Hutt Valley DHB Emergency Department Alcohol Card: Evaluation Report

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EXECUTIVE SUMMARY

In 2005, staff of the Hutt Valley District Health Board (DHB) Emergency Department (ED) and Regional Public Health approached the Alcohol Advisory Council of New Zealand (ALAC) with a proposal to pilot an alcohol-related intervention in the ED.

They proposed that ALAC develop a resource in the form of a "business card" that could be made available to patients in the ED to help them to address alcohol-related issues. ALAC agreed to the proposal, and an "alcohol card" was distributed through the Hutt Valley DHB ED between April and August 2006. The card invites recipients to contact the Alcohol and Drug Helpline for information and/or to request a copy of the *Had Enough?* video/DVD resource.

This report is the result of an evaluation of the pilot project, which aimed to identify:

- Theoretical support for the model of intervention and the strengths and weaknesses of evaluations of similar interventions in ED settings.
- The population reached by the intervention.
- The motivating factors that supported the development of the concept within the ED.
- Barriers and enablers to implementing the initiative.
- Perceptions of the impact of the initiative on staff and patients.
- Opportunities for future expansion of the pilot.
- Any changes required to the alcohol card or modes of distribution.
- Any additional supports required in an ED setting to maximise the reach and potential impact of the intervention.

The evaluation was undertaken using five key processes:

- A review of relevant background documents supplied by ALAC.
- A review of relevant New Zealand and international literature.
- An analysis of data gathered by the Alcohol Drug Helpline.
- Interviews with staff from the ED and Regional Public Health.
- A brief written survey of ED staff.

The evaluation concludes that, while the card's effectiveness cannot be conclusively demonstrated at this stage, findings from the literature and the evaluation of the pilot project itself indicate that it shows promise as a viable and effective intervention in the ED.

For example, the literature review suggests that:

- The prevalence of alcohol-related presentations in the ED is a strong rationale for the provision of interventions to reduce alcohol-related harm.
- The ED provides a potential opportunity to intervene early before problems become worse.
- Through "teachable moments", ED practitioners are well placed to help patients to consider the link between alcohol consumption and associated negative consequences, thereby increasing patient receptivity to access further intervention.
- However, the barriers to provision of alcohol-related interventions by ED staff are significant

and necessitate development of time-efficient interventions, suited to ED conditions.

- There is an increasing recognition of the interface between EDs and public health and the potential for EDs to enhance the provision of public health interventions.

The staff interviews and survey supported the alcohol card concept and experience. Staff described the card as a useful intervention that to some extent fills a gap in having something to offer ED patients who may have alcohol-related issues. They also commented on:

- The intervention being consistent with ED health-promotion objectives. This fit, combined with ease of use, is seen as a significantly positive aspect of the intervention.
- The accessibility of the intervention – that the card is easy to use, places minimal burden on their time, requires little input and yet has the potential to link patients with the ongoing assistance they require.
- The acceptability of the intervention, particularly the card's ease of use and the emphasis on patients being responsible for picking it up and using it.

The report recommends that:

- The alcohol card pilot project is continued, with the objective of further trialling and refining aspects of the intervention.
- Further training is provided to ED staff on the presenting conditions associated with hazardous drinking, the services provided by the Alcohol and Drug Helpline and the skills needed to take a more active role in helping patients make the link between their drinking and their health issues.
- ALAC and Hutt Valley DHB ED explore the potential benefits of providing bigger display stands for the alcohol cards and developing a poster for the ED to draw patients' attention to the cards.

1. INTRODUCTION

During 2005, staff of the Hutt Valley District Health Board (DHB) Emergency Department (ED) and Regional Public Health approached the Alcohol Advisory Council of New Zealand (ALAC) with a proposal to pilot an alcohol-related intervention in the ED.

Hutt Valley DHB staff proposed that ALAC develop a resource in the form of a "business card" that could be made available to patients in the ED to assist them to address alcohol-related issues.

There are clear links between alcohol and reasons for attendance at EDs and the intervention was considered consistent with ALAC's Early Intervention strategy. ALAC agreed to the proposal, and the pilot project to develop and trial the use of an alcohol card commenced in December 2005.

A tailored palm-sized "business card" (referred to in this report as the alcohol card) was provided by ALAC and distributed through the Hutt Valley DHB ED from April 2006 to August 2006. The alcohol card was designed to raise a question regarding the link between alcohol and the event that had led the person accessing the card to require treatment in the ED. The alcohol card invites recipients to contact the Alcohol Drug Helpline for information and/or to request a copy of the *Had Enough?* video/DVD resource.

The alcohol card was made available to ED patients through the following routes:

- Patient self-selection from card-holder display stands in the ED waiting room, the ED whānau room and the short-stay unit.
- Selection by family/whānau members for passing on to patients.
- Direct provision to patients by ED practitioners[1].

An evaluation of the pilot project for the period from April to the end of July 2006 was undertaken by Health & Safety Developments. This report contains a discussion of the aims, method and results of the evaluation.

[1] ED practitioners are defined as doctors and nurses.

2. EVALUATION AIMS AND METHOD

The aims of the evaluation, agreed by ALAC and Hutt Valley DHB, were to identify the following:

- Theoretical support for the model of intervention and the strengths and weaknesses of evaluations of similar interventions in ED settings.
- The population reached by the intervention.
- The motivating factors that supported the development of the concept within the ED.
- Barriers and enablers to implementing the initiative.
- Perceptions of the impact of the initiative on staff and patients.
- Opportunities for future expansion of the pilot.
- Any changes required to the alcohol card or modes of distribution.
- Any additional supports required in an ED setting to maximise the reach and potential impact of the intervention.

The evaluation has been undertaken using the following processes:

1. Review of relevant background documents
   Background documents were supplied by ALAC and were mainly concerned with project establishment. Included were the project brief and evaluation framework.

2. Review of relevant literature
   The literature review aimed to identify:
   - International theoretical support for the model supporting the alcohol card intervention.
   - The strengths and weaknesses of evaluations of similar interventions in ED settings.

   Literature was initially selected and provided by the ALAC Information Service, including articles on the following:
   - Brief interventions in ED settings, hospital settings, primary care and educational settings.
   - Interventions relevant to managing other types of health issue in EDs eg, chronic asthma.

   Additional material was located via:
   - Further searching to source articles on health promotion and the provision of health information in the ED setting.
   - Articles sourced from the reference lists within the sourced literature.
   - Internet sources.

   Articles were selected for relevance to the aims outlined above. Not all selected articles were accessible within the review timeframe.

   In the interests of efficiency, this summary has drawn on other relevant literature summaries where possible.

   Very limited literature directly applicable to the alcohol card intervention was found, however related areas that provide some relevant information have been reviewed. These are:
   - ED and alcohol-related interventions.

- ED and health promotion.
- Intervention for other health issues in the ED.

3. Analysis of Alcohol and Drug Helpline data
   Data from the Alcohol and Drug Helpline were reviewed for the period from April to the end of July 2006. The Alcohol and Drug Helpline Clinical Manager was also interviewed in order to clarify issues relating to the data.

4. Key informant interviews
   Key informant interviews were conducted with staff in various roles within the ED and a key staff member from Regional Public Health. Interview participants were selected in consultation with Hutt Valley DHB staff and interviews took place in July 2006. Medical staff were not available for the face-to-face interviews and did not respond to invitations to participate in the evaluation via telephone interviews. The absence of the perspective of the medical staff is a limitation of the evaluation.

   A copy of the key informant interview template is provided in Appendix 1.

5. Written survey of ED staff
   A brief written survey of ED staff was undertaken. This survey was not included in the original evaluation design and was added at the suggestion and with the support of the ED Clinical Nurse Manager, in an attempt to ascertain further information about the level of support for the intervention from the wider ED staffing group. The survey was designed in consultation with the ED Clinical Nurse Manager, distributed within the ED via staff pigeonholes and returned via the ED Clinical Nurse Manager. The purpose of the survey, reporting processes and confidentiality of responses were clearly outlined.

