



State Issue Brief

Current Research on Screening and Brief Intervention and Implications for State Alcohol and Other Drug (AOD) Systems

This State Issue Brief has been prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) primarily for distribution to State Alcohol and Other Drug (AOD) Agencies and their constituents through support from the National Institute on Alcohol Abuse and Alcoholism (NIAAA). This Brief is unique in that it is not intended to be a comprehensive review of the science around a topic but rather a compilation of selected findings in an area and an exploration of the implications for administrators of AOD treatment systems.

INTRODUCTION

Screening- a preventive service provided in general health care settings- allows clinicians to intervene early in the course of disease or to prevent the disease before it can develop. Screening for alcohol problems can be used to identify individuals who may be at-risk for developing a problem with alcohol or who may already have a serious problem with alcohol. When used in conjunction with a brief intervention or referral to a treatment program, alcohol screening can be a powerful tool for improving the public health. Individuals who screen positive for at-risk drinking should receive what is called a "brief intervention" - one or more brief counseling sessions with a health professional that focuses on motivation to reduce harmful levels of drinking. Individuals who are found to have more severe problems including alcohol abuse or dependence, should be referred to the care of addiction professionals in specialized treatment programs. This brief will review current research in screening and brief intervention (SBI) in various settings, provide some examples of how State Alcohol and Other Drug (AOD) Agencies have implemented SBI programs, and discuss the implications for State AOD systems.

At-risk drinking is defined as having more than 14 drinks per week or more than 4 drinks per occasion for men, and more than 7 drinks per week or more than 3 drinks per occasion for women, and for men over 65 (U.S. Preventive Services Task Force, 2004). Additionally, even lower levels of alcohol use can create difficulties for individuals with co-existing mental health problems, or who are taking medications, or who are pregnant.

Epidemiological researchers have found that those who exceed the recommended limits are at increased risk for alcohol-related problems (Dawson, Grant, & Li, 2005). Nearly 3 in 10 U.S. adults engage in at-risk drinking; of that group of at-risk drinkers, about 1 in 4 suffers from alcohol abuse or dependence (NIAAA, 2006). The aim of SBI is to identify those 3 in 4 who are at-risk drinkers but may not be aware that their level of alcohol consumption puts them at risk and to deliver a brief intervention to lower their risk and consumption and to refer the 1 in 4 who suffer from alcohol abuse or dependence to traditional substance abuse treatment.

In 2005, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) published three documents that summarize the current research on SBI and encourage its use. Two Alcohol Alerts were published, titled "Screening for Alcohol Use and Alcohol-Related Problems" (NIAAA, 2005a) and "Brief Interventions" (NIAAA, 2005b). The third publication, "Helping Patients Who Drink Too Much: A Clinician's Guide" (NIAAA, 2005c) is aimed at clinicians in primary care and mental health settings and provides a step-by-step guide to clinicians on how to screen for alcohol problems, how to assess the different levels of alcohol problems, and how to offer advice and answer frequently asked questions. These reports can be found on the NIAAA web-site: www.niaaa.nih.gov.

SCREENING

Screening is the process of identifying whether or not an individual is an at-risk drinker who may be likely to develop or have an alcohol problem by evaluating responses to questions about drinking. A screening instrument that can be administered and scored quickly is often used. Through the use of valid screening instruments, clinicians can determine whether their client is a low-risk drinker who does not need an intervention or is an at-risk drinker who needs further assessment to determine the extent of his/her alcohol problem. After further assessment, the clinician may determine that the client could benefit from a brief intervention or may meet the criteria of alcohol use or dependence and benefit from a referral to a specialized treatment program.

In the NIAAA Clinician's Guide (2005c), two screening approaches are recommended. One recommended approach is to ask: How many times in the past year have you had five (for men) or four (for women) or more drinks in a day? If the answer is one or more times, the patient is considered an at-risk drinker. The other recommended approach is to administer the Alcohol Use Disorders Identifications Test (AUDIT), a written self-report instrument that takes about five minutes to complete. The AUDIT has been tested internationally in primary care settings, has high levels of validity and reliability, and is especially useful when screening women, minorities, and adolescents and young adults (Reinert & Allen, 2002). The AUDIT was developed by the World Health Organization and a free AUDIT manual with guidelines for use is available online at www.who.org. A score of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 is considered a positive screen. If positive screening results are obtained, the Clinician's Guide (2005c) provides a step-by-step set of instructions on how to proceed in delivering a brief intervention.

