because of drinking? (Perform) • Do you sometimes take a drink in the morning when you first get up? (Starter/Eye opener) • During the last year have you had more than six drinks (per drinking occasion) at least once a month?) (QF 1)
5. Assess for withdrawals	<ul style="list-style-type: none"> • Assess for evidence of withdrawal symptoms • Use a standard assessment tool such as the CIWA-Ar 	<ul style="list-style-type: none"> • “ 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”

		<ul style="list-style-type: none"> • “Have you ever experienced DT’s when you were coming off drink” • “We have a short questionnaire which helps us to assess your risk of developing withdrawal symptoms. Do you mind answering a few short questions”
--	--	--

6. Explore the context	<ul style="list-style-type: none"> • Gain an understanding of the patients lifestyle and issues related to <u>or</u> affected by drinking Including; <ul style="list-style-type: none"> ○ Age ○ Gender ○ Work/School ○ Family & other support networks ○ Mental health ○ Physical health/Alcohol related injuries 	<ul style="list-style-type: none"> • “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	<ul style="list-style-type: none"> • Assess the patients interest in and commitment to changing his/her drinking behaviour 	<ul style="list-style-type: none"> • “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 & give feedback
2. Assign responsibility
3. Allow for a menu of options
4. Agree goals

Key Objectives	Actions/Strategies	Sample Questions, Comments & Reflections to Patient
1. Advise the patient and give feedback	<ul style="list-style-type: none"> • Give the patient clear & explicit advice regarding the risks of current behaviour. This may be verbal, written or both • Give personalised, non – judgemental, 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 limits • Make a connection between alcohol use and hospital attendance where appropriate 	<ul style="list-style-type: none"> • “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 A&E” • “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” • “You have made major improvements since your last

	<ul style="list-style-type: none"> • 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 prescriptive or dogmatic 	<p>visit. You have cut down dramatically on your drinking and your overall health appears to have improved considerably”</p>
2. Assign responsibility for change	<ul style="list-style-type: none"> • Locus of control for change must rest within the client • Clarify roles & responsibilities <ul style="list-style-type: none"> ○ Patient is responsible for making any changes ○ Helper is responsible for supporting the patient in making changes ○ The patient <u>not</u> the helper will have to make the changes 	<ul style="list-style-type: none"> • “ 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	<ul style="list-style-type: none"> • Make patient aware that there are a range of alternative change options available • Options will vary depending upon his/her level of dependence, physical & psychosocial circumstances. They may include; 	<ul style="list-style-type: none"> • “ 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 <u>or</u> giving

	<ul style="list-style-type: none"> ○ Making no change ○ Cutting down ○ Abstaining from alcohol 	<p>up drinking for a period of time”</p> <p>“There are several ways to change your drinking..... What do you think might suit you best”</p>
4. Agree Goals	<ul style="list-style-type: none"> ● Agree realistic & achievable drinking goals with the patient ● Ensure that they are collaborative rather than imposed goals 	<ul style="list-style-type: none"> ● “ 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”

Refer

KEY Components

1. Discuss treatment options with the patient

2. Make a referral to appropriate services if required

3. Ensure that there is appropriate follow up care

Key Objectives	Actions/Strategies	Sample Questions, Comments & Reflections to Patient
<p>1. Discuss treatment options with the patient</p>	<ul style="list-style-type: none"> • Discuss treatment & intervention options; <ul style="list-style-type: none"> ○ Evidence of dependence – refer to specialist addiction service for comprehensive assessment and intervention ○ Lower risk & hazardous use – Brief intervention & advice by hospital staff or referral to hospital substance misuse liaison service ○ Evidence of self harm or mental health problems – Mental health services & ensure safe environment • Ensure that the patient is actively involved in choosing a treatment option 	<ul style="list-style-type: none"> • “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”