   A copy of the survey is provided in Appendix 3.

The processes to undertake this evaluation were selected in consultation with ALAC and with Hutt Valley DHB staff.

2.1 LIMITATIONS TO THE EVALUATION

The following limitations to the scope of the evaluation and methodology used are of note:

1. Patients were not included in the evaluation for two reasons:
   - The intervention is at an early stage of development.
   - The processes that would be necessary to include the patient perspective were beyond the scope of an initial evaluation and arguably incompatible with the nature of the intervention.

2. Financial aspects of the project have not been evaluated and were not included in the scope of the evaluation.

3. There has been no specific evaluation of the pilot from a Maori perspective.

4. Limitations to the methods used in the evaluation include:
    - Medical staff of the Hutt Valley DHB ED did not respond to invitations to participate in the evaluation.
    - The self-selection of interview participants and survey respondents may introduce some bias to the results.
    - The number of respondents to the written survey is small. The survey was not part of the initial evaluation design and no further activity was undertaken to boost survey response numbers as this was outside the timeframe and resource allocation for the evaluation.

These methodological limitations have been highlighted throughout the report alongside results from each data source.

3. EVALUATION RESULTS

3.1 SUMMARY OF SELECTED LITERATURE: FINDINGS

3.1.1 ED and alcohol-related interventions

Literature on alcohol-related interventions in the ED highlights the following key considerations in relation to the alcohol card intervention type:

- The need for alcohol-related interventions in the ED setting and the potential for alcohol-related interventions to reduce alcohol-related harm are established.
- Screening and brief intervention is the key type of intervention that has been studied. Screening and brief intervention has been shown to be effective in reducing alcohol-related harm, however there is a range of activities incorporated in this term, making comparisons between initiatives difficult. Additionally, very few studies have been undertaken using "real world" conditions involving ED practitioners.
- The barriers for implementing screening and brief intervention are significant eg, time constraints, chaotic environment, lack of privacy and lack of training and support for ED staff, and must be fully considered in the implementation of any ED-based intervention. Many researchers argue that ED-based interventions must incorporate simple and time-efficient procedures.
- One study suggests that the alcohol card intervention may be effective and the use of this intervention type is recommended (although not trialled) by an additional study.

The key findings are discussed in more detail below.

Prevalence of patients presenting to the ED with alcohol-related issues

The prevalence of alcohol-related presentations in the ED is cited as a strong rationale for the provision of interventions to reduce alcohol-related harm.

The high prevalence of patients presenting to the ED with alcohol-related issues is well established. ED practitioners routinely provide treatment for patients who are experiencing adverse health effects related to alcohol (D'Onofrio and Degutis, 2004/2005). Studies cite prevalence rates of alcohol-related issues among all patients presenting to the ED as being in the range of 10-40% (D'Onofrio and Degutis, 2004/2005; Crawford et al, 2004; Patton et al, 2003; Hadida et al, 2001; Simpson et al, 2001; Peters et al, 1998).

In contrast to other studies, a German study by Baune et al (2005) cites a prevalence of only 3%. However, the authors note that the figure is likely to be an underestimate of the true alcohol-related burden in hospitals.

Prevalence studies establish a strong link between alcohol and injury (Cherpital et al, 2005; D'Onofrio and Degutis, 2003) with up to 50% of patients presenting with injury having consumed alcohol prior to presenting at the ED (D'Onofrio and Degutis, 2003). Studies report that 47% of patients were

intoxicated at the time of injury (Soderstrom et al, 1997; Rivara et al, 1993 cited in Apodaca et al, unpublished, undated).

There is also a clear link between those presenting with problems derived from assault and mental health issues such as suicide attempts and self-harm (Simpson et al, 2001; Connigrave et al, 1991).

Studies have identified the key presenting conditions associated with hazardous drinking. These conditions are: fall, collapse, head injury, assault, non-specific gastrointestinal problem, "unwell", psychiatric, cardiac, self-neglect and repeat attendance (Huntley et al, 2001; Crawford et al, 2004). Huntley et al (2001) state that these conditions account for up to 77% of hazardous drinkers presenting to EDs and suggest that alcohol interventions may be best targeted at those who present with these conditions.

Potential of the ED to provide alcohol interventions

Many studies highlight the potential for the provision of alcohol-related interventions in the ED. These studies state that the ED provides an ideal base for the detection and intervention of alcohol-related problems and is an opportunity that should not be missed (Apodaca et al unpublished, undated; Baune et al, 2005; Crawford et al, 2004; D'Onofrio and Degutis, 2002; Hadida et al, 2001; Huntley et al, 2001; Simpson et al, 2001; Connigrave et al, 1991).

A review of preventive care in the ED undertaken as part of the US Preventive Services Task Force concluded that evidence is sufficient to support offering alcohol screening and brief intervention in ED settings on the basis that these interventions have efficacy and are cost effective (Babcock et al, 2000). This recommendation was supported by a subsequent study by D'Onofrio and Degutis (2002).

A cost-benefit analysis of brief interventions to trauma patients (largely seen in EDs) demonstrated that routine screening and intervention results in net dollar savings (Gentilello et al, 2005).

The concept of the "teachable moment" is put forward as a key rationale for providing alcohol-related brief interventions in the ED (Apodaca et al unpublished, undated; Rodriguez-Martos Dauer et al, 2006; Patton et al, 2005; Williams et al, 2005). It is suggested that ED practitioners are well placed to assist patients to consider the link between alcohol consumption and associated negative consequences, such as injury and other health consequences (Apodaca et al unpublished, undated; Rodriguez-Martos Dauer et al, 2006; Williams et al, 2005; Patton et al, 2005; Crawford et al, 2004; Patton et al, 2004a; Patton et al, 2003; Longabaugh et al, 2001; Lockhart, 1997). It is strongly suggested that this can increase patient receptivity to access further intervention (Apodaca et al unpublished, undated; Rodriguez-Martos Dauer et al, 2006; Patton et al, 2005; Williams et al, 2005; Patton et al, 2004a; Patton et al, 2003; Gentilello et al, 1999). For example, Patton et al (2005) state that patients who demonstrate insight into the connection between drinking and their presentation at the ED are almost three times as likely as those who do not demonstrate such insight to attend an appointment with an alcohol health worker. They recommend that ED practitioners ensure that they assist patients to establish this awareness wherever possible.

The ED also provides an opportunity to intervene early before problems become worse (Hadida et al, 2001; Gentilello et al, 1999; Wright et al, 1998).

Types of alcohol interventions provided in the ED

The ED-based alcohol interventions outlined in the literature are generally described as "brief intervention". Brief intervention is defined as short screening followed by education as a primary preventive measure for non-dependent drinkers (Nordqvist et al, 2005).

The brief intervention activities outlined in the literature vary considerably in levels of intensity, the least intense being screening only with no feedback and no follow-up of any kind (Nordqvist et al, 2005), and the most intense being full assessment and counselling (Wright et al, 1998). Other activities include the provision of health information pamphlets, brief assessment, bibliotherapy, brief advice/counselling, booster sessions and referral to an alcohol worker or alcohol treatment programme (Apodaca et al, unpublished, undated; Schermer et al, 2006; Crawford et al, 2004; Williams et al, 2005; Hadida et al, 2001; Longabaugh et al, 2001; Gentilello et al, 1999; Monti et al, 1999; Peters et al, 1998).

Most interventions are aimed at patients drinking at hazardous or harmful levels or at early problem drinkers (Rodriguez-Martos Dauer et al, 2006; Patton et al, 2005; Patton et al, 2004a; Patton et al, 2003; Huntley et al, 2001; Longabaugh et al, 2001; Simpson et al, 2001; Lockhart, 1997; Connigrave et al, 1991).

