Evidence-Based Practices: Screening and Early Intervention for Alcohol and Prescription Medication Use

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Motivational Brief Prevention and Intervention Methods
SBIRT MODEL

- Screening
- Brief Intervention
- Referral to Treatment
Who Can Conduct Brief Alcohol Interventions?

• Physicians
• Nurses/Nurse Practitioners
• Physician Assistants
• Social Workers
• Psychologists
• Health Educators
• Home Health Workers
• Other Allied Health Providers
Settings for Brief Interventions

- Primary Care
- Emergency Department
- Hospitals
- Community
- Workplace
- Home Health Care
- Substance Abuse Treatment Programs
Empirical Support for Brief Interventions with Older Adults

Project GOAL (Guiding Older Adult Lifestyles)

Physician advice for older adult at-risk drinkers led to reduced consumption at 12 months
(University of Wisconsin; N=156; 35-40% change)

Health Profile Project

Elder-specific motivational enhancement session conducted in-home reduced at-risk drinking at 12 months
(University of Michigan; N=454; 35% change)
Current Knowledge

- Brief Interventions (BI) can reduce alcohol use for at least 12 months among older adults
- Motivational enhancement effective
- Approach is acceptable to older adults and can be conducted in health clinics and in-home
- BI appears to reduce alcohol-related harm
- BI appears to reduce health care utilization
Barriers to Seeking Alcoholism Treatment for Older Adults

- Resistance to asking for help
- Disdain of labels (alcoholic, old)
- Lack of transportation
- No significant others to assist in motivation to seek help
- Providers less likely to refer older adults
- Gaps in substance abuse, aging, and mental health services
Elements of Brief Intervention

• FRAMES
  – Feedback
  – Responsibility
  – Advice
  – Menu
  – Empathy
  – Self-efficacy
Feedback

• Present information to client
  – Based on history, exam, labs, etc.

• Increase awareness of adverse consequences

• Help make the case for change in drinking, med use, or illicit substances
Responsibility

- Client has the ultimate responsibility for change
- Practitioner can’t force client to change
- Client chooses goals, not practitioner
  - Should be realistic
  - Clarify client’s goals
  - Develop discrepancy
Advice and Menu

• Give clear, concrete advice to change
• Give choices (menu)
  – 3 is ideal
  – Making a choice is first step to making a change in behavior

“Lose some weight, quit smoking, move around more, and eat the carrot.”
Empathy

- Listen carefully
- Clarify client’s meaning
- Don’t impose practitioner’s values on client
Self-efficacy

- Build up client’s belief in ability to succeed
- Be optimistic
- Simple goals early
  - Success breeds success
  - Increases self-confidence
Motivating patients not yet ready to quit drinking: The 4 “R’s”

- RELEVANCE to that patient
- RISKS of continuing to use
- REWARDS of quitting
- REPETITION at each encounter
## Confrontation vs. Motivational Interviewing

<table>
<thead>
<tr>
<th>Confrontational Approach</th>
<th>Motivational Interviewing Approach</th>
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<tbody>
<tr>
<td>• Accept self as alcoholic</td>
<td>• De-emphasis on labels</td>
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<tr>
<td>• Personal pathology - reduces personal choice, judgment, control</td>
<td>• Emphasis on personal choice and responsibility</td>
</tr>
<tr>
<td>• Present evidence of problems</td>
<td>• Elicit concern/evidence</td>
</tr>
<tr>
<td>• Resistance = “denial”</td>
<td>• Resistance influenced/induced by interviewer</td>
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<tr>
<td>• Meet resistance with argumentation and correction</td>
<td>• Meet Resistance with Reflection</td>
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<tr>
<td>• Goals and strategies prescribed</td>
<td>• Goals and Strategies negotiated - involvement and acceptance of goals are vital</td>
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Brief Intervention Session
Steps in Brief Alcohol Intervention

- Identifying future goals
- Summary of health habits
  - Individualized feedback on health, drinking, consequences
- Standard drinks
- Types of Older Drinkers
- Consequences of At-Risk drinking
- Reasons to quit or cut down
- Drinking agreement and plan
  - Controlled drinking vs. abstinence goal
- Risky situations/Alternatives
Brief Intervention Steps

**Identifying future goals**

- Participants are asked to identify their goals
  - Physical and mental health
  - Social lives/relationships
  - Finances, etc.

- *This makes certain issues affected by alcohol salient, and may assist in developing a discrepancy between current drinking and valued goals during the course of the intervention.*
Brief Intervention Steps

Summary of health habits

- Participants provide information regarding
  - physical and mental health functioning
  - health habits, nutritional issues, tobacco use
  - alcohol consumption

- This is an opportunity for the interventionalist to give individualized Feedback, and facilitates self-reflection regarding health status and alcohol use.
What's a standard drink?
1 standard drink =

1 can of ordinary beer or ale
12 oz.

a single shot of spirits
1.5 oz.
whiskey, gin, vodka, etc.

a glass of wine
5 oz.

a small glass of sherry
4 oz.

a small glass of liqueur or apertitif
4 oz.
Brief Intervention Steps

Standard Drinks and Types of Older Drinkers

- Participants are introduced to the concept of standard drinks.
- Participants are shown how their level of alcohol consumption compares to other older adults.

- This assists participants in understanding that the effects of alcohol are similar across beverage groups and puts their drinking in perspective.
Brief Intervention Steps

Reasons to quit or cut down

- Participants are asked to identify positive and negative aspects of their alcohol use.
- Participants are asked to identify "benefits of change" and "barriers to change".

