Administration of the Alcohol and Tobacco Screening Tool and Brief Intervention Procedure

1. GUIDING PRINCIPLES

The WA Country Health Service (WACHS) has introduced an Alcohol and Tobacco Brief Intervention (BI) Policy with the aim of reducing the health risks associated with drinking alcohol and smoking tobacco.

This procedure underpins the WACHS Alcohol and Tobacco Brief Intervention Policy and describes the WACHS procedure for the administration of the Alcohol and Tobacco Screening Tool and Brief Intervention.

2. PROCEDURE

TRAINING

It is recommended that staff complete BI training before administering the tools described in this procedure. WACHS has developed a self-directed BI learning package which is available online.

TOBACCO BRIEF INTERVENTION

Please read in conjunction with the Department of Health Clinical Guidelines for Management of Nicotine Dependent Inpatients, Flow Chart – Summary Management of Nicotine Dependent Inpatients and the Framework for Treatment of Nicotine Addiction.

Assessment
All patients admitted to hospital are to have their smoking status assessed using the Standard Admission Tool for the unit.

Following the identification of patients that smoke tobacco, the admitting nurse/midwife is to complete the Fagerstrom Test for Nicotine Dependence (found in the MR202E Alcohol and Tobacco Screening Tool) and brief intervention. Only patients that identify as tobacco smokers are to be asked to complete the Fagerstrom test.

Brief Intervention
Upon completion of the Fagerstrom Test for Nicotine Dependence, the admitting nurse/midwife will have established smoking status, assessed level of dependence and offered advice on the benefits of quitting. The situation allows for an opportunity to conduct a ‘brief motivational interview’ and advise the patient of their nicotine dependence score in a non-judgemental manner.

The following is not a checklist but provides a description of the process to guide the clinician in conducting BI with his/her patient. Variations will arise from patient to patient.

Brief Motivational Interview

1. Ask the patient if they would be willing to discuss their smoking use e.g. "Thanks for completing the Fagerstrom Test. I wanted to let you know your score of 4 suggests you are moderately dependent on tobacco. Do you mind if we spend a few minutes talking about your score and what you might like to do about your smoking?"
2. Ask patient what they like about smoking. e.g. "Can you tell me some of the good things for you about your smoking?"
3. Ask patient about some of the less good things about smoking. e.g. "Are there any things that are not so good about your smoking…anything else?" Probe for further responses.
4. Summarise the good things and less good things the patient has identified e.g. "So on one hand (positives)….and on the other hand…(negatives)"
5. Obtain a decision from the patient as to what they would like to do about their smoking e.g. "Given your Fagerstrom score was…and you are experiencing…consequences from your smoking, what do you think you might want to do in terms of your smoking?"
6. Provide advice about treatment options, such as Nicotine Replacement Therapy (NRT) and remind the patient of the Smoke Free Policy. Provide patients with a copy of the Smoke Free WA Health: Advice for Patients brochure.
7. Provide referral and self-help information, for example Quitline (13 7848) and the quitting products information sheet.

Further information on strategies to reduce tobacco related harm and combat cravings when giving up smoking can be found via the Australian Government Quitnow web site.

ALCOHOL BRIEF INTERVENTION

Please read in conjunction with the WACHS Administration of the Alcohol Brief Intervention Flowchart.

Assessment

All patients admitted to hospital should have their alcohol status assessed using the Standard Admission Tool for the unit.

Following the identification of patients that drink alcohol, the admitting nurse/midwife is to determine the suitability for the patient to undertake the Alcohol AUDIT questionnaire (found in the MR202E Alcohol and Tobacco Screening Tool) and brief intervention.

Only patients that have identified that they drink alcohol should be asked to complete the Alcohol AUDIT questionnaire.

Alcohol Audit

The alcohol AUDIT questionnaire includes 10 questions, all of which must be answered. As the questionnaire makes reference to 'standard' drinks, (a concept which may not be familiar to many patients), care is to be taken to explain this concept. For information about standard drinks please view the Standard Drinks Guide.

The alcohol AUDIT may be administered as an interview or the patient may complete the questionnaire. Where language, literacy or disability is a barrier to understanding the Audit tool, it is highly recommended and encouraged that the alcohol AUDIT questionnaire be conducted as an interview. Health professionals are also to consider the use of interpreters where required.

The following groups and wards are suitable for the Alcohol AUDIT and Brief Intervention:

- Patients 16 years and above[1]
- Surgical, medical, orthopaedic, maternity and psychiatric wards, and
- Day surgery/peri-operative.

The following groups and wards are NOT suitable for the Alcohol AUDIT and brief intervention:

- Patients under 16 years of age[1]
- Patients with inappropriate health status, e.g. acute psychiatric episodes, seriously ill, intoxicated patients (in some cases intervention can be offered once patient health improves), and
- Palliative care and hostel patients and those awaiting transfer to nursing homes and hostels.

