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ALCOHOL INTERVENTION IN ALICE SPRINGS HOSPITAL
WHAT'S POSSIBLE?

AN EVALUATION OF A TWO WEEK PILOT PROGRAM
ALCOHOL INTERVENTION IN ALICE SPRINGS HOSPITAL -
WHAT'S POSSIBLE?
AN EVALUATION OF A TWO WEEK PILOT PROGRAM

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October 1990
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1. THE ALCOHOL INTERVENTION PROGRAM

1.1 Introduction

There is now considerable evidence that identification of people whose alcohol use puts them at risk before serious health and social damage occurs is a most sensible and cost effective strategy. As Heather and Tebbutt (1988) point out:

Over the last ten or fifteen years, there has been accumulating evidence that there are far more people in the community who experience some form of harm as a result of their drinking or drug use than just "addicts" or "chronic alcoholics". Although individually their problems are less severe, the fact that there are four or five times as many in this category as there are addicts or alcoholics means that, of the sum total of problems in the community, most are experienced by people who are not severely or chronically dependent (p 51).

Brief interventions giving patients information about responsible drinking or encouraging the patient to use self help manuals have been shown to be effective, with "treated" drinkers consuming less alcohol and experiencing fewer problems up to a year later (Chick et al, 1985; Heather and Tebbutt, 1988).

An Early Intervention Program has been operating in the Royal Darwin Hospital and in other hospitals in Australia for several years (Chalmers et al, 1988; Chalmers n.d.; Spencer, 1988). In January 1990, funds were allocated to establish an Alcohol Intervention Program in Alice Springs Hospital (see attachment 1 for Chronology of Events).

This evaluation documents the development of the pilot program, describes the intervention program, reports the results of the two week pilot and makes recommendations regarding the implementation and evaluation of the program in the future.

1.2 Background

Previous attempts to establish some type of intervention program in Alice Springs Hospital under a directive from the Regional Director had not been successful for various reasons. Fortuitously the Regional Director took on the job as Chief Executive Officer of Alice Springs Hospital during a four month period in late 1989 and early 1990. During this period, he held discussions with medical and nursing staff about establishing an intervention program and some agreement was reached that something should be done. A new medical superintendent and Chief Executive Officer were appointed in 1990, both express commitment to the concept of an alcohol intervention program in Alice Springs Hospital.
In March 1990 a committee composed of hospital staff (Chief Executive Officer, Medical Superintendent, Senior Surgeon, Senior Physician, Casualty Head), Dependency Resource staff (Director, Counsellor), the Regional Director, Menzies School of Health Research researcher and an independent research consultant (see attachment 2) began to hold meetings to discuss the intervention program. It was decided to pilot an Alcohol Intervention Program as soon as possible. A working group consisting of the Medical Superintendent, the Director of Dependency Resource Services and the independent research consultant met on an irregular basis to plan the pilot program and gain staff co-operation.

A decision was made that doctors would screen patients for alcohol-related problems. The rationale:

1. a patient's use of alcohol could affect the diagnosis, treatment and prognosis of the presenting problem and, therefore, it is good medical practice to inquire about alcohol (and other drug) use;

2. patients are used to doctors questioning them about personal issues;

3. patients are responsive to advice given by doctors and it was envisioned that the doctor would become involved in reinforcing the alcohol intervention.

Resident Medical Officers and Casualty Medical staff were trained individually by the researcher on how to administer the questionnaire. The researcher also checked with medical staff periodically throughout the period of the pilot in order to sort out problems the staff might be having with the project.

A two week time period was chosen to pilot the intervention: at least one hundred patients were expected to be admitted to the wards during any two week period and it was thought to be a manageable time period for medical staff involvement. The pilot took place from 23 April to 6 May 1990. In the two weeks preceding the pilot, announcements about the study appeared on the local television station and in the local newspaper.

The program was evaluated in the following week and preliminary results reported to hospital staff at the Friday lunch-time meeting on the 11th of May.
1.3 The Program

The stated aim and objectives of the program are as follows (Peterkin and Borger, 1990):

Aim: "The overall aim of these strategies (screening and brief intervention) is the minimisation of harm associated with alcohol use (Chalmers, n.d.)."