BRIEF INTERVENTION

A brief intervention is usually a short, one-on-one counseling session delivered by professionals such as physicians, nurses, psychologists, social workers and counselors who have been trained in delivering brief interventions. The length of time and number of sessions that constitute a brief intervention varies considerably; NIAAA's Alcohol Alert (NIAAA, 2005b) states that a brief intervention can range from one to four short counseling sessions. The intervention can take the form of computerized feedback or a follow-up telephone call as well. Brief interventions can easily be delivered in primary care settings,

emergency departments in hospitals and in other settings that include colleges, prenatal care and DWI programs. The goals of a brief intervention are to moderate a person's alcohol consumption to sensible levels, to eliminate binge drinking (defined as a pattern of drinking alcohol that brings blood alcohol concentration to 0.08 gram percent or above, typically five or more drinks, for males, or four or more drinks, for females, in about two hours ([NIAAA, 2004]), and to motivate those who need additional treatment to take the next step. A brief intervention typically includes a motivational interviewing (MI) approach, such as the one developed by Miller and Rollnick (Miller & Rollnick, 1991) which includes the following elements: Feedback, Responsibility, Advice, Menu or choice, Empathy, and Self-efficacy (FRAMES). Patients are provided feedback on where they fit in the spectrum of alcohol consumption. As described in the Clinician's Guide (NIAAA, 2005c), a brief intervention involves being matter-of-fact and non-confrontational, providing the patient educational materials, offering choices on how to make changes, emphasizing the patient's responsibility for changing drinking behavior, and conveying confidence in the patient's ability to change drinking behavior.

EFFECTIVENESS OF BRIEF INTERVENTIONS

In a large-scale study of primary care patients called Project TrEAT (Trial for Early Alcohol Treatment) the brief intervention consisted of two brief face-to-face sessions scheduled one month apart, with a follow-up telephone call two weeks after each session. The brief intervention was found to be effective, up to four years later, in reducing alcohol use, days of hospitalization, and emergency department visits as compared to control group patients (Fleming et al., 2002). Interventions that involve follow-up have been found to be more effective than single-contact interventions (Whitlock, Polen, Green, Orleans & Klein, 2004).

In their study of patients in a trauma center, Gentilello et al. (1999) were able to identify patients with unhealthy alcohol use based on screening (their response to a questionnaire) or testing (analysis of alcohol levels). Patients were then randomly assigned either to the control group or to the intervention group, which received a single 30-minute motivational interview conducted by a doctoral-level psychologist. Follow-up was conducted after 6 and 12 months. After 12 months, the intervention group decreased their weekly alcohol consumption significantly more (by 21.8 drinks) than the control group (by 6.7 drinks).

SCREENING AND BRIEF INTERVENTION SETTINGS

Primary Care

In primary care settings, SBI can be performed by a physician, a nurse practitioner or the trained office staff. In their research study, Ockene, Adams, Hurley, Wheeler & Herbert (1999) showed that nurse practitioners, with 2.5 hours of training, were able to successfully deliver brief interventions. With the assistance of office support staff, who gave a summary of the patient's alcohol history and handed out educational materials, nurse practitioners delivered a 5-10 minute patient-centered counseling session. Compared with patients who received usual care, at 6 months the intervention group had a significant reduction in the number of drinks consumed per week, but not in the number of binge episodes per month.

Another option for providing SBI in a physician's office is for patients to use an interactive computer program, via a computerized kiosk such as the Health Habits Survey, developed by Butler, Chiauzzi, Bromberg et al. (2003). This interactive, bilingual survey can provide tailored feedback intended to reduce the user's risky drinking; the user can print the report to take home and may authorize the physician or nurse practitioner to review the report. Though research studies have shown that real-life doctors were somewhat more effective than "video doctors," computer programs available in the doctor's waiting room have proven to be effective in reducing alcohol consumption, and they provide a low-cost alternative (Gerbert et al., 2003).

Emergency Departments and Trauma Centers

Hospital emergency departments and trauma centers are two other settings for delivering screening and brief intervention. As many as 24 to 31 percent of all patients who are treated in hospital emergency departments (ED) and as many as 50 percent of severely injured trauma patients have positive results when screened for alcohol problems (D'Onofrio & Degutis, 2002). In addition, patients treated in EDs are 1.5 to 3 times more likely than those treated at primary care clinics to report heavy drinking, adverse consequences of drinking, or having ever been treated for an alcohol problem (Cherpitel, 1999). In their article on SBI in emergency departments, D'Onofrio and Degutis (2004/2005) cite a number of studies that document the need for SBI, particularly among younger ED patients who tend to use EDs as their usual source of care. Younger ED patients may also have alcohol problems, such as binge drinking, and tend to drink and drive. D'Onofrio and Degutis (2002) cite a number of studies of ED patients who received SBI that showed promising results but had some methodological problems. Gentilello et al. (1999) were able to avoid these methodological problems in a study of trauma patients that showed that after a year, the intervention group decreased their weekly alcohol consumption significantly more (by 21.8 drinks) than the control group (by 6.7 drinks). This research suggests that a comparable study of emergency department patients might yield positive results.

