

# What is the evidence for drug SBIRT in general health settings and what does it mean?

July 1, 2015

*IRETA Webinar*

Richard Saitz MD, MPH

Chair, Department of Community Health Sciences  
Professor of Community Health Sciences & Medicine  
Schools of Public Health and Medicine  
Boston Medical Center

Senior Editor, *Journal of Addiction Medicine*

BOSTON  
UNIVERSITY



Clinical Addiction Research and Education

# Disclosures of potential conflicts of interest

- Grants to the institution that employs me, from the US government (National Institutes of Health) to study this topic
- Payments to me as editor of publications on this topic (e.g. UpToDate)
- I am interested in practice and policy being based on the best available evidence, whatever that evidence is

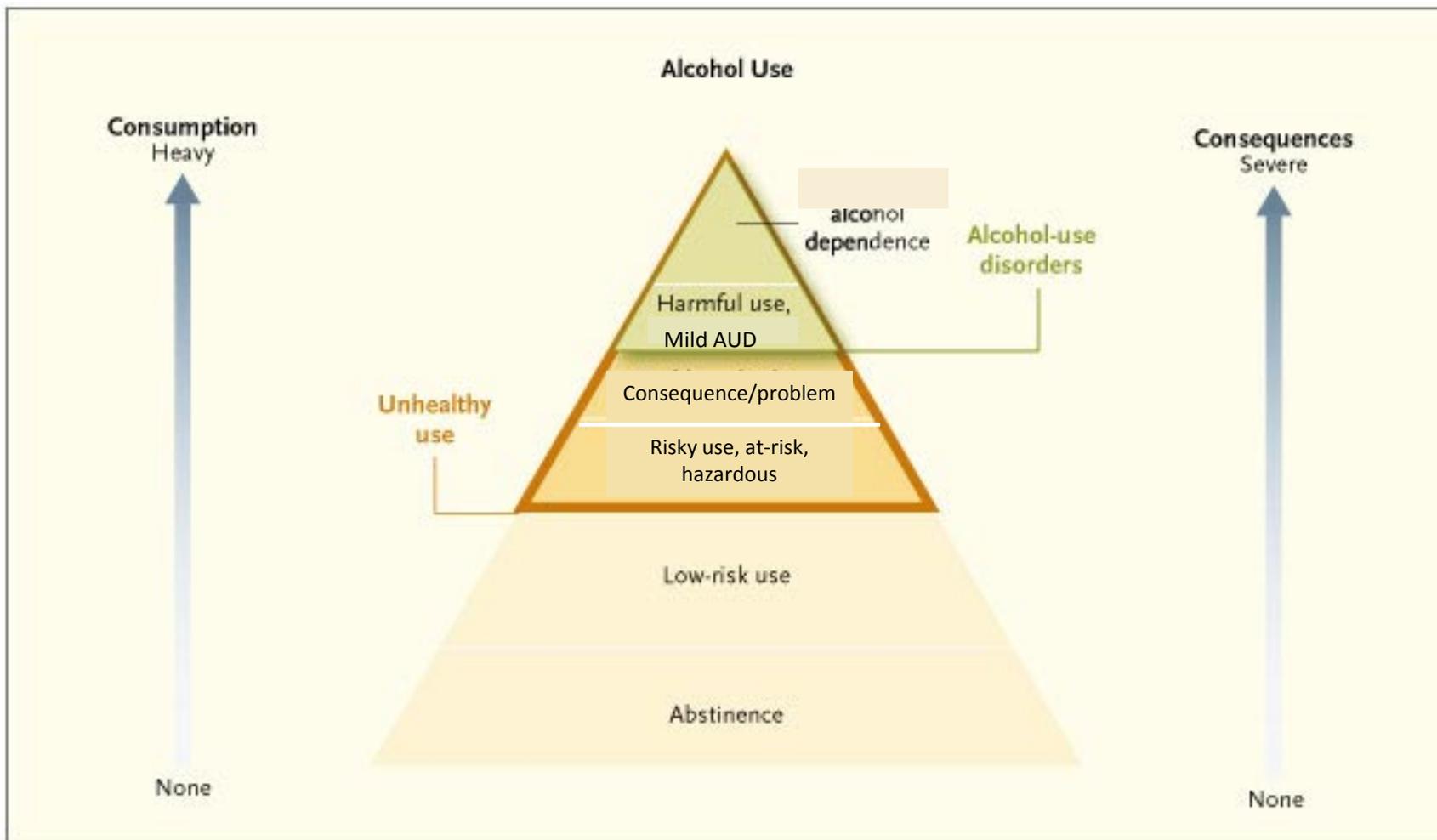
# Objectives

- Review randomized controlled trial evidence in the peer-reviewed literature that addresses whether or not drug SBIRT is efficacious for adults in general health settings
- Interpreting such trials
- Implications for clinical practice and SBIRT programs

# A few assumptions/definitions

- Screening (universal, brief); not treatment-seeking
- General health setting
- Evidence for efficacy IN SUCH PEOPLE AND SETTINGS (CONTEXT) is required (randomized trials)
  - Well-agreed upon by bodies that recommend preventive interventions in general health
  - Precautionary principle: action in face of uncertainty is not without consequences
- Adults
- Unhealthy use

# UNHEALTHY USE





Search SAMHSA.gov

Search



[Find Help](#) [Health Topics](#) [Programs & Campaigns](#) [Grants](#) [Data](#) [Health Reform](#) [About Us](#) [Publications](#)

[Programs & Campaigns](#) » [Screening, Brief Intervention, and Referral to Treatment](#)



Give your **feedback** today! ↗



## Screening, Brief Intervention, And Referral To Treatment (SBIRT)

SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. Many different types of community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

### Contact

**Reed Forman**  
Lead Public Health Advisor  
[Reed.Forman@SAMHSA.hhs.gov](mailto:Reed.Forman@SAMHSA.hhs.gov) ✉  
240-276-2416

**Erich Kleinschmidt**  
Public Health Advisor  
[Erich.Kleinschmidt@SAMHSA.hhs.gov](mailto:Erich.Kleinschmidt@SAMHSA.hhs.gov) ✉  
240-276-2912

**Kellie Cosby**  
Public Health Advisor  
[Kellie.Cosby@SAMHSA.hhs.gov](mailto:Kellie.Cosby@SAMHSA.hhs.gov) ✉  
240-276-1876

### About SBIRT

» Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.

### Coding for Reimbursement

Reimbursement for screening and intervention is available through...



## Alcohol Screening and Counseling

An effective but underused health service

At least 38 million adults drink too much and most are not alcoholics. Drinking too much includes binge drinking, high weekly use, and any alcohol use by pregnant women or those under age 21. It causes about 88,000 deaths in the US each year, and costs the economy about \$224 billion. Alcohol screening and brief counseling can reduce drinking on an occasion by 25% in people who drink too much, but only 1 in 6 people has ever talked with their doctor or other health professional about alcohol use. Talking with a patient about their drinking is the first step of screening and brief counseling, which involves:

- ◊ Using a set of questions to screen all patients for how much and how often they drink.
- ◊ Counseling patients about the health dangers of drinking too much, including women who are (or could be) pregnant.

### A Step-by-Step Implementation Guide for Trauma Centers



 **38 Million**

At least 38 million adults in the US drink too much.

**1 in 6** 

Only 1 in 6 adults talk with their doctor, nurse, or other health professional about their drinking.







# Physician Unawareness of Serious Substance Abuse

Richard Saitz, M.D., M.P.H.<sup>1\*</sup>

Kevin P. Mulvey, Ph.D.<sup>2,5</sup>

Alonzo Plough, Ph.D., M.P.H.<sup>2,3,5</sup>

Jeffrey H. Samet, M.D., M.A., M.P.H.<sup>1,2,4</sup>

*<sup>1</sup>Clinical Addiction, Research and Education Unit  
Section of General Internal Medicine  
Boston Medical Center  
Boston University School of Medicine*



**Ask the screening question about heavy drinking days:**

**How many times in the past year have you had . . .**

**5 or more drinks in a day?**  
*(for men)*

**4 or more drinks in a day?**  
*(for women)*



One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

82% sensitive  
79% specific  
for unhealthy use



NIAAA. Clinicians Guide to Helping Patients Who Drink Too Much, 2007.  
Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. J Gen Intern Med 2009 24:783-8.

“How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?”

93% sensitive

94% specific

for past year use

### **Validation of Self-Administered Single-Item Screening Questions (SISQs) for Unhealthy Alcohol and Drug Use in Primary Care Patients**

*Jennifer McNeely, MD, MS<sup>1,2,3</sup>, Charles M. Cleland, PhD<sup>3,4</sup>, Shiela M. Strauss, PhD<sup>3,4</sup>, Joseph J. Palamar, PhD, MPH<sup>1,3</sup>, John Rotrosen, MD<sup>5</sup>, and Richard Saitz, MD, MPH<sup>6,7</sup>*

*J Gen Intern Med May 19, 2015*



*Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R.  
Arch Intern Med. 2010;170(13):1155-1160. doi:10.1001/archinternmed.2010.140.*

## Screening and Brief Intervention:

- \*Feedback w/-permission
- \*Advice
- \*Goal-setting
- \*Follow-up



“How many times in the past year have you had 5 (4 for women) or more drinks in a day?”

“You are drinking more than is safe for your health.”

“My best medical advice is that you cut down or quit.”

“What do you think? Are you willing to consider making changes?”

