Washington State Screening, Brief Intervention, and Referral to Treatment Program

Final Program Performance Report: October 1, 2003 through September 30, 2009

JULY 2010

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About this Publication

Title: Washington State Screening, Brief Intervention, and Referral to Treatment Program
Final Program Performance Report: October 1, 2003 through September 30, 2009

Abstract: This report provides a description of the accomplishments of the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) Program, funded by federal grant number 4 TI015962-05-1. The WASBIRT Program was conducted in nine hospitals within six counties in the state. Over 104,000 screenings were completed in the hospital emergency departments. This report provides detailed information about the results of the WASBIRT evaluation project which found reductions in substance use, reductions in medical costs, improvements in social and mental health outcomes, and reduced risk of death. The Division of Behavioral Health and Recovery has undertaken a number of activities to sustain SBIRT services in Washington state in the future, including the publication of a training manual for acute care settings and changes to Washington Administrative Code to provide screening and brief intervention as certified services.

Keywords: Alcohol/Drug Treatment, Cost Offsets, Medicaid, Substance Abuse, Alcohol/Drug Screening, Addiction Costs, Brief Intervention, Referral, Emergency Department Intervention,

Category: Substance Abuse Intervention and Referral to Treatment

Geography: Washington State

Research Time Period: October 2003 to September 2009

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Project Name: Washington State Screening, Brief Intervention, and Referral to Treatment Program

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Cover Design by: DSHS Research and Data Analysis Division
TO: Substance Abuse and Mental Health Services Administration

It is my privilege to transmit the final program performance report for Washington State’s Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program. As one of the first states to receive funding from SAMHSA for the SBIRT grant initiative, I am pleased to report the many accomplishments we have been able to achieve.

Over 104,000 screenings for substance abuse disorders were completed in nine separate hospital emergency departments. Washington State successfully implemented our SBIRT program in nine hospitals located in six counties.

SBIRT was associated with a number of improvements in substance use, mental health, and other outcomes. Patients who got at least a brief intervention reported significant declines in the use of alcohol and other drugs, increased abstinence, reduced anxiety and depression, increased employment, and reductions in homelessness. We also found significantly lower death rates for working-age disabled Medicaid clients than for a statistically matched set of emergency department patients.

Admissions to chemical dependency treatment increased for those who got brief interventions and even more for those who received brief treatment. The odds of entering chemical dependency treatment were significantly greater among Medicaid and other low-income patients who received at least a brief intervention compared to those who did not.

Medical costs were significantly lower among working-age disabled Medicaid clients. Providing at least a brief intervention to working-age disabled Medicaid clients was associated with significant reductions in subsequent medical costs compared to costs for similar patients who did not get SBIRT services.

The work continues. Several of the participating hospitals chose to continue to offer SBIRT services once the federal grant ended. In addition, the Division of Behavioral Health and Recovery collaborated with the state’s Medicaid program to propose an amendment to the state’s Medicaid plan to include screening and brief intervention (SBI) services. Our division modified our state’s Administrative Code to include SBI as a new form of certified service. We recently published an SBIRT training manual for providers in acute medical care settings. We continue to seek ways to incorporate SBIRT services into our state’s health care system.

We look forward to future collaborations working toward our common goals to improve the continuum of care for patients with substance use disorders.

David A. Dickinson, MA, Director
Division of Behavioral Health and Recovery
Washington State Screening, Brief Intervention, and Referral to Treatment Program (WASBIRT)

Final Program Performance Report, October 1, 2003 through September 30, 2009

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I. Legal Authorities: Washington Administrative Code (WAC)
Washington State Screening, Brief Intervention, and Referral to Treatment Program (WASBIRT)

Final Program Performance Report: October 1, 2003 through September 30, 2009

PROJECT MANAGEMENT:
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GRANT NUMBER: 4 TI015962-05-1

IN THE FALL OF 2003, the U.S. Department of Health and Human Services, Center for Substance Abuse Treatment (CSAT) awarded funding to the Office of the Governor for the State of Washington for a five-year cooperative agreement, titled the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program. The Governor’s Office directed the Division of Alcohol and Substance Abuse, now the Division of Behavioral Health and Recovery (DBHR), of the Department of Social and Health Services (DSHS) to implement a Washington State SBIRT (WASBIRT) Project in large hospital emergency departments across the state.

The WASBIRT Action Plan submitted by the Division of Alcohol and Substance Abuse to CSAT in January 2004 identified six specific goals for the Project. This report describes the activities undertaken during the project to address each goal.

GOAL 1 | Identify a large number of emergency department (ED) patients with substance abuse problems.

In April 2004, the first patients were enrolled in the WASBIRT Project at Harborview Medical Center in Seattle. Enrollment began shortly thereafter at several other sites and continued through the end of January 2009 culminating in a total of 106,464 screenings by the end of the project (see Appendix A for final WASBIRT Internal Tracking Report, April 12, 2004 – January 31, 2009).
The WASBIRT project was a joint partnership of the Washington State Department of Social and Health Services, six county governments, nine hospitals, and over a dozen chemical dependency treatment agencies. A unique feature of the WASBIRT project was the use of Chemical Dependency Professionals (CDPs) as the staff to screen patients in hospital Emergency Departments (EDs) and to conduct brief interventions immediately thereafter for patients who screened high for potential substance use disorders. CDPs also provided brief treatment within chemical dependency (CD) treatment agencies or in behavioral health units within the hospital, depending on the site.

A chart depicting the patient flow using the Washington State model for implementing SBIRT services is shown below. The instruments used for screening patients were the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST-10), shown in Appendix B.

**Washington State Patient Flow Chart for Screening, Brief Intervention, and Referral to Treatment of Substance Abuse**

The overall goal of the project was to enroll 122,905 patients. The project completed 106,464 screenings with a total of 96,090 patients since some patients were screened more than once during the project. Below are total intakes in four SBIRT modalities that reflect the level of service a patient was expected to receive according to the risk level defined by their screening scores. These categories were based on an intent-to-treat model for the Government Performance and Results Act (GPRA) reporting.

### Patients Served by WASBIRT: Targets and Actual Number Served
October 1, 2003 – September 30, 2009

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>TARGET</th>
<th>ACTUAL SERVED</th>
<th>PERCENT OF TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Feedback (SF)</td>
<td>72,528</td>
<td>58,733</td>
<td>81%</td>
</tr>
<tr>
<td>Brief Intervention (BI)</td>
<td>45,362</td>
<td>22,357</td>
<td>49%</td>
</tr>
<tr>
<td>Brief Treatment (BT)</td>
<td>3,783</td>
<td>5,837</td>
<td>154%</td>
</tr>
<tr>
<td>Referral to Treatment (RT)</td>
<td>1,232</td>
<td>9,163</td>
<td>744%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>122,905</strong></td>
<td><strong>96,090</strong></td>
<td><strong>78.2%</strong></td>
</tr>
</tbody>
</table>
GOAL 2  |  Deliver screening and brief interventions (BI) in six hospital EDs.

Although the initial goal for this project was to implement the project in only six hospital EDs, the project was ultimately implemented successfully in nine separate hospitals in six different counties. The locations are shown in the map to the left. These included several of the largest urban centers in the state, notably the cities of Seattle, Tacoma, Everett, and Vancouver. In addition, several hospitals joined the project that were located in medium-sized cities and one small town, including Olympia, the state capital; Yakima, a medium-sized city located in the largely agrarian center of the state; and Toppenish, a small rural community.

The sites that participated in the WASBIRT project and the dates of implementation were:

- Harborview Medical Center in Seattle, King County – April 12, 2004
- Tacoma General in Tacoma, Pierce County – April 26, 2004
- Southwest Washington Medical Center in Vancouver, Clark County – May 3, 2004
- Providence Everett Medical Center in Everett, Snohomish County – July 5, 2004
- Yakima Regional Medical and Heart Center, in City of Yakima, Yakima County – December 22, 2004
- Toppenish Community Hospital in Toppenish, Yakima County – December 22, 2004
- Yakima Valley Memorial Hospital in Yakima, Yakima County – July 10, 2005
- Allenmore Hospital in Tacoma, Pierce County – September 12, 2005
- Providence St. Peter Hospital in Olympia, Thurston County – September 19, 2006

The WASBIRT Project incorporated CD treatment agencies as important partners in this project. A dozen certified CD treatment programs operating either as independent agencies or as separate units within a hospital or medical center participated actively in the WASBIRT Project, as follows:

- Clark County
  - Lifeline Connections*
  - Northwest Recovery Center*
  - Columbia River Mental Health
- Pierce County
  - Metropolitan Development Council*
- King County
  - Harborview Mental Health Services, Outpatient Program*
  - Recovery Centers of King County
- Snohomish County
  - Providence Recovery Program - Behavioral Health Services*
  - Evergreen Manor
- Thurston County
  - Providence St. Peter Chemical Dependency Program*
- Yakima County
  - Triumph Treatment Services*
  - Merit Resources Services
  - Casa de Esperanza

*Denotes programs that hired Chemical Dependency Professionals to work in participating hospitals to perform WASBIRT functions (screenings, brief interventions, and referrals). All of the CD treatment programs provided brief treatment and, in most programs, chemical dependency treatment to patients screened through the WASBIRT Project.
These agencies and behavioral health programs were responsible for hiring and supervising the Chemical Dependency Professionals (CDPs) who conducted the WASBIRT activities in each of the participating hospitals, including screening patients, providing brief interventions, and giving referrals. These programs also provided brief treatment on an outpatient basis and, for some patients, more traditional forms of chemical dependency treatment. Using CD treatment agencies as partners in the project contributed greatly to improving the links between the medical and CD treatment communities, which was one of the underlying emphases of this project.

Training for Screening, Brief Intervention, and Referral to Treatment for Substance Abuse

Training of the CDPs was a high priority for the WASBIRT Project. At the onset, Chris Dunn, Ph.D., a national expert on motivational interviewing and brief intervention for substance use disorders, joined the WASBIRT Project as its training expert. Dr. Dunn, who works as a clinical psychologist at the University of Washington Harborview Medical Center, remained the WASBIRT training expert for the entire project. Dr. Dunn provided group and one-on-one training whenever new counselors were hired. He also conducted fidelity monitoring at all sites during the implementation phase of the project.

During the course of this project, Dr. Dunn trained all of the CDPs how to use standard screening tools to identify potential risk for substance disorders among emergency department patients. He also trained the counselors in the use of motivational interviewing techniques in brief interventions and brief treatment sessions in order to motivate patients to modify their behavior and to act upon referrals to treatment. Dr. Dunn provides similar trainings nationwide and employs these techniques routinely in his own clinical practice at Harborview Medical Center.

As a culmination of Dr. Dunn’s training program for the WASBIRT Project, he prepared an SBIRT training manual for staff in acute care medical settings. The manual reflects Dr. Dunn’s expertise in training clinicians how to incorporate screening into acute clinical care and how to use motivational interviewing techniques to provide feedback to patients when conducting brief interventions in emergency departments and trauma centers.

As a result of Dr. Dunn’s extensive experience as a trainer in this field, the training manual that he prepared as a final product of the WASBIRT project is clear and easy to use. The Division of Behavioral Health and Recovery anticipates using this manual to train professionals throughout the state in the use of SBIRT for patients, particularly in acute care medical settings, although the manual would also be very useful to those who plan to provide SBIRT services in primary care as well. A copy of this manual is attached (see Appendix C) and is available at http://www.dshs.wa.gov/pdf/hrsa/dasa/SBIRT_TrainManual2010.pdf.

GOAL 3 | Provide brief treatment (BT) on an outpatient basis at certified treatment agencies.

To ensure that brief treatment would be readily available for patients upon referral, the WASBIRT program was designed so that CD treatment agencies or behavioral health units within participating hospitals hired chemical dependency counselors to perform this function. In four of the six counties, separate counselors were hired full-time as brief therapists serving only WASBIRT clients. In one county, three of the four counselors who conducted screenings and brief interventions in the hospital also provided brief therapy at the affiliated CD treatment agency. In the remaining county, WASBIRT clients who received brief treatment were incorporated into the caseload of existing counselors who received
specific training on brief therapy using motivational interviewing techniques. In this county, brief treatment for WASBIRT clients was reimbursed with grant funding on a fee-for-service basis. Overall, about one in five patients who were referred to brief treatment subsequently went to at least one brief therapy session. At one site with very strong outreach protocols, one in three patients referred to brief treatment went to at least one session. The average number of sessions was four, with a maximum of 12 sessions at most of the participating sites.

According to the Center for Substance Abuse Treatment’s definition, brief treatment is “a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies.”1 In Washington State, the counselors who provided brief treatment were trained to use motivational interviewing techniques to help clients identify and achieve rapid behavioral change. During the process of providing brief therapy, counselors were also expected to identify the potential need for traditional CD treatment and to help clients obtain access to such treatment, as needed. To examine whether or not brief treatment appeared to improve the likelihood of entering CD treatment, the WASBIRT Evaluation Project conducted two separate analyses: (1) entrance to CD treatment within 90 days of receiving a brief intervention among WASBIRT patients at all sites who were covered by Medicaid and a similar type of state-funded medical assistance program (see Appendix D), and (2) admissions to CD treatment within one year of receiving a brief intervention among WASBIRT patients at Harborview Medical Center who were uninsured or on Medicaid or the state-funded medical assistance program (see Appendix E, page 7).

As shown in the charts below, the likelihood of entering CD treatment was much higher among patients who received brief treatment in addition to a brief intervention compared to patients who received only a brief intervention. These results were based on regression analyses in which substance abuse risk scores, demographic characteristics, prior substance abuse, mental health, and physical health indicators were taken into account. While the two sets of analyses used somewhat different outcome periods and variations in some of the prior health indicators, the results were remarkably similar. The findings of both analyses suggest that brief treatment may be an important means for facilitating entrance to CD treatment among patients at higher substance abuse risk levels.

RECENT FINDINGS: Patients participating in brief treatment in addition to receiving a brief intervention were more likely to be admitted to chemical dependency treatment

ALL WASBIRT SITES | MEDICAID AND STATE-FUNDED
Medicaid patients screened in the WASBIRT project were more likely to enter chemical dependency treatment after receiving a brief intervention (BI) and brief treatment than those at comparable risk levels who only got a BI

Percent entering CD treatment in 90 days of receiving a BI

ODDS RATIO: 3.04  
\[ p = 0.001 \]

Brief Intervention Only

17%

Brief Intervention + Brief Treatment

38%

Regression Adjusted

SOURCE: Estee, et al. Impact of Screening, Brief Intervention, and Referral to Treatment on Entrance to Chemical Dependency Treatment: Medicaid Patients Screened in Hospital Emergency Departments. Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2010.

HARBORVIEW MEDICAL CENTER | LOW INCOME
HMC patients who received brief treatment in addition to a BI were more likely to be admitted to CD treatment in the following year than similar patients who received a BI and were referred to but did not engage in brief treatment

Percent entering CD treatment in 1 year of receiving a BI

52%

Brief Intervention + Brief Treatment

34%

Brief Intervention Only

42%

Regression Adjusted


1 Center for Substance Abuse Treatment, Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs, Question-by-Question Instruction Guide, Substance Abuse and Mental Health Services Administration, June 2005, p.3.
GOAL 4 | Increase referrals to certified treatment agencies of chemically dependent persons from generalist medical settings.

The WASBIRT Project was designed to provide a particularly strong model for improving both referrals to chemical dependency treatment and actual engagement in such treatment programs. In particular, the use of chemical dependency counselors to screen patients and provide brief interventions and referrals was intended to improve the effectiveness of the referral process. These counselors were based in either CD treatment agencies or in behavioral health units within one of the hospitals, and they typically had a priori experience in working within the chemical dependency treatment system. Most WASBIRT CDPs had extensive knowledge of the local CD treatment system and how to get people admitted into treatment. A number of tactics were used to assist in the referral and engagement process, including regular staff meetings of counselors who provided brief treatment with those who screened and made referrals; established procedures for scheduling brief treatment appointments for patients after a brief intervention session; calling patients before scheduled appointments; and, at one site, using the same counselors who did the screenings and brief interventions in the hospital to provide brief treatment at the outpatient clinic. Overall, WASBIRT counselors made 16,928 referrals to brief treatment and/or CD treatment.

The WASBIRT Evaluation Project was designed to assess whether or not WASBIRT improved the rate at which patients were admitted to subsequent CD treatment. Two separate sets of analyses were conducted: (1) an examination of the degree to which Medicaid patients entered CD treatment within 90 days after receiving a brief intervention at any of the nine hospitals participating in WASBIRT and (2) an analysis of admissions to CD treatment within one year after receiving a brief intervention among Medicaid and low-income, uninsured patients at Harborview Medical Center. Both sets of these analyses produced positive results that show the potential impact of SBIRT on admission to CD treatment.

Entrance into Chemical Dependency Treatment among Medicaid Patients, All WASBIRT Sites

Medicaid and other low-income patients who received at least a brief intervention at the nine WASBIRT hospitals were much more likely to enter CD treatment within 90 days of the intervention than patients in statistically matched groups who were not screened. The odds of entering CD treatment within 90 days of an emergency department visit were more than twice as high for patients who received a brief intervention during their visit compared very similar patients who did not. These results were found in three separate medical coverage groups: the working-age disabled covered by Medicaid, the working-age disabled covered by a state-funded General Assistance Program for the Unemployed, and patients with families covered under Temporary Assistance for Needy Families (see Appendix D).

