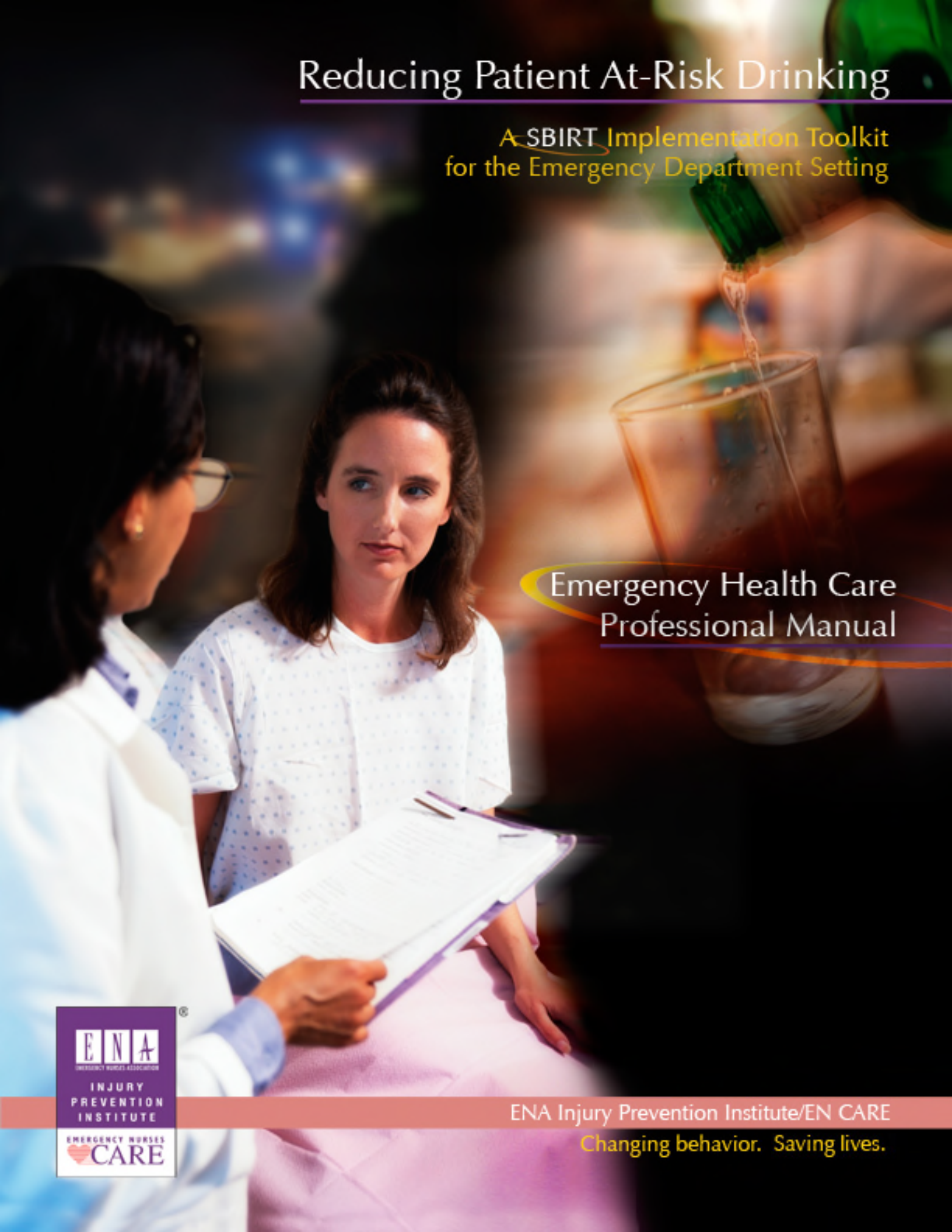
Reducing Patient At-Risk Drinking

A SBIRT Implementation Toolkit for the Emergency Department Setting



Emergency Health Care Professional Manual

ENA Injury Prevention Institute/EN CARE

Changing behavior. Saving lives.

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This manual is designed to provide emergency department (ED) practitioners with the knowledge and skills to perform alcohol screening, brief intervention, and referral to treatment (SBIRT).

Terms Used

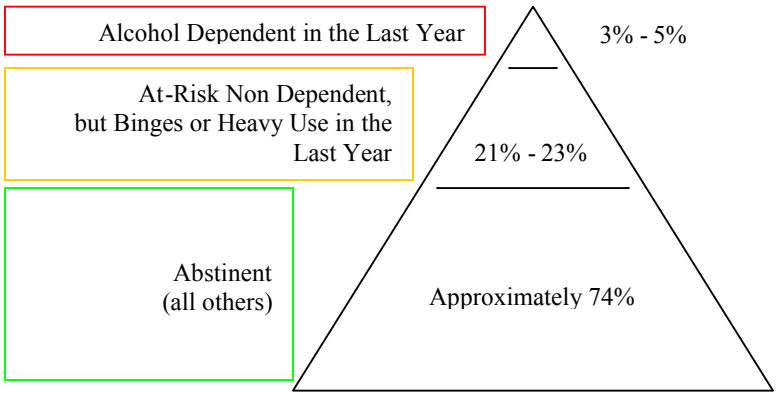
Throughout the manual, we use unhealthy and at-risk drinking interchangeably. These terms refer to the middle section of Figure 1 and Table 1.

Scope of the Problem

For every U.S. adult who is alcohol dependent (alcoholic), more than 6 other adults who are not dependent are at risk of or have already experienced problems from their drinking.[1] Many of these at-risk drinkers sustain injuries that require medical care.

The pyramid of alcohol problems (Figure 1) shows that at-risk non dependent drinking individuals comprise approximately 21% to 23% of the general U.S. population.[1] In your emergency department setting, depending on your particular patient population, these figures may vary. Throughout this manual, we refer to this group as the "at-risk drinking" group. Individuals in this group drink at levels that put them at increased risk for future alcohol-related problems, but they are not alcohol dependent.[1]

FIGURE 1. Pyramid of Alcohol Problems[1]



Note: The prevalence estimates in this figure are for non-institutionalized U.S. adult population, not trauma or emergency department patients.

How Much Is Too Much?

Drinking alcohol becomes excessive when it causes or increases the risk for alcohol-related problems or complicates the management of other health problems. According to epidemiologic research, men who drink more than 4 standard drinks in a day (or more than 14 per week) and women and all adults age 65 and older who drink more than 3 in a day (or more than 7 per week) are at increased risk for alcohol-related problems.[2] A standard drink is equal to 14 grams of pure alcohol (12 ounces of beer, 5 ounces of wine, 1.5 ounces of hard liquor). Binge drinking is defined as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. This typically happens when men consume more than 4 drinks and women consume more than 3 drinks in about two hours.[3]

Drinking Types, Patterns, and Recommended Interventions

There are three major types of drinking behaviors: alcohol dependent, at-risk non dependent, and abstinent. Alcohol dependent drinkers represent approximately 3%–5% of the U.S. general adult population.[1] The drinking habits of these individuals have led them to physical

dependence and/or experience with severe problems related to drinking. The goal of the brief intervention with these patients is to *motivate* them to accept a referral to seek further assessment and treatment. The intervention could consist of an educational brochure and a list of referrals tactfully offered to patients at the bedside or simply included with discharge instructions. ***At-risk*** non dependent drinking individuals represent about 21%–23% of the U.S. general adult population.[1] This group represents a greater proportion of your emergency department patient population than dependent drinkers and is usually less than the majority. These individuals are men who consume more than 4 standard alcoholic drinks in a day (or more than 14 per week), women who drink more than 3 in a day (or more than 7 per week), or older adults (65 years old and older) of both genders who drink more than 3 in a day (or more than 7 per week).[2] At-risk drinkers are categorized as alcohol abusers, harmful, or hazardous drinkers.[2] The goal of the brief intervention that is recommended with the at-risk drinking patients is to *motivate* them to cut back or quit drinking and to eliminate risky behaviors such as drinking and driving. The third group of individuals consists of those who are mostly abstinent. This group includes people who never drink alcohol and those occasional drinkers who drink within recommended NIAAA guidelines. Patients in the abstinent group generally do not require intervention (Note: Binge drinkers are an exception).

TABLE 1. Drinking Types, Patterns, and Recommended Interventions

Drinking Types	Drinking Patterns	Recommended Intervention by ED Nurses
Alcohol Dependent	Drinking has led to physical dependence and/or experience with severe problems related to drinking	**GOAL**: ***Motivate*** patient to accept a referral ▪ Referral for further assessment or treatment ▪ Approximately 3% to 5% of general population
At-Risk Non Dependent	Drinking level exceeds NIAAA guidelines ▪ Alcohol abuse: Differs from alcoholism in that it does not include an extremely strong craving for alcohol, loss of control over drinking, or physical dependence ▪ Harmful drinking: Individuals and others currently experiencing problems (medical/social) related to alcohol use ▪ Hazardous drinking: Alcohol use pattern puts individuals and others at-risk for injury/illness or other social/psychological problems	**GOAL**: ***Motivate*** patient to cut back or quit drinking and to eliminate risky behaviors ▪ Referral to further assessment, if necessary ▪ Approximately 21% to 23% of general population
Abstinent	▪ Lower risk drinkers: drinking level is below NIAAA guidelines Alcohol use unlikely to affect health or result in problems ▪ Drinks no alcohol	▪ No intervention required ▪ Approximately 74% of general population

The ***at-risk*** drinking patients are the main target population for which the brief intervention procedure described in this toolkit is intended. At-risk drinking behaviors increase the likelihood for patients to utilize the emergency department and to be readmitted to trauma centers due to injury recurrence.[4,6] At-risk alcohol use plays such a significant role in trauma that efforts to reduce the risk of injuries or their recurrence are unlikely to be successful if the underlying risk factors remain untreated.[7]

Yet, even for patients presenting with obvious unhealthy drinking habits, as few as 15 percent have their at-risk behavior addressed during their visit or are referred for further treatment.[8] Since the development of trauma systems, trauma centers have focused on treating the injury, but have consistently failed to treat the underlying alcohol problem.[9,10] This continues to be the case in spite of the fact that nearly half of all trauma beds are occupied by patients who were injured while under the influence of alcohol.[10]