A large concern among ED personnel is that, because of outdated Uniform Accident and Sickness Policy Provision Laws (UPPLs) that have been repealed in only a few States, if patients are identified as having been involved in an alcohol-related injury, insurance companies will deny coverage for the cost of their ED visit. Even though the National Association of Insurance Commissioners has adopted a new model law that bars insurers from denying coverage for alcohol-related injuries or conditions, supported by such other national organizations as the National Conference of Insurance Legislators and the American College of Emergency Physicians, State legislation has not caught up with these calls for reform (Chezem, 2004/2005). *Screening* with the use of structured questionnaires, as opposed to *testing* of blood alcohol levels, can perhaps avoid the problem of denial of insurance coverage in some cases, since it is more difficult for the insurer to demonstrate that the patient's general alcohol use was directly related to the insured's injury or other problem. Patients may also be denied benefits if they were injured in a criminal act, such as Driving While Intoxicated (DWI). These legislative matters still need to be addressed to enable successful delivery of SBI in EDs.

Prenatal Care Settings

According to the U.S. Surgeon General's recent advisory (Office of the Surgeon General, 2005), no amount of alcohol is considered safe for pregnant women, at any time in their pregnancy, and children whose mothers consumed 7 to 14 drinks per week suffered deficits in growth, behavior, neurocognition, visual-spatial abilities, attention and speed of information processing. The Surgeon General also noted that nearly half of all births in the U.S. are unplanned, encouraging health professionals to routinely inquire about alcohol consumption by women of childbearing age, informing them of the risks of drinking during pregnancy, and advising them to abstain from alcohol if they are considering becoming pregnant. The Centers for Disease Control and Prevention (CDC) report that the women who are more likely to drink during pregnancy are older (at least 35), non-Hispanic, educated beyond high school and have a high household income (CDC, 2002). The prevalence of any alcohol use by pregnant women was 12.8 percent in 1999, with 2.7 percent reporting frequent drinking (8 or more drinks per week) and 3.3 percent reporting binge drinking (5 or more drinks per episode) (CDC, 2002).

In her article on SBI in prenatal care settings, Chang (2004/2005) notes that the T-ACE Test (Tolerance - Annoyed, Capacity, Eye-opener Test [Sokol, Martier & Ager, 1989]) has been shown to be an effective screening instrument for identifying a range of alcohol use, including pre-pregnancy drinking and also found that brief interventions were effective in a number of prenatal research studies. In one example, 304 pregnant women who had screened positive on the T-ACE were randomized with a support partner of their choice to receive a brief intervention or not. Results indicated that the women with the highest levels of drinking at enrollment had the greatest reductions in drinking when they received the brief intervention, particularly when their partner participated (Chang et al., 2005). In another study, designed to intervene with women who had been drinking during their last pregnancy (Hankin, 2002), it was found that women who received the brief intervention drank

significantly less than those in the control group during their subsequent pregnancies and had better birth outcomes with fewer low-birth-weight babies.

College Settings

In their review of efforts to reduce problematic alcohol consumption including binge drinking among college students, Larimer and Cronce (2002) concluded that, although educational and awareness models had not been effective, brief motivational interventions were found to be relatively effective. They also found that the use of mailed or computerized feedback rather than in-person contact was effective in reducing alcohol use during relatively short follow-up periods.

More recently, Larimer, Cronce, Lee & Kilmer (2004/2005) reviewed SBI in college settings and discussed ways in which college students could be screened. Screening of all entering students could be one way to identify high-risk drinkers, but universal screening is expensive and presents institutional liability problems if a problem is identified and not addressed. Screening could also occur in campus health or counseling centers, or through campus judicial or grievance systems, where students who have violated campus alcohol policies would be required to be screened and to complete treatment. Several screening instruments have been found to be effective for this population, which include the College Alcohol Problems Scale - revised (CAPS-r), the AUDIT, and the Young Adult Alcohol Problems Screening Test (YAAPST).

Driving While Intoxicated (DWI) Programs – Criminal Justice Setting

SBI has the potential to become a promising approach when used for DWI offenders in the criminal justice system. A review of State administrative data systems found that in 2002, DWI/Criminal Justice referrals accounted for 40 percent of admissions for treatment of alcoholism only (SAMHA, 2004). In their review of 12 instruments used to screen DWI offenders, Chang, Gregory & Lapham (2002) found that the MacAndrew Alcoholism Scale (MAC) and the Alcohol Use Inventory (AUI) were rated the best at predicting recidivism and determining concurrent alcohol use disorders. Given the extended period of time for cases to move through the criminal justice system, a brief intervention delivered close to the time of arrest might be beneficial. The personalized feedback of a brief intervention might prove to be an effective supplement to the general education received in DWI Programs, or may even motivate the offender to seek treatment.