Objectives:
To establish alcohol screening as part of the hospital culture.
To identify all patients with hazardous or harmful drinking behaviour.
To provide information to patients in the casualty setting that will facilitate them using/seeking agencies to address their problem at a future time.
To identify and refer inpatients while hospitalized.

Because of the considerable impact that alcohol-related problems are known to have on Alice Springs Hospital (Porges, 1989; Lyon, 1990), a decision was made to screen patients in the medical and surgical wards, the intensive care unit and the Casualty department. The plan was to offer the identified problem drinker a menu of interventions from brief patient education using a pamphlet for referral to a residential treatment unit if requested, depending on the nature of the problem drinking. Other Early Intervention Programs (Royal Darwin Hospital, W.A. Hospitals) seek to identify problem drinkers among orthopedic patients or trauma patients only (Chalmers et al, 1988; Spencer, 1988).

1.4 Method

1.4.1 Screening - Casualty

Medical Officers were asked to screen each patient over 14 years of age by using a very simple questionnaire (attachment 3). If a patient answered "yes" twice in either of the two sections, they were to be handed a pamphlet entitled "Are we Happy with Grog?" which contains some information about alcohol and contact numbers for counselling and referral. It was suggested to the Medical Officers that they use a standard phrase, "I think you should see someone about the problems you are having with alcohol/grog" when offering the pamphlet. If the patient presented in an intoxicated state and the problem they were presenting with could be directly attributed to alcohol, the medical officer assessed the patient, "positive" and supplied a pamphlet (attachment 4). The forms were collected every day (except weekends) from Casualty and pamphlet supplies renewed.
1.4.2 Screening - Wards 6, 7, 9, and ICU

Resident Medical Officers (RMO's) were asked to screen (attachment 5) all patients over 14 years of age when they admitted them to Wards 6 (Medical), 7 (Medical plus other), 9 (Surgical) and ICU. They were also asked to screen patients admitted to their care through the Casualty Department.

If a patient responded "yes" twice to any section of the questionnaire, they were to be referred to Dependency Resource Services for additional assessment. It was suggested that the RMO use a standard phrase, "I think you should see someone about the problems you are having with grog and I am referring you to someone you can talk to about it". It was also suggested that, if they preferred, they could tell the patient that they were referring him/her to a counsellor or to the Dependency Resource Services. The point was made that the RMO should feel comfortable with the terminology used.

The screening instrument also had a question for non-drinkers who may be affected by a relative's use of alcohol. If the response was positive, the patient was to be asked if he/she would like to talk to someone about it. If "yes", the patient would be seen by someone from Dependency Resource Services who was experienced in counselling "co-dependents".

The doctor was also asked to judge and record how the patients responded to the screening on a scale of 1 to 5 with 1 indicating a negative response, 3 a neutral response and 5 a positive response.

The screening forms were collected every day (except weekends) from the wards by a Dependency Resource Services staff member. The counsellor would review the forms and attempt to see all the referred patients.

1.4.3 Assessment

A Dependency Resource Services drug and alcohol counsellor assessed each referred patient using a standard questionnaire which contained questions about drinking behaviour, problems associated with alcohol use and consumption patterns (attachment 6). If the patient's use of alcohol was determined to be problematical, he/she was counselled using a pamphlet about safe alcohol use and given the opportunity for further counselling or referral to another drug and alcohol agency.

In the second week of the pilot, an attempt was made to assess every patient who admitted to drinking alcohol. The aim of the exercise was to test the sensitivity of the screening instrument with regard to the possible exclusion of patients consuming hazardous or harmful levels of alcohol but not yet experiencing any problems.
Immediately after the assessment, the counsellor filled in a standard form thanking the doctor for the referral and informing him/her about the results of the intervention (attachment 7). These forms were returned to the ward medical station for inclusion in the patients notes.

1.4.4 Medical Officer Evaluation

In the week following the pilot program, 10 of the 12 doctors who participated in the program were interviewed individually by the researcher. The evaluation instrument contained questions to gauge the doctors' background with regard to drug and alcohol intervention and treatment programs, their comfort with the instruments, their support for the program and their suggestions to improve the program (attachment 8). The interviews varied in length from 30 minutes to 2 hours.

