2008

SCREENING & BRIEF INTERVENTION:

Making A Public Health Difference

JOIN TOGETHER

SCREENING & BRIEF INTERVENTION:

Making A Public Health Difference

Authors
Pamela Anderson, Join Together
Susan Aromaa, Join Together
David Rosenbloom, Join Together
Gary Enos

Acknowledgements
Join Together would like to thank the following experts for their contributions to this report:

David Anderson, MGA, Communications Director/Senior Research Scientist, Ensuring Solutions to Alcohol Problems, George Washington University Medical Center.

Edward Bernstein, MD, Professor of Emergency Medicine and Social and Behavioral Sciences, Boston University; Medical Director, Project ASSERT.

Richard Brown, MD, MPH, Associate Professor, University of Wisconsin School of Medicine and Public Health; Clinical Director, Wisconsin Initiative to Promote Healthy Lifestyles.

John C. Higgins-Biddle, PhD, Assistant Professor (retired), University of Connecticut Health Center, Department of Community Medicine.

David C. Lewis, MD, Professor Emeritus of Medicine and Community Health, Brown University; Board of Directors, Physicians and Lawyers for National Drug Control Policy.

Bertha Madras, PhD, Deputy Director for Demand Reduction, White House Office of National Drug Control Policy.

Jeffrey H. Samet, MD, Professor and Section Chief of the Division of General Internal Medicine, Boston University School of Medicine.

Jennifer Smith, MD, Assistant Professor of Medicine, Rush Medical College; Director Illinois SBIRT Initiative, Cook County Bureau of Health Services.

Richard Saitz, MD, MPH, Professor, Boston University School of Medicine.

Christopher Tompkins, PhD, Associate Professor, Brandeis University Heller School for Social Policy and Management.

Mark Willenbring, MD, Director, Division of Treatment and Recovery Research, National Institute on Alcohol Abuse and Alcoholism.

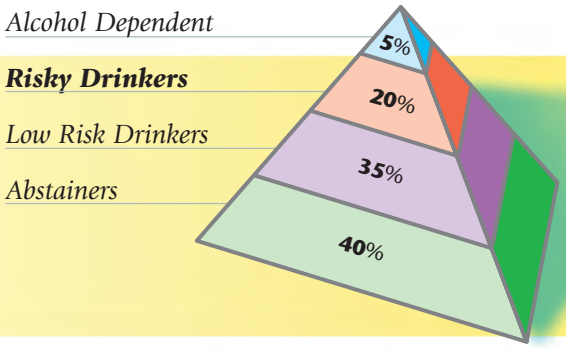
Published 2008 by Join Together with support from the Robert Wood Johnson Foundation.

Screening and brief intervention (SBI) for risky alcohol and drug use is moving from research into the mainstream of preventive medicine and public health. The past few years have seen policy makers, health professionals, medical societies, and advocates successfully advancing the use of these techniques.

Most attention on alcohol and drug issues has appropriately been focused on the population of alcohol and illicit drug users who meet clinical criteria for substance dependence. However, at the population level, the risky drinkers incur more adverse consequences and costs. A "risky drinker" is someone who is not dependent on alcohol, but has a drinking pattern, for example episodic heavy drinking, that can lead to a variety of problems such as alcohol-related traffic crashes, other accidents, and alcohol-involved violence.

Research shows that risky drinking causes more total accidental harm than the heavy drinking of alcoholics.[1] Though risky drinkers are individually less likely to cause alcohol-related problems, they make up a much greater portion of the general population than alcoholics, so the most significant amount of damage is caused by those who engage in risky drinking from time to time but are not dependent on alcohol. Additionally, people who drink above recommended guidelines, up to one drink per day for women and up to two drinks per day for men[2], face several health risks even if they are not dependent on alcohol. Risks increase for depression, high blood pressure, anemia, heart failure, liver damage, ulcers, inflammation of the pancreas, and some types of cancer.[3]

The Drinkers' Pyramid[4]



Screening and brief intervention (SBI) has begun to emerge as a critical strategy for targeting this large but often overlooked population of individuals who exceed low risk guidelines. The primary goal of screening and brief intervention efforts is not to identify alcohol- or drug-dependent individuals for referral to treatment. Rather, these approaches are intended to meet the public health goal of reducing the harms and societal costs associated with risky drinking.

A significant advantage for those working to create a positive impact on this problem is the potential to make significant gains by virtue of the large, easily identifiable, and accessible group of risky drinkers. Small positive changes spread over a large group will manifest themselves in the lives of the subjects, their families and all those around them - an encouraging multiplier effect.

SBI efforts hinge on finding opportunities in general medical, public health and other systems to identify and address individuals who may benefit from education and guidance about their substance use. These educational efforts are directly aimed at helping risky drinkers change their behavior.