A number of articles discuss the role of ED practitioners in preparing patients to attend further treatment and linking them to alcohol treatment workers or further services (Patton et al, 2005; Williams et al, 2005; D'Onofrio and Degutis, 2003; Huntley et al, 2001; Wright et al, 1998). It is suggested that role clarity is required for ED practitioners in relation to alcohol-related interventions (Huntley et al, 2001). The ED practitioner's role is to ensure patients connect negative health consequences with their alcohol consumption, encourage patients to recognise that they have a problem (building receptivity to treatment) and provide referral to those who can help patients to resolve this (Longabaugh et al, 2001; Huntley et al, 2001). Huntley et al (2001) argue that alcohol treatment facilities should be integrated with EDs to minimise missed opportunities for early intervention in the treatment of alcohol abuse.

There is minimal reference in the literature to the alcohol card intervention type. Green et al (1993) cite a study by Brooks published in 1987 on the use of cards to offer follow-up to ED patients with alcohol-related problems. Patients in the study were given an information card if their attendance at the ED was alcohol related. The card provided details of local agencies providing help and advice. Results indicated that 30% of those given cards subsequently attended alcohol treatment agencies. Green et al (1993) conclude that this might be a useful method of introducing patients to the services available.

A study by Hadida et al (2001) highlights that patients presenting to the ED with alcohol-related issues are not a homogenous group and suggests that different screening methods identify different groups of patients, who may respond to different types of intervention. The authors suggest that patients assessed on the basis of staff assessment are often intoxicated and are unlikely to respond to immediate intervention. This group is usually made up of hazardous drinkers rather than alcohol-dependent drinkers. Hadida et al (2001) suggest giving information cards to intoxicated patients inviting them to attend the ED the next day to discuss their alcohol problems.

The evidence base for brief alcohol interventions provided in the ED

Studies evaluating the effectiveness of brief interventions in the ED are difficult to compare for a number of reasons, including:

- Some focus on restricted populations eg, young adults.
- The interventions provided vary in length and content.
- Methodological limitations are reported.

D'Onofrio and Degutis (2004/2005) provide summary information on four randomised controlled trials that have analysed the effectiveness of brief interventions within the ED. All studies demonstrate a positive effect of brief intervention, showing the following outcomes:

- Decrease in alcohol consumption (Longabaugh et al, 2001; Gentilello et al, 1999; Monti et al, 1999).
- Reduction in alcohol-related injuries during follow-up period (Longabaugh et al, 2001; Gentilello et al, 1999; Monti et al, 1999).
- Reduction in other alcohol-related problems (Longabaugh et al, 2001; Monti et al, 1999).
- Reduction in ED visits (Gentilello et al, 1999).
- Reduction in frequency of drinking and binge drinking for patients with pre-existing problematic alcohol use (Spirito et al, 2004).

However, methodological issues, the range of interventions studied and the different populations studied limit the ability to generalise the results.

It is also noted that while these studies show that providing brief intervention is beneficial, the specific message that should be delivered is less clear, mainly because the control groups in the studies all received some form of brief advice, information or assessment. An additional significant factor is that the interventions in these studies were implemented by research staff rather than ED practitioners. D'Onofrio and Degutis (2004/2005) conclude that it is not known if or how the study findings might be translated into the "real world" setting ie, undertaken by ED practitioners.

Crawford et al (2004) provide one example of a randomised controlled trial of brief interventions in the ED setting where the brief interventions were carried out by regular ED staff. The interventions included the use of the Paddington Alcohol Test (PAT) screen, which has been specifically designed for the ED setting (Patton et al, 2004b). Those who screened positive were allocated to the control group or the experimental group. All study participants were provided with a health leaflet with contact numbers for national help lines and local treatment services. The experimental group members were provided with appointments with an alcohol health worker. Referral for an appointment was associated with lower alcohol consumption at six months compared with the simple provision of a health information leaflet. At 12 months follow-up there was no significant difference due to a fall in alcohol consumption within the control group.

In a more recent Swedish study, Nordqvist et al (2005) also attempted to study interventions under more "real world" conditions ie, interventions provided by ED clinicians as part of their routine duties. The study did not use a control group, but provided two types of intervention, screening only and screening plus simple written advice, both administered by regular ED staff. The premise of the study was that for alcohol-related interventions to be used routinely in the ED context they need to be simple and time efficient. The study showed a significant reduction in heavy episodic drinking in both groups,

albeit the reduction was not as significant as that demonstrated in other studies that employed a more intensive intervention. The authors conclude that there may be some value in reducing heavy episodic drinking by simply providing the patient with a screening tool in the ED setting.

A significant point of difference in this study was that all screened patients, both risky and non-risky drinkers, were followed up. The results showed that alcohol consumption increased among those who were drinking at non-risky levels. This result was unexplained, but speculated to be either a result of alerting those drinking at non-risky levels to the fact that their consumption levels were low or because of general increases in drinking in the general population or normal variation in consumption.

In summary, screening and brief intervention has been shown to be effective but many studies do not reflect "real world" conditions, so the extent to which results can be generalised is limited. Screening alone may be effective but there is a suggestion that this may also increase drinking for those who drink at non-risky levels. This requires further investigation.

Barriers to providing alcohol brief intervention in EDs

Despite the efficacy of brief intervention, the number of brief interventions provided in EDs remains small (Nordqvist et al, 2005).

There is considerable discussion within the literature on the barriers to providing alcohol-related interventions in the ED. These include:

- Lack of time and high workload of staff (D'Onofrio and Degutis, 2004/2005; Hadida et al, 2001; Longabaugh et al, 2001; Lockhart, 1997; Connigrave et al, 1991).
- Chaotic environment (Longabaugh et al, 2001; Connigrave et al, 1991).
- Lack of time alone with the patient (McKenna, 1993).
- The primary need to treat the presenting problem and lack of attention to preventive approaches (Lockhart, 1997; Connigrave et al, 1991).
- Apathy regarding alcohol-related interventions (Huntley et al, 2001).
- Negative attitudes, lack of knowledge and confidence among ED staff eg, moralistic attitudes, lack of understanding of issues and interventions, lack of confidence in effectiveness of interventions, belief that patients are not receptive to intervention (Longabaugh et al, 2001; Wright et al, 1998; Lockhart, 1997).
- Lack of role definition for ED staff (D'Onofrio and Degutis, 2004/2005; Huntley et al, 2001; Lockhart,1997).
- Lack of follow-up support for identified patients (Lockhart, 1997).
- Absence of policy and procedure for alcohol interventions in the ED (Lockhart, 1997).
- Lack of resources eg, health education and information resources (Lockhart, 1997).
- Issues with insurance cover (D'Onofrio and Degutis, 2004/2005).

In response to the challenges presented by the ED environment, Karlsson and Bendtsen (2005) undertook a small study to test the acceptability of computerised alcohol screening and advice in the ED setting. Their study found that patients in the ED generally do not object to answering questions about alcohol consumption and that most patients are positive about gaining personalised feedback and advice regarding their drinking. Karlsson and Bendtsen (2005) argue that, given the barriers in the ED environment, there is a need to develop other empirical realistic models, such as computerised

screening, so that these can eventually be tested in large-scale controlled trials in order to develop preventive measures that can be viable for delivery in a routine ED setting.

In summary, it is clear that any planned alcohol-related intervention in the ED setting must take account of the identified barriers.

3.1.2 Health promotion in the ED

The literature on health promotion in the ED highlights increasing recognition of the interface between EDs and public health and the potential for EDs to enhance the provision of public health interventions. The alcohol card intervention could be viewed as having a legitimate place within health-promotion strategies. This is discussed in more detail below.

Health promotion is the process of enabling people to increase control over and improve their health and the factors that influence their health (Bensberg et al, 2003). Patient empowerment is a key theme in the health-promotion literature (McKenna, 1993).