2. RESULTS

2.1 Casualty

There were 1013 people seen by Medical Officers in Casualty during the study period. Of these, 89 people were screened representing 12 per cent of the patient population. It is likely that these were patients seen by doctors who supported the program and who had the time to screen. Because there are no records kept on the age, sex and ethnicity of casualty patients, it is not known how many of the 1013 people were children under the age of 14 years.

Of the people screened, 12 said that they did not drink alcohol and 77 said they did. Most of the non-drinkers were Non-Aboriginal and Aboriginal females (75 per cent).

Of the 77 drinkers, 33 admitted to or were determined to be having problems due to their use of alcohol (43 per cent). Most of these people were Aboriginal (70 per cent), about half each male and female.

Of the 44 drinkers who said that alcohol was not causing them problems, 4 had a positive CAGE score (two "yes" responses). Most of the remaining 40 drinkers were Non-Aboriginal males and females (85 per cent).

It is not known how many of the drinkers who were experiencing problems were handed a referral pamphlet. When interviewed, some of the doctors said that they gave pamphlets to some of the patients.

2.2 Wards 6, 9 and ICU

Because Ward 7 admitted a diverse population of patients, including private patients and day patients as well as public medical patients, it was decided to omit it from the study. The following results are based on Ward 6, 9 and ICU patients.
There were 124 admissions to the wards during the study period. Eighty patients were screened by the admitting RMO's, representing 65 per cent of the adult patient population. Fifty-five (69 per cent) were Aborigines, 13 (16 per cent) were European or other and 12 (15 per cent) were unknown as to age, sex and race.

Of the people screened, 30 people said they did not drink alcohol (37 per cent) and 50 people said they did drink (63 per cent). Information was obtained on 24 of the abstainers. Most were Aboriginal men (10) and Aboriginal women (12). There was one each male and female Non-Aboriginal abstainer. The men ranged in age from 31 to 73 and the women in age from 21 to 60.

Of the non-drinkers, 5 admitted to being affected by family member's use of alcohol (4 Aboriginal females and one 73 year old Non-Aboriginal male); one drinker who was not personally experiencing problems was also affected by a family member's drinking. Three requested to speak to a counsellor and all were seen.

Of the 50 drinkers, 31 (62 per cent) were assessed by a drug and alcohol worker. Nine drinkers who were referred to a counsellor were not assessed, either because they had already been discharged or were unavailable at the time of assessment. Information was available on 5 of the 9 unassessed drinkers; four were Aboriginal males between the ages of 22 to 50 and one was a 21 year old Aboriginal female. Ten drinkers reported no problems associated with their use of alcohol (5 Aboriginal females, 1 Aboriginal male, 1 Non-Aboriginal female, 1 Non-Aboriginal male, 2 no information).

<table>
<thead>
<tr>
<th>Drinkers</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ab</td>
<td>Non-Ab</td>
</tr>
<tr>
<td>Responsible</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hazardous</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Harmful</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
<td>7</td>
</tr>
</tbody>
</table>

Of the 31 assessed drinkers, there were 11 Aboriginal males, 11 Aboriginal females, 7 Non-Aboriginal males, 2 Non-Aboriginal females.
Twenty-four out of the 31 assessed drinker (77 per cent) were consuming alcohol at hazardous or harmful levels when they drank. Significantly, they also indicated that they experienced some problems associated with drinking. All were given education using an appropriate pamphlet. Seven individuals contracted for further intervention with Dependency Resource Services or one of the referral agencies.

Table 2: Patient Response to Screening and Assessment

<table>
<thead>
<tr>
<th>Patient response</th>
<th>Screening</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&amp;2 - Negative</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>3 - Neutral</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>4&amp;5 - Positive</td>
<td>37</td>
<td>28</td>
</tr>
<tr>
<td>Unknown</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>80</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Patient acceptance of both the screening and the assessment was high as judged by Resident Medical Officers and counsellors respectively.

2.3 Medical Officers' Evaluation

2.3.1. Background of Doctors

Ten of the twelve doctors who were asked to participate were interviewed.