RECENT FINDINGS: Patients who received at least a brief intervention were more likely to enter CD treatment than similar emergency department patients who received no screening or intervention for substance use disorders

<table>
<thead>
<tr>
<th>WORKING AGE DISABLED</th>
<th>GENERAL ASSISTANCE-UNEMPLOYABLE</th>
<th>TEMPORARY ASSISTANCE FOR NEEDY FAMILIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODDS RATIO: 2.62</td>
<td>ODDS RATIO: 3.19</td>
<td>ODDS RATIO: 3.24</td>
</tr>
<tr>
<td>p = &lt;.0001</td>
<td>p = &lt;.0001</td>
<td>p = &lt;.0001</td>
</tr>
</tbody>
</table>

Odds of entering CD treatment within 90 days of receiving a Bi

SOURCE. Estee, et al. Impact of Screening, Brief Intervention, and Referral to Treatment on Entrance to Chemical Dependency Treatment: Medicaid Patients Screened In Hospital Emergency Departments. Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2010.

The results of these analyses have been presented in a fact sheet published on the Research and Data Analysis Division’s website at [http://www.dshs.wa.gov/rda/](http://www.dshs.wa.gov/rda/) (see Appendix D). An article that will be submitted to a professional journal is in progress.
Admissions to Chemical Dependency Treatment among Medicaid and Uninsured Patients, Harborview Medical Center

RECENT FINDINGS: Patients at Harborview Medical Center who received at least a brief intervention were more likely to enter CD treatment than similar emergency department patients who received no screening or intervention for substance use disorders

Patients at Harborview Medical Center who received at least a brief intervention were significantly more likely to be admitted to CD treatment within the following year compared to similar emergency department patients who were not screened and did not receive an intervention for substance abuse from WASBIRT counselors.

Analyses were based on a quasi-experimental design using hospital medical records to select a comparable set of hospital emergency department patients with evidence of possible substance use disorders to those who received at least a BI through WASBIRT.

The results of these analyses, prepared by researchers at the University of Washington Harborview Medical Center, in collaboration with the WASBIRT Evaluation team at the Washington State Department of Social and Health Services, have been published in Drug and Alcohol Dependence (see Appendix E). These findings suggest the importance of including screening, brief interventions, and referrals to treatment in emergency departments as a means of improving subsequent admissions to CD treatment among patients who need this form of treatment.

GOAL 5 | Reduce subsequent ED utilization, medical costs, criminal behavior, disability, and deaths of patients with alcohol and drug problems of all severity levels.

The evaluation of the WASBIRT Project conducted by the DSHS Research and Data Analysis Division relied upon analyses of the six-month follow-up GPRA survey, state-level administrative data and medical payment records. Analyses provided evidence of reduced substance use, lower medical costs for Medicaid clients, less involvement in criminal activities, improved employment activity, and lower death rates among high-risk patients. Subsequent emergency department utilization, however, appeared to increase among patients who received at least a brief intervention based on those receiving medical coverage through state and federal programs for working age, disabled people or families with low income.

Reduced Substance Use for Patients from All WASBIRT Sites

Receiving an intervention through the WASBIRT program was associated with significant positive changes in recent alcohol or other drug use including significant decreases in average days of alcohol use, binge drinking, and drug use. In addition, engaging in additional therapy through brief treatment or standard CD treatment was associated with even greater declines in alcohol and drug use and increases in abstinence from both alcohol and other drugs. Comparable results were found in changes in substance use by patients at each of the WASBIRT sites, when analyzed separately. These analyses are based on the comparison of baseline substance use data with data from the six-month follow-up survey. The report for all WASBIRT sites was based on a sample of 5,598 patients who were selected out of 30,210 patients with moderate or high risks for substance use disorders. Interviews were completed with 4,168 of the patients in the sample, which represents a 79 percent response rate. (See Appendix F for fact sheets prepared for all WASBIRT sites combined and for individual site, which are also published on the Research and Data Analysis Division website at http://www.dshs.wa.gov/rdar/)
**RECENT FINDINGS:** Average days of alcohol use, binge drinking, and use of other drugs declined six months after receiving a brief intervention

<table>
<thead>
<tr>
<th>ALCOHOL USE</th>
<th>BINGE DRINKING</th>
<th>DRUG USE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average number of days in the past 30 days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Before</strong></td>
<td><strong>After</strong></td>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>Brief Intervention + BT/CD Tx*</td>
<td>Brief Intervention*</td>
</tr>
<tr>
<td>0</td>
<td><strong>7.4</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
<td><strong>BEFORE</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>n = 3,271</td>
<td>Brief Intervention + BT/CD Tx*</td>
</tr>
<tr>
<td><strong>4.0</strong></td>
<td><strong>1.7</strong></td>
<td><strong>7.9</strong></td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
<td><strong>BEFORE</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>n = 3,280</td>
<td>Brief Intervention + BT/CD Tx*</td>
</tr>
<tr>
<td><strong>5.8</strong></td>
<td><strong>3.3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
<td></td>
</tr>
</tbody>
</table>

**RECENT FINDINGS:** Percentage of patients who were abstinent from alcohol or other drugs increased six months after receiving a brief intervention

<table>
<thead>
<tr>
<th>ALCOHOL USE</th>
<th>DRUG USE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of patients abstinent</strong></td>
<td>Receiving a brief intervention through the WASBIRT program was associated with significant increases in abstinence from alcohol and from drug use. Similar results occurred for patients who received a BI plus brief treatment and/or CD treatment. <strong>SOURCE.</strong> Estee, et al. Substance Use Outcomes for All WASBIRT Hospitals. Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009. p &lt; .05</td>
</tr>
<tr>
<td><strong>Before</strong></td>
<td><strong>After</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>Brief Intervention + BT/CD Tx*</td>
</tr>
<tr>
<td>0</td>
<td><strong>28%</strong></td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>n = 3,271</td>
</tr>
<tr>
<td><strong>30%</strong></td>
<td><strong>65%</strong></td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>n = 3,280</td>
</tr>
<tr>
<td><strong>56%</strong></td>
<td><strong>72%</strong></td>
</tr>
<tr>
<td><strong>BEFORE</strong></td>
<td><strong>AFTER</strong></td>
</tr>
</tbody>
</table>

**Reduction in Medical Costs, per member per month, for Medicaid Clients**

Medicaid costs among working age, disabled clients were $366 lower per member per month (pmpm) (p = .05) for those who received at least a brief intervention compared to a statistically matched sample of clients who were treated in an emergency department but did not get a brief intervention through WASBIRT. The relative decline appeared to be due to a decline in inpatient costs for stays that originated in an emergency department visit. The primary factor contributing to reduced costs appeared to be a reduction of 0.12 pmpm inpatient hospital days (p = .04) which equals a reduction of roughly 1.2 hospital days per person per year. These results have been published in Medical Care (see Appendix G).
Social and Mental Health Outcomes

The WASBIRT Evaluation Project examined the degree to which hospital emergency department patients experienced changes in important social and mental health indicators six months after receiving a brief intervention for substance use disorders. Some of the patients also received additional counseling through brief treatment using motivational interviewing techniques, CD treatment or both. Among patients with higher levels of substance abuse risk (i.e., AUDIT score of 16 or above or DAST-10 score of 5 or above), we found that six months after receiving at least a brief intervention there were:

- Fewer arrests among those who also got brief treatment and/or CD treatment
- Fewer patients living in homeless shelters or outdoors
- Higher rates of full- or part-time employment
- Decreased rates of anxiety
- Lower rates of depression

**RECENT FINDINGS: Social outcomes improved**

<table>
<thead>
<tr>
<th>PATIENTS ARRESTED</th>
<th>LIVING IN HOMELESS SHELTERS OR OUTDOORS</th>
<th>EMPLOYED FULL-TIME OR PART-TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of patients in the past 30 days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>Brief Intervention + BT/CD Tx*</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>n = 910</td>
<td>n = 508</td>
<td>n = 2,104</td>
</tr>
<tr>
<td>BEFORE</td>
<td>AFTER</td>
<td>BEFORE</td>
</tr>
<tr>
<td>8%</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**RECENT FINDINGS: Mental health problems decreased**

<table>
<thead>
<tr>
<th>DECREASED ANXIETY</th>
<th>REDUCED DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of patients in the past 30 days</strong></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention*</td>
<td>Brief Intervention + BT/CD Tx*</td>
</tr>
<tr>
<td>n = 849</td>
<td>n = 459</td>
</tr>
<tr>
<td>BEFORE</td>
<td>AFTER</td>
</tr>
<tr>
<td>61%</td>
<td>53%</td>
</tr>
</tbody>
</table>

SOURCE: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2010.

Deaths among Working Age, Disabled Medicaid Clients

Analyses completed as part of the evaluation of WASBIRT Project outcomes found a statistically significant lower death rate among working age, disabled Medicaid clients who received at least a brief intervention compared to a one-to-one matched set of similar clients who were treated in an emergency department but were not screened by WASBIRT counselors. The death rate in the year after being screened by WASBIRT was 47.1 per 1000 for 2,465 Medicaid patients who received at least a brief intervention compared to 60.9 per 1000 for patients in the statistically matched comparison group. The adjusted odds ratio was 0.705 (p < .01) based on a model that included a number of prior risk factors related to substance abuse, mental health, treatment for injuries, and other health-related issues. The WASBIRT evaluation team will present these analyses in a paper that will be submitted to a peer-reviewed journal.
Clinical Indicators of Substance Use Problems Relative to Screening Scores

The WASBIRT evaluation relied heavily on clinical indicators of substance use problems as well as other health issues to construct statistically matched samples of patients for outcome analyses in several of the research papers described above. Therefore, the evaluation team examined the relationship between the clinical indicators from medical claims data and other administrative records relative to the screening scores of patients who participated in the WASBIRT project. The analyses examined how well alcohol or drug (AOD)-related administrative indicators predicted self-reported AOD use based on screening scores obtained from the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST-10).

Administrative records were from Medicaid data, Harborview Medical Center medical records, publicly funded chemical dependency treatment data, and statewide arrest data. Data from these sources were used by the WASBIRT evaluation teams at the University of Washington (UW) and the state’s Department of Social and Health Services (DSHS) to create indicators of potential AOD problems. These AOD indicators were found to discriminate, at acceptable statistical levels, self-reported AOD use that indicated the potential need for moderate or more intensive levels of intervention.

These analyses may be useful to other SBIRT evaluators interested in using similarly created administrative indicators of the potential need for AOD interventions in their own research. Administrative AOD-need flags could be useful for selecting comparison groups using propensity score matching methodology. The analyses of the WASBIRT evaluation team help to demonstrate the validity of the AOD indicators created from administrative data, and we expect to continue using these indicators in our other research and policy development.

The results of the analyses will be published in Drug and Alcohol Dependence (see Appendix H).

GOAL 6 | Involve a multitude of perspectives to explore systems change to improve existing linkages to these services and to expand substance abuse services to include early intervention.

New Certified Service: Screening and Brief Intervention (SBI)

In describing this goal in more detail, the WASBIRT Action Plan also stated that, “By conclusion of the WASBIRT Center for Substance Abuse Treatment (CSAT) grant, expected results include brief intervention and brief treatment will be included in the Washington State continuum of care, per Washington Administrative Code (WAC) 388-805, and redirection of fund streams benefiting from WASBIRT to sustain these services.”

The Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) revised Washington Administrative Code (WAC) 388-805 effective January 1, 2009, to include the new certified service of Screening and Brief Intervention (SBI). SBI is defined in Section 005, described in Section 010, and specific requirements for SBI services are listed in Section 855. WAC 388-805 is located at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805. (See Appendix I for copies of Sections 005, 010, and 855 which contain details pertaining to the SBI services.)

DBHR decided to develop this new certified service—SBI—in order to put in place regulations to ensure consistency within the chemical dependency field for agencies that want to provide this service. In addition, when reimbursement mechanisms for SBI services are in place, agencies would be able to bill for DBHR-certified services.

In the last year, the DBHR Director of Certification Services, Dennis Malmer, who was the initial Project Director for WASBIRT, has worked with the Medical Director for Washington State’s Medicaid Program to include SBI services within the state’s Medicaid Plan. If the proposed change is approved by the Center for Medicaid and Medicare Services, this will be an essential step toward enabling SBIRT services to be part of the state’s Medicaid reimbursement system in the future.
WASBIRT Project Achievements that Contribute to Systems Change

The Division of Behavioral Health and Recovery (DBHR) is continuing to develop long-term, state-level support for SBIRT services. The most notable achievements of the WASBIRT Project toward long-term systems change could eventually lead to the inclusion of screening, brief intervention, and referral to treatment in more medical care settings.

During the close-out period, DBHR completed a number of activities that should contribute to the systems changes envisioned under the SBIRT initiative in Washington State (see Appendix J for the No-Cost Extension Final Report, April 1, 2009 through September 30, 2009).

The major accomplishments of the project during the no-cost extension period are:

- Modification of Washington Administrative Code to include the new certified service of Screening and Brief Intervention.
- Completion of the SBIRT training manual for providers in acute care settings.
- Continuation of locally funded SBIRT services by a number of the hospitals that participated in the WASBIRT project and expansion of these services to several more hospitals in King County.
- Publication of several papers in peer-reviewed journals demonstrating that SBIRT improves admissions to chemical dependency treatment and is associated with lower medical costs for high-cost, fee-for-service Medicaid clients.
- Continued collaboration with the Washington State Medicaid Program to develop a Medicaid state plan amendment that will include SBI services.

Among the most important achievements of the project was the successful continuation of SBIRT services at several of the hospitals that participated in this project. Following is a brief summary of the status of SBIRT services in the six counties that participated in the WASBIRT project:

- **Clark County**—Southwest Washington Medical Center dedicated hospital funds to pay for two CDP positions to continue SBIRT services.
- **King County**—Funding was obtained from a locally enacted excise tax directed toward behavioral health services to maintain SBIRT services in the emergency department of Harborview Medical Center and to create similar programs in several other community hospitals in that county.
- **Pierce County**—Tacoma General Hospital dedicated hospital funds to pay for two CDP positions to continue SBIRT services.
- **Snohomish County**—Providence Everett Medical Center maintained SBIRT services on a limited basis provided to patients who are hospitalized by using several existing staff in their Behavioral Health Services Department. At this time, an SBIRT project at Providence Everett Medical Center is under consideration by a managed care provider that oversees an integrated care management project for Medicaid patients in this county.
- **Thurston County**—Providence St. Peter Hospital hired three of the four WASBIRT CDPs to work in their emergency department crisis intervention unit to address substance abuse issues and assist in discharge planning. This hospital did not, however, retain a formal SBIRT service but did choose to include counselors with expertise in motivational interviewing and brief intervention as part of their acute care, crisis intervention medical team.
- **Yakima County**—The hospitals that participated in WASBIRT in this county did not continue any SBIRT-related services after the project ended in the fall of 2008.

Thus, of the six counties that participated in WASBIRT, three continued SBIRT services using local funding, one may be able to do so through the efforts of a local managed care provider, and one incorporated the staff who provided SBIRT services into their hospital crisis intervention team. Only one county was unable to provide support for local continuation of SBIRT services despite interest by a number of the hospitals and CD treatment agencies that collaborated in the overall project and despite favorable outcomes demonstrated for their patients who received SBIRT services through this project.
DBHR supports the use of SBIRT in medical care settings and has identified this as one of their long-term strategies for reducing the effects of substance abuse within the state. Unfortunately, the current economic conditions of Washington State’s economy and the fairly bleak revenue forecast for this state have made it impossible to incorporate funding for any SBIRT programs in the state’s budget. Nonetheless, DBHR has enacted a change to the state’s administrative code in order to certify screening and brief intervention services so that they can be included in the continuum of care. DBHR also plans to broadly disseminate the recently completed SBIRT training manual developed by Dr. Dunn for this project so that medical practitioners, particularly in acute medical care settings, can learn how to incorporate basic screening and brief intervention skills into their medical practice. Finally, DBHR has begun the necessary steps to include SBIRT in the Medicaid plan for this state.

With the benefit of the SAMHSA-funded SBIRT project, Washington State was able to accomplish the goals set forth in its initial action plan. The WASBIRT project was successfully implemented in nine separate hospitals. It completed more than 104,000 screenings for substance abuse among hospital emergency department patients. The receipt of brief interventions and, in some cases, brief treatment and/or CD treatment was associated with declines in substance use, reductions in medical costs for fee-for-service Medicaid clients, improvements in social outcomes such as fewer arrests and more employment, and lower death rates among working age, disabled Medicaid patients. Brief interventions and brief treatment also appeared to be related to significant increases in admissions to CD treatment both at a large, urban hospital and among Medicaid clients at all nine sites.