Screening involves the use of specific, evidence-based questionnaires in verbal, written or electronic formats that are designed to detect risky alcohol and/or drug use. The questions asked in formal screening are intended to measure quantity and frequency of substance use over defined periods, as well as the occurrence of its adverse consequences. These screenings are designed to be quick, often lasting only five to 15 minutes.

A brief intervention generally consists of a nonconfrontational encounter between a health professional and a patient that is designed to help improve chances that the patient will reduce risky alcohol consumption or discontinue harmful drug use. A brief intervention goes beyond the sharing of simple advice. It uses evidence-based approaches to give the patient tools for changing his beliefs about substance use and coping with everyday situations that exacerbate his risk for harmful use.

John C. Higgins-Biddle, PhD, retired assistant professor in the Department of Community Medicine at the University of Connecticut Health Center, summarizes current interest in SBI this way: "This has the capacity to save thousands and thousands of lives and billions and billions of dollars."[5]

The current pace of activity in screening and brief intervention has many experts believing that the nation is at the edge of a dramatic increase in the extent to which SBI becomes part of routine practice. "This will be a revolution

in the 21st century in the way we deal with alcohol issues," says John Higgins-Biddle, PhD.[6]

The American College of Surgeons' Committee on Trauma broke new ground when it became the first physician organization in North America to mandate that all members screen patients for alcohol problems. It also required in its action that members in Level I and II trauma centers provide interventions or referrals in appropriate cases. This move helped generate momentum for similar initiatives elsewhere. In May 2007, the Federation of State Medical Boards adopted a goal of universal screening for alcohol and drug problems. In addition, the Accreditation Council for Continuing Medical Education has designated screening and brief intervention as a demonstration project for new regulations on what a continuing medical education course should look like.

Federal agencies also have taken a major interest in screening and brief intervention. The most recent National Drug Control Strategy document from the White House Office of National Drug Control Policy (ONDCP) devotes several pages to SBI. In April 2008, ONDCP announced that federal health insurers have added SBI coverage for the 5.6 million federal employees covered by federal insurance. SAMHSA's Screening, Brief Intervention, Referral and Treatment (SBIRT) cooperative agreements are designed to expand states' continuum of care to include these services in general medical and other community settings, as well as to improve linkages between the community agencies providing the services and specialty substance abuse treatment agencies. Although these cooperative agreements are of a time-limited nature, many believe that the lessons learned from these grant-funded programs will assist the design of sound screening, brief intervention, referral and treatment continuums for years to come.

There are a number of effective tools available to health professionals for screening. In essence, asking a patient whether he/she drinks and, if so, how much can elicit basic information that can point to the need for a brief intervention.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends that all physicians use a one-question screen[7] about heavy drinking days that can help determine whether a patient is drinking at risky levels and requires further assessment. The single interview question asks men how many times in the past year they have had five or more drinks in a day (a drink being equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits), and asks women how many times in the past year they have consumed four or more drinks.

According to Jeffrey H. Samet, MD, professor and section chief of the Division of General Internal Medicine at the Boston University School of Medicine, the NIAAA's one-question approach to determine whether alcohol is an issue will tend to screen out about two-thirds of patients who are not engaging in at-risk drinking.[8]

Patients who are not screened out by NIAAA's single question can be given the AUDIT screen.[10] The AUDIT, a 10-item questionnaire, takes about five minutes to complete.[11] It has been tested internationally in primary care settings and has been judged to have high levels of reliability and validity.[12] The AUDIT questions center around levels of alcohol consumption and harmful effects from drinking. Each question is assigned a point value based on the frequency with which an event occurs.

Other screening tools are designed to help detect and manage both alcohol and other drug problems in patients. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[14], developed for the World Health Organization for use in general medical settings, is an eight-question instrument that asks patients about use patterns and consequences of use for alcohol, tobacco and a variety of illegal drugs. (For more information on the most widely-used screens, please see the appendix.)

NIAAA's One Question Approach[9]

Prescreen: *Do you sometimes drink beer, wine, or other alcoholic beverages?*

NO	YES	
Screening complete	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)

Techniques for brief intervention generally allow health professionals to leverage their rapport with a patient to help him become more aware of a problem with drinking or drug use, to motivate him to change, and to establish a sense that change can happen and will ultimately benefit him.

Project ASSERT, which uses motivational intervention in an emergency department setting, was a demonstration program funded by the federal Center for Substance Abuse Treatment (CSAT) in 1993 and later became an official program of Boston Medical Center's emergency department. It uses an intervention technique that project organizers call the "brief negotiated interview," adapted from the principles of motivational interviewing.

Edward Bernstein, MD, B.U. Professor of Emergency Medicine and Social and Behavioral Sciences, and the project's medical director, explains that trained health promotion advocates (many in recovery themselves) work as community outreach workers in the ER. They approach patients at the bedside and utilize a health and safety needs history to assess patients for an array of problems including smoking, depression, unsafe home situations, non-safety restraints use, and unhealthy drinking and drug use. Advocates ask permission, review screening and safe guidelines, negotiate health behavior change, provide information and resources, and, when appropriate, facilitate access to primary care and addiction treatment.

