

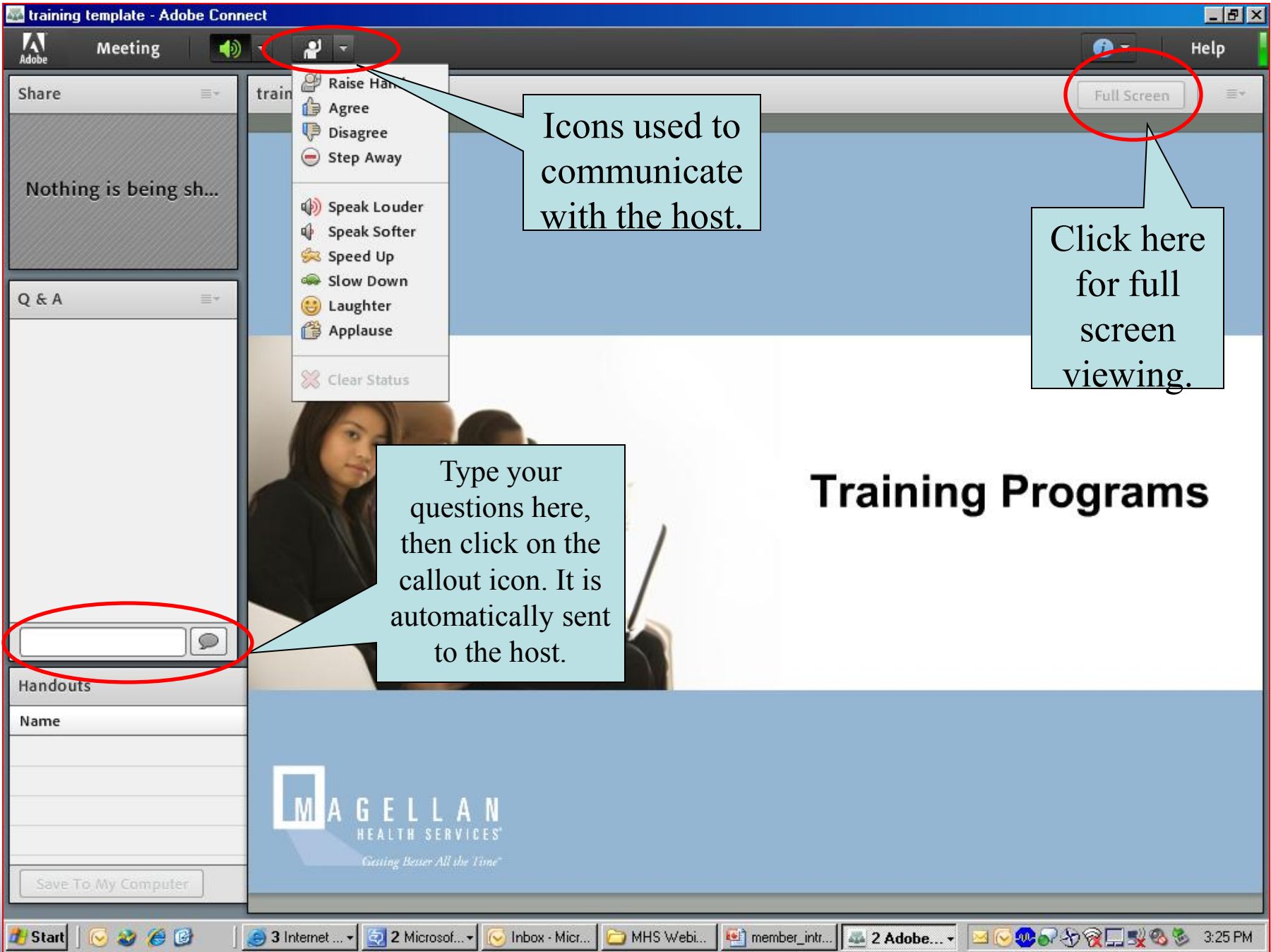


# Screening and Brief Intervention: Improving Health Changing Lives

Presented by Eric Goplerud, PhD

and Brie Reimann, MPA





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# Disclosures:

- Eric Goplerud has no relevant financial relationship commercial interest that could be reasonably construed as a conflict of interest.
- Brie Reimann has no relevant financial relationship commercial interest that could be reasonably construed as a conflict of interest.