Finally, at the state and at several of the participating hospitals, a number of initiatives demonstrate solid steps have been taken toward achieving the desired systems change leading to the adoption of SBIRT within medical care settings particularly for emergency care.
Washington State Screening, Brief Intervention, and Referral to Treatment Program

Final Program Performance Report: October 1, 2003 through September 30, 2009
WASBIRT Final Tracking Report
April 12, 2004 through January 31, 2009

Screenings, Brief Interventions and Referrals to Brief Therapy or Chemical Dependency Treatment

Sharon Estee, PhD and Lijian He, PhD

In collaboration with the Division of Alcohol and Substance Abuse, Douglas Allen, Director • John Taylor, Chief • Stephen O’Neil, Project Manager • Alice Huber, PhD, Evaluation and Quality Assurance Administrator

Since the start of Washington State Brief Intervention and Referral to Treatment (WASBIRT), 155,243 patients have been approached by Chemical Dependency Professionals (CDPs). Of these, 106,464 agreed to participate in WASBIRT and were screened for drug and alcohol use. Of the 106,464 patients, 51,116 (48 percent) were classified as a “Screening Only.” An additional 51,763 (49 percent) were screened and received a Brief Intervention; 3,585 (3 percent) were screened, received a Brief Intervention, and went on to receive either Brief Therapy or Chemical Dependency (CD) treatment.

Monthly Participant Totals by Hospital: February 2008 through January 2009

Hospital and Patient Summary: April 12, 2004 through January 31, 2008

<table>
<thead>
<tr>
<th>Type of Participation by Hospital</th>
<th>Patients Approached by Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Only</td>
<td>Participants</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td></td>
</tr>
<tr>
<td>BT/CD Treatment</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Harborview 6,636 10,911 737 18,284 18,284 6,381 24,665
100% 60% 4% 100% 74% 26% 100%

Tacoma & Allenmore 9,899 9,564 320 19,783 19,783 8,416 28,199
50% 48% 2% 100% 70% 30% 100%

Southwest 7,817 8,109 904 16,830 16,830 8,228 25,058
46% 48% 5% 100% 67% 33% 100%

Everett 7,289 9,449 985 17,723 17,723 11,725 29,448
41% 53% 6% 100% 60% 40% 100%

Yakima R&T 8,610 6,051 255 14,916 14,916 5,952 20,868
58% 41% 2% 100% 71% 29% 100%

Yakima Memorial 5,574 3,388 78 9,040 9,040 3,763 12,803
62% 37% 1% 100% 71% 29% 100%

St. Peter 5,291 4,291 306 9,888 9,888 4,314 14,202
54% 43% 3% 100% 70% 30% 100%

48% 49% 3% 100% 69% 31% 100%

1 Includes WASBIRT activity through January 31, 2008 and some cases that have not yet been sent to GPRA, pending RDA review of consent forms.

2 The Brief Therapy and CD Treatment category includes patients who see a brief therapist for at least one session. Patients who go to CD treatment without seeing a brief therapist are not counted here.
## Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>H08</td>
<td>1,674</td>
<td>2,699</td>
</tr>
<tr>
<td></td>
<td>37%</td>
<td>59%</td>
</tr>
<tr>
<td>H14</td>
<td>700</td>
<td>726</td>
</tr>
<tr>
<td></td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>H15</td>
<td>520</td>
<td>734</td>
</tr>
<tr>
<td></td>
<td>39%</td>
<td>55%</td>
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<tr>
<td>H16</td>
<td>209</td>
<td>448</td>
</tr>
<tr>
<td></td>
<td>31%</td>
<td>66%</td>
</tr>
<tr>
<td>HV Inactive</td>
<td>3,533</td>
<td>6,304</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>61%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,636</td>
<td>10,911</td>
</tr>
<tr>
<td></td>
<td>36%</td>
<td>60%</td>
</tr>
</tbody>
</table>

## Trend of WASBIRT screenings in the last 12 months

**Harborview Medical Center** (4.5 CDP Screener Positions)

![Bar chart showing WASBIRT screenings trend from Feb 08 to Dec 08]
Tacoma General and Allenmore Hospitals

Type of Participation

<table>
<thead>
<tr>
<th>Type of Participation</th>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 9,899</td>
<td>n = 9,564</td>
<td>n = 320</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td>48%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>T12</td>
<td>1,334</td>
<td>1,307</td>
</tr>
<tr>
<td></td>
<td>50%</td>
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<tr>
<td>T14</td>
<td>1,313</td>
<td>1,497</td>
</tr>
<tr>
<td></td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>T20</td>
<td>624</td>
<td>543</td>
</tr>
<tr>
<td></td>
<td>52%</td>
<td>46%</td>
</tr>
<tr>
<td>TG inactive</td>
<td>6,628</td>
<td>6,217</td>
</tr>
<tr>
<td></td>
<td>51%</td>
<td>47%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,899</td>
<td>9,564</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Trend of WASBIRT screenings in the last 12 months

Tacoma General (3.0 CDP Screener Positions)

<table>
<thead>
<tr>
<th>Month</th>
<th>FEB08</th>
<th>MAR08</th>
<th>APR08</th>
<th>MAY08</th>
<th>JUN08</th>
<th>JUL08</th>
<th>AUG08</th>
<th>SEP08</th>
<th>OCT08</th>
<th>NOV08</th>
<th>DEC08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>228</td>
<td>114</td>
<td>149</td>
<td>172</td>
<td>134</td>
<td>110</td>
<td>101</td>
<td>91</td>
<td>92</td>
<td>57</td>
<td>44</td>
</tr>
</tbody>
</table>

Allenmore Hospital (2.0 CDP Screener Positions)

<table>
<thead>
<tr>
<th>Month</th>
<th>FEB08</th>
<th>MAR08</th>
<th>APR08</th>
<th>MAY08</th>
<th>JUN08</th>
<th>JUL08</th>
<th>AUG08</th>
<th>SEP08</th>
<th>OCT08</th>
<th>NOV08</th>
<th>DEC08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>153</td>
<td>93</td>
<td>85</td>
<td>89</td>
<td>71</td>
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<td>82</td>
<td>103</td>
<td>86</td>
<td>87</td>
<td></td>
</tr>
</tbody>
</table>
Southwest Washington Medical Center

Type of Participation

<table>
<thead>
<tr>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>( n = 7,817 )</td>
<td>( n = 8,109 )</td>
<td>( n = 904 )</td>
</tr>
<tr>
<td>46%</td>
<td>49%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>S08</td>
<td>1,553</td>
<td>2,398</td>
</tr>
<tr>
<td>S18</td>
<td>1,518</td>
<td>1,337</td>
</tr>
<tr>
<td>S20</td>
<td>944</td>
<td>1,337</td>
</tr>
<tr>
<td>S23</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>S24</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>S30</td>
<td>347</td>
<td>183</td>
</tr>
<tr>
<td>SW Inactive</td>
<td>3429</td>
<td>2816</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,817</td>
<td>8,109</td>
</tr>
<tr>
<td></td>
<td>46%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Trend of WASBIRT screenings in the last 12 months

Southwest Washington Medical Center (4.0 CDP Screener Positions)

Project continued with local funds after January 2009
Providence Everett Medical Center

Type of Participation

<table>
<thead>
<tr>
<th></th>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 7,289</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41%</td>
<td></td>
<td>53%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>P04</td>
<td>1,550</td>
<td>2,449</td>
</tr>
<tr>
<td></td>
<td>37%</td>
<td>59%</td>
</tr>
<tr>
<td>P09</td>
<td>429</td>
<td>943</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>63%</td>
</tr>
<tr>
<td>P11</td>
<td>616</td>
<td>1,642</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>69%</td>
</tr>
<tr>
<td>P13</td>
<td>902</td>
<td>726</td>
</tr>
<tr>
<td></td>
<td>53%</td>
<td>43%</td>
</tr>
<tr>
<td>PE Inactive</td>
<td>3,792</td>
<td>3,689</td>
</tr>
<tr>
<td></td>
<td>48%</td>
<td>46%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,289</td>
<td>9,449</td>
</tr>
</tbody>
</table>

Trend of WASBIRT screenings in the last 12 months

Providence Everett (4.0 CDP Screener Positions)

*Temporary break in enrollment.
Yakima Regional Medical and Heart Center & Toppenish Community Hospital

Type of Participation

<table>
<thead>
<tr>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>( n = 8,610 )</td>
<td>( n = 6,051 )</td>
<td>( n = 255 )</td>
</tr>
<tr>
<td>57%</td>
<td>41%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>Y01</td>
<td>2,580</td>
<td>1,175</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>31%</td>
</tr>
<tr>
<td>Y03</td>
<td>650</td>
<td>927</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>57%</td>
</tr>
<tr>
<td>Y04</td>
<td>3,082</td>
<td>2,344</td>
</tr>
<tr>
<td></td>
<td>56%</td>
<td>42%</td>
</tr>
<tr>
<td>Y08</td>
<td>1,361</td>
<td>992</td>
</tr>
<tr>
<td></td>
<td>57%</td>
<td>42%</td>
</tr>
<tr>
<td>Y09</td>
<td>470</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>32%</td>
</tr>
<tr>
<td>Y10</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>YK Inactive</td>
<td>447</td>
<td>369</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>44%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8,610</td>
<td>6,051</td>
</tr>
<tr>
<td></td>
<td>58%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Trend of WASBIRT screenings in the last 12 months

Yakima Regional Medical and Heart Center & Toppenish Community Hospital (4.0 CDP Screener Positions)
Yakima Valley Memorial Hospital

Type of Participation

<table>
<thead>
<tr>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 5,574</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62%</td>
<td>37%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>M06</td>
<td>1,845</td>
<td>1,462</td>
</tr>
<tr>
<td>M09</td>
<td>1,853</td>
<td>709</td>
</tr>
<tr>
<td>M10</td>
<td>289</td>
<td>87</td>
</tr>
<tr>
<td>M13</td>
<td>1,083</td>
<td>846</td>
</tr>
<tr>
<td>YM Inactive</td>
<td>504</td>
<td>284</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,574</td>
<td>3,388</td>
</tr>
</tbody>
</table>

62% 37% 1%

Trend of WASBIRT screenings in the last 12 months

Yakima Valley Memorial Hospital (4.0 CDP Screener Positions)
Providence St. Peter Hospital

Type of Participation

<table>
<thead>
<tr>
<th>Screening Only</th>
<th>Brief Intervention</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 5,291</td>
<td>n = 4,291</td>
<td>n = 306</td>
</tr>
<tr>
<td>54%</td>
<td>43%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Chemical Dependency Professional (CDP) Activity

<table>
<thead>
<tr>
<th>Chemical Dependency Professional ID</th>
<th>Type of Participation by CDP</th>
<th>Patients Approached by CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Only</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>O01</td>
<td>1,057</td>
<td>835</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>43%</td>
</tr>
<tr>
<td>O06</td>
<td>1,716</td>
<td>1,314</td>
</tr>
<tr>
<td></td>
<td>55%</td>
<td>42%</td>
</tr>
<tr>
<td>O08</td>
<td>427</td>
<td>245</td>
</tr>
<tr>
<td></td>
<td>63%</td>
<td>36%</td>
</tr>
<tr>
<td>O09</td>
<td>181</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>58%</td>
<td>40%</td>
</tr>
<tr>
<td>OL Inactive</td>
<td>1,910</td>
<td>1,770</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>46%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,291</td>
<td>4,291</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Trend of WASBIRT screenings in the last 12 months

Providence St. Peter Hospital (3.0 CDP Screener Positions)
## Average Daily Contacts

The following tables show the total number of workdays, the average number of participants, the lowest and the highest number of participants in a day for each Chemical Dependency Professional.

### Harborview Medical Center

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP H08</td>
<td>689</td>
<td>6.61</td>
</tr>
<tr>
<td>CDP H14</td>
<td>268</td>
<td>5.44</td>
</tr>
<tr>
<td>CDP H15</td>
<td>254</td>
<td>5.26</td>
</tr>
<tr>
<td>CDP H16</td>
<td>148</td>
<td>4.61</td>
</tr>
</tbody>
</table>

### Tacoma General and Allenmore Hospitals

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP T12</td>
<td>323</td>
<td>8.28</td>
</tr>
<tr>
<td>CDP T14</td>
<td>479</td>
<td>5.88</td>
</tr>
<tr>
<td>CDP T20</td>
<td>173</td>
<td>6.9</td>
</tr>
</tbody>
</table>

### Southwest Washington Medical Center

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP S08</td>
<td>761</td>
<td>5.46</td>
</tr>
<tr>
<td>CDP S18</td>
<td>587</td>
<td>5.09</td>
</tr>
<tr>
<td>CDP S20</td>
<td>486</td>
<td>4.88</td>
</tr>
<tr>
<td>CDP S23</td>
<td>43</td>
<td>1.23</td>
</tr>
<tr>
<td>CDP S24</td>
<td>22</td>
<td>2.68</td>
</tr>
<tr>
<td>CDP S30</td>
<td>99</td>
<td>5.66</td>
</tr>
</tbody>
</table>

### Providence Everett Medical Center

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP P04</td>
<td>558</td>
<td>7.48</td>
</tr>
<tr>
<td>CDP P09</td>
<td>239</td>
<td>6.24</td>
</tr>
<tr>
<td>CDP P11</td>
<td>421</td>
<td>5.69</td>
</tr>
<tr>
<td>CDP P13</td>
<td>235</td>
<td>7.18</td>
</tr>
</tbody>
</table>

### Yakima Regional Medical & Heart Center and Toppenish Community Hospital

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP Y01</td>
<td>540</td>
<td>7.09</td>
</tr>
<tr>
<td>CDP Y03</td>
<td>745</td>
<td>2.17</td>
</tr>
<tr>
<td>CDP Y04</td>
<td>588</td>
<td>9.38</td>
</tr>
<tr>
<td>CDP Y08</td>
<td>455</td>
<td>5.23</td>
</tr>
<tr>
<td>CDP Y09</td>
<td>115</td>
<td>6.10</td>
</tr>
<tr>
<td>CDP Y10</td>
<td>150</td>
<td>0.29</td>
</tr>
</tbody>
</table>

### Yakima Valley Memorial Hospital

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP M06</td>
<td>504</td>
<td>6.62</td>
</tr>
<tr>
<td>CDP M09</td>
<td>362</td>
<td>7.13</td>
</tr>
<tr>
<td>CDP M10</td>
<td>116</td>
<td>3.26</td>
</tr>
<tr>
<td>CDP M13</td>
<td>344</td>
<td>5.65</td>
</tr>
</tbody>
</table>

### Providence St. Peter Hospital

<table>
<thead>
<tr>
<th></th>
<th>TO DATE</th>
<th>LAST QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Days*</td>
<td>Average</td>
</tr>
<tr>
<td>CDP O01</td>
<td>550</td>
<td>3.56</td>
</tr>
<tr>
<td>CDP O06</td>
<td>462</td>
<td>6.71</td>
</tr>
<tr>
<td>CDP O08</td>
<td>89</td>
<td>7.62</td>
</tr>
<tr>
<td>CDP O09</td>
<td>53</td>
<td>5.92</td>
</tr>
</tbody>
</table>

**NOTES:**
- # of days to date/last Qtr – days on which a CDP approached at least one patient, regardless of whether the patient was screened or became a non-participant.
- Avg to date/last QTR – average number of patients screened per day.
- Max to date/last Qtr – maximum number of patients screened on any day the CDP worked.
Referral Outcomes

This figure shows the overall resolution of those patients who received a referral. If the patient failed to go to the treatment agency they were referred to, they are considered not engaged for treatment and the service received is recorded as a Brief Intervention (Referral now BI).

These figures show the resolution of referrals made for each individual hospital site. As can be seen, the actual rates of engagement of patients into BT or CD treatment vary across sites.

Brief Therapy and CD Treatment have been combined into one category. Earlier monthly reports may have under counted the number in CD treatment for patients who receive both.

Status of WASBIRT Participants Referred for Brief Therapy or CD Treatment

<table>
<thead>
<tr>
<th>ALL SITES TOTAL REFERRALS = 16,928</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>79%</strong> n = 13,343</td>
<td></td>
</tr>
<tr>
<td><strong>21%</strong> n = 3,585</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Harborview Medical Center TOTAL REFERRALS = 4,571</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>84%</strong> n = 3,834</td>
<td></td>
</tr>
<tr>
<td><strong>16%</strong> n = 737</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tacoma General and Allenmore Hospitals TOTAL REFERRALS = 1,480</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>78%</strong> n = 1,160</td>
<td></td>
</tr>
<tr>
<td><strong>22%</strong> n = 320</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southwest Washington Medical Center TOTAL REFERRALS = 2,623</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>66%</strong> n = 1,719</td>
<td></td>
</tr>
<tr>
<td><strong>34%</strong> n = 904</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providence Everett Medical Center TOTAL REFERRALS = 5,170</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>81%</strong> n = 4,185</td>
<td></td>
</tr>
<tr>
<td><strong>19%</strong> n = 985</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yakima Regional Medical &amp; Heart Center and Toppenish Community Hospital TOTAL REFERRALS = 1,282</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>80%</strong> n = 1,027</td>
<td></td>
</tr>
<tr>
<td><strong>20%</strong> n = 255</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yakima Valley Memorial Hospital TOTAL REFERRALS = 421</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>82%</strong> n = 353</td>
<td></td>
</tr>
<tr>
<td><strong>18%</strong> n = 78</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providence St. Peter Hospital TOTAL REFERRALS = 1,371</th>
<th>BT/CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>78%</strong> n = 1,065</td>
<td></td>
</tr>
<tr>
<td><strong>22%</strong> n = 306</td>
<td></td>
</tr>
</tbody>
</table>
Monthly WASBIRT Participant Trends

Cumulative WASBIRT Participant Trends by Hospital, August 2008 through January 2009

ALL SITES

Harborview Medical Center

Tacoma General and Allenmore Hospitals

Southwest Washington Medical Center

Providence Everett Medical Center

Yakima Regional Medical & Heart Center and Toppenish Community Hospital

Yakima Valley Memorial Hospital

Providence St. Peter Hospital

DSHS | RDA
Washington State Screening, Brief Intervention, and Referral to Treatment • 11
HOSPITAL START DATES
Harborview Medical Center – April 12, 2004
Tacoma General Hospital – April 26, 2004
Allenmore Hospital – September 12, 2005
Southwest Washington Medical Center – May 3, 2004
Providence Everett Medical Center – July 5, 2004
Yakima Regional Medical and Heart Center – December 22, 2004
Toppenish Community Hospital – December 22, 2004
Yakima Valley Memorial Hospital – July 10, 2005
Providence St. Peter Hospital – September 19, 2006

PARTICIPANT VS. NONPARTICIPANT DESCRIPTION
Participants – Patients who agreed to be in the WASBIRT study and received a Screening, a Brief Intervention, or a Referral.
Non-Participants – Patients who were approached but refused to participate or were excluded due to sampling criteria.

