



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government



# **TACKLING ALCOHOL MISUSE THROUGH SCREENING AND BRIEF INTERVENTIONS IN HOSPITAL TRAUMA CLINICS:**

## **A Knowledge Transfer Partnership**

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## **1. Summary**

Alcohol misuse is a major problem and costs the NHS in Wales approximately £70 million per year. The Cardiff University Violence and Society Research Group (VRG) has identified cost effective means of reducing alcohol misuse in patients whose misuse results in face and other injury and hospital treatment. In particular, screening and brief interventions delivered by maxillofacial and trauma clinic nurses have been found to reduce problematic drinking and the risk of repeat injury (Smith et al 2003).

Funded by a shorter Knowledge Transfer Partnership (sKTP) between the Welsh Assembly Government, NHS Wales and Cardiff University, knowledge about this intervention is currently being transferred into maxillofacial and trauma services in eight target hospitals in Wales through training events delivered by the University of Wales Institute, Cardiff (the training agency). In this knowledge transfer partnership, the KTP Associate reviewed the relevant evidence, identified and contacted key personnel in the target hospitals, set up and facilitated training events and venues, led seminars and produced a 'how to do it' guide, a clinical audit protocol, an article for publication, a review of relevant evidence and assisted with the preparation of a classic KTP application.

## **2. Background**

The National Substance Misuse Strategy 2008-2010 “Working Together to Reduce Harm” describes the scale and impact of alcohol misuse in Wales. The strategy places an emphasis on those drinkers who do not need specialist alcohol treatment interventions but whose drinking levels or patterns are causing them longer term damage or are causing problems for the wider community.

Alcohol misuse is placing a huge burden on health service in Wales. The estimated cost to the Welsh health service for both chronic and acute alcohol problems is between £70 million and £85 million a year (Coles and Pates 2009). Fifteen per cent of all hospital admissions have been reported as alcohol related and alcoholic liver disease is responsible for around 1.600 hospital admissions in Wales each year (Welsh Assembly Government 2008).

Research carried out by Professor Jonathan Shepherd and colleagues in Cardiff University’s Violence and Society Research Group (VRG) has demonstrated that it is possible to detect alcohol misuse and treat it using brief interventions when patients return to trauma and maxillofacial clinics for standard injury care. This is supported by various reviews of evidence which conclude that brief interventions are cost effective in a variety of healthcare settings.

Eight out of twelve NHS emergency departments in Wales (Ceredigion, Denbighshire, Swansea, Neath Port Talbot, Merthyr, Newport, Monmouthshire and Bridgend) are currently familiar and engaged in primary prevention of violence through ‘data sharing’ – a feature of the VRG’s Cardiff Model. No nursing staff in these hospitals however, had received training in the delivery of brief interventions which are the secondary prevention component of the Cardiff Model.

The training of nurses in maxillofacial and trauma clinics and the roll out of the Cardiff Model has therefore been the subject of a successful application for a shorter Knowledge Transfer Partnership (sKTP) project. The University of Wales Institute Cardiff was awarded the contract for delivering the training to nurses. The aim of the KTP project, with the collaboration of UWIC as the training agency, is to train approximately 150 band 5-7 hospital nurses, from trauma and maxillofacial departments in eight NHS hospitals on how to identify alcohol misuse and deliver brief interventions to reduce risky drinking.

**Aim of the sKTP: To reduce alcohol misuse and alcohol-related injury in Wales through transferring and embedding new knowledge about screening and brief interventions into the relevant NHS services.**

### **3. The Brief Intervention**

Individuals who sustain an alcohol related injury often attend Emergency Departments. Potentially, this is an opportunity for nurses and other health care professionals to discuss the effects of alcohol on patients' health. This is however, not always possible in the Emergency Department as many patients are still intoxicated on arrival. However, these patients often require follow up wound care at out-patient clinics (trauma and maxillofacial) and this provides an ideal opportunity for nurses to encourage patients to reflect on their alcohol consumption. Patients are usually sober when attending these follow up clinics and will have had time to reflect on their injury, which may leave them feeling vulnerable and susceptible to advice. Because of this, clinic visits represent 'teachable moments' (Longabaugh et al 1995) where a nurse can deliver a brief intervention.

This brief intervention is based on 'Motivational Interviewing', which is a psychological therapy developed by Miller and Rollnick 1991). Motivational Interviewing has a 'directive client-centred' counselling style (Rollnick 1996). The aim of the brief intervention is to use the opportunistic conversation between the nurse and patient during routine wound care to guide the patient towards making a positive change to their drinking.

The intervention was developed as part of a randomised controlled clinical trial conducted in the maxillofacial department in Cardiff by Dr Alyson Smith, Professor Jonathan Shepherd, Professor Ray Hodgson and Sister Kathryn Bridgeman (Smith et al 2003). The trial investigated the impact of the brief intervention delivered by a nurse compared to a control group in a sample of 151 young males who had sustained an alcohol related facial injury. In three months prior to admission to the Emergency Department, 60% of the intervention group and 54% of the control group was consuming alcohol at levels above the recommended limits. At one year follow up, 27% of the intervention group and 50% of the control group were drinking above recommended limits. These findings indicated that the brief intervention was more effective at reducing alcohol consumption than treatment as usual (injury itself can motivate individuals to modify their consumption).

#### **3.1) Features of the brief intervention**

There are a number of characteristics, goals and key ingredients to the brief intervention. The overall aim is to motivate individuals to reduce their alcohol consumption and to avoid becoming involved in risky, violent or confrontational situations when intoxicated (this information is taken from the UWIC training manual – designed for the sKTP project - Appendix I)

There are some basic key therapeutic skills which form the foundation for the brief intervention:

- Reflective listening
- Asking open ended questions
- Affirming

- Summarising
- Eliciting self-motivational statements

These skills are useful as they elicit responses from patients and can also be used in other clinical conversations. They can also be utilised in conjunction with the key ingredients of the brief intervention; which Miller and Rollnick (1991) summarise according to the acronym FRAMES (information taken from the journal article, Appendix II):

**Feedback** – feedback to the patient about their drinking levels and how drinking has contributed to their injury.

**Responsibility** – emphasis that the responsibility for reducing consumption is the patient’s alone.

**Advice** – provision of simple advice.

**Menu** - helping the patient identify from a menu of options specific actions that will change their behaviour

**Empathy** – maintaining an empathetic (non judgemental, collaborative) approach throughout.

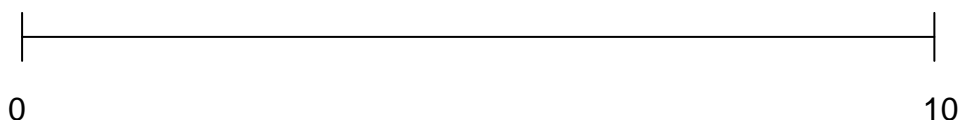
**Self Efficacy** – Helping the patient to believe that they are capable of making a sustainable change to their behaviour and instil confidence in them to do so: *“You can do it!”*

Other goals of the brief intervention are to express empathy (ability to make sense of patient’s situation), avoid argument, roll with resistance (use resistance as a cue to change therapeutic style) and promote self efficacy (help patients believe that they can change their behaviour).

### 3.2) Brief intervention strategies

The characteristics and goals of the brief intervention can encourage the patient to consider the effect drinking is having on their lifestyle and help motivate them to make a positive change. Nurses can use a number of strategies to develop this motivation and help the patient identify feasible ways to reduce their drinking

- **Quick assessment of self efficacy:** this can assess the patient’s motivation to change and their confidence in doing so. A visual scale can be used to ask the patient where they would place themselves in terms of motivation and then further discussions can be facilitated about how the patient could increase their motivation/confidence to change.



- **Typical Day/drinking session:** it can be useful to discuss regular drinking patterns so the patient can reflect on their consumption (for example calculating the number of units consumed on a typical drinking session can be helpful).
- **Good/bad things:** Discussions about these conflicting aspects of drinking can help develop ambivalence; the aim is for the nurse to tip the balance towards change.
- **Exploring concerns:** highlighting concerns about drinking can make the patient feel uncomfortable and this can prompt them into action.
- **Information exchange or provision:** Nurses can give the patient information about government guidelines, units, safe drinking levels and other helpful facts about alcohol. Leaflets and unit wheels can also be distributed (these can be accessed from the [drinkware.co.uk](http://drinkware.co.uk) website)
- **Self comparison:** Patients can be shown national drinking patterns and asked to compare themselves; this can be useful for individuals who have not previously considered their drinking levels to be hazardous.
- **Future/present comparison:** it can be useful to encourage the patient to consider their present drinking patterns and what they would like to be consuming in the future; targets and achievable goals can be set at this point.
- **Help with decision making:** the nurse can help the patient to identify some achievable goals (similar to the Menu aspect of FRAMES). This may include reducing the number of drinking nights per week, opting out of rounds or alternating between alcohol and soft drinks. These goals need to come from the patient, it is their responsibility to change
- **Summing up:** it is useful to provide the patient with a summary of the discussion, with particular focus on any goals that have been set. The discussion should end with optimism.

#### 4. The FAST Screening Questionnaire

The screening measure that was chosen for the sKTP project is the Fast Alcohol Screening Questionnaire (FAST) which was developed by Hodgson et al (2002); the authors included Dr Tina Alwyn and Dr Alyson Smith (members of the UWIC training agency). The FAST was designed for use in busy medical settings, has been shown to be valid and can be used for a range of medical services (Health Development Agency 2002). It takes approximately 15 minutes to complete and can be easily scored.

#### **The FAST**

### Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

**1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits**

**1 MEN:** How often do you have EIGHT or more drinks on one occasion?  
**WOMEN:** How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

**2** How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

**3** How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

**4** In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one occasion

#### **Scoring Key**

Score questions 1, 2 and 3 as follows:	Score question 4 as follows:
Never = 0 Less than monthly = 1 Monthly = 2 Weekly = 3 Daily or almost daily = 4	No = 0 Yes, on one occasion = 2 Yes, on more than one occasion = 4

## **5) Knowledge Transfer: Objectives, Outputs and Products**

The sKTP objectives are listed below, together with KTP products (see Appendices), KTP outputs and knowledge transfer activities. Barriers and facilitators to implementation are also highlighted here.

**Objective I:** To collate the evidence already compiled by VRG for brief interventions in A&E, trauma and maxillofacial care settings to gain an understanding of the current literature and issues.

- The Associate reviewed implementation projects for screening and brief interventions in secondary care. This included Emergency Department, maxillofacial and trauma clinic settings.  
**Product:** The Associate produced a summary of evidence and key findings in relation to screening and brief interventions in secondary care.
- The Associate observed the delivery of brief interventions by two nurses working in the maxillofacial clinic in Cardiff who were trained in the original clinical trial (Smith et al 2003).  
**Output:** Knowledge gained about the clinical context and how brief interventions can be delivered in busy medical settings.
- The Associate piloted the screening process using a short screening tool (the M-SASQ) in the Cardiff maxillofacial department to identify any barriers, prior to initiation of the training.  
**Knowledge transfer:** the Associate transferred the knowledge gained through the screening trial into the development of the screening process. This included a discussion about the potential barriers and facilitators to screening, such as the importance of getting the receptionists on board, making sure the screening questionnaire is clear and making sure patients are aware of why they are being asked about their drinking (the receptionist can provide this information when they hand out the questionnaire).

**Objective II:** To establish key contacts within each of the targeted departments including consultants, nursing and managerial staff.

- The Associate contacted the seven target Health Boards in Wales to identify key managers.  
**Output:** Document detailing all the Chief Executives; their names and contact numbers. This was prepared ready for the training agency.
- The Associate contacted the Executive Directors of Nursing for each of the Health Boards where the target hospitals are located (6/7). This was achieved via telephone and email. The Directors were notified about the project and the Associate provided them with information and sent them the letter from the Chief Medical Officer, Chief Nursing Officer and the Chief Dental Officer (Appendix III).  
**Output:** Support for the project gained from key managerial officials.
- The Directors of Nursing identified an individual to liaise with the Associate regarding the training. This typically involved the nomination of the Nurse Education, Training and Development Officer. These

individuals are responsible for nurse training for the Health Boards and helped facilitate the identification of training venues, circulated information and helped recruit nurses.

**Table I. Directors of Nursing and Nominated Nurse Training Officers:**

Health Board	Director of Nursing	Nurse Education, Training and Development Officer
Hywel Dda Health Board	Caroline Oakley	Chris Walsh
Betsi Cadwalder University Health Board	Jill Galvani	Lynne Grundy
Abertawe Bro Morgannwg University Health Board	Victoria Franklin	Lynne Jones
Cwm Taf Local Health Board	Angela Hopkins	Greg Mackenzie
Aneurin Bevan Local Health Board	Denise Llewellyn	Sue Ball
Cardiff and Vale University Health Board	Ruth Walker	Lesley Jones

The Associate contacted all the targeted departments in the eight hospitals:

- Bronglais District General Hospital: Ceredigion
  - Wrexham Maelor Hospital: Denbighshire
  - Morriston Hospital: Swansea
  - Neath Port Talbot Hospital: Neath Port Talbot
  - Prince Charles Hospital: Merthyr Tydfil
  - Royal Gwent Hospital: Newport
  - Nevill Hall Hospital: Monmouthshire
  - The Princess of Wales Hospital: Bridgend
  - The University Hospital of Wales: Cardiff (the nurses expressed interest in further training and a refresher course as the clinical trial was conducted 10 years ago)
  - The head nurse for each targeted clinic was contacted by the Associate, notified about the upcoming training dates and given information about the projects.
- Facilitator:** The head nurses were all very supportive and enthusiastic about the training. They could see how it would allow them to help tackle alcohol misuse.

**Objective III:** To raise awareness about the project through visits to departments, meeting nurses and providing presentations to key contacts.

- The Associate used a variety of methods to raise awareness about the project. A news article for example, was developed for hospital newsletters. It gave information about the project and contact details  
**Output:** The news piece was published in Bronglais Hospital's newsletter and adapted as a flyer to recruit nurses in Cardiff.
- Visits were made by the Associate to hospitals including Morriston, Royal Gwent and Nevill Hall Hospitals. The other hospitals requested information via email and through the post to disseminate to nurses. They also wished to circulate information by email.
- *Example: With the help of the head nurse in the Royal Gwent (Sheila Richards) two half hour information sessions were held to inform nurses about the project and raise awareness of the programme. The nurses were rotated over their lunchtime hour so they all could sit in on the session where the Associate and the training agency gave a presentation about the project.*
- **Output:** key contacts in full support of the programme and the Associate able to begin arranging training dates with the Nurse Education, Training and Development Officers.
- **Barrier:** some of the head nurses anticipated problems with nurse release.

**Objective IV:** To arrange training events, recruitment of nurses and to collate lists of nurses to be trained

- The Associate liaised with the training agency to identify suitable dates for holding the training events. The Associate then contacted the Nurse Education, Training and Development Officers to arrange dates and venues for the training. These individuals compiled the list of nurses to be trained for their Health Board.
- **Cwm Taf:** Dates were arranged with Greg Mackenzie for nurses working in Prince Charles Hospital for the 2<sup>nd</sup> and 3<sup>rd</sup> of March. He booked the lecture hall in the Royal Glamorgan Hospital and circulated the information in an email memo.
- **Abertawe Bro:** Training events were arranged by the Associate for nurses working in Morriston Hospital with the help of Lynne Jones. The dates were arranged for the 22<sup>nd</sup> and 23<sup>rd</sup> of March in the Postgraduate Centre (on site). Lynne also helped arrange the dates and venues for Neath Port Talbot (15<sup>th</sup> & 16<sup>th</sup> March) and Bridgend (29<sup>th</sup> and 30<sup>th</sup> March).
- **Cardiff and Vale:** The training dates were arranged with the help of Lesley Jones and David Brough (Nurse Education Team) to be held on site on the 19<sup>th</sup> and 20<sup>th</sup> of April.  
**Facilitator:** Louise Poley (Consultant Substance Misuse Nurse, UHW) contacted the Associate requesting to be involved with the project. She said she would help facilitate the training and help with recruitment for the Cardiff dates.

- **Hywel Dda:** Chris Walsh put the Associate in contact with the Outpatient Manager for Bronglais Hospital (Carol Grinszpan). Carol explained that she would be responsible for recruiting the nurses and circulating the information. Training dates were arranged for the 26<sup>th</sup> and 27<sup>th</sup> of April in the Postgraduate Centre (on site).
- **Aneurin Bevan:** The head nurse of the maxillofacial department in the Royal Gwent Hospital (Sheila Richards) contacted the training agency and the Associate in order to arrange a number of training events so that all her nurse could be covered. Shelia Richards collaborated with nurses in the fracture clinic and ENT to maximise recruitment. She also circulated emails and information about the dates to nurses in Nevill Hall Hospital so that they could also attend. Dates were arranged for the 13<sup>th</sup> & 18<sup>th</sup> of May and the 7<sup>th</sup> of June in the Postgraduate Centre in the Royal Gwent Hospital and at a local community hospital.
- **Betsi Cadwalder:** Lynne Grundy nominated Andrew Davies to help with arranging the training events for Wrexham Maelor Hospital.  
**Barrier:** Due to financial cut backs (in February) Wrexham Maelor Hospital were unable to hold any training until after April. The Associate therefore negotiated holding dates after the end of the financial year. Dates were arranged for the 10<sup>th</sup> and 11<sup>th</sup> of May, however these days were unsuitable for the training agency so were rearranged for the 20<sup>th</sup> and 21<sup>st</sup> of May.  
**Output:** Training dates arranged for all eight targeted hospitals (and Cardiff)
- Information about the dates, locations and times were sent out by the Nurse Education, Training and Development Officers. The Associate also personally called, visited or emailed the head nurses who she had established a working relationship with to notify them and encourage nurse recruitment.