Kennedy and Bensberg (2002) outline the intention of the Australasian College of Emergency Medicine to increase its role in public health in line with the emerging concept of health-promoting hospitals and health-promoting EDs. They state that emergency medicine is a key interface between the acute hospital health care setting and the community.

The provision of health information is one of the strategies for health-promotion activity in the ED. EDs are credible sources of health information and they are an established point of entry to the health system, so are well placed to provide health information (Kennedy and Bensberg, 2002).

Health information aims to improve people's understanding of the causes of health and illness and the services and support available, as well as personal responsibility for actions affecting their health. Improving access to health information enables people to make informed choices about their behaviours and the use of health care services (Bensberg and Kennedy, 2002).

The alcohol card intervention could be regarded as a health-promotion activity provided within the health information strategy. The intervention fits within a health-promotion framework as a secondary preventive health care intervention activity aimed at encouraging patients to adopt health-promoting activities (Stanton et al, 1996).

Quality of written health information

A limited number of articles on the quality and nature of health information was sourced for this review, but most were not relevant to the alcohol card intervention type. However, the following key points regarding health information pamphlets and written discharge instructions may have some relevance:

- Written health information is a valuable adjunct in patient education (Duffy and Snyder, 1999).
- Adult literacy may present a problem with written discharge information, with many studies indicating that literacy levels for patients presenting at the ED may be low (Taylor and Cameron, 2000a; Duffy and Snyder, 1999).
- Cultural diversity must be considered (Duffy and Snyder, 1999).

- Nurses must be involved in designing and selecting patient education materials (Duffy and Snyder, 1999).
- Clear, simple, non-technical language should be used (Taylor and Cameron, 2000a; Duffy and Snyder, 1999).
- Patient education material should be evaluated periodically (Duffy and Snyder, 1999).

Health information can complement discharge instructions. Discharge instructions assist with communication between practitioner and patient in order to:

- Assist patients in the management of current health issues.
- Assist patients in the ongoing management of associated health issues.
- Reinforce verbal instruction.
- Protect practitioners by providing evidence that relevant issues have been addressed.

Discharge instructions can also be provided to general practitioners (GPs) in lieu of a discharge letter and for quality assurance activities (Taylor and Cameron, 2000a; Taylor and Cameron, 2000b).

The alcohol card intervention type provides simple, clear information on follow-up health care and could be used to support discharge instructions.

3.1.3 Non-alcohol-related card and health information interventions

A small number of articles unrelated to alcohol have some relevance to the alcohol card intervention. Of the card-type interventions, one was used to refer to further services and this was found to be ineffective. However, limitations are highlighted that are likely to have reduced effectiveness. The self-help interventions produced minimal benefit and one study found that opportunistic reminders by doctors had minimal benefit.

These studies are summarised briefly below.

Card-type interventions

Evans et al (2005) report on a “crisis card” intervention used for patients presenting at hospital with self-harm-related injuries. The card offered the availability of a telephone consultation to prevent further self-harm episodes. The study reported no effect in preventing further self-harm-related presentations to hospital, but noted that those using the card were connected to a junior doctor via the hospital switchboard, rather than being connected with a crisis team member. This may have diminished the value of the intervention.

D’Souza et al (1996) report on a small New Zealand-based study that provided patients with a “credit card” containing simple guidelines on self-management of asthma. The card was not given out at the time of presentation to the ED but distributed later at a series of outpatient clinics. The authors report that the credit card was effective for improving asthma care in a high-risk group.

Self-help information interventions

Stevens et al (2002) conducted a randomised controlled trial providing education packs to parents whose pre-school-aged children were admitted to hospital or treated at an ED for asthma. The study demonstrated no effect on morbidity over a subsequent 12-month period.

Turpin et al (2005) conducted a randomised controlled trial to test the provision of a self-help booklet following acute traumatic injury. The results failed to support the efficacy of a self-help booklet as a preventive strategy to ameliorate post-traumatic stress disorder, depression and anxiety subsequent to acute traumatic injury.

Berger et al (1997) studied the provision of health pamphlets in the ED to improve compliance with recommendations for patients to have follow-up pap smears, mammograms and pneumococcal vaccinations. The results showed limited effect in improving pap smear compliance.

Opportunistic reminders from ED doctors

Ward and Proude (1999) studied the effects of doctors' reminders to ED patients who were overdue for cervical smear tests. The results showed that this strategy was likely to be of minimal benefit and that the delivery of reminders in other settings, such as inpatient clinics, was likely to yield better results.

3.2 ALCOHOL AND DRUG HELPLINE DATA

As part of the evaluation, it was intended that data from the Alcohol and Drug Helpline for the period from April to the end of July 2006 be analysed to determine the number of calls prompted by the Hutt Valley DHB ED alcohol card.

Contact was made with the Alcohol and Drug Helpline Clinical Manager, who advised that no callers had identified the alcohol card as the source of their information about the Alcohol and Drug Helpline.

The Alcohol and Drug Helpline Clinical Manager was interviewed by telephone to determine the nature of data collected by the Alcohol and Drug Helpline, primarily regarding the kinds of question callers are asked and the demographic details that are collected.

The Clinical Manager confirmed that every caller is asked how they found out about the Alcohol and Drug Helpline. The overwhelming majority of callers indicate that they found their information in the telephone book. From discussion it would appear that callers identify where they obtained the Alcohol and Drug Helpline telephone number rather than specifically how they first became aware of the service.

Demographic data is collected for regions and, from the advice of the Alcohol and Drug Helpline Clinical Manager, because Hutt Valley sits within a large geographical area, it would not be possible to infer that any increases in calls from the region were attributable to the alcohol card.

A further potentially confounding issue is that the Alcohol and Drug Helpline has developed alcohol cards for the ED context, although it would appear that these have been distributed only in the South Island. Further, Health Action Trust in Nelson has developed cards with information about "legal highs" with Alcohol and Drug Helpline details on the back. Helpline data, to date, indicate that no calls have

been received that identify these interventions as the prompt for calling the Alcohol and Drug Helpline. However, discussion with the Project Coordinator of the Youth Access to Alcohol Project, Health Action Trust suggests that the "legal highs" card prompted people to approach local GPs.

It is difficult to draw any firm conclusions from this information, other than that the Hutt Valley DHB ED alcohol card has not been identified as a source of information by Helpline callers. It may be that the card is ineffective in directing people to the Helpline for assistance or it may be that it would be necessary to ask a more precise question of callers eg, "Where did you first learn about the Alcohol and Drug Helpline?".

At this stage, it not possible to state that the card is having the intended effect of prompting participants to call the Alcohol and Drug Helpline.

3.3 KEY INFORMANT INTERVIEWS

Five Hutt Valley DHB staff were interviewed for the evaluation: four ED staff members and one staff member from Regional Public Health.

3.3.1 Intervention development

Interview participants confirmed that the ED alcohol card intervention was precipitated by an ALAC presentation on the "Changing the Drinking Culture" campaign at the Hutt Hospital Grand Round, arranged by Regional Public Health. The issue of high numbers of alcohol-related presentations to the ED was raised by ALAC. ED staff requested input from ALAC to assist with this issue in the ED.

Regional Public Health convened a meeting with ALAC and senior ED staff (Clinical Head and Clinical Nurse Manager) to progress the project. The idea of the alcohol card was proposed by ED staff, in part because senior ED staff had worked with card-type interventions in UK. The original concept was that:

- The card would be available to patients and other visitors as a self-help resource.
- ED staff could provide the card to patients and/or family members in the context of a discussion re alcohol consumption.
- ED staff could provide the card to intoxicated patients by placing it in their pockets or with their belongings so that the patients would have access to the resource when they were sober enough to take in information.