INTERVENTIONS DESCRIPTION
Screening Only – Patient screened for alcohol/drug use, Brief Intervention not given.
Brief Intervention – Patients received a Screen for alcohol/drug use and received a Brief Intervention to the Hospital.
Brief Therapy – Patient received a Brief Intervention by the Chemical Dependency Professional plus Brief Therapy sessions.
CD Treatment – Patient received a Brief Intervention by the Chemical Dependency Professional plus chemical dependency treatment.

DATA SOURCE
All information used in this report is based on data reported in the WASBIRT study database. Additional data contained in TARGET on BT or CD treatment were not used in these analyses.

AVERAGE DAILY CONTACTS
# of Days – The total number of days where there was either a screen, Brief Intervention, or referral given. Days with refusals only were excluded.
Mean – The average number of participants Screened, given a BI or Referral for each workday.
Minimum – The least number of participants Screened, given a BI or Referral for any given day (in most cases the lowest number will be a 1).
Maximum – The highest number of participants Screened, given a BI or Referral for any given day.
### Alcohol Use Disorders Identification Test (AUDIT)

I am going to ask you several questions about drinks of alcohol. One drink equals a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink.

#### A.1. In the past 12 months, that is, since <MONTH> <DAY> <YEAR>, have you, even once, had a drink of any type of alcoholic beverage, more than just a sip?
- **Yes**
- **No**
- **Refused**
- **Don’t know**

→ IF “YES,” CONTINUE (DO NOT SCORE THIS ITEM)
→ IF “NO,” SKIP TO A10

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2. How often do you have a drink containing alcohol?</td>
<td></td>
<td>Monthly or less</td>
<td>2 to 4 times a month</td>
<td>2 to 3 times a week</td>
<td>4 or more times a week</td>
<td>Refused</td>
<td>Don’t know</td>
</tr>
<tr>
<td>A.3. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td></td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
<td>Refused</td>
</tr>
<tr>
<td>A.4. How often do you have 4 or more drinks on one occasion?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

IF A3 & A4 = 0, SKIP to A10

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.5. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.6. How often during the last year have you failed to do what was normally expected from you because of drinking?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.7. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.8. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.9. How often during the last year have you been unable to remember what happened the night before you had been drinking?</td>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td>Refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.10 Have you or someone else been injured as a result of your drinking in the past year or any time in your life?</td>
<td></td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, today or during the last year</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
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<tr>
<th>ITEM VALUE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.11. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down in the past year or any time before that?</td>
<td></td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, today or during the last year</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

**AUDIT SCORE:** Add scores for each column, then sum across.
**DRUG ABUSE SCREENING TEST (DAST-10)**

I would now like to ask you a few questions about your use of drugs during the past 12 months. The various kinds of drugs may include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. These questions also refer to the use of prescribed medicine or over-the-counter drugs if used more than directed.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ITEM VALUE:</th>
<th>1</th>
<th>0</th>
<th>No Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1. In the past 12 months have you used drugs other than those required for medical reasons?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>→ If “YES” CONTINUE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>→ If “NO,” END DRUG SCREENING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.2. Do you use or abuse more than one drug at a time?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.3. Are you unable to stop using drugs when you want to?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.4. In the past year, have you ever had blackouts or flashbacks as a result of drug use?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.5. Do you ever feel bad or guilty about your drug use?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.6. Does your spouse, partner, or members of your family ever complain about your involvement with drugs?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.7. Have you neglected your family because of your use of drugs?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.8. Have you engaged in illegal activities in order to obtain drugs?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.9. In the past 12 months, have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>B.10. In the past 12 months have you had medical problems as a result of your drug use, for example, memory loss, hepatitis, convulsions, or bleeding?</td>
<td>Yes</td>
<td>No</td>
<td>Refused</td>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

**DAST SCORE** = Total number of items checked YES
Screening, Brief Intervention, and Referral to Treatment for Substance Abuse

... bringing substance abuse counseling to acute medical care

A training manual for staff in acute medical settings

MAY 2010
This training manual is dedicated to the WASBIRT substance abuse counselors who have advanced their field by learning to do Brief Interventions in a very challenging environment.

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About this manual

What is the purpose of this manual?

This is a “how to” manual to guide clinicians who have some experience in patient counseling to perform Screening, Brief Intervention, and Referral to Treatment (SBIRT). It’s like a book of recipes for chefs who already know how to cook. It is not a book about how to perform basic counseling techniques.

Who is this manual for?

It is written for acute medical care staff as well as for state-certified substance abuse counselors without experience in acute medical settings, who want to learn protocols for SBIRT in acute care. Due to the cross-disciplinary nature of this manual’s audience, it necessarily provides some information about acute medical care that is elementary for some medical workers.

What this manual is not:

It is not a book about how to perform basic counseling techniques or have discussions with patients about sensitive topics. It is not a manual for learning Motivational Interviewing, which is one method of behavior change counseling (one possible “style” of doing Brief Intervention [BI]) that requires extensive coaching and practice to learn.

How to learn to do Brief Interventions:

To learn BI, we recommend attending an intensive SBIRT workshop, followed by lots of practice. Workshops can be found via resources listed on the next page of this manual. Practice can include role-playing with friends, family, or colleagues and listening to audiotapes of these practice sessions. These practice sessions are basically “walk-throughs” of the basic BI tasks to enable learners to become more fluent with the language and steps involved in BI. It is best to practice (if possible) with a colleague who will also perform Brief Interventions in the acute care setting where you work. Regular meetings with a supervisor trained in SBIRT are very helpful. Although learners should read, study, and then reread this manual, they should not have it with them for BIs with real patients. The manual does, however, provide a Brief Intervention Checklist and patient handouts that learners have found helpful to refer to during patient encounters.
Internet resources for SBIRT that are beyond the scope of this manual:

http://www.ed.bmc.org/sbirt/
The BNI ART Institute prepares health care providers, peer educators and social service professionals to screen patients for substance abuse and other behaviors that compromise health, motivate them to change behavior through a brief negotiated interview, and refer them to resources that will support their agenda for change. The Institute offers expert technical assistance and consultation for needs assessment, project development, implementation, billing, data collection and evaluation.

http://www.motivationalinterviewing.org/
Extensive information about Motivational Interviewing outcome literature and currently scheduled trainings.

http://sbirt.samhsa.gov/about.htm
The Substance Abuse and Mental Health Services Administration offers a repository of SBIRT resources.

Announcements of upcoming SBIRT trainings offered in the U.S.

http://www.jointogether.org/
A comprehensive information source on substance abuse policy, prevention and treatment.

http://sbirt.samhsa.gov/coding.htm
Reimbursement for SBIRT services is available through commercial insurance CPT codes, Medicare G codes, and Medicaid HCPCS codes. Information regarding these codes can be found on this website.

http://www.ena.org/IPINSTITUTE/SBIRT/Pages/video.aspx
Emergency Nurses Association website providing demonstration videos of SBIRT.

http://www.sbirttraining.com/
For physicians, a website that will soon offer online continuing medical education credits in SBIRT knowledge and skills.

http://www.cdc.gov/InjuryResponse/alcohol-screening/resources.html
Website from which one can download “Screening and Brief Intervention (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers”, by John Higgins-Biddle, PhD; Dan Hungerford, DrPH; & Kathryn Cates-Wessel.

Website by Center for Disease Control offering background on SBI and downloadable proceedings of a 2003 conference organized by CDC on SBIRT.

http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=986
Offers Alcohol Exclusion Law toolkits. In some states, insurance policies can block SBIRT efforts, if their state governments allow insurers to deny payment for injuries that occur while the insured person is under the influence of alcohol. These alcohol exclusion laws (AELs) can interfere with effective treatment via SBIRT.

http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=989
Research-based information about drug/alcohol treatment and recovery.
CHAPTER 1

Some basics about “SBIRT”

SBIRT terms

SBIRT  Screening, Brief Intervention, and Referral to Treatment is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance abusers before more severe consequences occur.

ED  The correct term for the Emergency Department of a hospital, same thing as “Emergency Room”, which is an outdated term. Now that Emergency Medicine is a bona fide area of medicine (like primary care, surgery, or gynecology), ERs are now called EDs.

Hazardous Substance Users  These are people who drink or use drugs hazardously but are not yet chemically dependent. They are at high risk of getting injured or ill from their drinking or using. They are our prime targets for BI.

Substance Abuser  A more severe but less prevalent substance disorder describing patients who are addicted to alcohol or drugs.

S  Screening all patients with questionnaires to find out which ones use drugs or alcohol in a risky way and patients with more severe problems who may need a referral to treatment. Screening means giving brief drug and alcohol questionnaires to every patient. Patients scoring above the cutoff score on these questionnaires are called “positive screens.” Patients scoring under the cutoff are “negative screens.”

BI  Brief Intervention. This means giving immediate counseling, at bedside in the ED, to all patients who screen positive. This counseling usually lasts from 5-20 minutes.

MI  Motivational Interviewing, a very effective style of counseling that can be used to perform the BI. MI helps patients prepare for change, and to uncover motivation in patients who aren’t sure they want to change. Learning MI takes lots of commitment, training, supervision and practice. All MI literature is accessible from the MI web page listed on previous page.

Change Talk  Statements made by patients during a BI in favor of change.

Status quo  Statements made by patients during a BI in favor of not changing.

RT  Referring certain patients to treatment after the BI happens. Either these patients score very high on screening questionnaires and/or you may assess during the BI that they need more than a BI. RT happens at bedside, usually toward the end of the BI. To help the most patients, RT should not monopolize your time. RT should take up less of your day than SBI does.

BT  Brief Treatment. One-on-one outpatient counseling with a substance abuse counselor, by appointment, after the patient leaves the ED. Usually 1-4 sessions, maximum. Less intensive than American Society of Addiction Medicine Level 1. BT is a new treatment level and is not yet commonly offered. If you have a BT program to refer lower severity patients to, please make the most of it.
Questions and answers that gave rise to SBIRT

**Do hazardous substance users outnumber the dependent (addicted) ones?**

**Yes.** Researchers have discovered that the sheer number of hazardous substance users in the world is far greater than the number of people who are substance abusers (addicted). Why does this surprise so many clinically-trained providers? On any given day, nurses and doctors will see many chemically dependent patients but not know that they are also seeing many more hazardous substance users. After all, hazardous substance users don’t usually show up severely intoxicated or suffering withdrawal; nor do they present with obvious medical problems caused by severe addiction. This discovery has made us painfully aware that many patients who are in danger of harm were falling through the cracks because they received no services.

**So how can we identify hazardous substance users who are not clinically obvious?**

We have to go looking for them proactively. This means giving screening questionnaires to all patients, even though they may appear to be unaffected by drug or alcohol problems. This is called screening (the S in SBIRT). This involves approaching patients in the ED as they lie on gurneys and asking them questions about alcohol and drug use. It takes skill to do this without offending patients or making them uneasy. Trained counselors are particularly good at this type of screening, because they usually have excellent people skills.

**Is mainstream alcohol/drug treatment overkill for hazardous substance users?**

**Yes.** Addiction researchers have found that chemical dependency treatment works well for people who are substance abusers. But they also found that it is over the top for hazardous substance users, because it takes longer and costs more than necessary to treat less serious problems. To refer hazardous substance users to addiction treatment would be to recommend a mismatched service and to waste resources. Sometimes a BI is all hazardous users need to quit or cut down to safer levels of consumption. Some may need only a few more hours of counseling, and that is why BT was developed. This means that a very large number of people could be helped with relatively few resources—if only those resources were made available.

**Why acute care?**

Acute care has very high rates of patients who are hazardous substance users. BI is known to be effective with hazardous substance users, it makes sense to deploy BI in settings where we know their prevalence is high. The only public settings in which rates of substance abuse are higher are bars and prisons!

**Who are trauma and non-trauma patients**

**For counselors unfamiliar with acute medical care**

In the ED, there are 2 types of patients:

1. Trauma patients, and
2. Non-trauma patients.

“Trauma patient” means injured patient (falls, cuts, bruises, gunshot, burns, car crashes, etc).

“Non-trauma” means all other patients who were not injured (illness, fever, chest pain, etc).

Brief Interventions for both types of patients are similar, but the strategies may differ. During a brief intervention, it may not always be possible to link the patient’s drinking or drug use to the patient’s chief medical concern which is the purpose of that medical visit. But interventionists usually explore this possibility with patients during a BI.

**Trauma BI strategy:** Try to link drug/alcohol use to current injury (if possible) or to future injury.

**Non-trauma BI strategy:** Try to link drug/alcohol use to their current illness (if possible) or to future illness.

> In either case, the focus of the interview is on direct consequences of drug or alcohol use, not on whether or not the patient has a “problem.”
What to expect in the ED

Of acute care settings, Emergency Departments are one of the most common locations in which SBIRT programs are being started up in the U.S. In some SBIRT programs, the interventionists are hired from outside the hospital, and their only purpose is to provide SBIRT to acute care patients. This section is written for those clinicians unfamiliar with the ED environment.

The environment

EDs are fast-paced, crowded, tense, distracting, smelly, noisy environments packed with tragedy, joy, and passion. You will find people at their worst and people at their best in EDs, and this rule includes patients and ED staff. Designated interventionists who join the medical staff only for the purpose of providing SBIRT are at first guests in the hospital. Although they will eventually be valued for what they do, it can take several months for staff to understand what they actually do.

Many staff members do not understand what BI is, and many of them doubt that BI helps patients. Some staff may think that the interventionist’s only job is to place severely addicted patients in treatment, and they may refer only severe addiction cases to their interventionist, who must continually remind staff daily that placing severely addicted patients in treatment is only a part of what they do in the ED.

Cold calling patients

You will be approaching patients “cold” in the ED, that is without an introduction by someone else. So, you’ll need to develop a smooth approach. “Hi, my name is ____________, and I am a counselor here in the Emergency Department. My job is to spend a few moments with each patient in order to ask several routine screening questions about alcohol and drugs. These questions are asked to all patients; it’s not the case that you have been singled out. Would it be okay to do this now?”

If patients refuse, simply leave on good terms. Screening is voluntary, just like the rest of medical care.

Some patients are defensive

You will need to reassure patients occasionally: “Our drug and alcohol screening program is a bit like screening all patients for high blood pressure. We do not assume that you have a drug problem, or even that you use drugs or alcohol. We are simply checking for anything that could harm your health or safety . . . .”
Reminding staff that you are not God

Medical staff tend to believe that medical care should be available to all patients, and they believe this is also true of chemical dependency treatment. It simply makes no sense to them that addiction treatment is not always available to those who need it most. Therefore, when it comes to placing severely addicted patients in treatment, you may need to continually educate staff that treatment attendance is voluntary, and that even then, many patients have no way to pay for treatment. As you know, counselors can only refer patients to treatment; they can’t make them go. Fortunately, working on this willingness is something you will do during the BI, thus raising the chances that a given patient will follow through on your referral.

Permitting interruptions

Occasionally, you may be in the middle of an interview that is going along beautifully, and a nurse or doctor may step in to do something with your patient. When this happens, it is best to promptly and politely step aside. Simply tell the patient that you will return later. This will make staff appreciate you more, because they won’t have to worry that you are going to impede them from carrying out their medical responsibilities.

So where’s the good news?

When you perform screening and brief interventions in the ED, you have the privilege of meeting people who are in the midst of a personal crisis. “Crisis” comes from a Chinese word meaning “danger” and “opportunity.” Patients in crisis are in danger, but there is also the opportunity to help them link their drug or alcohol use to these immediate and tangible concerns. Patients in crisis are often more open to the possibility of change than they might otherwise be. This makes for fertile counseling ground.
CHAPTER 2

Screening patients for drugs and alcohol in acute care

Why we need routine screening for all patients

Suppose there are 100 typical acute care patients inside the circle . . . .

Let’s see how many need help:

About 75 will not have any substance abuse issues.

About 5 (orange with “stripes”) are severely dependent (obvious to the clinical staff).

About 20 (blue, wearing hats) are hazardous substance users who need a BI (not obvious to clinical staff).