Brief Intervention

Upon completion of the AUDIT questionnaire, the admitting nurse/midwife is, in a non-judgemental manner, to advise the patient of their AUDIT score, provide appropriate feedback about the health risks and give the patient as a minimum a copy of the Drug and Alcohol Office - Alcohol and *my health* brochure.

As part of the AUDIT feedback, the Alcohol and *my health* brochure or the Indigenous brochure 'How Risky is My Drinking: AUDIT feedback tool' is also to be provided to patients. **Using these brochures,** the admitting nurse/midwife is to explain the AUDIT score to patient using the following guidelines:

- **If patient scores 0 – 7** (low risk) provide positive feedback focussed on the continued benefits of low risk drinking, including lowered risk of health and social problems. Provide information on the risks associated with higher levels of consumption and explain that low risk does not equate to no risk – refer to the appropriate brochure.

[1] Those patients under 16 years who are suspected of consuming alcohol at risky levels will be referred to an appropriate health professional in the first instance.

- **If patient scores 8 to 12** (risky) provide feedback focussed on the harms associated with "risky" drinking, referring to the appropriate feedback brochure and proceed where appropriate with brief motivational interview (see section 2.3.5 instructions).

- **If patient scores 13 and above** (high risk) this indicates the patient is at high risk of experiencing significant physical and mental harm. Provide feedback and explore the harm associated with this drinking pattern referring to the appropriate feedback brochure and proceed, where appropriate, with brief motivational interview (see section 2.3.4 for guidelines). Endeavour to explore strategies to reduce harm as outlined in the appropriate feedback brochure.

- **If patient scores 20 or above** provide feedback, explore the harm associated with this drinking pattern, commence Alcohol Withdrawal Scale, and refer to the Medical Officer immediately for management of potential withdrawal symptoms.

  For further information on decreasing harm associated with risky or high risk drinking levels refer to information provided in the Alcohol, Tobacco and other Drugs Guidelines for Nurses and Midwives: Clinical Guidelines produced by Flinders University and Drug and Alcohol Services Council (2003). This document is available on wards.

The feedback brochures should ONLY be given to patients who have completed the AUDIT. The brochures are not for general distribution.

Brief Motivational Interview

If patient scores 8 or above on the AUDIT, conduct a "Brief Motivational Interview" using the steps outlined below. These steps are not a checklist but provide a description of the process to guide the clinician in conducting BI with his/her patient. Variations will arise from patient to patient.

1. Ask the patient if they would be willing to discuss their alcohol use e.g. "Do you mind if we spend a few minutes talking about your alcohol use?".
2. Ask patient what they like about drinking alcohol e.g. "Can you tell me some of the good things for you about drinking?".
3. Ask patient about some of the less good things about alcohol. e.g. "Are there any things that are not so good about your drinking…anything else?". Probe for further responses.
4. Summarise the good things and less good things the patient has identified e.g. "So on one hand (positives) ... and on the other hand … (negatives)". Further exploration of patients drinking can occur given time.
5. Obtain a decision from patient as to what they would like to do about their drinking e.g. "Given your AUDIT score was … and you are experiencing … consequences from your drinking, what do you think you might want to do in terms of your drinking?"
6. Discuss strategies to reduce risky alcohol consumption.

7. Provide referral information, for example Alcohol and Drug Information Service (ADIS) (free call for country callers: 1800 198 024) and other services listed on the back of the feedback brochures. Patients who score 13 or above are at high risk of alcohol related harm and therefore are to be strongly encouraged to contact specialist help e.g. ADIS, Community Drug Service Team (CDST), General Practitioner (GP) or Aboriginal Medical Service.

Patients at Risk of Alcohol Withdrawal

Alcohol withdrawal can start six to 12 hours after a patient's last alcoholic drink. Withdrawal ranges from mild to severe, with severe alcohol withdrawal being potentially life threatening. The most important thing is to anticipate alcohol withdrawal and manage the symptoms before they arise.

The AUDIT tool can help to identify patients who may be at risk of alcohol withdrawal. Those with an AUDIT score of 20+ may experience alcohol withdrawal and need to be commenced on an alcohol withdrawal scale and referred to a medical officer **immediately**.

If the patient scores below 20 on the AUDIT but the nurse/midwife has reason to suspect the patient may experience alcohol withdrawal, they are encouraged to explain to the patient, the risk of alcohol withdrawal. If a nurse/midwife is still concerned for a patient's health due to risk of alcohol withdrawal they are encouraged to seek advice from the medical officer.

Conducting the Audit with Aboriginal Patients

The AUDIT screening tool is considered a valid tool to use with Aboriginal[2] patients. It is highly recommended that the tool be conducted face-to-face with those Aboriginal patients with low literacy levels to avoid misinterpretation of questions.

It is essential that all Aboriginal patients are able to effectively participate in the Brief Intervention process. The use of appropriate language and the 'How Risky is My Drinking: AUDIT feedback tool' is highly recommended.