**Objective V:** To oversee the screening and brief intervention programme

- The Associate organised information and materials for the training days. This included compiling the folders, arranging the printing and binding of the brief intervention and screening manuals collating all the PowerPoint handouts and printing attendance lists. The training agency developed an evaluation questionnaire which assesses nurse's knowledge and confidence surrounding their screening and brief intervention skills. The questionnaire is completed after the second day of the training event.
- The Associate arranged the catering for all the training events. This involved identifying final nurse numbers, choosing lunch and refreshment options with the help of the training agency and then contacting the catering department for each venue.  
**Output:** Materials compiled for each of the training dates  
**Knowledge transfer:** The Associate prepared a PowerPoint presentation for the training events about the KTP project, the evidence base for screening and brief interventions, the clinical trial held in the maxillofacial clinic in Cardiff and the Cardiff Model. This PowerPoint

was presented by the Associate at each training event. The Associate also took part in role plays and transferred knowledge she had learned about brief interventions and Motivational Interviewing into the training events.

- The Royal College of Surgeons of England (RCS) published a position statement encouraging the use of brief interventions during standard wound care (Appendix IV). This is endorsed by the Royal College of Nursing (RCN) and the College of Emergency Medicine (CEM).
- The RCS invited Professor Shepherd and the Associate to write an article about brief interventions to be published in their journal (the Faculty Dental Journal (FDJ)).

**Knowledge transfer:** Professor Shepherd and Sister Kathryn Bridgman worked with the Associate to write the article; their knowledge and expertise surrounding brief interventions was summarised in the paper.

**Product:** Journal article written by the Associate, Professor Shepherd and Sister Kathryn Bridgeman. The article is due to be published in the next addition of the FDJ (Appendix I)

- **Cwm Taf:** 27 nurses attended this training event. Unfortunately some of these nurses were unsuitable as they worked in areas such as mental health and midwifery. In addition only one nurse attended from Prince Charles Hospital, the reason being that the nurses were not notified by Greg Mackenzie. The majority of nurses worked in the Royal Glamorgan Hospital. Further training dates are currently being arranged following a visit by the Associate and the training agency to Prince Charles Hospital to meet with Sue Jones – head nurse of the maxillofacial clinic. Sue will collaborate with the head nurse of the fracture clinic (Angela Rich) who attended the training.
- **Abertawe Bro:** The training event was held for nurses working in Morriston Hospital. Only six nurses were able to attend, five from the maxillofacial department and one from the fracture clinic. This was disappointing and the reasons for this poor attendance were problems with nurse release, particularly in the fracture clinic. The events for Bridgend and Neath Port Talbot had to be cancelled at the last minute due to insufficient numbers. Discussions were instituted with the head nurses and the barriers that were identified included general staff shortage, sickness and annual leave. The Associate and the training agency immediately looked into rearranging dates for these hospitals. It was decided, following negotiations with Lynne Jones that two full days should be set aside at the three hospitals at a convenient location instead of the standard day and a half. Two dates were arranged. However, the training agency was unable to staff one of these events. Therefore a training event was arranged for the 28<sup>th</sup> of May in Neath Port Talbot Resource Centre and Lynne Jones circulated this information to all departments and clinics. Unfortunately, there were again problems with nurse release and only five nurses attended from the three hospitals, three from the maxillofacial department in Morrison Hospital, the head nurse from the fracture clinic in Morriston Hospital and a nurse from the Princess of Wales Hospital. A training afternoon has been arranged for the 19<sup>th</sup> of August in the fracture clinic in

Morrison Hospital. Further dates are currently being arranged for Neath Port Talbot and Bridgend with Lynne Jones.

**Facilitator:** In discussions with head nurses it was apparent that how holding training events on clinical audit days may increase numbers as clinics will be closed. The afternoon session in Morrison Hospital fracture clinic for example, was arranged on an audit day.

- **Cardiff and Vale:** Despite a flyer and circulatory emails being sent to all head nurses in relevant clinics (trauma, ENT etc); only five nurses attended the Cardiff training events. Three were from the maxillofacial department, one from ENT and the substance misuse liaison nurse. Again staff shortages were the reason behind this poor level of attendance.
- **Hywel Dda:** 11 nurses attended the Bronglais Hospital training event. The training went extremely well; all nurses were very enthusiastic about implementing the process across the board in outpatients. The fracture clinic was identified as the main target and Carol Grinszpan has set up further training events to cascade the training (using nurses who attended the event as experts) so that all her nurses can be trained and implementation can be facilitated.

**Facilitator:** There was support and interest from Ceredigion community services. The Community Safety Partnership (CSP) wanted to find out more information – which Carol Grinszpan relayed to them and Lisa Blair (commissioner for local substance misuse services) attended the training. Lisa Blair will be developing cards with contact numbers for local services (for nurses to hand out if needed) to integrate the screening and brief intervention process with the community.

- **Anerurin Bevan:** The three training events allowed for the majority of the Royal Gwent maxillofacial team to be trained (17/18). Three nurses were trained from the fracture clinic, three from ENT and five from Nevill Hall outpatients. To implement the screening and brief intervention process, the majority of nurses need to be trained, therefore more events are soon to be arranged for the fracture clinic and ENT nurses in the Royal Gwent Hospital and a visit was made to Nevill Hall Hospital to discuss future training.

**Barrier:** The head nurse of outpatients in Nevill Hall Hospital (Karen Williams) explained the difficulties with releasing nurses for the training: *“It is difficult now as when we have cancelled clinics they are being backfilled. It is hard to identify when the best time is”*

- **Betsi Cadwalder:** There was a problem with the Wrexham Maelor Hospital dates as the individual responsible for compiling the list of nurses was on sick leave for a period of time and the information was not circulated effectively. Nurse release was poor and following communication with the Head of Nursing East and Central (Sue Williams), the dates were cancelled. A new date for a training event has been arranged for the audit day on the 2<sup>nd</sup> of September.

**Output:** To date 82 nurses have been trained in this initial wave of training. Further training events are currently being arranged.

**Product:** A nurse database with the contact details for each of the nurses was created by the Associate.

**Objective VI:** To develop a clinical audit protocol in collaboration with VRG personnel to facilitate audits of screening and brief intervention services:

- The Associate and the training agency discussed the process of implementing screening and brief interventions into the target departments after the nurses have been trained. It was suggested in the sKTP LMC meetings that patient sticky labels be used to track patients who have received a brief intervention by placing them in a book and getting the nurses to record some basic information.
- The Associate identified the information which would need to be collected (from the training agency specification) and purchased some record materials (known as 'Screening and Brief Intervention – SBI books').

**Output:** Development of a method to record screening and brief intervention activity.

- To evaluate the success of implementation, a clinical audit protocol was developed by the Associate and Professor Shepherd.

**Knowledge transfer:** Knowledge about clinical audit methods was transferred from VRG personnel, clinical staff and Health Board managers into the development of the protocol so that clinics will be able to evaluate the progress of implementation.

**Product:** A clinical audit protocol was produced which describes how to evaluate screening rates, nurse skills and the fidelity of the brief interventions being delivered (Appendix V)

**Objective VII:** To oversee the implementation of the screening and brief intervention process and to audit the delivery of screening and brief interventions by trained nurses in the targeted hospitals

- **Abertawe Bro:** The Associate visited the maxillofacial department in Morriston Hospital to initiate implementation. As most of the nurses from this clinic were trained, they felt they could adequately implement the process into the department. The nurses were given an SBI record book and Sister Karen Humphreys and Deputy Sister Janet Jones volunteered to be nurse champions. The Associate visited the department a week later to check progress; the nurses had been filling in the book but explained there had been few patients with alcohol related injuries. The nurses explained that they have been screening all patients that attend, especially for casualty clinic.

**Barrier:** The nurses explained how there is not a specific treatment room for wound care or casualty patients. Therefore, they use whichever room is available. This can create problems when delivering brief interventions (privacy and time spent with patient)

**Barrier:** The nurses in Morriston Hospital explained that there were problems with the screening process. Patients were questioning why the nurses were asking about their alcohol use and were also unsure about what to do with completed questionnaires – many were being

kept or handed back to reception. Possible solutions were discussed and it was suggested that the Associate create a screening poster.

**Product:** The Associate created a screening poster which notifies patients that alcohol screening is part of a Welsh Assembly Government initiative and that they need to return their completed questionnaires to the nurses when they enter the treatment room (Appendix VI)

- **Aneurin Bevan:** The Associate visited Nevill Hall Hospital to initiate implementation. A meeting was held with the head nurse of outpatients (Karen Williams) and she felt the process could not be implemented until more of the nurses were trained (she explained that there were approximately 30 nurses and only five had attended the training). She also suggested that the Associate inform the consultants about the screening process through the monthly directorate meeting as they may have suggestions about how best to implement the screening tool.  
**Output:** A letter was requested from the Associate for the meeting. The letter included information about the project and what is required from the consultants (suggestions about how best to implement screening). The outcome of this meeting is not known at this point in time.
- The Associate visited the fracture outpatient clinic for a meeting with the head nurse (Gill Newman) who attended the training. She said she would need more nurses to be trained before being able to implement the screening measure. The Associate provided an SBI book and other materials and a training event or afternoon is currently being set up.
- The nurses in the maxillofacial department in the Royal Gwent Hospital have been extremely enthusiastic. The head nurse (Sheila Richards) agreed to be the nurse champion and has successfully implemented the screening and brief intervention process for patients who attend the casualty clinic on Fridays (this is the most suitable clinic as most alcohol related injuries will be treated here). Sheila Richards has also looked into incorporating the FAST into general assessments. The Associate attended a meeting with Sheila Richards and her deputy (Angela Kembrey) to discuss implementation progress. They explained that the best way (after trialling a number of methods) to screen patients has been to get Emergency Department staff to attach a copy of the FAST to the front of all Emergency Department patient notes ready for when the patient attends the follow up clinic. The nurse then gives the FAST to the patient whilst in the treatment room and then scores it and delivers a brief intervention when appropriate.  
**Facilitator:** The nurses thought of different ways to help make the process work smoothly. Angela Kembrey laminated and cut holes into a FAST scoring key so it can be placed over completed questionnaires in order to speed up scoring.
- The nurses have been recording progress in the SBI book.  
**Barrier:** The nurses initially expressed concerns over placing patient sticky notes in the SBI books - they felt it raised confidentiality and consent issues. When discussed at a sKTP LMC meeting it was agreed that the sticky labels are necessary and accepted for clinical audit and service evaluation. The nurses were still uneasy so have

been explaining to patients that they may be followed up at a later date. If the patient is unhappy with this the nurses record this in the SBI book.

- The nurses also asked for some information cards which described national statistics and other facts surrounding alcohol misuse

**Product:** The Associate developed the cards, laminated them and made them into key rings so nurses can attach them to their uniforms if needed. The cards include information on units, the calorie content of drinks, national drinking levels and a scale that can be used to assess confidence and motivation (a brief intervention strategy taught in the training).

- **Cardiff and Vale:** The Associate visited the maxillofacial department to initiate implementation of the screening and brief intervention process with the three nurses who cover suture clinic (an ideal clinic where alcohol related injuries are often treated). Sister Bridgeman (head nurse of the maxillofacial clinic) explained that the nurses already practising brief interventions and the Associate supplied an SBI book. The Associate returned to check progress and it was explained that the nurses are doing really well and Sister Bridgeman described how '*it is part of routine practice now*'. It was apparent however that not all the nurses were recording information in the SBI book. Sister Bridgeman said she would make sure the nurses are filling it in correctly. Sister Bridgeman also agreed to be a nurse champion. The Associate supplied the nurses with screening posters which they displayed in the clinic.

- **Hywel Dda:** Nurses who attended the Bronglais Hospital training events have all been very enthusiastic about implementing the SBI process. A nurse working in sexual health outpatients rang the training agency the next day to explain how they had already screened 15 people, delivered at least five brief interventions and that this progress was being recorded in the SBI book. The nurse (Louise Lewis) also asked for the FAST in Welsh.

**Output:** The Associate arranged for the FAST to be translated into Welsh and then sent it to the nurses in Bronglais Hospital.

- Carol Grinszpan (the outpatient manager) volunteered to be a nurse champion and has been arranging meetings with key personnel in order to get the screening and brief intervention process set up fully. She has all orthopaedic consultants on board and attended a meeting with the Head of Nursing (Helen Williams) who asked Carol to put together a task and finish group to set up the screening and brief intervention process and organise a launch date. One of the Orthopaedic Staff Grade doctors has come on board and Carol Grinszpan has also been setting up meetings with Lisa Blair regarding the help cards (she wants to have them developed ready for the launch date). Dates have been set up for some cascade training on the 21<sup>st</sup> of September.

**Objective VIII:** To produce a training aid which will be used for the implementation of the programme at other NHS hospitals.

**Product:** The Associate and Professor Shepherd developed the training aid which is a 'How to do it manual for implementing screening and brief interventions into trauma and maxillofacial clinics' (Appendix VII).

**Knowledge transfer:** The Associate and Professor Shepherd transferred the knowledge they had gained about implementing the screening and brief intervention process over the course of the KTP project into the manual.

- Implementation of the screening and brief intervention process was not possible for some of the targeted clinics as there was poor attendance at some of the training events (e.g. Nevill Hall Hospital). The training agency is however contracted for another year and are currently arranging further training events so that the majority of nurses in the targeted clinics can be trained. The targeted clinics will be able to use the manual to implement the screening and brief intervention process and will be able to evaluate progress using the clinical audit protocol.

**Objective IX:** To identify a nurse champion in each targeted clinic.

Table II: Nurse Champions:

Hospital	Clinic	Champion Name
Morrison	Maxillofacial	Karen Humphreys/Janet Jones
	Fracture	Janet Pardoe
UHW	Maxillofacial	Kathryn Bridgeman
Bronglais District General	Outpatients (fracture)	Carol Grinszpan
Royal Gwent	Maxillofacial	Sheila Richards/ Angela Kembrey
	Fracture	Gill Newman
Prince Charles	Maxillofacial	Sue Jones

Due to cancellations and the rescheduling of dates, nurses in the Princess of Wales Hospital, Wrexham Maelor Hospital, Nevill Hall Hospital, Neath Port Talbot Hospital and Prince Charles Hospital have not yet been fully trained. It is envisaged that the head nurses with whom the Associate has ongoing contact with will become nurse champions:

Table III: Anticipated Nurse Champions

Hospital	Clinic	Champion Name
Princess of Wales	Fracture	Jill Smith
Neath Port Talbot	Fracture	Delyth Davies
Wrexham Maelor	Fracture	Kathy Williams
	Maxillofacial	Dwynwen Parry
Prince Charles	Fracture	Angela Rich
Nevill Hall	Outpatients (fracture)	Karen Williams

## **6. Service Evaluation using Clinical Audit Protocol**

The Associate visited the departments which had successfully implemented the screening and brief intervention process to carry out a service evaluation using the components of the clinical audit protocol.

### **Royal Gwent Hospital: Maxillofacial Department**

Sheila Richards (head nurse) provided the Associate with a progress report about the screening and brief intervention process. The report gave details on the initial approach to screening which commenced on the 14<sup>th</sup> of June for all casualty patients aged 16 years and over. Patients were given a FAST questionnaire on arrival at reception and asked to fill it in whilst in the waiting area. The FAST questionnaire was then scored as the patient arrived into the clinic room and a brief intervention was delivered by a nurse where appropriate during suture removal. There were difficulties with this approach: the FAST questionnaires were not always handed out by the receptionist due to other duties and frequent change of staff. The forms were also given out to the wrong age group e.g. young children. Patients also completed the FAST questionnaire but left it in the waiting area and nursing staff did not always remember to check for a completed FAST questionnaire, consequently some brief intervention opportunities were missed. Sheila added a table in the report to show implementation progress (the information was taken from the SBI book). The table reflected the initial trial period of brief intervention activity for the period 14<sup>th</sup> of June to the 2<sup>nd</sup> of July. During this period there were several clinics where no activity or very limited activity was recorded:

Date	FAST Test (positive)	Brief Intervention
14 <sup>th</sup> June	1	0
15 <sup>th</sup> June	1	1
16 <sup>th</sup> June	0	0
17 <sup>th</sup> June	No clinic	
18 <sup>th</sup> June	0	0
21 <sup>st</sup> June	0	0
22 <sup>nd</sup> June	0	0
23 <sup>rd</sup> June	1	1
Nurses were then reminded to check clerical staff awareness of FAST form		
25 <sup>th</sup> June	8	5
29 <sup>th</sup> June	1	0
30 <sup>th</sup> June	1	1
1 <sup>st</sup> July	No clinic	

An evaluation was undertaken on the 30<sup>th</sup> of June with the view of improving compliance. Changes in the process were implemented from the 2<sup>nd</sup> of July. This included moving the area of responsibility from the receptionist to the clerk to see if compliance of FAST questionnaires increased, identifying a

lead nurse for each clinic with each primary responsibilities for brief intervention – and to keep this to one or two nurses initially. Nurses were asked to screen patient notes and have a FAST questionnaire ready on front of the notes acting as a prompt prior to patient arriving. The patients were given the FAST questionnaire on arrival to clinic room followed by scoring and brief intervention where applicable. This change was beneficial as it allowed the nurse to give the patient a clear explanation of the reason for being offered a FAST questionnaire. An increase was seen in compliance of FAST questionnaires being distributed and a note was recorded at the end of each clinic regarding the numbers of casualty patients and their suitability to receive the FAST questionnaire:

Date	Number screened	FAST (positive score)	Brief Intervention	Rationale
2 <sup>nd</sup> July	7	2	1	Of 9 casualty patients, 4 were children and 1 non-English speaking
5 <sup>th</sup> July	0	0	0	4 casualty patients, 3 children 1 adult DNA
6 <sup>th</sup> July		0	0	None suitable, all children
8 <sup>th</sup> July		No clinic		
9 <sup>th</sup> July am	3	1	0	3 casualty patients, 2 DNA
9 <sup>th</sup> July pm	4	1	1	All patients screened
12 <sup>th</sup> July	1	0	0	No records made
13 <sup>th</sup> July	0	0	0	No suitable patients
14 <sup>th</sup> July	3	1	1	No records made
16 <sup>th</sup> July	1	0	0	No records made
19 <sup>th</sup> July	3	1	1	No records made
20 <sup>th</sup> July	1	1	1	No records made
21 <sup>st</sup> July	0	0	0	No suitable patients

Sheila's report ended here, the Associate reviewed the SBI book to collect the remaining data:

Date	Number Screened	FAST (positive score)	Brief Intervention	Rationale
23 <sup>rd</sup> July	4	2	2	
26 <sup>th</sup> July	0	0	0	None suitable
27 <sup>th</sup> July	1	1	1	Other patients were children
30 <sup>th</sup> July	3	3	3	

From reviewing the book and Sheila's report it seems the nurses are screening patient notes beforehand to identify who is suitable for filling in the FAST questionnaire and consequently for receiving a brief intervention. This method can be beneficial as less time is used screening unsuitable patients (e.g. children). Patients who have an alcohol related injury are therefore less likely to be missed and more likely to receive a brief intervention. The target screening rate for patients entering the clinic is 80% in the clinical audit protocol. As the nurses in this department are screening the notes beforehand to assess suitability, and the FAST questionnaire is given out by the nurse in the treatment room, it is not feasible to calculate the percentage of patients being screened. The clinical audit protocol describes how 80% of patients who score positive on the FAST questionnaire should receive a brief intervention. From the data above it appears that 73% of patients who scored positive received a brief intervention (19/26), which is a positive figure for the first month and a half of implementation.