# Learning Objectives:

At the end of this exercise, the participant will be able to:

- Discuss evidence that supports screening and brief intervention for tobacco and alcohol use.
- Identify core components of screening and brief intervention practice.
- Explain needs assessment to determine readiness to implement Screening and Brief Intervention.
- Review solutions to commonly perceived barriers to implementation.

# About the Presenter: Eric Goplerud, Ph.D.

- Dr. Goplerud is a clinical psychologist and senior vice president of the Substance Abuse, Mental Health and Criminal Justice Department at NORC at the University of Chicago. Until April 2011, he was a research professor of health policy at the George Washington University Medical Center. Since 2002, Dr. Goplerud has directed Ensuring Solutions to Alcohol Problems, a research program at GW supported by grants from the Pew Charitable Trusts, the Robert Wood Johnson Foundation, and various Federal agencies. He also directs the Center for Integrated Behavioral Health Policy in the Department of Health Policy at GW. Dr. Goplerud is president of ACMHA: the College for Behavioral Health Leadership.
- Previously, Dr. Goplerud was Associate Administrator for Policy and Planning at the Substance Abuse and Mental Health Administration (SAMHSA) in the Department of Health and Human Services. As Associate Administrator for Quality and Finance, he managed SAMHSA's public and private sector managed behavioral healthcare activities and the agency's "science to service" initiatives to speed transmission of evidence-based practices into everyday clinical practice. He served on President Clinton's National Health Care Reform Task Force, where he had lead responsibility for substance abuse prevention. He has also held senior policy and research positions at the Center for Substance Abuse Prevention and the Office of National Drug Control Policy.
- Dr. Goplerud has published widely in peer-reviewed journals and has received many awards and honors, including the DHHS Secretary's Distinguished Service Award for individual service, and four times the DHHS Secretary's Distinguished Service Award for group services. He received the Walter Barton Distinguished Fellow Award from the American College of Mental Health Administration. He is a member of the Behavioral Measures Advisory Group of the National Committee for Quality Assurance for 13 years, and frequently chairs behavioral health quality and performance measurement committees for the Joint Commission, the National Quality Forum, and the Federal government. .

# About the Presenter: Brie Reimann, MPA

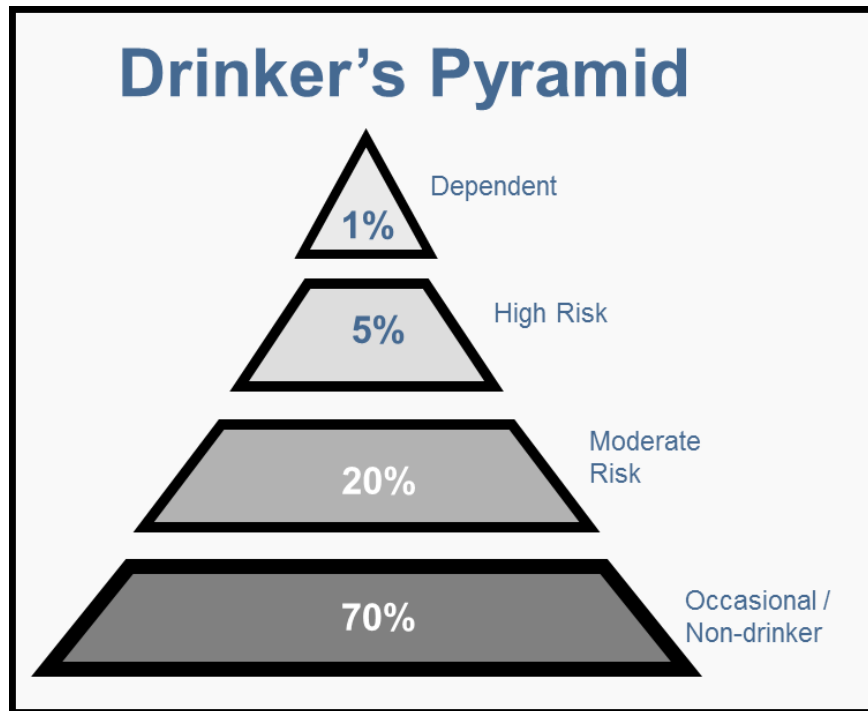
- Brie Reimann currently works for Peer Assistance Services, Inc. as the Program Director for SBIRT Colorado, an initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Colorado Office of the Governor. The goal of SBIRT Colorado is to implement routine screening and brief intervention services to address substance use as a standard of healthcare in Colorado. Reimann co-authored both the SBIRT and ATR grants and has a special interest in developing and implementing public policies to address behavioral health issues and improve systems integration.
- Her primary role at Peer Assistance has been to manage and provide oversight to several prevention-focused contracts. Before working as program director for SBIRT Colorado, Reimann managed a program funded by SAMHSA to prevent women from drinking during pregnancy and to prevent Fetal Alcohol Spectrum Disorders in Colorado. Prior to Peer Assistance Services, Reimann worked on the start-up program for Denver's Community Development Institute to implement an English Language Learner's program at Head Start programs nationwide.
- She received a Bachelor of Arts from Colorado State University and a Master of Public Affairs with an emphasis in public policy from the University of Colorado at Denver.

