Introduction

Approximately half of all trauma patients admitted to trauma centres have positive blood alcohol levels (BAL) on admission (Soderstrom et al 1992, Dunn et al 2005, Schermer et al 2006). The incidence at SMH is difficulty to ascertain, as over 10% of patients admitted from April 2005 to March 2006 did not have a BAL assessment. The majority of individuals who suffer injury due to alcohol use are not alcoholics or dependant drinkers but rather, are moderate drinkers who drink excessively (Gentilello et al 1995, Field et al 2001, Schermer 2006). When injury is related to alcohol use, it is this drinking behavior that is most often responsible.

Those individuals that engage in moderate ‘at risk drinking’ drink at levels that place them at increased risk for future health problems, legal problems, relationship problems and alcohol related injuries. The risk of reinjury among trauma patients with any type of alcohol use is 2 times that of those with no alcohol use (Worrell et al 2006). Alcohol screening and brief interventions (ASBI) can mitigate that risk, reducing alcohol consumption, monthly number of binge drinking episodes, recurrent driving under the influence charges and the risk of trauma recidivism (Gentilello et al 1999, Monti et al 1999, Worrell et al 2006). Trauma recidivism has been shown to be reduced by as much as 50% if patients receive a single, brief intervention during their hospitalization (Longabaugh et al 1995, Bombardier et al 1995 Monti et al 1999, Gentilello et al 1999).

Trauma units provide an ideal location for secondary injury prevention, taking advantage of a teachable moment generated by the injury, capitalizing on the fact that the patients’ injuries can help motivate behavior change (Schermer et al 2003, Gentilello et al 2005, Schermer 2006).

The goal of the brief intervention is to raise the patient's awareness of their alcohol problem and to explore options to change their drinking behavior. Brief interventions have been evaluated in varied populations of problem drinkers and have been shown to be as effective as more intensive counselling (Ockene et al 1999, Gentilello et al 1999, Monti et al 1999 Longabaugh et al 1999, Hungerford et al 2003, Hoyt et al 2005). The brief intervention is designed to help patients who are not severely addicted to alcohol and who have enough control over their drinking that they can cut...
down or quit with minimal help. It is not within the scope of this brief intervention to provide intensive therapy for chronic alcohol abuse issues.

Guidelines

Outline:

1. All trauma patients assessed by the trauma team will receive a toxicology screen, which includes at minimum, a BAL.
2. All trauma patients assessed by the trauma team and screened as likely having alcohol or drug problems of any severity will be identified by trauma program staff and will receive a brief intervention during their hospitalization.
3. Those patients whose cognitive status is compromised to the extent that they cannot participate in the intervention interaction will be excluded.
4. The brief intervention providers must be trained in the Alcohol Screening and Brief Intervention Process.
5. Interventions will occur at the patients’ bedside or in other locations (i.e. a quiet room) where patients’ concerns about privacy can be met.

Screening and Identifying Patients:

In order to ensure that all patients that could potentially benefit from the ASBI are captured, trauma service staff will identify all patients eligible for the ASBI. Identification begins with a review of the results of the BAL and toxicology screen performed in the emergency department. The ASBI interventionists will review all trauma patients on admission identifying patients that meet the criteria for the ASBI intervention.

The initial screening criteria are considered positive if the admission BAL or toxicology screen is positive. Patients with positive screens for benzodiazepines and/or opiates are not considered positive, because these drugs are frequently administered for medical management of injury.

Patients are also considered to have screened positive if information from a staff member or medical record suggests drug or alcohol involvement. Those patients that screen positive will be assessed daily by the intervention provider until it is determined based on the interventionist’s clinical judgment that the patient’s cognitive status (capability) and receptiveness (consent) to intervention are deemed appropriate. The intervention will usually take place once the patient has been discharged to the floor, but early enough in the patient’s stay that opportunities to follow-up with the interventionist prior to discharge are available.

Brief Intervention:

Initial screening offers sufficient cause to begin an intervention but additional information about severity and dependence should be elicited through further screening and completion of the AUDIT 10 question screening tool (appendix 1 and 2). The AUDIT screening and intervention is usually a single interaction lasting 20-60 minutes. The goal of the brief intervention is to explore in this teachable moment whether the patient wants to explore options to change their drinking behavior and involves 3 components: information, understanding and clear, professional respectful advice.

**Information:** Engaging the patient in a dialogue where feedback is provided on screening results, BAL/toxicology screen on admission, the link between drinking and injury, the
guidelines for moderate consumption (see Appendix 3 and 4), and methods for reducing or stopping drinking (see Appendix 5 and 6). When interventions are in response to another staff member’s request, the interventionist is responsible for following up with that staff member to address the staff members concerns.

