Webinar Question 1

- question: at the beginning of the presentation, you said it's a problem that PCPs aren't aware of certain patients' substance use disorder. if not SBIRT, what are some strategies to improve PCP awareness of the prevalence of SUDs in their patient population?

ANSWER: SBIRT is a full package that should lead to an improved clinical outcome. It generally does not so it is difficult to justify it. There is a subtle distinction here. Generalist clinicians when they are getting to know their patients should know about their substance use. One way to do that is universal screening of all patients with validated tools. But it is difficult to justify a specific approach to do that without a concrete outcome that will improve (note: the US Preventive Services Task Force does not recommend drug SBIRT. They are the premier professional practice organization with high standards when it comes to recommendations for preventive services and their recommendations in part relate to coverage under the affordable care act). Clinicians also need to know about substance use to diagnose and treat other conditions. But the screening tools promulgated in SBIRT are not necessarily the best ways to achieve that goal. For example, if an anesthesiologist needs to know if someone has used cocaine or opioids in the last 24 hours, knowing that the 10-item DAST score is 2 is useless information for them and does not give them the critical information they need.

The question sounds almost rhetorical, as if SBIRT, which largely is inefficacious except perhaps for risky alcohol use, is the only option, and as if the presence of a problem somehow justifies doing something that doesn't work because it is all we know how to do. Doesn't seem like a great argument. Of note, when I present the results of research on SBIRT internationally, audiences are not surprised at all and the questions are usually about why anyone would think it would work. In contrast, presentation of such findings in the US is often met with surprise and questioning of the results of the null studies, despite their consistency. This is likely in large part due to the existence of federal programs that support SBIRT, and the materials that claim SBIRT to be "evidence based."

Instead of applying something with limited or no efficacy to address a large and very important health problem just because it is seemingly the only thing we have, we need to address this in a better way through research and clinical care. For example, no one would be satisfied with "SBIRT" for heart disease. In fact most would think it ridiculous to try to affect such a wide ranging set of conditions by brief screening and brief intervention and then referral to a specialist for some. Clearly more is needed. The same is true for unhealthy substance use, likely.

Before research provides better answers, clinically I would suggest clinicians do need to ask about substance use and valid screening questions are one way to do so but they may need to ask more depending on the reason. When people are recognized, substance use does need to be addressed. But we need to be realistic and aware that a single brief intervention is unlikely to change the course of anything and done poorly could be counterproductive. Instead my best guess is that discussion over time, and addressing substance use like we address other chronic disease risk factors will be fruitful. And we need research on how to encourage people to seek more specialized help when needed, and on how to manage this risk factor and condition (depending on severity) longitudinally.

So the short answer is: do what we do for other health conditions. Make clinicians aware of the problem and how it connects to other conditions and symptoms. Given them tools to identify and manage. Make them aware of resources. This is entirely different from a universal SBIRT approach. That said many tools adopted for SBIRT do come from science and are of value, like screening questionnaires, and brief health behavior change counseling, to be used when appropriate. This is different from a universal preventive approach to treat a combination of risk conditions and diseases.

- Could part of the problem with SBI be in the difficulty of overcoming the fear of accurate selfreport? Fear of consequences of having drug use being in the medical record?

ANSWER: I am not sure what is meant by "problem: I don't think this is an explanation for null efficacy research results because in those cases participants are told their information will be confidential. However, yes, such fear can account for under-reporting in clinical practice. This is an issue that has been swept under the rug in "SBIRT." One issue is that we may miss people with the problem. More importantly however, is the issue the potential harm of having it in a record. For clinical reasons substance use should be in the record, but given discrimination and record releases for many purposes, more policies and regulations (both restrictions, and to encourage appropriate sharing in clinical teams and systems) around this are necessary to allow better care for people with substance use.

- Would you please talk more about the study utilizing a computer intervention with youth? What studies are underway for SBIRT and youth?

