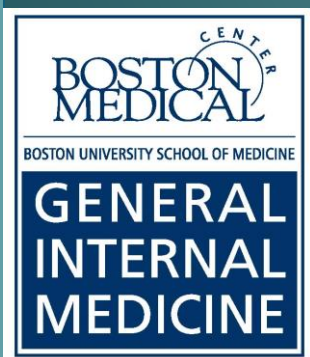


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Brief Intervention Efficacy

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What is Brief Intervention?

- 10-15", empathic, non-confrontational
- Feedback
 - Ask permission
 - Ask what patient thinks of it
- Advice (clear)
- Goal setting
 - Negotiate
 - Menu of options
 - Support self-efficacy
- Follow-up



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

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

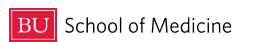
“What do you think? Are you willing to consider making changes?”

How to Advise or Refer Patients	Examples or Explanations
Elicit information about how the patient views the problem.	“What do you think about your drinking? Are you ready to make a change in your alcohol use? How confident are you that you could cut down if you wanted to?”
Express concern and provide clear advice regarding the ideal goal (abstinence or reduced consumption for those with nondependent alcohol use, achieved through brief counseling; abstinence for patients with alcohol dependence). ³	“I am concerned about your drinking; my medical advice is that the healthiest choice for you is to cut down or abstain.”
Provide specific feedback about alcohol consumption in comparison with population norms, and link existing problems to alcohol use when appropriate, to make information relevant to the patient.	“Ninety-three percent of adults drink less than the amounts you report drinking. You mentioned your heartburn is worse when you drink. Alcohol is probably causing your heartburn.”
Express empathy, let the patient know you believe that change is possible, and acknowledge that it is the patient’s responsibility to change.	“The fact you were able to quit before for a week tells me you can do it again. But it must be difficult. It is up to you to make these changes.”
When the patient expresses interest or gives permission, provide information, including a menu of options, about how to change.	“Would you like information on how to cut down or abstain? Other people have found a range of options helpful, such as keeping a drinking diary, counseling, and mutual-help groups. What do you think about these?”
Anticipate and discuss situations in which the patient feels at risk for drinking excessively, and talk about strategies to avoid drinking excessively.	“What ways might help you avoid drinking excessively when you go out with friends who drink?” Have the patient keep a drinking diary (including the number of drinks consumed per day).



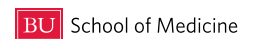


EFFICACY



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

NONE



EFFICACY OF ALCOHOL BI VS. NO BI

- Efficacious: **10-15” multi-contact**
 - **≥23** original RCTs, * 9 systematic reviews, **primary care, non-dep, screen id'd**
 - **Lower proportion of drinkers self-reporting risky amounts**
 - 57% vs. 69% at 1 year (n=2784)**; 11% risk diff (n=5973)*
 - **Lower self-reported consumption** (n=5639)
 - by 15% (38 grams per week)(n=5639)***; 3.6 drinks/wk (n=4332)*
 - Accidents, injuries, liver problems, hospital/ER/primary care use, legal problems, quality of life: **insufficient evidence***
 - Decreased hospital utilization (≥2 RCTs)
 - Cost-effective (spend \$166, save \$546 medical, \$7780 society)
 - Decreased mortality (RR 0.47)(4 RCTs (n=1640))
 - Prevention of disorder – no evidence

*Jonas DE et al. *Ann Intern Med* 2012;157:645-54.

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

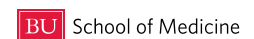
**Beich et al. *BMJ* 2003;327:536

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

Kristenson H, et al. *Alcohol Clin Exp Res* 1983;7:203 (mortality, 3-16 yrs)

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

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



SETTING

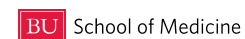
- Evidence is mixed for emergency and hospital
- Most people identified by screening in hospitals have a mod/severe disorder
- Different expectations and goals
 - Comprehensive care?
 - Preventive care?
 - Longitudinal care? Long-term therapeutic alliance?
 - Teachable vs. learnable moments?



Belen Martinez et al INEBRIA 2007
Saitz et al. Ann Intern Med 2007;146:167-76
Freyer-Adam J et al. Drug Alcohol Depend 2008
Bischoff G et al. Drug Alcohol Depend 2008
Bischof et al. Int J Pub Health 2010
Saitz et al. Int J Pub Health 2010



McQueen J. Cochrane review 2011
D'Onofrio RCTs; Schmidt CS. Et al. Addiction, 2016;111: 783–794
Very small effect (meta-analysis).
Gentilello et al 1999 and subsequent studies



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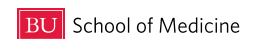
0-95

ol of Medicine

SBI FOR DRUGS IN ADULTS

Study	Result
Bernstein 2005	5-9% incr coc/her
Zahradnik, Otto	Less ad...
WHO (Humeniuk)	
Woodruff	
Opinion	
EDITORIAL	
Screening and Brief Intervention and Referral to Treatment for Drug Use in Primary Care Back to the Drawing Board	
Ralph Hingson, ScD, MPH; Wilson M. Compton, MD, MPE	
Blow	... self report drug use (es 0.2)
Field	Unpub; Cant put on slide but I will tell
	Large trauma bio testing
	ED; n=1284; >80% F/U
	PC; n=334 ASSIST 4-26; 78% F/U; Combined, repeated; some urine tests
	ED; 81% F/U; ?urine in some
	... 57% F/U; urine tests