Hazardous substance users are not clinically obvious.

If we don’t screen to find them, they will fall through the cracks.

NOTE: This is only an example of alcohol prevalence rates for EDs, according to Stewart et al. (2010). Rates for other drugs in other acute care settings vary, but the principle of hazardous substance users outnumbering severely afflicted holds in all cases.
FAQs on screening for drugs and alcohol

Q. Which screening questionnaires work well for EDs?

For alcohol, the Alcohol Use Disorders Identification Screening Test (AUDIT) consists of 10 questions that have been asked to hundreds of thousands of patients in medical settings. AUDIT scores range from 0 to 40 and can be scored in less than a minute by the substance abuse counselor. Men who score under 8 (under 7 for women) are immediately informed that their screen is negative, and they are encouraged to keep their drinking within low risk guidelines recommended by the NIAAA. Men who score 8 or higher (7 or higher for women) are positive screens, meaning they should immediately undergo a BI at bedside. Patients above 15 on the AUDIT generally also receive RT. This is a recommended guideline only, not a rigid rule; clinical judgment should prevail.

Other useful screening instruments for alcohol are the CAGE, CRAFT, or single Binge Drinking Question. Sources for these tools can be found in the Committee on Trauma Quick Guide for SBIRT, available at www.sbirt.samhsa.gov.

For drugs, the Drug Abuse Screening Test-10 consists of 10 questions about drug use. DAST scores range from 1 to 10. Patients whose score is 0 are encouraged to maintain their healthy lifestyles. Patients who score greater than 0 are positive screens and those patients should receive a BI. Patients above 3 on the DAST generally also receive RT. The DAST-A has been developed for adolescents. For very rapid screening, a 2-item screening tool has also been developed for drugs.

Q. Why do we need routine screening for all patients?

Hospital staff cannot identify which patients have high blood pressure or fever unless they proactively screen all patients. Likewise, we cannot identify which patients are hazardous substance users unless we routinely screen all patients. Without routine screening, a huge number of acute care patients would fall through the cracks and never get a BI, because they are not severe enough to be recognized during standard medical care.

Q. What about patients who are too young to screen?

Do not withhold screening from any patient, regardless of age, gender, sexual orientation, or any other demographic. If the patient is an adolescent, use an adolescent screening tool.

Q. Are there any patients who should not be screened?

Yes. Various screening exclusions always occur in public health screening programs across different sites. However, it is difficult to generalize about which patients a particular hospital might decide to exclude from screening. Who to screen versus who not to screen should not be established by a universal rule but rather be decided among a particular hospital’s stakeholders such as clinical supervisors and risk management professionals. Examples of a few common—but not universal—exclusions are patients with severely compromised mental status, those with profound developmental delay, and victims of sexual assault.

Q. What does one do with the screening results?

All patients who screen positive should immediately get at least a BI, and they may also be referred to Brief Treatment if it is available. If a given patient’s score is very high or if during the BI, you assess a more serious problem, then you should consider referring them to chemical dependency treatment.

Q. What about patients already in recovery?

Because drug and alcohol problems can be chronic relapsing conditions, it is very important to perform BI with patients identified as having a past problem from which they are recovering. Do not withhold BI from these patients, because it can help them re-establish their commitment to preserving the change they have started.

Q. What about underage patients who screen negative but still drink or use drugs?

You should perform BI with these patients, regardless of their screening scores.
Q. Why not simply wait for medical staff to refer patients to us?

The fraction of all ED patients who are chemically dependent is small. The fraction of all ED patients who are hazardous substance users is much larger. If we stand by like other hospital consultants and wait for the ED staff to request our expert services, we will most likely be referred only the most severe cases of addiction, and the hazardous substance users will fall through the cracks. The staff typically recognizes only clinically obvious cases and the only way to find risky users is to use screening questionnaires on all patients.

Q. But don’t most patients lie on the screening questionnaires if they have a problem?

Hospital patients are free to disclose as little or much personal information to doctors and staff as they wish, including personal facts about drug and alcohol use. Missing a small fraction of patients who underreport their use doesn’t hurt a large SBIRT program—there are plenty of positive screens to keep interventionists busy. The advantage of using standardized screening questionnaires is that they were developed on large numbers of patients in acute medical settings, including those patients who chose to lie on the questionnaires. Standardized questionnaires such as the AUDIT and DAST-10 allow patients to compare their drug or alcohol use to that of many other people, so they can decide for themselves whether they should be concerned.
What are the goals of a BI?

Generally, the goal is to first elicit from each patient his/her reasons for change, and to highlight those reasons with an accurate summary. Then, one offers the patient a menu of options for change and helps them to explore those options and ideally pick one. You must always be prepared to accept patients’ choices in this regard.

What are the BI tools?

To help clinicians to learn the brief intervention counseling process and to help them stay on task while performing interventions, a useful tool is the acronym, “FLO,” representing the three main tasks of a BI. We will first describe each task, then offer tips for performing them. Finally, a “FLO checklist” is provided to serve as a guide during a BI.

The F in “FLO” stands for Feedback on screening results, because public health screening programs (e.g., hypertension, diabetes) typically notify patients of their screening results. Giving patients feedback about abnormal screening results can help them to answer the question, “Would it be important for me to change?” In SBIRT, this feedback usually consists of giving patients normative feedback so they can understand how their use of alcohol or drugs compares to that of the population as a whole. Sometimes, for example, just telling a patient that their alcohol use is higher than average and places them in harm’s way is enough to cause change.

The L in “FLO” stands for Looking for patient’s reasons for change. This involves helping patients to answer the question, “What might my reasons be for wanting to change?” Most people have their own, unique reasons for wanting to change, even if they are not ready to go into immediate action. During a BI, the interventionist actively searches for these reasons and summarizes them. At this point, interventionists can offer patients new information not mentioned by the patient about why change might be important for a given patient.

The O in “FLO” stands for discussing Options for change. This involves helping patients to answer the question, “HOW would I change?” This task involves the interventionist presenting patients with a menu of options for change (e.g., no change, cut back, quit, get counseling). The interventionist helps the patient rule out certain options and choose others.

In cases where patients are actually ready to take immediate action, a discussion of concrete plans follows. At this point, interventionists can offer advice about actions the patient might take to be successful. Finally, the interventionist ends the interview on good terms in an effort to make the encounter a pleasant one.

First, be prepared to listen to and address the patient’s more immediate concerns:

Avoid having the patient think that you see the BI as more important than his/her other concerns. Often, patients have more pressing concerns than discussing their alcohol or drug use—at the very moment you wish to discuss this topic—and these should be respected.

For example, a number of issues commonly emerge for patients at the start of or during a BI, such as acute pain (“The nurse hasn’t given me anything for pain yet”), emotional discomfort (“I can’t believe my stepfather hasn’t shown up here; after all, I AM in the emergency room…”), or need for medical information (“I’ve been here for 4 hours and nobody has told me what’s wrong with me yet.”) Regardless of whether you are qualified by training to fix any of these problems, you should in all cases make an effort to help, such as bringing a patient another blanket or relaying a message from the patient to a nurse or physician. This builds rapport in service of when you decide to raise the topic of the BI.
How does one get a BI started?

The BI is usually part of the same patient encounter as the screening, unless the screening and BI are performed by two different staff members, in which case the screener would notify you of a patient who has screened positive and needs a BI. Often but not always, the screening results are a nice way to start a productive interview:

- “Thank you for answering all those questions. I wonder if you would be interested in learning what your scores were on those screening questionnaires . . . ?”
- “I appreciate your answering those drug and alcohol questions . . . . How was it for you to answer those questions . . . ?”
- “Thanks for answering those questions. If it’s okay with you, I would like now to go over your scores on those two questionnaires . . . ?”

Tips for “F” (giving feedback)

The goal for “F” is simply to help the patient to understand his/her screening score in a way that makes sense to them, not to convince patients that they should change. Visual guides are provided in the Patient Handouts section of this manual, to help patients better understand the meaning of their screening feedback.

Set the stage for Feedback:

- Ask permission to give feedback.
- Assure the patient that you are not judging him/her nor trying to get them to change anything that they are not ready to change.
- Tell your patient that it is up to them to decide whether they are concerned.

Tell the patient the following so they will understand their score (RANGE):

- **R RANGE**: The range of possible scores (0-40 on the AUDIT, 0-10 on the DAST).
- **A ASK**: Ask the patient what he or she thinks her score might be.
- **N NORMAL**: Tell the patient what normal scores are (below 7 for women or 8 for men on the AUDIT, below 1 for men and women on the DAST).
- **G GIVE** patient their score.
- **E ELICIT** patient’s reaction and avoid argument. (“What do you think about that?”)

After giving patient the score:

Say nothing except making reflections back to the patient about his/her reactions. (“I can see you’re surprised to hear your screening results were so high.”)

- Do not argue that the test is correct or valid.
- Do not get into debates about whether the patient is an “alcoholic” or “addict.” It is not necessary for patients to accept a label before they can change. They just have to become concerned with the status quo to become motivated to change. (“I’m less concerned about labels and more concerned whether you think your use of cocaine is hurting you at all.”)
- Stay on message. (“Your score simply tells us that you are risking harm from drinking; the test is really about risk and harm, not labels.”)
- Argue not. (“It’s really up to you to decide to believe or be concerned about these screening results. I certainly can’t tell you how you should feel about it.”)
- Your job is to deliver the message; the patient’s job is to decide what he/she thinks about it.

▶ It’s up to your patient to decide if they are concerned . . .
Tips for “L” (looking for change talk)

Using the following IMPORTANCE and CONFIDENCE questions will:

- Keep the conversation positive and reduce push-back from the patient
- Make the interview more like dancing than wrestling
- Help us assess what things patients value or cherish, that may be threatened by drinking and using (e.g. Being a good father? Having fun? Getting physically healthy? Looking good? Staying out of legal trouble? Keeping a job? Getting a job? Staying in a relationship?).
- Identify the drivers that may eventually motivate them to change.

The IMPORTANCE questions:

- “On a scale of 1 to 10, how important is it to you to make a change in your drinking or using?”
- “Why didn’t you give it a lower number?” (Elicits Change Talk)
- “What would make you give it a higher number?” (Patient explores the future)

The CONFIDENCE questions:

- “If you decided to make a change in your drinking or using, on a scale of 1 to 10, how confident are you that you would succeed?”
- “Why didn’t you give it a lower number?” (Elicits Change Talk)
- “What would make you give it a higher number?” (Patient explores the future)

Now, summarize both sides of the patient’s view:

On one hand, you don’t think you’re addicted . . .

. . . on the other hand, your legal problems make you think you will do something different fairly soon.


Useful questions:

- Ask about the link between what is precious and drugs/alcohol: “I heard you say that the most important thing for you now is keeping a paycheck coming in . . . How does your marijuana use fit in with that goal, given your company’s drug testing practices?”
- Ask about the future: “How would you like your drinking or drug use to look 5 years from now? Be gone? Be less? Be the same?”

Tips for “O” (Options for change discussed)

Following these FLO guidelines will:

- Reduce push-back from patients who often get told they must abstain from all substances.
- Guide patients to explore options that they have never before considered.
- Reduce status quo talk (“I’m not an addict, therefore I don’t need to change . . .”).
- Encourage patients to consider each substance that they use separately, and avoid the “quit everything” or “quit nothing” conflict.

First, ask about the future:

Q. “So where does that leave you?”
Q. “So what do you think you will do?”
Q. “So, what are your options for the future?”

Don’t forget!

Take one drug at a time; don’t lump “drugs and alcohol” together. Doing this prevents confusion when discussing options, because sometimes patients choose different options for different drugs. (“Seems like you are most concerned about cocaine, and less so about alcohol or marijuana . . . . Is it okay if we just focus on cocaine for now?”)
Start with a menu of options:

**M** MANAGE YOUR USE: Cut down to within low risk guidelines for alcohol, or reduce drug use. (“One thing you might try is cutting down on how often you get high, like try doing it only on weekends, instead of on workdays.”)

**E** ELIMINATE USE: Quit drugs or alcohol or both (“Another option might be to stop using marijuana altogether.”)

**N** NEVER TAKE CERTAIN RISKS: Drive after using, share needles, mix drugs and alcohol (“Some people don’t want to cut down or quit, but they are willing to take a look at some of the risks they incur when they do use.”)

**U** UTTERLY NO CHANGE: Don’t quit, don’t cut down, don’t avoid harm (“You might decide not to make any changes at all in your lifestyle right now.”)

**S** SEEK HELP (“Some people decide they need to get help.”)

Example: “ Seems to me there are several ways you could go with drinking in the future: you could cut down to within low-risk guidelines; you could quit; you could neither cut down nor quit but try to drink more safely; you could make no change, or you could seek counseling. Which of those makes the most sense to you?”

What to do with patients high in CONFIDENCE but low in IMPORTANCE? (“I can change if I want but it’s not important”):

- **Ask hypothetically:** “If for some odd reason you someday decided to change, what would you do? M? E? N? U? S?”

- **Prove to them that you respect their choice not to take action yet:** “I can see although you’re taking this seriously, you’re not entirely ready to take action right away.”

- **Try to “leave a pebble in their shoe” by planting doubt about the status quo:** “I hear that you don’t think that alcohol caused you to be stabbed, but I can’t help but wonder if you would even be here if you weren’t drinking that night, because you might have gone somewhere else instead of the club. What do you think?”

- **Remind patients of their autonomy:** “Nobody can decide this for you. It’s completely up to you to choose what you will do . . .”

What to do with patients low in CONFIDENCE? (“I need to change, but it’s too hard”):

- **Be optimistic:** loan patients your confidence until they have their own: “I believe that your chances are actually better than you think . . .”

- **Tell them about the success of others:** “I can tell you that many people have successfully quit drugs, despite not believing at first that they could do it. They tell me they enjoy life much more, compared to when they were using.”

- **Tell them that most people have to try to change several times before it sticks:** “The fact that you’ve tried several times to quit bodes well for your success. Actually, it’s the people who fail once and never try again who don’t make it.”

Tips for closing on good terms

**Why it is important to close on good terms**

- So the next interventionist will have it easier than you did.

- Because if you close on bad terms, they will remember the conversation as unpleasant and therefore discount your message.

- Because you will enjoy your work more.

- It will promote better relationships within the ED if you’re seen as a positive addition, and not someone who angers/upsets patients.

Examples:

- “I think you did a great job talking about this, under very tough circumstances.”

- “Thanks for taking the time to discuss this matter. You really kept an open mind throughout.”

- “I admire your honesty and determination. I believe that you will know what the right thing to do is, once you make up your mind.”

People are most likely to change if they like you and if they feel that you value them.
F*LO checklist

Use this to practice BIs

Thank you for answering our drug and alcohol questions. If you are interested in knowing your scores, I would like to go over them with you now. But I won’t be pushing you to change; no one can decide that but you.

Feedback on alcohol screening results:

**Range:** AUDIT scores can range from 0-40

**Ask:** What would you guess your score was?

**Normal:** Normal scores are below 8 for males (7 for females)

**Give Score:** Your score was . . .

**Elicit Reaction:** What do you make of that?

Feedback on drug screening results:

**Range:** DAST scores can range from 0-10

**Ask:** What would you guess your score was?

**Normal:** Normal scores are 0 on the DAST

**Give Score:** Your score was . . .

**Elicit Reaction:** What do you make of that?

(Summarize patient’s reactions to their feedback)

Now I would like to ask you a few more questions to better understand how you see things. Is that okay?

Listening for Change Talk:

How **Important** is it to change your drinking, 1-10?

Why didn’t you give it a lower number?

What would it take to give yourself a higher number?

How **Confident** are you that you could change, 1-10?

Why didn’t you give it a lower number?

What would it take to give yourself a higher number?

So, how do you want your drinking to be in the future?

There are several options:

---

Options for change discussed:

**Manage your drinking/drug use** (cut down)

**Eliminate drinking or using** (abstain)

**Never drive after using alcohol or drugs**

**Utterly nothing** (no change in the status quo)

**Seek help** (counseling, AA, family, church)

Close on good terms:

In summary, your reasons to make a change are . . .

You have decided to do the following . . .

And I think you can do it because . . .

➤ Thank the patient and end on good terms.

FAQs on doing Brief Interventions

**Q. How do I know when a BI is going well?**

**When patients make “Change Talk:”**

“I really want to do something different. I know I can do it.”

“I need to take a new direction in my life. If I don’t change, bad things could happen.”

“I’m going to make this happen.”

“Even though I don’t think I’m addicted, some bad things are happening when I use.”

“I’ll do whatever it takes to cut down. I really want some help.”

“I’m sick and tired of being around druggies.”

“I don’t have to drink to have fun.”

“I’ve decided to cut down and I really mean it.”

“My wife would definitely be happy if I quit.”

“I’ve got to change, or I could lose my kids.”

