Module IV: Intervention and Referral

I. Learning Objectives –

At the end of the training, health care professionals will be able to:

- Summarize the data in support of universal substance abuse intervention in generalist health care and social services settings.
- Perform substance abuse brief intervention, and referral in their health care and social services settings.
- Document substance abuse activities appropriately with attention to legal and ethical issues.
- Teach trainees to teach others.

II. Chronology

This material is best taught over approximately 1 hour and 20 minutes with interspersed, supplementary experiences. Below is a suggested schedule for lecture and practice of brief intervention and referral.

5 minutes – Introduction of Brief Intervention and Referral
Lecture: Give Learning objectives for this Module.

5 minutes – Description and Effectiveness of Brief Interventions
Lecture: Describe brief interventions, and summarize research on their effectiveness.

5 minutes – Effectiveness of Treatment for Substance Dependence
Lecture: Various kinds of treatment for substance dependence and their effectiveness. Conceptualization of substance dependence as a chronic, relapsing and remitting condition.

10 minutes – Describe Steps of Brief Intervention/Referral
Lecture: Describe the principles and steps in detail.

10 minutes – Discuss Documentation and Implementation
Lecture: Describe the issues involved in appropriate documentation of substance abuse activities and implementation in the clinical setting.

15 minutes – Demonstration of Brief Intervention
Demonstration: Ask a learner to portray the same patient/client as in the last session. Ask the learner to portray a client who is initially resistant but willing to considering changing their substance use pattern if negative consequences are cited in a caring, respectful manner. As in the last session, advise the other learners that you may stop the interview periodically to ask them: (1) What was I doing and how did I do it (content and process)? (2) What worked well, and what might I have

done differently? (3) What might I do next? Begin the demonstration, top periodically, discuss the above questions as appropriate, and build a list of Do's and Don'ts.

20 minutes – Brief Intervention Practice and Feedback
Practice, feedback, and discussion: Have the students pair up and practice brief interventions using the same scenario. One student plays the clinician at first; then the other. Allow 5 minutes for the role-play itself, stating that screening must be accomplished quickly if learners are to incorporate substance abuse screening into routine practice. Allow 2 minutes for feedback from the patient/client to the practitioner. In the next 3 minutes, take comments from patients/clients about what the practitioner did well, and take comments from the practitioners what they found challenging and need to practice. Repeat after swapping roles.

10 minutes - Summary
Wrap-up: Summarize the main points about brief interventions. Emphasize that the formula for brief interventions can be used for referrals of substance dependent individuals to substance abuse treatment; referral simply becomes the practitioner's first recommendation; the next recommendations would be to decrease substance use as much as the individual is willing. Entertain questions. Summarize the main points from all four sessions. Empower students to practice these skills in appropriate situations, if possible.

Possible Activities After Module III
- Read a review article on brief intervention
- Read an original research report on the effectiveness of brief interventions
- Practice brief intervention with simulated or instructor patients/clients*
- Practice brief intervention in a practice setting*

* Some practice is highly recommended.

III. Instructor materials
- Hard copies of slides
- Reading list for possible assignments
- Guide to administering role play exercises
- Sample case scenarios – Instructors may wish to develop their own scenarios to better reflect their own settings.

IV. Participant materials
- Participant handouts
- Skill self-assessment sheets for intervention

Module III: Intervention and Referral

This handout is organized in the order of the Module III Slides. Following the number and title of each slide are notes that the presenter can use to educate the participants about each area of the material.

Slide 1, Module III: Intervention and Referral – In this module you'll learn how to intervene and refer clients/patients for alcohol and drug problems.

Slide 2, Learning Objectives –You'll be able to cite data on the effectiveness of substance abuse intervention. You'll be able to perform brief intervention and referral. You'll understand the issues around documenting information on substance abuse in clinical records. You'll understand issues around implementation in the clinical setting. And you'll be able to teach others these skills.

Slide 3, Generalist Care for Substance Use and Related Disorders – This slide shows a scheme for generalist care of individuals with regard to substance use. We've already talked about screening and assessment in Module II. Now we will discuss brief intervention and referral. For high-risk users or abusers, deliver brief interventions and follow up. For substance dependent individuals, attempt to refer to treatment. If treatment is declined or not available, try brief and full motivational interventions, and follow up (See Module IV). All of these steps will be discussed in further detail, and now we'll talk more about intervention.