ANSWER: Sorry, that is beyond the scope of the talk but I would suggest searching google scholar for studies published by Sharon Levy, John Knight, Fred Blow and Maureen Walton, Judith Bernstein and Elizabeth D'Amico. I only mentioned adolescent SBI as a conceptual contrast to the work among adults. I can summarize though that to date there has been insufficient evidence to support adolescent SBIRT and the US Preventive Services Task Force does not recommend it. (in contrast to evidence for adult drug SBIRT—where there is good evidence it does not have efficacy). That said, I believe (not evidence) that if SBI is to work (not RT) that it will be more likely to have an effect when the condition or risk has not been present for a long time, like in younger people. That is a group in whom prevention may be efficacious and should be studied more.

- What interventions other than SBIRT do you think are most promising for addressing substance use disorders in general health settings?

ANSWER: Longitudinal care like we do for other disorders and risk factors. Assess it when relevant, and follow-up over time with reassessment. Offer those interested further counseling and feedback, referrals, medication when relevant, self-assessments and interventions (electronic for example). These approaches need study but my best guess is that repeating assessment and feedback over time will be helpful. At the same time, anything we do in the office will not be as successful as it could be until we make changes in culture and society. In other words, a 5 minute brief intervention is much less likely to be successful in a society and culture that promotes or minimizes the harms of alcohol and other drug use.

- in any of the studies cited: are there any indiations of assessing "fidelity" (or at least consistency) in the BI and/or RT?

ANSWER: Yes, I answered this one orally. The better methodological quality studies report this information in detail and also tend to be the null studies despite better and known quality intervention. It is beyond the scope of this Q&A to detail each study but for example the ASPIRE study from 2014 in primary care had very good fidelity and was measured systematically. A number of other studies have done similar assessments. Of note, many reports are beginning to appear in the literature finding that the specific skills that we teach in brief intervention and motivational interviewing, such as eliciting change talk, are *not* associated with improved outcome. This is a critical area for research to figure out what successful ingredients of BI might be.

- Could Dr. Saitz provide the citations for when SBIRT is deliverd in MH settings.

ANSWER: There are very few and I didn't mention these. In general SBIRT doesn't makes sense---it is too minimal---for MH settings. In MH settings all patients should detailed substance use assessments because 1) they may be causes of the MH problem, 2) they may exacerbate it, 3) they may interfere with treatment. A brief screen would be inadequate and one needs to know about risky use as well as severity. So in this circumstance SBIRT particularly makes little sense. A more extensive approach is indicated. The only study I mentioned related to mental health symptoms was the Kaner et al review that appears on the slide in which BI was found to lack efficacy when other substance use or mental health symptoms co-existed (of course, most people with substance use will be using another or have a mental health symptom so this too speaks to the limited possibilities with SBIRT).

- Can you discuss trials with direct comparison of multilpe vs. single alcohol SBI or is the inference of benefits for multiple contacts based on indirect comparisons?

ANSWER: I cant provide the citations of individual studies with direct comparisons. There are a few out there but not so much for primary care alcohol sbi per se. Many of the direct comparisons are not in that universal screening setting. But mostly what I was referring to, and this is for the risky nondependent alcohol use literature (for dependence, and other drugs the literature is too limited to draw any conclusions), was the Whitlock et al meta-analysis in 2004 and the Kaner et al 2009 review. Whitlock found that studies with multiple contacts were consistently positive, not so for single or very brief. Kaner found a nonsignificant association between duration and effect.

- Can you speak to the fact that your study had approx 80% of participants were Medicaid pts and the Roy-Bynes study had 90% participants were unemployed and both studies approx 50% had co-occuring mental health conditions? The participants in both studies appear to be quite unhealthy beyond their identified drug use.

