Brief Interventions in the USA

- Expert committee reports
- Standards and practices
- National Alcohol Screening Day
- SBIRT National demonstration program
- Implementation research

Expert committee reports

- Institute of Medicine: The Furture of Emergency Care
- US Preventive Services Task Force
- Robert Wood Johnson Foundation: Multiple behavioral risk factor initiative

US Preventative Services Task Force Recommends that Primary Care Clinicians Screen and Counsel Adults to Prevent Misuse of Alcohol

AHRQ, April, 2004

- Primary care clinicians should screen all adults and pregnant women for alcohol misuse and refer them for counseling if necessary
- Women who drink more than 7 drinks per week or more than 3 drinks per occasion and men who drink more than 14 drinks per week or more than 4 drinks per occasion are considered to be risky or hazardous drinkers
- The term alcohol misuse includes risky drinking as well as harmful drinking
- Effective counseling sessions for risky drinkers should include advice to reduce current drinking; feedback about current drinking patterns; explicit goal-setting, usually for moderation; assistance in achieving the goal; and followup through telephone calls, repeat visits, and repeat monitoring.

Addressing Multiple Behavioral Health Risk Facrors in Primary Care: Broadening the Focus of Health Behavior Change Research and Practice
A Robert Wood Johnson Foundation Initiative

- The Big Four:
  - Smoking
  - Risky drinking
  - Sedentary lifestyle
  - Unhealthy diet
- Review of epidemiological evidence
- Summary of effective screening, intervention and system-based strategies
- Recommendations for research, practice and policy

***Full Report**: American Journal of Preventive Medicine, August, 27 (2S), 2004*

Standards and practices

- Insurance policy legislation can restrict or facilitate SBI
- American College of Surgeons, Committee on Trauma, recommends new standards requiring Level 1 and level 2 trauma centers to "include identification and intervention for problem drinkers."

SBIRT
Screening, Brief Intervention, Referral and Treatment

A National Demonstration Program funded by the
US Center for Substance Abuse Treatment

Goal: To expand the continuum of care available for treatment of substance use disorders by:

- Adding services in general medical and other community settings
- Supporting clinically appropriate treatment services for nondependent substance users
- Improving linkages among generalist community agencies performing SBIRT and specialist substance abuse treatment agencies
- Identifying policy changes needed to increase access to treatment in generalist and specialist settings

SBIRT Awards

- California
- Alaska
- Illinois
- New Mexico
- Pennsylvania
- Texas
- Washington

SBIRT Program: California

- 36 medical settings in four counties in San Diego area
- Services concentrated in hospital emergency and trauma settings where patient volume and substance use rates are high
- A specialist model of SBI using trained health educators
- Goals over a five year period:
- Screen one million adult patients
- Engage 190,000 at-risk patients in brief interventions or brief treatments
- Refer 40,000 dependent individuals to specialized care
- Give educational interventions to 770,000 patients not at risk

National Alcohol Screening Day

- The largest and most visible SBI activity in the USA
- Established in 1999
- Three objectives:
  - Administer free and anonymous alcohol screening in an accessible setting
  - Provide referrals for treatment
  - Provide public education about the impact of alcohol on health

National Alcohol Screening Day

Participating sites receive a kit that includes

- Procedures to conduct the program
- Educational materials such as brochures
- Posters
- Videos
- Screening forms

Also: A national publicity campaign and a list of participating sites sent to local agencies

Characteristics of National Alcohol Screening Day Sites: 2001 - 2003

	2001	2002	2003
Number of Sites Registered	567	1,589	2,983
Number of Sites Reporting Data	391	865	851
Number of Screening Forms Collected	13,833	36,918	44,071
Mean Number of Participants per Site	35.7	42.8	51.8

Characteristics of National Alcohol Screening Day Participants: 2001 - 2003

	COLLEGE			**COMMUNTY**		
	2001	**2002**	**2003**	**2001**	**2002**	**2003**
	(N=11,113)	(N=24,051)	(N=24,060)	(N=2,566)	(N=12,042)	(N=19,700)
GENDER						
Male	45.3%	44.7%	43.8%	49.3%	44.9%	45.9%
Female	54.7	55.3	56.2	50.7	55.1	54.1
	100.0	100.0	100.0	100.0	100.0	100.0

AUDIT SCORES						
% No problem (-8)	71.6	66.0	67.6	79.2	75.8	73.9
% Hazardous (8-19)	24.3	29.5	27.9	14.4	17.4	19.4
% Harmful (20+)	4.1	4.5	4.5	6.4	6.8	6.7
	100.0	100.0	100.0	100.0	100.0	100.0

Table 3 Implementation Performance Measures Correlated with Professional and Organizational Factors

Factors	Number of Screens	Percent of Screens per Patient Visit	Number of Interventions	Percent of Interventions per Positive At-Risk Drinker
Predisposing Factors				
Peer approval for alcohol screening *b*	0.38	0.28	0.38	0.47
Organizational approval of alcohol screening b	-0.21	-0.23	-0.21	-0.30
Frequency clinicians asked about alcohol consumption f	0.62*	0.39	0.59*	0.44
Frequency clinicians educated patients about health risks f	0.64*	0.42	0.67*	0.42
Frequency clinicians advised patients with problem drinking to cut down or stop drinking f	0.42	0.59*	0.47	0.37
Stable patient membership [a]	0.91**	0.10	0.82**	0.33
MCO instability [a]	-0.74**	-0.31	-0.79**	-0.38