Although more research needs to be done in this area, the results of two studies demonstrate the value of considering this approach for this population. Davis, Baer, Saxon and Kivlahan (2003) found that DWI offenders who received brief motivational feedback (after completion of their jail sentences) were more likely to schedule follow-up treatment than were the control group. In the other study of first time DWI offenders attending a court mandated intervention, two 20-minute individual interventions and a brief follow-up session were added to the traditional intervention (three 2 ½ hour sessions of group discussion). It was found that the additional brief interventions reduced recidivism for offenders

with evidence of depression but not for offenders without evidence of depression (Wells-Parker & Williams, 2002).

National Alcohol Screening Day in a Variety of Settings

National Alcohol Screening Day (NASD) is an annual April event coordinated by Screening for Mental Health, Inc. and formerly funded by several federal agencies. NASD provides information about alcohol and health as well as free, anonymous screening for alcohol-use disorders. Event sites are located in community, college, primary health care, military and employment settings. Participating organizations receive detailed instructions for setting up a site, educational handouts, publicity materials, and the AUDIT screening test, with specific instructions on how to administer and score the test. In their overview of NASD from 2001 to 2003, Dupre, Aseltine, Wallenstein & Jacobs (2004/2005) show that both the number of sites and the average number of people screened at each site increased significantly in those three years. In 2001, 567 sites registered to participate; by 2003 that number had grown to 2,621. The average number of participants screened at each site grew from 36 in 2001 to 52 in 2003.

SCREENING AND BRIEF INTERVENTION AND STATE AOD SYSTEMS

Screening, Brief Intervention, Referral and Treatment (SBIRT) Programs

Screening and Brief Intervention, Referral and Treatment (SBIRT) is a grant program that includes a screening and brief intervention component for alcohol and other drugs, and a referral program for either brief treatment (a limited course of highly focused cognitive behavioral clinical sessions) or referral to traditional treatment providers for more intensive treatment. In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) funded five-year SBIRT Targeted Capacity Expansion grants with six States and a Tribal Council (SAMHSA/CSAT, 2006). The grant recipients include: Cook Inlet Tribal Council (Anchorage, Alaska), California, Illinois, Pennsylvania, New Mexico, Texas, and Washington State. In an additional \$15.5 million grant program over three years, in 2005 SAMHSA/CSAT awarded 12 SBIRT grants to colleges and universities to integrate SBIRT into campus health programs (SAMHSA, 2005).

The settings for many of these State SBIRT projects are hospital emergency departments and trauma centers as well as community health centers. They also involve some innovative new technologies; in New Mexico, the Sangre de Cristo Community Health Partnership is using videoconferencing

technology to provide SBIRT services to rural primary health clinics and school-based settings across ten counties. In addition to their services provided in emergency departments, community health centers, school-based clinics and primary care settings, Texas' project has partnered with Ask-Your-Nurse, a telephone information and referral system. Most projects target their interventions at adults; the New Mexico and Cook Inlet Tribal Council projects also target adolescents.

The State AOD Agencies collaborated with other agencies and partners in the States as they developed their plans, secured funding and implemented their programs. SBIRT grantees have implemented their projects differently in each State, in collaboration with county agencies, universities, foundations, and Addiction Technology Transfer Centers. Rather than providing a comprehensive review of all the different projects, this brief focuses on a case study, the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program and is based on an interview conducted on April 28, 2006 with Stephen O'Neil, WASBIRT Project Director.

WASBIRT has placed full-time chemical dependency professionals (CDPs) in nine hospitals statewide in six different counties. It should be noted that the use of CDPs to deliver the SBI is somewhat unusual. In other State SBIRT programs, SBI services are frequently delivered by health educators either alone or in combination with existing medical staff. The Division of Alcohol and Substance Abuse administers the project funds (\$16 million for five years), contracting with the different counties, who then contract with hospitals or community agencies to provide the services, so each program looks a little different based on the community. In some counties, the CDPs work directly for the hospital; in other counties, they are employed by community agencies and chemical dependency providers. Initially, only patients in emergency departments were targeted, but as social workers and doctors began to see the beneficial effects of SBIRT services, the program was expanded to the other floors.