If a patient is exhibiting strong resistance to discussing alcohol issues, the advocate helps him examine the pros and cons of his drinking behavior. Leading the patient to examine what he likes and dislikes about drinking may help initiate the conversation and lead to the patient eventually acknowledging some of the harmful effects experienced from his drinking. Success of Project ASSERT's approach depends on the advocate not blaming or confronting the patient, but listening in an empathic style, promoting change talk, and offering feedback, ongoing support and affirmation.

Alcohol Use Disorders Identification Test (AUDIT)[13]

How often do you have a drink containing alcohol?

How many drinks containing alcohol do you have on a typical day when you are drinking?

How often do you have six or more drinks on one occasion?

How often during the past year have you found that you were not able to stop drinking once you had started?

How often during the past year have you failed to do what was normally expected from you because of drinking?

How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

How often during the past year have you had a feeling of guilt or remorse after drinking?

How often during the past year have you been unable to remember what happened the night before because you had been drinking?

Have you or someone else been injured as a result of your drinking?

Has a relative or a friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

"This is all about creating a meaningful conversation with peers," Bernstein says. "The first barrier is motivation. Through this conversation, a teachable moment may open up and Project ASSERT can help steer patients in the right direction."[16]

A similar interviewing technique based on an empathic style is known as the FRAMES model of intervention. It instructs users to take these approaches to addressing a patient's drinking problem: give the patient verbal feedback regarding personal alcohol consumption; leave responsibility for change to the patient; give advice to make a change; provide a menu of options; use an empathic conversational style, mostly through reflective listening, and boost the patient's self-efficacy to make a change.

Brief Negotiated Interview[15]

- Establish rapport
- Ask permission
- Raise subject
- Explore pros and cons
- Explore discrepancies between actual state and goals
- Assess readiness to change
- Assess readiness to enter treatment
- Explore options
- Negotiate an action plan

While some studies have found mixed results on the effectiveness of SBI,[17] even a small change spread across a large population will have a positive public health effect.

A number of studies that have examined the research evidence on screening and brief intervention's effectiveness have concluded that SBI has clinically meaningful effects, both when administered in primary care and in emergency care settings. These effects include reductions in harmful levels of drinking and some of the consequences of risky drinking. For example, a randomized controlled trial of SBI in patients at an urban trauma center found a 47% reduction in subsequent injuries requiring an emergency department visit.[3]

Outside of the primary care arena, research has found that screening and brief intervention for alcohol problems can be cost-effective and merits widespread application in trauma care settings. Research also has found that trauma patients generally are amenable to learning more about the effects of their drinking in the "teachable moment" that can occur in the emergency setting.

Research also has indicated that screening and brief intervention can be successfully tailored to other subpopulations of harmful drinkers. The iHealth Study found that Internet-based screening and brief intervention show promise in addressing unhealthy alcohol use by college students.[18]

The overall evidence has led to the determination by the U.S. Preventive Services Task Force, an agency charged with reviewing evidence for health prevention-oriented activities, that screening and brief intervention should be implemented on a widespread basis, with these preventive services available to all U.S. adults.

Screening and brief intervention can be effective as part of a public health strategy and there is an emerging consensus that SBI ought to be implemented in medical settings. However, in practice it has been slow to catch on in the United States. One survey from 2000 found that only 13% of primary care physicians, obstetrician/gynecologists and psychiatrists use standardized screening instruments as a tool to discuss alcohol use with their patients.[19]

While it is not unusual in health care to see a significant time gap between the introduction of a health-related screening and its widespread application in routine practice, the relatively low use of formalized screening in general medical practice points to several barriers to the implementation of SBI.

PHYSICIANS' OFFICES

Physicians' offices have not routinely engaged in screening and brief intervention for risky levels of drinking and drug use.

They are not trained

Alcohol and drug issues are not covered in the training of the vast majority of medical students, contributing to physicians' uneasiness about addressing these topics. This lack of training has also meant that physicians have been exposed to few role models in their profession who have a broad knowledge of alcohol and drug issues.

Many physicians simply believe that interventions for alcohol and drug problems are generally ineffective when compared with treatments for other health problems. Additionally, many do not recognize the impact excessive, but not dependent, drinking can have on health problems.

They do not have time

Time constraints also pose a significant barrier for physicians in a managed care-driven system. A 2002 survey of leaders conducted by the organization Physicians and Lawyers for National Drug Policy (PLNDP) found lack of time to be the greatest perceived obstacle to physician implementation of SBI.[20]

Mark Willenbring, MD, director of the Treatment and Recovery Research Division of the National Institute on Alcohol Abuse and Alcoholism, explains, "When you've got 10 to 12 minutes to deal with diabetes, high blood pressure, and obesity, physicians aren't about to spend time doing prevention stuff like, 'Wear your seatbelts.'"[21]

Arguably the most important barrier for generalist physicians is the inherent conflict in introducing routine SBI to a system not presently oriented to these particular types of interventions. Medical practice is a procedure-dominated specialty in which psychosocial interventions are generally valued low and reimbursement systems do not favor prevention and early intervention services. SBI approaches are designed to uncover risky behavior as opposed to a treatable disease. If a particular health service carries a small risk of finding a diagnosable problem, physicians will tend to avoid performing that service.