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



YOUTH DRUG SBI RCTS: PROMISING

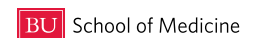
- ① n=59 **adolescents in primary care** in Brazil-decreased MJ and stimulant use and problems
- ② Decreased marijuana use by **adolescents in the emergency department** in a pilot study (n=210)
- ③ Decreased cannabis problems and drug use (computer BI) and cannabis DUI (therapist) by **adolescents in primary care** (n=328)
- ④ Computer (but not therapist) BI *prevented* cannabis (17% vs 24%, 1 yr) use in adolescents in primary care (n=714)

DeMicheli D et al. Rev Assoc Med Bras 2004; 50(3): 305-13

Bernstein E et al. Acad Emerg Med 2009; 16: 1174-85

Walton MA (Blow) et al. Drug Alcohol Dependence 2013;132:646-53.

Walton MA (Blow) et al. Addiction 2013;109:786-97.



Original Investigation
Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gal D'Onofrio, MD, MS, Patrick C. O'Connor, MD, MPH, Michael V. Fennell, PhD, Mark C. D'Onofrio, PhD, Susan H. Bush, PhD, Patricia H. Owens, MD, Steven L. Bernstein, MD, David A. Fiello, MD

IMPORTANCE: Opioid-dependent patients often use the emergency department (ED) for medical care.

OBJECTIVE: To test the efficacy of 3 interventions for opioid dependence: ED screening and referral to treatment (terrestri), ED screening, brief intervention, and facilitated referral to community-based treatment services (brief interventions), and ED screening, brief interventions, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

DESIGN, SETTING, AND PARTICIPANTS: A randomized clinical trial involving 520 opioid-dependent patients who were treated at an urban teaching hospital ED from April 2, 2012, through June 16, 2013.

MAIN RESULTS AND MEASURES: Enrollment in and receiving addiction treatment 30 days after randomization was the primary outcome. Self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services were the secondary outcomes.

RESULTS: The buprenorphine group had significantly higher rates of enrollment in and receiving addiction treatment 30 days after randomization (78% vs 41%, $P < .001$). The buprenorphine group had significantly lower rates of self-reported days of illicit opioid use (5 to 1 vs 2 days/wk, $P < .001$).

CONCLUSIONS AND RELEVANCE: Among opioid-dependent patients, ED-initiated buprenorphine treatment vs brief interventions and referral significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services but did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk. These findings require replication in other contexts.

KEY WORDS: Emergency department, buprenorphine, naloxone, opioid dependence, randomized clinical trial.

INTRODUCTION: Opioid dependence is a leading cause of death in the United States, with an estimated 16,000 deaths in 2010.¹ The majority of these deaths are attributed to the use of prescription opioids, which are often prescribed for pain management in the emergency department (ED).²

Emergency department-initiated buprenorphine/naloxone treatment has been shown to be effective in increasing engagement in addiction treatment and reducing self-reported illicit opioid use.³

However, the effectiveness of brief interventions and referral to community-based treatment services remains unclear.⁴

This study compares the effectiveness of 3 interventions for opioid dependence: ED screening and referral to treatment (terrestri), ED screening, brief intervention, and facilitated referral to community-based treatment services (brief interventions), and ED screening, brief interventions, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

The primary outcome was enrollment in and receiving addiction treatment 30 days after randomization. Secondary outcomes included self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services.

The study was conducted at an urban teaching hospital ED from April 2, 2012, through June 16, 2013. The study was approved by the Institutional Review Boards at the study site and the University of Massachusetts Lowell.

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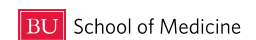
JAMA Report Video and Author Video Interview at jama.com
CME: Go to jama.com and CME: Questionnaire page 1670

(screen), TREAT AND REFER (vs SBI vs S...RT)...

- ✓ increased engagement in addiction treatment (78% vs 41%),
 - ✓ reduced self-reported illicit opioid use (5 to 1 vs 2 days/wk)
 - ✓ decreased use of inpatient addiction treatment services
 - ✓ did *not* decrease the rates of urine samples positive for opioids
- *34% seeking treatment, 9% overdose, 73% past drug treatment

(*e.g. Terrific! Though not SBIRT)

D'Onofrio et al. JAMA 2015



SBI DRUGS

- Harder to change a behavior that is not socially sanctioned yet being done or that is not particularly problematic from the patient's perspective
- Injection, heroin, cocaine, MJ, qualitatively different
- Other reasons to ask/intervene: interactions/safety, diagnoses, help-seeking/recognized
- Need better ways to address in general medical settings...repeated BI and/or just treat



What works?
Clinical effectiveness.

BMJ

BMJ 2013;346:e8501 doi: 10.1136/bmj.e8501 (Published 9 January 2013)

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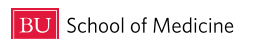
RESEARCH

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

 OPEN ACCESS



EXCEPTIONAL CARE, WITHOUT EXCEPTION.



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

SUMMARY/IMPLICATIONS

- Brief intervention involves feedback, advice and goal setting
- Among those identified by screening, the best evidence for efficacy is for reducing self-reported alcohol consumption in primary care settings
 - Efficacy for disorders, drugs and in acute care settings limited
- Likely effective for health behaviors (e.g. drug use) among those seeking your help
- Feasible in general health settings
- Can be done by generalists
- Repeat or just treat