**Understanding:** Engaging the patient in a discussion so that they can come to their own decisions about drinking; this involves eliciting patients' perceptions of why they drink, how drinking may have contributed to their injury and how they may want to change their behavior to reduce their risks.

**Clear, professional respectful advice:** Engaging the patient in a discussion to enable the patient to establish and articulate their own drinking goals and formulate a plan to achieve their goals. This interaction will likely require negotiation between the clinician’s suggested guidelines for what is best for the patient and what the patient is willing and able to do. The intervention provider is responsible for broaching the topic in a respectful and considerate manner, and conducting the intervention so as not to add to the patients current distress.

**Follow-up:**

Whenever possible, patients are seen again by the interventionist during their hospitalization for follow-up and reinforcement of the brief intervention.

Patients with severe alcohol dependency problems are referred to resources within the hospital or in the community (appendix 7).

**Documentation:**

ASBI documentation will be included on the ASBI Tracking Form which will be stored separately from the chart in the Trauma office. Notation will be made in the chart that an ASBI has been performed.

**References**

American College of Surgeons Committee on Trauma Alcohol Screening and Brief Intervention for Trauma Patients COT Quick Guide U.S. Department of Health and Human Services.


Appendix Document

See following pages
AUDIT: Self-Report Version

Instructions to patients: 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 describes your answer to each. Please think about your drinking in the past year and remember that a drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>Two to four times a month</td>
<td>Two to three times a week</td>
<td>Four or more times a week</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
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<tr>
<td>3. How often do you have five or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
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<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
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<tr>
<td>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>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?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
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<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
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<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before you had been drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>9. Have you or someone else been injured as a result of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
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<tr>
<td>10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
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</table>

Total

Available for clinical use without permission from the World Health Organization. The international version has been slightly altered here to adjust it partially to the 14 g. standard drink in the U.S.A. by changing “six” to “five” in Question 3. A manual on the use of the AUDIT and another on brief interventions are available at http://www.who.int/substance_abuse/publications/alcohol/en/index.html. In interview or computer format, questioning can stop if the first question receives a negative answer or if the score of questions 2 and 3 are zero. Note that women who drink somewhat above recommended guidelines of 7 drinks per week may score zero on question 2 and not receive a positive screening result.
Appendix 2 AUDIT Score guidelines

AUDIT Score (takes 2-3 minutes to administer) used to evaluate severity of patients drinking problem. Patients meeting or exceeding cut off scores (NIAAA recommendation) should be offered a brief intervention:

- adult men 8 or >
- adult women 4 or >

An AUDIT Score 16-19 suggests severe alcohol related problems
An AUDIT score of 20 or more suggests alcohol dependency syndrome which may require specialized treatment.
Appendix 3 NIAAA Drinking Guidelines

<table>
<thead>
<tr>
<th>NIAAA Drinking Guidelines</th>
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<tbody>
<tr>
<td>Healthy men up to age 65:</td>
<td>• No more than 4 drinks in a day AND</td>
</tr>
<tr>
<td></td>
<td>• No more than 14 drinks in a week</td>
</tr>
<tr>
<td>Healthy women and healthy men over age 65:</td>
<td>• No more than 3 drinks in a day AND</td>
</tr>
<tr>
<td></td>
<td>• No more than 7 drinks in a week</td>
</tr>
<tr>
<td>Lower limits or abstinence for patients who:</td>
<td>• Take medications that interact with alcohol</td>
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<tr>
<td></td>
<td>• Have a health condition exacerbated by alcohol</td>
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</table>
Appendix 4

University of Toronto and the Centre for Addiction and Mental Health, Low Risk Drinking Guidelines.

Low - Risk Drinking Guidelines

Maximize Life, Minimize Risk

- 0: Zero drinks = lowest risk of an alcohol-related problem
- 2: No more than 2 standard drinks on any one day
- 9: Women: up to 9 standard drinks a week
- 14: Men: up to 14 standard drinks a week

One Standard Drink = 13.6 g of alcohol

- 5 oz/142 mL of wine (12% alcohol)
- 1.5 oz/43 mL of spirits (40% alcohol)
- 12 oz/341 mL of regular strength beer (5% alcohol).

Higher alcohol beers and coolers have more alcohol than one standard drink

- If you don't already drink, don't start for health reasons.
- If you do drink, avoid getting intoxicated or drunk.
- Wait at least one hour between drinks.
- Have something to eat. Drink non-alcoholic beverages, such as water, soft drinks or fruit juice.

The Low-Risk Drinking Guidelines are for people of legal drinking age

The Guidelines do not apply if you:

- have health problems such as liver disease or mental illness
- are taking medications such as sedatives, painkillers or sleeping pills
- have a personal or family history of drinking problems
- have a family history of cancer or other risk factors for cancer
- are pregnant, trying to get pregnant or breastfeeding
- will be operating vehicles such as cars, trucks, motorcycles, boats, snowmobiles, all-terrain vehicles or bicycles
- need to be alert, for example, if you will be operating machinery or working with farm implements or dangerous equipment
will be doing sports or other physical activities where you need to be in control
are responsible for the safety of others at work or at home
are told not to drink for legal, medical or other reasons

If you are concerned about how drinking may affect your health, check with your doctor.