ALAC agreed to support the intervention and arranged for a card to be developed. A proof of the alcohol card was provided to ED staff for comment. ED staff suggested some changes to the wording on the card with the intention of producing more of a "cringe" (psychological squirm) in the card recipient. The suggested re-wording was:

> *"We believe you may be here today because of alcohol."*
> (Rather than: "*Are you here today because of alcohol?*")

However, the original wording, "*Are you here today because of alcohol?*", was retained[2].

In order to implement the intervention, there were a number of DHB requirements to be met. These requirements included gaining approval from various Hutt Valley DHB departments and forums (see below).

A policy for the card intervention was drafted by Regional Public Health staff (a copy of this policy is provided in Appendix 2). The intervention and accompanying policy were submitted for sign-off by the:

- DHB Communications Director.
- DHB lawyer.
- Service Manager – Surgery.
- DHB Clinical Board (which operates like an ethics committee, overseeing and approving new interventions etc).

On direction from the above the intervention was amended, with amendments reflected in the final policy. The key amendment was the removal of the option of providing an alcohol card to an intoxicated person by placing it in their pocket or with their belongings. This option was thought to constitute a risk to the DHB, especially in relation to assessing the level of a patient's intoxication. The decision was that staff would only directly provide the card to patients with whom there had been a discussion regarding alcohol consumption and preferably where the patient had initiated that discussion.

3.3.2 Intervention implementation

The amended policy was signed off and training on the intervention and associated policy was provided to ED staff by Regional Public Health.

Approximately 40 staff attended the training, which was timed so that as many staff as possible could attend.

Training content included:

- Information on alcohol, intoxication and the prevalence of alcohol presentations at the ED.
- An overview of brief alcohol interventions.
- An introduction to the alcohol card intervention.
- An overview of policy.
- A discussion of staff's own alcohol use and relevance to the intervention – a key message in the training was that staff could choose not to use the intervention if the health message was not congruent with their own behaviour in relation to alcohol.
- A discussion of the link between the alcohol card intervention and ALAC's Changing the Drinking Culture campaign.

Cards were provided in the ED the day following the training (early April 2006) in the following locations:

- ED reception.
- Whanau room.

[2] ALAC has confirmed that the original wording on the card was retained as this is more consistent with key messages and the overall approach adopted in the ALAC Changing the Drinking Culture campaign (email communication with Sue Paton, September 2006).

- Triage desk.
- Nurses' station.

The ED Nurse Educator agreed to keep up the profile of the intervention within the ED.

The Senior Administration Officer agreed to keep the stocks of cards replenished.

A slow start to the intervention was observed, with few cards being taken by or provided to patients. At some indeterminate point staff observed that the cards started to move and have moved steadily since. Approximately 2,000 cards have been accessed by patients in the three to four months since the intervention was introduced.

Interview participants were confident that patients were taking the cards with them when they left the hospital. The cards were not being found in rubbish bins or lying around as litter on the hospital site.

3.3.3 Perceived barriers to the intervention

Interview participants noted the following key points in relation to barriers to implementing the intervention.

There were few perceived barriers to the intervention; it is a simple idea and there was almost no resistance to trialling the card from ED staff.

There were frustrations with the timeframe between deciding to do something and actually doing it.

It seems likely that the intervention would not have got off the ground without the partnership approach (the ED, Regional Public Health and ALAC). Each partner was able to take up some of the responsibilities.

Now that the intervention has been trialled, it would be relatively easy to replicate in another ED.

3.3.4 Positive aspects of the card intervention

Interview participants were asked to comment on the positive aspects of the alcohol card. Overall, the card was described as a useful intervention that to some extent fills a gap in terms of having something to offer ED patients who may have alcohol-related issues.

The following comment is provided as an example:

> *"We have got something to offer now. We have to do something, there is a real need especially since the drinking age is lower."*

Other key themes identified by participants encompassed three broad categories:

- The alcohol card intervention is consistent with ED health-promotion objectives.
- The accessibility of the intervention.
- The acceptability of the intervention.

Consistent with ED health-promotion objectives

The fit between the alcohol card and ED health-promotion objectives, context and roles was consistently noted by interview participants. This fit, combined with ease of use, is seen as a significantly positive aspect of the intervention. ED staff noted their professional obligation to assist people with health issues and indicated that the alcohol card helped them to meet this obligation.

An example of this type of response is:

> *"The intervention meets ED objectives to provide health promotion without involving too much time and effort. It is consistent with the health promotion aspects of the ED nursing role."*

The empowering nature of the intervention was also consistently mentioned. Interview participants spoke about the potential of the card to point people in the right direction for further help if they chose to take up the opportunity.

For example:

> *"The intervention is passive and the emphasis is on the patient taking action of his or her own volition, which is what needs to happen."*

Accessibility

The alcohol card intervention is viewed as a means by which accessible help can be provided in the ED context. The accessibility applies from both a staff and a patient perspective. Staff reiterated the issues outlined in the literature regarding the ED context (ie, focus on acute issues, busy, unpredictable environment, lack of privacy, lack of time). For staff, the card is easy to use, places minimal burden on their time, requires little input and yet has the potential to link patients with the ongoing assistance they require.

Examples of responses of this nature are:

> *"For some patients, the ED is the main or only point of access to the health system so it is important that we make the most of the opportunity to assist."*

> *"You don't often get the luxury of being able to provide any kind of counselling intervention in the ED – maybe sometimes at night."*

> *"Getting and maintaining a supply of the cards has been easy. There is no undue burden on staff."*

In relation to patients, staff identified that the alcohol card is easy to access for those who are interested and provides useful information for some who do not have any other contact with health services.

Acceptability

The acceptability of the intervention was also raised in relation to both staff and patients. For staff the acceptability of the intervention relates to the ease of use and the emphasis on patients being responsible for picking up and using the card.

For example:

> *'The cards are available and they all go, so patients are picking them up. This is a good option to support self-motivation."*

> *"It is a very user-friendly option for both patients and staff."*

In relation to patients, the alcohol card is seen as discreet and attractive.

Examples of comments are:

> *"The cards are discreet, so people don't have to ask for help if they don't want to."*

> *"The cards have disappeared, which means people are taking them – so the information must be useful."*

> *"The card is eye-catching and doesn't put people off."*

One participant commented that the process of introducing the intervention to the ED had been very acceptable for staff.

For example:

> *"You need staff buy-in for this kind of intervention. It is important to have a process which allows for staff feedback. The process used in the pilot has worked well."*

Overall the acceptability of the intervention to both patients and staff is a critical success factor for the intervention. Senior staff have clearly stated that should there be sufficient levels of staff negativity or negative feedback from patients, the likelihood of continuing the intervention would be significantly diminished.

3.3.5 Negative aspects of the card intervention

Interview participants were also asked to comment on the negative aspects of the alcohol card. The key issue identified was the difficulty in evaluating the impact or effectiveness of the intervention.

For example:

> *"It is difficult to evaluate – how can we know if it is having any effect at all?"*

Other issues highlighted were:

- The difficulty in raising the subject of alcohol use with ED patients and the associated reluctance on the part of some staff to do this.
- The difficulty of providing any kind of intervention with intoxicated patients ie, patients are not necessarily in a receptive state for discussion of alcohol issues.

3.3.6 Impact on practice

Interview participants were asked to identify the impact of the intervention on their own practice or, in the case of senior clinicians, the impact on the practice of other ED staff.

It would appear from the responses that the intervention has made minimal or no change to staff practices. Impacts discussed were non-specific.

For example:

> *"It seems to have made staff more generally aware of their role in health promotion – not just in relation to alcohol but other health/lifestyle issues. Possibly staff are more rounded in their practice."*

> *"Has not made any impact on my practice. We deal with the acute physical effects of alcohol. It is a hard area to address and we really don't address it, except for young people and even then it is difficult."*

> *"I have not observed any staff giving the card to patients. In the ED, it is difficult to know when to raise the subject of alcohol with patients."*

A further issue raised was the limitation imposed by the intervention policy that does not allow staff to place the card in the pocket or with the belongings of an intoxicated patient. Some staff see this as one useful thing that they are able to do for an intoxicated patient who may have ongoing alcohol-related problems that need to be addressed. However, the potential legal and ethical issues of such a practice were also acknowledged.