The most effective approaches conflict with physicians' preferred styles

Physicians also may find themselves in a quandary over whether to perform substance-focused interventions themselves or to refer patients to other providers. Physicians are not trained in the empathic, reflective listening approach used in most brief interventions for risky alcohol or drug use. Empathic listening may be seen as conflicting with the more authoritative form of communication to which physicians are accustomed in the doctor-patient relationship.

"Physicians won't re-engineer their practices to become counselors," says Christopher Tompkins, PhD, associate professor at The Heller School for Social Policy and Management at Brandeis University and a researcher in the university's Schneider Institutes for Health Policy.[22]

Most physicians are also largely unfamiliar with where they can turn to tap into available community resources for addressing alcohol and drug issues for patients.

In cases where screening may indicate that a patient has a more serious alcohol or drug problem that justifies referral to treatment, physicians are likely to be largely unaware of the referral options that exist in their community, or how to distinguish among them.

EMERGENCY ROOMS AND TRAUMA CENTERS

Screening and brief interventions are being increasingly being performed in ERs and trauma centers. Research shows that support for SBI in trauma centers depends on whether surgeons see trauma centers as an appropriate setting to address alcohol use and whether performing SBI will be cost prohibitive.[23]

UPPL

At the emergency and trauma care level, a legal statute that dates to the 1940s has created a significant financial obstacle for making SBI routine

practice in trauma settings. The National Association of Insurance Commissioners developed the Uniform Accident and Sickness Policy Provision Law (UPPL) as model state legislation, including an alcohol exclusion clause that allows insurance carriers to deny coverage for alcohol- or narcotics-related injuries. The statute states that insurers "shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."[24]

Twenty-eight states still have the original-model UPPL on their books, despite the fact that in 2001 the National Association of Insurance Commissioners recommended that states repeal the law and bar insurers from denying benefits in cases of injuries sustained under the influence of alcohol or narcotics. An additional nine states do not have any laws on the books, and courts have ruled that insurance companies can use alcohol/drug exclusions in states that are silent on Alcohol Exclusion Law.[25]

Privacy regulations

The federal regulations governing the privacy of persons receiving alcohol and drug treatment and prevention services are known as 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records). If a trauma center houses staff whose primary purpose involves screening patients for substance use disorders and offering interventions, patient information collected for those purposes is considered protected under the confidentiality statutes. However, if information about blood alcohol level or drug toxicology is collected in these settings for purposes of managing a patient's injuries, that information is exempt from the confidentiality requirements, an exemption that was put in place by the U.S. Department of Health and Human Services (HHS) in 1990. These different regulations can be ambiguous to trauma center personnel and may dissuade them from providing certain services.

Some experts suggest that segregating information collected in screening and brief intervention efforts in order to make sure that it does not end up in the medical record constitutes an important policy step for trauma centers. Unfortunately, some believe that keeping this information separate also reinforces the prevailing split between substance abuse services and the rest of medical care, which can often exacerbate the stigma associated with substance use.

Financial

Despite all of these obstacles from the physician's point of view, it is generally believed that they could be overcome if reimbursement systems valued SBI services at a level similar to the medical procedures they tend to favor. "With all due respect to medical education, if doctors get paid this issue will get attention," says David C. Lewis, MD.[26]

The Centers for Medicare & Medicaid Services (CMS) approved billing codes allowing for SBI services to be billed under Medicaid in 2006. The Healthcare Common Procedure Coding System (HCPCS) codes for screening and brief intervention became available for use by providers serving Medicaid beneficiaries on Jan. 1, 2007. While this was a victory, it was only the beginning. Having codes on the books is one thing; getting them used often requires initiating another process altogether.

State Medicaid programs operate relatively autonomously, and it is generally the position of CMS that it is up to individual state Medicaid agencies to determine whether and how new billing codes will be used in a particular state. As a result, proponents of SBI have found they have to work on a state-by-state basis to familiarize Medicaid officials with these new codes and their importance. They have also found that some work is required at the legislative level in states that mandate legislation or a formal listing process before a service can be officially considered reimbursable under Medicaid. Progress at the state level has been relatively slow so far.