#### Brief Intervention Fidelity check

The Associate observed one of the nurses deliver three brief interventions to patients with alcohol-related injuries. All three interventions included at least five of the key ingredients in the fidelity checklist table (part of the clinical audit protocol, Appendix V). The brief intervention strategies that were used included the review of the injury event with a discussion about the role of alcohol, an exploration of typical drinking sessions; advice was given about units and government daily consumption guidelines; feedback and information was exchanged and the patient discussed a menu of options for reducing their drinking with the nurse.

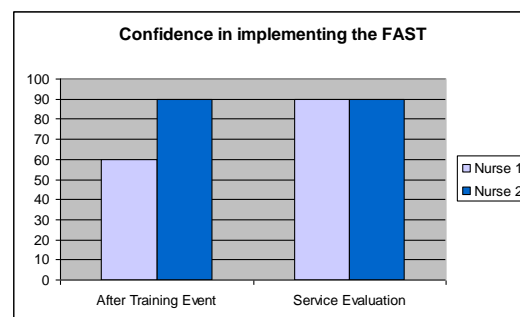
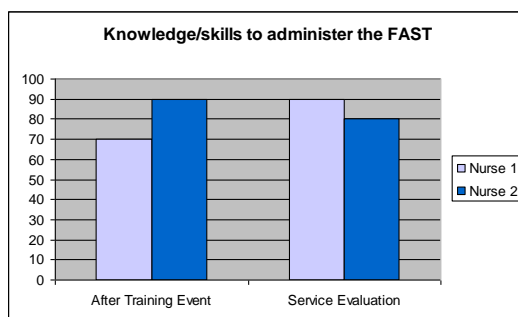
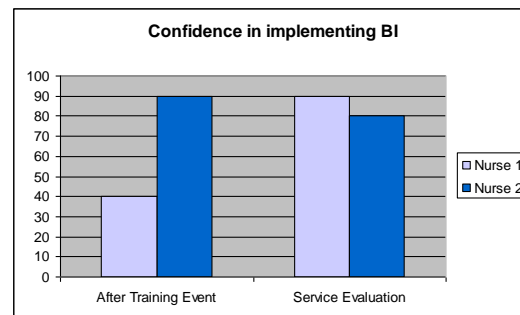
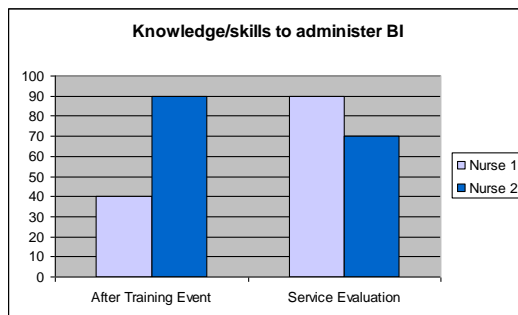
**Example:**

Brief Intervention Strategy	Observed
Review of injury event – role of alcohol	✓ <i>“I’m never drinking again”</i>
Typical drinking day/session	✓ <i>Typical drinks/places where patient drinks</i>
Exploring concerns	
Good/bad things about alcohol consumption	
Future/present comparison	
Motivation to change/confidence of success	
Feedback: Information exchange/ Self comparison to national consumption levels	✓ <i>Feedback from FAST and comparison to national levels on card</i>
Responsibility	
Advice	✓ <i>Advice about unit – contents of drinks</i>
Menu: Help with decision making	✓ <i>Discussed options, e.g. rotate with soft drinks</i>
Empathy: Express	✓
Self- efficacy: Promote	

Evaluation forms

The Associate asked Sheila to distribute the evaluation questionnaires to the nurses who were trained, however Sheila explained that not all of the nurses have been rotated onto the casualty clinics and will therefore not have received the opportunity to deliver brief interventions yet. She suggested that at this stage in the implementation process it was too early to ask the nurses to fill the questionnaires in again. The Associate was however, able to ask two of the nurses who were interviewed as they had been able to deliver some brief interventions:

## Evaluation form graphs: nurse's scores after the training compared to scores at the time of the service evaluation



From viewing the graphs above it seems that one nurse felt their knowledge, skills and confidence surrounding screening and brief interventions had increased over the time period between the training event and the service evaluation. The second nurse's scores however, decreased over time. When asked about this the nurse explained that she is getting used to delivering the brief interventions and sometimes finds it challenging. The Associate was able to provide feedback after observing this nurse and gave some helpful tips on how to improve some of her skills. The Associate also explained that the training agency will be visiting the department to offer a supervision session where the nurses can discuss any issues and refresh their skills.

### Qualitative interviews with Royal Gwent maxillofacial clinic nurses

The Associate asked three nurses to take part in a qualitative interview using the qualitative interview schedule (Appendix VIII). A number of themes emerged from the nurses' answers. On the whole the nurses found that screening and brief interventions have brought positive changes to the department, particularly in the form of raising awareness about alcohol related health issues: *'it's making patients more aware, especially about units'*. The nurses described that screening and delivering brief interventions can be very informative for patients *'it definitely gives them food for thought'* and many patients are shocked or surprised at a positive score on the FAST

questionnaire: *'patients find it very surprising, they think they are doing ok with their drinking but the scores mount up quickly'*.

The nurses' attitudes seem very positive towards the process, for example they explained that it allows for health promotion: *'It gives us the opportunity to help with health promotion'* and most patients have been receptive to advice about their drinking: *'it's been pretty positive, nobody has objected so far and all realised alcohol played a part in their injury'*. Nurses are already reporting the benefits of the screening and brief intervention process. One nurse for example, explained how a patient had returned to the clinic following a brief intervention: *'we had someone who had a brief intervention come back in and he said he had cut his drinking down considerably'*.

The nurses also described how they are looking into implementing the process into other areas: *'we will be looking into other clinics where we could do it, for example we are going to add the FAST to pre-assessment'*. The nurses were all confident that their skills will improve over time: *'its getting easier the more we do it'* and that the service will be maintained in their department: *'yes I can see it being maintained over time, I think we will get more confident and feel more relaxed doing it and it will become more routine'*.

The nurses who were interviewed identified a number of barriers to the screening and brief intervention process. These included time: *'time is a factor, I think we are definitely screening successfully but it's not always as easy as it seems'* and the sensitive nature of the topic, particularly as many of the nurses drink themselves: *'sometimes I feel a bit uncomfortable because I like having a drink myself'*. They also highlighted solutions to the perceived barriers; the nurses explained that more time would improve screening and brief intervention rates and some feedback sessions with the training agency would help the nurses identify ways of working with different types of patients: *'some feedback would be really useful'*.

#### Cardiff Dental School: Maxillofacial Clinic

The Associate reviewed the SBI book and it appears that the nurses are recording brief interventions and FAST scores when they treat patients with alcohol related injuries. The book did not contain a lot of information, the nurses explained that they have not seen many alcohol-related injuries in the suture clinic in the past weeks and believe that many patients are returning to their GPs for suture removal:

Date	FAST (positive score)	Brief Intervention
13/5/10	1	1
25/5/10	2 Refused FAST	2 Leaflet given, one patient's daughter stopped the intervention 'my mums not a pisshead'
Date unspecified	Refused FAST	1
16/6/10	1	1

No information was given about screening but when asked by the Associate, the nurses confirmed that they have been screening; the receptionist has been handing out the FAST to appropriate patients (adults over 18) and they are being scored and placed in the patient's notes. The Associate explained to the nurses that screening information needs to go into the SBI book to evaluate and calculate implementation rates using the clinical audit protocol; therefore the nurses will be correcting their practice from now on.

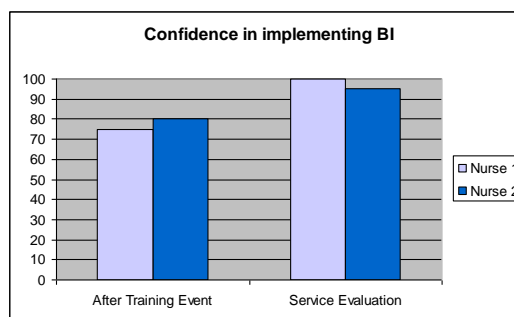
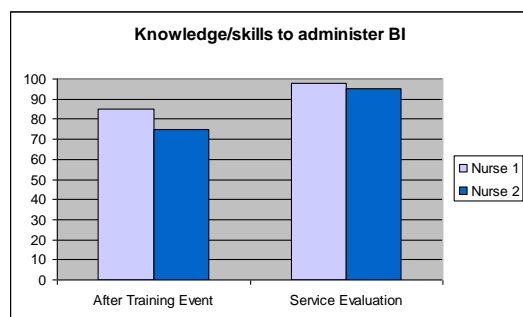
### Brief Intervention Fidelity check

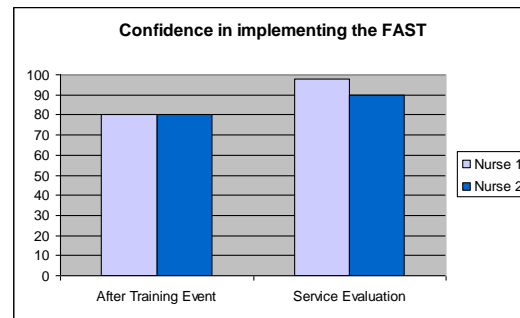
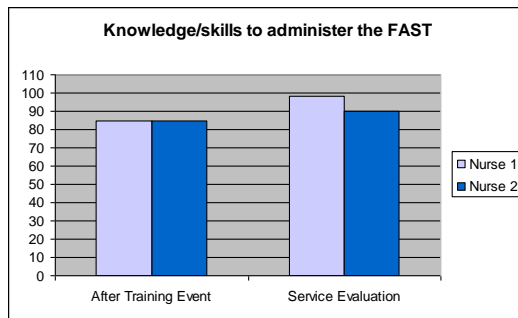
The Associate attended a number of suture clinics in order to carry out a fidelity check but was unable to observe a nurse delivering a brief intervention as no suitable patients attended the clinic. Many patients were either receiving follow up care for a surgical procedure, were children, did not score positive on the FAST questionnaire or in some cases no patients attended the clinic at all.

### Evaluation Questionnaires

The Associate was able to ask two out of the three nurses that were trained to complete the evaluation questionnaire again (the third was on leave).

### **Evaluation form graphs: nurse's scores after the training compared to scores at the time of the service evaluation**





The graphs above show how scores on each of the evaluation questions increased for both nurses. This can suggest that the nurses are feeling confident with their knowledge, skills and ability to administer the FAST questionnaire and deliver brief interventions. This is supported by the answers given in the qualitative interviews, for example one nurse explained how 'we have it down to a fine art now' when discussing brief interventions.

### Qualitative interviews with Cardiff maxillofacial clinic nurses

The Associate was able to interview two nurses from the Cardiff maxillofacial clinic. The nurses felt that screening and brief interventions have brought positive changes to the department, particularly through improving awareness about the effects of alcohol, both for the patients: *'Yes I think it has, its made people more aware, especially those who are binge drinking at the weekend'* and for the nurses in the department *'it has made all the staff think about alcohol, we also use it with pre-assessments...its been a learning curve for us all'*. The nurses seem to be confident in their skills for administering the FAST and delivering brief interventions: *'We are all clued up now, those that went on the training and do it; we are developing our own style'*, especially since refreshing their skills through attending the training event (some were trained in the original clinical trial): *'we used to do it but we didn't have the background knowledge that we do now'*.

Following the training, the nurses were given some materials to help with the interventions such as unit calculators and drink diaries. The nurses explained how these materials have been useful when delivering brief interventions: *'we give out the unit wheels and leaflets, one guy took a few drink diaries for him and his friends as he thought it would be good for them all to have a go'*. There have been mixed reactions from patients towards the brief interventions; some reactions have been positive: *'most of them are positive when they understand the reason why you are discussing alcohol'*, and some negative: *'initially some people thought it was intrusive...one lady walked out, she said she is here to be seen about her teeth, not to discuss social issues'*. The nurses said that these instances were in the minority and that most patients listened well and have been co-operative. The two nurses who were interviewed both agreed that the service would be maintained over time in the department and that the process of screening and delivering brief

interventions has improved the service they provide for patients with alcohol-related injuries: *'you're not just taking sutures out anymore, you're doing something positive'*.

Morrison Hospital: Maxillofacial clinic

The maxillofacial clinic in Morrison Hospital adopted the screening method where the receptionist hands out the FAST questionnaire when patients arrive, and the completed FAST questionnaire is attached to the patient notes before being seen by a nurse/consultant. The FAST questionnaire is then scored by the nurse and the information is recorded in the suture book. The SBI book revealed inconsistent information. The nurses had been recording FAST scores, whether the patient received a brief intervention and any comments as to why a brief intervention was not possible. There were, however a number of missing dates in the book and three pages of sticky labels did not display a date and were therefore unable to be interpreted. The nurses explained that the inconsistencies in recording information regarding whether patients had been screened or received a brief intervention were due to the nature of the clinic; that there are many consultant clinics running at the same time and there is not necessarily a suture clinic. Furthermore there is no designated suture removal room like in Cardiff maxillofacial department; therefore the nurses explained how they often move from room to room which can make it difficult to deliver brief interventions. It was also explained that there have been very few alcohol-related injuries in the past months; the nurses believed this is because many patients are returning to their GP surgeries for follow up wound care. In order to overcome the problem of recording information, the Associate has arranged a meeting with the head nurse when she returns from leave to discuss the inconsistencies in the SBI book. The available information in the book can be seen below:

Date	Number Screened	FAST (positive score)	Brief Intervention	Comments
11 <sup>th</sup> May	5	3	1	
18 <sup>th</sup> May	15	2	0	
Sticky labels with missing date – 3 pages	Unable to interpret			
9 <sup>th</sup> June	1	0	0	
8 <sup>th</sup> July	5	0	0	
29 <sup>th</sup> July	6	3	1	Not enough time for 2/3
3 <sup>rd</sup> August	5	0	0	

From observing the available data available above, it appears that the nurses are having difficulties delivering brief interventions as not all patients who score positive have received a brief intervention. Screening and brief intervention rates cannot be calculated as there is substantial missing data (which will be discussed with the head nurse on her return). The nurses described how the casualty clinics are often 'chaotic' therefore a lack of time with patients is a significant barrier against delivering brief interventions. Based on these findings, the Associate has suggested a further supervision session with the training agency where they can give helpful tips on delivering a minimal intervention, so nurses can feel confident using a few very brief strategies with patients in situations where there may not be time to complete a standard brief intervention.