Music to your ears? That’s “change talk.” Change talk is usually not abundant, even during a successful BI. But if listened for carefully, these statements usually occur several times during the interview. They are highlights that should be stored and summarized by the interventionist, so the patient can hear them again near the end of the interview. (“You mentioned that it’s time for you to take new direction in your life, and one of the things you’re contemplating is quitting drinking.”)
**Q. What can I do if my patient is “in denial”?**

Most patients feel two ways about change: 1) they want to change, and at the same time, 2) they don’t want to change. This is why, during the same interview, you will usually hear patients make statements both for and against change. Statements against change, “status quo statements,” are not usually attempts to deceive you, nor are they lies or attempts to manipulate you. For most patients, both sides are true. Some clinicians believe that statements against change constitute “denial” or “resistance.” However, the view from a Motivational Interviewing perspective is that these statements are not manipulative or self-delusional. Instead, they are simply one side of a patient’s ambivalence—the other side being a desire to change. So ambivalence is a normal part of lifestyle change, and for interventionists, it is actually an opportunity to enhance rapport.

A simple way to enhance rapport in the face of “status quo talk” is to “reflect and find the good news” in the patient’s statement. When one hears status quo talk, it is best to summarize it and try to find the good news in it—instead of arguing with it. Below are a few examples of “status quo talk,” followed by a few choices for ways to reflect and find the good news in what the patient is saying.

**STATUS QUO STATEMENT:** “I don’t see why everybody is making such a big deal about my drinking. I have a few beers after work to relax, that’s all.”

**Response:** “You work hard, and you need to unwind so you can get your energy back after work.”

**Response:** “You’ve taken a good hard look at your drinking and in your opinion, it’s not something to worry about.”

**Response:** “Seems like you’re looking for a healthy way to chill out after work.”

**STATUS QUO STATEMENT:** “You might think that my drinking is risky, but I don’t drink as much as my friends. You should be talking to them instead of me!”

**Response:** “Compared to the people you drink with, you’re much healthier.”

**Response:** “When you compare yourself to some of your friends, you’re actually more responsible.”

**Response:** “It’s important to you to control your drinking, and you know some people who aren’t in good control.”

**STATUS QUO STATEMENT:** “I’m not a drug addict.”

**Response:** “You’re being careful to keep your drug use under control.”

**Response:** “You work hard to remain aware of where your drug use is going.”

**Response:** “You’re a responsible, happy person.”

**STATUS QUO STATEMENT:** “Marijuana is not a drug. It’s an herb that I use for my chronic pain. It’s way safer than alcohol, and they should make alcohol illegal, not marijuana.”

**Response:** “You’re pretty careful about what you put in your body.”

**Response:** “You’ve been thoughtful about how and why you use marijuana.”

**Response:** “So you don’t use marijuana to get high.”

**Q. How do I know when the BI is finished?**

Beginners tell us that it is often difficult to know whether to stop or keep going.

- Have you given screening feedback (F) and summarized your patient’s responses?
- Have you elicited and summarized your patient’s reasons for change (L)?
- Have you explored options for change (O)?
- Is the patient becoming less involved in the conversation?

If so, you should end on good terms. Patients sometimes signal that they wish to end the interview before these tasks are complete—and this should be respected. Common signals include shutting the eyes, making obvious efforts to change the topic, eagerly answering their phone and seeming relieved to greet the caller, or even asking, “So, is there anything else?”

These behaviors should be seen not as evidence that you have done something wrong or the interview has failed so much as signals that patients simply have very limited energy and attention while undergoing acute medical care. Such signals are common in Brief Interventions, and when you recognize them, close on good terms.
**Chapter 4: Motivational Interviewing**

**FAQs about Motivational Interviewing:**

**What is Motivational Interviewing (MI) and is it the same thing as BI?**

Motivational Interviewing is a style of counseling that can be used to perform the FLO tasks of a BI, but MI is not the same thing as the FLO tasks, which can be done without using MI. MI is a patient-centered style of counseling that empowers patients to explore their ambivalence about change. It demands advanced listening skills on the part of the counselor as well as strategies of motivational psychology to elicit and highlight the patient’s reasons for change. MI helps patients to resolve their ambivalence and move toward change. As such, MI requires relatively advanced counseling skills that not all brief interventionists have.

**Is it necessary to learn MI in order to perform BI?**

No. MI is not the only way to interact with patients during a BI, nor is it clear that MI is the best way. Other styles of counseling have worked well in BI studies, including Cognitive Behavioral counseling as well as simple, brief advice. This manual does not teach any particular style of interacting with patients, although several suggestions in the section, How to do a BI, are informed by and congruent with the spirit and methods of MI.

**How would the style of a BI differ when using MI versus not using MI?**

MI has been shown to elicit less status quo talk and more change talk than a more confrontational style.9 (See the two tables on page 20 contrasting two styles of interacting with patients.) The MI style is more quiet and eliciting than most other styles, because it does not emphasize educating patients about substance abuse. The most common thing that an MI interventionist does is ask open questions and reflect the patient’s answers, in an attempt to help patients gain perspective on how alcohol or drugs fit into their lives.

**What is involved in learning MI?**

It takes more than a workshop to become proficient at MI. In general, a counselor with good baseline listening skills can attain basic MI proficiency from a 2-day group workshop plus several months of weekly supervision and coaching. It can take longer for medical providers without counseling backgrounds to learn MI.10

We have included the following synopsis of MI by Bill Miller, PhD, not to teach MI to the reader of this manual, but for readers who are potentially interested in learning MI to see at a glance the philosophy, strategies, and style that they would have to learn. The reader can find resources for learning MI in the Reference section.

**Things to know about Motivational Interviewing (MI)**

Adapted from condensed notes by Bill Miller11

**MI is a patient-centered approach**

- Working in partnership and with the patient.
- Listening happens much more than telling.
- Eliciting happens much more than “installing correct ideas.”
- Honoring the person’s autonomy and ability to choose happens instead of deciding for the patient.

**Ambivalence is the key**

- “Lack of motivation” is really just ambivalence: Both sides are already within the person.
- If you argue for one side, an ambivalent person is likely to defend the other.
- As a person defends the status quo, the likelihood of change decreases.
- Resist the “righting reflex”—to take up the “good” side of the ambivalence.
Four essential micro-skills: OARS
- Ask OPEN questions—not short-answer, yes/no questions.
- AFFIRM the person—comment positively on strengths, effort, and intention.
- REFLECT what the patient says ("mini summaries").
- SUMMARIZE—collect the patient’s perspectives on change ("maxi summaries").

Reflective listening: A valuable skill in itself
- A reflection seeks to summarize what the person means; it makes a guess.
- A good reflection is a statement, not a question.

Levels of reflection:
- Repeat—Direct restatement of what the person said.
- Rephrase—Saying the same thing in slightly different words.
- Paraphrase—Making a guess about meaning, continuing the paragraph, usually adds something that was not said directly.

Other types of reflection:
- Double-sided reflection—Captures both sides of the ambivalence (. . . AND . . .)
- Amplified reflection—Overstates what the person says.

Change Talk
- Invite the person to make the arguments for change.
- Ask about desire ("Want to change?"), ability ("Can you change?") reasons ("Why do it? What would be good?"), need ("Important to do it?").
- Commitment language—the bottom line ("I will do it!"). This predicts actual change.

Eliciting Change Talk
- The simplest way: Ask for it, in open questions to elicit desire, ability, reasons, and need:
  "In what ways would it be good for you to . . . ?"
  "If you did decide to . . . , how would you do it?"
  "What would be the good things about . . . ?"
  "Why would you want to . . . ?"

Importance and confidence rulers
- "On a scale from 0 to 10, how important is it for you to . . . ?"
- "And why are you at ____ and not zero?" (The answer is change talk.)
- "On a scale from 0 to 10, how confident are you that you could . . . .""And why are you at ____ and not zero?" (The answer is ability talk.)

What to do when you hear Change Talk?
- When you hear change talk, don’t just sit there!
- Reflect it—Restate it back to the person.
- Ask for examples/elaboration: "When was the last time? In what ways?"
- Ask for more: "What else? What other reasons?"
- Affirm change talk—reinforce, encourage, support it.
- Summarize—"Collecting flowers into a bouquet."

Looking forward
- "If you don’t make any change, what do you think will happen?"
- "Where would you like to be in ___ years? What do you hope will be different?"
- "And how does drinking fit into that?"

Is it OK to give advice?
- Yes. But the person is more likely to heed your advice if you have permission to give it:
  "There’s something that worries me here. Would it be all right if I . . . ."
  "Would you like to know . . . ?"
  "Do you want to know what I would do, if I were in your situation?"
  "I could tell you some things other patients have done that worked . . . ."
  "This may or may not be important to you . . . ."
  "I don’t know if this will make sense to you . . . ."
  "You may not agree . . . ."
  "I don’t know how you’ll feel about this . . . ."
  "Tell me what you think of this . . . ."
- It’s better to offer several options, rather than suggesting only one.
Responding to resistance

- Remember that “resistance” is just the other side of the ambivalence.
- Don’t argue against it. Pushing against resistance entrenches it.
- Respond in way that does not increase resistance. Roll with it.
- Some effective responses that tend to defuse resistance and refocus on change:
  Reflection — Simply acknowledge it by reflecting it back.
  Amplified reflection — Overstating it a bit.
  Double-sided reflection — “On the one hand . . . And on the other . . .”
  Emphasize the person’s ability to choose, to be in control, to have autonomy.
- It’s not something the client does that’s bad. It’s a result of the interaction, of the chemistry between you and your patient. It usually predicts a poor outcome. So it is a sign for you to switch strategies.

Strengthening commitment

- Change talk (desire, ability, reasons, need) increases commitment. Commitment language signals behavior change.
- Encourage even low-strength commitment language: “I’ll think about it. I might. I’ll try. I could.”

Closing. Complete a consultation by giving a summary:

- Bouquet: Draw together the person’s desire, ability, reasons, need themes.
- Briefly acknowledge areas of reluctance, if appropriate.
- Summarize the person’s commitment strength.

► If commitment is strong, elicit/negotiate a change plan.
MI-consistent and MI-inconsistent responses

**MI-Consistent responses (these tend to increase patient change talk)**

**Open questions**
- “What are your concerns about alcohol?”
- “What role did alcohol play in your injury?”

**Reflections**
- “You’re really surprised to hear how high your alcohol level was.”
- “So you don’t think alcohol is hurting you all that much.”
- “I can see that your AUDIT score is higher than you expected . . . .”

**Summaries**
- “So you don’t think you’re an alcoholic and at the same time you’re concerned about some of the risks you have taken with alcohol.”

**Screening feedback**
- “Your alcohol level was .15 when you came in…what do you make of that?”
- “Your AUDIT score was 15, placing you in the very high-risk zone.”

**Emphasize control**
- “It’s totally up to you whether you make a change.”
- “I’m not here to tell you how to live.”
- “You may decide to change after we talk, you may not.”

**Give advice**
- “If I may, I’d like to suggest you consider cutting down or quitting, to prevent future injury.”

**Affirmations**
- “I appreciate your honesty.”
- “You’re a person who really does follow through once you make up your mind.”

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**MI-Inconsistent responses (these tend to increase patient status quo talk—you want to avoid these)**

**Closed questions**
- “Do drugs cause problems in your life?”
- “Do you think you have a problem with drugs?”
- “Do you think alcohol caused your crash?”
- “How much did you drink the night you were injured?”

**Confronting**
- “You said you only had 2 beers, but that’s impossible.”
- “You say it’s not hurting you, but I can see that it really is.”

**Warning**
- “If you don’t change, you could be killed next time.”

**Interpret reality**
- “This is a lot more serious than you think.”

**Giving approval, appeasing**
- “Good for you, that’s the right thing to do.”
- “We often tell ourselves that to seek comfort.”
Referring patients from acute care to substance abuse treatment

Either BT or community substance abuse treatment

Which patients should be referred to treatment?

No universal formula should dictate the answer to this question. In the Washington SBIRT project, we used the guidelines in the table below to determine which patients received a BI and/or were referred on for BT or intensive treatment. However, our interventionists sometimes referred lower-scoring patients to treatment if during the screening or BI interviews, their clinical judgment suggested that this was appropriate. The following are only general guidelines that should be adjusted by individual SBIRT programs after considering issues such as treatment availability and a given hospital’s populations served.

General Guidelines for Referral to Treatment

<table>
<thead>
<tr>
<th>Refer to intensive community substance abuse treatment</th>
<th>Refer to BT*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide BI only in the ED</td>
<td></td>
</tr>
<tr>
<td>Considered a negative screen, no further counseling needed</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AUDIT-Female</th>
<th>AUDIT-Male</th>
<th>DAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 7</td>
<td>Less than 8</td>
<td>0</td>
</tr>
<tr>
<td>7-15</td>
<td>8-15</td>
<td>1-4</td>
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<td>16-19</td>
<td>16-19</td>
<td>5-7</td>
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<td>20-40</td>
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<td>8-10</td>
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</table>

*BT is not commonly available in many states as a routine level of intervention.

The question of which patients to refer on for treatment—and how much time to invest in making these referrals—is a cost-benefit issue that every SBIRT program should carefully consider, given its unique environment. Is BT available to refer patients to? (see BT description below) Is intensive treatment reasonably accessible by your patients? Are your patients mostly Medicaid/Medicare, or are they privately insured? Is your hospital committed to a public health screening program to identify hazardous substance users, or is the culture of your hospital more committed with trying to place severely addicted patients in treatment?

How much time should be spent referring patients to intensive treatment?

Doing a good job of helping a patient to enter treatment is a time-consuming case management effort consisting of far more than merely giving patients a list of treatment agencies and phone numbers. Consider a clinical example:

A patient was found down in the street extremely intoxicated and injured from an assault. He was brought to the ED, where a minor scalp laceration was sutured and he was then held until sober enough to be discharged. The ED’s designated brief interventionist was asked by an ED nurse to see the patient, who was at first too intoxicated to undergo a brief counseling intervention. Five hours later, the patient was sober enough to talk, so the interventionist met with the patient for 20 minutes.

During this BI, the interventionist learned that the patient had had multiple prior treatment episodes and routinely suffers alcohol withdrawal symptoms when he stops drinking. The interventionist then contacted the ED physician (30 minutes to find the doctor and wait until she was available).

The physician asked the interventionist to try placing the patient in the local public detox program to manage his anticipated withdrawal—preferably before he went into withdrawal in the ED—in which case he might then have had to stay for 2 or 3 more days in the ED while his acute withdrawal was managed. The interventionist then had to coordinate with the ED social worker to discuss the patient (30 minutes) and contact the detox program to see if a bed was available for which the patient would qualify clinically and financially.

During this time, the interventionist had to update nurses, physicians, and social workers on the patient’s disposition status, which changed from time to time, depending upon the patient’s motivation for entering detox and bed availability. Finally, the interventionist coordinated transportation by walking the patient out of the hospital and waiting 20 minutes for a cab to take the patient to detox.

Finally, the interventionist coordinated transportation by walking the patient out of the hospital and waiting 20 minutes for a cab to take the patient to detox.
NOTE: This was a successful effort because the patient actually went to detox. However, more often than not, case management time is spent and then the patient decides not to go at the last minute. The only way to know this is to try to get the patient help and hope that he/she agrees to go to treatment.

- Total face-to-face time with patient: **40 minutes**
- Total time spent case managing one patient, spread over one day: **2-4 hours**
- Number of Screens and BIs that could have been done in 2-4 hours: **4-6**

Before devoting precious resources to treatment referral that might otherwise be devoted to performing BIs, SBIRT program administrators should consider how likely it is that referred patients will actually enter treatment as a result of a referral from their acute medical settings. Different SBIRT programs serve very different populations in terms of their attitudes toward substance abuse treatment and the availability of their public or private resources to pay for it.

Research on referring patients from acute medical care to treatment has yielded markedly different outcomes. For example, one SBIRT program referring to treatment as a medical necessity might enjoy a high rate for referrals to intensive treatment, but agreed to go to BT. Once they become engaged in BT, some of them were subsequently referred to more intensive community treatment as they become ready to deepen their commitment to change. This improved the show-up rate for referrals to intensive treatment.

**How much education of hospital staff is needed about SBIRT?**

Substance abuse counselors, who sometimes serve as SBIRT interventionists, are very skilled at RT, because they are familiar with the community substance abuse treatment system. Hospital staff deeply appreciate this expertise. However, other interventionists less familiar with substance abuse treatment may be less successful than specialists in making referrals. SBIRT is a new service that is often misunderstood by hospital staff who may think that its sole purpose of SBIRT is RT.

In the Washington SBIRT project, the greatest impact in cost-savings to the state come from the first part (SBI) of SBIRT, and less so from the RT. So until hospitals learn the value of a balanced SBIRT program (one providing BI and RT), interventionists may face a discrepancy between SBIRT program goals and ED staff wishes:

- **ED staff wishes** → **SBIRT**
- **SBIRT program** → **SBI**
- **SBIRT jobs entail constant re-education of ED staff. This is true of all acute medical settings.**

Nurses or other medical workers could provide BT, if also trained in counseling and substance abuse. Abstinence is usually not required (although this could vary by state), and BT is usually not mandated by the courts. BT is an opportunity for some clients to explore their drug and alcohol use and decide whether they want to change. If they decide to change during BT, they choose their own goals, with counselor guidance. This may mean quitting one drug and cutting down on another, using more safely (never before driving, never before work), or total abstinence.

During the Washington SBIRT project, we discovered another value of BT. In addition to being a stand-alone treatment for less severely impacted patients, we discovered that BT worked well as a bridge to more intensive community substance abuse treatment for more severely impacted patients. For example, some severely impacted patients declined a referral to intensive treatment, but agreed to go to BT. Once they become engaged in BT, some of them were referred to more intensive community treatment as they become ready to deepen their commitment to change. This improved the show-up rate for referrals to intensive treatment.