Procedure codes (CPT) for SBI were approved by the American Medical Association effective January 1, 2008. This move removed one of the most significant financial impediments to more physician involvement in SBI. Under these codes, services are assigned a relative weight that will determine the level at which they are reimbursed in Medicare and private insurance plans (private insurers such as Blue Cross tend to follow Medicare's lead in terms of the value they place on specific medical services). A 2008 survey of American health plans found that 58% will pay for SBI services.[27]

The dollar value assigned to these procedures under the CPT codes could present some challenges however, particularly if physicians are expected to shoulder much of the workload in the expansion of SBI services in primary care. Leaders who have been involved in advocacy efforts in the coding area emphasize that doctors will choose not to do the work if paperwork costs exceed the rate that is paid.

Do not expect physicians to bear the sole responsibility for widespread public health implementation of SBI. Physicians tend to focus on procedure-oriented medicine and may not be compelled to shift their practices to accommodate a technique based on empathic listening. If SBI is to become a routine element in health care practice, it must be organized and delivered in a way that does not rely solely on physicians.

Richard Brown, MD, MPH, associate professor of family medicine at the University of Wisconsin and clinical director of the state's Screening, Brief Intervention, Referral and Treatment (SBIRT) program funded by the federal government, says, "After doing lots of training over lots of years, it's become very obvious that training itself is not the answer. It's difficult to attract primary care people to come to these kinds of trainings. Research shows that most physicians tend to attend trainings in areas of prior interest and keep growing in those areas. So it's hard to get someone interested in a new topic if they're not coming to the training to begin with."[28]

In general, physicians will identify a problem when they have widely accepted protocols for medically treating it. This explains why there has been such a substantial increase in primary care detection and treatment for depression, as physicians have been able to rely on the newest generation of antidepressants as first-line treatment. Physicians will want to see treatment standards in place if there is a national call for them to address substance use issues more directly.

It is likely to be more practical and cost-effective for trained members of the practice staff or health workers brought in from outside the practice to be performing SBI under physician supervision. It is important from the patient's perspective to know that office personnel's interest in addressing these issues comes with the physician's support.

Efforts to use trained medical assistants to perform SBI tasks in primary care and other health care settings are showing promise. The SBIRT cooperative agreements program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is illustrating the potential of using trained health workers to perform SBI.[29]

At some Illinois health centers participating in SBIRT, the health counselor screens the patient in the time between the nurse taking the patient's vital signs and the physician seeing the patient, explains Jennifer Smith, MD, who is with the Cook County Bureau of Health Services.[30] At other centers, physicians and

nurse practitioners are engaging in quick pre-screenings of patients, with those who are found to possibly benefit from further assessments referred to peer mentors (each mentor is a person who has been in recovery from a substance use disorder for at least two years).

Involve specialty health providers to share the responsibility for providing SBI services. NIAAA has targeted mental health providers as well as generalist physicians with information on screening and brief intervention. Because the prevalence of risky and heavy drinking is higher among people with mental health disorders, efforts to integrate SBI into psychiatry practice could benefit many individuals who are seeking treatment for mental health problems. Efforts to expand SBI should seek a diversity of partners from the specialty health community.

Repeal state insurance laws that discourage screening and brief intervention services. It is clear that some state lawmakers are having second thoughts about the appropriateness of statutes that can stifle efforts to identify and address alcohol and drug problems before they worsen. Several states are considering removing UPPL statutes from their books.

Include SBI as part of medical school curriculum and residency training. Making sure that medical students have an awareness of SBI and its concepts will make it more likely that they will incorporate it into their regular practice. Where SBI techniques are unknown or underutilized, a professional with prior awareness of the tools can make the difference in getting routine use of SBI established. The straightforward and easily understood concepts of SBI increase the likelihood that it will be welcomed as an effective curriculum addition. Coverage in medical exams will help solidify it's acceptance as part of routine practice.

Use screening tools that emphasize ease of use, and integrate screening for alcohol and drug use with other routine preventive screenings. Physician practices will be more likely to phase routine screenings into their work when automated screening and feedback tools are widely available. One of the lingering impediments to physician adoption of SBI is physicians' lack of familiarity with pen-and-paper screening instruments and how to integrate them into their practice settings.

Many experts see an important opportunity in integrating screening for alcohol and drug problems with other preventive screenings. They see blended screening approaches as potentially saving time in busy practice settings, as well

as reinforcing alcohol and drug issues as health issues that merit the same attention as other areas commonly addressed in screening. Automated systems may allow for easy administration of "a bundled screen" at the medical office before a patient sees her physician.

Time is indeed a critical factor, of course, with one study of U.S. Preventive Services Task Force literature showing that the typical primary care practice would have to spend 7.5 hours a day just to provide all of the recommended preventive services.[31] Blended approaches to screening could help a great deal in improving the efficiency of a comprehensive effort at prevention.

Encourage professional associations to endorse SBI as routine health care practice. The American College of Surgeons' Committee on Trauma gave important momentum to the cause in issuing its groundbreaking requirement that members screen patients for risky drinking. Other professional societies whose members can have a role in helping patients reduce harmful levels of drinking and drug use also should endorse efforts to make screening and brief intervention a routine element of practice.