This assists participants in weighing the issues, and hopefully "tipping the decisional balance" in favor of changing drinking habits.
Participants are asked to choose a drinking goal (reduction vs. abstinence), their start date for addressing their drinking, their rate of reduction, and target date. This provides a menu of options to participants. Intervention staff may offer additional feedback/advice. Goal choice increases a sense of personal responsibility.
Brief Intervention Steps

Risky Situations/Alternatives are identified

- Participants are asked about the situations and environmental cues that may trigger drinking.

  - Increases insight into consumption, allows participants to identify their own strategies for cutting down. Staff are trained in Empathic techniques and to Support Self-efficacy.
Practical Summary

- Assess both consumption and consequences
- Consider possible goals (engage in treatment/quit or reduce drinking)
- Use the FRAMES/Motivational Enhancement Approach
Special Circumstances

⇒ Alcohol Withdrawal
⇒ Excessive Drinking
  28+ drinks/week
⇒ Benzodiazepine/Opioid Use
  5+ days/week for 3+ months
Follow-up Sessions

• The timing of these sessions are flexible
  – Patients should receive a follow-up session at 6 and 12 weeks after the initial session

• The purpose is multifaceted
  – Assess progress
  – Show concern and empathy
  – Provide support and advice
How to Improve Implementation of Alcohol Brief Interventions for Older Adults Across Systems?
PRISM E
Primary Care Research in Substance Abuse & Mental Health for the Elderly
A Comparison of Two Service Models for Depression and At-risk Alcohol Use in Older Adults

- Integrated/Collaborative Care
  - Co-Located
  - Concurrent
  - Collaborative

- Enhanced Referral to Specialty Mental Health and Substance Abuse Clinics
  - Preferred providers and facilitated appointments, transportation, payment
Study Design

• Randomized trial comparing integrated (collaborative) care to referral care

• Target conditions
  – Depression
  – Anxiety
  – At-risk Drinking

• Study Phases
  – Screening
  – Baseline assessment
  – Follow-up assessments at 3 and 6 months
Greater engagement in care for integrated care (65%), compared with enhanced specialty referral (38%)

In integrated care, 120 participants (43%) received one BAI
  - Only 24 patients in integrated care (9%) had recommended 3 BAI sessions
  - Fewer participants in this group with a dual diagnosis received BAI (32%), compared with those without such a diagnosis (47%)

Significant reductions in quantity and frequency of drinking and binge drinking over 6 months; no differences in drinking outcomes between models

Minimal uptake and implementation of BAI in both study groups

(Oslin et al., 2006)
Rates of Engagement in MHSA Care: By Diagnosis/Condition

- Overall
- Depression
- Anxiety
- At-risk drinking
- Dual diagnosis

Integrated vs Referral
Treatment
Figure 2. All Admissions, by Age Group and Referral Source: 2001

Source: 2001 SAMHSA Treatment Episode Data Set (TEDS).
Models of Substance Abuse Care for Older Adults

• Current bias toward institution-based services conflicts with expressed preferences and needs of older persons
  – Home and community-based settings preferable
• Mixed-age treatment viable if integrated with individualized, age-appropriate, and culturally competent components
• **Age-appropriate** treatment models essential
• Integrated substance abuse and mental health care in primary care settings
• Alternative modalities: phone, web-based, group
Types of treatment

- Detoxification
- 12-Step groups
- Outpatient counseling
  - Cognitive-behavioral
  - Case management
- Intensive outpatient
- Inpatient
- Residential
Treatment Adherence

- Older adult adherence to medically-based psychosocial intervention and naltrexone was compared to younger adult adherence
- Older adults had greater attendance at therapy sessions and greater medication adherence
- Less relapse for older adults
- Mixed-age treatment settings can be successful for older adults when age-appropriate, individualized psychotherapeutic approaches are included

(Oslin et al., 2002)
Outpatient Treatment Outcomes

- In matched samples of adults with substance use disorders
  - Older (> 55) and younger patients received comparable amounts of outpatient mental health care
  - Older patients had better substance use and functioning outcomes compared to younger patients at 12-month follow-up

(Brennan et al., 2003)
12-Step Groups

• A.A., N.A., C.A.
• Group format
• Anonymous
• No cost
• No affiliations or endorsement
• Different groups have different characteristics
  – “Gray A.A.” for Older Adults

12 Steps

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

These steps are from the book, “Alcoholics Anonymous.”
Addiction Counseling

- Motivational Interviewing
- Network therapy
- Family therapy
- Supportive psychotherapy
- Building Social Networks

- Twelve-Step facilitation
- Perceptual Adjustment Therapy
- Rational Recovery
- Medication Management
- Brief Interventions
Treatment Matching

- Engage patients with addiction by matching to optimal setting and modalities for most effective and least restrictive level of care.
- Base matching on:
  - Intoxication and withdrawal
  - Medical complications, psychiatric factors
  - Treatment acceptance/resistance
  - Relapse potential, recovery environment
Treatment in older adults

• Focus on coping
  – Depression, loneliness
  – Losses
• Rebuild social support network
  – Socialization groups
  – Alumnae meetings
• More compliant
• Outcomes as good or better than younger patients
Treatment works for Older Adults

- Sustained remission rates of up to 60%
  - Better success than treatment of hypertension, diabetes
- Every $1 spent on treatment saves $7 in costs to society
- Lots of new research
Bridging the Gaps: Implementation

• National imperative to implement Evidence Bases Practices (EBPs)

• Science to service gap: scientifically proven effective practices are not widely used

• Implementation gap: positive outcomes achieved by research are not replicated in the field

• Both effective interventions and successful implementation are necessary for positive outcomes
Take Home Messages

- Early identification of and early intervention for substance abuse in older adults is crucial.
- For those with serious problems/addiction: TREATMENT WORKS!
- National focus on substance abuse prevention and treatment is critically important as the “Baby Boom” generation reaches later adulthood.
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