**What is BT and when available, how should it be used?**

BT is a stand-alone treatment for hazardous substance users who don’t need more intensive substance abuse treatment. Please note, however, that BT is not part of the “traditional” SBIRT model, nor is it well established yet as a treatment element in most states. One thing that makes BT a new element of substance abuse treatment is the size of the BT “dose”: it is more intensive than a BI (more sessions) and less intensive than traditional community substance abuse treatment, which can last more than a year in some cases. BT has been funded in some states by the U.S. federal government specifically to treat hazardous substance users. BT can last from 1 to 4 sessions, usually weekly one-on-one counseling sessions with substance abuse counselors or other mental health clinicians trained in substance abuse.
Pothole #1: Damned lies

“I don’t drink and drive . . . .”
Patient was an intoxicated driver admitted to the ED

“I only had a couple of beers . . . .”
Patient’s alcohol level was .25 upon admission

Patients may lie from time to time during BIs. After all, they are talking to strangers about a sensitive topic that they did not ask to discuss, while under stress. When you think that your patient is lying, you are at risk for being distracted (how could his alcohol level be that high if he wasn’t drinking?), and it’s hard to concentrate and stay on task doing FLO. So what should you do? Some patients have good reasons to withhold information (legal, cultural, pride). When you hear a lie, it is your signal to focus on something else.

Remind yourself that:

- Listening and understanding is what makes BI effective—not confronting patients on their lies.
- Lies are like the wind on the golf course . . . you can’t stop it, but you still have to hit your best shot. If you let the wind distract you, you’ll hit a bad shot.
- BI studies were successful even when patients lied some. People can still change even if they don’t tell you the whole truth in the moment.

Workarounds:

Find the good news in the lie:

- If you cannot find any good news in the lie, simply ignore it and refocus yourself.
- Ask yourself which BI task you should be doing (F? L? O?).
- Find the meaning behind the lie (what might the patient really mean by that?)

Examples:

Patient: “I don’t see why you’re making such a big deal about drinking a few beers now and then.”
Response: “This must be a tough topic for you to talk about…”

Patient: “I’m not a drug addict!”
Response: “Seems like you don’t want anybody to label you…”

Patient: “Alcohol never caused me to miss a day of work in my life.”
Response: “You’re a responsible person…”

Patient: “I never drink and drive.”
Response: “You believe it’s wrong to do that.”

Patient: “I hardly ever get very drunk.”
Response: “You don’t think it’s good to get extremely drunk…”

Pothole #2: Unrealistic thinking

“I’m just going to quit, no problem”
Severely addicted patient

“I’m gonna keep hanging with my buddies, but I won’t drink.”

Patient is simply swearing off alcohol or drugs, but with no plan for doing so—and he seems to be avoiding thinking about slippery people, places, or things. So you’re not very confident in his chance for success. And you fall into the pothole of suggesting numerous action plans, which he shoots down one at a time with “yes, buts.” The patient shoots them down, because he doesn’t believe he needs them.
Remind yourself that:

- Swearing off is how people begin the process of quitting. Many smokers swear off and relapse before they discover what works for them. If this is your patient’s first attempt at quitting, you should be celebrating, not feeling discouraged. It’s just a first attempt by somebody who has very little experience in quitting. Most people try to fix the problem with the least amount of effort—all humans do this. People are more likely to commit to making a greater effort (counseling) after they have first tried and failed to do it on their own.
- Acknowledge to that patient that this is actually an experiment in quitting, and the results of the experiment will tell him if his plan is working. You can always ask him what else he would try if for some reason his plan didn’t work . . .
- Many people stop drinking and using without treatment or AA. Some people use church, family, hobbies, and some merely delete drinking from their lives without doing anything else—successfully. Maybe this patient actually intends to do one of these things but just hasn’t said so. Try asking him . . .

Workarounds:

- “People who succeed at quitting or cutting back often use ‘tools’, such as avoiding certain people or places, having a substitute beverage in mind, or announcing their commitment to a loved one . . . how about you?”
- Try for a verbal commitment from them as to how they will know if their plan is working or not working. Try for a verbal commitment to ask for help if they relapse.

Examples:

Patient: “I’m just gonna stop, no problem…”
Response: “That’s great news. What sort of situations have you decided to avoid to do that?”

Patient: “I’m still going to spend just as much time in bars as I did before, if that’s what you mean. I’m just not going to drink.”
Response: “Some people have good luck trying that, some don’t. In addition to going to bars, how else do you enjoy spending time?”

Patient: “I don’t need treatment. I’m just going to do it by myself.”
Response: “Many people succeed without going to treatment. It’s really just a matter of each person figuring out for himself what works best for him. What sort of things have worked for you in the past?”

Patient: “I dunno, I just know I can quit whenever I want.”
Response: “You sound determined. Are there any people that you may spend less time with, now that you have quit?”

Pothole #3: The angry patient

“I don’t have to talk about this . . . .”
“What right do you have to judge me?”
“This hospital has no right asking me about all this personal stuff . . . .”
“I wish that nurse would get me my pain medicine; she’s delaying intentionally . . . .”

Remind yourself that:

- Do not take this personally.
- There is usually good news to be found in anger.
- A little listening goes a long way
- Anger can be defused . . . if not, you can always just leave the room.

Workarounds:

- Back down, give in. Let go.
- Agree to leave it for now, close on good terms.
- Go into customer service mode and try to address the complaint if there is one.
- Acknowledge to the patient that he is in control and nobody can tell him how to live his life.
Examples:

Patient: “This is stupid, you walking around the emergency room lecturing everybody. Marijuana never hurt anybody!”

Response: “It’s totally up to you whether you talk to me, I’m sure not here to make you any more uncomfortable than you already are. You look like you’re in some pain there; is there anything I can do to help?”

Patient: “There sure is. You can tell my nurse to get me the amount of pain medicine I need to control my pain.

Response: “No wonder you’re feeling lousy. Let me go and find her and see what she says. Of course, I can’t tell her what to do, but I can sure find out for you what’s going on with your pain meds. I’ll be right back once I find out. Is there anything else I can do for you while I’m gone?”

Patient: “This hospital has no right asking me about all this personal stuff . . . .”

Response: “It seems to you that it’s inappropriate for strangers to be prying into your private life.”

Patient: “Well, I guess the doctors need to know whether I take drugs or not, but I’m not interested in any treatment, I can tell you that right now.”

Response: “I hear you loud and clear. You’re not interested in any treatment and you sure don’t want anybody trying to tell you how to live your life. I can assure you that I won’t be trying to get you to do anything you don’t want to do. I’m just interested in understanding if your drug use is causing you any harm, that’s all. And, it’s totally up to you to decide whether you’re concerned or not. I didn’t single you out: I ask all of our patients these questions.”

▶ These approaches make it easier for patients to discuss it later with another person, if they see that they can control the course of such conversations.
Handouts for your patients

1. Is the way you typically drink within low-risk limits? .............................................................. 28
2. How risky is your use of alcohol compared to other people? .................................................... 29
3. How risky is your use of drugs compared to other people? ......................................................... 30

Screening tools

1. The Alcohol Use Disorders Identification Test: Interview Version .............................................. 31
2. Drug Abuse Screening Test-10 ....................................................................................................... 32
Is the way you typically drink within low-risk limits?

Below are the low-risk guidelines for adults

MEN: 3 drinks per day, max, and 14 drinks per week, max.

WOMEN: 2 drinks per day, max, and 9 drinks per week, max.

Any time you exceed these limits, you are at risk of harm

ONE DRINK  = One bottle of beer (12 oz)
= One glass of wine (5 oz)
= One “single” drink (1¼ oz of liquor)

No amount of alcohol is safe if you are driving.

No amount of alcohol is safe if you are pregnant or planning to conceive.
How risky is your use of alcohol compared to other people?

**RANGE:** AUDIT scores can range from 0-40

**ASK:** What would you guess your score was?

**NORMAL:** Normal scores on the AUDIT are below 8 for adults.

**GIVE SCORE:** Based on your answers to the audit, your score was ________.

*This places you in the following category:*
- ☐ No/Low-Risk
- ☐ At-Risk
- ☐ High-Risk
- ☐ Severe-Risk

**ELICIT:** What do you make of that?

**LOW-RISK DRINKING:**

**MEN:** 3 drinks per day, max, and 14 drinks per week, max.

**WOMEN:** 2 drinks per day, max, and 9 drinks per week, max.
How risky is your use of drugs compared to other people?

- The DAST-10 (Drug Abuse Screening Test) is a questionnaire that has been given to many adults.
- DAST scores can range from 0 to 10.
- Based on your answers to the DAST, your score was _____.

  This places you in the following level of drug risk:
  - No risk
  - Low
  - Moderate
  - High
  - Very High

- These problems can include: medical, injury, mental or emotional consequences.
- Health experts advise people to quit or cut back in order to get into the No Risk zone.
**The Alcohol Use Disorders Identification Test: Interview Version**

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during the past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   - (0) Never [Skip to Qs 9-10]
   - (1) Monthly or less
   - (2) 2 to 4 times a month
   - (3) 2 or 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) 1 or 2
   - (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 Questions 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 needed a first drink in the morning to get yourself going after a heavy drinking session?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

7. 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

8. 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

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

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    - (0) No
    - (1) Yes, but not in the last year
    - (2) Yes, during the last year

*If total is greater than recommended cut-off, consult User’s Manual.*

Record total of specific items here
Drug Abuse Screening Test-10

The following questions ask about your possible drug use over the past 12 months. Do not include your alcohol use when answering the questions.

"Drug abuse" refers to:

- The use of prescribed or over-the-counter drugs in a way that does not follow the directions.
- Any non-medical use of drugs.

Drugs may include:

- Cannabis (marijuana, hashish)
- Solvents, such as paint thinner
- Tranquilizers, such as Valium
- Barbiturates
- Cocaine
- Stimulants, such as speed (meth)
- Hallucinogens, such as LSD
- Narcotics, such as heroin

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?

These questions refer to the past 12 months: Yes  No

3. Are you unable to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (for example, memory loss, hepatitis, convulsions, bleeding)?

Scores indicate the degree of problems that drug use may cause:

- 0 = No problems related to drug use.
- 1 to 2 = Low level of problems related to drug use. Talk to your doctor about this.
- 3 to 5 = Intermediate level. Make an appointment with your doctor to discuss this.
- 6 to 8 = Substantial level. Call your doctor now to make an appointment.
- 9 to 10 = Severe level. Call your doctor now to make an appointment.

Adapted from "Drug Use Questionnaire," © Copyright 1982 by Harvey A. Skinner, PhD, and the Centre for Addiction and Mental Health, Toronto, Canada.
References


8 This acronym was successfully used for the Washington SBIRT project interventionist training. It’s sources are numerous, mostly from the work of SBIRT colleagues Craig Field, PhD; Judith Bernstein, PhD; Ed Bernstein, MD; Gail D’Onofrio, MD; Linda Degutis, DrPH, Dan Hungerford, DPH.


Learning more about MI


3 The Motivational Interviewing Page: A repository of resources on motivational interviewing, including links, training resources, reprints and videotapes: motivationalinterview.org.


5 An international web site where you can get certified in MI: http://www.mi-campus.com/.
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT FOR SUBSTANCE ABUSE
Screening, Brief Intervention, and Referral to Treatment for Substance Abuse

...bringing substance abuse counseling to acute medical care

A training manual for staff in acute medical settings

MAY 2010
Impact of Screening, Brief Intervention, and Referral to Treatment on Entrance to Chemical Dependency Treatment

Medicaid Patients Screened in Hospital Emergency Departments
Sharon Estee, PhD; Lijian He, PhD; Melissa Ford Shah, MPP; David Mancuso, PhD, and Barbara Felver, MPA, MES

One of the main goals of the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) Project was to improve admissions to chemical dependency (CD) treatment among hospital Emergency Department (ED) patients who received a brief intervention (BI) for substance use disorders. To assess how well the project achieved this goal, patients with publicly funded medical assistance who received at least a BI through one of nine WASBIRT hospitals between April 2004 and June 2008 were compared to statistically matched publicly funded patients treated in hospital EDs during the same time period who were not screened through WASBIRT. The odds of obtaining CD treatment were significantly higher for those who received at least a BI relative to their matched counterparts, and this finding was consistent across three distinct client populations served by DSHS: the working-age disabled, recipients of General Assistance-Unemployable (GA-U), and those on Temporary Assistance for Needy Families (TANF).

Key Findings
This report analyzes the odds of entering CD treatment within 90 days of receiving at least a BI in an ED setting. Across three Medicaid populations, WASBIRT patients were more likely to enter treatment.

- **Working-age disabled patients who received a BI had 2.6 times the odds of entering CD treatment** compared to their matched counterparts. The subset of these patients who had not received CD treatment in the two years prior to receiving a BI had odds of going to treatment that were 3.5 to 1 compared to their matched peers.

- **General Assistance-Unemployable (GA-U) patients who received a BI had 3.2 times the odds of entering CD treatment** compared to their matched peers. The subset who had not received CD treatment in the prior two years had odds of entering treatment that were 3.1 times higher.

- **Temporary Assistance for Needy Families (TANF) patients who received a BI had 3.2 times the odds of entering CD treatment** compared to patients in the comparison group. The subset who had not received CD treatment in the year prior to receiving a BI had odds of entering treatment that were 4.6 times higher relative to the comparison group.

- **The pooled group of working-age disabled, GA-U, and TANF patients who received brief therapy following a BI had 3 times the odds of entering treatment** compared to individuals with the same levels of substance abuse risk who received only brief intervention.

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1 A relatively small number of clients in the TANF group were eligible for Medicaid through non-TANF programs for pregnant women or children who were age 18 at the time of the ED visit.
OUTCOMES | Effect of Brief Intervention

We used statistical modeling to estimate the impact of receiving a brief intervention (BI) through WASBIRT on the odds of entering CD treatment within 90 days of the index ED visit. We controlled for basic demographics (age, gender, and race/ethnicity), county of residence or service, and whether or not the patient was injured in the index month. We also controlled for the following pre-period measures: months of enrollment in ABD, GA-U, or TANF medical coverage, an indicator of need for CD treatment, receipt of CD treatment, prior arrests, prior ED visits, prior injuries, prior medical risk (expected future medical costs), and diagnoses for liver disease, poisoning, and depression. In addition, for TANF patients, we included a control variable that was an indicator of whether or not an individual had any diagnoses or procedures in their medical claim or encounter records indicating a pregnancy or delivery in the index month or eight months prior to it. Overall, the unadjusted differences we observe between the WASBIRT group and the comparison group tend to mirror the regression-adjusted differences. This suggests that the matching process itself likely removed much of the observable “selection bias” (that is, the greater likelihood of patients with certain characteristics receiving a BI).

We observe three major findings across the three client populations. First, WASBIRT patients consistently have higher odds of entering CD treatment relative to their matched counterparts. Secondly, patients in both the WASBIRT and comparison group are more likely to receive treatment within 90 days of the index event if they had CD treatment in the prior year (TANF clients) or two years (working-age disabled and GA-U clients). Lastly, we find that among working-age disabled and TANF clients, WASBIRT patients who have not had CD treatment in recent history have greater odds of entering CD treatment following a BI compared to their matched peers.

**BI Links Working-Age Disabled Patients to CD Treatment**

Among working-age disabled adults, the odds of entering CD treatment within 90 days of receiving a BI were 2.6 times higher relative to similar patients treated in EDs who did not receive BIs. The effect of WASBIRT on linking patients to CD treatment was even greater among the subset of working-age disabled patients who had not received CD treatment in the two years prior to the index ED visit. For these patients, the odds of entering CD treatment were more than 3 to 1 when compared to their matched peers.

![FIGURE 1](image)

**FIGURE 1**

Working–age disabled WASBIRT patients more likely to enter CD treatment

Odds of entering CD treatment within 90 days of receiving a BI

<table>
<thead>
<tr>
<th>WASBIRT vs. Comparison Group</th>
<th>Comparison</th>
<th>WASBIRT Unadjusted</th>
<th>Odds Ratio Point Estimate</th>
<th>WASBIRT Regression-adjusted</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients n=5,034</td>
<td>4.7%</td>
<td>11.1%</td>
<td>2.62</td>
<td>11.3%</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>No Prior CD Treatment n=3,786</td>
<td>2.5%</td>
<td>7.6%</td>
<td>3.45</td>
<td>8.1%</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Prior CD Treatment n=1,230</td>
<td>12.7%</td>
<td>21.8%</td>
<td>1.97</td>
<td>22.2%</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

2 These pre-period measures were constructed using data from the 24 month period prior to the index month for working-age disabled and GA-U patients and from the prior 12 month period for TANF patients.
**BI Links GA-U Patients to CD Treatment**

Among patients enrolled in GA-U, the odds of entering CD treatment within 90 days of receiving a BI were approximately 3 times higher relative to similar patients treated in EDs who did not receive BIs. WASBIRT patients enrolled in GA-U who had not received CD treatment in the prior 24 month period also had odds of entering treatment following a BI that were about 3 to 1 when compared to their matched counterparts.