<p>2. Make a referral to appropriate services if required</p>	<ul style="list-style-type: none"> • Provide the patient with a list of local addiction services including contact names, telephone numbers & an e mail 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 	<ul style="list-style-type: none"> • “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”
<p>3. Ensure that there is appropriate follow up care</p>	<ul style="list-style-type: none"> • Provide patients GP with a summary of the hospital treatment episode highlighting concerns regarding drinking • Contact alcohol treatment service to which patient was referred to ensure continuity of care (with patients consent) • Ensure that patient is re-screened on next hospital attendance • Ensure integrated care pathway 	<ul style="list-style-type: none"> • “It may be helpful if you discuss your drinking with your GP on your next visit. He 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”

Conclusion

This paper has detailed an innovative model for the delivery of Screening and Brief Intervention (SBI) to people with alcohol related problems who present to ED's and other acute hospital settings. The model has emerged from our clinical practice coupled with extensive experience of training nurses and other frontline health care professionals in the delivery of SBI for alcohol problems. We have reviewed relevant literature, presented contemporary models of SBI, outlined the rationale for the proposed model and key components of the intervention. This is augmented with a comprehensive practice guide to facilitate practitioners in the delivery of SBI in the ED and other hospital settings.

SAOR which is the Irish word for “free” is utilised as an acronym to facilitate health care professionals in remembering the key components of SBI. The four principle aspects of the intervention are (i) **S**upport, (ii) **A**sk and assess, (iii) **O**ffer assistance and (iv) **R**efer.

This model will guide clinical practice and form a key component of future continuing professional education programmes for nurses and other health care professionals on the delivery of SBI. The SAOR model is designed as a guide to SBI and should be utilized by practitioners as an adjunct to their existing professional repertoire and a guide to practice rather than a model to be slavishly adhered to. Those who utilize the model should do so within their level of competence, in the context of their scope of practice and within existing policies, procedures and protocols for their clinical environment.

We acknowledge that this is a wide-ranging model which may need to be adapted by practitioners taking cognisance of their clinical practice area and time constraints. Future

development of this model will inevitably lead to its adaptation for a variety of settings including primary care and mental health. Future enhancement of the model may also include the development of a companion guide for structured care pathways which are congruent with the clients (i) level of use, (ii) severity of alcohol dependence and (iii) extent of associated physical and psychosocial problems.

Bibliography

- Ali, R. Miller, M and McCormack, S. (1992). Future Directions for Alcohol and other Drug Treatment. Australian Government Publishing Service, Canberra.
- Allen, K. (1998) Essential concepts of addiction for general nursing practice. Nursing Clinics of North America 33 (1) 1 – 13.
- Anderson, P. and Baumberg, B. (2006) Alcohol in Europe London: Institute of Alcohol Studies.
- Anderson, R. (2006) Helping Patients with Alcoholic Problems; A Guide for Primary Care Staff Dublin, I.C.G.P.
- Anderson, S., Eadie, D.R. and Mackintosh, S.H. (2001) Alcohol misuse in Scotland; the role of A & E nurses Accident and Emergency Nursing (9) 92 – 100.
- 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 (WHO).
- Bazargan-Hejazi, S., Bing, E., Bazargan, M., Der-Martirosian, C., Hardin, E., Bernstein, J. and Bernstein, E. (2005). Evaluation of a brief intervention in an inner-city emergency department Annals of Emergency Medicine 46 (1) 67-76.
- Bein, T.H., Miller, W.R. and Tonigan, J.S. (1993). Brief interventions for alcohol problems Addiction 88 (3) 315-336.
- Borsari, B. and Carey, K. B. (2000). Effects of a brief motivational intervention with college student drinkers Journal of Consulting and Clinical Psychology 68 728-733.
- Charalambous, M. (2002) Alcohol and the accident and emergency department: a current review Alcohol and Alcoholism 37 307 – 312.

Cherpitel, C.J., Bond, J., Ye, Y., Borges, G., MacDonald, S. and Giesbrecht, N.A. (2003). A cross-national meta-analysis of alcohol and injury: data from the Emergency Room Collaborative Alcohol Analysis Project (ERCAAP) Addiction 98 1277-1286.