Module 4, Brief Intervention – The definition of a brief intervention is a bit problematic, as the distinction between minimal, brief, and extended interventions is unclear. We're defining a brief intervention as an intervention designed to promote behavior change that includes an initial 5 to 15 minute session, up to 3 follow-up contacts, and possibly some educational materials.

Slide 5, Evidence on Brief Intervention – Now, it wouldn't make sense to screen individuals if there were no help for substance use disorders. So, next we'll quickly examine research on the effectiveness of brief interventions and specialized treatment of substance use disorders. Brief interventions are rather brief sessions with individuals aimed at getting an individual to cut down or quit their substance use. Sometimes one, two, or three follow-up sessions are planned, too. More than a dozen randomized controlled trials have been performed on brief interventions. Most of those brief interventions studied embraced the following motivational philosophies:

- Individuals were given feedback on the risks and/or negative consequences of their substance use
- However, the interventionist emphasized that the individual is responsible for making his or her own decision about their substance use.
- The interventionist, however, gave straightforward advice on modifying substance use.
- Individuals were often given menus of options to choose from in strategies to help them modify their substance use.

- The interventionist was empathic, respectful, and non-judgmental.
- The interventionist expressed optimism that the individual could modify their substance use if they so chose.

Slide 6, Evidence on Brief Interventions (Continued) – Most of the randomized controlled trials focused on at-risk drinkers and alcohol abusers. A random half of the subjects received a brief intervention. The other half, the control group, received usual care, a simple suggestion to drink less, or a pamphlet about drinking. Most studies used self-report to assess outcomes, as other research has substantiated the accuracy of self-report in research settings where subjects are not penalized or judged for their responses. In every study, the individuals who received brief interventions had a greater decline in their drinking than the controls. In studies that measured other outcomes, subjects who received brief interventions had decreases in liver inflammation as measured by blood tests, improved attendance at work, fewer days in general hospitals, less health care utilization, fewer car crashes, and less involvement with the criminal justice system.

Slide 7, Evidence on Brief Intervention (Continued) - Perhaps the best known and most rigorous study of brief interventions was performed by Dr. Michael Fleming and colleagues at the University of Wisconsin. They found that for every individual involved in a screening and brief intervention program, there was a savings of $1146 after one year. On average, it the screening and brief intervention cost $250 per subject. Therefore, there was a net savings of $946 per individual after one year. There may well be additional savings in subsequent years, but these were not measured. Thus, the data suggest that screening and brief intervention are not only effective but also save money within one year.

Slide 8, Evidence on Treatment – Next we'll look very briefly at the research findings for substance abuse treatment. When asking the question whether treatment works, it's important to frame the question appropriately. Some individuals believe that treatment is not effective, because their benchmark is abstinence and complete cure. Experts recommended, however, that we assess treatment for substance use disorders in the framework of a chronic disease model. In this framework, we accept that relapses are inevitable, and the appropriate outcomes are reductions in substance use, improved function, better quality of life, and lower mortality. This framework is used for assessing research relating to other chronic conditions, including cancer, heart disease, diabetes, arthritis, and depression.

Slide 9, Evidence on Treatment (Continued) - In this framework, there is no dispute – typical treatments for substance abuse are effective for the individuals who typically receive them. All of the treatments on this slide have been found effective in a study by the Institute of Medicine of the National Academy of Sciences. In fact, many treatments for substance use disorders are more effective than many conventional, commonly used treatments for other health problems. Therefore, particularly for patients who are alcohol or drug dependent, referral to treatment programs is highly recommended.

Slide 10, BI/Referral Principles – For individuals who are in the at-risk or abuse categories, brief interventions are recommended. As we discussed previously, these are the principles underlying successful brief interventions:

- Give feedback on the risks and/or negative consequences of substance use
- Emphasize that the individual is responsible for making his or her own decision about their substance use.
- Give straightforward advice on modifying substance use.
- Gives menus of options to choose from, fostering the patient's/client's involvement in decision making
- Be empathic, respectful, and non-judgmental.
- Expressed optimism that the individual can modify their substance use if they choose to

Slide 11, BI/Referral - Steps – There is no one right way to deliver a brief intervention. This slide shows some suggested steps as a starting place. Notice that the steps follow the mnemonic FERNSS.

Feedback – First deliver feedback on the risks and/or negative consequences of substance use. I'll suggest how to do this in a minute.

