Utilization of Pastoral Care Services for a Screening, Brief Intervention, and Referral-to-Treatment Program at an Urban Level I Trauma Center

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Excessive alcohol consumption is currently the third leading cause of preventable death within the United States, accounting for roughly 80,000 deaths each year. Excessive alcohol consumption also takes a toll on hospitals and health care centers, specifically emergency departments and trauma units. Each year, over 20 million adults in the United States sustain injuries requiring emergency care, and 15% to 20% screen positive for alcohol. These figures increase further within the trauma department, where up to half of all trauma accidents are linked to alcohol use (25%-50%).

Screening for excessive alcohol use and brief motivational interventions—screening, brief intervention, and referral to treatment (SBIRT) programs—have been shown to reduce the number of alcohol-related injuries. The American College of Surgeons has mandated the use of SBIRT programs at all designated trauma centers since 2008. The CAGE (cut back, annoyed, guilt, and eye opener) questionnaire and the Alcohol Use Disorders Identification Test (AUDIT) are used to detect individuals who may be abusing alcohol and/or other drugs. In 1993 an SBIRT program was developed to identify at-risk individuals while continually monitoring their progress. The CAGE and AUDIT questionnaires have shown more efficacy in the identification of alcohol use problems than other screening methods, even the use of direct questions about the quantity and frequency of use, with the AUDIT slightly more effective than the CAGE questionnaire.

For the first step in the SBIRT process, the previously mentioned screening procedures (CAGE and AUDIT questionnaires) are commonly used to assess alcohol consumption behaviors in patients with an elevated blood alcohol content. Brief intervention can range from brief motivational conversations to more extensive interventions, with the ultimate goal of motivating individuals to change their substance use behaviors. The last step of the SBIRT program, referral to treatment, consists of helping clients identify resources to assist with alcohol or substance abuse recovery.

Research has shown that the implementation of SBIRT programs is associated with reductions in excessive alcohol consumption. The implementation of SBIRT programs has shown reductions in negative consequences associated with drinking, as well as reduced consumption after 3 months. Given their efficacy, SBIRT programs are recommended by several national organizations to reduce alcohol misuse among injured patients.

SBIRT Program Using Chaplains

SBIRT programs are most frequently conducted by nursing staff and social workers. In January 2010, SBIRT protocols were implemented at our hospital and assigned to providers of pastoral care services because of their ability to meet personnel demands without imposing additional requirements on clinicians. On presentation, all trauma patients are tested for drugs and alcohol, and their results are recorded in their electronic medical records. Trauma registrars provide daily reports of trauma patients presenting with a blood alcohol content greater than 0.01 percent blood alcohol content, and pastoral care providers attempt...
to conduct brief visits with all listed patients who are still in the hospital and are able to respond.

SBIRT visits are frequently 3 to 4 minutes in length, and visitors in patient rooms are asked to leave unless given permission to stay by the patients. Patients are asked the CAGE questions, and if they answer yes to 2 or more questions, they are asked about their consumption (number of drinks per session, days per week on which they drink, and so on). After patients are asked about their drinking habits, they are shown how high their alcohol level was at the time of their injury. Levels on the scale range from 0.02 percent blood alcohol content (this level seldom hurts anyone) to 0.30 percent blood alcohol content (most injured patients are in this range) and all the way up to 0.50 percent blood alcohol content (breathing and heart would stop). On the back of the sheet is information for the Recovery Resource Council and referral to agencies where patients can seek additional help. Once the 3- to 4-minute SBIRT conversation is concluded, pastoral care staff typically express their interest in discussing patients’ motivations for drinking, allowing time for additional counseling if it is desired by patients.

After the SBIRT conversation, patients are asked whether they would like to provide a phone number so that they can be contacted in a few months to follow up their recovery. If provided, this information is recorded on the SBIRT tracking form, along with the answers to the CAGE questions and the patients’ plan of action—none, attend Alcoholics Anonymous meetings, reduce drinking, abstinence, or counseling. At the end of the visit, pastoral care services are offered because excessive drinking is often a symptom of coping with emotional distress. Patients are invited to discuss their reasons for drinking.