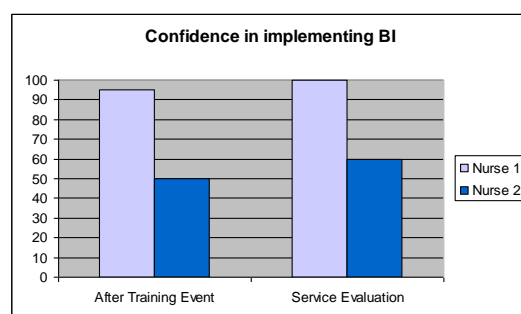
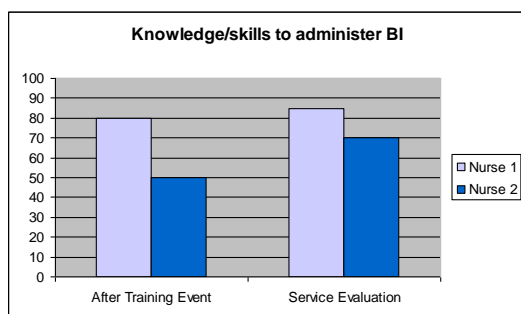
Brief Intervention Fidelity Check

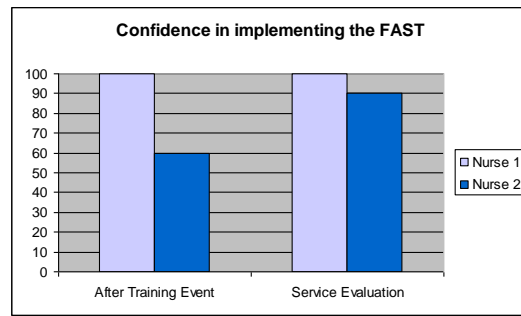
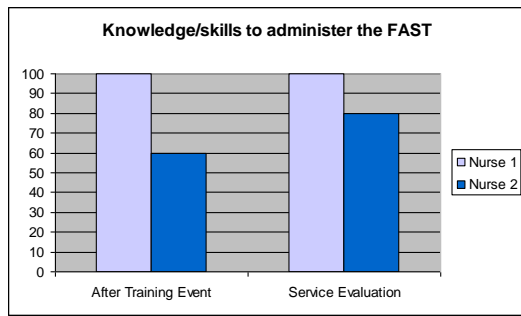
As with Cardiff maxillofacial clinic, the Associate was unable to observe a brief intervention being delivered in Morrision Hospital. The nurses described how they have seen very few alcohol-related injuries in the past month and again when the Associate was present there were no suitable patients to observe.

Evaluation Questionnaires

Two nurses completed the evaluation forms. A third nurse who attended the training was available, however she had not yet delivered any brief interventions so asked to complete the evaluation form at a later date.

**Evaluation form graphs: nurse's scores after the training compared to scores at the time of the service evaluation**





Scores on the evaluation questionnaires increased for both nurses, suggesting their knowledge, skills and confidence surrounding screening and brief interventions have improved over time. This result is promising, especially as the nurses have not yet received the opportunity to deliver many interventions.

### Qualitative Interviews with Morrision maxillofacial clinic nurses

The Associate interviewed three nurses from the maxillofacial department in Morrision Hospital. When asked if the screening and brief intervention process has brought any positive changes to the department, all three nurses agreed that it has raised awareness about the consequences of alcohol: *'people are looking at drinking a lot differently now'*. One nurse explained how they can see the benefits of practicing screening and brief interventions: *'its re-educating patients so hopefully they'll not end up in here again and in the long term it will save us money'*.

However, the nurses that were interviewed reported that they have not received the opportunity to deliver many brief interventions *'I havent really had anyone in'* but when they have the responses have generally been positive: *'they are quite positive, some of them know they are drinking over the limits so they are receptive and listen well, but whether change happens its unknown'*. The nurses' attitudes towards the process have also been positive: *'even if its only one out of ten its still worth it'*. One nurse who had been able to practice their skills more than the other two nurses explained how confidence in discussing the topic of alcohol with patient improves with practice: *I'm still a bit edgy but it comes with time, its getting easier and easier'*. The nurses in Morrision maxillofacial clinic have utilised a number of materials, for example one nurse described the use of the screening poster: *'it was a lot better once we put the poster up, it made it easier to bring up alcohol in the conversation, especailly with non-trauma patients'*. The leaflets, diaries and unit calculators have also been given out and well received by patients. One of the nurses also tried a new strategy: *'for one patient I asked them some easy questions about the information I had just told them to check they were listening and that they understood'*.

A number of barriers were discussed, one nurse described how it is easy to bring alcohol into the conversation by discussing the FAST score but only if

the clinic is relatively quiet: *'its difficult when we are busy, sometimes we are not even in the room long enough with a patient or we will need to move from room to room'*. In order to screen and deliver brief interventions effectively, one nurse reported how more time and staff were needed: *'I suppose we need more time and more staff around to do it, the trauma clinic is the busiest and most chaotic clinic'*. The nurses also highlighted issues with the department, such as staff being on leave or off due to sickness and a general shortage in patients attending with alcohol-related injuries: *'hardly any have been done as a lot are being sent to their GPs'*. Some patients were also described as difficult to work with, such as cancer patients, elderly patients: *'especially the older generation'* and individuals who do not see a problem with their drinking: *'it's the usual Friday, Saturday night 'louts' who aren't gonna listen because they don't see anything wrong with doing it once a week'*. These statements are interesting and provide an insight into nurses' perceptions about whether they feel it is appropriate to screen certain patients, thus it appears that they make judgements rather than use routine screening for everybody.

Despite these barriers, the nurses agreed that the process should be maintained in the department over time. One of the nurses suggested it might be useful for a meeting to be held to discuss strategies: *'perhaps the staff need to have a meeting to discuss national statistics and other information about alcohol so that we are reminded, things change regularly'*.

## Summary

It is clear that the three departments have implemented and are practicing screening and brief interventions. In some areas the process has been adopted routinely and in others more sporadically. Where the FAST questionnaire has been routinely used and the information recorded, the figures for the number of brief interventions being delivered are positive with up to 19 brief interventions being delivered over the period of a month and a half. In general, according to the evaluation questionnaires, the nurses' skills and confidence in administering the FAST questionnaire and delivering brief interventions have improved since the training events. The participating nurses believed that the process will get easier as they practice their skills, and that they will become more confident over time. When observations were feasible, the brief interventions being delivered included at least five of the key ingredients from the fidelity checklist. Further observations will be carried out by the training agency.

Different methods of screening have been adopted by the departments, some are distributing the questionnaire via reception and in others the nurses are handing the questionnaire to patients in the treatment room. Nurses' perceptions and judgements appear to be impacting on whether the screening measure is distributed routinely. These factors, along with barriers such as time, busy clinics, staff shortages and unsuitable patients have lead to

inconsistencies in the information recorded in the SBI books. These issues have been and will be discussed with the head nurses.

Some of the nurses expressed how they have not been able to deliver many brief interventions due to a shortage in patients attending clinics with alcohol-related injuries or in other cases due to patients not scoring positive on the FAST questionnaire. It was also believed that many suitable patients are returning to their GPs for follow up care. As some nurses have not been able to deliver many interventions, they suggested that it is too early for an evaluation and two departments requested that an evaluation take place at a later date when more nurses have been able to practice their skills. Further evaluations will be carried out by the training agency at the stages of three, six and twelve months following the training events.

To conclude, success in implementing the screening and brief intervention process has been demonstrated to some extent in each of the departments. In the Royal Gwent for example, the process has been routinely adopted and the success rate of brief intervention delivery is evident. In Cardiff, where patients are identified and brief interventions are given there is success, however only a limited number of nurses have been trained throughout the department (3) and some nurses are delivering interventions to patients who score positive on the FAST, whereas others are only delivering them to patients with alcohol-related injuries. In Morriston Hospital there is enthusiasm from the nurses who were trained to implement the screening and brief intervention process, however a number of barriers have been reported which seem to prevent this happening routinely. It appears that patients are being screened but they are few who score positive and some of those that do score positive are not routinely receiving brief interventions.

Screening and brief interventions are being carried out in these departments yet the pragmatic reality of the clinical setting seems to be impacting on success rates. The nurses are however all enthusiastic and supportive of the process, are confident that their skills will improve and are optimistic about the service being maintained over time in their departments.

## **7. Appendices**

UWIC

# **A Brief Intervention for Reducing Binge Alcohol Consumption**

Dr Alyson Smith



2010

This manual was prepared to support nurses in the implementation of brief interventions for reducing binge alcohol consumption

It is a component of the University of Wales Institute Cardiff study module entitled: **Brief Interventions and Screening for Alcohol Misuse**

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## Introduction

When patients attend Accident and Emergency Departments following an alcohol related injury, it is not always possible to conduct an alcohol intervention due to intoxication. However, such patients often require follow up at out-patient clinics (e.g. oral and maxillofacial surgery, trauma) and are usually sober at this time. This presents a unique opportunity to encourage patients to review their alcohol consumption. It is thought that patients may feel vulnerable after an injury and this represents a “teachable moment” (Longabaugh et al. 1995) – an ideal opportunity to give patients a “gentle nudge” to think about their drinking. One study of drunk drivers found that an alcohol related injury was the best predictor of long term abstinence (Booth and Grossweiler 1978). The intervention can be conducted as part of a clinical consultation or as a natural extension of it.

This intervention is based upon a psychological therapy called “Motivational Interviewing” (Miller and Rollnick 1991). This approach may be used over a brief intervention of 10-15 minutes or used over a more extended time period, as required.

MI can be defined as,

“A directive client-centred counselling style for helping clients to examine and resolve ambivalence about behaviour change.” (Rollnick 1996)

It has been used with a wide range of populations and health behaviour issues where behaviour change is important. For example:

- Diabetes care (Stott et al. 1996)
- Smoking (Rollnick et al. 1997)
- Problem gambling (Diskin and Hodgins 2009)
- Drug dependence (e.g. Saunders et al. 1995, Miller et al. 2003)
- Excessive drinking (e.g. for a review see Vasilaki et al. 2006)

The intervention described here was developed as part of a randomized controlled trial to evaluate the effectiveness of a brief alcohol intervention in an Oral and Maxillofacial surgery outpatients’ clinic (Smith et al. 2003). The study recruited 150 young men who had sustained an alcohol related facial injury. They were randomised to receive a brief nurse-led alcohol intervention or treatment as usual. In the 3 months prior to admission to Accident and Emergency, 60% of the intervention group and 54% of the control group were drinking above recommended limits. One year later, 50% of the control group and 27% of the intervention group were drinking above recommended limits. This suggests that a brief intervention is clearly more effective at reducing alcohol consumption than the passage of time alone. In practical terms, the intervention took less than 20 minutes to complete, and nurses were able to administer it whilst performing other duties e.g. suture removal. No additional resources were required for nurses to implement this intervention

## Role of the Nurse or Therapist

We have all encountered experiences where medical or nursing staff tried to “persuade” us to change our behaviour (e.g. cut down on fatty foods, exercise more, quit smoking). At times, this may have even bordered on “confrontation”. These strategies have been found to be ineffective (Rollnick 1996) and also alienate the patient. Clinicians have often attributed the low success of such strategies to a lack of motivation on the part of the patient. However, this implies that an individual’s level of motivation is static and does not change. This intervention is based upon a more optimistic perspective, that motivation is something which fluctuates, and can be influenced under the right circumstances. This brief intervention is an opportunity for nurses (or other clinicians) to provide this set of circumstances.

This approach offers a therapeutic style and philosophy, plus a set of strategies which will be discussed in further detail later in this manual. A number of basic key skills (which may be used in any clinical conversation) form the foundations for this approach. These are:

- Reflective Listening
  - Asking Open Ended Questions
  - Affirming
  - Summarising
  - Eliciting Self-motivational Statements
- **Reflective Listening** – Communication is a complex process that involves coding, receiving the message (verbal or non verbal) and decoding. It can go wrong at any stage in the process. Reflective listening is how you respond to what an individual says – often, making a reasonable guess at what they mean and checking this with them. Many statements can have multiple meanings, so checking is important. E.g. for one person “feeling depressed” may simply mean they are having a bad day, for someone else, it may mean that they feel suicidal. You can check meaning by forming reflections. This is similar to saying “do you mean...?” but in a statement form. For example: “you’re feeling...” “So you....” “It seems that you...” “It sounds like you are feeling...”
  - **Asking Open Ended Questions** – In the early stages, it is important to encourage the patient to talk and the professional should be listening carefully and encouraging. Open ended questions facilitate this process. They are questions which encourage a longer answer, for example: “Tell me about your drinking – what do you enjoy about it, and what concerns you?” “I understand you have some concerns about ..., tell me about that”. Closed Questions are those which

yield a “yes/no” answer e.g. “Do you like...?” These tend to close a conversation down.

- **Affirming** – this is supporting the patient, offering genuine compliments, appreciation or understanding.
- **Summarising** – this should be done periodically through out the session. It shows the client that you have been listening and prepares to move them on or to sum up at the end of a session. It is a useful way of helping the client to hear what they have said e.g. express ambivalence – “on the one hand..., and on the other hand...” Check the client’s view of the summary e.g. “is that a fair summary so far?” “Have I left anything out?”
- **Eliciting Self-Motivational Statements** – It is the client who presents the arguments for change. There are 4 types of self motivational statement:
  - *Problem Recognition* – e.g. “I never realised how much I was drinking, this is going to damage me in the long term”
  - *Expression of Concern* – Can be verbal e.g. “I am really worried” or non-verbal e.g. frown, tears.
  - *Intention to Change* – e.g. “I’ve got to do something about this.”
  - *Optimism about Change* – e.g. “I can do this.”

These all represent different aspects of commitment to change: behavioural (intention to act), emotional (concern), and cognitive (recognition, optimism). When a self motivating statement is presented, it can be reinforced verbally (e.g. “I can see this is difficult for you”) or non-verbally (e.g. nod). Sometimes questions can be asked which evoke self motivational statements, and these can lead on to further discussion. For example:

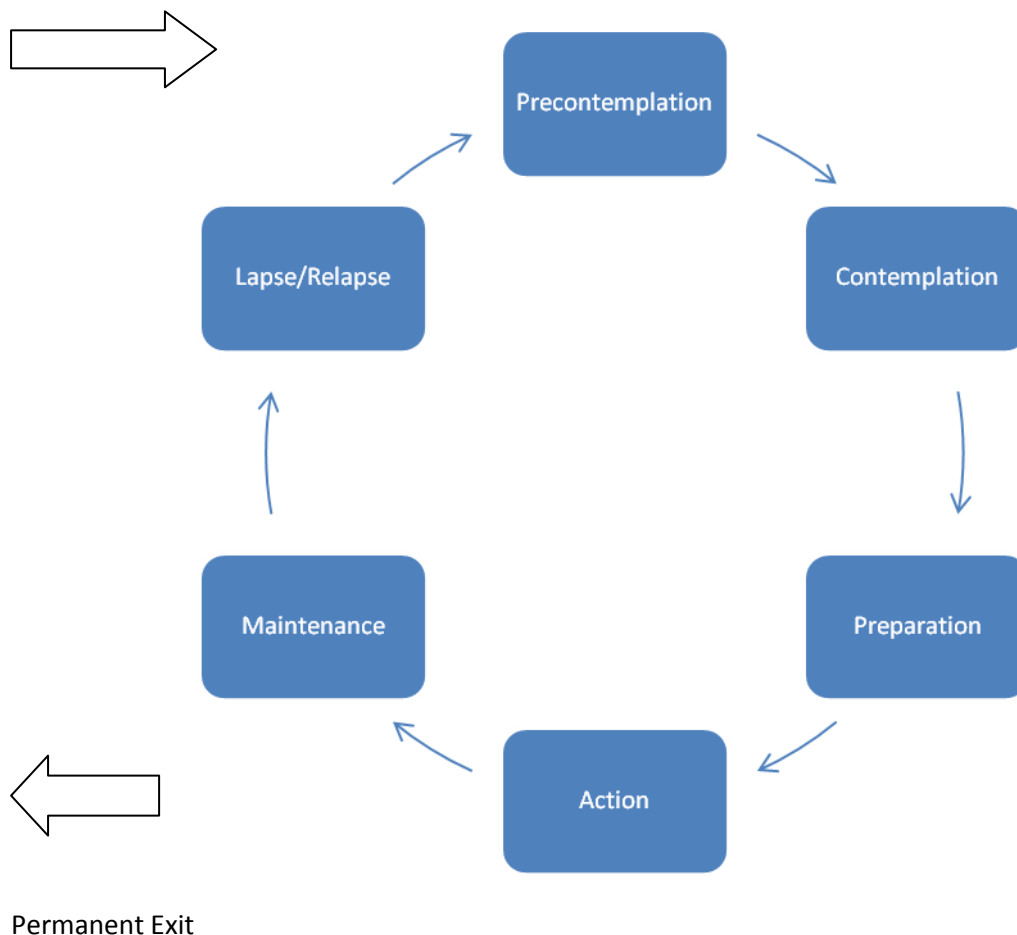
- *Problem Recognition* – “what makes you think there is a problem?” “how has your drinking stopped you from doing other things that are important to you?”
- *Expression of Concern* – “How do you feel about your drinking?” “How much does this concern you?”
- *Intention to Change* – “What reasons do you see for changing your drinking?” “What would be the advantages of reducing your drinking?”
- *Optimism* – “What encourages you that you could cut down on your drinking if you wanted to?” “What else makes you think you could succeed?”

The approach is one of partnership, where the patient is seen as the expert in what may work best for them. The intervention is collaborative and matched to their individual requirements and where they locate themselves in the change process. A simple and helpful way of thinking about this process is offered by the **Transtheoretical Model** (sometimes

known as the Stages of Change Model). Prochaska and DiClemente (1986) devised this model to describe some of the processes involved in behaviour change.

The process begins with *precontemplation* where no consideration has been given to change. Individuals may not even be aware or want to acknowledge that their drinking is problematic. *Contemplators* have moved to a stage of ambivalence, where they are beginning to weigh up the costs and benefits of their drinking. The *preparation* stage involves making the necessary plans for behaviour change, thinking about the issue and setting realistic goals. Following this comes the *action* stage, where a commitment to change has been made, but has not yet become part of an established behaviour pattern. *Maintenance* is the stabilisation of the new behaviour. *Lapse or relapse* are seen as an integral part of the change process and, in this model, viewed as opportunities for learning. The model is shown in the diagram below.

Enter here...