The project staff works very closely with the Research and Data Analysis Division staff, who are responsible for the integrity of the data collection and the analysis of the results of the project. Each CDP has a personal digital assistant (PDA) so every response is recorded in the PDA. Before patients are screened, they are asked to fill out an 8-page consent form. About 70% of those approached agree to participate and, of those, 75% allow examination of administrative records as well. (It should be noted that Washington State is one of a handful of States that has repealed its UPPL laws regarding denial of insurance coverage due to alcohol related injuries.) Two screening instruments are used: the AUDIT (with a cutoff score of 8 for men, 7 for women) and the Drug Abuse Screening Test (DAST - 10). An intervention may also be delivered, even when the patient scores lower than the cut-off score, if there is an indication of binge drinking, the patient has used alcohol 6 hours before an injury, or if the CDP makes a clinical decision that a brief intervention would be beneficial to the specific patient. If an individual scores high enough to need a brief intervention, he/she is also asked to complete the Government Performance and Results Act (GPRA) Questionnaire, which collects extensive

demographic data. (In Pennsylvania's SBIRT program, screeners have found it helpful to ask just the first 2-3 questions on the AUDIT before determining if the full AUDIT is necessary (communication with Robin Rothermel, Pennsylvania Department of Health, May 24, 2006).

The brief intervention takes from 5 to 15 minutes, and is based on a motivational interviewing approach. The AOD Agency provides 24 hours of training for new staff on the consent process and the PDA application. The motivational interviewing training is delivered on an ongoing basis, as few CDPs have received that training in school and it is considered an integral part of the intervention.

As of May 16, 2006, 39,642 people have been screened and 22,792 had negative results. Of those that screened positive, 16,850 received a brief intervention. Of those who received a brief intervention 3,011 engaged in brief therapy and 2,152 engaged in traditional substance abuse treatment. In a sixth-month follow-up survey conducted on patients who were screened from April 2004 to January 2005, the 565 interviewed patients were broken down into three groups: those who received a brief intervention only; those who were referred to more therapy but chose not to engage in therapy; and those who were referred and did seek additional therapy (Estee, Lee & He, January 2006). Days of alcohol use dropped 26% for those who received only a brief intervention, 40% for those who were referred but did not seek additional therapy, and 77% for those high-risk users who obtained brief therapy or chemical dependency treatment. Binge drinking in the last 30 days declined even more significantly—46% for those who received only a brief intervention, 51% for those who were referred for further therapy but did not go, and 88% for those who were referred and did seek additional therapy. In another recent study, WASBIRT found that about 1 out of 2 ED patients used alcohol at potentially harmful levels (Estee, Lee & He, February 2006).

With regard to making the program sustainable beyond 2008, WASBIRT is working to make its SBIRT services funded under Medicaid, so they can be expanded to other hospitals and to other environments, such as medical clinics and colleges. Through newsletters and training, hospital staff is being exposed to SBIRT as a valid concept. Nursing staff at one of the sites have been trained (and they use a communal PDA) and another site has asked for a formal training of all the nurses (and as many doctors as can be recruited). WASBIRT does a monthly report on each site, and collects 6-month follow-up data. A significant amount of data has been generated on cost offsets. The data can be analyzed for each counselor regarding how many of those approached agreed to participate, how many were referred to therapy, and how many of those referred actually received therapy. Future plans include bringing together the most successful CDPs in order to develop a best practice model for how to conduct a brief intervention.

Screening and Brief Intervention (SBI) Program and Access to Recovery Program

The State of Connecticut Department of Mental Health and Addiction Services (DMHAS) is supporting screening and brief intervention services through two federal Center for Substance Abuse Treatment (CSAT) funded grants, a Targeted Capacity Expansion grant and an Access to Recovery grant. In October 2004, DMHAS, as the Connecticut AOD Agency, was awarded a three-year, \$1.5 million Targeted Capacity Expansion grant, the CT SBI Program, to implement SBI in two sites, the emergency department in the Hospital of St. Raphael's and a federally qualified health center, the Hill Health Center, which provides primary healthcare for inner-city residents of New Haven, Connecticut. At the same time the Connecticut AOD Agency was awarded an Access to Recovery (ATR) grant, another SAMHSA/CSAT-funded initiative that has as its goal to increase access to substance abuse services through independent assessment, participant choice of service providers, service linkages with faith-based and community-based organizations, and a voucher method of payment. Selected State AOD Agencies, through their Governor's Offices, are the grantees who received funds based on their proposed program to meet their particular needs. The Connecticut State AOD Agency chose to devote a portion of its ATR funds to support implementation of the CT SBI Program. Specifically, the Connecticut ATR Program provides clinical services, including Brief Treatment, and recovery support services to individuals screened and referred through the CT SBI Program.

Connecticut's project grew out of a policy paper and recommendations by the State's Alcohol and Drug Policy Council, a public/private group of stakeholders that develops Connecticut's strategic plan. The information presented below was derived from an interview with Sabrina Trocchi, the Executive Assistant to the Commissioner, Connecticut Department of Mental Health and Addiction Services, on May 9, 2006 and from materials she subsequently provided.