# UNDERSTANDING THE PROBLEM

# Alcohol Usage in the U.S.

- More than half of the U.S. population over age 12 drinks alcohol.
- The majority of Americans who drink do so without negative consequences.
- For some, alcohol use leads to physical, emotional, legal, financial, family and work problems.

# Four Patterns of Alcohol Use



## U.S. Recommended Guidelines for Low-Risk Drinking

No more than:

- 2 drinks per day or 14 drinks per week for men
- 1 drink per day or 7 drinks per week for women and men over age 65
- 0 drinks per day for pregnant women and anyone using prescription medication where alcohol use is contraindicated

# Costs of Unhealthy Drinking Patterns

- 18.7 million Americans drink alcohol in ways that are potentially unhealthy - only 3 million get help.
- Cost of alcohol problems = at least \$185 billion annually.
- Annual medical bill for alcohol-related problems = over \$24 billion.
  - 4/5 going to treat the injuries and illnesses caused or complicated by alcohol use.

# **SBIRT: A SOLUTION**

# Why SBIRT?

- SBIRT is simple, brief and effective.
- An analysis of more than 360 controlled clinical trials of treatments for alcohol use disorders found that screening and brief intervention was the most effective treatment method of more than 40 methods studied.
- The U.S. Preventive Services Task Force reviewed the research literature on screening for unhealthy alcohol use and brief counseling and recommended that it be routinely provided to adolescents and adults.
- American College of Surgeons requires hospital trauma centers to provide SBI to remain accredited.
- SBI is becoming the standard of good healthcare because it works.

# Understanding SBIRT: The Process

- Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) is the leading way to reduce the impact of unhealthy alcohol use.
  - Introducing SBIRT
  - Brief Screen/Screening
  - Brief Intervention
  - Referral to Treatment and Follow-Up

# Introducing SBIRT

“I would like to ask you several questions about your alcohol use. I ask all of my clients these questions because sometimes drinking makes it harder to solve the problems that led you to come to me.  
May I talk with you about this?”

# Brief Screen

- *Brief questionnaire to screen out clients. More than a third of adults in the U.S. do not drink alcohol*
- “Do you sometimes drink beer, wine or other alcoholic beverages?”
  - One third will say “no.” No further alcohol screening is necessary. If the answer is “yes,” you can proceed to the AUDIT-C and, if necessary, the full AUDIT.
- You may also choose to ask a similar question about drug use that NIDA recommends:
  - “In the past year, how many times have you used the following: alcohol (more than 4 or 5 drinks in a day for women or men, respectively); tobacco products; prescription drugs for non-medical reasons; and illegal drugs?”

# Screening

- *The process of assessing risk*
  - If you do not ask, clients will not tell you about unhealthy drinking.
  - Asking 3 simple questions about the quantity and frequency of alcohol use (the 3 question AUDIT-C) takes 30 seconds to 2 minutes.
  - This is followed by the 7 remaining questions of the AUDIT if responses to the first 3 questions suggest higher than average unhealthy use.
  - Other good, brief screening instruments exist but the AUDIT is the benchmark questionnaire that we recommend.

