

Preliminary Test of a Brief Intervention in Promoting Treatment Initiation in Middle-Aged and Older Adults with Markedly Elevated AUDIT Scores

Kenneth R. Conner, PsyD, MPH; Tracy Stecker, PhD;
and Stephen A. Maisto, PhD

University of Rochester Medical Center
Department of Emergency Medicine and Psychiatry
Rochester, NY USA

Paper presented at INEBRIA
Lausanne, Switzerland
September, 2016

Agenda

- 1) Summary of research on SBIRT and initiation of alcohol-related care.
- 2) Limitations of SBIRT for promoting alcohol-related care, and potential alternatives.
- 3) Results of published RCT that used such alternatives (Stecker et al., 2012).
- 4) Need for the study of promoting alcohol-related care in middle-age and older adults.
- 5) Secondary analysis of the Stecker et al., (2012) of middle-age and older adults

SBIRT and Alcohol-Related Care

There has been intensive study of Screening, Brief Intervention, and Referral to Treatment (SBIRT) interventions for individuals with alcohol-related problems (Babor et al., 2007; Young et al., 2014).

SBIRT interventions have three core components (screening, intervention, and referral).

Unlike substantial gains with the first two components, it may be argued that progress with the third has lagged.

To this point, Glass and colleagues (2015) conducted a meta-analysis of published RCTs of brief interventions with patients recruited from medical settings that reported data on alcohol-related care following intervention.

Glass et al., 2015 Meta-Analysis (adult samples)

Study	Country	Setting	Total N	N (%) with ¹ alcohol depend.	Increased alcohol-related care	Improved alcohol-related outcome	Mediating role of care on outcome
³ Apodaca et al., 2007	U.S.	emergency	40	not reported	no	no	untested
² Batel et al., 1995	U.S.	emergency	369	369 (100%)	yes	untested	untested
² Bischof et al., 2008	Germany	medical	408	124 (30%)	no	yes	untested
² Cherpitel et al., 2010	Poland	emergency	446	not reported	no	yes	untested
² Copeland et al., 2003	U.S.	VA primary care	228	not reported	no	untested	untested
² Field and Cataeno, 2010	U.S.	hospital	1336	588 (44%)	no	yes	untested
² Gentilello et al., 1999	U.S.	hospital	762	not reported	no	yes	untested
² Kuchipudi et al., 1990	U.S.	VA hospital	114	114 (100%)	no	no	untested
³ Liu et al., 2011	Taiwan	hospital	616	305 (50%)	yes	no	untested
² Monti et al., 2007	U.S.	emergency	198	not reported	no	yes	untested
² Saitz et al., 2007	U.S.	hospital	341	261 (77%)	no	no	untested
² Wutzke et al., 2002	Australia	medical	554	0 (0%)	no	yes	untested

Notes. ¹Met criteria for alcohol dependence under former diagnostic criteria (DSM-III-R, DSM-IV). Source: ²Study identified in Glass et al. (2015a) meta-analysis; ³Study missed in the original meta-analysis and included for the purpose of a re-analysis (Glass et al., 2015b).

Limitations of SBIRT in Promoting Treatment Engagement

1) Use of non-severe samples that do not require treatment (Saitz, 2015).

Alternative: Intervene with a more severe sample.

2) Insufficient dose of intervention (e.g. “15 minutes”) (Saitz, 2015).

Alternative: Use a more intensive intervention.

3) The reliance on screening -- individuals are not seeking care for alcohol-related difficulties, creating challenges in promoting treatment engagement (Saitz, 2015).

Alternative: Recruit a sample that may be interested in treatment, for example by recruitment through advertisements.

4) Delivery of intervention in medical settings (busy pace, competing demands).

Alternative: Deliver the intervention at a convenient time without such competing demands, for example during a phone call to the individual’s home.

5) Limited focus of SBIRT interventions on treatment engagement per se.

Alternative: Use an intervention with an explicit focus on engagement.

Stecker and colleagues (2012) used each of these alternative strategies.

Regular article

An intervention to increase alcohol treatment engagement: A pilot trial

Tracy Stecker, (Ph.D.)^{a, b, *}, Mark P. McGovern, (Ph.D.)^a, Beverly Herr, (B.A.)^c

^aPsychiatric Research Center, Dartmouth Medical School, Lebanon, NH, USA

^bVA Health Services Research and Development, White River Junction Veterans Administration, White River Junction, VT, USA

^cChildren's Hospital Boston, Boston, MA, USA

Received 2 February 2011; received in revised form 26 September 2011; accepted 25 October 2011