Expand SBI beyond the health care system. Use online screening instruments, EAPs, and other private sector settings. AlcoholScreening.org, a service of Join Together, has been successful in enabling individuals to anonymously screen themselves for risky and hazardous alcohol use using and online version of the AUDIT screening tool. Users receive feedback about their drinking including comparisons of their drinking patterns with national norms. Two-thirds of the visitors to AlcoholScreening.org drink at hazardous levels, and users who report the most severe problems are the most likely to access areas of the site that offer educational resources and contact information for local treatment providers.[32] Join Together launched DrugScreening.org, a self-screening site for drug use based on the ASSIST, in 2007. Sites such as AlcoholScreening.org and DrugScreening.org have great potential for reaching individuals who otherwise might not have their behavior addressed.

Employee assistance programs (EAPs), corporate wellness programs, and private-sector disease management programs offer logical structures for promoting screening and brief intervention as an integral part of preventive health. These strategies may find favor in the corporate sector if the screening efforts for risky drinking or drug use are integrated with screening questions on stress, anxiety, and other problems seen as affecting worker productivity.

Use direct to consumer marketing to raise the demand for screening and brief interventions. Much in the same way that pharmaceutical companies have succeeded in driving demand for their products by marketing directly to consumers, proponents of SBI implementation can educate the public directly on harmful use, potentially getting patients to initiate discussions with their health care providers. This strategy has been employed to increase the visibility of NIAAA's guide for clinicians. As part of the online guide, NIAAA has included a downloadable page that includes tips for reducing alcohol consumption. Similarly, AlcoholScreening.org targets the public directly in an online format by offering guidance on what constitutes unsafe drinking patterns, then encouraging individuals who believe they may be at risk to learn more about alcohol and/or to locate treatment and support resources in their community.

NIAAA: Strategies for Cutting Down[33]

Small changes can make a big difference in reducing your chances of having alcohol-related problems. Here are some strategies to try. Check off some to try the first week, and add some others the next week.

Keep track of how much you drink.

Know the standard drink sizes so you can count your drinks accurately.

Decide how many days a week you want to drink and how many drinks you'll have on those days.

When you do drink, pace yourself. Sip slowly. Have no more than one drink with alcohol per hour.

Don't drink on an empty stomach.

Avoid "triggers"

Plan to handle urges

You're likely to be offered a drink at times when you don't want one. Have a polite, convincing "no, thanks" ready.

Addiction prevention and treatment professionals can get involved to help facilitate wider implementation of screening and brief intervention:

Train professionals in SBI/MI techniques so they can provide leadership and training for medical teams. Prevention and treatment professionals can play an important role by helping develop referral networks that health providers can use for patients who need full assessment and treatment.

As part of the Demand Treatment program, a team of activists in Rochester, NY, trained physicians to screen patients to identify risky drinkers. They then helped facilitate partnerships between physicians and community treatment providers for those dependent drinkers who needed treatment.

Expand SBI in non-clinical settings. Treatment and prevention professionals can help facilitate the development of SBI programs in non-clinical settings such as the workplace. Employers are becoming increasingly interested in implementing screening programs through employee assistance programs. A recent survey found that 46% of employers either already had an SBI program or that SBI was important to them.[34] These employers need training and leadership to support their efforts.

APPENDIX

This appendix contains an overview of the most widely used screening questionnaires for drug and/or alcohol use. The information provided here is not sufficient to complete and score the screenings. Please see the cited reference materials for more information on the individual screens.

NIAAA Single Question: [35]

Prescreen: Do you sometimes drink beer, wine, or other alcoholic beverages?

NO
Screening complete

YES
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)

AUDIT:[36]

1. How often do you have a drink containing alcohol?
(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Question 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
(0) No
(2) Yes, but not in the last year
4) Yes, during the last year

Record total of specific items here
If total is greater than recommended cut-off, consult User's Manual

A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption and warrants more careful assessment.

CAGE:[37]

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticising your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

Answering" yes" to any of these questions signifies possible hazardous drinking.

Michigan Alcoholism Screening Test (MAST):[38]

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
3. Does any near relative or close friend ever worry or complain about your drinking?
4. Can you stop drinking without difficulty after one or two drinks?
5. Do you ever feel guilty about your drinking?
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
7. Have you ever gotten into physical fights when drinking?
8. Has drinking ever created problems between you and a near relative or close friend?
9. Has any family member or close friend gone to anyone for help about your drinking?
10. Have you ever lost friends because of your drinking?
11. Have you ever gotten into trouble at work because of drinking?
12. Have you ever lost a job because of drinking?
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
14. Do you drink before noon fairly often?
15. Have you ever been told you have liver trouble such as cirrhosis?
16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?
17. Have you ever gone to anyone for help about your drinking?
18. Have you ever been hospitalized because of drinking?
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?
21. Have you been arrested more than once for driving under the influence of alcohol?
22. Have you ever been arrested, even for a few hours because of other behavior while drinking?