# Screening

- There are several screening tools including AUDIT, DAST, ASSIST, CAGE, CRAFFT (adolescents).
- The Alcohol Use Disorder Identification Test (AUDIT) is the benchmark questionnaire for alcohol screening because it detects hazardous and harmful use, as well as probable alcohol dependence.

## AUDIT

Screening questionnaire that gives clinicians and clients immediate information about an individual's level of risk for alcohol-related problems by asking 10 multi-choice questions about the quantity and frequency of alcohol use, symptoms of dependence and negative consequences of drinking.








# Why use the AUDIT?

- Valid
- Reliable
- Brief
- Public domain
- Free
- Multiple languages
- Widely used in the U.S. and Canada
- Identifies risky and dependent
- Results guide treatment
- Monitors change in use
- Fits with other screeners (e.g. PHQ-9 for depression)
- Multiple ways to administer (paper, online, verbal, smartphone)

# Screening

- The AUDIT can be used with other screening questionnaires, such as the Drug Abuse Screening Test (DAST), the NIAAA Single-item Drug Screen, or the ASSIST for drug and tobacco use.
- Screening for unhealthy alcohol use also fits naturally with other health and mental health screeners, such as the Patient Health Questionnaire-9 (PHQ-9) for depression.

# Screening: Identify Standard Drink

<p><b>12 oz. of beer or cooler</b></p>  <p>~5% alcohol</p>	<p><b>8–9 oz. of malt liquor</b> 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor</p>  <p>~7% alcohol</p>	<p><b>5 oz. of table wine</b></p>  <p>~12% alcohol</p>	<p><b>3–4 oz. of fortified wine</b> (such as sherry or port) 3.5 oz. shown</p>  <p>~17% alcohol</p>	<p><b>2–3 oz. of cordial, liqueur, or aperitif</b> 2.5 oz. shown</p>  <p>~24% alcohol</p>	<p><b>1.5 oz. of brandy</b> (a single jigger)</p>  <p>~40% alcohol</p>	<p><b>1.5 oz. of spirits</b> (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show the level before adding a mixer*</p>  <p>~40% alcohol</p>
<b>12 oz.</b>	<b>8.5 oz.</b>	<b>5 oz.</b>	<b>3.5 oz.</b>	<b>2.5 oz.</b>	<b>1.5 oz.</b>	<b>1.5 oz.</b>

# Standard Drinking Guidelines

	Maximum Daily Limits	Maximum Weekly Limits
Women	3	7
Men	4	14
Men >65	3	7
Less is Better!		

# Brief Intervention

- *A behavioral change strategy that is short in length and duration that is aimed at helping a person reduce or stop a problematic behavior*
  - If screening indicates unhealthy alcohol use, you may choose to provide immediate feedback on how drinking compares to others, offer simple advice, explore pros and cons of drinking and ask if willing to change.
  - Can take as little as 30 seconds to deliver brief advice or can extend to several sessions.
  - Can help many, but certainly not all, clients to make changes.
  - Some will not be ready to change or may need specialized addiction treatment.

# Brief Intervention: Effectiveness

<b><i>Study</i></b>	<b><i>Results – conclusions</i></b>	<b><i>Reference</i></b>
Trauma patients	<ul style="list-style-type: none"> <li>• 48% fewer re-injury (18 months)</li> <li>• 50% less likely to re-hospitalize</li> </ul>	Gentilello et al, 1999
Hospital ER screening	<ul style="list-style-type: none"> <li>• Reduced DUI arrests</li> <li>• 1 DUI arrest prevented for 9 screens</li> </ul>	Schermer et al, 2006
Physician offices	<ul style="list-style-type: none"> <li>• 20% fewer motor vehicle crashes over 48 month follow-up</li> </ul>	Fleming et al, 2002
Meta-analysis	<ul style="list-style-type: none"> <li>• Interventions reduced mortality</li> </ul>	Cuijpers et al, 2004
Meta-analysis	<ul style="list-style-type: none"> <li>• Treatment reduced alcohol, drug use</li> <li>• Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence)</li> </ul>	Burke et al, 2003
Meta-analysis	<ul style="list-style-type: none"> <li>• Interventions can provide effective public health approach to reducing unhealthy use.</li> </ul>	Whitlock et al, 2004

# Brief Intervention Goal

- Brief interventions are designed to help your clients take the first steps towards making healthy changes.
- Your client has to choose to change and to do the work.
- Change is difficult!