- \*other alcohol screening tools (e.g. AUDIT-C)
- \*assessment of severity and readiness
- \*non-confrontational, motivational interviewing-consistent/adaptations



# EFFICACY

# RANDOMIZED TRIALS OF SCREENING AND BRIEF INTERVENTION VS. NO SCREENING

NONE

# EFFICACY of BI among screen-identified patients with non-dependent unhealthy alcohol use

- Efficacious: **10-15" multi-contact**
  - $\geq 23$  original RCTs,\* many systematic reviews, **primary care**
    - **Lower proportion of drinkers of risky amounts**
      - 57% vs. 69% at 1 year (n=2784)\*\*; 11% risk diff (n=5973)\*
    - **Lower consumption** (n=5639)
      - by 15% (38 grams per week)(n=5639)\*\*\*; 3.6 drinks/wk (n=4332)\*
    - Accidents, injuries, liver problems, hospital/ER/primary care use, legal problems, quality of life: **insufficient evidence\***
      - Decreased hospital utilization ( $\geq 2$  RCTs)
      - Cost-effective (spend \$166, save \$546 medical, \$7780 society)
      - Decreased mortality (RR 0.47)(4 RCTs (n=1640))

\*Jonas DE et al. *Ann Intern Med* 2012

Kaner et al. *Drug and Alcohol Review* 2009;28:301–23

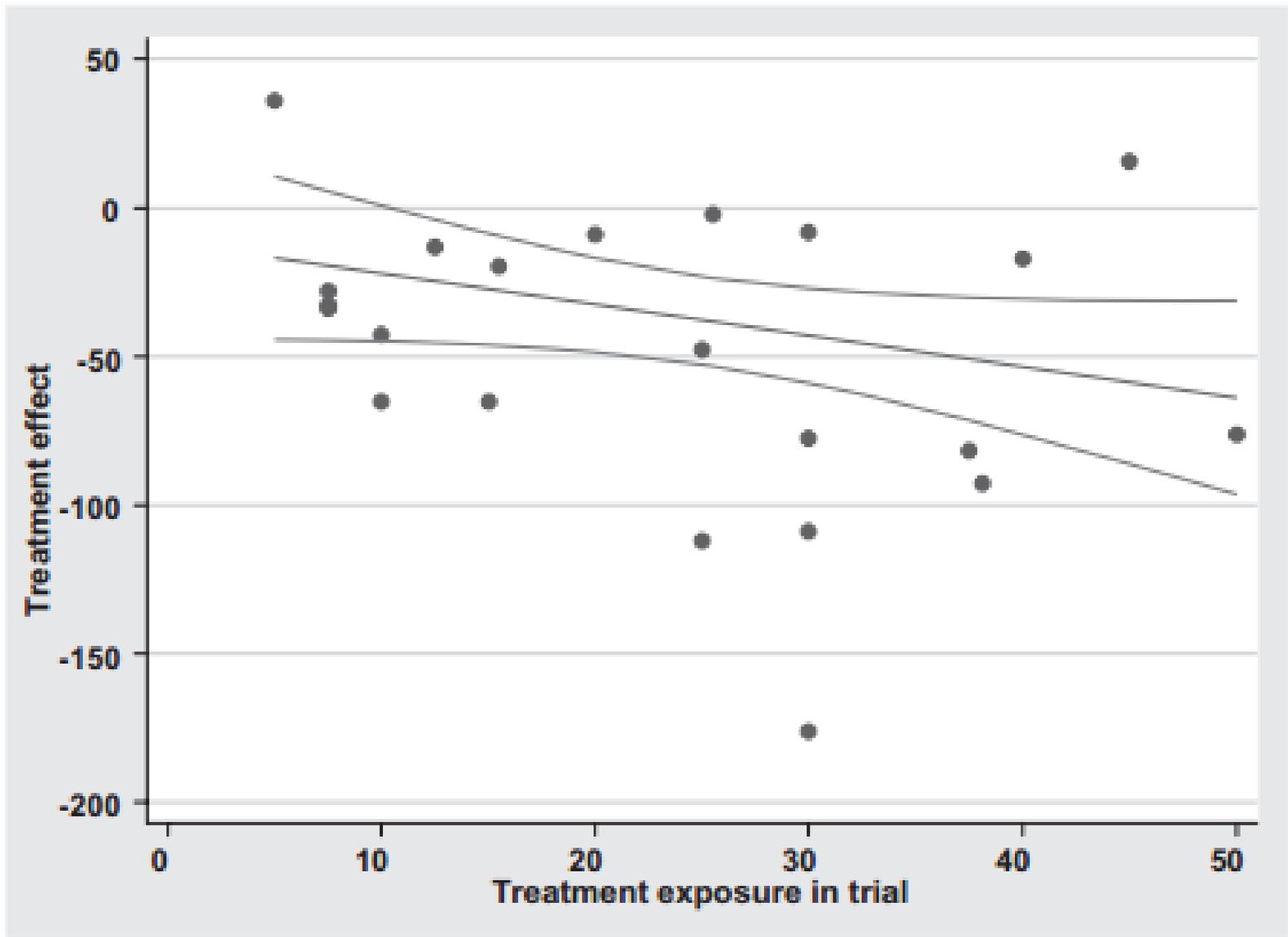
\*\*Beich et al. *BMJ* 2003;327:536

\*\*\*Bertholet et al. *Arch Intern Med.* 2005;165:986

Kristenson H, et al. *Alcohol Clin Exp Res* 1983;7:203 (mortality)

Fleming MF et al. *Alcohol Clin Exp Res.* 2002;26(1):36-43 (cost)

Cuijpers et al. *Addiction* 2004;99: 839–845 (mortality)



# MODIFIERS OF EFFICACY



*Whitlock et al. Ann Intern Med 2004;140:557-68*

*Kaner EFS et al. Ment Health Subst Use. 2011;4(1):38-61*

*Saitz R. Drug Alcohol Rev 2010; 29:631-640.*

*Jonas DE et al. Ann Intern Med 2012;157(9):645-654.*

*Kaner et al. Drug and Alcohol Review 2009;28:301-23*

# MODIFIERS OF EFFICACY

- Frequency (alcohol)
  - **Brief multi-contact**, 6/7 trials find efficacy
  - Very brief or brief single contact, 3/7 trials find efficacy



*Whitlock et al. Ann Intern Med 2004;140:557-68*

*Kaner EFS et al. Ment Health Subst Use. 2011;4(1):38-61*

*Saitz R. Drug Alcohol Rev 2010; 29:631-640.*

*Jonas DE et al. Ann Intern Med 2012;157(9):645-654.*

*Kaner et al. Drug and Alcohol Review 2009;28:301-23*

# MODIFIERS OF EFFICACY

- Frequency (alcohol)
  - **Brief multi-contact**, 6/7 trials find efficacy
  - Very brief or brief single contact, 3/7 trials find efficacy
- Comorbidity (BI among those with mental health condition or use of >1 substance)
  - **No effect** on use (or mental health)



*Whitlock et al. Ann Intern Med 2004;140:557-68*

*Kaner EFS et al. Ment Health Subst Use. 2011;4(1):38-61*

*Saitz R. Drug Alcohol Rev 2010; 29:631-640.*

*Jonas DE et al. Ann Intern Med 2012;157(9):645-654.*

*Kaner et al. Drug and Alcohol Review 2009;28:301-23*

# MODIFIERS OF EFFICACY

- Frequency (alcohol)
  - **Brief multi-contact**, 6/7 trials find efficacy
  - Very brief or brief single contact, 3/7 trials find efficacy
- Comorbidity (BI among those with mental health condition or use of >1 substance)
  - **No effect** on use (or mental health)
- Severity (alcohol)
  - **Little evidence for effect** (use/consequences) on those with **very heavy use or dependence**



*Whitlock et al. Ann Intern Med 2004;140:557-68*

*Kaner EFS et al. Ment Health Subst Use. 2011;4(1):38-61*

*Saitz R. Drug Alcohol Rev 2010; 29:631-640.*

*Jonas DE et al. Ann Intern Med 2012;157(9):645-654.*

*Kaner et al. Drug and Alcohol Review 2009;28:301-23*

# Addiction

Review

## Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials



Joseph E. Glass<sup>1,\*</sup>, Ashley M. Hamilton<sup>2</sup>,  
Byron J. Powell<sup>3</sup>, Brian E. Perron<sup>4</sup>,  
Randall T. Brown<sup>5</sup> and Mark A. Ilgen<sup>6</sup>

DOI: 10.1111/add.12950

This article is protected by copyright. All rights reserved.

Issue



Addiction

Accepted Article (Accepted, unedited articles published online and citable. The final edited and typeset version of record will appear in future.)

# Addiction

Review

## Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials

Joseph E. Glass<sup>1,\*</sup>, Ashley M. Hamilton<sup>2</sup>,  
Byron J. Powell<sup>3</sup>, Brian E. Perron<sup>4</sup>,  
Randall T. Brown<sup>5</sup> and Mark A. Ilgen<sup>6</sup>

DOI: 10.1111/add.12950

This article is protected by copyright. All rights reserved.

Issue



Addiction

Accepted Article (Accepted, unedited articles published online and citable. The final edited and typeset version of record will appear in future.)