To date, more research related to alcohol screening and brief intervention has been conducted in trauma patients than in the overall emergency department population. Therefore, the outcomes of conducting alcohol screening and brief intervention with the general emergency department patient population are not clearly known. However, since many ED patients do not have primary care physicians for preventive services and/or do not have their unhealthy drinking habits identified in other health care settings, the emergency department is an appropriate environment for alcohol screening, brief intervention, and/or referral.[8,11]

The Emergency Department Situation and Response

Everyday, over 20,000 people enter emergency departments in the United States for alcohol-related injuries and illness — an estimated 7.6 million annually.[4,12] Alcohol use disorders and dependence are the most common underlying causes of injuries in the U.S.[13,14] The annual cost of alcohol abuse is estimated at $185 billion, including lost productivity due to illness, injury and death, health care expenditures, property damage, and crime.[8,15]

Unhealthy drinkers annually average almost twice as many injury-related events and four times the number of hospitalizations.[16] For emergency department patients with at-risk alcohol use, there is immediacy between the event bringing them to the care setting and the connection between at-risk drinking behaviors and injury.[4,8] An alcohol-related illness or injury that requires emergency or trauma care can produce a crisis that helps motivate a person to change his or her drinking behavior,[17] thus creating the optimal time for emergency personnel to intervene. Under these circumstances, each patient becomes a potential candidate for alcohol screening and brief intervention (SBI) when they enter the emergency medical care system. It is during this "teachable moment" that the detection of and intervention for at-risk drinking and the opportunity to motivate behavior change are seen as particularly effective.[8,11,17,18] Researchers have suggested that patients seeking treatment in the emergency department are more likely to self-disclose their alcohol use than those receiving treatment in a primary care setting.[19] Studies have shown that a patient's openness to discuss alcohol problems and other risky behaviors decreases significantly after a couple of days due to factors such as fear about legal responsibility, family advice, and individual rationalizations.[20]

SBIRT Implementation Toolkit Description

The purpose of this SBIRT Toolkit is to provide emergency and trauma nurses as well as other emergency health care professionals with the information they need to implement the SBIRT procedure in emergency care settings. This toolkit is designed to be used as both a *self-study guide* and/or as *didactic material* to educate emergency health care professionals about alcohol screening, brief intervention, and referral to treatment. The toolkit incorporates evidence-based concepts from *The Emergency Practitioner & the Unhealthy Drinker: Motivating Patients for Change* and the *Alcohol Screening and Brief Intervention (SBI) for Trauma Patients: Committee on Trauma Quick Guide.*

Before you implement the SBIRT procedure within your emergency or trauma services, we strongly recommend that you read the content of this manual and all supplemental materials. While the self-educational nature of this toolkit gives you a critical overview of the SBIRT procedure and its implementation, we also recommend that you participate in a live training session that includes demonstrations and opportunities to practice the SBIRT procedure. The SBIRT Implementation Toolkit is comprised of multiple components. Each component is discussed below.

The following elements should be distributed to all providers who attend the educational session.

- *Pocket Guide (Tool 1)*
- *NIAAA Guidelines and Alcohol Consumption Norms (Tool 2)*
- *Readiness to Change Ruler and Reducing Alcohol Consumption: Pros and Cons (Tool 3)*
- *Drinking Agreement (Tool 4)*
- *Referral Resources (Tool 5)*
- *Alcohol: How Much is Too Much brochure (Tool 6)*
- *Discharge Instruction Model (Tool 7)*
- *SBIRT Nursing Implementation Model (Tool 8)*

Emergency Health Care Professional Manual

The purpose of the health care professional educational manual is to increase health care providers' knowledge of alcohol-related injuries incidence, to provide a description of the screening, brief intervention, and referral to treatment procedures, and to provide an overview of the effectiveness of the SBIRT procedure.

SBIRT PowerPoint Presentation

The PowerPoint presentation is provided as part of this toolkit for educators to use in live training sessions. The slide contents can easily be covered in 45 minutes. The purpose of the presentation is to:

- Introduce the scope of unhealthy drinking as it pertains to the ED setting
- Review the effectiveness of alcohol screening and brief intervention
- Describe a recommended SBIRT procedure in the ED setting
- Discuss SBIRT implementation model
- Discuss readiness to implement SBIRT procedure

SBIRT Implementation Video

The purpose of the 22 minute video is to demonstrate the benefits of implementing SBIRT; hear from emergency and trauma health care professionals about why it is important to implement SBIRT in your hospital; hear from patients about the personal impact of SBIRT; and become familiar with the SBIRT procedure through a role-play scenario.

Role Plays/Case Studies

Elements of the Implementation Toolkit that should be reviewed by future SBIRT providers:

- *Emergency Health Care Professionals Manual*
- *Educational Video*
- *PowerPoint Presentation*
- *Case Studies and Role Plays*

Didactic sessions alone are not enough to maximize the learning of the SBIRT procedure. Effective screening, brief intervention, and referral to treatment require skills that develop over time. Just like obtaining intravenous peripheral access, individuals' skills at implementing SBIRT improve with practice. Your first attempt at implementing SBIRT may be awkward. Do not get discouraged. Practice, practice, practice!

The toolkit includes two demonstration cases:

- A ***sample role-play*** is included in the video and can be viewed in both the self-study format and live training sessions
- A case study (see toolkit filename ***Demonstration Case***) can be demonstrated by educators in live training sessions.

Three additional skill–based role-plays (see toolkit filenames ***Role Play 1, 2, and 3***) are provided for practice. Ideally, learners will divide in groups of three (one nurse/provider, one patient, and an observer). The nurse/provider and patient should receive the scripted tool with a description of the role they are playing. Each takes a few minutes to review the scenario and prepare their role responses. The patient prepares his or her readiness to change response, including the pros and cons of drinking and any intended behavior modifications. The

observer should have the nurse/provider's script and prepare to provide feedback on both nurse/provider and patient responses (e.g., what statements evoked a positive or negative patient response). The role of the observer is twofold: 1) to monitor and provide feedback on adherence to all critical "prescribed" components of the intervention; *and* 2) to monitor and provide feedback regarding avoidance of all "proscribed" components (i.e., labeling the patient or argumentative statements). When time is limited or groups are smaller in size, an alternative is to divide into pairs and conduct role play activities without the observer. However, there is potential for much to be lost in translation with this method because both participants are usually engrossed in their role and less able to critique one another. An option in this case, is for the educator to float between each pair and provide general feedback to the entire group once the role-play activity is completed. In either format, the entire group should debrief on successes and difficulties encountered during their practice. If time allows, a second set of role-plays can be practiced with learners reversing roles.

Pocket Guide

The pocket guide is a two-sided guide for nurses/providers that includes all essential elements to perform a complete SBIRT procedure. All nurses/providers should carry the pocket guide with them, especially when first learning to conduct SBIRT. A single laminated pocket guide is enclosed in the toolkit amaray case. Additional copies can be printed from the electronic version on the toolkit CD-ROM (see Tool 1). You can also download all the SBIRT tools free of charge at http://www.ena.org/ipinstitute/SBIRT/ToolKit/toolkit.asp

Description of the SBIRT Procedure

The SBIRT procedure is designed to help identify individuals whose drinking behaviors place them at risk (yellow row in Table 1) for developing adverse health outcomes (injuries, illnesses, and psychosocial problems) or alcoholism.[21] The SBIRT procedure is a risk-reduction approach that consists of routine screening (S) to identify at-risk individuals who might benefit from a more in-depth assessment of their drinking behavior; a brief intervention (BI) that provides personalized feedback and harnesses patient's self-efficacy to modify unhealthy alcohol-related behaviors; and referral to treatment (RT) for services appropriate to the individual's alcohol risk level.[22]

Note: The pocket guide contains all the following key points for conducting the SBIRT procedure.

Screening (S)

"Screen every patient, every time."

The purpose of alcohol screening is to identify individuals who might benefit from a more in-depth assessment of their drinking behavior. **The procedure does not target alcohol dependent individuals and is not meant to diagnose alcohol use disorders** (i.e., DSM diagnoses of alcohol abuse and alcohol dependence). **All patients should be screened for alcohol problems that may put them at greater risk for injuries and developing adverse health outcomes or alcoholism**.[10] Early intervention may prevent at-risk drinking patients from becoming alcohol dependent.

Step 1: The screening procedure should begin with a **Universal Alcohol Screening question**. The main purpose of this question is to eliminate abstainers who rarely or never consume alcohol (green row in Table 1).

➲ If your patient is abstinent, the SBIRT procedure ends after that first universal question.

Universal Screening Question: How often in the past year did you drink beer, wine, or distilled spirits?

Interpretation of Answers

Scenario 1: For all patients who answer "never," the screening procedure ends and standard ED care is provided.

Scenario 2: For all patients who answer "once or more," continue with Step 2.

Step 2: Continue with the **three NIAAA Quantity and Frequency** questions. The answers to these questions will help you differentiate patients who are at-risk drinkers and need further intervention.

NIAAA Quantity and Frequency questions

1. On average, how many days per week do you drink alcohol?
2. On a typical day when you drink, how many drinks do you have?
3. What's the maximum number of drinks you had on a given occasion in the last month?

Preface the three NIAAA questions by explaining that the questions relate to drinking in the prior month. It is also recommended that you show patients what is a standard drink of liquor, beer, and wine (Figure 2; also on the pocket guide).

FIGURE 2. **What is a Standard Drink?** A standard drink = 14gram of pure alcohol or…

Interpretation of Answers—NIAAA Guidelines: How Much Is Too Much?

	Drinks Per Week	Drinks Per Occasion
Men	**More than 14**	**More than 4**
Women	**More than 7**	**More than 3**
Age 65+	**More than 7**	**More than 3**

➲ If your patient's drinking habits are *below* the NIAAA recommended levels, the alcohol screen is considered negative and the SBIRT procedure ends after the NIAAA questions. This patient is in the abstinent/lower risk group and does not need brief intervention (green row in Table 1).

Optional: To identify patients who do not drink regularly, but binge drink sometimes, (therefore putting themselves and others at greater risk for injuries), you can ask an additional question**. In the last year, did you ever drink more than 5 drinks on one occasion (more than 4 drinks for women, adolescents, and adults 65 years and older)?**

An optional question to identify patients who do not drink regularly, but binge drink sometimes is: In the last year, did you ever drink more than 5 drinks on one occasion (more than 4 drinks for women, adolescents, and adults 65 years and older)?

➲ If you find that your patient's drinking habits are *above* the NIAAA recommended levels, the screening procedure continues to determine if your patient is an **at-risk** non dependent or **alcohol dependent** drinker. Different levels of interventions are recommended for each group.