# Brief Intervention

- If screening indicates unhealthy alcohol use, brief, solution-focused counseling can be very effective in helping your client to reduce or stop hazardous drinking.
- Usually, brief interventions (BI) immediately follow screening.
- A gap of a few days or a week does not seem to dilute the effectiveness of the brief intervention.
- But, a delay increases the likelihood that clients will not show and the immediacy of the linked screening and brief intervention (SBI) is lost.

# Brief Intervention

- Provide feedback about the AUDIT scoring.
- Compare results to national averages.
- Express concern about the potential effects of unhealthy drinking.
- Advise to cut down or quit.
- Explore pros and cons of use.
- Develop a plan and set goals.
- Commitment plan.
- Document plan and follow-up.

# Brief Intervention: Feedback

- Low Risk
  - “You are at low risk of experiencing problems associated with your drinking. If you stay within the guidelines (14-4 [men]; 7-3 [women]), you will likely not experience any consequences. This is great!”
- Moderate Risk
  - “Your pattern of drinking places you at risk for experiencing health, emotional, social, financial, occupational and/or legal problems, and I am concerned. Would you be willing to discuss how you could reduce your risks?”
- High Risk
  - “I am concerned about your drinking. You may be at risk of developing alcohol dependence. I have some information on resources that may help. Would you be willing to discuss?”

# Brief Intervention Feedback: Compare to National Drinking Rates

<i>Drinking Patterns in U.S. Adults</i>		
9%	Drink more than <b>both</b> the single-day limits <b>and</b> the weekly limits (20 to 40 on the AUDIT)	High Risk
19%	Drink more than <b>either</b> the single-day limits <b>or</b> the weekly limits (8 to 19 on the AUDIT)	Moderate Risk
37%	<b>Always</b> drink <b>within</b> low-risk limits (1 to 7 on the AUDIT)	Low Risk
35%	<b>Never</b> drink alcohol (0 on the AUDIT)	No Risk