- Systematic review, 13 RCTs, 1 excluded due to high risk of bias (results unchanged if included), 9 with sufficient data meta-analyzed
  - The only positive study: a letter mailed advising patient to go

# Addiction

Review

## Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials

Joseph E. Glass<sup>1,\*</sup>, Ashley M. Hamilton<sup>2</sup>,  
Byron J. Powell<sup>3</sup>, Brian E. Perron<sup>4</sup>,  
Randall T. Brown<sup>5</sup> and Mark A. Ilgen<sup>6</sup>

DOI: 10.1111/add.12950

This article is protected by copyright. All rights reserved.

Issue



Addiction

Accepted Article (Accepted, unedited articles published online and citable. The final edited and typeset version of record will appear in future.)

- Systematic review, 13 RCTs, 1 excluded due to high risk of bias (results unchanged if included), 9 with sufficient data meta-analyzed
  - The only positive study: a letter mailed advising patient to go
- 6 studies had referral-specific interventions in the intervention group only; 2 in both groups; rest motivational but not specific referral description

# Addiction

Review

## Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials

Joseph E. Glass<sup>1,\*</sup>, Ashley M. Hamilton<sup>2</sup>,  
Byron J. Powell<sup>3</sup>, Brian E. Perron<sup>4</sup>,  
Randall T. Brown<sup>5</sup> and Mark A. Ilgen<sup>6</sup>

DOI: 10.1111/add.12950

This article is protected by copyright. All rights reserved.

Issue



Addiction

Accepted Article (Accepted, unedited articles published online and citable. The final edited and typeset version of record will appear in future.)

- Systematic review, 13 RCTs, 1 excluded due to high risk of bias (results unchanged if included), 9 with sufficient data meta-analyzed
  - The only positive study: a letter mailed advising patient to go
- 6 studies had referral-specific interventions in the intervention group only; 2 in both groups; rest motivational but not specific referral description
- Specialty care 2%-56% over next 3-18 mo (1 was 10 y)

# Addiction

Review

## Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials

Joseph E. Glass<sup>1,\*</sup>, Ashley M. Hamilton<sup>2</sup>,  
Byron J. Powell<sup>3</sup>, Brian E. Perron<sup>4</sup>,  
Randall T. Brown<sup>5</sup> and Mark A. Ilgen<sup>6</sup>

DOI: 10.1111/add.12950

This article is protected by copyright. All rights reserved.

Issue



Addiction

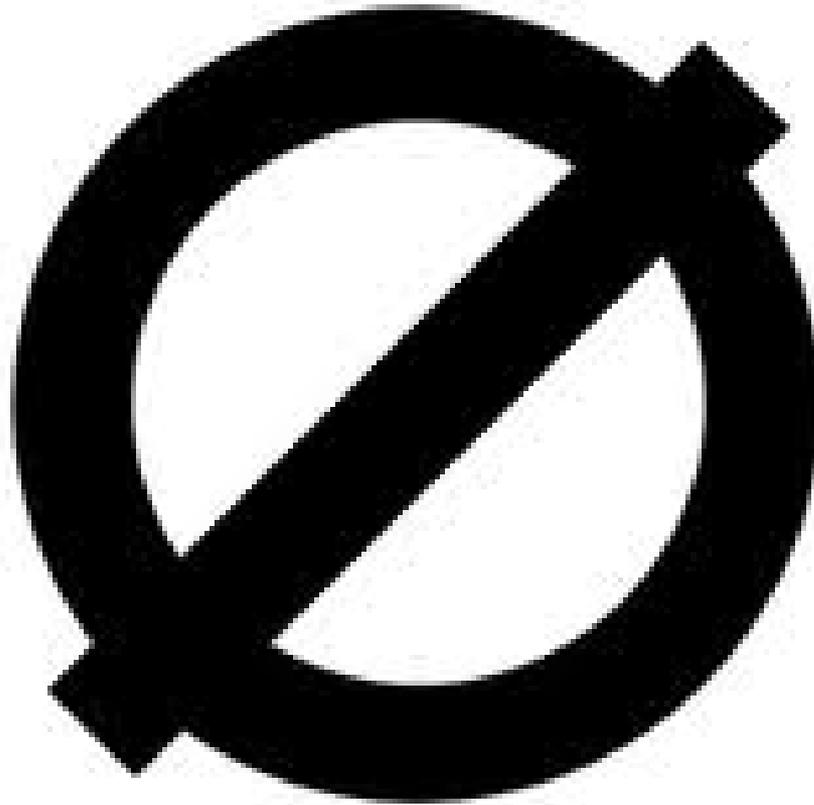
Accepted Article (Accepted, unedited articles published online and citable. The final edited and typeset version of record will appear in future.)

- Systematic review, 13 RCTs, 1 excluded due to high risk of bias (results unchanged if included), 9 with sufficient data meta-analyzed
  - The only positive study: a letter mailed advising patient to go
- 6 studies had referral-specific interventions in the intervention group only; 2 in both groups; rest motivational but not specific referral description
- Specialty care 2%-56% over next 3-18 mo (1 was 10 y)
- RR 1.08 (95% CI: 0.91-1.29)

# LACK OF, FOR THE RT IN SBIRT

**EFFICACY**

# Evidence that SBI prevents dependence (disorder)



# SETTING

- Most people identified by screening in hospitals have *dependence* (57-79%)
- Different expectations and goals
  - Comprehensive preventive longitudinal care?
  - Long-term therapeutic alliance?
  - Teachable vs. learnable moments?



4 hosps in Germany, Spain, US  
Belen Martinez et al INEBRIA 2007  
Saitz et al. *Ann Intern Med* 2007;146:167-76  
Freyer-Adam J et al. *Drug Alcohol Depend* 2008  
Bischof et al. *Int J Pub Health* 2010  
Saitz et al. *Int J Pub Health* 2010

# Cochrane Review: General Hospital

- 4 RCTs studied effects on drinking
- No effect on drinking when trial with high risk of bias excluded (and 3 trials excluded dependence\*)

\*or more severe drinking or treatment

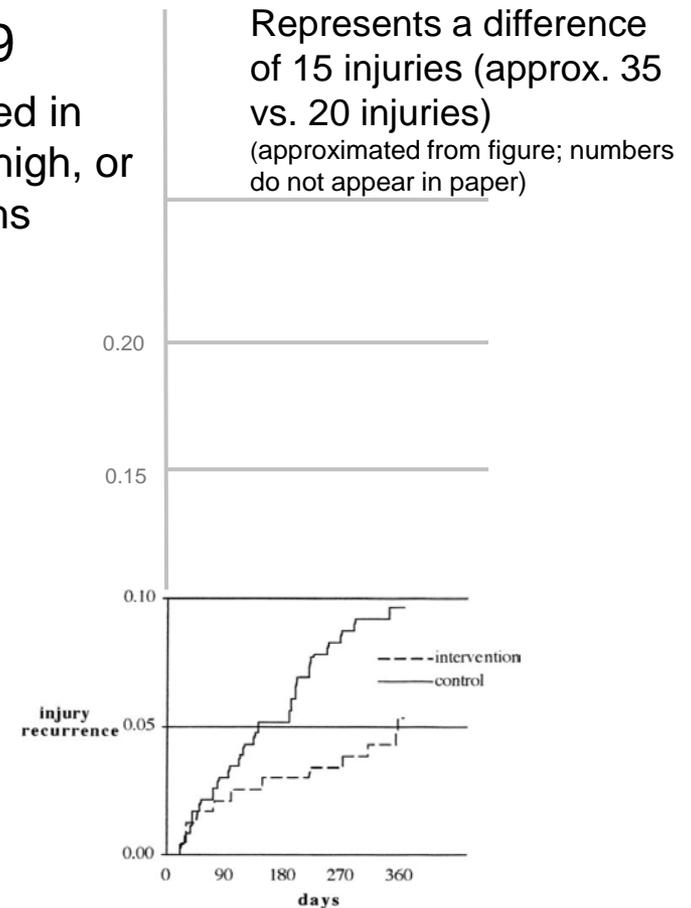
McQueen J et al. *Cochrane Database Syst Rev* 2011;8:CD005191.  
DOI: 10.1002/14651858.CD005191.pub3. NB 2009 “inconclusive”



# Trauma centers-hospitalized patients

- 1999, n=762
  - NS reduction in injury HR 0.52, CI 0.21-1.29
    - decreased consumption in 54% sub-sample located in follow-up, among those with intermediate but not high, or low, SMAST scores, evident at 12 but not 6 months
- 2006, n=126: no decrease in DWI except in adjusted analyses
- 2006, n=187: no differences
- 2007, n=497: no differences
- 2010, n=1336: effect among dependent

% hospitalized not reported



Gentilello LM et al. *Ann Surg* 1999;230:473  
 Schermer CR et al. *J Trauma*. 2006;60:29-34  
 Sommers MS et al. *J Trauma*. 2006;61:523-31  
 Soderstrom CA et al. *J Trauma*. 2007;62:1102-11  
 Field & Caetano *Drug Alcohol Dep* 2010;111:13-20

# A (small) bit of good news



© 2014 Society for the Study of Addiction



Addiction, 109, 754-765

- 20 sites-enhanced training MI (10 hrs); 878 patients
  - +BACs (but AUDIT <20)
- Providers: greater MI skills and time at bedside on SBI
  - RR 0.88 (95% CI 0.79-0.98) for unhealthy alcohol use,\*
  - 3 more abstinent days/90
  - No difference in heavy drinking days or alcohol-related consequences
  - No effect on the 50% who had traumatic brain injury