Crawford, M.J., Patton, R., Touquet, R., Drummond, C., Byford, S., Barrett, B., Reece, B., Brown, A. and Henry, J.A. (2004). Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: a pragmatic randomised controlled trial Lancet 364 (9442) 1334-1339.

Cullen, B. (2005). Report on Developing an Operational Plan for Drug and Alcohol Services in the South East Region T.C.D. Dublin: Addiction Research Centre.

D'onofrio, G., Nadel, E.S., Degutis, L.C., Sullivan, L.M., Casper, K., Bernstein, E. and Samet, J.H. (2002) Improving emergency medicine residents approach to patients with alcohol problems: a controlled education trial Annals of Emergency Medicine 40 (1) 51 – 59.

Fleming, M. and Baier Manwell, L. (1999). Brief interventions in primary care settings Alcohol Research and Health 23 (2) 128-137.

Goodall, C.A., Ayoub, A.F., Crawford, A, Smith, I., Bowman, A., Koppel, D. and Gilchrist, G. (2008) Nurse-delivered brief interventions for hazardous drinkers with alcohol-related facial trauma: a prospective randomised controlled trial British Journal of Oral and Maxillofacial Surgery 46 96-101.

Government of Ireland (2004) Strategic Taskforce on Alcohol; Second Report Dublin, Department of Health and Children.

Health Research Board (2006) National Drug Treatment Reporting System (NTRDS): Training Protocol Dublin: Drug Misuse Research Division.

Health Research Board (2007) Health-related Consequences of Problem Alcohol Use

Dublin: Health Research Board.

Hearne, R., Connolly, A. and Sheehan, J. (2002) A & E nurses and alcohol related attendances Nursing Times 1 (95) 59 – 62.

Herring, R. and Thom, B. (1999) Alcohol-related attendances in the A&E department: could nurses have a preventative role? Nursing Times 95 59–62.

Hibell, B., Andersson, B., Bjarnason, T., Ahlström, S., Balakireva, O., Kokkevi, A. and Morgan, M. (2004). European School Project on Alcohol and Other Drugs (ESPAD)
Stockholm: Modintryckoffset.

Hoeksema, H.L. and de Bock, G.H. (1993) The value of laboratory tests for the screening and recognition of alcohol abuse in primary care patients. Journal of Family Practice 37 268-276.

Hope, A., Gill, A., Costello, G., Sheehan, J., Brazil, E. and Reid, V. (2005) Alcohol and Injuries in the Accident and Emergency Department: A National Perspective Dublin: Department of Health and Children.

Hope, A. (2008). Alcohol-related Harm in Ireland. Health Service Executive: Alcohol Implementation Group.

Indig, D., Copeland, J., Conigrave, K.M. and Rotenko, I. (2008) Attitudes and beliefs of emergency department staff regarding alcohol-related presentations International Emergency Nursing doi:10.1016/j.ienj.2008.08.002

Irish college of General Practitioners (ICGP) (2007). Guide for Primary Care Staff on Alcohol Problems Dublin: ICGP Publications.

Lock, C. (2004). Alcohol and brief intervention in primary health care: what do patients think? Primary Health Care Research and Development 5 162-178.