**Tips for following these Guidelines:**

- Know what a standard drink is.
- Keep track of how much you drink -- daily and weekly.
- Never drink and drive -- or ride with a driver who has been drinking.
- Don't start drinking for health reasons. To keep your heart healthy, eat better, exercise more and don't smoke.
- Don't drink if you are pregnant or planning to become pregnant.
- Be a responsible host -- encourage your guests to follow these guidelines.
- Talk to your kids about alcohol.
- Find out about programs and policies that support low-risk drinking.
- Develop an alcohol policy for your home, workplace, school or community organization.

Note: These are "low-risk" guidelines. They are not "no-risk" guidelines.

**You may have heard that alcohol is good for your heart. What you may not have heard is that:**

- The health benefits of alcohol apply mainly to people over the age of 45. A little goes a long way. In most cases, one drink of beer, wine or liquor every other day is enough.
- For most people, more than two drinks a day does more harm than good.
- Women who have more than nine drinks a week have higher rates of cancer and other problems than women who drink less.
- Men who have more than fourteen drinks a week also have higher rates of alcohol-related problems.
- Young people have very low rates of heart disease but very high rates of alcohol-related injuries and death.
- If you want to improve your health, you're better off eating a healthier diet, getting more exercise, and giving up smoking, rather than drinking more or starting to drink.

So bring a little balance into your life... For advice on alcohol and health, talk to your doctor or other health professional or call 1-800-463-6273 (416-595-6111 in Toronto).

The Low-Risk Drinking Guidelines were developed by a team of medical and social researchers from the University of Toronto and the Centre for Addiction and Mental Health.
Appendix 5 Methods for Reducing or Stopping Drinking

May include:

- Advising patients to cut down or quit
- Negotiating a plan for cutting down or quitting
- Advising patients to keep track of how much they drink and knowing what a standard drink is
- Avoiding driving after drinking
- Possibly seeking professional help
- Joining a mutual support group (AA)

Seeking a compromise between what clinician thinks is safest and what patient is willing to do may involve:

- Goal setting (quitting drinking versus cutting down). Ask the patient to decide how many days a week they will drink and how many drinks they will have on those days.
- Formulating a plan (avoiding situations and places where the patient drinks-i.e not going to the bar after work). Ask the patient to figure out who might be willing to support their efforts to cut down or quit and develop a plan to seek the support of those individuals.
- Suggest that the patient avoid the triggers to drink (people/places/activities that make the patient want to drink). Ask the patient to formulate plans for what they will do instead of drinking.
- Discuss how to say no to offers of drinks (polite and convincing).
A Simple Alcohol Screening and Brief Intervention Didactic Model:

1. **Introduction:** Introduce self, role, outline rules of confidentiality and permission to speak with patient.
2. **Establish basic rapport:** Invite patient to tell you what brought them to SMH and what they were doing at time of fall, accident, or assault. For example; were you at a party/celebration, where you having a few drinks?
3. **Assess Readiness/Drinking Feedback:** Invite patient to explore other situations where drinking may have been precursor of a traumatic event, concretize any pattern if present. Question their knowledge of their BAL and share level.
4. **Recommended Limits:** Inquire what patient understands are recommended limits in everyday situations. Make sure patient understands the Canadian Health Guide Limits.
   **Limits:** A standard drink is the amount of alcohol in one beer, on glass of table wine, or one shot or spirits.
   Doctors recommend that people who drink alcohol always keep the BAL below .05. The legal limit for driving is .08, but this is considered heavy social drinking and can lead to problems. For most healthy men Doctors recommend: no more than 3 standard drinks per occasion and no more than 14 total drinks per week.
5. **Risk Education:** Explore with patient any experiences or problems directly related to alcohol consumption. Set examples related to accidents, debt, relationship problems etc.
6. **Assess Readiness:** Explore the patients readiness (not important, somewhat important or extremely important)
7. **Education and Contracting:** Assess patient motivation and willingness to address this issue using open ended questions i.e. what do you think? Is this something you wish to change? Then negotiate a contract using the patient’s direction as to what is manageable for them. Give basic referral information and handout with education.
8. **Commendation:** End intervention by commending them on their openness, honesty and willingness to talk about a difficult subject. Leave opportunity for questions if appropriate.

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<th>Effective Date(s)</th>
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<th>Author or Reviewer</th>
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<td>Feb-01-2010</td>
<td>Trauma Quality Assurance Coordinator</td>
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