**Figure 1: Representation of Prochaska and DiClemente's Transtheoretical Model**

In the context of this model, the aim of the intervention is to move the patient closer to behaviour change. As every individual will be at a different stage in this process, interventions are tailored to individual requirements by selecting appropriate strategies. If the individual has not yet considered change (precontemplation), then the aim of the intervention would be to raise some doubt in the patient's mind about the issue of their alcohol consumption. If the individual has started to consider the possibility that there may be a problem (contemplation), then the nurse would attempt to tip the decisional balance in favour of healthy change. In determination and action, the nurse aims to help the client move towards change using the most personally appropriate course of action. Later on, in the maintenance stage (not usually seen in this context), the aim would be to encourage the patient to identify and use relapse prevention strategies. If there has been a lapse or relapse, the aim is to help the patient renew their commitment to change and to learn from their lapse experience.

## The Intervention

The intervention has two basic aims:

- To motivate individuals to reduce their alcohol consumption
- To motivate individuals to avoid becoming involved in risky, violent or confrontational situations when intoxicated.

The characteristics (or “feel”) of the intervention, goals, and a menu of specific strategies will be described below.

### Characteristics of the intervention

The “feel” of this intervention is based upon the spirit of Motivational Interviewing. The approach can be summarised as one of partnership, rather than expert – patient. Miller and Rollnick (1991) outline six characteristics which describe the way in which an intervention is ideally conducted. These are collectively known as FRAMES:

**Feedback** – give feedback in a respectful manner

**Responsibility** – emphasise that the patient is responsible for behaviour change

**Advise** – should be given in a clear neutral manner. Consent to give advice should be sought first.

**Menu** – patients are offered a number of choices and ask select the one that best suits their personal circumstances

**Empathy** – a vital characteristic in any helping relationship.

**Self Efficacy** – is a combination of the individual’s motivation to change and confidence in their ability to do this successfully. The intervention should support the individual’s self-efficacy and communicate (realistic) optimism about the possibility of change.

### Goals of the intervention

The goals of this intervention are based on those of MI, as described by Miller and Rollnick (1991). These are:

**Express Empathy** – Empathy is the ability to make sense of the patient’s experience. This is communicated to the patient through reflective listening, selective reinforcement, affirmation and the way the nurse summarises the patient’s current situation.

**Develop Discrepancy** – Motivation for change emerges when there is a gap between an individual’s current situation and where they would like to be. The aim

of the intervention is to focus the client's attention on this discrepancy (in relation to their drinking). This may involve raising awareness of the consequences of continued drinking for them *personally*.

**Avoid Argument** – Argument can make people feel uncomfortable and does not help people to move towards change. It can make the patient feel that the nurse does not understand them. A human reaction to attack is defence; this means that argument can be an impediment to a frank discussion.

**Roll with Resistance** – ambivalence (mixed feelings) about change is regarded as normal, not pathological. Ambivalence can be explored openly (e.g. through strategies such as good/bad things – see below).

**Promote Self Efficacy** – Clients need to believe that they have a chance of succeeding and it is important to communicate (realistic) hope and optimism to them. If a client is not optimistic about change, there is little reason for them to consider it.

## **Strategies for use during the intervention**

A number of strategies may be useful in motivating patients to reduce their alcohol consumption. Not all strategies will be appropriate to every patient, but will depend on their "readiness to change". The idea is to select from the "menu" of possible strategies, according to needs of the individual patient. A quick reference guide to these interventions is shown at the end of this section. This can be photo-copied and used as a convenient memory aid.

### **Opening**

The patient is encouraged to review the injury incident with the nurse, with the aim of coming to a better understanding of the event and their role in it. At this point, it may also be appropriate to discuss other aspects of the patient's current lifestyle such as: stress, anger, violence, alcohol and health.

Possible Questions:

Where does your use of [alcohol] fit into your lifestyle?

How does it affect your health?

### **Agenda Setting**

The patient is encourage to bring up topics for discussion and indicate their preferences for the direction of the consultation

### **Quick Assessment of Self-Efficacy**

This is a method for gauging the patient's motivation for change and confidence of success. This can be done easily using two questions:

On a scale of 1 to 10, how motivated are you to change your drinking?

And,

How confident are you of success?

Patients can be asked to mark their answers on an illustration of a scale:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Answers may provide enlightening points for further discussion, for example

How could motivation be increased? (What would it take for you to move from a score of 5 to a score of 8 or 9?)

What makes you so confident that you will be successful?

What factors might increase your confidence of success?

### Typical Day or Session

This strategy is a useful tool that can be used to quickly build up a picture of a patient's current drinking behaviour. It may also be used effectively in conjunction with the Quick Assessment for building up a picture of a patient's attitudes and behaviour when limited time is available

Possible Question:

What/how much would you drink in a typical day/session?

This can be supplemented by questions about duration of drinking session and frequency. Contextual issues such as location and others present may also be important information.

### Good/Bad Things

The patient is asked to list the good and bad things about their drinking. This strategy may also be adopted for violent behaviour if appropriate – there may be links or similarities between the two sets of information.

This task can easily be performed in a visual manner if appropriate. For example:

<b>Good Things about Drinking</b>	<b>Not so good things about Drinking</b>
<i>Social – meet friends at pub</i>	<i>Hangover</i>
<i>Good laugh</i> <i>Part of life</i>	<i>Expensive</i>
<b>Not so good things about Cutting down on Drinking</b>	<b>Good things about Cutting down on Drinking</b>
<i>Mates would say I am boring</i>	<i>My girlfriend would be pleased</i>
<i>Might have less fun</i>	<i>Have more cash to spend on doing up my camper van</i>

For some patients, it may be appropriate to work through the first two pro's and con's only (that is, Good things and Not so good things about drinking). Some others may be ready to consider the pro's and cons of change also. If so, the Good and Not so good things about cutting down (or stopping) drinking may also be considered.

### **Exploring Concerns**

This is a further opportunity for the patient to discuss any concerns they may have about their drinking (if appropriate). This may cover a wide range of issues, from health, through to relationships and alternatives to drinking.

Possible Questions:

What concerns you about your use of ...?

Why does it concern you?

Can you give me an example of this?

### **Information Exchange or Provision**

Patients may find a range of information helpful. This may include information about government recommended weekly alcohol consumption levels or contact details for local alcohol services (e.g. community alcohol team). Other patients may find it helpful to have a discussion around the prevalence of alcohol related injuries and the effects of alcohol on health. For example, as little as 8 units of alcohol can leave a person more vulnerable to assault or injury (Shepherd et al. 1990). Alcohol consumption is implicated in 65% of head injuries. This may also be a good opportunity to feedback FAST screening results.

Initially, nurses should seek to establish the patient's level of knowledge, and then, if appropriate, provide information in a neutral manner, and then elicit a response. Some young men may perceive injury sustained through a violent interaction as a "badge of honour" or reinforcer of their "maleness". With these individuals, care should be taken to present information in a manner that does not serve to emphasize these ideas.

Possible Questions:

Would you be interested in some more information on ...?

What do you make of this ...?

How does this relate to your drinking?

### **Self Comparison**

The patient is shown a simple histogram of national alcohol consumption levels and asked to locate his/her drinking on this. This task can be a revelation for many binge drinkers as they may not have realised that only a small percentage of the nation consumes as much as they do.

### **Future/Present Comparison**

This strategy involves encouraging the patient to examine the contrast between their behaviour now and their preferred (realistic) vision of the future. At this point, discussion might include barriers to change, possible sources of support and how alcohol affects the

patient currently. Present options can be explored and (if appropriate) the patient may be encouraged to start to think about a plan. The patient should set their own targets, and these should be small achievable goals.

### **Help with Decision Making**

This strategy is appropriate for patients who are considering modifying their drinking. All the options are explored and the patient is encouraged to set some (achievable) goals. The emphasis here is very much on the individual as decision maker and “self-expert” – being the best judge of what is the most suitable plan of action. However committed a person is to change, resolution may some times break down and this may happen several times before the new behaviour pattern is established. Patients can be reassured that this does not constitute failure, but that each lapse can be used as a learning experience.

### **Summing Up**

For some patients who are closer to a commitment to change, this will be a natural continuation from the “help with decision making”. However, for patients who have not yet made a commitment to change, this strategy involves encouraging them to briefly recap on the main points of the discussion. This type of feedback can be used to check understanding and help the patient to remember the salient information at a later date. Further referrals, contacts or information that the patient may require are supplied. Final queries can be addressed.

A pocket sized summary guide to these strategies is shown on the next page. This is followed by some case examples and a reference list.

## Patient Interview Menu: Quick Reference Guide

<p><b>Opening</b> Review injury event Role of alcohol Alcohol and health Current lifestyle and stress</p> <p><b>Quick Assessment</b> How motivated are you to change/how confident are you of success? Scale of 1-10</p>	<p><b>Agenda Setting</b> Encourage patient to raise topics and indicate direction of the consultation</p> <p><b>Typical Day/Session</b> Drinking on a typical day or typical drinking session – current behaviour</p>
<p><b>Good/Bad Things</b> Ask about the positive aspects of alcohol consumption, and then the negative. Use grid table if it helps</p>	
<p><b>Depending on how ready patient is to change, select from:</b></p>	
<p><b>Information Provision/Exchange</b> Establish patients level of knowledge “Would you be interested in more information on...?” Provide information in neutral way (if patient consents) Ask for reaction – “what do you think of this?”</p>	<p><b>Self Comparison</b> Show patient simple graph of national alcohol consumption levels (for their gender and age group) Ask them to locate themselves/their consumption level on the graph</p>
<p><b>Future/present</b> Contrast patient’s current situation with how s/he would like things to be in future What’s stopping you? How does alcohol affect you now?</p> <p><b>Exploring Concerns</b> What concerns do you have about your use of alcohol?</p>	<p><b>Help with Decision Making</b> Where does this leave you now? Explore present options You are the best judge of what is right for you Make sure patient may understand that resolution may falter at times Encourage patient to 1. Set own targets and 2. Set small achievable targets</p>
<p><b>For All:</b></p>	
<p><b>Summing Up</b> Recap main points of conversation (or encourage patient to do this) Opportunity to deal with any final queries, pass on information and check understanding</p>	

## **Case Examples: Matching Interventions to Patient's Circumstances**

### **Case 1**

A young man goes out to celebrate his 18<sup>th</sup> birthday. He is an inexperienced drinker and consumes a large number and variety of drinks. He falls off his bicycle on the way home, hitting his mid-face on the kerb. He is shocked and upset by the incident.

Aim: In the long term, to prevent the development of a binge-drinking pattern

Intervention: The shock and upset of this incident may provide a “teachable moment” where this patient may be receptive to considering issues around drinking. “Brief advice” may be all that is needed. This can be reinforced by verbal or written information on “sensible drinking” and road use whilst intoxicated.

Duration: 5 minutes

### **Case 2**

A 25 year old van driver drinks moderately in the evening during the week, but binges every Friday and Saturday night, consuming a minimum of 10 pints. One Friday night, he takes a short-cut home down an isolated alley that he would normally avoid and is assaulted by 2 youths. Until now, he has not considered his drinking to be problematic in any way.

Aim: To explore the possibility of reducing his level of alcohol consumption at weekends in order that he does not unnecessarily put himself into risky situations in the future. This may help the patient to make a cognitive link between his alcohol consumption and injury.

Intervention: The feeling of vulnerability following an assault may be a good motivator for this patient to reconsider his drinking patterns, particularly if encouraged to do so by a health care professional. Information leaflets on recommended weekly alcohol consumption levels and tips for cutting down may be useful.

Duration: 10 minutes

### **Case 3**

A 35 year old man whose long-term relationship ended four months ago gets into a fight with his ex-girlfriend's new partner. He has a history of binge-drinking, but this stopped as the relationship became established. Since the split, he has reverted to his old drinking patterns. Two months ago, he fractured his mandible in a fall after drinking and has recently lost his job after being repeatedly late for work due to hangovers. He does not see his drinking as a problem. In fact, he sees it as his only source of enjoyment.

Aim: This individual is at the “pre-contemplation” stage – he has not thought about the “down” side of his drinking e.g. job loss, injury. The aim with this patient would be to encourage him start to make the link between drinking and consequences and to move toward the next stage – “contemplation”.

Intervention – This patient may benefit from a slightly longer session, utilising strategies such as “good and bad things” and “quick assessment” in order to help him to reappraise his situation. He is unlikely to commit to behaviour change in this session, but the aim of the intervention is simply to encourage the patient to start considering the situation and his options. He is unlikely to accept a referral to alcohol services, but written information on local organizations can be offered for future reference.

Duration: 20 minutes

## References

### Key References

Miller, W., and Rollnick, S., (2002) *Motivational Interviewing – Preparing People for Change*. Guilford Press.

Smith, A., Hodgson, R. Bridgeman, K and Shepherd, J. (2003) A randomised controlled trial of a brief intervention after alcohol related facial injury. *Addiction*, 98: 43-52

Smith, A., Shepherd, J., and Hodgson, R., (1998) Brief interventions for patients with alcohol-related trauma, *British Journal of Oral and Maxillofacial Surgery*, 36: 408-415.

### Other References

Booth, R., and Grossweiler, R., (1978) Correlates and predictors of recidivism amongst drinking drivers, *International Journal of Addiction*, 13(1): 79-88.

Diskin, K. M., & Hodgins, D. C. (2009). A Randomized Controlled Trial of a Single Session Motivational Intervention for Concerned Gamblers. *Behaviour Research and Therapy*, 47(5), 382-388

Longabaugh, R., Minugh, A., Nirenburg, T., Clifford, P., Becker, B., and Woolard, R., (1995) Injury as a motivator to reduce drinking, *Academic Emergency Medicine*, 2: 817-825.

Miller, W., Yahne, C., Tonigan, J., (2003) Motivational Interviewing in drug abuse services: a randomised trial, *Journal of Consulting and Clinical Psychology*, 71: 754-763.

Prochaska, J., And DiClemente, C., (1986) Towards a comprehensive model of behaviour change. *In: W. Miller and N. Heather (eds.) Treating Addictive Behaviours*. New York: Plenum.

Rollnick, S., (1996) Behaviour change in practice: targeting individuals. *International Journal of Obesity*, 20 (Suppl 1): S22-S26.

Rollnick, S., Butler, C and Stott, N., (1997) Helping smokers make decisions: the enhancement of brief intervention for general medical practice. *Patient Education and Counselling*, 31: 191-203.

Saunders, B., Wilkinson, C., Phillips, M., (1995) The impact of a brief motivational intervention with opiate users attending a methadone programme, *Addiction*, 90: 415-424.

Shepherd, J., Robinson, L., and Levers, B., (1990) Roots of Urban Violence, *Injury*, 21: 139-141.

Stott, N., Rees, M., Rollnick, S., Pill, R., and Hakett, P., (1996) Professional response to innovation in clinical method: Diabetes care and negotiating skills, *Patient Education and Counselling*, 29: 67-73

Vasilaki, E., Hosier, S., and Cox, M., (2006) The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review, *Alcohol and Alcoholism*, 41(3): 328-335.

## **7.2. Appendix II: Journal Article**

### **The Use of ‘Brief Motivational Interventions’ to Reduce Hazardous Drinking by *Elisabeth Zabel, Kathryn Bridgeman, Jonathan Shepherd***

**The Royal College of Surgeons of England has recently published a position statement on the treatment of alcohol misuse using brief interventions combined with maxillofacial and trauma care. This article gives an overview of the reasons for this statement, the evidence which provides the foundation for this new standard of care and practical advice about how to implement this.**

**Key words:** Alcohol, brief intervention, Motivational Interviewing, trauma, maxillofacial

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#### **Introduction**

Early in 2010 the Royal College of Surgeons of England published its position statement ‘Reducing Alcohol Misuse in Trauma and other Surgical Patients’ which challenges surgeons, dental surgeons and emergency medicine specialists to help curb the epidemic of alcohol misuse. The Royal College of Nursing and the College of Emergency Medicine have endorsed this new clinical standard, which incorporates brief structured advice into standard trauma care.

Alcohol consumption in the UK has increased substantially over the last three decades and although levels have begun to decrease, alcohol abuse – particularly damaging ‘binge drinking’ is an integral feature of modern British culture<sup>1</sup>. It is a major cause of physical and psychological morbidity and premature death<sup>1,2</sup> and is causally linked with more than 60 medical conditions<sup>3</sup>. Deaths from cirrhosis of the liver, for example, have doubled over the past decade<sup>4</sup> and there were more than 18,000 UK deaths from this condition in 2009.

The Department of Health<sup>5</sup> in England has reported that the alcohol consumption of more than 10 million people (31% of men and 20% of women) in 2009 regularly exceeded Government guidelines for sensible drinking and as a consequence, concluded that most of these individuals will suffer from ill-health or injury because of their drinking. Alcohol misuse places a significant burden on the National Health Service, with an estimated cost of £2.7billion a year in England in 2008. This includes expenditure on admissions to hospital, prescription drugs and specialist alcohol treatment.

Hazardous drinking has been defined by the World Health Organisation as “*a pattern of drinking which poses a high risk of future damage to physical or mental health*”<sup>6, 7</sup>. UK Government guidelines recommend an upper limit of three to four units of alcohol a day for men and two to three units of alcohol a day for women. However, NHS statistics on alcohol in England for 2009 indicate that 25% of men reported drinking over 8 units, and 16% of women reported drinking over 6 units on at least one individual occasion in a week<sup>8</sup>. NHS statistics for England also highlighted that 33% of men and 16% of women were classified as hazardous drinkers, equating to 24% of all adults. This hazardous drinking in individuals who may also display symptoms of alcohol dependence has a significant impact on NHS workload and resource utilisation, particularly in trauma services where alcohol-related admissions after accidents and violence increased by 69% in 2007/2008 compared with 2002/2003<sup>8</sup>. Worryingly, a large number of adolescents are now drinking at levels above the upper limits set for adults<sup>9</sup>, putting them at risk of early alcohol dependence and physical complications<sup>10</sup> as well as the complications of binge drinking itself.