ANSWER: yes. First, one could discount the results as being not generalizable. And then you would be left with no randomized trials to support efficacy in primary care. Second, in the ASPIRE study we assessed whether the intervention worked in people who did not have significant mental health symptoms and in people of higher SES. In both cases, the brief intervention still lacked efficacy. Third, it turns out that people who drink too much and use drugs often have other social ills. If the questioner is suggesting that SBIRT might work, but just not for people with low socioeconomic

status or mental health symptoms, having an intervention that doesn't work in those circumstances would be, well, close to useless, wouldn't it? The Gelberg et al study was done in FQHCs (similar low SES) and the Blow et al study was done in one of the poorest communities in the US (Flint Michigan) and 1/5 had recent suicidal ideation. And they detected effects on self report drinking. So perhaps those results should not be generalized if they are deemed to be valid? The efficacy of SBI for reducing self report drinking has not been limited to high SES populations (mental health symptoms are common there too). Note: in ASPIRE it was MH symptoms not diagnoses we measured. Does SAMHSA limit SBIRT recommendations only to high SES patients or patients with no MH symptoms? I don't think so. All that said, more trials would be useful. The onus is on all of us to produce a practice that has proven efficacy in a population that has the relevant condition. Has not yet been the case for drug SBIRT. It would not be informative to do a study of drug SBIRT in a population that is comprised only of wealthy, employed people with no mental health symptoms, if one could find such a population.

- Based on the evidence, what setting would you choose and how would you design the most effective SBIRT alcohol model

This was asked orally. In short, I would ask patients validated questions electronically before a primary care visit and give the results to a clinician. Clinicians should be able to counsel using good health behavior change techniques and also state how they think the problem is of particular importance to the specific patient. Behavioral health specialists should be available in the primary care practice to speak with patients who are willing immediately and to follow up as needed.

- have any trials looked at referral to education vs control or treatment?

ANSWER: Not to my knowledge. In general education is not effective for behavior change. And the issue with the R in SBIRT isn't so much what they receive it is that they don't go or receive anything. We are not good at changing someone who has just been screen-identified from not thinking it is a problem to wanting help and to change (despite motivational interviewing). But the questioner brings up a very good point. Maybe people aren't going because they don't want whatever it is they perceive treatment to be, yet they might be amenable to something else. What that is and looks like it s good question for research.

- Could you place some parameters on a few BIs?

ANSWER: in the literature it has ranged from 1-2 minutes to four 45 minute sessions. BI that is 1-2 to 15 minutes is often referred to as brief advice, and longer or repeated, Brief intervention. But it isn't only duration that has varied. Sometimes it is content, and approach (more or less like motivational interviewing, feedback or not, advice or not, etc). So they can differ and it isn't clear what might be essential if anything, for efficacy. Some have begun to speculate that efficacy is all about the therapist/counselor and less so about the specific technique.

- Has there been any studies about SBIRT with utilization of a peer support worker, individual with life experience, who is responsible for conducting the brief intervention?

ANSWER: Yes although I hesitate to guess at what "life experience" means. Does the questioner mean for example for a cocaine user who is an executive that there would be a counselor who is a peer? Or does this mean someone with a substance use disorder? In general, (as is true for other

medical conditions, people who have had the condition are no more successful at treatment than those who have not. This has been found to be specifically true for substance use disorders. I am not aware of a study that has compared peer counselors to others. I am aware of a review by Lynn Sullivan in which efficacy was not at all related to who did the counseling though most of the studies showing efficacy for alcohol were with primary care physicians. Bernstein et al tested SBI drug with health promotion advocates hired from the local community and found efficacy in urgent care as I cited. This raises questions about how well peers would need to be matched to patients and how feasible that would be? Would peer need to be matched on race, ethnicity, age, SES, gender, the community they live in, the specific type and severity of substance use disorder or risky use? Lastly, it has been observed that many people with a focus on alcoholism or drug addiction, and not risky use, have greater difficulty addressing risky use (not disorder) using motivational interviewing, perhaps in part due to personal experience and training in more severe disorders. The skills are quite different. So this is an unanswered question.

- "Hello Dr. Saitz. I know it was not the aim of this webinar, but could you explain more the issue "Teachable VS Learnable?"

ANSWER: Teachable refers to a circumstance that is ripe for behavior change counseling. Someone has a bad consequence of substance use and is hospitalized for it. They don't want it to happen again. The counselor connects the two things (substance use and the consequence) and discusses it as a way to motivate change and the person changes. Learnable is my own term. I mean that sometimes patients in the same circumstance make the connection themselves and they learn the two are connected and change on their own with no need for a counselor or other clinician to do BI.