3.3.7 Perceptions of impact on patients and families

Participants were asked to comment on the impact of the intervention on patients and families. Two key themes were identified: the absence of any negative feedback from patients and families and the fact that people are taking the alcohol cards away with them.

Examples are:

> *"Some patients willingly pick up the cards and take them away with them."*

> *"I have not had any comments about the card from patients. No one has been negative about it."*

3.3.8 Opportunities for improving or expanding the pilot

Participants made the following suggestions for improving the alcohol card intervention:

- Ensure the card is always available in the waiting room.
- Look for ways to boost staff support for the intervention; for example, provide a refresher course for staff to keep up the profile of the intervention.
- Target young people.
- Expand the intervention to include assistance for cigarette smoking.
- Ensure that the intervention continues.
- Provide feedback to staff about the number of people who call the Helpline.

Participants made the following suggestions for expanding the alcohol card intervention:

- Make the card available in other parts of the hospital – staff from other areas are already taking cards to their units.
- Other EDs are interested in health promotion eg, in Wellington and Nelson. It could be useful to give a presentation on the intervention at the local ED forum.
- The work that has been done in this project eg, clarifying the structure and purpose of the intervention, having a clear policy would be very helpful for other EDs that are interested in introducing this intervention.
- It may be useful to promote the intervention eg, enter it for a Health Innovation Award.

3.4 WRITTEN SURVEY OF ED STAFF

Surveys were distributed to approximately 60 staff. Only eight surveys were returned, which significantly limits the extent to which the information gained from the survey can be generalised. Results therefore must be regarded with caution. Reponses are summarised below.

3.4.1 ED staff practices in relation to the card

Staff were asked to indicate how often they point out the card to patients and how often they have directly given the card to patients. Results, as outlined in table 1 below, suggest that staff are unlikely to provide the card to patients.

Table 1. Staff practices in relation to the alcohol card

	Never	Rarely (1 – 5 times)	Sometimes (6 – 10 times)	Frequently (11+ times)
Pointed out the card	3	2	3	0
Directly given out the card	4	3	1	0

One respondent commented that there had been no opportunity to either point out the card or give the card out. Reasons for this were not indicated.

In order to determine whether or not staff are using the card to assist patients to make a link between alcohol consumption and negative consequences, respondents were provided with three statements and were asked to indicate which statement best described their practice. Responses indicate a range of practices. Statements and number of responses are outlined in table 2 below.

Table 2. The link between alcohol and negative consequences: staff practices

Option	No. of responses
I leave it to the patient to take an alcohol card if they are interested	3
When appropriate for the patient I suggest they take a card and think about phoning the Helpline	3
When appropriate for the patient I suggest they take a card and think about phoning the Helpline and I discuss the possible link between alcohol and their injury/illness	2
Other (please specify)	0

The results shown in tables 1 and 2 indicate that staff are more likely to point out the card than provide it directly to patients, however in those instances where they consider it appropriate they may be more active. It is difficult to know why it would not be more appropriate to take an active role in more instances. A range of factors could be involved, such as staff underestimating the number of alcohol-related presentations, the ED environment being unsuited to a more active role, and staff lacking confidence in the intervention. Further discussion with ED staff may assist with further clarifying this.

3.4.2 Level of staff support for the card intervention in the ED

Survey respondents all support the use of the alcohol card in the ED, as shown in the table below. These responses are in line with the feedback from the key informant interviews ie, the intervention is acceptable and staff have not noted any negative feedback from patients.

Table 3. Results from questions 4 of staff survey

	Strongly support	Support	Neutral	Don't support	Strongly don't support
No.	3	5	0	0	0

3.4.3 Suggestions for improving the intervention

Respondents made the following suggestions to improve or support the intervention:

> *"Make the stands for the cards larger and provide posters to inform patients of the cards."*

> *"Call the clients' parents, especially the younger ones because sometimes parents are not aware of their children's whereabouts."*

> *"I would like to know more about what the Helpline has to offer. It would be helpful when advising patients/clients."*

> *"Advise ED House Officers not to give/chart IVF to patients with ETOH [ethyl alcohol] problems, especially the young patients, so that they will experience hangover or the after effects of drinking too much ETOH."*

3.4.4 Discussion of survey results

As noted above, the number of respondents to the survey is insufficient to enable the results to be generalised. However, the survey information adds to the information from the key informant interviews

and supports the contention that the alcohol card intervention is highly acceptable and useful to ED staff.

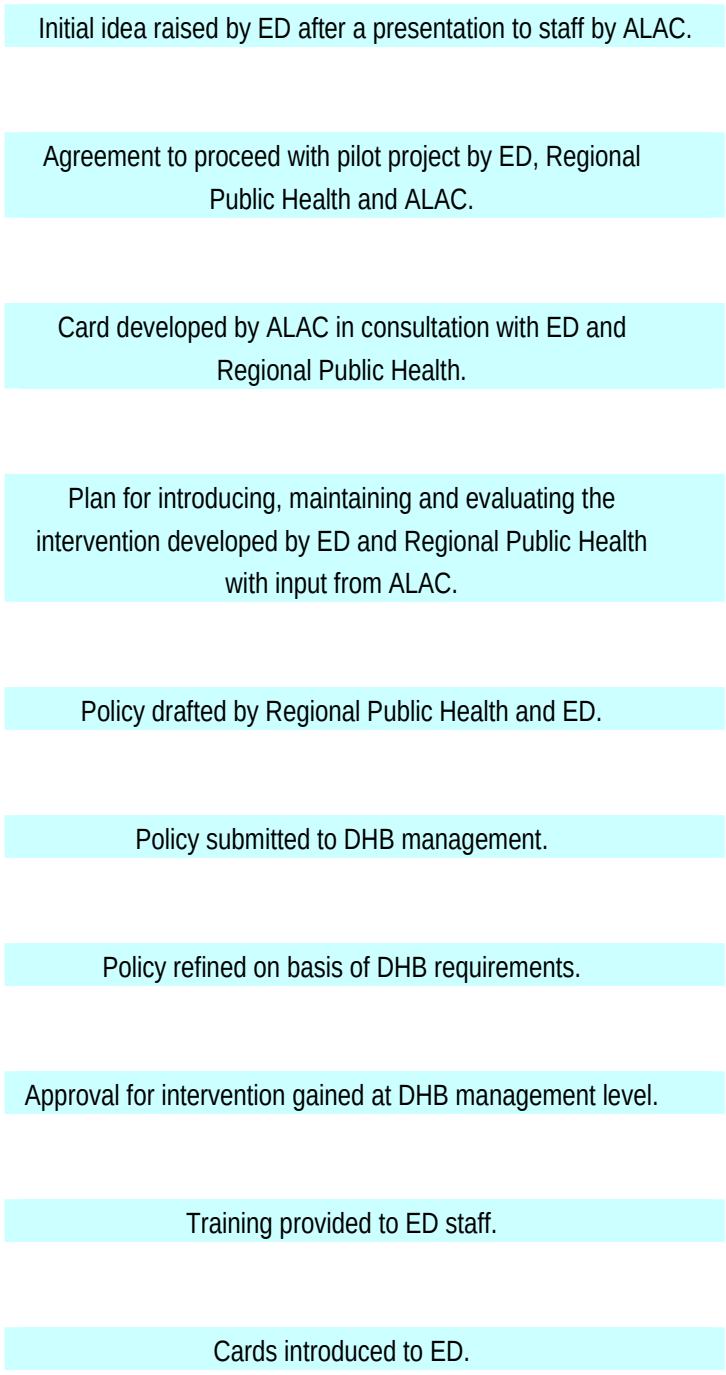
It also appears that the card has not significantly changed the interaction between staff and patients who may have alcohol-related problems. The intervention is mainly passive, with patients left to pick up the cards if they choose to and it would appear that staff only occasionally discuss the link between a patient's alcohol consumption and their presentation at the ED. Given the findings in the literature, this is likely to limit the effectiveness of the intervention, as supported by the apparent absence of calls to the Helpline.