It is important to weigh the pros and cons of each screening instrument so that the whole screening process matches your department's capacity to implement the SBIRT procedure.

Further assessment of at-risk and dependent drinking is accomplished by using one of several existing screening instruments. Each instrument has shown different strengths and weaknesses (Table 2). Operationally, we know that there is no "one size fits all" model. When deciding which screening instrument to use, what is most important is to weigh the pros and cons of each method so that the whole ***screening process matches your department's capacity*** to implement the SBIRT procedure.

TABLE 2: Screening Instruments

Instruments	Strengths	Limitations	Special Uses
AUDIT[23]	▪ Identifies those: · Unlikely to be at risk · At-risk drinkers · Who have already experienced problems related to their drinking · Who are likely to have alcohol dependence ▪ Relatively free of gender and cultural bias	▪ Long: 10 Qs, ▪ Complex to score and interpret ▪ Less effective in detecting alcohol abuse/ alcoholism	▪ Primarily used in medical settings, psychiatric inpatients, workplace environments
CAGE	▪ Short: 4 Qs ▪ Easy to remember ▪ Identifies patients with alcohol dependence	▪ May fail to detect low but risky drinking levels ▪ Performs less well among women and minorities	▪ Well-suited to busy medical settings, including emergency departments
RAPS4[24,25]	▪ Short: 4 Qs ▪ Detects alcoholism across genders and ethnic subgroups	▪ Unknown results for screening risky drinking or alcohol abuse	▪ Emergency-care settings

Note: In this SBIRT Toolkit, the combination of the NIAAA quantity and frequency questions and the CAGE questionnaire is suggested for use in the emergency department because it is short and well suited to the busy ED environment.[26] Other screening instruments may also be used. The AUDIT and RAPS4 screening instruments are included in Appendix 1.

In this SBIRT Toolkit, the combination of the NIAAA quantity and frequency questions and the CAGE questionnaire is suggested for use in the emergency department because it is short and is well suited to the busy ED environment

Step 3: CAGE Questionnaire

CAGE Questionnaire

In the last 12 months

1. Have you felt you ought to ***C****UT* down on your drinking use?
2. Have people ***A****NNOYED* you by criticizing your drinking use?
3. Have you ever felt ***G****UILTY* about your drinking use?
4. Have you ever had a drink first thing in the morning *(**E**YE OPENER)* to steady your nerves, get rid of a hangover, or get your day started?

Interpretation of Answers — CAGE Questionnaire

Scenario 1: A person is an **at-risk non dependent** drinker if he/she has one positive response.

Scenario 2: A person is identified as a **potentially dependent drinker** if he/she has a positive response to:

- The CAGE "Eye-Opener" question, or
- Two or more CAGE questions

Brief Intervention (BI)

The brief intervention is a short 5 to 15 minute negotiated interview used to motivate a patient in changing his/her drinking patterns.[24] The purpose of a brief intervention is to:

a) provide information or feedback about screening results, BAC, if applicable, the link between drinking and injury, guidelines for lower-risk alcohol consumption, and strategies to reduce or stop drinking;

b) understand the patient's view of drinking and enhancing their motivation to change. This part encourages patients to think about and express how drinking may have contributed to their injury, what they like and dislike about their current drinking pattern, and how they might want to change to reduce their risks. The practitioner engages patients in a conversation so that they can come to their own decisions about drinking; and

c) provide clear and respectful professional advice about the need to reduce risk by cutting down or quitting drinking and to avoid high-risk alcohol-related situations. The optimal result is for patients to establish and articulate their own goals and make a plan to achieve them. Explore different options and negotiate a feasible plan by ***listening*** to the patient's concerns and identifying potential strengths, resources, and past successes.[27] The interaction is patient-centered and the patient's ***readiness to change*** determines the intervention strategy.

It is important for the practitioner to accept that *resistance to change* is a *normal* response. Before they can change their behavior, patients must first recognize there is a problem and perceive the need to change. Brief intervention can be a powerful catalyst for patients to recognize that they have or may be developing an alcohol problem. Health care providers can help raise patient awareness by creating an opportunity to discuss the pros and cons of drinking behavior, and making the link with the reason for the ED visit. In order to establish a rapport with the patient, the provider must be careful to *provide feedback empathetically and without judgment, shame, or blame*.

The term "brief intervention (BI)" is based on the concept of motivational interviewing developed by Miller and Rollnick and encapsulated in the FRAMES acronym (Feedback, Responsibility, Advice, Menu of strategies, Empathy, and Self-Efficacy).[28,29] Bernstein,

Bernstein, D'Onofrio, and Project ASSERT at Boston Medical Center adapted this approach to the ED setting. You can visit their Web site at http://www.ed.bmc.org/sbirt to learn more.

Brief Intervention with Drinkers at Different Risk Levels

Brief interventions can be conducted with patients who screen as ***at-risk*** non dependent **and** ***alcohol dependent*** drinkers (yellow and red row in Figure 1). With ***at-risk*** drinkers, the goal of the brief intervention is to negotiate with patients to motivate them to reduce their alcohol use to lower-risk limits (or abstinence) to ultimately reduce their risk of negative consequences such as injury.[30] In addition, a referral to the patient *primary care provider* for further assessment of alcohol problems may be needed. With ***alcohol dependent*** drinkers, the goal of the brief intervention is to motivate them to accept a referral to further assessment and /or treatment. The following pages will guide you through the four major steps of the brief intervention.

*The brief intervention is used to explore different options and negotiate a feasible plan by **listening** to the patient's concerns and identifying potential strengths, resources and past successes.*

Components of the Brief Intervention (BI) [31]

The BI procedure consists of four major steps.

Step 1: Raise the Subject

Critical Components	Actions	Questions/Comments
Establish rapport	▪ Explain practitioner's role ▪ Avoid a judgmental stance ▪ Set the climate	*"Hello, I am ____."*
Raise the subject	▪ Engage the patient	*"Would you mind taking a few minutes to talk with me about your alcohol use?"* ***<PAUSE>***

Notes:

- Be prepared before you approach a patient. Make sure that you review his/her medical record.
- **Obtaining permission** from the patient to discuss his/her alcohol use is an important aspect of the intervention.
- Avoid arguing or being confrontational
- If a ***patient shows resistance and clearly expresses that he/she does not want to talk*** about his/her alcohol use, simply say something non-threatening like, *"It's OK! We don't need to talk about it now."*
- **Continue to step 2 only if the patient agrees to discuss his/her alcohol problem.**

Summary: This first step sets the climate for a successful brief intervention. Asking permission to discuss the subject of alcohol formally lets the patient know that his/her wishes and perceptions are central to the procedure.

Step 2: Provide Feedback

Critical Components/ Objectives	Actions	Questions/Comments
Review current drinking patterns	▪ Review screening data ▪ Express concern ▪ Be non-judgmental	*"From what I understand you are drinking* [state the amount]*… We know that drinking above certain levels can cause problems such as…* [refer to presenting ED problem, or to future increased risk of illness and injury). *I am concerned about your drinking."*
Make the connection between alcohol and reason for ED visit or other medical problems (if applicable)	▪ Discuss specific patient medical issues (e.g., motor vehicle crash (MVC), GI complaints, hypertension)	*"What connection do you see between your drinking and this ED visit?* If your patient sees a connection, reiterate what he/she has said. If the patient does not see a connection, then make one using facts (e.g., MVC). Then say, *"We know that our reaction time decreases even with one or two drinks. Drinking at any level can impair your ability to react quickly when you* [state activity]*."*
Compare to national norms	▪ Give NIAAA guidelines specific to patient gender and age Show NIAAA Guidelines and Alcohol Consumption Norms (Tool 2)	*"These are considered to be the upper limits of low risk drinking for your age and gender.* *By low risk we mean that you would be less likely to experience illness or injury if you stayed within these guidelines."*

Notes: Do not give feedback or advice without permission.
Make sure that you have the chart and tables on drinking norms.

Summary: Linking the ED visit to drinking and comparing patient drinking patterns to national norms is a good way to motivate patients to reflect on their own drinking habits and to consider change. This creates an opportunity to provide education related to specific patient issues.

Step 3: Enhance Motivation

Critical Components/ Objectives	Actions	Questions/Comments
Assess readiness to change	Have patient self-identify readiness to change, on a scale of 1—10 Show Readiness to Change Ruler (Tool 3)	*"On a scale from 1-10, how ready are you to change any aspect of your drinking?"*
Develop Discrepancy	▪ Identify areas to discuss ▪ Discuss pros and cons Show Reducing Alcohol Consumption – Pros and Cons (Tool 3)	If patient answers: ▪ **Two or more, ask,** "*Why did you choose that number and not a lower one?"* ▪ **One or unwilling, ask,** "*What would make this a problem for you?* Or, "*How important would it be for you to prevent that from happening?"* Or, *"Have you ever done anything you wished you hadn't while drinking?"* Finally, you can ask, *"What would it take to make it higher in importance?"*
	▪ Use reflective listening	Restate what you think the patient meant by his/her statement. For example, in the context of discussing drinking less with friends, the statement, *"It's difficult,"* maybe followed by *"So it's difficult because you're worried about what your friends think."* This should be delivered with downward intonation.

Critical Components of Step 3

1. Assess readiness to change
2. Develop discrepancy
3. Listen reflectively
4. Ask open-ended questions

Summary: Patients are often ambivalent about change. Developing discrepancies between the patient's present behavior and their own expressed concerns may tip the scales towards readiness to change. Reflective listening is a way to check the meaning of, and help clarify, patient statements.

Note: To encourage patients to respond to your statements, the intonation of your voice should turn down at the end of your remarks.