\*AUDIT >8 (men) >5 (women)

# Emergency Departments

- Two systematic reviews
- MAIN RESULT: Most studies-no impact on drinking; mixed effects on other outcomes (e.g. injuries)

(some, not all, with injured patients)

- Two later RCTs

- 2008: risky use or alcohol+injury, n=500, **no effect**
- 2012: risky use, n=899, BI **reduced** drinking, driving p drinking
  - No assessment effects (see also Daepfen et al 2007)

LIGHTER  
DRINKING  
12-14 drks/wk, 5-6 HDDs/mo;  
2/3rds AUDIT<8

HEAVIER  
DRINKING  
20-21 drks/wk, 7-8 HDDs/mo;  
mean AUDIT 11-12

*6 studies are included in both reviews*

*Nilsen P et al. J Subst Abuse Treat 2008; 35:184-201*

*Havard A et al. Addiction 2008; 103:368-76*

*D'Onofrio G et al. Ann Emerg Med. 2008; 51(6):742-750*

*D'Onofrio G et al. Ann Emerg Med 2012;60(2):181-92.*



UNKNOWN EFFECTIVENESS



DOES NOT WORK

# Before-After study of alcohol/drug SBIRT

- 10% sample of >450,000 screened + heavy alcohol or any drug use
  - The 3622 at 4 sites with good follow-up (<10% of initial 10% sample)
- Of those using the drug at baseline (100%), 6 month use was:
  - 100%>>33% marijuana
  - 100%>>21% cocaine
  - 100%>>15% methamphetamine
  - 100%>>27% heroin
  - 100%>>16% other drugs

# Small or focused studies of drug SBI

- n=59 adolescents in primary care in Brazil-decreased MJ and stimulant use and problems
- Short-term decrease in addictive prescription drug *use* by hospitalized patients
- Decreased marijuana use by adolescents in the emergency department in a randomized pilot study

- RCT in urgent care
  - 5-9% increase in cocaine/heroin abstinence
  - No difference in linkage to treatment
- RCT in varied outpatient settings, 5 countries
  - Excluded mild and severe; 3-month follow-up
  - Small (clinically insignificant?) decreases in drug use scores
    - US findings negative (trend towards worse in BI group, 9% diff,  $p=0.11$ )
      - Total score (range 0-338):
        - BI 36>30 vs Control 36>32 (7% diff)
      - Cannabis (range 0-39)
        - BI 18>14 vs Control 17>15 (8% diff)
      - Stimulant (range 0-39)
        - BI 17>12 vs Control 15>12 (14% diff)
      - Opioid (Studied in India only)
        - BI 23>13 vs Control 23>18

Research

Original Investigation

# Screening and Brief Intervention for Drug Use in Primary Care The ASPIRE Randomized Clinical Trial



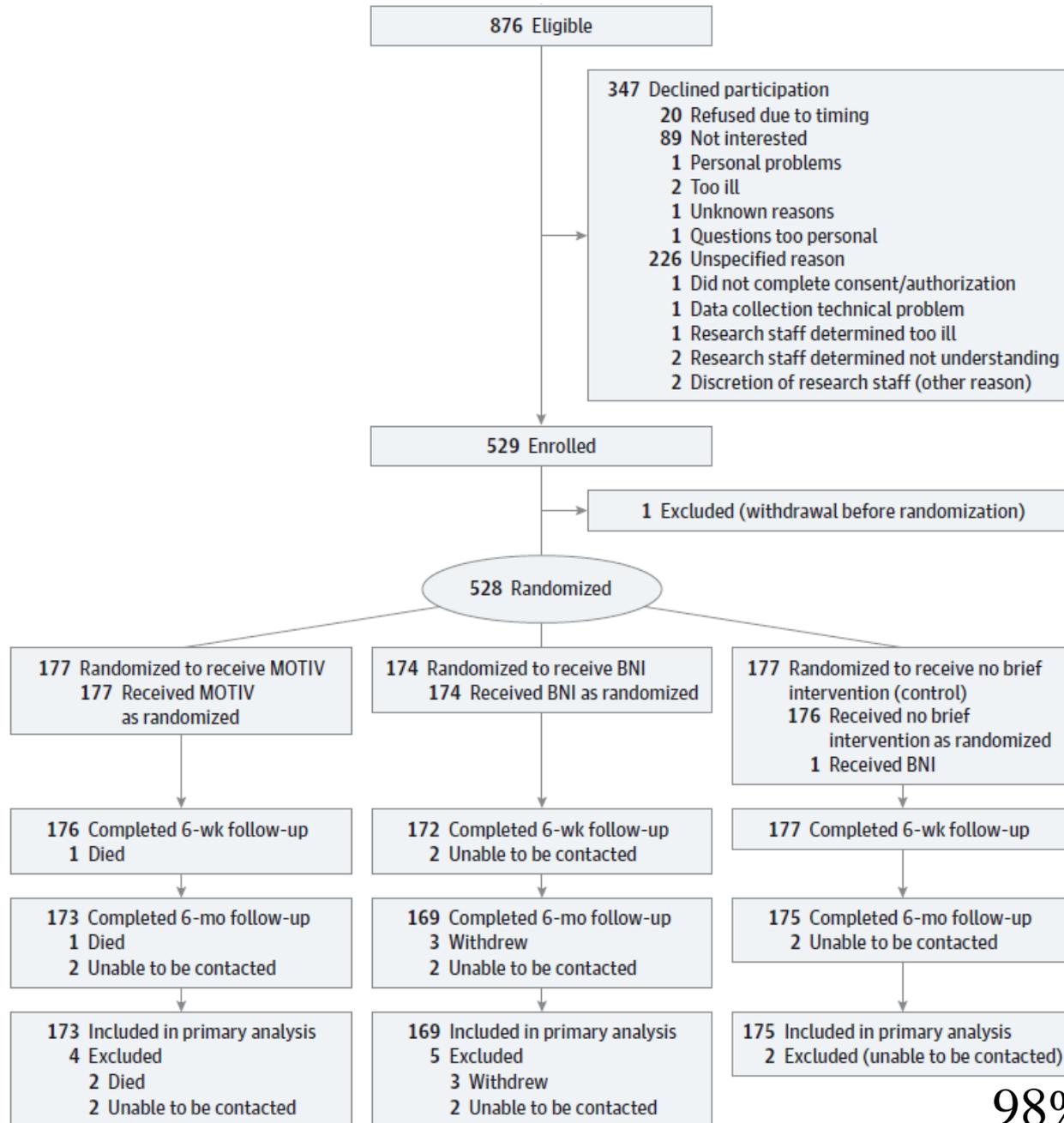
Richard Saitz, MD, MPH; Tibor P. A. Palfai, PhD; Debbie M. Cheng, ScD; Daniel P. Alford, MD, MPH; Judith A. Bernstein, PhD, RN, MSN; Christine A. Lloyd-Travaglini, MPH; Seville M. Meli, MPH; Christine E. Chaisson, MPH; Jeffrey H. Samet, MD, MPH, MA

**IMPORTANCE** The United States has invested substantially in screening and brief intervention for illicit drug use and prescription drug misuse, based in part on evidence of efficacy for unhealthy alcohol use. However, it is not a recommended universal preventive service in primary care because of lack of evidence of efficacy.

**OBJECTIVE** To test the efficacy of 2 brief counseling interventions for unhealthy drug use (any illicit drug use or prescription drug misuse)—a brief negotiated interview (BNI) and an adaptation of motivational interviewing (MOTIV)—compared with no brief intervention.

- ← Editorial page 488
- + Author Video Interview at [jama.com](http://jama.com)
- ← Related articles pages 492 and 543
- + Supplemental content at [jama.com](http://jama.com)

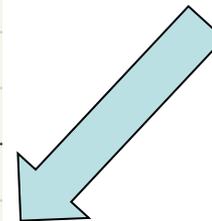




98% follow-up

Characteristic	Study Entry (n = 528)			
	Overall	BNI	MOTIV	Control
<b>Substance Use</b>				
<b>Main drug, No, (%)<sup>a</sup></b>				
Opioid (includes heroin, prescription, and others)	90 (17.1)	31 (17.8)	28 (15.8)	31 (17.5)
Prescription opioid only	30 (5.7)	8 (5.7)	10 (5.7)	12 (6.8)
Cocaine	98 (18.6)	32 (18.4)	33 (18.6)	33 (18.6)
Marijuana	331 (62.7)	109 (62.6)	111 (62.7)	111 (62.7)
CIDI-SF positive <sup>b</sup>	245 (46.4)	80 (46.0)	83 (46.9)	82 (46.3)
Tobacco use past year	403 (76.3)	142 (81.6)	130 (73.5)	131 (74.0)

Days using main drug past 30 d	
Median (IQR)	12.0 (3.0-27.0)
Mean (SD)	14.4 (11.5)
Days >1 time using main drug past 30 d	
Median (IQR)	5.0 (0.0-18.0)
Mean (SD)	9.8 (11.1)
Injection drug use past 3 mo, No. (%)	63 (12.1)
Use of >1 drug past 90 d, No. (%)	167 (31.6)
Misuse any prescription drug past 90 d, No. (%)	112 (21.2)
Heavy alcohol or drug use past 90 d, No. (%)	528 (100.0)
Any heavy drinking past month, No. (%)	254 (48.1)
No. of heavy drinking days past month	
Median (IQR)	0.0 (0.0-4.0)
Mean (SD)	4.5 (8.0)
ASSIST Scores <sup>c</sup>	
ASSIST score $\geq 27$	97 (18.4)
Substance-specific score	
Main drug, median (IQR)	15.0 (9.0-23.0)
Mean (SD)	16.8 (9.6)