The suggestions for a larger display stand, posters and further training for ED staff in relation to the services provided by the Alcohol and Drug Helpline are all practical suggestions that could assist with encouraging more patients to pick up the card and staff to take a more active role in using the card.

4. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Hutt Valley DHB and ALAC have collaborated to pilot an alcohol card intervention in the Hutt Valley DHB ED. The card was developed as a result of a partnership between the ED, Regional Public Health and ALAC. Various processes were undertaken in the development and implementation of the intervention; a summary of these is shown in figure 1 below.

Figure 1. Overview of intervention processes



According to feedback collected in the course of the evaluation, the intervention was developed and introduced according to plan, with some delays both in the development of the card and in the approval

process for introducing the intervention. Staff made positive comments about the process of introducing the intervention, highlighting the benefits of providing opportunity for staff input.

The card directs patients to contact the Alcohol and Drug Helpline and can be accessed by patients themselves or provided to patients by ED staff. ED staff support the intervention. They see it as consistent with health-promotion principles and suitable for the ED. The time efficiency and low level of staff input required make the alcohol card very acceptable to staff. From feedback it appears that the card is being accessed in significant numbers, with 2,000 cards used in the three- to four-month period of the pilot.

Data from the Alcohol and Drug Helpline shows that, as at the end of July 2006, no callers had identified that their call to the Helpline had been prompted by the Hutt Valley ED alcohol card. Given that most callers to the Alcohol and Drug Helpline identify the telephone book as their source of information, there are indications that these data may not reflect how people become aware of the Helpline.

The need for alcohol-related interventions in the ED setting is well established in the literature. Studies highlight ten key presenting conditions associated with hazardous drinking and it is suggested in the literature that ED practitioners target patients presenting with these conditions in order to maximise the use of resources. This warrants further consideration in the Hutt Valley DHB ED pilot project as a means of supporting staff to be more active in engaging with patients who may have alcohol-related issues.

Brief alcohol intervention in EDs has been shown to be effective in research studies, however the evidence for brief interventions provided under “real world” conditions is at an early stage. There is also an emerging view that other alcohol-related interventions should be trialled that are less time intensive and more suited to ED conditions. The card intervention fits well with this view.

Only one study of a card-type intervention has been sourced for this evaluation and it appears that the evidence base for this intervention type has not yet been established. The Hutt Valley DHB pilot project provides an opportunity to continue to trial and refine a time-efficient intervention that is acceptable to staff and workable within the ED.

A key finding in the literature is the concept of the “teachable moment” or the ability of ED practitioners to increase patient receptivity to further intervention by assisting them to consider the link between alcohol consumption and associated negative consequences. It has been shown that patients who demonstrate insight into the connection between drinking and their presentation at the ED are almost three times more likely than those who do not demonstrate such insight to attend an appointment with an alcohol health worker. It is likely that the alcohol card intervention will be more effective if ED practitioners utilise the teachable moment. Information collected for this evaluation suggests that this opportunity could be considerably enhanced.

The barriers to implementation of alcohol-related interventions in the ED are well documented. The alcohol card intervention appears to address many of these barriers, from the staff perspective. It is

time efficient, requiring minimal input from ED practitioners and minimal distraction from attending to the presenting issues. ED practitioners require minimal training to provide or support the intervention. Additionally, the alcohol card intervention is conducive to supporting role clarity for ED practitioners ie, their role is to facilitate the link between alcohol and the injury or health issue and prepare and support the patient to seek intervention for the alcohol issue elsewhere. Feedback from staff provided for this evaluation supports this, however it also indicates that the role taken by staff in providing the intervention is minimal at best and most take no role in it.

There is nothing to suggest that the alcohol card intervention in itself addresses other issues highlighted in the literature, such as negative attitudes and general apathy on the part of staff in relation to alcohol-related interventions.

Management support within the ED for the alcohol card appears to have been critical to the successful introduction of the intervention. In order to implement the intervention it has been necessary to guide it through management channels and meet associated requirements. In this case, this has been achieved via collaboration with Regional Public Health, which took on part of this role. In order to introduce this kind of intervention to other EDs, this is a critical step and responsibility for achieving it needs to be assigned clearly.

There is increasing recognition of the potential for EDs to provide or support the provision of public health interventions and health promotion. This is clear from the literature and supported strongly by Hutt Valley DHB staff in the evaluation. EDs are credible sources of health information and they are an established point of entry to the health system. The alcohol card intervention is viewed by staff as a health-promotion strategy, empowering and linking patients with services to improve their health. The card is likely to be seen as credible by patients when provided in the ED environment.

In conclusion, the evidence base for the alcohol card intervention has yet to be established, however given the well documented needs and the barriers in the ED context, the findings from the literature and the evaluation of the pilot appear to provide some support for continuing to trial and refine this innovative intervention.

In terms of the Alcohol and Drug Helpline data, there is no “evidence” that the card is effective. However, this needs to be considered in light of the following:

- There is some indication that the data may not reflect how callers become aware of the Helpline.
- The timeframe for the intervention has been reasonably short.
- Patients are accessing the alcohol cards.
- ED staff and management find the intervention acceptable and workable in the ED context and are willing to continue with it.
- There has been no negative feedback about the card from patients.
- The intervention addresses many of the ED contextual barriers.
- The intervention has gained approval at DHB management level and was instituted in policy.

It would appear that, although the effectiveness of the ED alcohol card cannot be conclusively demonstrated at this stage, on balance the intervention shows promise as one that is viable in the ED and has the potential to be effective. Therefore the following recommendations are submitted for consideration by ALAC and Hutt Valley DHB ED and Regional Public Health staff.

Overall recommendation: It is recommended that the Hutt Valley DHB ED alcohol card pilot project be continued, with the objective of further trialling and refining aspects of the intervention (see more detail in following recommendations).

It is recommended that ALAC explore options with the Alcohol and Drug Helpline regarding the feasibility of the Helpline asking questions that generate more specific data regarding how callers first come to know of the services offered by the Alcohol and Drug Helpline.

It is recommended that further training be provided to ED staff, incorporating some or all of the following:

- Information regarding key presenting conditions associated with hazardous drinking.
- Information regarding the services provided by the Alcohol and Drug Helpline.
- Skill building to support ED practitioners in taking a more active role in assisting patients, as appropriate, to make the link between their drinking and their health issues.

It is recommended that ALAC consult further with the Hutt Valley DHB ED to explore the potential benefits of providing bigger display stands for the alcohol cards and developing a poster for the ED to draw patients' attention to the cards.

APPENDIX 1. KEY INFORMANT INTERVIEW INFORMATION SHEET AND TEMPLATE

Health & Safety Developments

Management research & consultancy

21 July 2006

HUTT VALLEY DHB ED ALAC CARD EVALUATION
Information sheet for participants

The Alcohol Advisory Council of New Zealand (ALAC) has commissioned a preliminary evaluation of a pilot project, which has involved disseminating an "emergency department business card" to patients of the Hutt Valley DHB Emergency Department (ED). Paula Parsonage, Health and Safety Developments has been contracted by ALAC to undertake the evaluation.

The pilot commenced early in 2006 and the card was designed to direct relevant ED patients to an alcohol Helpline and/or to prompt them to request the ALAC "Had Enough?" video/DVD.