Most of the doctors had drug and alcohol education associated with courses or clinical experience in psychiatry and medicine. Most of the doctors had been taught to take a drinking history during their clinical training. Three of the doctors had considerable experience in doing so.

Most had not received "formal" instruction in intervention techniques; most knew to refer to psychiatric and drug and alcohol units (if they existed) for treatment and to medical units for alcohol-related disorders. Some doctors regularly counselled their patients about harmful drinking if they detected either an alcohol-related medical problem or heavy consumption.

Only four doctors had worked in a hospital with a drug and alcohol unit; none of the doctors had worked in a hospital with an early intervention program.
2.3.2. Alice Springs Hospital Program - The Concept

Four of the five Resident Medical Officers thought that an alcohol intervention program is a "good idea"; one doctor said it was "definitely necessary". Two of the Casualty doctors said it was a "good idea" but (various qualifications given), one thought it was necessary that something be done but not sure what, and two were not convinced that anything could be done in hospital, especially in Casualty.

In the ward situation, three of the doctors thought the screening should be done by a drug and alcohol worker or dedicated nurse; one thought the form should be self-administered and one thought it was the doctor's responsibility.

2.3.3. The Instrument

Most of the doctors who used the form found it simple to use and understand. Two of the doctors felt somewhat uncomfortable asking some of the questions. Some doctors felt more comfortable explaining to the patients that a study was going on. Most also felt more comfortable asking the patient's permission to refer to Dependency Resource Services; one doctor motivated reluctant patients to accept.

2.3.4. The Process

In casualty, three of the doctors mentioned the lack of consultation regarding the development of the program and questioned the motivation of the people involved in setting up the program.

On the wards, one doctor expressed surprise that the Resident Medical Officers were the last to know about the program; two doctors did not appreciate being reminded to fill in the forms by the administration; one doctor did not appreciate the change in procedure regarding admissions to the wards through casualty.

2.3.5 Medical Officers' Comments

Cross-cultural factors were mentioned by all doctors in different contexts.

Several doctors expressed frustration about the enormous problem of alcohol abuse in Alice Springs and the problem of the "revolving door" syndrome in the highly dependent drinkers.

In Casualty, given that each patient is seen for less than five minutes, is it appropriate to be asking questions about alcohol use, especially since there is no time to counsel?
Nursing staff and some medical staff need training in how to manage intoxicated patients.

One doctor mentioned, in particular, the need for a change in community attitudes regarding alcohol abuse and whose problem it really is.

Who are the referral agencies? Some doctors felt reluctant referring to Dependency Resource Services who would refer some clients to community agencies. The doctors were unfamiliar with these agencies and considered some of them inappropriate.

3. DISCUSSION

3.1 Casualty

It is unfortunate that some Casualty staff felt unable to support the pilot study. Inappropriateness of the Casualty setting for questioning people about their alcohol use, perceived lack of consultation, and time constraints were the major reasons given by medical officers for not screening patients.

Although only 12 percent of the patients in Casualty were screened, it is of interest that of the 77 drinkers, 43 percent admitted to having problems with alcohol. The Tangentyere Report by Pam Lyon (1990) reported on a survey done in Alice Springs Hospital Casualty where medical staff estimated that 52 percent of the Aboriginal patients and 20 percent of the Non-Aboriginal patients were either directly affected by their own use of alcohol or were affected indirectly by a relative's alcohol use.

An alcohol intervention study done at the Accident and Emergency Department of the Sir Charles Gairnder Hospital in Perth identified 18.4 percent of the trauma patients as problem drinkers. However, the researchers concluded that it was "only worthwhile identifying problem drinkers among those trauma patients admitted to hospital". That conclusion was based on the fact that none of the 22 problem drinkers who were not admitted to hospital "availed themselves of the counselling service offered (Freeland et al, n.d.)".

There is no question about alcohol abuse having a major impact on the Alice Springs Hospital Casualty Department. There is also acknowledgement by the medical staff that something should be done. The questions remain "What is an appropriate alcohol intervention in the Casualty setting?" (see Recommendations).
3.2 Wards 6, 9 and ICU

Nearly two-thirds of the patients admitted to the wards in the two week period were screened by the Resident Medical Officers. It is striking that in this period, 69 percent of the screened admissions to the three wards were Aboriginal people. The percentage of Aboriginal patients in general is about 50 percent. What this discrepancy means is not clear. It is possible that the Resident Medical Officers preferentially screened Aboriginal people or that, for some reason, there was an unusually high number of Aboriginal people admitted to hospital in that particular two week period.