**Table 4. Main Results: Effects on Days Using the Main Drug by Primary Care Patients With Unhealthy Drug Use Identified by Screening of Brief Interventions**

	No.	Predicted Mean <sup>a</sup> No. of Days Using Main Drug <sup>b</sup> in Past 30 Days at 6 Months <sup>c</sup>			BNI vs Control		MOTIV vs Control	
		BNI	MOTIV	Control	IRR (95% CI)	<i>P</i> Value <sup>d</sup>	IRR (95% CI)	<i>P</i> Value <sup>d</sup>
<b>Overall analysis<sup>e</sup></b>								
Unadjusted	517	14.2	14.1	13.8	1.03 (0.80-1.34)	.85	1.03 (0.79-1.33)	.85
Adjusted <sup>f</sup>	516	11.2	12.1	11.5	0.97 (0.77-1.22)	.81	1.05 (0.84-1.32)	.81
<b>Stratified by Main Drug<sup>b</sup></b>								
<b>Opioids</b>								
Unadjusted	88	7.0	8.0	8.8	0.80 (0.33-1.92)	.84	0.91 (0.38-2.21)	.84
Adjusted <sup>g</sup>	88	6.4	7.4	7.6	0.85 (0.35-2.07)	.96	0.98 (0.41-2.34)	.96
<b>Cocaine</b>								
Unadjusted	97	8.0	7.4	5.3	1.51 (0.78-2.91)	.31	1.41 (0.73-2.72)	.31
Adjusted <sup>g</sup>	97	5.7	7.2	5.0	1.15 (0.62-2.14)	.66	1.44 (0.78-2.65)	.48
<b>Marijuana</b>								
Unadjusted	323	18.3	18.2	18.0	1.02 (0.80-1.31)	.91	1.01 (0.79-1.30)	.91
Adjusted <sup>g</sup>	322	16.7	17.1	16.7	1.00 (0.80-1.25)	.99	1.02 (0.82-1.28)	.99
<b>Stratified by ASSIST Score<sup>h</sup></b>								
<b>ASSIST&lt;27</b>								
Unadjusted	424	14.3	14.3	14.2	1.01 (0.76-1.33)	.96	1.01 (0.76-1.33)	.96
Adjusted <sup>f</sup>	423	11.1	11.7	11.5	0.97 (0.76-1.23)	.86	1.02 (0.80-1.30)	.86
<b>ASSIST≥27</b>								
Unadjusted	93	13.5	13.1	12.2	1.11 (0.55-2.23)	.84	1.07 (0.54-2.12)	.84
Adjusted <sup>f</sup>	93	10.7	12.6	10.6	1.01 (0.52-1.98)	.97	1.19 (0.63-2.26)	.97

	Study Entry (n = 528)				6 Months (n = 517)			
	Overall	BNI	MOTIV	Control	Overall	BNI	MOTIV	Control
SIP-D score, median (IQR) <sup>a</sup>	6.0 (1.0-21.0)	6.0 (1.0-19.0)	7.0 (1.0-23.0)	5.0 (1.0-18.5)	3.0 (0.0-16.0)	4.0 (0.0-14.0)	3.0 (0.0-16.0)	3.0 (0.0-16.0)
Mean (SD)	12.0 (13.6)	12.1 (13.8)	12.7 (13.7)	11.3 (13.3)	9.3 (11.7)	9.3 (11.8)	9.2 (11.3)	9.4 (12.1)
Unsafe sex past 3 mo, No. (%)	277 (57.6)	95 (59.0)	94 (58.0)	88 (55.7)	263 (55.8)	88 (55.4)	82 (51.9)	93 (60.4)
No. of unsafe sex encounters past 3 mo, median (IQR)	3.0 (0.0-13.5)	3.0 (0.0-17.0)	2.0 (0.0-10.0)	2.0 (0.0-13.0)	2.0 (0.0-15.0)	2.0 (0.0-10.0)	1.0 (0.0-12.0)	4.0 (0.0-15.5)
Mean (SD)	16.1 (39.7)	13.9 (24.2)	17.6 (46.7)	16.7 (44.5)	13.2 (29.0)	12.7 (26.0)	14.0 (38.0)	12.9 (19.9)
Unsafe sex with nonprimary or transactional partners past 3 mo, No. (%)	50 (10.3)	14 (8.6)	19 (11.7)	17 (10.6)	65 (13.5)	21 (13.1)	19 (11.7)	25 (15.6)
Hair Testing, No. (%) <sup>b</sup>								
Any drug use	475 (96.2)	160 (97.0)	158 (95.8)	157 (95.7)	422 (92.8)	142 (94.7)	142 (92.8)	138 (90.8)
Any drug use (missing as positive)	490 (96.3)	164 (97.0)	163 (95.9)	163 (95.9)	452 (93.2)	150 (94.9)	152 (93.2)	150 (91.5)
Any opioids	86 (18.4)	34 (22.2)	19 (12.2)	33 (20.9)	67 (16.3)	28 (20.9)	21 (15.6)	18 (12.6)
Any cocaine or benzoylcegonine	249 (53.4)	81 (52.9)	89 (56.7)	79 (50.6)	199 (49.1)	62 (45.9)	70 (52.2)	67 (49.3)
Any carboxy-tetrahydrocannabinol	366 (75.6)	120 (75.9)	125 (77.2)	121 (73.8)	328 (74.7)	106 (73.1)	117 (79.6)	105 (71.4)
Days using main drug past 30 d								
Median (IQR)	12.0 (3.0-27.0)	14.0 (3.0-28.0)	10.0 (3.0-27.0)	12.0 (3.0-28.0)	11.0 (2.0-29.0)	11.0 (2.0-29.0)	11.0 (2.0-28.0)	9.0 (2.0-29.0)
Mean (SD)	14.4 (11.5)	15.1 (11.7)	13.8 (11.2)	14.3 (11.4)	14.0 (12.2)	14.2 (12.5)	14.1 (12.1)	13.8 (12.1)

92% used any drug by self-report, 3 mo

ASSIST scores 2,3 only. Adjusted for baseline use

		No BI	BNI	MOTIV	BNI vs. no BI		MOTIV vs. no BI	
	N	Adjusted Means			IRR (95% CI)	p-value	IRR (95% CI)	p-value
<b>Days used main drug</b>	57	6.4	2.1	2.3	0.33 (0.15,0.74)	0.01	0.36 (0.15,0.85)	0.02
<b>Exploratory analyses stratified by main drug</b>								
<b>Days used main drug (Cocaine, Opioids, and Other<sup>§</sup>)</b>	17	2.3	0.3	1.9	0.12 (0.03,0.43)	0.003	0.81 (0.17,3.91)	0.79
<b>Days used main drug -Marijuana</b>	40	7.4	3.6	3.1	0.49 (0.19,1.25)	0.13	0.42 (0.15,1.14)	0.13

Original Investigation

# Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings

## A Randomized Clinical Trial

Peter Roy-Byrne, MD; Kristin Bumgardner, BS; Antoinette Krupski, PhD; Chris Dunn, PhD; Richard Ries, MD; Dennis Donovan, PhD; Imara I. West, MPH; Charles Maynard, PhD; David C. Atkins, PhD; Meredith C. Graves, PhD; Jutta M. Joesch, PhD; Gary A. Zarkin, PhD

**IMPORTANCE** Although brief intervention is effective for reducing problem alcohol use, few data exist on its effectiveness for reducing problem drug use, a common issue in disadvantaged populations seeking care in safety-net medical settings (hospitals and community health clinics serving low-income patients with limited or no insurance).

**OBJECTIVE** To determine whether brief intervention improves drug use outcomes compared with enhanced care as usual.

**DESIGN, SETTING, AND PARTICIPANTS** A randomized clinical trial with blinded assessments at baseline and at 3, 6, 9, and 12 months conducted in 7 safety-net primary care clinics in Washington State. Of 1621 eligible patients reporting any problem drug use in the past 90 days, 868 consented and were randomized between April 2009 and September 2012. Follow-up participation was more than 87% at all points.

← Editorial page 488

← Related article page 502

+ Supplemental content at  
jama.com

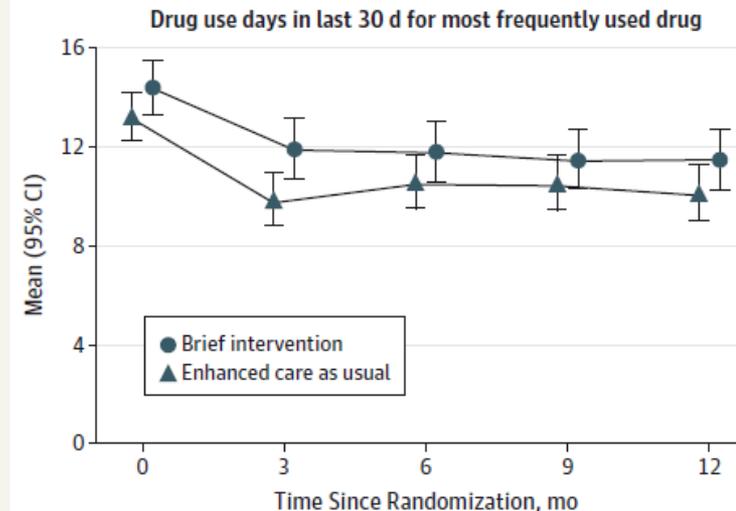
**INTERVENTIONS** Participants received a single brief intervention using motivational interviewing, a handout and list of substance abuse resources, and an attempted 10-minute telephone booster within 2 weeks (n = 435) or enhanced care as usual, which included a handout and list of substance abuse resources (n = 433).