### **The ‘teachable moment’**

Dental specialists, surgeons and nurses working in emergency departments and trauma services are in an ideal position to identify and intervene in the lives of injured drinkers<sup>11</sup>. Injury sustained through alcohol misuse often leaves individuals feeling vulnerable and more receptive to advice that they reduce their drinking<sup>12</sup>. This presents health professionals with a unique opportunity to encourage patients to consider their drinking habits. This opportunity is known as a ‘teachable moment’<sup>11,13,14</sup>, where an individual is encouraged to move from a state of

unawareness ('pre-contemplation') about their alcohol problem to a state of awareness ('contemplation')<sup>15</sup>, which are 'stages of behaviour change' defined by Prochaska and DiClemente<sup>16</sup> (Fig. 1)

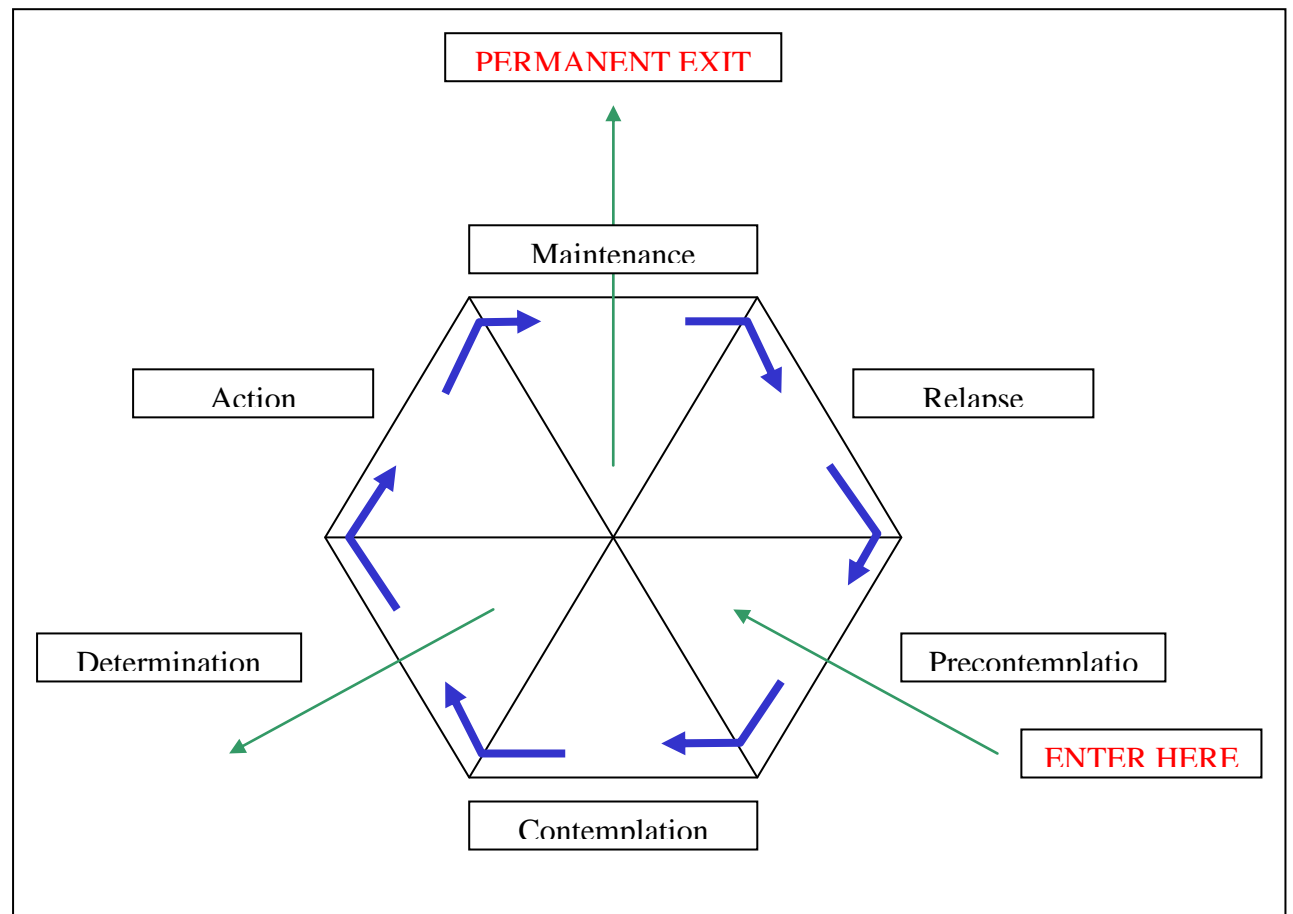


Fig. 1 Model of behaviour change

A teachable moment presents itself during or after a hospital visit following an alcohol-related injury or, in another health behaviour context, a chest infection following heavy smoking - which is an opportunity to deliver a smoking cessation intervention. This event in itself can move the individual into a state of contemplation about a lifestyle factor. They may begin to think about the effect their behaviour is having on their life and may begin to experience a conflict between likes and dislikes associated with a particular behaviour. Through weighing up the cost and benefits of a particular behaviour – in this case heavy drinking - an individual can then, on their own or with prompting, set themselves goals or consider ways to help them reduce

their drinking. The action stage follows, in which an individual initiates behaviour change. If the new behaviour is sustained the individual moves into the maintenance phase. Because behaviour change is often challenging, particularly in the longer term, an individual may relapse and revert to an earlier stage and benefit from further help to review and increase their motivation.

### **Brief Motivational Interventions**

Longabaugh and colleagues<sup>13</sup> described how motivation to change drinking behaviour can be increased if the patient perceives and acknowledges the association between alcohol consumption and the injury they sustained. Motivational Interviewing can be used to help establish this link. Motivational Interviewing is a therapeutic technique developed by Miller and Rollnick<sup>17</sup> which uses a client-centred method for enhancing intrinsic motivation enabling individuals to examine and resolve ambivalence about behaviour change<sup>18</sup>. This approach was developed from work in the field of addiction but has been used with a wide range of behavioural health issues. Brief interventions using Motivational Interviewing have been subject to numerous clinical trials<sup>19,20,21,22</sup> in a range of healthcare settings and have been defined as interactions between a patient and a healthcare professional during a medical visit or hospital admission, which last from five minutes to 20 minutes<sup>23</sup>. Brief interventions of this duration do not differ in effectiveness from more intensive treatments delivered by therapists<sup>14</sup>. This technique can therefore be used to intervene early with hazardous or harmful drinkers, before the development of alcohol dependence or the need for referral to specialist services to reduce associated problems such as vulnerability to violence or injury<sup>25,26</sup>. Identifying and reflecting on the harmful effects of excessive drinking can motivate patients to change their behaviour<sup>27</sup>. Smith and colleagues developed a brief intervention based on Motivational Interviewing specifically for young men who had sustained an alcohol-related face injury and attended a follow up appointment in a maxillofacial clinic<sup>22</sup>. This randomised controlled trial investigated the impact of a brief motivational intervention compared to treatment as usual in a sample of 151 young males. Significant decreases were found in 84 day total alcohol consumption across a year and a significantly greater reduction in the percentage of hazardous drinkers in the intervention group; 60% compared with 27% (baseline to 12 month follow up) compared to 54% to 51% in the control group. This study demonstrated

that a ‘teachable moment’ alone can reduce alcohol consumption, but also that when a brief intervention is added, reductions in alcohol misuse can be significantly higher.

Vasilaki and colleagues conducted a meta-analysis of randomised controlled trials of brief interventions published in 1983-2003<sup>27</sup>. Of the 22 trials that were identified, nine compared a brief motivational intervention with no treatment and met methodological criteria for inclusion. The brief motivational technique was found to be more effective for reducing alcohol consumption in the short term amongst hazardous drinkers both in studies which compared the technique to no treatment (aggregate effect size: 0.18, 95% C.I. 0.07, 0.29) and alternative treatment options (aggregate effect size: 0.43, 95% C.I. 0.17, 0.70).

The evidence shows that brief motivational interventions are effective in medical settings, particularly in outpatient clinics when individuals return for follow up care. Interventions performed in A&E departments are problematic because patients are often intoxicated and do not have time to reflect on their injury. Interventions conducted in outpatient settings allow staff much greater opportunity to capitalise on the ‘teachable moment’. Removal of sutures and attendances at fracture clinics are key opportunities to incorporate brief motivational interventions into everyday practice. Furthermore this approach reduces the cost of the intervention to a minimum, an important benefit compared with the involvement of expensive alcohol health workers.

### **Characteristics of a Brief Motivational Intervention.**

The aim of a brief intervention is to direct the conversation between the nurse/health care professional and the patient in a way which:

- 1) Helps the patient to understand the link between alcohol and their current injury
- 2) Identifies their drinking patterns
- 3) Encourages the patient to identify for themselves the positive and negative aspects of their current drinking habits
- 4) Explores concerns about the patient’s current drinking

- 5) Gets the patient to identify safe drinking behaviour
- 6) Provides information
- 7) Motivates the patient to reduce their drinking to safe levels

The effectiveness of this conversation depends on communication skills such as reflective listening, summarising, asking open ended questions and affirmation; all skills which should already be in the nurse's armoury. The targeted deployment of these skills can elicit information in a non-judgemental, non confrontational style and lay the foundation for the nurse or other health professional to increase a patient's motivation to reduce their drinking. It is also beneficial for the health professional to consider where the patient may be in terms of the Stages of Change model and their willingness to change their behaviour. If a patient is in the pre-contemplation stage, the aim of the intervention would be to raise some doubt about the wisdom of their drinking. If, on the other hand, a patient has already decided they would like to make a change to their drinking, the nurse or other health care professional can support them to reduce their consumption by recommending safe limits.

Miller and Rollnick<sup>17</sup> described six key ingredients of effective brief interventions, these are summarised as the acronym **FRAMES**:

**Feedback** – feedback to the patient about their drinking levels and how drinking has contributed to their injury.

**Responsibility** – emphasis that the responsibility for reducing consumption is the patient's alone.

**Advice** – provision of simple advice.

**Menu** - helping the patient identify from a menu of options specific actions that will change their behaviour

**Empathy** – maintaining an empathetic (non judgemental, collaborative) approach throughout.

**Self Efficacy** – Helping the patient to believe that they are capable of making a sustainable change to their behaviour and instil confidence in them to do so: “*You can do it!*”

Other goals of brief interventions include developing discrepancy, avoiding argument and rolling with resistance<sup>17</sup>.

- **Develop Discrepancy:** where a patient identifies a gap between where they would like to be and their current situation. This can be achieved by exploring how a patient’s alcohol consumption is impacting on their current goals or values.
- **Avoid Argument:** argument or confrontation needs to be avoided at all times since it does not facilitate effective interaction<sup>17</sup> or promote motivation to change behaviour.
- **Roll with Resistance:** patients can present a variety of forms of resistance, from behaving defensively to denial. These are usually signs that the patient is uncomfortable with what is being discussed. Because motivation to change needs to come from the patient, the health care professional can use these cues to change their style or explore a strategy that makes the patient feel more comfortable. This can include, for example, moving the conversation from the personal to the general; instead of saying “your drinking” using the phrase “having a drink”.

In busy clinical settings, it may not be feasible to provide all these prompts in one session. However, even if some of these are incorporated into the conversation a patient may be encouraged to change their drinking behaviour. Alcohol consumption and binge drinking is often of course a sensitive subject for health professionals themselves<sup>28</sup>, which explains clinicians’ reservations about discussing this topic with their patients. However, Schermer<sup>28</sup> found that a large percentage of trauma patients believe that this topic should be discussed with them and are not offended by the process of alcohol screening or brief interventions. Miller and Rollnick<sup>17</sup> helpfully summarised brief interventions as “a partnership between the parties concerned”, rather than an expert-to-patient exchange.

## Conclusion

It is an integral part of the role of all healthcare professionals to support health promotion initiatives and facilitate discussions with patients about healthy lifestyle or the benefits of behaviour change. They also need to implement treatments which are cost-beneficial - as here<sup>5,29,30</sup>. Developing skills in brief motivational interventions can easily be built on health professionals' existing skills of communication and empathy. The new Royal College of Surgeons treatment standard has been set in this context.

For this approach to be embedded into clinical practice, it is essential that NHS Trusts support this initiative. Successful implementation requires collaborative effort from all members of the multi-disciplinary team. The support of dental and trauma surgeons for brief interventions depends on their understanding of the concept of brief interventions and whether they believe that clinics in which trauma patients are treated are appropriate settings to deliver them<sup>28</sup>. Information, support and encouragement therefore needs to be provided for all staff involved with delivering brief interventions; this is recognised in the RCS statement below ([Fig. 2](#))



The Royal College of Surgeons of England

**Reducing Alcohol Misuse in Trauma and other Surgical Patients**

**Position statement**

Alcohol misuse is a major cause of injury and trauma death which is high on public and healthcare agendas. Young UK drinkers are drinking more than ever before. Intervening early in the lives of drinkers, before they develop alcohol dependence, is an important priority. Cost effective interventions, particularly short cognitive behavioural approaches (“brief interventions”) which reduce alcohol misuse and repeat trauma have been developed but are not yet widely delivered. Surgeons have unique opportunities to institute these interventions by combining them with standard trauma and other surgical care. The aftermath of injury and surgery, when patients attend outpatient clinics, represents a “teachable moment” which can be capitalised on to screen for alcohol misuse and motivate patients to reduce their drinking.

**Policy context**

The Government’s national alcohol harm reduction strategy was updated in 2006 in the form of “Safe Sensible Social”. A multi-department government group is responsible for delivering this updated strategy, which includes treatment services in a range of healthcare and other settings. The Welsh Assembly Government is funding targeted nurse training to facilitate the intervention described in this policy.

The College of Emergency Medicine (CEM) has published a position statement and guidelines on alcohol and violence prevention which fit with the proposal set out here. The Royal College of Nursing (RCN) has published a learning package on brief interventions. The National Institute for Health and Clinical Excellence (NICE) is currently finalising three pieces of guidance which aim to reduce alcohol misuse and improve the management of the complications of alcohol disorders.

**Position statement**

There is a strong evidence base for brief, cognitive behavioural advice delivered by nursing staff as a routine part of trauma and other surgical care for conditions known to result from alcohol misuse. Patients should be screened for alcohol misuse, and those where there is evidence of misuse should receive advice concurrent with surgical treatment (for example, suture removal). Surgeons should initiate, promote and support this contribution to care and collaborate for this purpose with nursing colleagues and with consultants in emergency medicine and other relevant medical specialties.

The Royal College of Surgeons is championing the introduction of this approach for the identification and management of patients who misuse alcohol. This will reduce the risk not just of surgical conditions associated with alcohol misuse but also the risk of a much wider spectrum of illness.

The College can help achieve this by increasing surgeons’ awareness of this approach, highlighting the training opportunities for staff who deliver the interventions, and supporting the work of the RCN and CEM in this context. Surgeons themselves can identify ways in which this treatment can be facilitated in their hospitals, and encourage nurse colleagues to make use of the training resources provided by the RCN and others.

**Endorsements**

This position statement has been endorsed by the Royal College of Nursing and the College of Emergency Medicine

**Fig 2.** Royal College of Surgeons of England Position Statement

## References

1. BMA (2009, September) *Under the influence: The damaging effect of marketing on young people*. Retrieved on 24 September from [http://www.bma.org.uk/health\\_promotion\\_ethics/alcohol/undertheinfluence.js](http://www.bma.org.uk/health_promotion_ethics/alcohol/undertheinfluence.js)
2. Tolley, K., Rowland, N., (2006) Identification of alcohol-related problems in a general hospital setting: a cost-effectiveness evaluation. *British Journal of Addiction*. 86: 429-438.
3. Room, R., Babor, T., Rehm, J., (2005) Alcohol and Public Health. *Lancet*. 365: 519-530.
4. Pincock, S., (2003) Binge drinking on rise in UK and elsewhere. *Lancet*. 362: 1126-1127.
5. Department of Health (2008) Reducing Alcohol Harm: health services in England for alcohol misuse. *National Audit Office*. Retrieved 23 January 2010 from [http://www.nao.org.uk/publications/0708/reducing\\_alcohol\\_harm.aspx](http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx)
6. Dunn, C., Zatzick, D., Russo, J., Rivara, F., Roy-Byrne, P., Ries, R., Wisner, D., Gentilello, L., (2003) Hazardous Drinking by Trauma Patients during the Year after Injury. *The Journal of Trauma: Injury, Infection and Critical Care*. 54: 707-712.
7. Allen, J.P., Litten, R.Z., Fertig, J.B., Babor, T., (1997) A Review of Research on the Alcohol Use Disorders Identification Test (AUDIT) *Alcoholism: Clinical and Experimental Research*. 21:4
8. NHS (2009) Statistics on Alcohol: England 2009, *The Information Centre for health and social care*. Retrieved on 29 January 2010 from <http://www.ic.nhs.uk/webfiles/publications/alcoholeng2009/Final%20Format%20draft%202009%20v7.pdf>
9. Alcohol Concern (2009, July) *Too many young people drinking at or above safe adult levels- Alcohol Concern- As NHS statistics show children's drinking has doubled since 1990*. Retrieved on 20 September 2009 from <http://www.alcoholconcern.org.uk/servlets/doc/1490>
10. Pirmohamed, M., Brown, C., Owens, L., Luke, C., Gilmore, I.T., Breckenridge, A.M., Park, B.K., (2000). The burden of alcohol misuse on an inner-city general hospital. *QJM*, 93: 291-295.
11. Smith, A.J., Shepherd, J.P., Hodgson, R.J., (1998) Brief interventions for patients with alcohol-related trauma. *British Journal of Oral and Maxillofacial Surgery*. 36: 408-415.
12. Apodaca, T.R., Schermer, C.R., (2003) Readiness to Change Alcohol Use after Trauma. *The Journal of Trauma: Injury, Infection, and Critical Care*. 54: 990-994.
13. Longabaugh, R., Minugh, P.A., Nirenberg, T.D., Clifford, P.R., Becker, B., Woolard, R., (1995) Injury as a Motivator to Reduce Drinking. *Academic Emergency Medicine*. 2: 817-825.
14. Moyer, A., Finney, J.W., (2005) Brief Interventions for Alcohol Problems: Factors that Facilitate Implementation. *Alcohol Research and Health*. 28: 44-50.
15. Monti, P.M., Colby, S.M., O'leary, T.A., (2001) *Adolescents, Alcohol, and Substance Abuse*. New York: The Guilford Press.