Reasons given by the Resident Medical Officers for not screening patients included forgetting and being too busy, especially on weekends and holidays when one RMO admits all the patients to the three wards.

The two week pilot program enabled 31 people to be educated about responsible drinking; seven people undertook further intervention. Three people affected by another's drinking were able to discuss it with a counsellor. In the two week period following the pilot, there was not a single referral from the hospital wards 6, 9 and ICU even though the Resident Medical Officers were strongly encouraged to continue to refer patients who they suspected might have drinking problems.

This study complements other studies that have been done on the impact of alcohol on Alice Springs Hospital. A 1982 study estimated alcohol-related (excluding obstetric) admissions to be 20.8 percent of adult admissions (NT Drug and Alcohol Bureau, 1982). A more recent study stated that 27 percent of all admission (excluding obstetric and pediatric admissions) were alcohol-related (Porges, 1989). The Menzies study found that 54 percent of the surgical patients admitted during the three week study period were estimated to be in hospital for a definite or suspected alcohol-related problem (Lyon, 1990). In the latter two studies, Aboriginal people were over-represented. Certainly the drinking histories obtained in this study would indicate that both Aboriginal and Non-Aboriginal people, especially men, consume alcohol in such a way as to put them at risk of alcohol-related health problems.
4. CONCLUSIONS

The pilot study and evaluation support the following points:

- It is possible for Resident Medical Officers to identify problem drinkers using a simple questionnaire and thereby provide referrals to the Dependency Resource Services.

- There is high patient acceptance of the procedure. Patients expect to be questioned about personal problems by doctors. Some patients identified as problem drinkers will discuss their use of alcohol with an experienced counsellor. Some will choose to contract for further intervention.

- Patients who are abstainers or responsible consumers may be affected by a relative's use of alcohol. It is possible to identify these people and give them the opportunity to discuss the situation with a trained counsellor while in hospital and, perhaps, join a co-dependency program when discharged.

- Doctors will not routinely screen patients for alcohol-related problems and refer them to a drug and alcohol counsellor for further assessment and intervention without the procedure being "institutionalized". Evidence to support this statement is documented in the dirth of referrals from the wards up to the present time even though at least 20 per cent to 45 per cent or more of adult patients will be experiencing alcohol related problems of some description.

- Most medical officers have not been trained in alcohol intervention or the use of self help manuals or material; most have had no training in managing intoxicated people. They certainly have received no training on communicating with and caring for traditional Aboriginal people. The same can probably be said for nursing staff.

- All the studies point to the fact that alcohol abuse in the community is having an important impact on Alice Springs Hospital - not only in the actual number of alcohol-related admissions and the subsequent number of bed days utilized and hence the considerable cost in dollars, but also on the morale of the staff. Medical and nursing staff have expressed despair at the trauma, the illness and unrelenting repetitiveness of it all.
Most medical officers and the hospital executive have expressed support for an alcohol intervention program in Alice Springs Hospital. What remains is for that support to be translated into commitment and action.

5. RECOMMENDATIONS

It is recommended:

- That a Medical Advisory Group be established and chaired by the Medical Superintendent or committed specialist.

- That an Alcohol Intervention Program be implemented, initially in Wards 6, 9 and ICU.

- That the process of screening, referral and feedback be similar to that set out above. A procedure for the distribution and collection of screening forms will need to be decided.

- That for patients requiring detoxification, ongoing medical or surgical care, standard treatment protocols be drawn up, ratified by the specialist medical officers and implemented in all areas.

- That drug and alcohol counsellors make themselves available to attend ward meetings once a week to report on the progress of referred patients.

- That Casualty staff be consulted about what would be an appropriate intervention in that setting. They may wish to consider:

  - Introduction of a breath tester in emergency ward for use by the Director and staff for conducting a limited alcohol impact survey.

  - Review of the results of Casualty blood alcohol tests.