Enabling Factors

Number of clinicians trained at each clinic *d*	0.65*	0.30	0.62*	0.44
Provider lack of time [a]	0.07	'-0.74**	-0.21	'-0.70*
Nursing staff lack of time [a]	-0.33	0.14	-0.41	-0.22
Receptionist staff lack of time [a]	-0.58*	0.19	-0.50	-0.17
Provider staff turnover [a]	0.14	-0.48	-0.15	'-0.59*
Nursing staff turnover [a]	0.04	-0.10	-0.04	-0.30
Receptionist staff turnover [a]	-0.07	-0.26	-0.37	-0.40
Competing organizational priorities [a]	-0.69*	-0.34	'-0.79**	'-0.58*
Influential MCO Coordinator [a]	0.70*	0.59*	0.74**	0.75**
Involvement of clinic staff in planning [a]	0.25	.64*	0.46	0.37

Organizational Variables	Number of Screens	Percent of Screens per Patient Visit	Number of Interventions	Percent of Interventions per Positive At-Risk Drinker
Facilitation by computer technology[a]	0.23	-0.68*	-0.02	-0.29
Amount of technical assistance [a]	0.65*	0.50*	0.75**	0.72**
Successful implementation of staff changes to screening and interventions	0.72**	0.41	0.88**	0.75**
Reinforcing Factors				
MCO support [a]	0.20	0.94**	0.34	0.68*
Financial incentives [a]	0.17	0.70*	0.40	0.41

From Research to Real World: Transitioning a Screening and Brief Intervention Program for Smokers and At-risk Drinkers to Community-based Dental Clinics

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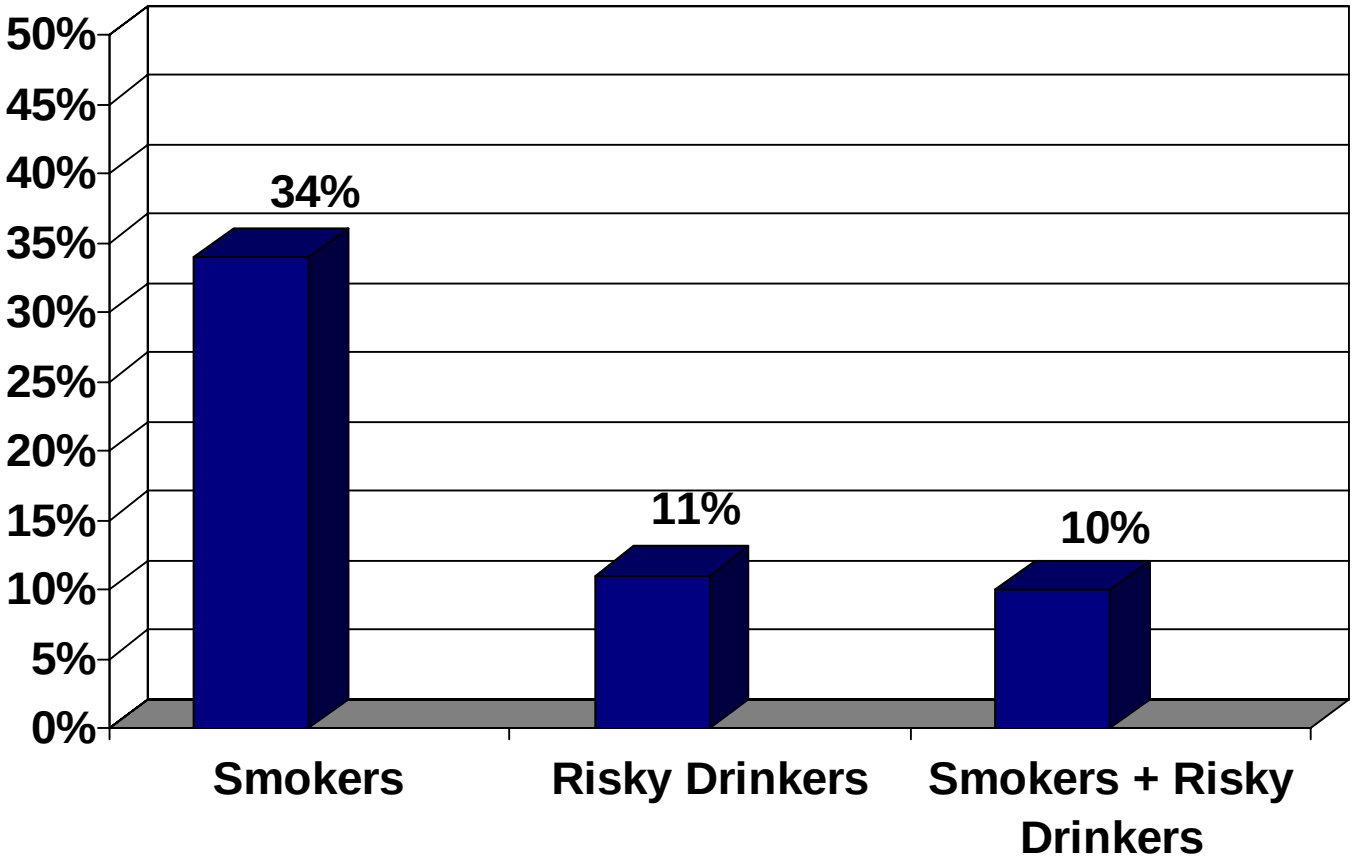
Implementation Study Design