The CT SBI Program employs four full-time health educators (two at each site) to conduct the SBI. In developing this pilot project, the AOD Agency collaborated with the University of Connecticut Health Center and the Yale University School of Medicine, both of whom train (two weeks) and monitor the health educators. All individuals 18 or over are approached for screening at the two sites. Patients are asked to sign a consent form agreeing to answer questions and to participate in a 6-month follow-up evaluation. Patients are screened with the ASSIST, which consists of 8 questions covering alcohol, tobacco, and other drugs and takes about three minutes to complete. Individuals whose ASSIST score is between 6 and 15 (for alcohol, between 2 and 15 for other substances) are offered a brief intervention; if it is higher than 15, or they have injected any substance within the last 3 months, they are referred to treatment by another provider, and the health educator assists in scheduling the appointment. (An important part of the ATR grant is the linkages with providers and the expansion of the list of providers, with new service providers bringing the number of providers to over 120).

The brief intervention lasts an average of 6-8 minutes and is generally no longer than 15 minutes. A Motivational Interviewing approach is used, along with an ASSIST personalized score card that describes the relevance of the patient's score in terms of potential harms and associated risks and how that level compares with the population norms. A booklet discussing strategies and coping skills, identifying high-risk situations etc., is provided along with the brief intervention; it is written in easy-to-understand language (English and Spanish) and is pictorial. A follow-up phone call is scheduled within a week of the intervention.

From April 2005 through March 2006, 5,256 individuals were screened, 850 were provided a brief intervention, and 75 were referred to other services. The State of Connecticut has applied to SAMSHA/CSAT for a SBIRT grant in 2006. In terms of sustainability, the project is hoping to replicate the success of Yale University School of Medicine, who through their research grant on SBI in the Yale-New Haven Hospital (implemented five years ago), were able to have the costs of the two SBI health educators absorbed into the hospital's administrative costs.

The Role of State AOD Agencies

Screening with the use of a validated screening instrument has been shown to be effective at identifying clients who need further assessment, brief intervention, or referral. Brief Intervention has been shown to be effective at getting at-risk drinkers to cut down on their consumption. When combined, screening and brief intervention is an evidence-based practice that can be applied in a variety of settings. State AOD Agencies have worked with different partners to implement their SBI programs – policy councils, universities, county agencies, hospitals, health centers, school clinics, foundations, and providers – but their central role has remained the same, to seek out collaborative partners and facilitate the institutionalization of another promising approach to treating substance use disorders. State AOD Agencies have designed and developed SBI programs and obtained and secured funding to support the programs. Their current role has been to administer, coordinate, monitor, and evaluate the programs as they are implemented. Their role may also include devising ways to sustain SBI in the future once special funding is no longer available. State AOD Agencies with experience in SBI could share their knowledge and experience with other interested State AOD Agencies and serve as role models.

Successful implementation of SBI requires increased collaboration and coordination among stakeholders in the AOD treatment system and other related systems. Partnerships between State AOD Agencies and others in a variety of settings can be established that support the application of SBI as an evidence-based practice in non-specialty settings and, at the same time, recognize the importance of referring individuals with alcohol abuse and dependence to traditional treatment. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) and other interested stakeholders recently participated in a workgroup to identify, define, and request approval of HCPCS procedure codes from the Centers for Medicare and Medicaid (CMS). As a result, CMS announced in

its October 2006 Quarterly Update that two AOD HCPCS codes have been approved, H0049 Alcohol/Drug Screening – Alcohol and/or Drug Screening, and H0050 Alcohol/Drug Service 15 min. – Alcohol and/or Drug Service, Brief Intervention, per 15 minutes that are effective January, 2007. These codes will enable providers to bill more easily for treatment services.

State AOD Agencies may also wish to consider other ways that SBI could be used in the public treatment and prevention system. For example, screening and brief intervention or brief treatment could be delivered in the public treatment system after a client is screened and/or assessed but does not meet the diagnostic criteria of alcohol abuse and/or dependence. SBI could also be used for relapse recovery prevention to maintain recovery as recovered individuals return for aftercare or check-ups that are consistent with the chronic care delivery model. SBI is an evidence-based intervention that can be viewed as both a prevention strategy and a treatment approach, and offers additional avenues in various settings to reach individuals who may be at risk of developing or have a substance use disorder.