  - Implementation of a monitoring system to collect sound data on the impact of alcohol in this area in order to identify the need for additional staff and intensive inservice.

*The recommendations include suggestions by Dr J. Santamaria.
That Resident Medical Officers receive a three day orientation upon commencement of duties at Alice Springs Hospital: Day 1-orientation to hospital procedures; Day 2-Alcohol Impact and Management (Dependency Resource Services - utilizing Drug and Alcohol Services Association Sobering-up Shelter and visiting specialist,); Day 3-Cultural Factors and Communication - (Staff Development Officer, Institute for Aboriginal Development, Menzies, Aboriginal Health Workers). Unless there is a commitment by the hospital administration to give doctors the necessary knowledge and skills to implement the program and to practice medicine in a cross-cultural situation, the program will fail to achieve its stated objectives.

That the present resident medical officers be involved in trailing the orientation program.

That the involvement of medical staff as opposed to nursing staff in this particular program continue to be assessed. Training in the use and trial of relevant self help material will require the involvement of all staff.

At this stage, "The importance of medical input in planning a total strategy to control alcohol abuse and to identify and treat patients wherever they present eg. hospital, general practice, elsewhere" (Santamaria, p.c.) cannot be stressed too heavily.
6. REFERENCES


CHRONOLOGY OF EVENTS

9 June 1988 - Workshop with Dr Elizabeth Chalmers to examine the options for an appropriate Alcohol and Drug Early Intervention Service in Alice Springs Hospital. Convened Medical Superintendent Peter Bradford.

20 June 1989 - Discussion with Margaret Borger, Sue Jefford, Chris Nestor and Mike Tyrrell on database on alcohol-related admissions in response to memo from Regional Director to Medical Superintendent requesting progress report on the development of an early detection treatment program in the hospital (11 May, 1989).

4 - 24 September 1989 - Menzies data collection on the use of alcohol abuse on the broader community including Alice Springs Hospital Casualty for the Tangentyere Report.

January 1990 - Two positions made available by the Department of Health and Community Services for an intervention program.

28 February 1990 - Directive from Regional Director to establish an Alcohol Intervention Program in Alice Springs Hospital.

March/April 1990 - Meetings held to discuss and plan the Alcohol Intervention Program.

29 March 1990 - Approval of Alice Springs Institutional Ethics Committee.

23 April to 6 May 1990 - Alcohol Intervention pilot in Alice Springs Hospital.

11 May 1990 - Meeting to report results to Hospital staff.

30 May 1990 - Submission to Sessional Committee on the Use and Abuse of Alcohol.

9 July 1990 - Visit and consultation by Dr J. Santamaria, Australian authority on Hospital Alcohol Programmes.

24 July 1990 - Release of Tangentyere Report "What Everybody Knows About Alice" by Pam Lyon.

October 1990 - Report and discussion paper on intervention program available for staff.
LIST OF COMMITTEE MEMBERS

HOSPITAL STAFF

Chief Executive Officer  Ms Joyce Bowden
Medical Superintendent  Dr Ross Peterkin
Senior Surgeon  Dr Charles Butcher
Senior Physician  Dr T Htut
Casualty Registrar  Dr J R McKeon

DEPENDENCY RESOURCE SERVICES STAFF

Director  Ms Margaret Borger
Counsellor  Ms Carolyn Lane

************************

Regional Director  Mr Michael S Tyrrell

Menzies School of Health Research
Researcher  Dr David Scrimgeour

Independent Research
Consultant  Dr Carol Watson
# CASUALTY ALCOHOL ASSESSMENT

Please □ boxes

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
<th>F</th>
<th>M</th>
<th>ABORIGINAL</th>
<th>NON-ABORIGINAL</th>
</tr>
</thead>
</table>

IS PATIENT ADMITTED? Yes □ stop here No □ continue

H.R.N. ________

Do you drink alcohol/grog? Yes □ continue No □ stop here

Have you ever had trouble from your drinking? Yes □ refer No □ continue

e.g. health, hospital, police, family, work

N.B. - for intoxicated patients tick yes and refer.