Step 4: Negotiate and Advise

Critical Components/ Objectives	Actions	Questions/Comments
Negotiate goal	▪ Assist patient to identify a goal from a menu of options ▪ Avoid being argumentative	Reiterate what patient says in Step 3 and say, *"What's the next step?"* or, *"What are your options?"* or, *"What's going to happen now? Where do you go from here?"* Build self-efficacy: Ask about other times patient has been able to successfully make a change (quit smoking; gone back to school)
Give advice	▪ Deliver sound medical advice/education ▪ Provide harm reduction strategies (e.g., limiting risky behaviors such as drinking and driving)	*"If you can stay within these limits, you will be less likely to experience (further) illness or injury related to alcohol use."*
Summarize	▪ Provide a drinking agreement ▪ Help patient clarify goals to pursue ▪ Provide health information materials Provide Drinking Agreement (Tool 4) Provide Referral Resources (Tool 5) Provide the "*Alcohol: How Much is Too Much*" brochure (Tool 6)	*"This is what I have heard you say…Here is a drinking agreement I would like you to complete to reinforce your new drinking goals."* *"This is an agreement between you and yourself."* Suggest primary care follow-up for drinking level/pattern. Thank the patient for his/her willingness to talk. *"In case you decide you want to talk about this further with someone, here are some local phone numbers."* *"Thank you for taking the time to talk with me. I think you'll be able to do this. I wish you the best of luck…"*

Critical Components of Step 4

1. Negotiate a plan on how to cut back and/or reduce harmful drinking
2. Give advice
3. Provide *Drinking Agreement* and "*Alcohol: How Much is Too Much*" brochure

Note: A menu of options should be explored with patients. The patient is the decision-maker and should ultimately be responsible for choosing a plan. The practitioner provides advice, reinforces patient goals, and highlights patient's self-efficacy (ability to perform a specific task in a specific situation).

Additional Motivational Strategies[31]

- **Refrain from directly countering resistance statements**

  For example, the patient may say *"How can I have a drinking problem when I drink less than all my buddies?"* You can reply without insisting that there is a drinking problem per se. But rather, suggest that it is worthy of further assessment and discussion within the context of this brief intervention/interview.

- **Focus on the less resistant aspects of the statement**

  For example, the above patient may be wondering about how much drinking causes a problem. The response might be to restate his/her concern and ask about his/her level of drinking, which is the less resistant part of the statement. *"It sounds like you're confused about how you could have an issue with drinking if you drink less than your friends. I'd like to tell you."* (*This is a statement, not a question. The intonation should turn down at the end*). Repeat that the patient's drinking level exceeds NIAAA guidelines.

- **Restate positive or motivational statements**

  If a patient says, *"You know, now that you mention it, I feel like I have been overdoing it with my drinking lately,"* the ED health care professional could say, *"You don't need me to tell you you've been drinking a little too much lately, you've noticed yourself."* This serves to reinforce the patient's motivation – even if the motivational statement is a relatively weak one. If the patient says *"I guess I might have to change my drinking,"* this could be restated by you as, *"It sounds like you've been thinking about changing your drinking habits."*

- **Other helpful hints**

  Encourage patients to think about the last time they have cut back on their drinking or about other changes they have made (e.g., quitting smoking, exercising, etc.).

  Praise patients for their willingness to discuss such a personal topic.

Common Problems[31]

- **Refusal to engage in the discussion of the topic of drinking**

  Most patients will agree to discuss the topic. In the unlikely event that someone refuses to engage in the discussion, tell the patient that you respect their wishes, and instead, state that you would like to give them three pieces of information.

  1. His/her drinking exceeds safe-drinking limits (or is unhealthy)
  2. Safe-drinking limits recommended for his/her age and gender (NIAAA Guidelines)
  3. Suggestion that he/she cut down to low-risk drinking limits to avoid future harm

- **Refusal to self-identify along the readiness ruler**

  When this happens, it is usually a problem with understanding the numbers. There are several ways to help:

  1. Anchor the numbers with descriptors, such as "1" means not ready to change and "10" means completely ready to change
  2. Ask, "What would make this a problem for you?" Or, "How important is it for you to change any aspect of your drinking?"
  3. Discussion of pros and cons (use Tool 3)

  It is possible that a person may not want to participate in all or part of the conversation. For some patients this may be the first time they have been asked these questions. They may think about it and take action later. Do not see patients' refusal as a failure on their part or yours.

- **Unwilling to associate visit with alcohol use**

  Do not force the patient to make the connection. Make sure that he/she hears the connection in your medical opinion. Try to find some other negative consequences

of drinking alcohol that the patient ***can*** relate to and focus on finding agreement that ***those*** are bothersome enough to consider reducing their drinking habits.

- **Not ready to change drinking patterns to stay within safe limits**

  Tell the patient that the *best* recommendation is to cut back to safe drinking limits, but reiterate that any step in that direction is a good start. Give the referral list (see Tool 4) to the patient and say "*In case you decide you want to talk about this further with someone, here are some local phone numbers…*"

Referral (R)

After negotiating with the patient to establish drinking level goals, appropriate referrals may also be needed. With ***at-risk*** drinking patients, you may want to recommend that they have their alcohol use further evaluated. These patients should be given a list of local and national resources (Tool 5), educational information (Tool 6), and a referral to their primary care provider for further assessment (Tool 7). Tool 7 provides a template that can be modified to incorporate your own list of local resources and referrals to add to the national ones already included.

Treatment (T)

When the patient is clearly ***alcohol dependent***, an appropriate referral can be for further assessment or to treatment. Depending on patient needs and service availability, treatment options will vary. Treatment referrals may be to an inpatient or detoxification program or to recommend attending programs such as Alcoholics Anonymous combined with assessment by a primary care provider. You also can refer patients to a substance abuse professional who can determine the appropriate level of treatment and have a more in-depth conversation about available options.

Effectiveness of SBIRT

SBIRT contributes to:

- *Reductions in*
  - *emergency department utilization*
  - *alcohol consumption*
  - *repeat injuries and injury hospitalizations*
  - *drinking and driving violations*
- *Increases in successful referral to and participation in alcohol treatment programs*

Skepticism and misconceptions about the benefits and relevance of research on alcohol use problems to the emergency care setting still remain prevalent among emergency health care professionals.[32] Fortunately, there is a substantial body of evidence that demonstrates the efficacy of the SBIRT procedure when conducted by emergency health care professionals. For example, in a review of brief intervention studies (n = 6000), Bien and colleagues reported that brief intervention was more effective than no counseling and as effective as traditional therapy in seven out of eight randomized clinical trials conducted in a health care setting. They concluded that brief intervention is one of the most supported and cost-effective intervention modalities for alcohol problems.[33] Similarly, in a systematic review of the medical literature from 39 clinical trials on screening and brief intervention (30 randomized and nine cohort studies, six of which included emergency departments), D'Onofrio and Degutis found that 32 studies showed positive effects. They concluded that screening and brief intervention should be incorporated into clinical practice for treating alcohol-related problems in the emergency department.[22] Studies on brief intervention in emergency departments or trauma centers have documented positive effects such as reductions in alcohol consumption,[10,34-37] successful referral to and participation in alcohol treatment programs,[35,36,38-41] reduction in repeat injuries, and injury hospitalizations,[10,42] and reduction in drinking and driving and moving traffic violations.[37]

Numerous studies have found that patients who drink in unhealthy patterns are more likely to respond to brief intervention than those who are dependent drinkers.[43] Research has also shown positive results using brief intervention to motivate alcohol-dependent patients to enter long-term treatment.[17] Of patients who have received substance abuse treatment, 50%—60% were abstinent at one year. As in other chronic diseases, poor adherence and relapse are predicted by low socioeconomic status, co-morbid psychiatric conditions, and lack of family and social supports.[12]

Cost-Effectiveness

A decrease in unhealthy drinking and dependence within a patient population is generally followed by a reduction in hospitalization and health care costs.[11,33,44] Studies on brief interventions conducted in other health care settings demonstrate that a substantial portion of the reduction in costs is related to a reduction in the use of emergency department and hospital resources.[6,10,36,41,43,45] In a recent cost analysis of brief intervention in a primary care setting, researchers found that the net cost savings was $330 per intervention. The benefit in reduced injury-related health expenditures resulted in a net savings of $3.81 US for every $1.00 US spent on screening and intervention.[6]

The benefit in reduced injury-related health expenditures resulted in a net savings of $3.81 U.S. for every $1.00 U.S. spent on screening and intervention.

Recommendations for SBIRT Implementation

Emergency Nurses Association's Role

Despite a growing body of research to the contrary, many practitioners still believe that treating an underlying alcohol use problem (AUP) in patients who are sick or injured due to alcohol abuse is futile.[6,46] Consequently, SBIRT is not widely practiced in emergency medicine and trauma, thereby missing a prime opportunity to prevent an epidemic disease.[46] In an attempt to reverse this trend, emergency nurses and physicians who had a special interest in injury control, began meeting with the National Highway Traffic Safety Administration (NHTSA) in 1998 to disseminate information on alcohol impairment and treatment of patients with alcohol use problems among professionals in the field of emergency medicine. In 2000, ENA partnered with NHTSA and the American College of Emergency Physicians (ACEP) to co-sponsor a national conference on "Developing Best Practice Standards of Emergency Medical Care for the Alcohol-Impaired Patient." Professionals in the fields of emergency medicine, emergency nursing, and pre-hospital emergency services presented current research and participated in breakout sessions during which best practices for each area were developed. The recommendations for nurses are as follows.

Recommended Best Practices for Nurses

1. Listen to pre-hospital professionals' report and elicit patient information indicative of alcohol use problems (AUP)
2. Identify alcohol-related events in initial assessment of the patient
3. Perform an assessment using appropriate tools, such as history, physical examination, and screening tools
4. Document objective findings of assessment, interventions and plan of care for patient with AUP
5. Collaborate with health care team to implement interventions, such as brief intervention, discharge planning, and referral
6. Communicate plan of care to appropriate services, such as physicians, substance abuse counselors, referral agencies, and inpatient caregivers
7. Provide care for the alcohol-impaired patient(s) in a professional and non-judgmental manner
8. Advocate in the community for public education, prevention programs, public policy, and treatment programs for AUP
9. Participate in collaborative research, education, and data gathering to improve the care of patients with AUP
10. Integrate alcohol screening and alcohol education into curricula, continuing education, and standards for emergency health care professionals

Note: Recommendations for physicians and pre-hospital professionals can be found in reference number 47.

American College of Surgeons Committee on Trauma Recommendations

Alcohol screening and brief intervention is mandated for all Level I ACS-verified trauma centers.

Based on accumulating data to support the efficacy of brief interventions in trauma centers, in January 2006, the American College of Surgeons Sub-Committee on Trauma mandated that alcohol screening and brief intervention services be included as an essential component of all trauma centers receiving a Level I designation.[6,47] In addition, the Sub-Committee also mandated that alcohol screening be included as an essential component of all trauma centers receiving a Level II designation.[6,47]

Alcohol screening is mandated for all Level II ACS-verified trauma centers.