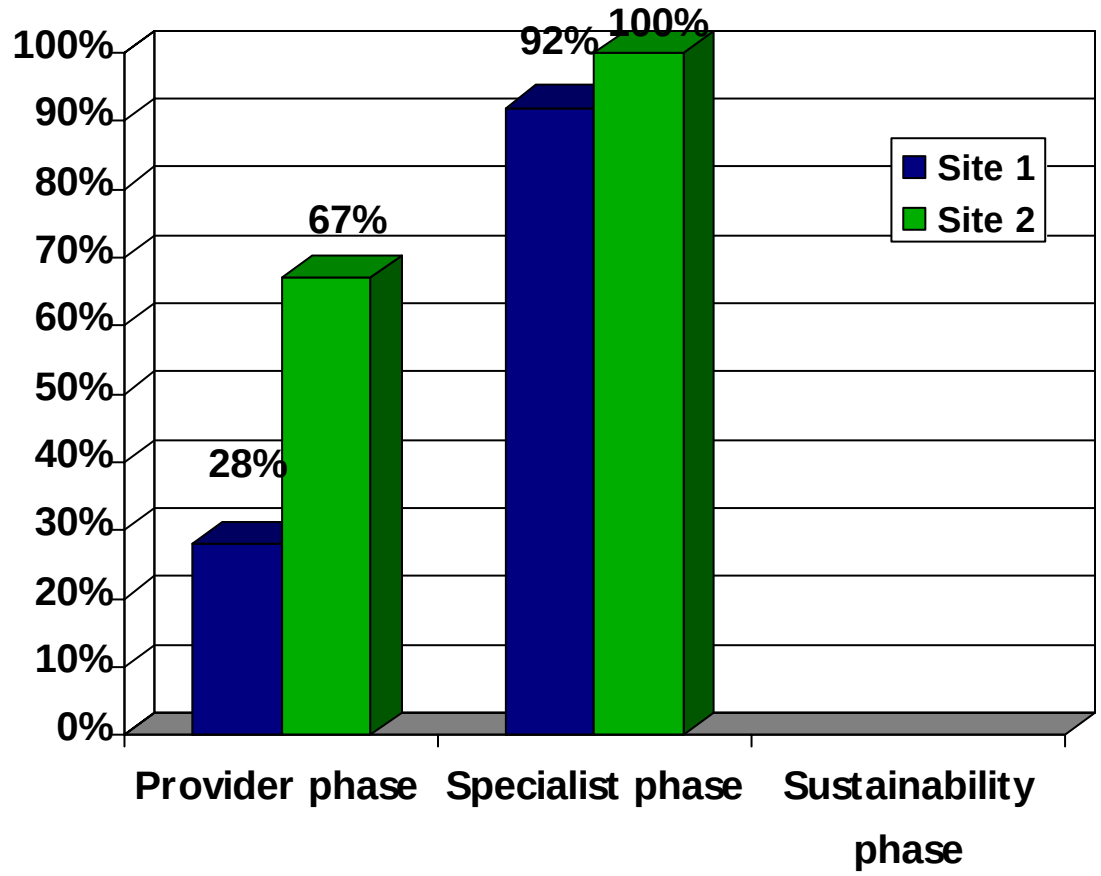
	Training Phase	Main Phase			Continuation Phase
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Weeks 5-13**
Site 1	SBI Training by Vital Signs Staff	*Provider* conducts SBI	*Specialist* conducts SBI	*Provider* conducts SBI	*Provider* conducts SBI
Site 2	SBI Training by Vital Signs Staff	*Specialist* conducts SBI	*Provider* conducts SBI	*Provider* conducts SBI	*Provider* conducts SBI

Patient Screening Prevalence Rates (n=410)



Site 1: Training -> Provider phase -> Specialist phase -> Provider
Site 2: Training -> Specialist phase -> Provider phase -> Provider

Brief Intervention Implementation Rates (Smoking Cessation) (n=410)



Conclusions

- Alcohol SBI has gained national prominence
- Research has been a stimulus to implementation
- New concepts are gaining credence
- Program implementation proceeding within health care systems

Conclusions

- Implementation models are inadequate to achieve adequate population reach
- Screening is the linchpin of SBI
- Carve out models may work better
- Fit the program to the population, rather than the population to the program
- Evaluate population impact
- Combine alcohol SBI with other risk factors