(If Yes, how many times _____)

Score one point if you answered the following:

1. No	5. Yes
2. Yes	6. Yes
3. Yes	7 through 22: Yes
4. No	

Add up the scores and compare to the following score card:

0 - 2 No apparent problem
3 - 5 Early or middle problem drinker
6 or more Problem drinker

CRAFFT (for adolescents):[39]

C Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself or alone?

F Do you ever forget things you did while using alcohol or drugs?

F Do your family or friends ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten into trouble while you were using alcohol or drugs?

2 or more yes answers suggests a significant problem

ASSIST:[40]

1. In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)
- Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
- Alcoholic beverages (beer, wine, spirits, etc.)
- Cannabis (marijuana, pot, grass, hash, etc.)
- Cocaine (coke, crack, etc.)
- Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
- Inhalants (nitrous, glue, petrol, paint thinner, etc.)
- Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
- Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
- Opioids (heroin, morphine, methadone, codeine, etc.)
- Other - specify:

2. In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?
- Never
- Once or twice
- Monthly
- Weekly
- Daily or almost daily

3. During the past three months, how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC)?
- Never
- Once or twice
- Monthly
- Weekly
- Daily or almost daily

4. During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?
- Never
- Once or twice
- Monthly
- Weekly
- Daily or almost daily

5. During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?
- Never
- Once or twice
- Monthly
- Weekly
- Daily or almost daily

6. Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?
- No, never
- Yes, in the past 3 months
- Yes, but not in the past 3 months

7. Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?
- No, never
- Yes, in the past 3 months
- Yes, but not in the past 3 months

8. Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)
- No, never
- Yes, in the past 3 months
- Yes, but not in the past 3 months

For scoring information, please see the full ASSIST Questionnaire available at: http://www.who.int/entity/substance_abuse/activities/assist_v3_english.pdf

Drug Abuse Screening Test (DAST):[41]

1. Have you used drugs other than those required for medical reasons?
2. Have you abused prescription drugs?
3. Do you abuse more than one drug at a time?
4. Do you use other drugs, meaning, do you use drugs other than those required for medical reasons
5. Is it difficult for you to stop using drugs when you want to?
6. Do you abuse drugs on a continuous basis?
7. Do you try to limit your drug use to certain situations?
8. Have you had "blackouts" or "flashbacks" as a result of drug use?
9. Do you ever feel bad about your drug abuse?
10. Does your spouse (or parents) ever complain about your involvement with drugs?
11. Do your friends or relatives know or suspect you abuse drugs?
12. Has drug abuse ever created problems between you and your spouse?
13. Has any family member ever sought help for problems related to drug use?
14. Have you ever lost friends because of your use of drugs?
15. Have you ever neglected your family or missed work because of your use of drugs?
16. Have you ever been in trouble at work because of drug abuse?
17. Have you ever lost a job because of drug abuse?
18. Have you gotten into fights when under the influence of drugs?
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?
20. Have you ever been arrested for driving while under the influence of drugs?
21. Have you engaged in illegal activities in order to obtain drugs?
22. Have you been arrested for possession of dangerous drugs?
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?
25. Have you ever gone to anyone for help for a drug problem?
26. Have you ever been in a hospital for medical problems related to drug use?
27. Have you ever been involved in a treatment program specifically related to drug care?
28. Have you been treated as an out-patient for problems related to drug use?

Your score is equal to the number of questions you answered YES.
A score of five or less points indicates a normal score.
A score of six or more points indicates a possible drug problem.