**MAIN OUTCOMES AND MEASURES** The primary outcomes were self-reported days of problem drug use in the past 30 days and Addiction Severity Index-Lite (ASI) Drug Use composite score. Secondary outcomes were admission to substance abuse treatment; ASI composite scores for medical, psychiatric, social, and legal domains; emergency department and inpatient hospital admissions, arrests, mortality, and human immunodeficiency virus risk behavior.

**RESULTS** Mean days used of the most common problem drug at baseline were 14.40 (SD, 11.29) (brief intervention) and 13.25 (SD, 10.69) (enhanced care as usual); at 3 months postintervention, means were 11.87 (SD, 12.13) (brief intervention) and 9.84 (SD, 10.64) (enhanced care as usual) and not significantly different (difference in differences,  $\beta = 0.89$  [95% CI, -0.49 to 2.26]). Mean ASI Drug Use composite score at baseline was 0.11 (SD, 0.10) (brief intervention) and 0.11 (SD, 0.10) (enhanced care as usual) and at 3 months was 0.10 (SD, 0.09) (brief intervention) and 0.09 (SD, 0.09) (enhanced care as usual) and not significantly different (difference in differences,  $\beta = 0.008$  [95% CI, -0.006 to 0.021]). During the 12 months following intervention, no significant treatment differences were found for either variable. No significant differences were found for secondary outcomes.

**CONCLUSIONS AND RELEVANCE** A one-time brief intervention with attempted telephone booster had no effect on drug use in patients seen in safety-net primary care settings. This finding suggests a need for caution in promoting widespread adoption of this intervention for drug use in primary care.

**TRIAL REGISTRATION** clinicaltrials.gov Identifier: NCT00877331



## Gelberg et al. 2014 abstract

**DESIGN:** RCT, primary care, drug ASSIST scores 4-26

**INTERVENTION:** brief clinician advice, a video doctor, and 2 30-40” drug-use health education/reinforcement telephone sessions.

**CONTROL:** information on cancer screening.

**RESULTS:** n=334, 3 mo. follow-up 78%.

Reduction in highest scoring drug use days was 3.9 days larger in the intervention than in the control group, larger in patients with high baseline drug use, and with 2 or more contacts.

Laboratory testing (urine) in a subset





## Screening and brief intervention for unhealthy drug use: little or no efficacy

Richard Saitz<sup>1,2\*</sup>

**Table 1 | Randomized trial evidence regarding drug screening and brief intervention in adult general health settings<sup>a</sup> that include at least some primary care patients.**

Citation	Intervention	Result (between group differences at follow-up)	Comment
Gelberg et al. (34)	Very brief advice, video doctor, and two booster sessions	Less frequent (4 days) drug use at 3 months; effect larger among more severe	78% Follow-up; attention control; no biological testing; excluded those with likely moderate to severe disorder
Roy-Byrne et al. (35, 48)	Single BI with 1 week phone booster done by social workers	3, 6, 9, and 12 months outcomes. No significant differences in days drug use or drug use severity	Biological testing; 87% follow-up
Saitz et al. (36, 37)	Single 10–15 min health promotion advocate/health educator BI 45-min psychologist BI with one booster	6-month outcomes. No differences in days drug use or drug use severity, health-related quality of life, emergency department or hospital utilization or HIV risk behaviors	Biological testing; 98% follow-up
Humeniuk et al. (38)	Single BI largely done by clinic staff (some by researchers in Brazil)	Seven points or smaller difference in drug use risk scale with 338 points theoretical maximum at most sites except US where control group had greater decrease in the score	86% Follow-up; no biological testing; excluded those likely to have moderate to severe disorder <sup>b</sup>
Bernstein et al. (39)	Single BI done by health promotion advocate	5% Absolute risk increase in cocaine abstinence; 9% risk increase in opioid abstinence	Biological testing; 82% follow-up <sup>b</sup>

<sup>a</sup>Two additional studies have been done exclusively in emergency department settings. One had 58% loss to follow-up and found no benefit of SBI (40). The other, a multi-site trial, has not yet had results published (41).

<sup>b</sup>Some participants in primary care (see text for details).

Research



Original Investigation

# Screening and Brief Intervention for Drug Use in Primary Care The ASPIRE Randomized Clinical Trial

Richard Saitz, MD, MPH; Tibor P. A. Palfai, PhD; Debbie M. Cheng, ScD; Daniel P. Alford, MD, MPH;  
Judith A. Bernstein, PhD, RN, MSN; Christine A. Lloyd-Travaglini, MPH; Seville M. Meli, MPH;  
Christine E. Chaisson, MPH; Jeffrey H. Samet, MD, MPH, MA

**IMPORTANCE** The United States has invested substantially in screening and brief intervention for illicit drug use and prescription drug misuse, based in part on evidence of efficacy for unhealthy alcohol use. However, it is not a recommended universal preventive service in primary care because of lack of evidence of efficacy.

**OBJECTIVE** To test the efficacy of 2 brief counseling interventions for unhealthy drug use (any illicit drug use or prescription drug misuse)—a brief negotiated interview (BNI) and an adaptation of motivational interviewing (MOTIV)—compared with no brief intervention.

← Editorial page 488

+ Author Video Interview at  
jama.com

← Related articles pages 492 and  
543

+ Supplemental content at  
jama.com



Research



## Original Investigation

# Screening and Brief Intervention for Drug Use in Primary Care

## The ASPIRE Randomized Clinical Trial

Richard Saitz, MD, MPH; Tibor P. A. Palfai, PhD; Debbie M. Cheng, ScD; Daniel P. Alford, MD, MPH; Judith A. Bernstein, PhD, RN, MSN; Christine A. Lloyd-Travaglini, MPH; Seville M. Meli, MPH; Christine E. Chaisson, MPH; Jeffrey H. Samet, MD, MPH, MA

**IMPORTANCE** The United States has invested substantially in screening and brief intervention for illicit drug use and prescription drug misuse, based in part on evidence of efficacy for unhealthy alcohol use. However, it is not a recommended universal preventive service in primary care because of lack of evidence of efficacy.

**OBJECTIVE** To test the efficacy of 2 brief counseling interventions for unhealthy drug use (any illicit drug use or prescription drug misuse)—a brief negotiated interview (BNI) and an adaptation of motivational interviewing (MOTIV)—compared with no brief intervention.

← Editorial page 488

+ Author Video Interview at jama.com

← Related articles pages 492 and 543

+ Supplemental content at jama.com

## Original Investigation

# Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings

## A Randomized Clinical Trial

Peter Roy-Byrne, MD; Kristin Bumgardner, BS; Antoinette Krupski, PhD; Chris Dunn, PhD; Richard Ries, MD; Dennis Donovan, PhD; Imara I. West, MPH; Charles Maynard, PhD; David C. Atkins, PhD; Meredith C. Graves, PhD; Jutta M. Joesch, PhD; Gary A. Zarkin, PhD

**IMPORTANCE** Although brief intervention is effective for reducing problem alcohol use, few data exist on its effectiveness for reducing problem drug use, a common issue in disadvantaged populations seeking care in safety-net medical settings (hospitals and community health clinics serving low-income patients with limited or no insurance).

**OBJECTIVE** To determine whether brief intervention improves drug use outcomes compared with enhanced care as usual.

← Editorial page 488

← Related article page 502

+ Supplemental content at jama.com



JAMA. 2014;312(5):502-513. doi:10.1001/jama.2014.7862.

JAMA. 2014;312(5):492-501. doi:10.1001/jama.2014.7860

Research



Original Investigation

# Screening and Brief Intervention for Drug Use in Primary Care

## The ASPIRE Randomized Clinical Trial

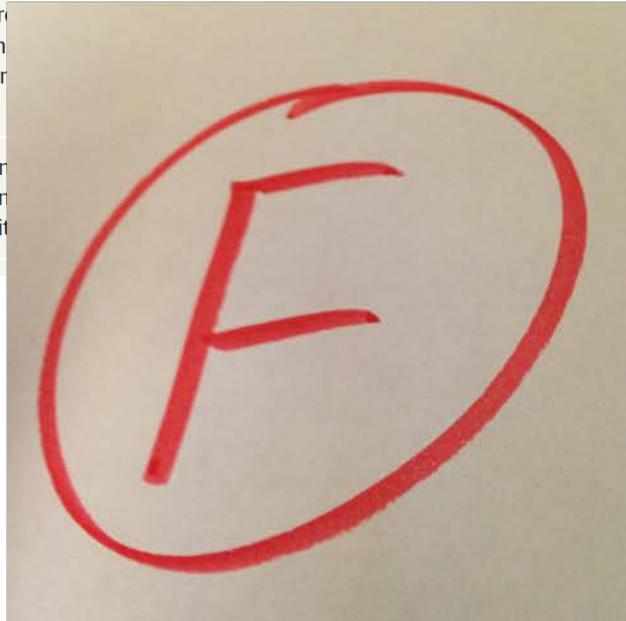
# NO DIFFERENCES

Richard A. Hays, MD, MPH; Tiffani P. A. Palfai, MD; Debbie M. Cheng, ScD; Daniel P. Alford, MD, MPH; Judith A. Bernstein, MD, RM, MSN; Christine A. Lloyd-Traglini, MPH; Sevil M. Mehta, MPH; Christine E. Chaisson, MPH; Jeffrey H. Samet, MD, MPH, MA

← Editorial page 488

**IMPORTANCE** The United States has invested substantially in screening for illicit drug use and prescription drug misuse, based in part on evidence of unhealthy alcohol use. However, it is not a recommended universal intervention in primary care because of lack of evidence of efficacy.