<table>
<thead>
<tr>
<th>1. Have you ever felt you ought to cut down on your drinking?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>or</td>
<td>Did you want to drink just a little bit?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Have people annoyed you by criticizing your drinking?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>or</td>
<td>Does your family make you angry, trying to stop you drinking?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Have you ever felt bad or guilty about your drinking?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>or</td>
<td>Do you feel sad or shame about your drinking?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Have you ever had a drink first thing in the morning to steady your nerves, or get rid of a hangover?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>or</td>
<td>Do you drink in the morning, first thing for your headache?</td>
<td></td>
</tr>
</tbody>
</table>

ANY TWO POSITIVE ANSWERS - PLEASE REFER

REFERRAL - make appointment and advise
DEPENDENCY
RESOURCE SERVICES
for information, counselling
and referral
- telephone (089) 50 2478
for relatives and friends of
people with alcohol problems
- telephone (089) 50 2479

DRUG & ALCOHOL
SERVICES ASSOCIATION
for information, counselling
and referral assessment non-
medical detoxification
- telephone (089) 52 8412

A.A.
Alcoholics Anonymous is a self
help organisation for people
with alcohol problems.
- telephone (089) 53 0802

C.A.A.C. - Phone 52 3377
ABORIGINAL CONGRESS
A.A. - Phone 52 5855
ABORIGINAL A.A.

A LITTLE LONGER
WE CAN HELP YOU LAST
LOOK US UP
NEED HELP GETTING OUT
KNOW THE LIMIT DON'T OVER DO IT
NOT FOR THE BOTTLE
REACH FOR THE SKY
KNOW YOUR LIMIT STAY ALIVE
THEN YOU'LL HAVE TO LAST
YOU WANT THE GOOD TIMES TO LAST
HOW MUCH IS TOO MUCH??

• when you can’t walk or talk

• when you’re flat on the floor

• when your friends are no longer around

• family break-up

• lost children with no parents

• loss of job

IS THIS A HAPPY LIFE STYLE?

- Flat on the floor
- can’t walk or talk

- Friends no longer around

- Family break-up

- Lost without parents

Graphics by Kenny Leechner
WARD ALCOHOL ASSESSMENT

Please ☐ boxes

A

Do you drink alcohol/grog?  
Yes ☐ continue  
No ☐ go to C.

Have you ever had trouble from your drinking?  
eg. health, hospital, police, family, work  
Yes ☐ continue  
No ☐ go to C.

B

1. Have you ever felt you ought to cut down on your drinking?  
   or  
   Did you want to drink just a little bit?  
   Yes ☐  
   No ☐

2. Have people annoyed you by criticizing your drinking?  
   or  
   Does your family make you angry, trying to stop you drinking?  
   Yes ☐  
   No ☐

3. Have you ever felt bad or guilty about your drinking?  
   or  
   Do you feel sad or shame about your drinking?  
   Yes ☐  
   No ☐

4. Have you ever had a drink first thing in the morning to steady your nerves, or get rid of a hangover?  
   or  
   Do you drink in the morning, first thing for your headache?  
   Yes ☐  
   No ☐

C

Have you been affected by (felt sad for) someone's drinking?  
eg. husband/wife, brother/sister, uncle/aunty.  
Yes ☐ continue  
No ☐ stop

Would you like some information that could help you understand this?  
   or  
   Would you like to talk and learn about this?  
   Yes ☐ refer  
   No ☐ stop

IF TWO “YES” ANSWERS IN ANY SECTION PLEASE REFER TO  
DEPENDENCY RESOURCE SERVICES - 50 2478

Patient's responses to screening: 5 4 3 2 1
ALICE SPRINGS HOSPITAL ALCOHOL INTERVENTION

H.R.N.: ___________ AGE: _______ SEX: M F
DATE: ___________ ABORIGINAL: YES NO

RELATIONSHIP: PERMANENT CASUAL NO
DEPENDENTS: YES NO
EMPLOYED: YES NO

IN THE LAST TWELVE MONTHS:

1. Has your doctor advised you to cut down on your drinking? Yes No

2. Have you had any money worries that have been due to or made worse by your drinking? Yes No

3. Have you been in an accident at work or on the road that was at least partly related to your drinking? Yes No

4. Have you ever been asked to leave a place (a party, pub or club) because you had had too much to drink? Yes No

5. Have there been arguments at home about your drinking? Yes No

6. Have you had any trouble with the police connected with your drinking?, (Sobering Up Shelter, drink driving). Yes No

7. Have you noticed, after a night of drinking, that your hands tremble the next day? Yes No

8. Have you tried to cut down on your drinking and found some difficulty in doing this? Yes No

9. What do you usually drink?
   - Beer
   - Wine (casks, flagons, bottles, glasses)
   - Spirits (whiskey, rum, vodka, brandy, gin)
   - Methylated Spirits (Metho)
   - Other (for example, sherry, port, cider)

10. How often do you drink grog?
    - Every day and/or night
    - Most days and/or nights
    - 1-3 days and/or nights a week
    - A few times a month
    - A few times a year

11. How many drinks per day? RESPONSIBLE
    (N.H. & M.R.C. Guidelines) HAZARDOUS HARMFUL

Patient's response to assessment + [5 4 3 2 1] -
Patient refused intervention,

Education and counselling using pamphlet undertaken,

Patient contracted for further counselling/follow up by:

Dependency Resource Services (D.R.S.)
Drug and Alcohol Services Association (D.A.S.A.)
Salvation Army (S.A.)
Aboriginal Alcoholics Anonymous (A.A.A.)
Central Australian Aboriginal Congress (C.A.A.C.)
Healthy Aboriginal Life Team (H.A.L.T.)
Alcoholics Anonymous (A.A.)
General Practitioners (G.P.)

Patient requests residential programme. Followed up by counsellor,

Patient contracted to undergo:

Medical Detoxification Ward 6
Medical Detoxification Ward 1
Non Medical Detoxification D.A.S.A.
11. When you drink, how much do you usually drink?
11. When you drink, how much do you usually drink?
Alice Springs Hospital Alcohol Intervention

Dr __________________________

Re patient - H.R.N.: ____________

Referred for Alcohol Intervention on: ____________

After assessment the following outcome was achieved:

☐ Patient refused intervention,

☐ Education and counselling using pamphlet undertaken,

☐ Patient contracted for further counselling/follow up by:

Dependency Resource Services (D.R.S.)
Drug and Alcohol Services Association (D.A.S.A.)
Salvation Army (S.A.)
Aboriginal Alcoholics Anonymous (A.A.A.)
Central Australian Aboriginal Congress (C.A.A.C.)
Healthy Aboriginal Life Team (H.A.L.T.)
Alcoholics Anonymous (A.A.)
General Practitioners (G.P.)

☐ Patient requests residential programme. Followed up by counsellor,

☐ Patient contracted to undergo:

Medical Detoxification Ward 6
Medical Detoxification Ward 1
Non Medical Detoxification D.A.S.A.

Thank you for referring this patient.

Counsellor ________________
Background

What training have you had in the drug and alcohol area (as part of medical school curriculum, clinical experience, specific course work, etc)?

How were you taught to elicit consumption information?

How were you taught to intervene and/or refer for drug and alcohol problems (to whom)?

Have any of the hospitals in which you have worked had a drug and/or alcohol intervention program? If yes, who did the interviewing and intervention?

ASH Program - the concept

What do you think about the idea of an alcohol intervention program in
ASH?

How do you feel about being the person responsible for screening and referring patients to DRS?

What ideas do you have about intervention into a person's harmful or hazardous drinking behaviour while that person is in hospital or in casualty?

The instrument

Do you have any comments about the screening form you have been filling in?

How did you feel about asking a person whether he or she drinks?

About problems related to drinking?

The Cage questions?

The Aboriginal Cage questions?
The questions about members of the family drinking?

What did you say to patients to let them know that you were referring them to DRS?

Do you think people understood the questions?

What are your recommendations regarding placement of the forms?

Management of referrals to DRS?

The process

What comments do you have on how the program was set up?

What is your impression of the amount of support given to the program by the specialist?

by the administration?

by the nursing staff?
by the patients?

What did you think about the "feedback letter" from the counsellor?

What feedback have you had from your patients regarding the counsellors who visited them?

Do you have any suggestions for in-servicing staff on the program?

Any other comments?