Organizations that Support SBIRT

The following list is not meant to be exhaustive, but to exemplify the level of support that alcohol screening, brief intervention, and referral to treatment receives nationally. We realize that many other organizations, institutions, research centers, public health departments, and government agencies also support SBIRT.

- Agency for Healthcare Research and Quality (AHRQ)
  http://www.ahrq.gov
- Alcohol Research Group — National Alcohol Research Center
  http://www.arg.org
- American Association for the Surgery of Trauma (AAST)
  http://www.aast.org
- American College of Emergency Physicians (ACEP)
  http://www.acep.org
- American College of Surgeons (ACS)
  http://www.facs.org
- Association for Medical Education and Research in Substance Abuse (AMERSA)
  http://www.amersa.org
- Centers for Disease Control and Prevention (CDC)
  http://www.cdc.gov
- Centers for Medicare and Medicaid Services (CMS)
  http://www.cms.hhs.gov
- Emergency Nurses Association (ENA)
  http://www.ena.org
- Ensuring Solutions to Alcohol Problems
  http://www.ensuringsolutions.org
- Governors Highway Safety Association (GHSA)
  http://www.ghsa.org
- Health Resources and Services Administration (HRSA)
  http://www.hrsa.gov
- Join Together — Boston University
  http://www.jointogether.org
- National Highway Traffic Safety Administration (NHTSA)
  http://www.nhtsa.gov
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
  http://www.niaaa.nih.gov
- National Institute on Drug Abuse (NIDA)
  http://www.nida.nih.gov
- Office of National Drug Control Policy
  http://www.whitehousedrugpolicy.gov
- Research Society on Alcoholism (RSoA)
  http://www.rsoa.org
- Robert Wood Johnson Foundation
  http://www.rwjf.org
- Substance Abuse & Mental Health Services Administration (SAMHSA)
  http://www.samhsa.gov

FAQs Related to SBIRT Implementation

Selecting the Appropriate Screening Instrument and Intervention

The selection of appropriate screening and intervention methods is an important concern. Based on the current body of knowledge, the Advisory Group involved in the development of this toolkit recommended utilizing the CAGE Questionnaire as screening instrument for the emergency department setting. We understand that there is no "one size fits all" model. Therefore, we suggest that when deciding which screening instrument to use, it is most important to weigh the pros and cons of each method, so that the whole ***screening process matches your department's capacity*** to implement the SBIRT procedure.

Additional information related to strengths and weaknesses of the different screening instruments can be found on the Web site of the National Institute on Alcohol Abuse and Alcoholism at http://www.niaaa.nih.gov.

Role Responsibility

Emergency and trauma nurses may not view prevention of alcohol-related injuries as a key responsibility. The words of nationally renowned trauma surgeon and SBIRT research expert, Dr. Larry Gentilello, provide a convincing argument to the contrary.

> "Treatment of alcohol use disorders in trauma settings differs from other specialty environments such as coronary care units, where acceptance of the responsibility to prevent repeat cardiac events has led to routine screening for hypertension, hypercholesterolemia, and other risk factors. In respiratory clinics, it is common for pulmonary specialists to ask their patients whether they use tobacco. Advice, assistance, and motivation are routinely offered in an effort to help them quit. Reducing the risk of alcohol-related injuries should be of similar vital interest to…[emergency and trauma nurses]."[48]
>
> "Unlike coronary artery disease that cripples or kills only the patient, more than one third of the deaths attributed to drunk driving include other drivers, passengers, or pedestrians, which further increases the rationale for screening and intervention.

Alcohol-related injury prevention should be a core responsibility for emergency nurses because alcohol is the most common risk factor for injury among patients in ED and trauma settings.

Alcohol-related injury prevention should be a core responsibility for emergency and trauma nurses because alcohol use is the most common cause of injury in ED and trauma center patients.

Competing Priorities

There is no doubt that the emergency department setting is an extremely busy workplace environment — ED nurses are often faced with conflicting demands and multiple responsibilities. On the other hand, only one out of five patients will screen as an at risk drinker and require a brief intervention. Therefore, the SBIRT procedure is feasible for the majority of patients. Furthermore, the positive effects of conducting SBIRT in the ED setting (i.e., reduction in repeat injuries and hospitalizations) justify the need to implement the procedure.

Access to Referral Services — Ethical and Moral Challenges

Some nurses/providers have voiced their concerns about conducting SBIRT in their emergency department when there are limited or no substance abuse treatment services available in their community. It is important to keep in mind that referral services for "at-risk" drinkers (individuals who drink more than the recommended NIAAA guidelines but are not alcohol dependent) do not involve inpatient treatment or detoxification programs. In most cases, patients need to be referred to a primary care provider or substance abuse professional for further assessment.

Insurance Laws and Regulations[31]

Some health practitioners are reluctant to screen patients for alcohol use because they are concerned that if an alcohol problem is identified, the patients' health insurance carrier may deny reimbursement for the ED visit. This concern is especially prevalent in ED and trauma care settings because many states have insurance regulations allowing insurers to exclude coverage for a loss sustained because the insured was under the influence of alcohol and other drugs.[49,50] These exclusions are based on the Uniform Accident and Sickness Policy Provision Law (UPPL) adopted in 1947 by the National Association of Insurance commissioners (NAIC). The law states that health insurers would not have to reimburse patients for costs incurred when an accident is a result of "the insured's being intoxicated or under the influence of any narcotic."

To date, 12 states and the District of Columbia have successfully repealed UPPL: Colorado (2006), Connecticut (2006), District of Columbia (2007), Illinois (2007), Indiana (2007), Iowa, Maryland, Nevada, North Carolina, Oregon (2007), Rhode Island, South Dakota, and Washington State. The arguments related to denial of insurance coverage, however, do not seem justifiable in the context of screening because screening differs from testing (determination of blood alcohol concentration [BAC]). To deny reimbursement, the insurer must demonstrate that alcohol or drug use to some degree ***caused*** the insured's injury or other medical problem. This demonstration is generally based on a ***diagnostic*** or ***laboratory test documenting*** a specific alcohol or drug concentration in the patient's blood, which is linked to the reason for the ED visit or hospitalization. Screening using structured questionnaires, in contrast, ***does not diagnose*** an alcohol problem but identifies risk levels without linking it directly to the patient's current visit. This makes it less likely for an insurer to attempt to connect an injury-related ED visit to the fact that a person drinks in excess of national guidelines. Consistent with this assumption, all legal cases to-date have based denial of coverage on lab tests done at the time of an injury incident, not on alcohol screening results.

*Screening using structured questionnaires **does not diagnose** an alcohol problem. Rather, it identifies the level of risky drinking without linking it directly to the reason for a patient visit.*

The larger issue of substance abuse treatment parity—that is, regulations requiring that alcohol and other drug abuse treatment be reimbursed at the same level as treatment for other diseases—still remains. A Federal law requiring insurance coverage parity for alcohol or drug abuse treatment was first introduced in both Houses of Congress in 1997 but has yet to pass. A few states have laws requiring parity, but these laws only apply to insurance plans that are regulated by the states. They do not include federally regulated plans (e.g., the Federal Employees Health Benefit Plan) that are governed by the Employment Retirement Income Security Act (ERISA) statutes.

Reimbursement

The Healthcare Common Procedure Code System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I is the CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Starting January 2008, a set of CPT codes released by the AMA became effective for substance abuse screening and brief intervention. The two new codes (***99408*** and ***99409***) will streamline reporting and reimbursement procedures for health care providers who perform alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Since January 2007, the U.S. Centers for Medicare and Medicaid Services (CMS) approved billing codes so that providers can receive reimbursement for the screenings under Medicare (G codes) and Medicaid (H codes): one code for drug and alcohol screening, and the other for brief intervention and counseling. Table 2 provides information on reimbursement codes which can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) at http://sbirt.samhsa.gov/coding.htm.

Alcohol screening and brief intervention is a reimbursable service.

TABLE 2. Insurance Reimbursement Codes

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00

You can find additional information about coding for SBI reimbursement on Georgetown University Medical Center's Ensuring Solutions to Alcohol Problems' Web site at http://www.ensuringsolutions.org/usr_doc/SBIbackground.pdf

Administrative Support

The support of hospital and emergency department administrators is vital to the successful implementation of SBIRT. You can identify other nurses, physicians and social service professional in your hospital to assist with efforts to obtain administrative approval. The *Alcohol Fact Sheet* and *SBIRT Benefits* (see CD-ROM) are two additional toolkit components that you can use to gain support from staff nurses, other health care professionals, and administrators.

Helpful Hints

Example of Discharge Instructions

Although we recognize that there are numerous models of ED discharge instructions, we provide you with a sample from the University of Kentucky Chandler Medical Center Emergency Department (Tool 7). You can use this model to design effective discharge instructions for your particular setting. It is recommended that you provide patients with discharge instructions in conjunction with your tailored list of resources for at-risk and dependent drinkers.

SBIRT Nursing Implementation Model

A good approach is to implement a collaborative model which uses emergency nurses to conduct the screening and mental health or substance abuse professionals to perform the intervention. Such collaboration has proven to be the most effective method of delivering psychosocial services in primary care settings.[51] We recognize that there is no "one size fits all" model of SBIRT implementation; therefore, we provide you with a generic implementation algorithm (Tool 8). You can use this model to tailor an effective implementation model for your particular ED setting.

Conducting an Environmental Scan

Before you implement the SBIRT procedure in your care setting, you may choose to conduct two assessments: Evaluate **health care providers' attitude toward alcohol users and abusers** (see the *Health Provider Assessment* in Appendix 2) and assess your **ED and/or Trauma Department's readiness to implement the SBIRT procedure**. The Nurse Assessment will allow you to identify any attitudinal barriers and to focus on specific barriers that need to be addressed to improve the implementation of the SBIRT procedure. Similarly, the ED/Trauma Readiness assessment will allow you to identify any barriers (administrative, financial, etc.) before you begin training and implementation.

The ED and/or Trauma Department readiness to implement the SBIRT procedure can be assessed using questions such as:

1. Does your ED/Trauma Department and hospital administration support the implementation of the SBIRT procedure?
2. How will the implementation of the SBIRT procedure be most efficient and effective for all staff? (Refer to the SBIRT Implementation Model section.)
3. What are the strengths, weaknesses, opportunities, and threats of your department related to the implementation of the SBIRT procedure?

SBIRT Toolkit Goals

The SBIRT Educational Toolkit has a series of goals for all levels of intervention.