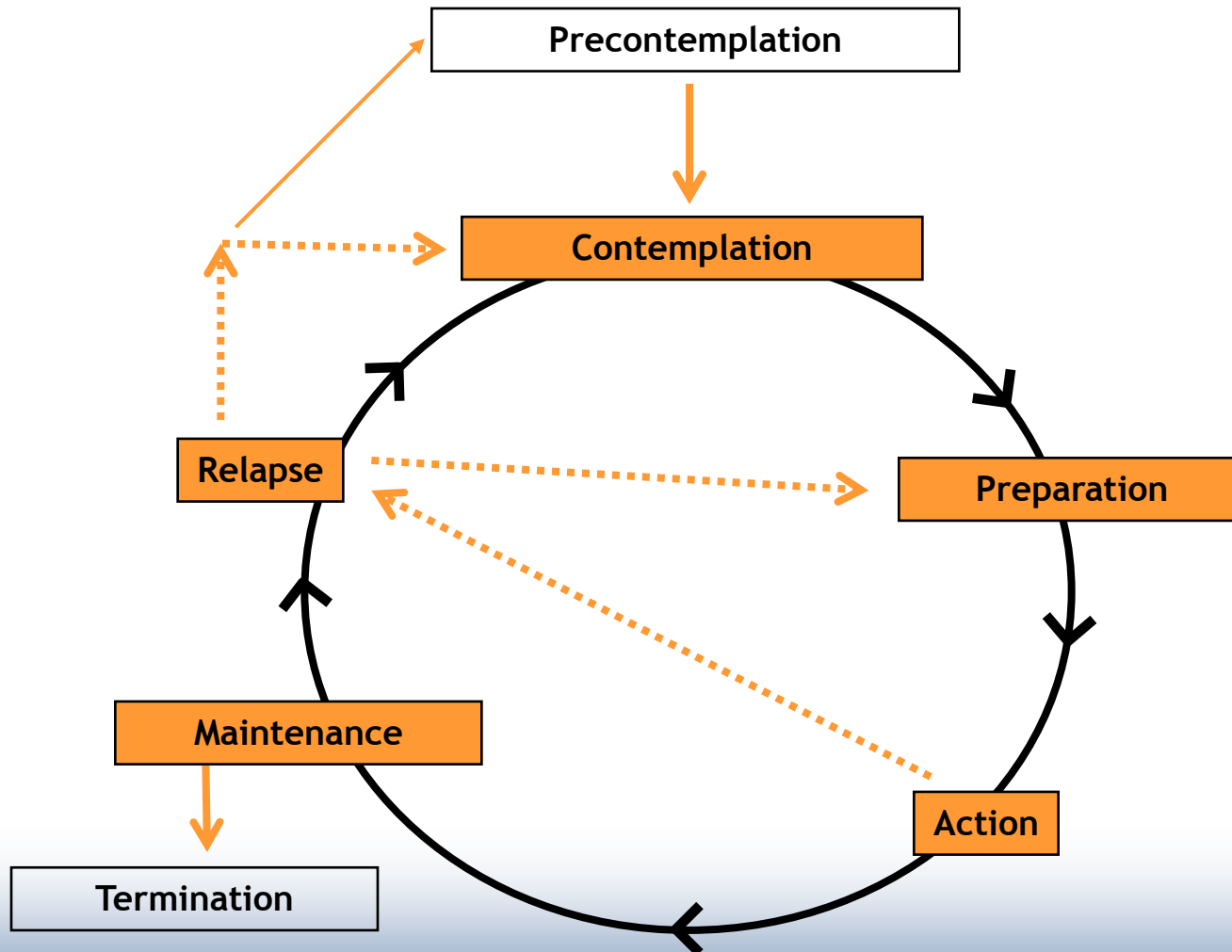
# The Stages of Change

- The Stages of Change Model is a way to identify the important tasks needed to make change happen, better understand the treatment needs of that client and identify which treatment options are most appropriate given your client's level of motivation to change.
- Prochaska and DiClemente found 5 stages of change over hundreds of behavior change studies involving thoughts of clients.
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

# Stages of Change

- Pre-contemplation: Raise awareness.
- Contemplation: Tip the balance.
- Preparation: Increase commitment to behavior change plan.
- Action: Support client in meeting goals.
- Maintenance: Identify barriers and solution and support client in sustaining behavior change.

# Stages of Change



# Brief Intervention Techniques

- Techniques from Motivational Enhancement Therapy (MET) and Cognitive-Behavioral Therapy (CBT) form the core of brief interventions.
  - Motivational Interviewing – a method of communicating that uses the perspective, ideas, beliefs and strengths of an individual to evoke internal motivation to change behaviors.
  - Cognitive-behavioral Therapy (CBT) is based on the idea that distorted thoughts, not realistic ones, lead to unhealthy, negative emotions and behaviors.

# Motivational Interviewing Skills

- Open-Ended Questions
- Affirming
- Reflective Listening
- Summarizing
- Eliciting Change Talk
- Asking Permission & Giving Advice
- Generating Options
- Rolling with Resistance

# Importance, Confidence, Readiness Rulers

- “On a scale of 0 to 10, how important would you say it is for you to reduce or stop drinking?”
- “On a scale of 0 to 10, how confident would you say you are about being able to stop drinking?”
- “On a scale of 0 to 10, how ready are you to make a change?”



- “Why are you at a [4] and not at a 0?”
- “What would it take for you to go from a [4] to a [7]?”

# Cognitive Behavioral Therapy

- Active and change-oriented.
- Identifies high risk situations, thoughts and cognitive distortions that increase the likelihood to bad outcomes.
- Practices alternative behaviors and thoughts.
- Perfection is not the goal.
- Everyone makes mistakes, especially when learning new behaviors.
- But, by actively practicing new skills and cognitive strategies, your clients will replace maladaptive habits with adaptive ones.
- Role-plays, constructive feedback from you, practice exercises (“homework” may have bad connotations) and more practice are fundamental to helping clients change learned, maladaptive thinking and drinking.