- Martinez, R.J. and Murphy – Parker, D. (2003) Examining the rehabilitation of addiction education and beliefs of nursing students towards persons with alcohol problems Archives of Psychiatric Nursing XVII (4) 156 – 164.
- Miller, W.R., and Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: The Guilford Press.
- Miller, W.R., and Rollnick, S. (2002). Motivational Interviewing, Preparing People for Change, 2nd Ed, London, Guilford Press.
- Miller, W.R. and Sanchez, V.C. (1993). Motivating young adults for treatment and lifestyle changes. In Howard, G. (ed.) Issues in Alcohol Use and Misuse in Young Adults Notre Dame: University of Notre Dame.
- Miller, W.R. and Wilbourne, P.L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatment for alcohol use disorders Addiction 97 (3) 265-277.
- Molyneux, G.J., Cryan, E. and Dooley, E. (2006). The point prevalence of alcohol use disorders and binge drinking in an Irish general hospital Irish Journal of Psychological Medicine 23 (1) 17-20.
- Moyer, A., Finney, J.W., Swearingen, C.E. and Vergun, P. (2002). Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations Addiction 97 279-92.
- National Institute on Alcohol Abuse and Alcoholism (2005) Helping patients who drink too much; A Clinicians guide. USA, N.I.A.A.A.
- Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes Journal of Studies on Alcohol 58 (1) 7-29.

- Rayner, G.C., Allen, S.L. and Johnson, M. (2005). Countertransference and self-injury: a cognitive behavioural cycle Journal of Advanced Nursing 50 (1) 12-19.
- Resnick, B. (2003). The impact of alcohol use in community-dwelling older adults Journal of Community Health Nursing 20 (3) 35–145.
- Rogers, C. (1961). On Becoming a Person Boston, MA: Houghton Mifflin.
- Royal College of Physicians (2001) Alcohol- can the NHS Afford it; Recommendations for a Coherent Alcohol Strategy for Hospitals London: Royal College of Physicians.
- Saunders, J., Aasland, O., Babor, T., Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (A.U.D.I.T.): W.H.O. Collaborative Project on Early Detection of Persons with harmful Alcohol consumption-11 Addiction 88 791-804.
- Scottish Intercollegiate Guidelines Network (2003) The management of Harmful Drinking and Alcohol Dependence in Primary Care; A National Clinical Guideline Edinburgh, S.I.G.N.
- Smith, A. J., Hodgson, R., Bridgeman, K. and Sheppard, J.P. (2003) A randomised controlled trial of a brief intervention after alcohol-related facial injury Addiction 98, 43–52.
- Sommers MS, Dyehouse JM, Howe SR, *et al.* (2006) Effectiveness of brief interventions after alcohol-related vehicular injury: a randomised controlled trial Journal of Trauma 61 523–33.
- Spirito A., Monti P., Barnett N. P., Colby S. M., Sindelar H., Rohsenow D. J. et al. (2004) A randomized clinical trial of a brief motivational intervention for alcohol positive adolescents. Journal of Pediatrics 145: 396–402.
- Walters, T.S. and Neighbors, C. (2005). Feedback interventions for college alcohol misuse: What, why and for whom? Addictive Behaviors [30 \(6\)](#) 1168-1182

Walton, M.A., Goldstein, A.L., Chermack, S.T., McCammon, R.J., Cunningham, R.M., Barry, K.L., et al. (2008) Brief alcohol intervention in the emergency department: Moderators of effectiveness Journal of Studies on Alcohol and Drugs 69 (4) 550-560.

Watson, H.E. (1999) Problem drinkers in acute care settings: validation of an assessment instrument International Journal of Nursing Studies 36 (5) 415 – 423.

Wilk, A.I., Jensen, N.M. and Havighurst, T.C. (1997). Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers Journal of General Internal Medicine 12 74-83.

World Health Organization (1992). The ICD-10 Classification of Mental and Behavioural Disorders World Health Organization: Geneva.

World Health Organization (2002) World Health Report 2002: Reducing risks, promoting healthy life Geneva: WHO.

World Health Organization (2004) Global Status Report on Alcohol 2004. Geneva: Department of Mental Health and Substance Abuse, WHO.

Yersin, B., Nicolet, J. F., Dercrey, H., Burnier, M., van Melle, G. and Pecoud, A. (1995) Screening for excessive alcohol drinking. Comparative value of carbohydrate-deficient transferrin, gamma-glutamyltransferase and mean corpuscular volume Archives of Internal Medicine 155 1907–1911.

James O’Shea and Paul Goff, May 2009 ©.