Individual Level

Goal 1: To increase the number of emergency and trauma care professionals who are knowledgeable about SBIRT

Goal 2: To increase the number of emergency and trauma care professionals who improve their skills for SBIRT implementation procedures

Goal 3: To increase the number of emergency and trauma care professionals who refer patients to primary care or specialized treatment

Organizational Level

Goal 4: To increase the number of emergency and trauma departments that implement SBIRT procedures as a standard protocol

Goal 5: To increase the percentage of emergency and trauma patients who receive alcohol screening, brief intervention, and referrals to treatment

Community Level

Goal 6: To reduce alcohol consumption

Goal 7: To reduce the number of alcohol-related injuries and deaths

Goal8: To reduce the number of alcohol-related emergency department visits

Goal 9: To increase community partnerships between health care institutions, mental health and substance abuse professionals, and community-based organizations

Resources

Alcohol and other drug problems among hospitalized trauma patients: controlling complications, mortality, and trauma recidivism.

http://www.cdc.gov/ncipc/Spotlight/JrnTraumaSupl.htm

Alcohol and Other Drug Screening of Hospitalized Trauma Patients (Tip 16)

http://www.jointogether.org/resources/tip-16-alcohol-and-other.html

Alcohol Use among Older Adults: Pocket Screening Instruments for Health Care and Social Service Providers

https://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=16071

Alcoholics Anonymous (English, Spanish, French)

http://www.alcoholics-anonymous.org/?Media=PlayFlash

American College of Emergency Physicians (ACEP)

http://risky.acep.org/

Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment

http://www.jointogether.org/aboutus/policy-panels/blueprint/order-form.html

Brief Interventions and Brief Therapies for Substance Abuse (Tip 34)
Treatment Improvement Protocol

http://ncadi.samhsa.gov/govpubs/BKD341/

Crossing Barriers in Emergency Care of Alcohol-Impaired Patients

http://www.nhtsa.gov/people/injury/alcohol/Crossing_Barrier_Web/index.htm

Centers for Disease Control and Prevention (CDC). Implementing prevention interventions in emergency medicine: strategic considerations. National Center for Injury Prevention and Control. Alcohol problems among emergency department patients: *Proceedings of a research conference on identification and intervention*. Available: www.cdc.gov/ncipc/pub-res/alcohol_proceedings/alcohol_proceedings.htm

Demand Treatment!
Demand Treatment! was based on the principle that the first step to increasing the availability and quality of treatment is for consumers, family members, and key leaders to take action to drive up demand of services across the spectrum—from early identification to the specialized treatment system. The project goal was to increase the number of people who receive alcohol and drug screening, brief interventions, and quality treatment in communities across the United States. *Demand Treatment!* activities were designed to provide a variety of ways for communities and individuals to participate, including community partnerships and other mechanisms.
Demand Treatment! Lessons Learned

http://www.jointogether.org/jump.jsp?path=/aboutus/ourpublications/pdf/dt_lessons_learned.pdf

Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient: Recommendations from the National Conference

http://www.nhtsa.dot.gov/people/injury/alcohol/EmergCare/

Emergency Department Alcohol Education Project: Screening, Brief Intervention, Referral, and Treatment (SBIRT)

http://www.ed.bmc.org/sbirt/index.htm

Emergency Nurses Association (ENA) Injury Prevention Institute/EN CARE. Alcohol Screening and Brief Intervention Position Statement

http://www.ena.org/about/position/PDFs/AlcoholScreening.PDF

Family Angels Program

http://angelprograms.org/

Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis

http://www.cdc.gov/ncbddd/fas/documents/FAS_guidelines_accessible.pdf

Motivational Interviewing

http://www.motivationalinterview.org/

Substance Abuse in Brief Fact Sheet — Pain Management without Psychological Dependence: A Guide for Healthcare Providers

http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17500

Project *MAINSTREAM*
The purpose of this website is to provide key resources for all health care professional educators who wish to enhance their teaching on substance use disorders.

http://www.projectmainstream.net/

http://www.projectmainstream.net/professions.asp?pid=6 (Nurses)

Quick Guide for Clinicians Based on TIPS 31 and 32: Screening, Assessing, and Treating Adolescents for Substance Use Disorders

https://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16158

Screening, Brief Intervention, Referral, and Treatment (SAMHSA)

http://sbirt.samhsa.gov/

Alcohol Screening and Brief Intervention (SBI) for Trauma Patients Committee on Trauma Quick Guide

http://www.mayatech.com/cti/sbitrain07/include/SBIRT_COT_Guide.pdf

Substance Abuse Among Older Adults (TIP26C)

https://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=13288

Substance Abuse Treatment for Adults in the Criminal Justice System (Tip 44)

https://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17183

Substance Use Screening & Assessment Instruments Database

http://lib.adai.washington.edu/instruments/

Talking with College Students about Alcohol: Motivational Strategies for Reducing Abuse

http://www.amazon.com/exec/obidos/ASIN/1593852223/jointogethero-20?creative=327641&camp=14573&adid=0GKYQPPCS158XPR8ZSXF&link_code=as1

The Alcohol Help Center

http://www.alcoholhelpcenter.net/

SELF TRAINING

Helping Patients Who Drink Too Much. A Clinician's Guide U.S. Department of Health & Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. NIH Publication No. 05-3769. 2005.

http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

AlcoholCME
This is an NIAAA-funded online continuing education course for intervening with alcohol problems (fee applies for CEU; registration and learning are free). It includes an introduction to the FRAMES model of brief intervention.

http://www1.alcoholcme.com/PageReq?id=1:8029

Alcohol Clinical Training (ACT)
This project disseminates research-based information and provides training to increase screening and brief intervention for alcohol problems.

http://www.bu.edu/act/index.html

Lifestyle Change (Rapid Reference Series) By Chris Dunn and Stephen Rollnick. Published by C.V. Mosby, London, England, 2003. 88 p. Price $27.95 (pocket sized, softcover).

Health Behavior Change: A Guide for Practitioners By Stephen Rollnick, Pip Mason, and Christopher Butler. Published by Churchill Livingstone, Robert Stevenson House, 1–3 Baxter's Place, Edinburgh, Scotland EH1 3AF, 1999. 240 p. Price $29.95 (paperback).

References

1. Substance Abuse and Mental Health Services Administration. (2007). *Alcohol screening and brief intervention (SBI) for trauma patients: Committee on trauma quick guide* (DHHS Publication No. SMA 07-4266). Rockville (MD).
2. National Institute on Alcohol Abuse and Alcoholism. (2005). *Helping patients who drink too much: A clinician's guide.* Washington, DC: Government Printing Office.
3. National Institute of Alcohol Abuse and Alcoholism. NIAAA council approves definition of binge drinking (PDF–1.6Mb). *NIAAA Newsletter* 2004; No. 3:3. Accessed March 6, 2008. http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf
4. Rivara, F. P., Koepsell, T. D., Jurkovich, G. J., Gurney J.,G., & Soderburg R. (1993). The effects of alcohol abuse on readmission for trauma. *Journal of the American Medical Association*, *270*, 1962–1964.
5. Lowenstein, S. R., Weissberg, M., & Terry, D. (1990). Alcohol intoxication, injuries, and dangerous behaviors and the revolving emergency department door. *Journal of Trauma*, *30,* 1252–1257.
6. Gentilello, L. M. (2007). Alcohol and injury: American College of Surgeons Committee on Trauma requirements for trauma center intervention. *Journal of Trauma, 62,* S44–S45.
7. Gentilello, L. M. (2000, June). Best practice standards: What has research revealed? Part II. In *Developing best practices of emergency care for the alcohol-impaired patient: Recommendations from the national conference*. Washington, DC: National Highway Traffic Safety Administration.
8. Maio, R. F., & Cunningham, R. E. (2002). Session 1. The spectrum of alcohol problems and the scope of emergency medicine practice. In D. W. Hungerford & D. A. Pollock (Eds.), *Alcohol problems among emergency department patients*: *Proceedings of a research conference on identification and intervention*. Retrieved February 8, 2008, from http://www.cdc.gov/ncipc/pub-res/alcohol_proceedings/Sesion1-PDF.pdf
9. Hungerford, D. W., & Pollock, D. A. (2003). Emergency department services for patients with alcohol problems: Research directions. *Academy of Emergency Medicine*, *10*(1), 79–84.
10. Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery*, *230,* 473–483.
11. Barry, K. L. (2002). Intervening with alcohol problems in emergency medicine: Discussion of the DiClemente and Soderstrom article. In D. W. Hungerford & D. A. Pollock (Eds.), *Alcohol problems among emergency department patients*: *Proceedings of a research conference on identification and intervention*. Retrieved February 8, 2008, from http://www.cdc.gov/ncipc/pub-res/alcohol_proceedings/alcohol_proceedings.htm
12. Center for Health and Justice at TASC. (2005). *Substance Use Disorder and Primary Care.* Retrieved February 11, 2008, from http://www.centerforhealthandjustice.org/BOSUDsandPrimaryCare.pdf
13. Gentilello, L. M., Donovan, D. M., Dunn, C., & Rivara F. P. (1995). Alcohol interventions in level 1 trauma centers: Current practice, future directions. *Journal of the American Medical Association*, *274*, 1043–1048.
14. Soderstrom, C. A., Smith, G. S., Dischinger, P. C., McDuff, D. R., Hebel, J. R., Gorelick, D. A., et al. (1997). Psychoactive substance use disorders among seriously injured trauma center patients. *Journal of the American Medical Association, 277*(22), 1769–1774.
15. National Institute on Alcohol Abuse and Alcoholism. (2001, January). *Economic perspectives in alcoholism research. Alcohol alert no. 51.* Retrieved September 10, 2007, from http://pubs.niaaa.nih.gov/publications/aa51.htm
16. National Highway Traffic Safety Administration. (1997). Current research in alcohol. *Annals of Emergency Medicine, 30*, 286-291.
17. 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.
18. Becker, B. M., Woolard, R. H., Longabaugh, R., Minugh, P. A., Nirenberg, T. D., & Clifford, P. R. (1995). Alcohol use among sub-critically injured emergency department patients and injury as a motivator to reduce drinking. *Academy of Emergency Medicine*, *2*, 784–790.
19. Brien, G. M., Stein, M. D., Zierler, S., Shapiro, M., O'Sullivan, P., & Woolard, R. (1997). Use of the ED as a regular source of care: Associated factors beyond lack of health insurance. *Annals of Emergency Medicine*, *30*, 286–291.