Education – Educate how substance use can lead to consequences that are relevant to the patient/client

Recommendation – Recommend quitting entirely or a particular amount to cut down to

Negotiation – If your recommendation is declined, attempt to elicit some commitment to change

Secure agreement – Confirm the agreement concretely and specifically

Set follow-up – Monitoring is critical

Slide 12, Feedback – Now I'll mention more specifics about each step. Again, there is no one right way to perform these steps, but you may find these suggestions helpful.

When giving feedback, initially list the negative consequences and risks without relating them to substance use. After the patient/client has tacitly agreed, raise concern that substance use – although it might have some positive aspects – might be contributing to the consequences and risks. Then seek reaction, listen, and acknowledge.

Slide 13, Education – If appropriate, educate the patient/client how substance use can lead to the relevant consequences. Initially ask what the patient/client knows about this. If there is a knowledge gap, and if the patient/client is interested in learning more, convey the information briefly, using appropriate vocabulary for the patient. Then ask whether this might apply to the patient/client, listen, and acknowledge.

Slide 14, Recommendations – Make a recommendation about reducing or quitting substance use. If the patient is substance dependent, or if there is a family history of substance dependence, or if the patient is using hard drugs, then the optimal recommendation is referral to a specialized individual or program at least for assessment. Otherwise, a recommendation to cut down may be appropriate. A standard recommendation is that men drink less than 14 drinks a week and less than 5 drinks per occasion, that women drink less than 11 drinks a week and less than 3 to 4 drinks per occasion, and that the elderly drink no more than one drink a day. Remember that these recommendations are based on averages; some patients/clients may need to drink less than this to eliminate some consequences.

Slide 15, Negotiation – If dependent individuals decline a referral, ask if they would be willing to attempt abstinence on their own. Ask alcohol dependent patients who decline abstinence try if they would attempt to adhere to low-risk drinking levels. Ask if drug dependent individuals who decline treatment or abstinence to cut down to levels that they believe will allow them to avoid negative consequences. Help individuals identify changes that they are willing to make. Identify reasons for resistance to the recommendations, such as some of the positive aspects of substance use, and brainstorm and problem-solve around these reasons. Support any change an individual is willing to make.

Slide 16, Secure Agreement – Make sure that you and the patient/client have a common understanding of any commitment to change. Be concrete and specific. For example, ask patients/clients to state the maximum numbers of drinks they will have per week and on specific days of each week. Record the patient's/client's commitment in writing. Give him or her a copy, and keep a copy; this is helpful for follow-up. Express optimism and support. Make this a positive experience for patients/clients.

Slide 17, Set Follow-Up – Finally, set follow-up – usually in a month, but sooner if the patient or client wishes. Make clear that you will not be judgmental or angry if the patient/client finds it difficult to stick to their commitment. Your approach will be to sit down and work out calmly with the patient/client how to proceed.

Slide 18, Follow-Up – During follow-up, assess the degree to which patients/clients were able to adhere to their plans. If they had difficulty, reassess for quantity and frequency, consequences, and evidence of lack of control. As before, make a recommendation. For patients/clients who succeeded, negotiate a long-term plan about limits of substance use and, perhaps, the substance use or consequences that should prompt a next step, such as a consultation by a substance abuse specialist. If a return visit to you is not possible, work with them to identify a professional, such as a primary care provider, who will follow them.

Slide 19, At Follow-Up, If No Better – For individuals who don't improve with this approach, a broader motivational interviewing approach can be helpful if patients/clients will not or cannot get treatment. For patients who are not dependent but choose to continue risky or problematic substance use, follow them, keep the conversation open, identify new negative consequences, and take advantage of these opportunities to assess for greater receptivity to change.

Slide 20, Documentation – When providing health services relating to substance use, documentation can raise difficult issues. Recording details can help remind you and colleagues to continue addressing this issue, provide information to enhance continuity, leave a record of the quality of care you're providing, and protect against legal challenges. There can be some disadvantages, too. Having information on substance use in records can work against patients/clients if other providers will be judgmental and if breaches of confidentiality occur.

Slide 21, Documentation (Continued) – There are potential legal ramifications to recording details about substance use. Records can be subject to subpoena, such as for child custody cases. When individuals apply for insurance, they are expected to give insurers permission to review past records. In some states, drug use or excessive alcohol use in pregnancy can lead to mandatory treatment and/or imprisonment. Most substance abuse and public health efforts believe that this approach is counter-productive, as it probably discourages many women from receiving prenatal care. This is especially tragic for some women, because prenatal care is especially important for women with high-risk pregnancies, such as those with alcohol or drug dependence.