- Is this a question of strategies focus: "Health Professional-centered vs. Patient-centered" (thank you in advance from Mexico).

ANSWER: I am uncertain of what the question means. BI is usually patient-centered, but sometimes a cookie cutter approach that suits a health system as a simple solution to a complex problem can be seen as Health professional centered.

- How applicable are studies done in other countries when it comes to SBIRT efficacy towards drug use? Cultural factors?

ANSWER: The only large one, and it included US patients too, was the Humeniuk WHO trial I cited and it had modest efficacy with no clinical significance. In general I think they are likely to be applicable. The approaches in BI are patient centered or are supposed to be. That said, some specific details like types of drugs, and cultural implications can be extremely important so BI may require cultural adaptation (drink sizes is one example; the way Muslim cultures view alcohol vs opioids is another). So there are issues here. But the literature on drug SBIRT is so limited we don't really know. That said, many alcohol SBI trials around the world have similar results. The onus is on us to show that drug SBIRT works in any circumstance. So far that has not been the case convincingly. There may be many reasons why it doesn't work and this comment raises the question of how many studies are enough to know something doesn't work? Usually studies are done to find out something has efficacy.

- After the Webinar I receive a comment from Eric Goplerud who asked that I clarify comments about the alcohol industry and SBIRT, the Brief Intervention Group (BIG) initiative and the hospital brief intervention group (BIG) initiative.

ANSWER: In an email Dr. Goplerud stated that "Diageo funding made up a small part of support for the BIG Initiative, and that no Diageo funds were used for the hospital BIG Initiative." "We sought and received unrestricted educational funds from Diageo to support the work that we had already begun to work with the EAP industry to screen EAP clients for alcohol problems and provide brief interventions or referral to specialists."

Substantively, regarding hospital alcohol screening and brief intervention, there was a Cochrane review which initially concluded lack of efficacy. The conclusion was amended in a revision to read that there was efficacy. However, the data upon which the statement was made was no different, and to summarize, there was no efficacy of alcohol BI for drinking when including only the 3 methodologically sound studies in the review. There are also no robust effects on any other outcomes. In addition, most alcohol SBI studies, including those in hospitals, exclude people with dependence. Yet the vast majority of unhealthy alcohol use identified by screening in hospitals is among people with dependence. So having a tool (BI) that doesn't match the population is not very useful even if one could show efficacy among a small subgroup. Offering alcohol and drug use disorder treatment at hospital discharge is a very good idea clinically, and is low hanging fruit because often these problems are ignored. Evidence to support efficacy of offering treatment to people with such disorders identified by screening, however, is nil. Best evidence so far is Glass et al's paper in the presentation, which provides evidence of no effect of referral (in primary care). In summary, offer treatment to people with the disorder in hospitals.

But as for SBI in hospitals as a universal recommendation or quality measure (such Joint Commission measures), the evidence is lacking. ""The BIG Hospital SBIRT Initiative is a ""learning collaborative to expand SBIRT into Hospitals and Other Medical Settings." It addresses unhealthy alcohol, drug and tobacco use. I have discussed the evidence regarding alcohol above and in my presentation. There is no convincing evidence for drug SBIRT in hospitals having efficacy. For tobacco there is evidence for efficacy though that was beyond the scope of the talk. The quality measures I displayed on the slide measure the occurrence of screening and brief intervention for alcohol in the hospital, and then also initiation of or referral to treatment for those with a disorder. Again, the evidence for efficacy of SBI for alcohol use in hospitals is not good (see above), and there is no evidence that starting treatment or referring to treatment of people identified by screening in hospitals will have efficacy. It may be a good idea as I note above, but that doesn't make it efficacious and certainly does not reach the level of evidence usually required by quality measures in general health care, where there have been many cases of unintended and costly and harmful consequences of quality measures implemented prematurely or with lack of sufficient evidence.

The only point to be made about liquor industry funding is that they appear to be funding SBI training and research efforts in the UK, the US and elsewhere. I speculate that this means they do not expect SBI to be very effective—that is my opinion, not based on evidence.