The card was available through a number of routes including:

- Self-selection by patients from card holders in the ED waiting room;
- Selection by family/whanau members to pass on to patients or others;
- Delivery by staff directly to patients who received treatment within the ED.

The preliminary evaluation comprises:

- A review of relevant literature to explore the evidence base for this type of intervention;
- Analysis of Alcohol Helpline data for the period February – end June 2006;
- Interviews with key ED staff to determine their experiences and perspectives on the piloted intervention.

If you have any queries about the project or interview, please contact Paula Parsonage, 09-378-1843 or Sue Paton (ALAC 04 917-0060).

22 Allen Road, Grey Lynn, Auckland 1002
Telephone: 09-378-1843 Mobile: 0274-53-33-82
E-Mail: hsd@xtra.co.nz

CONSENT FORM
HUTT VALLEY DHB ED ALAC CARD EVALUATION

Please complete this form.

- € I agree to be interviewed for this evaluation project by Paula Parsonage ('the researcher") on behalf of ALAC.

- € I agree to the researcher taking notes of the interview and storing these notes securely until the completion of the evaluation when they will be destroyed.

- € I understand that the discussions will be coded and identifying information will be removed when used in the evaluation report.

- € I understand that the researcher will send me a summary of the discussion asking me to check it and return it with any changes within one week of receiving it.

- € I understand that I may withdraw information for the project at any time up to the completion of the final evaluation report (approximately mid August 2006).

Signed: _____

Name: _____

Date: 25 / 07 / 2006

Email: _____

Telephone: _____

Proposed questions:

1. Can you give me a brief overview of how you have been involved in using the ED card.

2. Overall, what do you think about the use of a business card available from the ED setting encouraging people to contact an alcohol helpline?

3. From your perspective, what were some of the positive aspects of business card?

4. From your perspective, what were some of the negative aspects of business card?

5. To what extent has this pilot project had an impact on your practice?

6. Overall, what are your perceptions of the impact of the pilot on i. staff, and ii. patients and their families?

7. How could the pilot be expanded or otherwise improved in the future?

8. What (if any) barriers do you perceive for other EDs utilising such as card?

9. What things do you think would make it easier for other EDs to utilise the ALAC cards?

10. Do you have any other comments or suggestions?

APPENDIX 2. HUTT VALLEY DHB ALCOHOL CARD POLICY

Hutt Valley District Health Board	Manual	
	Doc No	
Use of the "Had Enough?" Alcohol Card for patients presenting to the Emergency Department	Issue Date	January 2006
	Review Date	July 2006
	Written by	Health Promoter ATOD RPH
	Approved	
	Page	32 of 2

PURPOSE

The purpose of this policy is to:

- Define the parameters for the use of the "Had Enough?" Alcohol Card within the Emergency Department
- Define the DHB's response to the use of this resource

POLICY

Scope

This policy relates directly to the "Had Enough?" Alcohol Card in the Emergency Department and its use by Emergency Department Medical and Nursing Staff.

Principles

- It is recognised that Emergency Department staff see a high number of presentations linked to alcohol
- It is recognised that Emergency Department staff may not be trained or experienced in Alcohol and Drug counselling and treatment
- It is recognised that levels of intoxication are not routinely recorded or quantified within the Emergency Department setting
- The academic literature supports interventions within the Emergency Department setting into a patient's drinking both as part of a patient's care plan and directly from an Alcohol Heath Worker

Procedure for Dissemination of Resource

The "Had Enough" card can be disseminated via two means.

1. Clients collecting cards of their own volition from card holders in public areas of the emergency department
2. Emergency Department staff providing a card to patients and describing its use

Cards will be available for clients to collect at their own discretion for those who may see a link between their presentation (or that of a loved one) and alcohol. These cards will be in three identified areas:

- Emergency Department Reception
- Emergency Department Waiting Room
- Family Room

Cards will, if appropriate, be provided to patients at the staff member's discretion where the patient volunteers their own concerns about their alcohol use. This volunteering of information may follow a discussion initiated by the patient or by the staff member. If staff do not deem it appropriate to distribute the card to a client; they can direct them to health promotion information in the ED reception.

When a card is supplied to a client at their own request, this action should be recorded in the patient's notes.

Full training will be provided to Emergency Department staff on the purpose and relevant theory behind the card so they are able to provide a better explanation to clients when distributing it. This training will be provided through:

- Presentations by the ATOD team at Emergency Department weekly meetings
- ED educator will devise a follow up program of education

Staff should at all times be aware of their own safety and remember that use of this resource is at their own discretion where they deem it appropriate.

If objection is taken to the Had Enough Card:

- Appropriately identified clients and/or relatives will be counselled prior to having the card dispensed to them
- In the event an individual wishes to complain they will be directed to the HVDHB complaints process

Questions about this resource should be directed to the Alcohol Tobacco and Other Drugs Team at Regional Public Health, the Alcohol Advisory Council or to the Communications Manager, HVDHB.

Supporting information

Alcohol is a major contributor to both accidental and non-accidental injuries in New Zealand every year. It contributed to almost 2000 Road Traffic Crashes in 2003[3] and accounts for 70% of emergency department admissions every year[4]. Emergency Departments have been viewed as sites where injury meets with alcohol and where early intervention into a patient's drinking can occur in an appropriate and effective manner.

New Zealand's drinking culture is currently coming under particular scrutiny in the media and from the public health workforce inline with the Alcohol Advisory Council's programme to change the drinking culture. This project outlines an early intervention tool within emergency departments to highlight the role alcohol consumption may have had in a patients presentation for treatment.

[3] **Land Transport Safety Authority.** 2003 Statistics. www.ltsa.govt.nz; last accessed 27 May 2005 1415hrs
[4] **Alcohol Advisory Council of New Zealand.** Interesting statistics about alcohol and New Zealand. Alcohol Advisory Council of New Zealand; Wellington: 2005

APPENDIX 3. STAFF SURVEY

Hutt Valley DHB ED Alcohol Card Evaluation ED Staff feedback survey

Hutt Valley DHB Emergency Department (ED) is involved in a pilot project disseminating an alcohol card designed to direct ED patients (as appropriate) to the Alcohol and Drug Helpline. The Alcohol Advisory Council of New Zealand (ALAC) and ED management are seeking the views of ED staff regarding this intervention. ***Please take a couple of minutes to complete this survey and return it, sealed in the attached envelope, to the pigeon hole of Mark Davies ED Clinical Nurse Manager, by Friday 18 August 2006. Responses will be reported collectively and individual responses will be confidential to the independent evaluator.*** *If you have any queries about the evaluation please contact Paula Parsonage (independent evaluator, ph: 09-378-1843, email: hsd@xtra.co.nz) or Sue Paton (ALAC, ph: 04 917-0060).*

1. How often have you *pointed out* the alcohol card to patients (tick one)?

€ Never	€ Rarely (1-5 times)	€ Sometimes (5 -10 times)	€ Frequently (11+ times)

Comment:

2. How often have you *directly given out* the alcohol card to patients (tick one)?

€ Never	€ Rarely (1-5 times)	€ Sometimes (5 -10 times)	€ Frequently (11+ times)

Comment:

3. Please tick the statement that best describes your practice:

€ A) I leave it to the patient to take an alcohol card if they are interested	€ B) When appropriate for the patient I suggest they take a card and think about phoning the Helpline
€ C) When appropriate for the patient I suggest they take a card and think about phoning the Helpline and I discuss the possible link between alcohol and their injury/illness	€ D) Other (please specify)

4. To what degree do you support ongoing availability of the card in the ED?

€ Strongly support € Support € Neutral € Don't support € Strongly don't support

Comment:

5. Do you have any suggestions for improving this intervention?

---

6. Do you have any suggestions about other possible alcohol interventions for the ED?

[continue comments over page if required…]

Thank you for your time and feedback – it's much appreciated

APPENDIX 4. REFERENCES

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