20. DiClemente, C. C., & Soderstrom, C. (2002). Session 3. Intervening with alcohol problems in emergency settings. In D. W. Hungerford & D. A. Pollock (Eds.), *Alcohol problems among emergency department patients*: *Proceedings of a research conference on identification and intervention.* Retrieved February 8, 2008, from http://www.cdc.gov/ncipc/pub-res/alcohol_proceedings/Sesion1-PDF.pdf

21. Schermer, C. R. (2005). Feasibility of alcohol screening and brief intervention. *Journal of Trauma, 59*, S119–123.

22. D'Onofrio, G., & Degutis, L. C. (2002, June). Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Academy of Emergency Medicine, 9*(6), 627–638.

23. Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M G. (2001). *AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary care* (2nd ed.). Geneva: World Health Organization.

24. Cherpitel, C. J. (1995). Screening for alcohol problems in the emergency department. *Annals of Emergency Medicine, 26*, 158–166.

25. Cherpitel, C. J. (2000) A brief screening instrument for problem drinking in the emergency room: the RAPS4. *Journal of Studies on Alcohol 61*, 447-449.

26. D'Onofrio, G., Bernstein, E., Bernstein, J., Woolard, R. H., Brewer, P. A., Craig, S. A., & Zink, B. J. (1998). Patients with alcohol problems in the emergency department, part 1: improving detection: SAEM Substance Abuse Task Force. Society for Academic Emergency Medicine. *Academic Emergency Medicine, 5*(12), 1200–1209.

27. Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption—II. *Addiction, 88*(6), 791–804.

28. Miller, W.R., & Rollnick, S., 1991. *Motivational Interviewing: Preparing people to change addictive behavior*, Guilford Press, New York.

29. Miller, W.R., & Rollnick, S., 2002. *Motivational Interviewing: Preparing people for change* (2nd ed.), Guilford Press, New York.

30. D'Onofrio, G., Bernstein, E., & Rollnick, S. (1996). Motivating patients for change: A brief strategy for negotiation. In E. Bernstein & J. Bernstein (Eds.), *Emergency medicine and health of the public* (pp.51–62). Boston: Jones and Bartlett.

31. D'Onofrio, G., Pantalon, M. V., Degutis, L. C., Fiellin, D. A., & O'Connor, P. G. (2005). Screening and brief intervention for unhealthy alcohol use in the ED. Retrieved September 10, 2007, from http://acepeducation.org/sbi/media/bni_manual.pdf

32. National Highway Traffic Safety Administration. (2002). Alcohol screening and brief intervention in the medical setting (DOT HS 809 467). Washington, DC: Author.

33. Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief intervention for alcohol problems: A review. *Addiction*, *88,* 315–335.

34. Greenberg, L. A., & Weinstock, B. M. (2006). Emergency department screening and brief intervention of alcohol use disorders: How to do it and does it work? *Annals of Emergency Medicine, 46*(3), S12.

35. Bernstein, E., Bernstein, J., & Levensons. (1997). Project ASSERT: An ED-based intervention to increase access to primary care prevention services and the substance abuse treatment system. *Annals of Emergency Medicine*, *30*, 181–189.

36. Soderstrom, C. A., DiClemente, C. C., Dischinger, P. C., Hebel, J. R., McDuff, D. R., Auman, K. M., et al. (2007, May). A controlled trial of brief intervention versus brief advice for at-risk drinking trauma center patients. *Journal of Trauma, 62*, 1102–1112.

37. Schermer, C. R., Moyers, T. B., Miller, W. R., & Bloomfield, L. A. (2006). Trauma center brief interventions for alcohol disorders decrease subsequent driving under the influence arrests. *Journal of Trauma, 60*, 29–34.

38. National Highway Traffic Safety Administration. (2000, June). *Developing best practices for emergency care for the alcohol-impaired patient: Recommendations from the national conference.* Washington, DC: Author.

39. Gentilello, L. M., Duggan, P., Drummond, D., Tonnesen, A., Degner, E. E., Fischer, R. P., et al. (1988). Major injury as a unique opportunity to initiate treatment in the alcoholic. *American Journal of Surgery*, *156*(6), 558–561.

40. Hungerford, D. W., Pollock, D. A., & Todd, K. H. (2000). Acceptability of emergency department-based screening and brief interventions for alcohol problems. *Academy of Emergency Medicine, 7,* 1383–1392.

41. Dunn, C. W., & Ries, R. (1997). Linking substance abuse services with general medical care: Integrated brief interventions with hospitalized patients. *American Journal of Drug and Alcohol Abuse*, *23,* 1–13.

42. Dinh-Zarr, T., Diguiseppi, C., Heitman, E., & Roberts, I. (1999). Preventing injuries through interventions for problem drinking: A systematic review of randomized controlled trials. *Alcohol, 34,* 609–621.

43. Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2000). Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Medical Care*, *38*(1), 7–18.

44. Babor, T. F., & Grant, M. (1992). *Report on Phase II: A randomized clinical trial of brief interventions in primary health care*. Geneva: World Health Organization.

45. Fleming, M. F., Barry, K. L., Manwill, L. B., Johnson, K., & London, R. (1997). Brief physician advice for problem drinkers: A randomized clinical trial in community based primary care practices. *Journal of American Medical Association, 277*(13), 1039–1045.

46. McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kieber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*, 1689–1695.

47. American College of Surgeons Committee on Trauma. (2006). *Resources for optimal care of the injured patient.* Chicago: Author.

48. Gentilello, L. M. (2005). Confronting the obstacles to screening and interventions for alcohol problems in trauma centers. *Journal of Trauma, 59*(3), S137–S143.

49. Rivara, F. P., Tollefson, S., Tesh, E., & Gentilello, L. M. (2000). Screening trauma patients for alcohol problems: Are insurance companies barriers? *Journal of Trauma, 48*(1), 115–118.

50. Gentilello, L. M., Donato, A., Nolan, S., Mackin, R. E., Liebich, F., Hoyt, D. B., et al. (2005). Effect of the Uniform Accident and Sickness Policy Provision Law on alcohol screening and intervention in trauma centers. *Journal of Trauma, 59*(3), 624–631.

51. Gentilello, L. M. (2002). Session 4. Implementing prevention interventions in emergency medicine: Strategic considerations. In D. W. Hungerford & D. A. Pollock (Eds.), *Alcohol problems among emergency department patients*: *Proceedings of a research conference on identification and intervention*. Retrieved February 8, 2008, from http://www.cdc.gov/ncipc/pub-res/alcohol_proceedings/Session4-PDF.pdf

52. Bradley, K. A., Boyd-Wickizer, J., Powell, S. H., Burman, M. L. (1998). Alcohol screening questionnaires in women: A critical review. *Journal of the American Medical Association, 280*(2), 166-171.

53. Fiellin, D. A., Reid, M C., O'Connor, P. G. (2000). Screening for alcohol problems in primary care: A systematic review. *Archives of Internal Medicine, 160*(13), 1977-1989.

54. Chung, T., Colby, S. M., Barnett, N. P., Rohsenow, D. J., Spirito, A., & Monti, P. M. (2000). Screening adolescents for problem drinking: Performance of brief screens against DSM-IV alcohol diagnoses. *Journal of Studies on Alcohol, 61*(4), 579-587.

Appendix 1

The Alcohol Use Disorders Identification Test (AUDIT)

Your emergency department may choose to have patients complete the AUDIT screening instrument. It takes approximately 5 minutes to complete, has been tested internationally in primary care settings, and has high levels of validity and reliability. The AUDIT instrument can be downloaded at http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm.

Scoring the AUDIT

Record the score for each response in the blank box at the end of each line, then total these numbers. The maximum possible score is 40.

Total scores of 8 or more for men to age 60 or 4 or more for women, adolescents, and men over 60 years old are considered positive screens.[52-54] For patients with totals near the cut-point, health care providers may wish to examine individual responses to questions and clarify them during the clinical examination.

AUDIT

Patient: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

This questionnaire is reprinted from the World Health Organization. As suggested by the National Institute on Alcohol and Alcoholism (NIAAA), to reflect standard drink sizes in the United States, the number of drinks in question three was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

RAPS4

Patient: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Questions	Yes	No
1. During the last year have you had a feeling of guilt or remorse after drinking? (**R**emorse)		
2. During the last year, has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember? (**A**mnesia)		
3. During the last year, have you failed to do what was normally expected from you because of drinking? (**P**erform)		
4. Do you sometimes take a drink when you first get up in the morning? (**S**tarter)		

This questionnaire is reprinted with permission from Cheryl J. Cherpitel at the Alcohol Research Group.

Rapid Alcohol Problems Screen (RAPS4)

Your emergency department may choose to have patients complete the RAPS4 screening instrument. It takes approximately 2 minutes to complete. The RAPS4 instrument can also be viewed on the Alcohol Research Group Web site at http://www.arg.org/RAPS4-1.

Scoring the RAPS4

A positive response on any one of the four items indicates a positive screen for alcoholism (alcohol dependence).[24]

Appendix 2
Health Care Provider Assessment

We are conducting a survey of Emergency Department health care providers to understand their attitude toward alcohol users and abusers. We would greatly appreciate your voluntary participation in this survey. We hope that this information will assist us in designing educational strategies for intervening with alcohol and other drug problems in ED patients.

THIS SURVEY IS COMPLETELY ANONYMOUS. Do not write your name anywhere on this form. All information will be kept strictly confidential. Please answer the following questions to the best of your ability. Return of this questionnaire in any form of completion constitutes your consent to participate in this project.

This survey has been designed for the purpose of assessing attitudes, knowledge, and beliefs concerning alcohol and alcohol related problems. Indicate your degree of agreement or disagreement by circling the appropriate number to the right of each statement. There are no right or wrong answers, so work quickly and do not worry over every item. We ask that you return the survey to us in the enclosed self-addressed, stamped envelope or Fax it to us at [Fax Number].

If you have any questions about this survey, or would like to receive a copy of the final results, please contact the [Department], [Telephone Number].

QUESTIONNAIRE

Directions: Read each statement and answer indicating how you feel right now. Do not spend too much time on any one statement but give the answer that seems to describe your present feelings best.