# Cognitive Behavioral Therapy

- Albert Ellis, the founder of Rational Emotive Behavior Therapy (REBT), argued that distorted thought patterns (“Beliefs”) come between an initial perception, event, thought, or feeling, called the “Activating Event,” and a “Consequence” follows.
- The” A-B-C’s” of functional analysis help clinicians and clients to uncover and confront the “Beliefs” that produce exaggerated and harmful “Consequences” that appear after the automatic response to “Activating Events.”

# Referral to Treatment

- *Referral to Treatment and Follow-up – linking your client to specialized addiction treatment and offering continued support*
  - When alcohol problems are more serious or complicated, more intensive, addiction-focused treatment may be a good option.
  - “Referral to treatment” means connecting your client to a physician for medical treatment or a specialty addiction treatment program, as well as bridging and supporting your client during treatment and following-up to assure problems are resolved.

# Referral to Treatment

- According to a 2004 Treatment Episode Data Set (TEDS) analysis:
  - Only 16% of clients discharged from detoxification programs start a new level of care.
  - Only 30% of clients discharged from residential care start a new level of care.
  - Only 50% of those who start outpatient care complete their regimen.

Far too many clients are lost to the system during handoffs from one level of care to another.

# Referral to Treatment

- Active referral to treatment builds from the brief motivational interview presented earlier.
- You may wish to suggest that clients who score on the AUDIT at 20 or above seriously consider more intensive treatment.
- As you and your client work to develop the steps of a plan, options for treatment will probably come up.
- The speed at which you can link a client to treatment dramatically impacts their likelihood to show up, stick with treatment and experience good outcomes.

# Follow-Up

- From your first encounter with your client, discuss that you would like to follow-up with her, regardless of her decisions about continuing to meet with you, cut down on risky drinking or getting additional treatment.
- If follow-up is presented as the standard of care and what you do for all of your clients, very few will refuse.
- Document goals client sets.

# Implementation Planning

- Needs assessment.
- Assess readiness of setting.
- Identify training needs.
- Build relationships with treatment providers.
- Identify site specific protocols.
- Identify solutions to commonly perceived barriers
  - Time constraints, belief that SBIRT is not my job, fear of antagonizing patients, etc.

# Conclusion

- “Suitable methods of identification and readily learned brief intervention techniques with good evidence of efficacy are now available. The committee recommends... broad deployment of identification and brief intervention.”
  - 1990 (21 years ago!)
  - (IOM, Broadening the Base of Treatment for Alcohol Problems, 1990, p. 8)

Thank You for Participating!

Please feel free to ask questions!

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# References

1. Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *J Consult Clin Psychol.*2003; 71 :843 –861
2. Cuijpers P., Riper H., Lemmers L. The effects on mortality of brief interventions for problem drinking: a meta-analysis. *Addiction* 2004; **99**: 839–45.
3. Fleming MF, Mundt MP, French MT, Manwell LB, Staauffacher EA, Barry KL. Brief physician advice for problem drinkers: Long-term efficacy and cost-benefit analysis. *Alcohol Clin Exp Res.* 2002;26:36-43.
4. Gentilello LM, Rivara FP, Donovan DM, Jurkovich GJ, Daranciang E, Dunn CW, Villaveces A, Copass M, Ries RR. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg* 1999; 230:473-80.
5. Schermer CR, Moyers TB, Miller WR, Bloomfield LA. Trauma centre brief interventions for alcohol disorders decrease subsequent driving under the influence arrests *The Journal of Trauma Injury Infection and Critical Care* 2006; Vol11: 29-34
6. Whitlock EP, Polen MR, Green CA, Orlean T, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the US Preventive Services Task Force. *Ann Intern Med.* 2004;140:557-568.

# Questions and Answers

- Use the Q&A pod to type your questions for Dr. Goplerud and Ms. Reimann. We will attempt to get to as many questions as possible.
- Post webinar course evaluation and post test link – <http://www.surveymonkey.com/s/MV2TNG8>
- For those seeking CE credits – post-test and course evaluation needs to be completed no later than 9:00 pm, Eastern, today.

# Upcoming Webinars

- August 25- 2:00 – 3:30 pm Eastern – Peer Support and Outcomes Measures
- September 29- 2:00 – 3:30 pm Eastern – Integrated Care Approaches