ADDITIONAL RESOURCES

For information on California's SBIRT program:

http://www.samhsa.gov/Matrix/programs_treatment_SBIRT.aspx

National Alcohol Screening Day (NASD) website: <http://www.mentalhealthscreening.org/events/nasd/>

Substance Abuse and Mental Health Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT): SBIRT website:

http://www.samhsa.gov/Matrix/programs_treatment_SBIRT.aspx

REFERENCES

- Butler, S.F., Chiauzzi, E., Bromberg, J.I., et al. (2003). Computer-assisted screening and intervention for alcohol problems in primary care. *Journal of Technology in Human Services, 21*, 1-19.
- Centers for Disease Control and Prevention (CDC). (2002). Alcohol use among women of childbearing age--United States, 1991-1999. *Morbidity and Mortality Weekly Report, 51*, 273-276.
- Chang, G. (2004/2005). Screening and brief intervention in prenatal care settings. *Alcohol Research & Health, 28*(2), 80-84.
- Chang, G., McNamara, T.L., Orav, E.J., Koby, D., Lavigne, B., Ludman, B. et al. (2005). Brief intervention for prenatal alcohol use: A randomized trial. *Obstetrics and Gynecology, 105*, 991-998.
- Chang, I., Gregory, C., and Lapham, S.C. (2002). *Review of screening instruments and procedures for evaluating DWI offenders*. AAA Foundation for Traffic Safety. Available online at http://www.aaafoundation.org/pdf/DWI_ScreeningReport.pdf
- Cherpitel, C.J. (1999). Drinking patterns and problems: A comparison of primary care with the emergency room. *Substance Abuse, 20*, 85-95.
- Chezem, Linda (2004/2005). Legal barriers to alcohol screening in emergency departments and trauma centers. *Alcohol Research & Health, 28*(2), 73-79.
- Davis, T.M., Baer, J.S., Saxon, A.J. & Kivlahan, D.R. (2003). Brief motivational feedback improves post-incarceration treatment contact among veterans with substance use disorders. *Drug and Alcohol Dependence, 69*, 197-203.
- Dawson, D.A., Grant, B.F. & Li, T.K. (2005). Quantifying the risks associated with exceeding recommended drinking limits. *Alcoholism: Clinical and Experimental Research, 29*(5), 902-908.
- D'Onofrio, G. & Degutis, L.C. (2002). Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Academic Emergency Medicine, 9*, 627-638.
- D'Onofrio, G. & Degutis, L.C. (2004/2005). Screening and brief intervention in the emergency department. *Alcohol Research & Health, 28*(2), 63-72.
- Dupre, M.A., Aseltine, R.H. Jr., Wallenstein, G.V. & Jacobs, D.G. (2004/2005). An overview of National Alcohol Screening Day: Trends from 2001 to 2003. *Alcohol Research & Health, 28*(1), 23-29.
- Estee, S., Lee, N. & He, L. (January 2006). *Substance Use Outcomes: Six-Month follow-up survey of WASBIRT clients April 2004-January 2005*. Department of Social and Health Services, Research and Data Analysis Division, Olympia, Washington Fact Sheet. Can be retrieved at: [http://www1.dshs.wa.gov/dasa/services/research/reports.shtml#Washington_State_Screening_Brief_Intervention_Referral_&_Treatment_\(WASBIRT\)](http://www1.dshs.wa.gov/dasa/services/research/reports.shtml#Washington_State_Screening_Brief_Intervention_Referral_&_Treatment_(WASBIRT))
- Estee, S., Lee, N. & He, L. (February 2006). *Substance-Use levels: Use of alcohol or other drugs reported by patients screened in hospital emergency departments April 2004 – December 2005*. Department of Social and Health Services, Research and Data Analysis Division, Olympia, Washington. Fact Sheet. Can be retrieved at: [http://www1.dshs.wa.gov/dasa/services/research/reports.shtml#Washington_State_Screening_Brief_Intervention_Referral_&_Treatment_\(WASBIRT\)](http://www1.dshs.wa.gov/dasa/services/research/reports.shtml#Washington_State_Screening_Brief_Intervention_Referral_&_Treatment_(WASBIRT))
- Fleming, M.R., Mundt, M.P., French, M.T., Maxwell, L.B., Stauffacher, E.A., & Barry, K.L. (2002). Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research, 26*, 36-43.
- Gentilello, L.M., Rivara, F.P., Donovan, D.M., Jurkovich, G.J., Daranciang, E., Dunn, C.W. et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery, 230*, 473-484.
- Gerbert, B., Berg-Smith, S., Mancuso, M., Caspers, N., McPhee, S., Null, D. et al. (2003). Using innovative video doctor technology in primary care to deliver brief smoking and alcohol intervention. *Health Promotion and Practice, 4*, 249-261.
- Hankin, J.R. (2002). Fetal alcohol syndrome prevention research. *Alcohol Research & Health, 26*(1), 58-65.
- Larimer, M.E. & Cronce, J.M. (2002). Identification, prevention, and treatment: A review of individual-focused strategies to reduce problematic alcohol consumption by college students. *Journal of Studies on Alcohol (Suppl. 14)*, 148-163.