[1]Higgins-Biddle, J., & Babor, T. (1996). Reducing Risky Drinking: A Report on Early Identification and Management of Alcohol Problems through Screening and Brief Intervention. Farmington, CT: The Alcohol Research Center, University of Connecticut Health Center.
[2]U.S. Department of Health and Human Services & U.S Department of Agriculture. (2005). Dietary Guidelines for Americans, 2005, 6th Edition. Washington, DC: U.S. Government Printing Office.
[3]Babor, T., Higgins-Biddle, J., Saunders, J., & Monteiro, M. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition. Geneva, Switzerland: World Health Organization.
[4]Higgins-Biddle, J., & Babor, T. (1996). Reducing Risky Drinking: A Report on Early Identification and Management of Alcohol Problems through Screening and Brief Intervention. Farmington, CT: The Alcohol Research Center, University of Connecticut Health Center.
[5]Higgins-Biddle, J. (2007). Personal interview.
[6]Higgins-Biddle, J. (2007). Personal Interview.
[7]National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health. (2005). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No. 07-3769. Bethesda, MD: National Institutes of Health.
[8]Samet, J. (2007). Personal Interview.
[9]National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health. (2005). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No. 07-3769. Bethesda, MD: National Institutes of Health.
[10]National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health. (2005). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No. 07-3769. Bethesda, MD: National Institutes of Health.
[11]Babor, T., Higgins-Biddle, J., Saunders, J., & Monteiro, M. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition. Geneva, Switzerland: World Health Organization.
[12]Allen, J., Litten, R., Fertig, J., & Babor, T. (1997). A review of research on the alcohol use disorder identification test. Alcoholism: Clinical and Experimental Research, 21(4): 613-619.
[13]Babor, T., Higgins-Biddle, J., Saunders, J., & Monteiro, M. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition. Geneva, Switzerland: World Health Organization.
[14]WHO ASSIST Working Group (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. Addiction, 97 (9): 1183-1194.
[15]Bernstein, E., Bernstein, J, & Levenson, S. (1997). Project ASSERT: An ED based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. Annals of Emergency Medicine, 30: 181-189.
[16]Bernstein, E. (2007). Personal interview.
[17]Fleming, M. (2003). Brief Interventions and the Treatment of Alcohol Use Disorders. Recent Development in Alcoholism, 16: 375-390.
[18]Saitz, R., Palfai, T., Freedner, N., et al. (2007). Screening and brief intervention online for college students: the iHealth study. Alcohol and Alcoholism, 42: 28-36.
[19]Friedmann, P., McCulloch, D., Chin, M., et al. (2000). Screening and intervention for alcohol problems: a national survey of primary care physicians and psychiatrists. Journal of General Internal Medicine, 15: 84-91.

[20]Physicians and Lawyers for National Drug Policy. (2002). PLNDP Leadership Council Meeting, Charleston, SC, Session: Barriers to Overcome in Implementing SBI, October 2002.
[21]Willenbring, M. (2007). Personal interview.
[22]Tompkins, C. (2007). Personal interview.
[23]Schermer, C., et al. (2003). National Survey of Trauma Surgeons' Use of Alcohol Screening and Brief Intervention. The Journal of Trauma, 55(5): 849-856.
[24]1950 Proceedings of the National Association of Insurance Commissioners, 81st Annual Session, June 13, 1950; Québec, Canada. Kansas City, MO: National Association of Insurance Commissioners, 1950-2, 161, 950. 1950 NAIC Proc. 398.
[25]Ensuring Solutions to Alcohol Problems. (2008). Alcohol Exclusion Laws Toolkit. Accessed at http://www.ensuringsolutions.org on April 30, 2008.
[26]Lewis, D. (2007). Personal interview.
[27]Ensuring Solutions to Alcohol Problems. (April 17, 2008). Many Health Plans Will Now Pay for Substance Use Screening and Brief Intervention [press release]. Washington, DC: George Washington University Medical Center.
[28]Brown, R. (2007). Personal Interview.
[29]http://www.sbirt.samhsa.gov/. Accessed April 7, 2008.
[30]Smith, J. (2007). Personal interview.
[31]Yarnall, K., Pollak, K., Ostbye, T., Krause, K., & Michener, J. (2003). Primary Care: Is There Enough Time for Prevention? American Journal of Public Health, 93(4): 635-641.
[32]Saitz, R., Helmuth, E., Aromaa, S., Guard, A., Belanger, M., & Rosenbloom, D. (2004). Web-based screening and brief intervention for the spectrum of alcohol problems. Preventive Medicine, 39: 969-975.
[33]National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health. (2005). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No. 07-3769. Bethesda, MD: National Institutes of Health.
[34]Ensuring Solutions to Alcohol Problems. (2008). 2007 Workplace SBI Survey Report: An Assessment of Employer Practices & Vendor Products & Services, Executive Summary. Washington, DC: George Washington University Medical Center.
[35]National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health. (2005). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No. 07-3769. Bethesda, MD: National Institutes of Health.
[36]Babor, T., Higgins-Biddle, J., Saunders, J., & Monteiro, M. (2001). The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition. Geneva, Switzerland: World Health Organization.
[37]Ewing, JA. (1984). Detecting Alcoholism: The CAGE Questionaire. Journal of the American Medical Association, 252: 1905-1907.
[38]Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127(12): 1653-1658.
[39]Knight, J., Shrier, L., Bravender, T., Farrell, M., Vander Bilt, J., & Shaffer, H. (1999). A new brief screen for adolescent substance abuse. Archives of Pediatrics and Adolescent Medicine, 153(6): 591-596.
[40]WHO ASSIST Working Group. (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. Addiction, 97(9): 1183-1194.
[41]Skinner, HA. (1982). The drug abuse screening test. Addictive Behaviors, 7: 363–371.

Join Together
Boston University
580 Harrison Avenue, 3rd Floor
Boston, MA 02118
Tel: 617-437-1500
Fax: 617-437-9394
info@jointogether.org
www.JoinTogether.org

Join Together, founded in 1991, works to advance effective alcohol and drug policy, prevention, and treatment. We are funded primarily by a grant from the Robert Wood Johnson Foundation to the Boston University School of Public Health.