Slide 22, Principles of Documentation – There are some important legal concepts to remember about documentation. One is that the patient/client owns the information, while the practitioner owns the record. In general, written permission is required for release of information, though in many states, oral permission, or sometimes no permission, is sufficient in emergencies. There is special federal law that provides minimum requirements for confidentiality of health care records pertaining to sensitive issues, including sexually transmitted diseases, HIV, mental health, and substance abuse. For release of information of these topics, there must be written consent that specifies the topic, the purpose of the release – for example, clinical care, administrative review, or research, and effective and expiration dates. It's helpful to have a standard record release form that satisfies these federal requirements.

Slide 23, Implementation – Before stopping, I would like to address some implementation issues. Even if every practitioner in your setting came to a weeklong workshop on this material, even if they learned the skills very well, even if they were committed to doing a good job on this, it's still likely that most patients/clients in your setting wouldn't receive these services. There are many systems barriers to performing these services. Many professionals already feel overburdened by current demands for current services. Many record systems are not set up well to prompt us to remember to provide this kind of service. In the long run, few practitioners would reap any reward for performing well in this realm, while there are rewards for performing well in other ways. Therefore, it's critical to consider systems issues and incentive issues when trying to implement substance abuse screening and intervention. It's helpful if an authority figure will buy into this. Directives may be useful in some settings. In others, a consensus building process might be more effective. Automated reminders can help. Having all office staff meet and work out procedures can be helpful so that responsibilities for various tasks are shared. For example, you might agree to have an administrator update your intake forms to include a substance abuse screen, and you might

have receptionists distribute and collect written screens and place copies where practitioners will see them. You might set up a flow sheet system to following screening results, intervention, and follow-up efforts. Establishing these kinds of systems and building in routine CQI procedures can yield a higher chance that these services will be delivered with the best quality possible on a lasting basis.

Slide 24, Summary – So, in summary, it's clear that intervention and treatment are effective. Since most people with alcohol and drug problems never receive these services, it's important that generalist health care and social services professionals learn to provide them. Intervene or make referrals in an empathic, respectful way, using the FRAMES principles and the FERNSS sequence. Provide follow-up to assess whether the intervention has been effective or whether other measures are appropriate. Document your care, choosing what details to document based on the legal and ethical issues of your practice setting. And set up systems to ensure that screening, intervention, referral, and follow-up services are delivered regularly and appropriately.

References

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Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Med Care* 2000;38(1):7-18.

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APPENDIX I

FEEDBACK FORM ON BRIEF INTERVENTION

I. Content

A. Biomedical Health ☐ Excellent ☐ Could be better
NOTES:____

B. Requested no interruption ☐ Excellent ☐ Could be better
NOTES:____

C. Listed negative consequences and risks ☐ Excellent ☐ Could be better
NOTES:____

D. Tied in patient's goals/agenda ☐ Excellent ☐ Could be better
NOTES:____

E. Stated your concern ☐ Excellent ☐ Could be better
NOTES:____

F. Solicited patient's response ☐ Excellent ☐ Could be better
NOTES:____

G. Made a recommendation regarding use ☐ Excellent ☐ Could be better
NOTES:____

H. Negotiated use, measures of success, and follow-up ☐ Excellent ☐ Could be better
NOTES:____

I. Confirmed agreement ☐ Excellent ☐ Could be better
NOTES:____

II. Process - words, intonation, eye contact, facial expression, body language

A. Displayed comfort and warmth ☐ Excellent ☐ Could be better
NOTES:____

B. Kept interview on track ☐ Excellent ☐ Could be better
NOTES:____

C. Showed respectful, nonjudgmental concern ☐ Excellent ☐ Could be better
NOTES:____

Module IV: Intervention and Referral

Project MAINSTREAM

Draft – 10/05

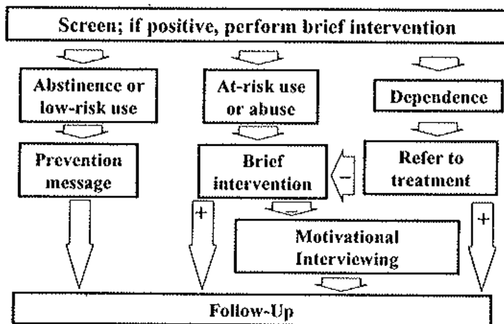
1

Learning Objectives

Health Care Professionals will be able to:

- Cite data on intervention effectiveness
- Intervene and refer effectively
- Document appropriately
- Understand issues around implementation
- Teach others

2



3

Brief Intervention

- One 5 to 15 minute session
- Up to 3 brief follow-up contacts, in person or by telephone
- May include educational materials
- Purpose is to elicit a behavior change

4

Evidence on Brief Interventions

- Intervention - up to 15 minutes of dialogue with up to 3 follow-up sessions
- Feedback
- Responsibility
- Advice
- Menu
- Empathy
- Self-efficacy

5

Evidence on Brief Interventions (continued)

- Several randomized controlled trials
- Subjects: at-risk and problem drinkers
- Control subjects improved - screening and assessment can elicit behavior change
- Experimental subjects improved more
- Statistically significant differences in:
  - Self-reported Q/F
  - Liver inflammation
  - Attendance at work
  - Days in hospitals
  - Costs of health care, car crashes and criminal justice

6

Evidence on Brief Interventions
(continued)

Per subject:

- Costs savings in health care, car crashes, criminal justice: $1146
- Cost of screening/intervention: $250
- **Net cost savings** **$946**

Fleming et al, *Medical Care*, 2000.

7

Evidence on Treatment

- Consider SUD's as chronic relapsing and remitting conditions
- Abstinence is but not sole criterion for evaluating effectiveness of treatment
- Other criteria for effectiveness are less substance use, better function, improved quality and duration of life

8

Evidence on Treatment (continued)

Effective for those who commonly receive them:

- Inpatient & outpatient alcohol treatment
- Naltrexone for alcohol dep. (short-term)
- Opioid maintenance treatment
- Long-term residential drug treatment

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BI/Referral - Principles

- Feedback
- Responsibility
- Advice
- Menu of options
- Empathy
- Self-efficacy

10

BI/Referral - Steps

- Feedback
- Education
- Recommendation
- Negotiation
- Secure agreement
- Set follow-up

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Feedback

- Summarize negative consequences
- Describe relevant risks
- Raise concern about substance use
- Seek reaction
- Listen and acknowledge

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Education

Educate about how substance use is linked to consequence or risk

- Assess prior knowledge
- Assess interest in information
- Convey information
- Assess

13

Initial Recommendations

For at-risk use or abuse:

- For + family history: abstinence
- For – family history: low-risk use

For dependence:

- Abstinence
- Referral to specialist/treatment

14

Negotiation

Listen and acknowledge response

If recommendation is resisted:

- Ask about interest in change
- Suggest further change if risks or consequences will continue
- Help remove barriers to change
- Accept decision; support any change

15

Secure Agreement

- Ensure specificity and concreteness
- Record agreement for client/pt and practitioner
- Express optimism and support

16

Set Follow-Up

- Suggest follow-up at one month
- Offer follow-up sooner
- Emphasize desire for follow-up regardless of progress
- Reassure about lack of anger and judgment if pt/client has difficulty

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Follow-Up

- Assess progress after intervention
- Reassess if necessary: consequences, dependence, Q/F
- Make recommendation
- Negotiate
- Secure agreement; set follow-up

18

At Follow-Up, If No Better

Use motivational interviewing, OR

For dependence:

- Recommend referral, continue discussing over time

For abuse or at-risk use:

- Continue discussing over time
- Consider specialized assessment or consultation

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Documentation

Advantages	Disadvantages
◆ Reminder to attend to issue in future	◆ Colleagues/staff may be judgmental
◆ Useful information for colleagues	◆ Breaches of confidentiality
◆ Documents quality of care	◆ Legal, economic, & social ramifications
	◆ Insurance issues

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Documentation (continued)

Possible Ramifications

- Subpoena
- Insurance applications
- Child custody decisions
- Mandatory or optional reporting of pregnant substance users may lead to imprisonment and/or forced treat-ment in some states

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Principles of Documentation

- Practitioner owns record; patient/client owns information
- Written permission required to release records (except when life is at stake)
- Federal confidentiality law
  - Must have specific permission to release information on substance abuse, mental health, HIV/AIDS, and STD's
  - Must include effective and expiration dates and purpose of information release

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Implementation

Practitioner training alone is minimally effective

Bolster training with:

- Directives
- Peer consensus
- Incentives
- Reminders
- Team approaches
- Systemization
- CQI

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Summary

- Intervention and treatment work
- All generalist health professionals should intervene and refer
- Intervene: FRAMES & FERNSS
- Follow-up
- Document with care
- Consider implementation issues

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