Larimer, M. E., Cronce, J. M., Lee, C. M. & Kilmer, J. R. (2004/2005). Brief intervention in college settings. *Alcohol Research & Health*, 28(2), 94-110.

Miller, W.R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford.

National Alcohol Screening Day (NASD) (2006). National Alcohol Screening Day 2006 provides outreach, screening and education. Retrieved on April 25, 2006 at <http://alcoholism.about.com/od/news/a/nasd2005.htm>

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2004). NIAAA Council approves definition of binge drinking. *NIAAA Newsletter* (3). Winter.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2005a). *Screening for alcohol use and alcohol-related problems*. Bethesda, MD: National Institutes of Health, NIAAA. Can be retrieved at <http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm>

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2005b). *Brief interventions*. Bethesda, MD: National Institutes of Health, NIAAA. Can be retrieved at <http://pubs.niaaa.nih.gov/publications/AA66/AA66.htm>

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2005c). *Helping patients who drink too much: A clinician's guide* (NIH Publication No. 05-3769). Bethesda, MD: National Institutes of Health, NIAAA. Can be retrieved at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2006). *Alcohol use and alcohol use disorders in the United States: Main findings from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)* (NIH Publication No. 05-5737). U.S. *Alcohol Epidemiologic Data Reference Manual*, 8(1). January. Bethesda, MD: National Institutes of Health, NIAAA.

Ockene, J.K., Adams, A., Hurley, T.G., Wheeler, E.V. & Herbert, J.R. (1999). Brief physician- and nurse-practitioner-delivered counseling for high-risk drinkers: Does it work? *Archives of Internal Medicine*, 159, 2198-2205.

Office of the Surgeon General. (2005). Press Release. *U.S. Surgeon General releases advisory on alcohol use in pregnancy*. February 21. Available at www.hhs.gov/surgeongeneral/pressreleases/sg02222005.html

Reinert, D.F. & Allen, J.P. (2002). The Alcohol Use Disorders Identification Test (AUDIT): A review of recent research. *Alcoholism: Clinical and Experimental Research*, 26(2):272-279.

Sokol, R.J., Martier, S.S., & Ager, J.W. (1989). The T-ACE questions: Practical prenatal detection of risk-drinking. *American Journal of Obstetrics and Gynecology*, 160, 863-871.

Substance Abuse and Mental Health Administration (SAMHSA). (2004). *Treatment Episode Data Set (TEDS). Highlights 2002. National admissions to substance abuse treatment services* (DHHS Pub. No. SMA 04-3946). DASIS Series S-22. Rockville, MD: SAMHSA, Office of Applied Studies.

Substance Abuse and Mental Health Administration (SAMHSA). (2005). Press Release. *SAMHSA announces \$15.5 Million for brief interventions to deal with college students at risk of substance abuse* July 6. Retrieved on March 27, 2006 at http://www.samhsa.gov/news/newsreleases/050706_college.html

Substance Abuse and Mental Health Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) (2006). Draft publication: *SBIRT: Screening, Brief Intervention, Referral and Treatment: A screening and treatment opportunity for at-risk substance users*.

U.S. Preventive Services Task Force. (2004). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. Recommendation statement. *Annals of Internal Medicine*, 140, 554-556.

Wells-Parker, E. & Williams, M. (2002). Enhancing the effectiveness of traditional intervention with drinking drivers by adding brief individual intervention components. *Social Science Research*, 63, 655-664.

Whitlock, E.P., Polen, M.R., Green, C.A. Orleans, T. & Klein, J. (2004) Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 140(7), 557-568.

About the National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and other fatal consequences of these problems.

NIAAA is one of 27 Institutes and Centers that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the Federal Government, charged with uncovering new knowledge that will lead to better health for everyone. NIH is a component of the Public Health Service within the Department of Health and Human Services.

Visit the NIAAA website at <http://www.niaaa.nih.gov/>

About the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD)

NASADAD is a private not-for-profit educational, scientific, and informational organization that was established in Washington, D.C. in 1971 to represent Directors of State Alcohol and Drug Abuse Agencies. NASADAD's basic purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State. NASADAD serves as a focal point for the examination of alcohol and other drug related issues of common interest for both State and Federal Agencies.

Visit the NASADAD website at <http://www.nasadad.org>

NASADAD
808 17th Street NW, Suite 410
Washington, DC 20006
Telephone: 202-293-0090
Fax: 202-293-1250

Prepared by Marcia Trick and Kathleen Nardini at the National Association of State Alcohol and Drug Abuse Directors Inc. (NASADAD), for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NASADAD is solely responsible for the content and recommendations herein.