**OBJECTIVE** To test the efficacy of 2 brief counseling interventions for illicit drug use or prescription drug misuse—a brief negotiated in primary care and an adaptation of motivational interviewing (MOTIV)—compared with



## Drug Use in Safety-Net

Chris Dunn, PhD; Richard Ries, MD; C. Atkins, PhD; Meredith C. Graves, PhD;

**IMPORTANCE** Although brief intervention is effective for reducing problem alcohol use, few data exist on its effectiveness for reducing problem drug use, a common issue in disadvantaged populations seeking care in safety-net medical settings (hospitals and community health clinics serving low-income patients with limited or no insurance).

**OBJECTIVE** To determine whether brief intervention improves drug use outcomes compared with enhanced care as usual.



- ← Editorial page 488
- ← Related article page 502
- + Supplemental content at [jama.com](http://jama.com)

Research



Original Investigation

# Screening and Brief Intervention for Drug Use in Primary Care

## The ASPIRE Randomized Clinical Trial

Richard A. Hays, MD, MPH; Timothy P. A. Palfai, MD; Debbie M. Cheng, ScD; Daniel P. Alford, MD; Judith A. Bernstein, MD, RN, MSN; Christopher A. Lloyd-Traglini, MPH; Scott A. Holmbeck, MD, MPH; Jeffrey H. Samet, MD, MPH; and

Editorials represent the opinions of the authors and JAMA and not those of the American Medical Association.

# NO DRUGS

**IMPORTANCE** The United States has the highest rates of illicit drug use and associated health care costs and deaths.

Opinion

**EDITORIAL**

# Screening and Brief Intervention and Referral to Treatment for Drug Use in Primary Care: Back to the Drawing Board

Ralph Hingson, ScD, MPH; Wilson M. Compton, MD, MPE

## Screening and Brief Intervention for Drug Use in Safety-Net

Chris Dunn, PhD; Richard Ries, MD; C. Atkins, PhD; Meredith C. Graves, PhD;

**IMPORTANCE** Although brief intervention is effective for reducing problem alcohol use, few data exist on its effectiveness for reducing problem drug use, a common issue in disadvantaged populations seeking care in safety-net medical settings (hospitals and community health clinics serving low-income patients with limited or no insurance).

**OBJECTIVE** To determine whether brief intervention improves drug use outcomes compared with enhanced care as usual.



- ← Editorial page 488
- ← Related article page 502
- + Supplemental content at [jama.com](http://jama.com)

## Original Investigation

## Brief Intervention for Patients With Problematic Drug Use Presenting in Emergency Departments

### A Randomized Clinical Trial

Michael P. Bogenschutz, MD; Dennis M. Donovan, PhD; Raul N. Mandler, MD; Harold I. Perl, PhD; Alyssa A. Forcimes, PhD; Cameron Crandall, MD, PhD; Robert Lindblad, MD; Neal L. Oden, PhD; Gaurav Sharma, PhD; Lisa Metsch, PhD; Michael S. Lyons, MD, MPH; Ryan McCormack, MD; Wendy Macias Konstantopoulos, MD, MPH; Antoine Douaihy, MD

**IMPORTANCE** Medical treatment settings such as emergency departments (EDs) present important opportunities to address problematic substance use. Currently, EDs do not typically intervene beyond acute medical stabilization.

**OBJECTIVE** To contrast the effects of a brief intervention with telephone boosters (BI-B) with those of screening, assessment, and referral to treatment (SAR) and minimal screening only (MSO) among drug-using ED patients.

**DESIGN, SETTING, AND PARTICIPANTS** Between October 2010 and February 2012, 1285 adult ED patients from 6 US academic hospitals, who scored 3 or greater on the 10-item Drug Abuse Screening Test (indicating moderate to severe problems related to drug use) and who were currently using drugs, were randomized to MSO (n = 431), SAR (n = 427), or BI-B (n = 427). Follow-up assessments were conducted at 3, 6, and 12 months by blinded interviewers.

**INTERVENTIONS** Following screening, MSO participants received only an informational pamphlet. The SAR participants received assessment plus referral to addiction treatment if indicated, and the BI-B participants received assessment and referral as in SAR, plus a manual-guided counseling session based on motivational interviewing principles and up to 2 "booster" sessions by telephone during the month following the ED visit.

# N=1284

Table 2. Primary Outcome Analyses

Label	Days of Use of the Primary Drug of Abuse in the Past 30 d at the 3-mo Visit					
	Estimate No. of Days (95% CI)	Normal Model		Odds Ratio Estimate (95% CI)	β-Binomial Model	
		Unadjusted	Adjusted		Unadjusted	Adjusted
MSO vs BI-B	0.7174 (-0.8044 to 2.2391)	.36	.57	1.0622 (0.8771 to 1.2866)	.63	.63
SAR vs BI-B	0.7003 (-0.8254 to 2.2261)	.37	.57	1.1798 (0.9746 to 1.4281)	.14	.35
SAR vs MSO	-0.01701 (-1.5327 to 1.4987)	.98	.98	1.1106 (0.9188 to 1.3423)	.36	.36
Baseline use days	0.4287 (0.3740 to 0.4834)	<.001	NA <sup>a</sup>	1.0559 (1.0485 to 1.0634)	<.001	NA <sup>a</sup>
DAST-10 score	-0.5581 (-0.8525 to -0.2637)	<.001	NA <sup>a</sup>	0.8355 (0.8644 to 0.9278)	<.001	NA <sup>a</sup>
AUDIT-C score	-0.1811 (-0.3520 to -0.01019)	.04	NA <sup>a</sup>	0.9702 (0.9501 to 0.9907)	.02	NA <sup>a</sup>
Site (variance)	3.99	.08	NA <sup>a</sup>	NA <sup>b</sup>	NA	NA <sup>a</sup>
Error (variance)	113.62	<.001	NA <sup>a</sup>	NA <sup>b</sup>	NA	NA <sup>a</sup>

Abbreviations: AUDIT-C, Alcohol Use Disorders Identification Test; BI-B, brief intervention with telephone booster sessions; DAST, 10-item Drug Abuse Screening Test; MSO, minimal screening only; NA, not applicable; SAR, screening, assessment, and referral.

<sup>a</sup> Not adjusted for multiple testing in the model.

<sup>b</sup> The β-binomial model does not include an error term, and site was not included in this model because the β-binomial model does not allow a random site effect.

Blow et al. 2015 (June)

RCT computer v. in person BI; in ED patients

ASSIST 4+, 90% MJ, mean age 31, low SES, 1/5 suicidal thoughts  
81% 3 mo. F/U, urine testing in some (?)

In-person BI reduced self-reported days drug use over 6-12 months  
(effect size 0.2; by approx. 13/90 days, from 48 to 35)

Abstract book p.14

CPDD 77th Annual Meeting • Arizona Biltmore, Phoenix, Arizona









*Copyright 2008 John Crowther*



*"I've heard the saying, but I never thought it was something that could actually happen."*

*i believe*





*"If it's all the same to you, I'd rather eat this not knowing what the latest science suggests."*

# *Counting* Drug SBI RCTs

- Primary care
  - 2 null
  - 1 positive (abstract; unpublished)
- Emergency Department
  - 1 positive
  - 1 null (abstract; unpublished)
- Various sites
  - 1 mixed, clinically insignificant
  - 1 positive

# *Summarizing* Drug SBI RCTs

Many more patients in null studies; effect size in positive study small >> summary likely null

Adding methodological differences: will favor null studies

But can/should SBI studies be combined if BIs are different? Maybe not

# Adolescents: promising? Need study

- If this is a preventive service, and most people who will ever develop an SUD do so by age 25, why are we studying and doing SBIRT for middle-aged/older adults?
- Decreased MJ use (pilot, ED)(Bernstein E et al. Acad Emerg Med 2009;16:1174-85)
- Walton et al: n=328 adolescents with MJ use in PC
  - Computer intervention decreased consequences but not use
  - Therapist intervention decreased DUI but not use or consequences
- Walton et al: n=714 adolescents with **NO** MJ use
  - Computer intervention decreased any MJ use (17% vs 24%) and frequency of use
  - Therapist intervention did not

# What does the evidence mean?

- SBI for alcohol: non-dependent, primary care, multiple
  - Positive findings may be due to self-report bias
  - What about meaningful outcomes?
  - What should we do about more severe?
  - Role for one-time advice?
  - Any chance it can be implemented *and* retain effectiveness?
- SBI for drug: little evidence for efficacy; evidence it does not work in primary care; similar for emergency departments
- At the very least it is possible to do SBI very well and have it yield no benefit

# What does the evidence mean?

- Does SBI drug work for anyone? Who?
  - Studies that suggest efficacy are inconsistent—why?
    - Methods? (e.g. not truth)
      - Need biological testing, outcomes that matter to people (utilization, consequences of use)
    - Different interventions? (video, computer, repeated)
    - Setting? It *does* matter
    - Main drug? Probably matters (e.g. Rx drug and pain...)
  - Inefficacy still more probable than not
    - At best, it can be done but how, and how to replicate? What is it that is essential to make it work? And what is “it”?