1. What is your profession?

CHECK ONE
☐ MD
☐ RN

2. How old are you?

AGE IN YEARS

3. Please indicate your gender

CHECK ONE
☐ MALE
☐ FEMALE

4. Which race/ethnicity category best describes you?

CIRCLE *ONE* FOR CATEGORY THAT BEST DESCRIBES YOU				
White (not Hispanic)	**Black (not Hispanic)**	**Hispanic**	**Asian**	**Other**
1	**2**	**3**	**4**	**5**

5. What year did you graduate from medical or nursing school?

YEAR
19____
20____

6. Which category best describes you?

CIRCLE *ONE* NUMBER TO INDICATE CATEGORY THAT BEST DESCRIBES YOU						
R.N.	**First Year EM Resident**	**Second Year EM Resident**	**Third Year EM Resident**	**Fourth Year EM Resident**	**Attending Physician**	**APRN**
1	**2**	**3**	**4**	**5**	**6**	**7**

7. In the past year, about how many lecture/seminar hours have you attended on alcohol and alcohol related problems?

_____ hours

8. During your medical, nursing, and/or postgraduate training, about how many lectures/seminars were devoted to alcohol problems?

_____ hours

9. Have you ever had a problem with alcohol (i.e., related illness/injury/DWI)?

CHECK ONE
☐ YES
☐ NO

10. Has someone you personally know (other than one of your patients) had an alcohol problem?

CHECK ONE
☐ YES
☐ NO

11. How close was/is this person to you?

CIRCLE *ANY* NUMBERS THAT APPLY IN THE RANGE BELOW					
Have Not Known Anyone	**Passing Acquaintance**	**Friend**	**Close Friend**	**Extended Family Member**	**Immediate Family Member**
1	2	3	4	5	6

12. What percent of patients that you care for in a typical ED shift have alcohol abuse or dependence problems? *(please fill in a number between 0—100)*

%

13. Please rate your experience working with patients with alcohol problems?

None	Little	Moderate	Large	Vast
1	2	3	4	5

14. Has your professional training included a formal class on alcohol problems?

CHECK ONE
☐ YES
☐ NO

15. If you answered yes to the previous question, how much time was spent on the topic of addiction and addictive behavior in health care professionals?

_____ hours

16. Rate the following statements according to your current beliefs. Circle one number on each line.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Talking to patients about their drinking makes me feel like a responsible physician/nurse.	1	2	3	4	5
It takes too much time to deal with patients' drinking behavior.	1	2	3	4	5
There are no/few adequate places to refer patients.	1	2	3	4	5
Advising a patient about his/her drinking behavior may lead to early, successful intervention.	1	2	3	4	5
There are too many legal issues regarding alcohol use and documentation to get involved.	1	2	3	4	5
There are no/few role models among my attendings/peers.	1	2	3	4	5
Patients will be angry if I ask these questions.	1	2	3	4	5
Patients with alcohol problems are behavioral problems in the ED.	1	2	3	4	5
People can stop abusing alcohol if they really want to.	1	2	3	4	5
Treatment does not work.	1	2	3	4	5
Referrals have not helped many of these patients in the past.	1	2	3	4	5
My involvement with a patient can make a difference regarding his/her alcohol use.	1	2	3	4	5

17. Circle the appropriate response regarding your clinical practice. Circle one number on each line.

	Never	Rarely	Sometimes	Usually	Always
How often do you ask patients about alcohol problems?	1	2	3	4	5
How often do you ask about quantity and frequency of use?	1	2	3	4	5
How often do you formally screen patients for alcohol problems using CAGE, AUDIT, TWEAK, or MAST questions?	1	2	3	4	5
How often do you assess patients' readiness to change their behavior?	1	2	3	4	5
How often do you discuss/advise patients to change their drinking behavior?	1	2	3	4	5
How often do you refer patients with alcohol problems for further assessment or intervention?	1	2	3	4	5
How often do you document your assessment, intervention, and referral?	1	2	3	4	5

18. Rate the following statements according to your confidence/ability level. Circle one number on each line.

	No Confidence	Low	Medium	Moderate	High Confidence
I am confident in my ability to ask patients about their alcohol use.	1	2	3	4	5
I am confident in my ability to ask patients about quantity and frequency of their alcohol use.	1	2	3	4	5
I am confident in my ability to screen patients for alcohol problems using CAGE, AUDIT, TWEAK, or MAST questions.	1	2	3	4	5
I am confident in my ability to assess patients' readiness to change their behavior.	1	2	3	4	5
I am confident in my ability to discuss/advise patients to change their drinking behavior.	1	2	3	4	5
I am confident in my ability to refer patients with alcohol problems.	1	2	3	4	5
I am confident in my ability to document my assessment, intervention, and referral.	1	2	3	4	5

19. Rate according to what you think your responsibility as an emergency physician/nurse is to the following. Circle one number on each line.

	No Responsibility	Minor	Medium	Moderate	Major
To ask patients about their alcohol use	1	2	3	4	5
To ask patients about quantity and frequency of their alcohol use	1	2	3	4	5
To screen patients for alcohol problems using CAGE, AUDIT, MAST or TWEAK questions	1	2	3	4	5
To assess patients' readiness to change their drinking behavior	1	2	3	4	5
To discuss/advise patients to change their drinking behavior	1	2	3	4	5
To refer patients with alcohol problems	1	2	3	4	5
To document your assessment, intervention, and referral	1	2	3	4	5

20. Rate the following statements according to your current beliefs. Circle one number on each line.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Alcohol dependence is associated with a weak will.	1	2	3	4	5
An alcohol or drug dependent person cannot be helped until he/she has hit "rock bottom."	1	2	3	4	5
Heroin is so addicting that no one can really recover once he/she becomes an addict.	1	2	3	4	5
Specialists in that field should only treat alcohol and drug abusers.	1	2	3	4	5
Smoking leads to marijuana use, which in turn leads to hard drugs.	1	2	3	4	5
Physicians who diagnose alcoholism early improve the chance of treatment success.	1	2	3	4	5
Daily use of one marijuana cigarette is not necessarily harmful.	1	2	3	4	5
Urine drug screening can be an important part of drug abuse treatment.	1	2	3	4	5
A physician who has been addicted to narcotics should not be allowed to practice medicine again.	1	2	3	4	5
Marijuana use among teenagers can be a healthy experiment.	1	2	3	4	5
An alcohol or drug dependent person who has relapsed several times probably cannot be treated.	1	2	3	4	5
Long-term outpatient treatment is necessary for the treatment of drug addiction.	1	2	3	4	5
Paraprofessional counselors can provide effective treatment for drug and alcohol abusers.	1	2	3	4	5
Lifelong abstinence is a necessary goal in the treatment of alcohol dependence.	1	2	3	4	5
Once a person becomes drug-free through treatment, he/she can never become a social user.	1	2	3	4	5
Drug addiction is a treatable illness.	1	2	3	4	5
Group therapy is very important in the treatment of alcohol or drug addiction.	1	2	3	4	5
A hospital is the best place to treat an alcoholic or drug addict.	1	2	3	4	5
Alcoholism is a treatable illness.	1	2	3	4	5
Most alcohol and drug dependent persons are unpleasant to work with as patients.	1	2	3	4	5
Pregnant women who use alcohol and/or other drugs should be punished.	1	2	3	4	5
Coercive pressure, such as a threat of punishment, is useful in getting resistant patients to accept treatment.	1	2	3	4	5
A recovering person who is active in Alcoholics Anonymous does not respond well to psychotherapy.	1	2	3	4	5
A nurse who has been drug dependent should not be allowed to give medications to patients.	1	2	3	4	5

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Active participation in a program such as AA is essential for a patient to recover from alcohol or drug dependence.	1	2	3	4	5

21. Approximately what percent of trauma is alcohol related?

A. 30%
B. 50%
C. 75%
D. 90%

22. One 12-ounce can of beer is equal to?

A. 5-ounce glass of wine
B. 8-ounce glass of wine
C. 1-ounce of distilled spirits
D. 1.5-ounce of distilled spirits
E. A and C
F. A and D
G. B and C
H. B and D

23. The medical history for alcohol-related problems may include all of the following except:

A. Abdominal pains
B. Sleep impairment
C. Bradycardia
D. Hypertension

24. A male patient may be at risk for alcohol-related problems if he drinks:

A. > 7 drinks per week
B. > 14 drinks per week
C. > 21 drinks per week
D. > 3 drinks per occasion
E. > 4 drinks per occasion
F. > 6 drinks per occasion
G. A and D
H. B and E
I. C and F
J. B and F

25. A female patient may be at risk for alcohol-related problems if she drinks:

A. > 7 drinks per week
B. > 14 drinks per week
C. > 21 drinks per week
D. > 3 drinks per occasion
E. > 4 drinks per occasion
F. > 6 drinks per occasion
G. A and D
H. B and E
I. C and F
J. A and E

26. Indicators for possible alcohol dependence include all of the following except:

A. Preoccupation with drinking
B. Drinking a six-pack and driving
C. Unable to stop drinking once started
D. Needing more alcohol than before to get high

27. What do the four letters in the CAGE acronym stand for?

C =
A =
G =
E =

28. Approximately what percentage of patient admitted to the hospital have alcohol-related problems?

A. 10%
B. 20%
C. 30%
D. 50%

29. Mr. Smith is a 30-year-old, non-restrained driver involved in a single car crash brought to the ED by EMS. He is awake and alert, and angry about crashing his new car. He sustained a laceration to his forehead. He has a noticeable smell of alcohol on his breath, and he reports drinking a six-pack of beer with his friends after work. His c-spine x-ray is negative and his laceration has been repaired. How appropriate would it be to ask/say the following?

	Very Appropriate	Somewhat Appropriate	Uncertain	Somewhat Inappropriate	Very Inappropriate
The four CAGE questions	1	2	3	4	5
"The only solution is for you to abstain from alcohol."	1	2	3	4	5
"Don't you realize you are an alcoholic?"	1	2	3	4	5
"What are some of the things you like about drinking?"	1	2	3	4	5
"What are some of the not-so-good things about your drinking?	1	2	3	4	5
"You should go to AA (Alcoholics Anonymous) and get some help."	1	2	3	4	5
"I am concerned about your drinking and driving."	1	2	3	4	5
"It must be very upsetting to have wrecked your new car."	1	2	3	4	5

30. The brief intervention model includes all of the following except?

A. Establish rapport
B. Raise the subject
C. Assess readiness to change
D. Prescribe solutions

THANK YOU FOR TAKING PART IN OUR SURVEY!

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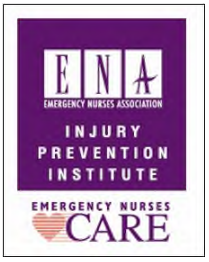

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