Where language, literacy or disability is a barrier to understanding the audit tool, assistance should be sought from the patient's friends/relatives or a staff member familiar to the patient. Explain to the patient what the alcohol brief intervention involves, and ask if they have a friend or relative who might be able to assist them, or ask if the patient would like the assistance of a staff member who is known to and trusted by them. If none of the above individuals are available, an Indigenous Health Worker, who is known to patient and readily available, should be contacted to help them through their admission and subsequent stay in hospital.

Some Indigenous patients may be anxious on admission to hospital, and may not understand the relevance of alcohol related questioning. Explain that this discussion is had with all patients.

Involvement of a local health service's Indigenous Health Worker (if available), is to be encouraged.

[2] The use of the term "Aboriginal" within this document refers to Australians of both Aboriginal and Torres Strait Islander people.

3. ROLES AND RESPONSIBILITIES

3.1 Hospital Health Staff

Hospital health staff have the responsibility of ensuring suitable patients are provided with a brief intervention for alcohol and tobacco. **The admitting nurse/midwife** has specific responsibility for ensuring the MR202E Alcohol and Tobacco Screening Tool is completed by (or with) suitable patients (those that smoke or drink alcohol) and kept in the patient's admission file.

It is essential that the MR202E Alcohol and Tobacco Screening Tool is completed with suitable patients within 6 to 12 hours post admission due to the risk of both alcohol and nicotine withdrawal.

Nurse Unit Manager (NUM) or Health Service Manager (HSM) in small hospitals

It is the responsibility of the NUM or HSM to:

1. ensure that staff complete the MR202E Alcohol and Tobacco Sreening Tool and conduct a brief intervention with all suitable patients, and to
2. ensure staff complete the 'staff only summary box' on the Alcohol and Tobacco Screening Tool.

Nursing Staff

It is the responsibility of all nursing staff to:

1. ask all patients about their alcohol and tobacco use using standard Admission Tool for the unit
2. assess alcohol and tobacco use of suitable identified patients using the MR202E Alcohol and Tobacco Screening Tool
3. advise patients of their AUDIT and Fagerstrom Test score and provide feedback using the appropriate feedback brochures
4. assist patients identified as being "risky" or "high risk" drinkers and/or 'high' or 'moderately' dependent on nicotine by conducting a brief motivational interview around changing their risky behaviours
5. where appropriate, arrange follow up and referral
6. complete information in the Staff Use Only summary found on the back of the Alcohol and Tobacco Screening Tool.

Medical Officer

It is the responsibility of all medical officers to:

1. conduct an alcohol withdrawal assessment for patients identified at risk of alcohol withdrawal (those patients with an AUDIT score of 20+) and administer appropriate medications in line with hospital procedures
2. review and prescribe appropriate NRT within 24 hours of nurse/midwife initiated NRT.

4. EVALUATION

The WACHS Central Office Population Health unit is to coordinate and collate periodic audits of patient notes to monitor the implementation of the tobacco and alcohol brief intervention in WACHS hospitals, using the 'staff use only' section on the Alcohol and Tobacco Screening Tool MRN Form.

WACHS regions are responsible for identifying and nominating staff to undertake the audit at nominated sites.

This procedure is to be reviewed (in line with the WACHS Alcohol and Tobacco Brief Interventions Policy) every two years or sooner, if required.

5. DEFINITIONS

AUDIT	Alcohol Use Disorders Identification Test (10 item questionnaire)
Brief Intervention	includes a range of activities that encourage a person (in this case a patient) to reduce health risks associated with a particular behaviour (in this case risky alcohol use). Can include screening, brief advice and feedback, counselling (motivational interviewing), support and referral to a specialist.
Brief Motivational Interview	describes a type of “conversation” used to move a patient towards changing a behaviour through exploring the good and less good things about the behaviour and eliciting a decision from the patient on what they want to do in terms of their behaviour. (Refer to '2.2.3 Tobacco Brief Motivational Interview and/or ‘2.3.4 Alcohol Brief Motivational Interview').
Low risk drinking	defines a level of drinking at which there is lowered risk of harm (short or long term)
Risky drinking	defines a level of drinking at which risk of harm (short and/or long term) is significantly increased
High risk drinking	defines a level of drinking at which there is a substantial risk of serious harm, and above which risk increases rapidly
Short term harm	refers to the risk of harm in the short term, usually associated with intoxication e.g. Accidents, injury, drink driving, domestic violence
Long term harm	refers to the level of risk associated with regular drinking i.e. the harm resulting from regular alcohol consumption over a period of time (usually years) e.g. pancreatitis, liver problems, mental health problems, sexual dysfunction
Standard drink	Refer to the Standard Drinks Guide

6. REFERENCES

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7. National Health and Medical Research Council. (2009). Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Canberra: NHMRC.

This document can be made available in alternative formats on request for a person with a disability

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