# What does the evidence mean?

We may decide to do something regardless of evidence for efficacy, for other reasons

- Be clear and honest about that
- SBI may be the entrée for beginning to address substance use in healthcare
- Precautionary principle:
  - “Substance use is a big problem; we have to do something about it”
  - SBIRT is “cheap” (not really)
  - Action in face of uncertainty is not without consequences (opportunity costs, “problem solved,” stigma/medical records, increased use if done poorly?)

# What does the evidence mean?

- Policymakers believe in this; practitioners and patients have known all along it is more complicated
- Evidence does not make decisions; it informs us what to expect from our actions
- There are reasons to identify, assess and manage
  - To diagnose symptoms (e.g. insomnia, anxiety, tremor, heartburn, chest pain...)
  - To treat, e.g. with medications (...opioids...)
  - Screening tools aimed at supporting BI don't provide what is needed for Dx and Rx
- Better approaches in general healthcare needed

[rsaitz@bu.edu](mailto:rsaitz@bu.edu)

@unhealthyalcdrg

@JAM\_1ww

@EvidBaseMed\_BMJ

<http://www.bumc.bu.edu/care/>

<http://www.bu.edu/sph/academics/departments/community-health-sciences/>







What works?  
Clinical effectiveness.

# Cautions for the real world

- 29 GP practices were given training, newsletters, progress reports, and paid to screen for unhealthy alcohol use, and provide advice and counselling (cluster RCT of leaflet, advice, counselling)
- 40% needed the research team to come and do it
  - Even then, 43% of patients did not receive brief counselling to which they were assigned
- No differences in consumption, problems or quality of life



## RESEARCH

### Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial

OPEN ACCESS

**KING'S College LONDON** Institute of Psychiatry

Alcohol Screening and Brief Interventions

# From Research into Practice

A one day conference including findings from the SIPS Alcohol Screening and Brief Intervention Trials and the launch of SIPS Junior

**Monday 5th March 2012**  
Institute of Psychiatry,  
King's College London

Outline programme and application details on reverse

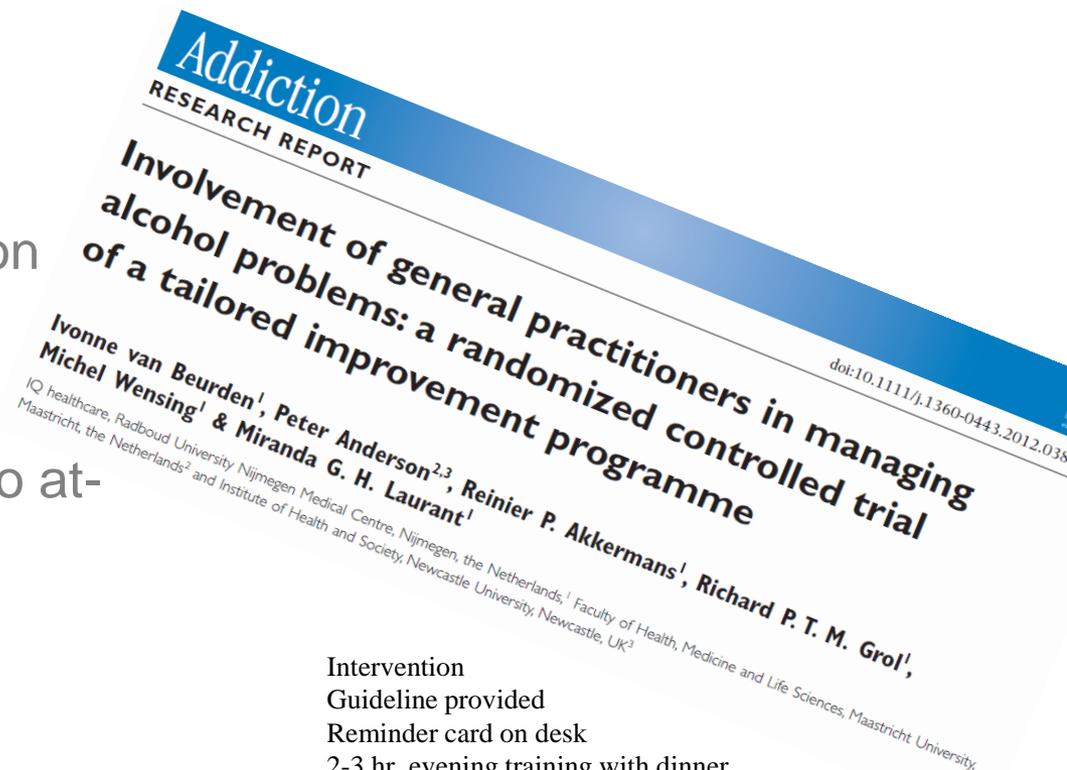
**SIPS**  
www.sips.iop.kcl.ac.uk  
Alcohol Screening & Brief Intervention Trailblazers

KING'S HEALTH PARTNERS

The poster features a large, detailed image of a glass of beer with a thick head of foam on the left side. The text is arranged to the right of the glass, with the King's College London logo at the top left and the SIPS logo at the bottom left. The overall design is clean and professional, using a mix of blue and black text on a white background.

# Cautions for the real world

- RCT of extensive implementation effort led to no increase and between group differences in screening of (10%) and advice to at-risk drinkers (3%)
- (No effect on drinking)



Intervention  
Guideline provided  
Reminder card on desk  
2-3 hr. evening training with dinner  
Feedback re: their own patients screened  
Facilitated linkage to local addiction treatment programs  
Outreach by trained facilitator  
Provision of self-help materials for distribution  
Waiting room poster



# Failures of implementation even with Herculean efforts Failures to effect change in drinking, consequences



746 clinicians in 120 European primary care practices **AGREED** to be in a trial of alcohol SBI implementation.

They screened **FIVE PERCENT** of 180,000 patients (most of whom were positive)

## What happens in real life screening and brief intervention EVEN WHEN PRACTITIONERS KNOW THEY ARE BEING OBSERVED?

VA: receipt of BI not associated with less drinking

VA: “do you drink?” “VA wants to know about it”

Audiotaped encounters with clinicians who were aware they were being recorded

Patient A: “Six beers . . . or maybe even 8 sometimes”

Provider 1: “Okay. Okay. Have you been able to take your medication on a regular basis?”

*No further exploration of patient’s drinking during this visit*

Patient B: “Well, I’ve been boozing”

Provider 2: “I know. I’m more concerned about your kidney function ...”

*Only reference to alcohol during this visit*



McCormick K et al. , J Gen Intern Med. 2006; 21(9): 966–972.

Bradley KA, et al. Am J Managed Care, 2006

Bradley KA and Williams EC. Principles of Addiction Medicine. 2009.

Lapham et al, Med Care, 2012

Williams EC et al. abstract presentations INEBRIA 2011, 2012

Characteristic	Study Entry (n = 528)			
	Overall	BNI	MOTIV	Control
Male sex, No. (%)	369 (69.9)	124 (71.3)	126 (71.2)	119 (67.2)
Race/ethnicity, No. (%) <sup>a</sup>				
Black	357 (68.8)	116 (68.2)	126 (72.4)	115 (65.7)
Hispanic	50 (9.6)	18 (10.6)	11 (6.3)	21 (12.0)
White	105 (20.2)	32 (18.8)	37 (21.3)	36 (20.6)
Other	7 (1.4)	4 (2.4)	0	3 (1.7)
Age, mean (SD), y	41.3 (12)	40.0 (12.2)	42.6 (12.2)	41.3 (12.5)
High school graduate or equivalent, No. (%)	369 (69.9)	119 (68.4)	127 (71.8)	123 (69.5)
Never married, No. (%)	328 (62.1)	105 (60.3)	108 (61.0)	115 (65.0)
Health insurance, No. (%)				
Private/commercial <sup>b</sup>	69 (13.1)	24 (13.8)	18 (10.2)	27 (15.3)
Medicaid/Medicare <sup>c</sup>	429 (81.3)	138 (79.3)	153 (86.4)	138 (78.0)
None	30 (5.7)	12 (6.9)	6 (3.4)	12 (6.8)

Health-related quality of life, mean (SD) <sup>f</sup>	70.3 (20.4)
Depressive symptoms (PHQ-9 $\geq 10$ ), No. (%) <sup>g</sup>	189 (35.8)
Anxiety symptoms (OASIS $\geq 8$ ), No. (%) <sup>h</sup>	176 (33.3)
Hospitalization past 3 mo, No. (%)	75 (14.2)
Hospitalization, addiction or mental health related past 3 mo, No. (%)	29 (5.5)
ED visit past 3 mo, No. (%)	189 (35.8)
ED visit for addiction or mental health past 3 mo, No. (%)	47 (8.9)
Mutual help group participation past 3 mo, No. (%)	93 (17.6)
Residential stay for addiction or mental health past 3 mo, No. (%)	43 (8.1)
Outpatient addiction or mental health treatment or counseling past 3 mo, No. (%) <sup>i</sup>	119 (22.6)