Abstract

Objectives: Previous research has documented the difficulty individuals with alcohol use disorders have initiating alcohol treatment. This study assessed the feasibility of a brief, cognitive–behavioral intervention designed to increase treatment initiation among individuals with alcohol use disorders. **Methods:** This randomized controlled trial included 196 participants who screened positive for a possible alcohol use disorder on the Alcohol Use Disorders Identification Test. Randomly assigned intervention participants were administered a brief cognitive–behaviorally-based intervention by telephone designed to modify beliefs that may interfere with treatment-seeking behavior. Beliefs about treatment and treatment-seeking behavior were assessed postintervention. **Results:** Participants receiving the intervention had significantly improved their attitudes toward addiction treatment ($p < .002$) and increased their reported intention-to-seek treatment ($p < .000$) postintervention. Further, intervention participants were almost three times more likely to attend treatment within a 3-month period (odds ratio = 2.60, $p < .025$) than participants in the control group. **Conclusions:** A brief, cognitive–behavioral intervention delivered by telephone and focused on modifying treatment-interfering beliefs holds promise for increasing alcohol treatment seeking among individuals in need. © 2012 Elsevier Inc. All rights reserved.

1. Introduction

Results of the most recent large-scale national mental health epidemiological research, the National Comorbidity Study–Replication (NCS-R), identified high community prevalence of substance use disorders. The NCS-R, conducted from 2001 to 2003 using structured psychiatric diagnostic interviews, found a 12-month prevalence of any substance abuse/dependence disorder of 3.8%, with a 12-month prevalence of alcohol abuse of 3.1% (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Kessler, Demler, et al., 2005). Lifetime prevalence of an alcohol use disorder has been found to be between 20% and 22% (Grant et al., 2004; Kessler et al., 1994; Regier et al., 1993).

Although the prevalence of alcohol use disorders is high,

Sobell, Cunningham & Sobell, 1996; Weisner, Greenfield, & Room, 1995). In fact, less than half (38%) of the patients with substance use disorders receive any mental health treatment in a 12-month period, and substantially fewer receive minimally adequate treatment (28%) based on evidence-based guidelines (Wang et al., 2005). Because most mental health providers do not address alcohol problems in treatment, the numbers of persons with alcohol problems who actually receive alcohol treatment are even lower (Harris & Edlund, 2005; Margules & Zweben, 1988). Although many individuals with alcohol problems recover without treatment (de Bruijn, van den Brink, de Graaf, & Vollebergh, 2006; Weisner et al., 1995), remission rates are highest for individuals who participate in both specialized treatment and Alcoholics Anonymous (AA; Moos & Moos,

AUD and Alcohol-Related Care in Middle Age and Older Adulthood

The prevalence of alcohol use disorder (AUD) in the U.S. peaks in 18-29 year olds (Grant et al., 2015).

Nonetheless, many experience AUD during middle adulthood and older age, with estimates that 10.0% of individuals ages 45-64 and 2.3% ages 65 and older in the U.S. meet criteria for AUD in the past year (Grant, 2015).

Middle-aged and older adults with AUD are also at elevated risk for a range of physical disorders and mental disorders including depression (Blazer & Wu, 2011).

Despite the morbidity associated with AUD during middle age and older adulthood, only a small percentage obtain treatment for AUD (Ilgen et al., 2011).

Research on promoting alcohol-related treatment in middle aged and older adults is needed.

Approach

- Secondary analysis of participants ages 50 and older in a published RCT (Stecker et al., 2012).
- Participants recruited through community advertisements in a mid-size city in the northeastern U.S.
- All interactions by telephone.
- Eligibility:
 - 1) No history of alcohol-related treatment;
 - 2) ≥ 16 on the AUDIT, indicative of a need for “counseling and monitoring” (Babor et al., 2001).
- Participants randomly assigned to:
 - 1) 45-60 minute CBT treatment session (experimental group);
 - 2) Being read a NIAAA pamphlet about alcohol treatment (control group).
- CBT intervention identified beliefs preventing treatment seeking using a structured measure and addressed up to 3 of these beliefs using cognitive restructuring.
- Of the original sample ($N=196$), $n=55$ (28%) were ages 50 and older, and their data were analyzed.
- Primary outcome: Initiation of alcohol-related treatment at 3-month follow-up assessed using the Treatment Services Review (McClellan et al., 1992).
- Data were analyzed using unadjusted logistic regression.

Results and Conclusion

Individuals in the subsample were 67% female, 91% white non-Hispanic, and with mean AUDIT score = 24.3.

Individuals in the treatment condition showed a trend to be more likely to initiate treatment, odds ratio (95% confidence interval) = 3.85 (0.93, 16.01), $p=0.068$.

These preliminary results suggest that a brief CBT intervention is efficacious in promoting treatment engagement in middle-aged and older adults that likely have significant alcohol-related problems.

Future directions include examining whether the intervention improves drinking outcomes (which were not assessed, a key limitation), and if treatment initiation serves as a mechanism for such improvement.

Thank you

kenneth_conner@urmc.rochester.edu