At 3, 6, and 12 months after the initial SBIRT interaction, every effort is made to follow up with patients by phone and reassess drinking behaviors. A successful follow-up is recorded if patients or immediate family members are able to be reached and their responses regarding reductions in drinking behaviors (or not) are recorded in the SBIRT database (JPS Health Network, Fort Worth, TX). These data are protected and accessible only to SBIRT chaplains for compliance and follow-up purposes. They were not used in this study, but we received approval from our institutional review board to extract overall compliance rates and short vignettes, which have been deidentified by the pastoral care staff.

The chaplains aim to keep the SBIRT completion rates above 90%, and they have had completion rates higher than 90% each month since the project’s inception. Discharged patients and those who refuse to participate count against the completion rates, whereas patients who die, patients who are unable to respond (because of a traumatic brain injury or intubation), and patients who leave against medical advice do not count against the completion rates.

Follow-Up Impact Stories

Since pastoral care has taken ownership of the SBIRT program, our chaplains have been successful at reaching patients. From January 2010 to October 2013, 2,477 patients have qualified for screening and the pastoral care department has completed 2,043 SBIRT visits. Although data are not available on the impact of pastoral care on the patient’s experience, this report presents some patients’ stories that are indicative of the impact on individual patients.

THREE MONTHS LATER

Lee, a 28-year-old man, came in with a head injury. His post-anesthesia care unit nurse said, “I’m going to be judgmental. I think it was a drug deal gone wrong. He said he got hit by a car, but he wasn’t. He was hit by a fist.... There was a lot of drama here yesterday between his ex-wife and girlfriend asking about him and trying to see him.”

A few days later, Lee’s mother told us that family members “have noticed that he has not drank since the accident, which is unusual for him.” Three months later, his mother said, “Oh, he’s doing so good! It’s like a real turnaround! He doesn’t drink, just coffee—he drinks a lot of coffee.... He is working 2 jobs. He’s too tired to be drinking or anything else that he shouldn’t be doing.”

When we mentioned how good sometimes comes from bad situations, she said, “And it’s given me such a peace, knowing that! I used to worry and couldn’t sleep.... Now I have so much more peace.” She thanked us warmly for our call.

SIX MONTHS LATER

James, a 45-year-old man, was transferred to our hospital after he was assaulted. When we first talked, he said he was annoyed when people criticized his drinking, adding, “I drink regularly. I don’t need to change.”

We lost contact with James for 6 months, but we left a message for him a few days ago and he called back a few minutes later. He was very friendly and told us that our message was much appreciated and most encouraging. He
said he is healed and doing well, adding, “I had to let my fiancé go. She had too many boyfriends.... I don’t drink no more.... Too much drama and trouble.... I don’t have to drink no more to fit in.... It sure woke me up, that’s for sure! The Lord sure works in mysterious ways.... He still works his miracles, and I’m sure glad he does.... That’s what he did for me.... I’m praying for you all, also.”

ONE YEAR LATER
A year ago, Jason, a 34-year-old man, said he was assaulted because of “some of the words” he used. At that time, he said that he wanted to reduce his drinking “but not today.” Six months later, he said, “I’ve given up one of my vices: I stopped drinking. It’s been since March, since that night. My family wanted to see that, so that helped also.” We congratulated him. A year later, Jason sounded so mellow and happy that we commented on that, noting that his life sounds like it is going well now. He said, “Well, it was going well before, but I was the one trash-ing it.... I’ve been 1 year sober.... Nothing like waking up like that! Makes you think, ‘Maybe I don’t want to live like this!’”

Conclusion
Utilization of pastoral care services for SBIRT visits serves 2 functions. First, our chaplains are able to take advantage of a teachable moment by helping patients make connections between drinking and their injuries, if such connections exist. Second, pastoral care providers have the ability to talk about the emotional dynamic behind the drinking (stress, guilt, and so on). Patients inherently trust chaplains, and chaplains are trained to listen and guide our patients. Our program is a perfect match between the two. When asked about the chaplains’ impact on patients through the SBIRT program, and what sets our institution apart from other SBIRT programs, one chaplain stated, “Pastoral care staff takes it to the next level by spending more time with patients and exploring the motivations for drinking.”

Unfortunately, because of recording procedures and incomplete data, we were unable to quantitatively analyze data regarding impacts on patients’ subsequent drinking habits. Recently, SBIRT has become a billable procedure and has been turned over to trained case workers for completion at our hospital. Before implementation, we are working on developing a standardized collection system for patient SBIRT data so that if future prospective studies are conducted, they can be performed in a way that allows for appropriate analysis.

REFERENCES