16. Prochaska, J.O., DiClemente, C.C., (1982) Transtheoretical therapy: Towards a more integrated model of change. *Psychotherapy: Theory, Research and Practice*. 19: 276-288.
17. Miller, W.R., Rollnick, S., (1991) Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press
18. Miller, W.R., Rollnick, S., (2002) Motivational Interviewing: Preparing People for Change. 2<sup>nd</sup> Edition. New York: The Guilford Press.
19. Gentilello, L. M., Rivara, F. P., Donovan, D. M. Jurkovich, G.J., Daranciang, E., Dunn, C.W., Villaveces, A., copass, M., Ries, R.R., (1999) Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery* 230: 473–483.
20. Monti, M., Colby, S. M., Barnett, N. P. et al., Spirito, A., Rohsenow, D.J., Myers, M., Woolard, R., Lewander, W., (1999) Brief intervention for harm reduction with alcohol positive older adolescents in a hospital emergency department. *Journal of Consulting and Clinical Psychology*. 67: 989–994.
21. Longabaugh, R., Woolard, R. E., Nirenberg, T. D., Minugh, A.P., Becker, B., Clifford, P.R., Carty, K., Sparadeo, F., Gogineni, A., (2001) Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. *Journal of Studies on Alcohol*. 62: 806–816.
22. Smith, A.J., Hodgson, R.J., Bridgeman, K., Shepherd, J.P., (2003) A randomized controlled trial of a brief intervention after alcohol-related facial injury. *Addiction*. 98: 43-52.
23. Centres for Disease Control and Prevention (2005) Recommendations for Trauma Centres to Improve Screening, Brief Interventions, and Referral to Treatment for Substance Use Disorders. *The Journal of Trauma, Injury, Infection and Critical Care*. 59: S37-S42.
24. Lovell, K., Richards, D., (2000) Multiple Access Points and Levels of Entry (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy*. 28: 379-391
25. Shepherd, J.P., Brickley, M., (1996). The relationship between alcohol intoxication, stressors and injury in urban violence. *The British Journal of Criminology*. 36: 546-566.
26. Warburton, A.L., Shepherd, J.P., (2002) Alcohol-related violence and the role of oral and maxillofacial surgeons in multi-agency prevention. *International Journal of Oral and Maxillofacial Surgery*. 31: 657–663
27. Vasilaki, E.I., Hosier, S.G., Miles Cox, W., (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: A meta-analytic review. *Alcohol and Alcoholism*. 41(3) 328-335.
28. Schermer. C.R., (2005) Feasibility of Alcohol Screening and Brief Intervention. *The Journal of Trauma: Injury, Infection and Critical Care*. 59: S119-S123
29. Wutzke, S.E., Shiell, A., Gomel, M.K., Conigrave, K.M., (2001) Cost effectiveness of brief interventions for reducing alcohol consumption. *Social Science and Medicine*. 52: 863-870.
30. Gentilello, L.M., Ebel, B.E., Wickizer, T.M., Salkever, D.S., Rivara, F.P., (2005) Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals: A Cost Benefit Analysis. *Annals of Surgery*. 241(4) 541-550.

### **7.3) Appendix III: Letter from CMO, CNO and CDO**

24<sup>th</sup> November 2009

Dear Colleague

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#### **BRIEF INTERVENTION TRAINING**

The National Substance Misuse Strategy 2008-2018 "Working Together to Reduce Harm" describes the scale and impact of the problem of alcohol misuse in Wales. The Strategy places an emphasis on those drinkers who do not need specialist alcohol treatment interventions but whose drinking levels or patterns are causing them longer term damage or are causing problems for the wider community.

Research carried out by Professor Jonathan Shepherd, Cardiff University Violence Research Group, has demonstrated that it is possible to detect alcohol misuse and treat it using brief interventions when patients with injuries return to A&E - trauma and maxillofacial clinics for standard injury care. This is supported by various reviews of evidence which conclude that brief interventions are cost effective in a variety of settings, including medical settings, such as primary care and Accident and Emergency Departments.

We have appointed the University of Wales Institute, Cardiff (UWIC) to develop and deliver a Brief Intervention training programme targeted at Band 5-7 nurses who work in the trauma and maxillofacial clinics. Professor Jonathan Shepherd will be overseeing the development of the training programme, the monitoring of the programme and evaluation to ensure its fidelity in relation to his original research and experience.

The training programme will provide nurses with an opportunity to practice

From the Chief Medical  
Officer/Chief Nursing  
Officer/Chief Dental Officer

Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ

Llywodraeth Cynulliad  
Cymru  
Parc Cathays  
Caerdydd  
CF10 3NQ

**CMO(2009)19**  
**CNO(2009)8**  
**CDO(2009)6**

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#### **BRIEF INTERVENTION TRAINING**

For action:

**Chief Executive Officers LHBs**  
**Medical Directors LHBs**  
**Nurse Directors LHBs**  
**Heads of Nursing & Midwifery HEI's**  
**Chief Executive Officer Public Health Wales**  
**Chief Executive Officer Velindre NHS Trust**  
**Chief Executive Officer Welsh Ambulance Service NHS Trust**  
**All-Wales Senior Nurse Advisor Groups**

For information:

**Welsh Assembly Government:**  
**Head of DHSS**  
**Nursing Officers,**  
**Regional Nursing Officers**  
**Head of Community Safety Division**  
**Home Office Crime Director**  
**Director of Dental Postgraduate Education**  
**Consultants in Dental Public Health - NPHS**

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Requests for further copies of this letter should be addressed to:

Ross Matthews  
Health Improvement Division  
Department for Public Health and  
Health Professions  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ

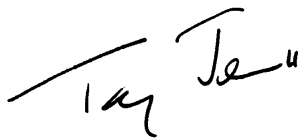
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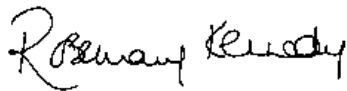
their skills when delivering the Intervention concurrent with standard wound care. The training programme will also provide an opportunity for continuing professional development and can be used as credits towards a relevant diploma or degree.

As excessive drinking is a major cause of disease and injury, mental and behavioural problems, we would encourage you and your staff to engage fully in this training programme in order to help reduce the long term damage from excessive drinking, the increasing burden on the NHS and to support an intervention which is evidence-based.

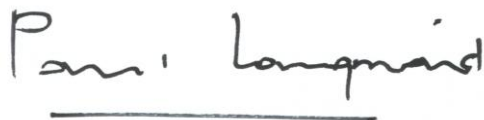
Should you have any queries regarding the programme, please do not hesitate to contact Cathy Weatherup, Head of Mental Health and Sexual Health, Health Improvement Division on 02920 825028.



DR TONY JEWELL  
CHIEF MEDICAL OFFICER



MRS ROSEMARY KENNEDY CBE  
CHIEF NURSING OFFICER/NURSE DIRECTOR FOR WALES



DR PAUL LANGMAID  
CHIEF DENTAL OFFICER FOR WALES

## **7.4) Appendix IV: RCS Position Statement**



### **The Royal College of Surgeons of England**

#### **Reducing Alcohol Misuse in Trauma and other Surgical Patients Position statement**

Alcohol misuse is a major cause of injury and trauma death which is high on public and healthcare agendas. Young UK drinkers are drinking more than ever before. Intervening early in the lives of drinkers, before they develop alcohol dependence, is an important priority. Cost effective interventions, particularly short cognitive behavioural approaches (“brief interventions”) which reduce alcohol misuse and repeat trauma have been developed but are not yet widely delivered. Surgeons have unique opportunities to institute these interventions by combining them with standard trauma and other surgical care. The aftermath of injury and surgery, when patients attend outpatient clinics, represents a “teachable moment” which can be capitalised on to screen for alcohol misuse and motivate patients to reduce their drinking.

#### **Policy context**

The Government’s national alcohol harm reduction strategy was updated in 2006 in the form of “Safe Sensible Social”. A multi-department government group is responsible for delivering this updated strategy, which includes treatment services in a range of healthcare and other settings. The Welsh Assembly Government is funding targeted nurse training to facilitate the intervention described in this policy.

The College of Emergency Medicine (CEM) has published a position statement and guidelines on alcohol and violence prevention which fit with the proposal set out here. The Royal College of Nursing (RCN) has published a learning package on brief interventions. The National Institute for Health and Clinical Excellence (NICE) is currently finalising three pieces of guidance which aim to reduce alcohol misuse and improve the management of the complications of alcohol disorders.

#### **Position statement**

There is a strong evidence base for brief, cognitive behavioural advice delivered by nursing staff as a routine part of trauma and other surgical care for conditions known to result from alcohol misuse. Patients should be screened for alcohol misuse, and those where there is evidence of misuse should receive advice concurrent with surgical treatment (for example, suture removal). Surgeons should initiate, promote and support this contribution to care and collaborate for this purpose with nursing colleagues and with consultants in emergency medicine and other relevant medical specialties.

The Royal College of Surgeons is championing the introduction of this approach for the identification and management of patients who misuse alcohol. This will reduce the risk not

just of surgical conditions associated with alcohol misuse but also the risk of a much wider spectrum of illness.

The College can help achieve this by increasing surgeons' awareness of this approach, highlighting the training opportunities for staff who deliver the interventions, and supporting the work of the RCN and CEM in this context. Surgeons themselves can identify ways in which this treatment can be facilitated in their hospitals, and encourage nurse colleagues to make use of the training resources provided by the RCN and others.

### References

Smith A J, Hodgson R, Shepherd J P. A randomised controlled trial of a brief intervention after alcohol-related facial injury. *Addiction* 2003; 98:43-52.

Gentilello LM, Rivara FP, Donovan DM, et al. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery* 1999; **230**:473–480.

Miller W, Sanchez V. Motivating young adults for treatment and lifestyle change. In: Howard G, ed. *Issues in alcohol use and misuse by young adults*. Notre Dame, USA: University of Notre Dame Press, 1994: 55-82.

College of Emergency Medicine. *Emergency Care 2015 - Building on the Evidence*. The evidence from the College of Emergency Medicine for the NHS (England) Review, Acute Care stream: CEM, 2008

Available from: [www.collemergencymed.ac.uk/asp/document.asp?ID=4679](http://www.collemergencymed.ac.uk/asp/document.asp?ID=4679)

Royal College of Nursing. Alcohol Misuse. Resources available from the RCN.

Available from:

[http://www.rcn.org.uk/development/practice/clinical\\_governance/closeup/public\\_health](http://www.rcn.org.uk/development/practice/clinical_governance/closeup/public_health)

Department of Health, Home Office et al. *Safe Sensible Social: the next steps in the National Alcohol Strategy*: Department of Health 2007

Available from:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH\\_075218](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218)

### Endorsements

This position statement has been endorsed by the Royal College of Nursing and the College of Emergency Medicine

January 2010

## **7.5) Appendix V: Clinical Audit Protocol**

### **Clinical Audit Protocol to Evaluate the Implementation of Screening and Brief Interventions (SBI) in Trauma and Maxillofacial Clinics in Wales.**

**Purpose:** To evaluate the implementation of screening and brief interventions into trauma and maxillofacial clinics. The following information is required:

- The number of patients who attend each clinic
- The number of patients screened using the FAST in each clinic
- The number of patients who scored positive on the FAST
- The number of patients with a positive FAST score who received a brief intervention
- The name of the nurse who delivered the brief intervention
- Patient details (sticky label from notes)

In order for this information to be collected, nurses working in the clinic need to have attended a screening and brief intervention training course held by UWIC. LHB directors of nursing and Trust managers need to be aware of the process and the head nurses (Sisters) of the clinics need to be involved. The Sister will also act as a champion for the screening and brief implementation process.

The screening measure (FAST) needs to be implemented so that all patients who attend the clinic will be screened. This can be achieved by either:

- The receptionist handing out the questionnaire and requesting that the patient fills it in while they are waiting to see the nurse. The patient then hands the questionnaire to the nurse when they enter the treatment room. The nurse then scores the questionnaire.

Or

- The nurse giving the patient the questionnaire when they enter the treatment room. The patient fills in the FAST while the nurse sets up the materials or washes their hands. The nurse then scores the questionnaire.

Completed questionnaires need to be attached to the patient's notes. Patients who score positive on the questionnaire and have an alcohol-related injury will receive a brief intervention, which will be delivered by a trained nurse. Patients who score positive on the questionnaire and do not have an alcohol-related injury can still receive a brief intervention; however they are more effective when the 'teachable moment' is present – where an individual's alcohol use has resulted in their injury.

### **Recording implementation progress**

Each department has been supplied with a 'Screening and Brief Intervention' book. In this, nurses will record the information listed above which translates into:

- Date and name of clinic e.g. suture clinic – maxillofacial department
- How many patients attended the clinic that day
- A sticky label from the patient's notes will be placed in the book, so they can be followed up if needed
- FAST score
- Brief intervention delivered YES/NO
- Nurse initials

**SBI book page example**

Date: \_\_\_\_\_ Clinic: \_\_\_\_\_ (e.g. suture clinic)

Number of patients attending clinic: \_\_\_\_\_

	FAST SCORE	BRIEF INTERVENTION?	NURSE INITIALS
Patient's Sticky Label – obtained from notes	4	✓	JD

This book will be kept either in the treatment room or another convenient location for easy access. The FAST screening questionnaires can be easily photocopied by the receptionists or administration staff.





nurses will have been trained to practice them all. It is acknowledged, however, that there may not be sufficient time in the clinic to cover each point fully. The brief intervention will therefore need to include at least one or two of the core ingredients to meet the required standard set by the training agency, whilst also including basic listening and reflective skills.

Brief Intervention Strategy	Frequency Observed
Review of injury event – role of alcohol	
Typical drinking day/session	
Exploring concerns	
Good/bad things about alcohol consumption	
Future/present comparison	
Motivation to change/confidence of success	
Feedback: Information exchange/ Self comparison to national consumption levels	
Responsibility	
Advice	
Menu: Help with decision making	
Empathy: Express	
Self- efficacy: Promote	

**7.6 Appendix VI: Screening Poster**



Welsh Assembly  
Government Initiative:



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

# ALCOHOL SCREENING

**One Standard Drink is**

 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs
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**The following quantities of alcohol contain more than 1 standard drink**

 <b>2</b>	 <b>3</b>	 <b>1.5</b>	 <b>2</b> 440ml	 <b>4</b> 440ml	 <b>2</b>	 <b>9</b>
Pint of Regular Beer/Lager/Cider	Pint of Premium Beer/Lager/Cider	Alcopop or can/bottle of Regular Lager	Can of Premium Lager or Strong Beer	Can of Super Strength Lager	Glass of Wine (175ml)	Bottle of Wine

The Welsh Assembly Government is currently aiming to reduce alcohol related harm. To do this they need to identify drinking patterns.

**We would be grateful if you could help us by filling out the Fast Alcohol Screening Test (FAST) and returning it to the nurse when you enter the treatment room.**

**Fast Alcohol Screening Test (FAST)**

For the following questions please circle the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

1 MEN: How often do you have EIGHT or more drinks on one occasion?  
WOMEN: How often do you have SIX or more drinks on one occasion?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

2 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

3 How often during the last year have you failed to do what was normally expected of you because of drinking?

0	1	2	3	4
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

0	2	4
No	Yes, on one occasion	Yes, on more than one occasion

## **7.7: Appendix VII: 'How to do it' Manual**

### **How To Do It Guide: Implementing Screening and Brief Interventions (SBI) in Trauma and Maxillofacial Clinics.**

#### **For Use by NHS Hospital Trusts and Health Boards**

#### **1) Setting up of the screening and brief intervention (SBI) process: management arrangements**

##### **Step 1: The management of SBI delivery**

**Problem:** Uncertainty about who will manage SBI delivery.

**Solution:** Identify continuum of management: Identify Director of Nursing and Director of Nursing's secretary, trauma and maxillofacial department clinical directors and relevant senior line manager (see Appendix I). These individuals will lead and manage the setting up of the SBI process.

##### **Step 2: The management of SBI training**

**Problem:** Uncertainty about who will manage training in SBI.

**Solution:** The Director of Nursing can identify a Nurse Training, Education and Development Officer who will select appropriate venues, set up training dates, circulate information about the SBI process and recruit nurses for training. They will also select an individual who will deliver the training; this may be an RCN trainer, an SBI local champion, or a trainer from local substance misuse services.

##### **Step 3: Recruitment of nurses for training**

**Problem:** Uncertainty about who should be trained and who is responsible for releasing nurses for training.

**Solution:** The Nurse Training, Education and Development Officer will identify and contact the head nurses in each of the targeted trauma and maxillofacial clinics in which the SBI process is to be implemented. The head nurse will be responsible for disseminating the information to their nurses and organising the clinic rota to allow the release of nurses for the training.

#### **Step 4: Identifying suitable dates for training**

**Problem:** Uncertainty about how SBI training will fit into the routine of the busy clinical setting and how nurse attendance will be maximised.

**Solution:** The Nurse Training, Education and Development Officer will arrange the training dates to fit with clinics. They will collaborate with the clinic head nurse to identify clinical audit days which may be suitable for training or work out a time period where the least amount of nurses are taking leave. A short news piece about the SBI process should be written by the Nurse Training, Education and Development Officer and published in the Hospital Trust newsletter to help maximise awareness of the SBI training, training dates, training content and CPD benefits.

#### **2) SBI training process**

**Question:** What does the training consist of?

**Answer:** The training must cover both how to distribute and score the FAST screening measure and how to deliver brief interventions using a Motivational Interviewing structure. To cover both parts of the SBI process, the training will need to be held over a day and a half so that nurses from each department are equipped with the necessary skills to implement the screening process and start practicing brief interventions when they return to their clinic.

#### **Step 1: Training pack and day structure**

**Problem:** Uncertainty about what training materials need to be included in preparation for the training days and the structure of the training days.

**Solution:** The trainer who has been identified to deliver the training will work with the Nurse Training, Education and Development Officer to compile a training pack. It will need to contain a manual for the SBI process, which can be developed with help from existing training materials such as the Royal College of Nursing Alcohol Identification and Brief Advice e-learning project (Alcohol IBA: <http://www.e-lfh.org.uk/projects/alcohol/index.html>). Information may also be available from the Alcohol Health Worker (AHW) - if the Trust

employs one - or from local alcohol services. The manual must include the following details:

- Information on the Fast Alcohol Screening Test (FAST)
- Copy of the FAST, how to fill in and scoring key.
- Theoretical background to Motivational Interviewing and brief interventions.
- Evidence base
- Key ingredients of brief interventions, including the FRAMES structure (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy) and a list of basic strategies e.g. reflective listening

The training days must reflect the contents of the manual. In the morning of the first day, the theoretical background and evidence based is covered by a PowerPoint presentation. In the afternoon the nurses will be taught the basic strategies and key ingredients of brief interventions through a combination of role play, workshops, and observations. The second (half) day needs to cover screening. This will include information about the FAST; its development and use in clinical contexts. The nurses then need to practice filling out the screening measure, scoring it and feeding back the result using the brief intervention skills they learned from the previous day.

### **Step 2: Other materials: timetable and evaluation forms**

**Problem:** Uncertainty about providing information about the training day contents, how nurse skills can be assessed following the training and how these skills can be maintained.

**Solution:** A timetable of the training day and its contents needs to be compiled by the Nurse Training, Education and Develop Officer and placed in the training packs so that the nurses are aware of what will be covered in the training. A contact sheet will also need to be included in the packs, which needs to be filled in by each nurse so that the Nurse Training, Education and Development Officer can arrange for supervision and top up training. An evaluation sheet needs to be given to the nurses at the end of the half training

day (day two) by the SBI trainer (Appendix II). This form will assess knowledge of, and confidence in screening and brief interventions.

### **Step 3: Nurse Database**

**Problem:** Uncertainty about how and where all the nurse contact details will be stored.

**Solution:** In order to check and maintain SBI skills and confidence at three, six and twelve month intervals, a database needs to be created where the nurse details from the contact and evaluation sheets can be entered. The database needs to be compiled by the Nurse Training, Education and Development Officer as they will be conducting the follow up and arranging the top up training.

## **3) Embedding SBI into clinical routine**

### **Step 1: Implementing the screening process**

**Problem:** Uncertainty about how the screening measure will be implemented into the relevant clinics.

**Solution:** The head nurse in each clinic needs to identify the optimal way to distribute the FAST screening questionnaire. This may involve either the receptionist distributing the questionnaire to patients when they first attend the clinic or by the nurse in the treatment room. The head nurse needs to ensure that all patients attending the clinic are screened and that this information is recorded.

### **Step 2: Recording SBI**

**Problem:** Uncertainty about how information about the SBI process will be recorded and how implementation will be evaluated.

**Solution:** Details about screening and intervention delivery need to be recorded in a 'Screening and Brief Intervention Book'. This information needs to be documented so that the head nurse can check the progress of SBI implementation and to ensure that patients who score positive on the FAST are receiving a brief intervention delivered by a trained nurse. The details that

are recorded in the book need to include patient details – obtained from sticky label – their FAST score; whether they received a BI and which nurse delivered the BI (see Appendix III). The head nurse needs to ensure that their nurses are recording these details so that, for example, the proportion of patients attending the clinic who are screened and who receive a brief intervention can be determined.

### **Step 3: Obtaining materials to help nurses practicing brief interventions**

**Problem:** Uncertainty about what the nurses should do if patients require more information following a brief intervention.

**Solution:** There are a range of materials which can aid the nurses in delivering brief interventions which include helpful phone numbers and website details if the patients need more information. The Nurse Training, Education and Development Officer or clinic head nurse can, for example, obtain the following from [drinkaware.co.uk](http://drinkaware.co.uk):

- Unit Wheels
- Drink Diaries
- Alcohol Information Posters
- Alcohol Information Leaflets

## **4) Clinical audit of SBI process**

### **Step 1: Maximising compliance**

**Problem:** Uncertainty about how to ensure that nurses continuously practise SBI delivery.

**Solution:** The clinic head nurse needs to ensure that the trained nurses continue to screen and provide brief interventions to appropriate patients. To do this the SBI book should be audited and action taken based on this audit. The book should be reviewed on a monthly and quarterly basis over the first two years and thereafter if necessary.

### **Step 2: Progress Report to Health Board/Trust**

**Problem:** Uncertainty about how the progress of SBI implementation is disseminated to the individuals who are managing the SBI process.

**Solution:** A progress report needs to be completed by the Clinical Director for the Trust or Health Board at three, six and twelve months, which can be viewed by the clinical director's line manager. The report will include details from the clinic head nurse's monthly reviews of the SBI book.

### **Step 3: Assessment of nurse skills and confidence**

**Problem:** Uncertainty about how to assess whether the nurses feel they are delivering the brief interventions correctly.

**Solution:** The Nurse Training, Education and Development Officer should ask the nurses to complete the evaluation questionnaire again at three six and twelve months to assess the nurses' confidence in their SBI skills. This will highlight any perceived changes in their SBI practice and can identify the need for top up training.

### **Step 4: Assessment of brief intervention fidelity**

**Problem:** Uncertainty about how to check that the nurses are delivering brief interventions correctly.

**Solution:** The Nurse Training, Education and Development Officer should observe or videotape the nurses delivering brief interventions at three, six and twelve months and use a fidelity checklist (Appendix IV) to assess whether the nurses are delivering brief interventions correctly.

### **Step 5: Provision of top-up training as determined by assessments**

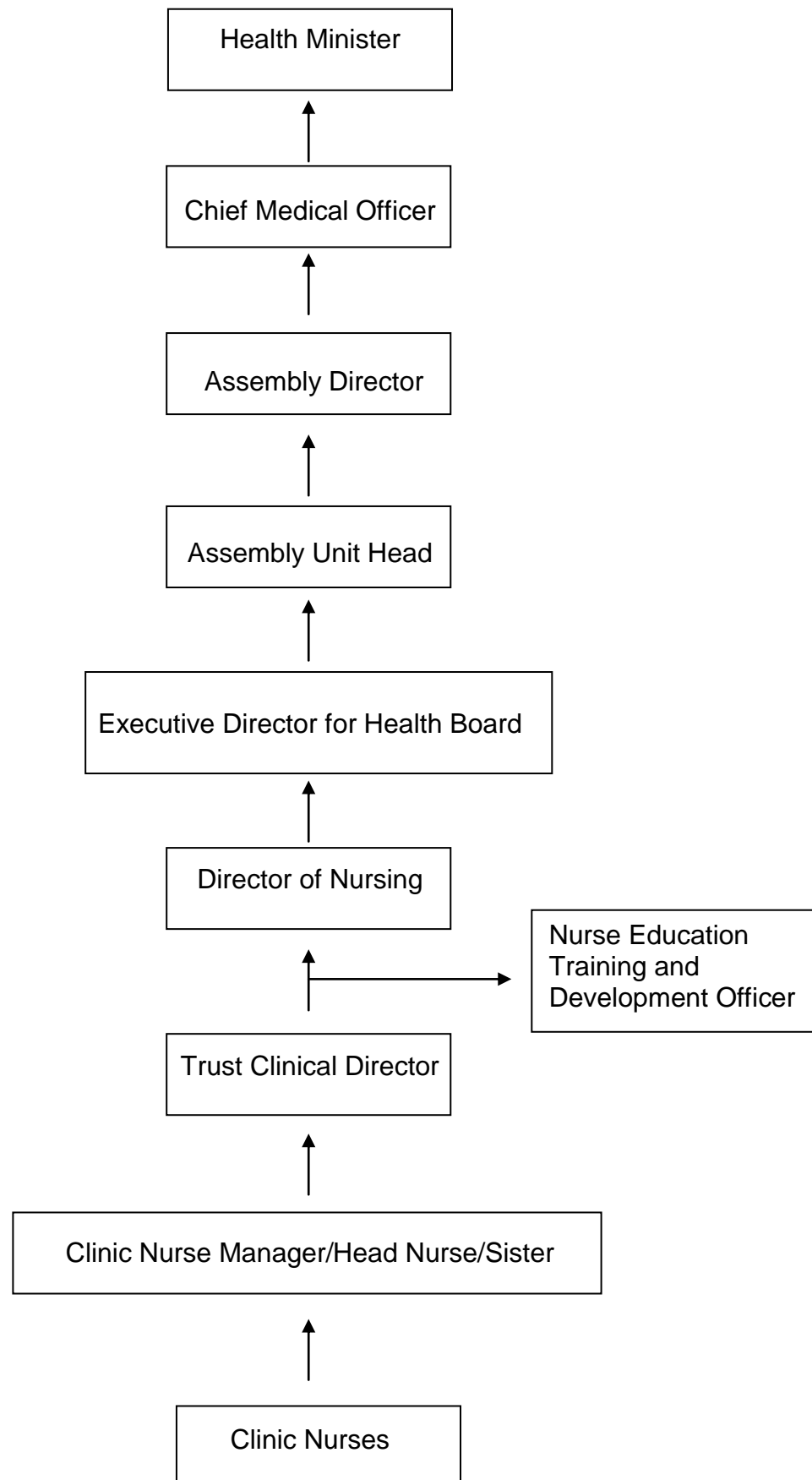
**Problem:** Uncertainty about how to identify which nurses need additional training or supervision

**Solution:** Based on the results from the evaluation questionnaire and from the brief intervention fidelity observations, the Nurse Training, Education and Development officer should assess the need to provide top-up training or further supervision.

## **SBI Endorsements**

This approach to delivering SBI has been endorsed and is been championed by all the relevant Royal Colleges: The Royal College of Surgeons, Nursing and Emergency Medicine (see Appendix V).

## Appendix I: Diagram of Management Continuum



## Appendix II: Evaluation Form

### Brief Intervention Training

1. To what extent do you feel that you have enough knowledge/skills to administer a brief alcohol intervention?

|-----|

0      10      20      30      40      50      60      70      80      90      100

Not at all Confident

Totally Confident

2. To what extent do you feel confident implementing a brief alcohol intervention?

|-----|

0      10      20      30      40      50      60      70      80      90      100

Not at all Confident

Totally Confident

### Screening Training

1. To what extent do you feel that you have enough knowledge/skills to administer the Fast Alcohol Screening Test?

|-----|

0      10      20      30      40      50      60      70      80      90      100

Not at all Confident

Totally Confident

2. To what extent do you feel confident implementing the Fast Alcohol Screening Test?

|-----|

0      10      20      30      40      50      60      70      80      90      100

Not at all Confident

Totally Confident

**Appendix III: Page from Screening and Brief Intervention Record Book**

Date: \_\_\_\_\_ Trauma/maxillofacial Clinic: \_\_\_\_\_

Total number of patients attending clinic: \_\_\_\_\_

	FAST SCORE	BRIEF INTERVENTION?	NURSE INITIALS
Patient's Sticky Label from notes	4	✓	JD

## Appendix IV: Brief Intervention Fidelity Checklist

**Note: To be completed when observing a nurse delivering a brief intervention**

Brief Intervention Strategy	Observed
Review of injury event – role of alcohol	
Typical drinking day/session	
Exploring concerns	
Good/bad things about alcohol consumption	
Future/present comparison	
Motivation to change/confidence of success	
Feedback: Information exchange/ Self comparison to national consumption levels	
Responsibility	
Advice	
Menu: Help with decision making	
Empathy: Express	
Self- efficacy: Promote	

## **Appendix V: Royal College of Surgeons Policy Statement (the treatment standard expected).**



### The Royal College of Surgeons of England

#### **Reducing Alcohol Misuse in Trauma and other Surgical Patients Position statement**

Alcohol misuse is a major cause of injury and trauma death which is high on public and healthcare agendas. Young UK drinkers are drinking more than ever before. Intervening early in the lives of drinkers, before they develop alcohol dependence, is an important priority. Cost effective interventions, particularly short cognitive behavioural approaches (“brief interventions”) which reduce alcohol misuse and repeat trauma have been developed but are not yet widely delivered. Surgeons have unique opportunities to institute these interventions by combining them with standard trauma and other surgical care. The aftermath of injury and surgery, when patients attend outpatient clinics, represents a “teachable moment” which can be capitalised on to screen for alcohol misuse and motivate patients to reduce their drinking.

#### **Policy context**

The Government’s national alcohol harm reduction strategy was updated in 2006 in the form of “Safe Sensible Social”. A multi-department government group is responsible for delivering this updated strategy, which includes treatment services in a range of healthcare and other settings. The Welsh Assembly Government is funding targeted nurse training to facilitate the intervention described in this policy.

The College of Emergency Medicine (CEM) has published a position statement and guidelines on alcohol and violence prevention which fit with the proposal set out here. The Royal College of Nursing (RCN) has published a learning package on brief interventions. The National Institute for Health and Clinical Excellence (NICE) is currently finalising three pieces of guidance which aim to reduce alcohol misuse and improve the management of the complications of alcohol disorders.

#### **Position statement**

There is a strong evidence base for brief, cognitive behavioural advice delivered by nursing staff as a routine part of trauma and other surgical care for conditions known to result from alcohol misuse. Patients should be screened for alcohol misuse, and those where there is evidence of misuse should receive advice concurrent with surgical treatment (for example, suture removal). Surgeons should initiate, promote and support this contribution to care and collaborate for this purpose with nursing colleagues and with consultants in emergency medicine and other relevant medical specialties.

The Royal College of Surgeons is championing the introduction of this approach for the identification and management of patients who misuse alcohol. This will reduce the risk not just of surgical conditions associated with alcohol misuse but also the risk of a much wider spectrum of illness.

The College can help achieve this by increasing surgeons' awareness of this approach, highlighting the training opportunities for staff who deliver the interventions, and supporting the work of the RCN and CEM in this context. Surgeons themselves can identify ways in which this treatment can be facilitated in their hospitals, and encourage nurse colleagues to make use of the training resources provided by the RCN and others.

### **References**

Smith A J, Hodgson R, Shepherd J P. A randomised controlled trial of a brief intervention after alcohol-related facial injury. *Addiction* 2003; 98:43-52.

Gentilello LM, Rivara FP, Donovan DM, et al. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery* 1999; **230**:473–480.

Miller W, Sanchez V. Motivating young adults for treatment and lifestyle change. In: Howard G, ed. Issues in alcohol use and misuse by young adults. Notre Dame, USA: University of Notre Dame Press, 1994: 55-82.

College of Emergency Medicine. Emergency Care 2015 - Building on the Evidence. The evidence from the College of Emergency Medicine for the NHS (England) Review, Acute Care stream: CEM, 2008

Available from: [www.collemergencymed.ac.uk/asp/document.asp?ID=4679](http://www.collemergencymed.ac.uk/asp/document.asp?ID=4679)

Royal College of Nursing. Alcohol Misuse. Resources available from the RCN.

Available from:

[http://www.rcn.org.uk/development/practice/clinical\\_governance/closeup/public\\_health](http://www.rcn.org.uk/development/practice/clinical_governance/closeup/public_health)

Department of Health, Home Office et al. Safe Sensible Social: the next steps in the National Alcohol Strategy: Department of Health 2007

Available from:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH\\_075218](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218)

### **Endorsements**

This position statement has been endorsed by the Royal College of Nursing and the College of Emergency Medicine



5) Do you believe your department is delivering brief interventions to the appropriate patients successfully?

6) How do you feel about discussing the topic of alcohol with patients?

7) What kind of responses have you received from patients?

8) Have there been any particular success stories you would be comfortable telling me about?

9) Have there been any difficult interactions that you would be comfortable telling me about?

10) Do you feel screening and delivering brief interventions has improved the service you provide to patients with alcohol related injuries? How? If not, why?

11) Can you see this service as something that will be maintained over time?

12) How confident are you that the service can be maintained over time?

13) What do you believe would need to happen in order for the process to be maintained over time?

14) Is there anything else you would like to add?