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**BI Links TANF Patients to CD Treatment**

The findings for WASBIRT patients enrolled in TANF mirror those of working-age disabled clients described above. For this client population, the odds of entering CD treatment within 90 days of receiving a BI were approximately 3 times higher relative to similar patients treated in EDs who did not receive BIs. Moreover, WASBIRT patients enrolled in TANF who had not received CD treatment in the prior 12 month period had even greater odds of entering CD treatment after a brief intervention. In this case, the odds were over 4 to 1 when compared to individuals in the comparison group.
OUTCOMES | Effect of Brief Therapy

Beyond brief intervention, patients with AUDIT and DAST screening scores that placed them at higher risk for substance abuse were referred to brief therapy (BT), which involved approximately four to twelve follow-up sessions with a counselor who continued to employ motivational interviewing techniques. Brief therapists provided additional support to WASBIRT patients as they attempted to reduce their substance use or abstain altogether. These therapists also referred patients to treatment—and helped remove barriers to entering treatment—for those determined to be chemically dependent.

To analyze the additional effect of BT in linking patients to CD treatment, we pooled working-age disabled, GA-U, and TANF patients together and restricted the study population to WASBIRT patients who received at least a BI. For the purposes of this analysis, we defined the treatment group as individuals who received BT within 30 days of the BI. The comparison group was defined as individuals who received BI but not BT. Once again, we estimated the odds of entering CD treatment within 90 days of the index ED event.

It is important to note that individuals who receive BT have more severe substance abuse problems by design and so are more likely to need CD treatment relative to those with lower risk levels. Therefore, it was important to match individuals in the BT group with individuals who received only BI but who had similar levels of risk based on (1) AUDIT and DAST scores, (2) an indicator of prior need for CD treatment constructed from administrative data, and (3) whether or not they had received CD treatment in the past. In addition, the regression analysis controlled for these three factors.

Brief Therapy Links Working-Age Disabled, GA-U, and TANF Patients to CD Treatment

The analysis of the effect of BT on receipt of CD treatment pooled working-age disabled, GA-U, and TANF patients due to the smaller number of observations available. In addition to the fact that only a subset of WASBIRT patients who received a BI also received BT, there were also a limited number of individuals in the comparison group who had similar risk levels but received only a BI. Thus, pooling information from the three client populations allowed us to get a credible 1:1 match.

The findings from this analysis suggest that, among patients who have received a BI, BT may play an important role in linking patients to CD treatment. The odds of entering CD treatment were 3 times higher for those who received a BI plus brief therapy when compared to a matched group of individuals who received only a BI.

<table>
<thead>
<tr>
<th>Working-Age Disabled, GA-U, and TANF Patients</th>
<th>Total n=806</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI + BT vs. BI Only</td>
<td>Comparison</td>
</tr>
<tr>
<td>All Patients (n=806)</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WASBIRT</th>
<th>Odds Ratio Point Estimate</th>
<th>WASBIRT Regression-adjusted</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unadjusted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.3%</td>
<td></td>
<td>38.4%</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>3.04</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 4

WASBIRT patients enrolled in ABD, GA-U, and TANF more likely to enter CD treatment after receiving a Brief Intervention + Brief Therapy

Odds of entering CD treatment within 90 days of receiving a BI

<table>
<thead>
<tr>
<th>Odds Ratio</th>
<th>Regression adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.04</td>
<td>p = &lt;.0001</td>
</tr>
</tbody>
</table>

| BI Only   | 17.0%               |
|           |                     |
| BI + BT   | 38.4%               |
DISCUSSION | WASBIRT Links Patients to CD Treatment

The findings presented in this report are encouraging and suggest that screening, brief intervention, and referral to treatment offered in an ED setting can help link Medicaid patients to needed CD treatment. To summarize, working-age disabled, GA-U, and TANF patients who received a BI through WASBIRT experienced significantly increased odds of entering CD treatment within 90 days of the index ED visit compared to their statistically matched peers. The odds of entering treatment were even higher among the subset of WASBIRT patients in two of the client populations (TANF and working-age disabled) who had not received treatment in the prior one or two years, respectively.

For many Medicaid patients who receive care through hospital Emergency Departments, this setting could provide an important venue in which to identify potential substance use disorders using simple self-report screening tools like those used in the WASBIRT project. Furthermore, providing brief interventions, brief therapy sessions, and referrals to CD treatment to ED patients identified as having possible substance use disorders could motivate these patients to seek treatment for their alcohol or drug use problem. In turn, linking these individuals to needed CD treatment may be a critical step to improving their overall health and well being.
**STUDY POPULATION | Working-Age Disabled, GA-U, and TANF Medicaid Patients**

This report examines outcomes for working-age disabled, GA-U, and TANF Medicaid patients who received a BI through WASBIRT in an emergency department (ED) setting between April 2004 and June 2008. For both WASBIRT patients and a comparison group constructed from DSHS administrative data, an "index ED event" (defined below) is used as the reference point for this analysis.

We constructed a comparison group from the pool of individuals who (1) were age 18 to 64 at the time of the index ED visit and alive 12 months later, (2) had at least one month of Medicaid (non-dual Medicare) coverage under one of these three programs in the 30 months prior to the index ED visit, (3) had at least one emergency department visit between April 2004 and June 2008 that did not occur while the patient was in the midst of a CD treatment episode, (4) resided or were treated in one of the six WASBIRT counties, and (5) were not screened through WASBIRT.

In the next step, we used a statistical technique known as propensity score matching to match each WASBIRT participant with the one individual in the comparison group sampling frame who was most similar to them on a variety of measures available in our administrative data. This information was used to predict the probability (propensity) that an individual received a BI. Individuals in the treatment group were excluded from the analysis if a suitable match could not be identified. A separate one-to-one matched sample was created for each client population (ABD, GA-U, and TANF) and for sub-analyses based on patients' prior CD treatment histories. In addition, a separate matched sample was created for the analysis of the effect of brief therapy among the population of WASBIRT patients enrolled in ABD, GA-U, or TANF who received at least a BI. This resulted in ten separate matched samples.

The index ED visit is a significant construct we use as a reference point for both pre- and post-period measures. For WASBIRT patients, we defined the first ED visit in which a BI occurred during the study time interval as the index ED visit and defined the month in which that visit occurred as the index month. For the comparison group, we randomly selected ED visits from the set of visits that occurred between April 2004 and June 2008. Given that the implementation of WASBIRT began at different time periods across the nine intervention hospitals, the statistical matching process took into account the county and month in which the ED visit occurred, as well as the interaction between these two variables. This ensured a comparable distribution of index months and counties for both the treatment and comparison groups.

**Study Description**

This report provides an analysis of the odds of entering CD treatment among individuals who were screened and received a brief intervention in one of nine emergency departments through the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) project between April 2004 and June 2008 compared to a matched comparison group composed of individuals from the six WASBIRT counties who were treated in emergency departments during the same time period but who did not get screened.

**Selection Criteria for Persons Included in Analyses**

**Overall Selection Criteria for Both Groups:**
- Aged, Blind or Disabled (ABD), General Assistance-Unemployable (GA-U), and Temporary Assistance for Needy Families (TANF) clients enrolled in one of the three programs at the time of the index ED visit
- At least 1 month of ABD or GA-U eligibility in the 24 months prior to the index month for ABD and GA-U patients, respectively, and at least 1 month of TANF eligibility in the 12 months prior to the index month for TANF patients
- Dual Eligibility Exclusion: excluded clients with any period of dual Medicaid-Medicare eligibility
- Age: 18-64 at the time of the index ED visit
- Alive 12 months after the index month
- Not in the midst of a CD treatment episode (defined as treatment activities occurring within a 30 day time period) at the time of the index ED visit

**WASBIRT Intervention Group:**
- Received a brief intervention and may have also received brief therapy
- Screening period: April 2004—June 2008
- Index Event: 1st screening for which at least a brief intervention was received
- Excluded 388 participants whose risk score was below standard AUDIT and DAST cutoffs even if they received a BI

**Comparison Group:**
- Emergency Department Use: at least one ED visit between April 2004 and June 2008
- Patients not screened by WASBIRT
- County: resident of one of six WASBIRT counties (Clark, King, Pierce, Snohomish, Thurston, Yakima)

---

3 Patients were categorized into the program in which they were enrolled at the time of their index ED visit. In addition, working-age disabled and GA-U clients had to have been enrolled in ABD or GA-U, respectively, at least one month in the prior two years. TANF clients had to have been enrolled in TANF at least one month in the prior year.

4 Treatment episodes are defined here as CD treatment activities occurring within a 30 day time period.
Regression Analyses

Logistic regression models estimated the probability of receiving a BI. Propensity scores obtained from these models were then used to create one-to-one matched samples for each analysis (10 in total). Next, separate logistic regressions estimated the odds of entering CD treatment within 90 days of the index ED visit for WASBIRT patients compared to their matched peers. Many of the same variables were included in the second set of logistic regressions as in the first (propensity score) regression models. Due to differences in the data we are able to observe for fee-for-service (ABD and GA-U) and managed care (TANF) patients, the pre-period measures included in both sets of models were based on data from the prior 24 month period for ABD and GA-U patients and from the prior 12 month period for TANF patients. The following measures were included in both sets of models:

- Demographics: age, gender, race, county
- Potential need for CD treatment based on medical diagnoses, arrests for alcohol or drug-related offenses, detoxification, or receipt of CD treatment in the pre-period
- Prior arrests
- Prior health risk scores: risk indicator based on diagnoses and prescriptions
- Prior medical use: treatment for injuries and ED use
- Diagnoses for liver disease, injuries in the index month, depression, and poisoning
- For TANF patients only, diagnoses and procedures indicating a pregnancy or delivery in the index month or eight months prior to it
- Prior Medicaid eligibility: number of months enrolled in ABD, GA-U, or TANF medical coverage in the 24 months prior to the index month

Criteria for Level of Intervention

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<th>BT</th>
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### Descriptive Information on Study Population Following 1:1 Matching

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<td>9.02</td>
<td>18.46</td>
<td>9.34</td>
<td>8.98</td>
</tr>
</tbody>
</table>

* Standard deviation in parenthesis.

### RDA CONTACT

Sharon Estee, PhD  
360.902.7655  

Copies of this paper may be obtained at [www.dshs.wa.gov/rda/](http://www.dshs.wa.gov/rda/) or by calling DSHS’ Research and Data Analysis Division at 360.902.0701. Please request REPORT NUMBER 4.68.1.2009.1.
APPENDIX E

Impact of Brief Interventions and Brief Treatment on Admissions to Chemical Dependency Treatment

PLEASE GO TO:
http://www.elsevier.com/wps/find/journaldescription.cws_home/506052/description#description
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

There are nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient’s level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients’ levels of alcohol or other drug use, a sample of 5,598 out of 30,210 WASBIRT patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 4,168 individuals in the sample – a response rate of 79%.

Patients from all WASBIRT hospitals who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 8.0 to 4.2 days for drinking (p<.05).
- From 4.7 to 1.7 days for binge drinking (p<.05).
- From 6.2 to 3.2 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey.

- 79% of 2,886 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 38% stopped drinking altogether.
- 87% of 1,824 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 85% of 1,840 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 35% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 7.4 to 4.4 days (40% decrease) for patients who received a brief intervention only (p<.05).

From 10.6 to 3.3 days (69% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 8.0 to 4.2 days (47% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 4.0 to 1.7 days (58% decrease) for patients who received a brief intervention only (p<.05).

From 7.9 to 1.6 days (80% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 4.7 to 1.7 days (65% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 28% to 43% (56% increase) for patients who received a brief intervention only (p<.05).

From 30% to 65% (116% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 28% to 47% (68% increase) overall (p<.05).
Drug Use Outcomes

Average days of drug use in the past 30 days decreased as follows:

From 5.8 to 3.3 days (43% decrease) for patients who received a brief intervention only (p<.05).

From 8.0 to 2.7 days (66% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 6.2 to 3.2 days (48% decrease) overall (p<.05).

Abstinence from drug use increased significantly:

From 56% to 72% (29% increase) for patients who received a brief intervention only (p<.05).

From 47% to 76% (64% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 54% to 73% (35% increase) overall (p<.05).

Abstinence from Alcohol and Drugs

Abstinence from alcohol and drug use increased significantly:

From 16% to 35% (127% increase) for patients who received a brief intervention only (p<.05).

From 16% to 58% (269% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 16% to 40% (150% increase) overall (p<.05).
OUTCOMES' RISK LEVELS WERE BASED ON SCORES ON THE ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT) AND THE DRUG ABUSE SCREENING TEST (DAST). TWO GROUPS WERE USED IN ANALYSES: (1) THOSE WHO RECEIVED ONLY A BRIEF INTERVENTION AND (2) THOSE WHO RECEIVED A BRIEF INTERVENTION PLUS BRIEF THERAPY, CD TREATMENT, OR BOTH WITHIN 120 DAYS OF THE BRIEF INTERVENTION. THE RECEIPT OF BRIEF THERAPY OR CD TREATMENT WAS IDENTIFIED FROM WASBIRT RECORDS OR FROM THE DIVISION OF ALCOHOL AND SUBSTANCE ABUSE'S TREATMENT DATA (TARGET) FOR THE 4,114 PARTICIPANTS WHO GAVE PERMISSION FOR THE USE OF ADMINISTRATIVE RECORDS.

THE AVERAGE AUDIT AND DAST SCORES ARE SHOWN BELOW FOR PATIENTS WHO RECEIVED A SCREEN ONLY, A BRIEF INTERVENTION ONLY, OR A BRIEF INTERVENTION PLUS BRIEF THERAPY OR CD TREATMENT. THE TABLE ALSO SHOWS THE RECOMMENDED LEVEL OF INTERVENTION BASED ON THE DEGREE OF RISK FOR A SUBSTANCE USE DISORDER.
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Harborview Medical Center (HMC) is one of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient's level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients' levels of alcohol or other drug use, a sample of 1,474 out of 7,552 HMC patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 966 individuals in the sample – a response rate of 72%.

Harborview Medical Center patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 9.4 to 5.4 days for drinking (p<.05).
- From 5.7 to 2.2 days for binge drinking (p<.05).
- From 7.1 to 4.1 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey.

- 79% of 663 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 35% stopped drinking altogether.
- 85% of 433 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 83% of 488 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 35% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 8.8 to 5.7 days (34% decrease) for patients who received a brief intervention only (p<.05).

From 11.8 to 3.7 days (69% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 9.4 to 5.4 days (43% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 5.1 to 2.4 days (54% decrease) for patients who received a brief intervention only (p<.05).

From 8.3 to 1.7 days (79% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 5.7 to 2.2 days (61% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 29% to 40% (38% increase) for patients who received a brief intervention only (p<.05).

From 24% to 60% (146% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 28% to 44% (57% increase) overall (p<.05).
Drug Use Outcomes

**Average days of drug use in the past 30 days decreased as follows:**

From 6.8 to 4.3 days (37% decrease) for patients who received a brief intervention only (p<.05).

From 8.5 to 3.3 days (61% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 7.1 to 4.1 days (43% decrease) overall (p<.05).

**Abstinence from drug use increased significantly:**

From 48% to 63% (31% increase) for patients who received a brief intervention only (p<.05).

From 45% to 71% (59% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 47% to 65% (38% increase) overall (p<.05).

**Abstinence from Alcohol and Drugs**

**Abstinence from alcohol and drug use increased significantly:**

From 17% to 33% (96% increase) for patients who received a brief intervention only (p<.05).

From 14% to 54% (288% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 16% to 37% (131% increase) overall (p<.05).
TECHNICAL NOTES

Six-Month Follow-up Survey Procedures

Out of the 7,552 HMC patients who received at least a brief intervention, a sample of 1,474 patients was selected for the follow-up survey. Interviews were completed with 966 individuals in the sample—a response rate of 72% percent (excluding 18 people who died by the time the interview was due).

Analyses were based on 925 participants with complete data on alcohol use, 917 with complete data on binge drinking, and 929 with complete data on drug use. Analyses excluded 3 participants (0.3%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Analyses also excluded 30 participants (3.1%) who did not give permission for the use of chemical dependency treatment records needed to classify the level of intervention. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

Measures of Substance Use Outcomes

Changes in alcohol and other drug use were based on a person’s answers on the baseline screening survey compared to answers on the six-month follow-up interview, using the following questions:

-During the past 30 days, how many days have you ...
  - Used any alcohol?
  - Had 5 or more drinks in one sitting? (This was used as a measure of binge drinking.)
  - Used any illegal drugs? (Use of illegal drugs included misuse of prescription drugs.)

Classification of Risk and Intervention Groups

Outcomes’ risk levels were based on scores on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Two groups were used in analyses: (1) those who received only a brief intervention and (2) those who received a brief intervention plus brief therapy, CD treatment, or both within 120 days of the brief intervention. The receipt of brief therapy or CD treatment was identified from WASBIRT records or from the Division of Alcohol and Substance Abuse’s treatment data (TARGET) for the 936 participants who gave permission for the use of administrative records.

The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

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<th>Screen Only (Not in follow-up survey)</th>
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<th>Brief Intervention Plus Brief Therapy or CD Treatment</th>
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<td>x</td>
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</tr>
<tr>
<td>Drank alcohol before injury</td>
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<td>x</td>
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</table>

This report was funded through grant number 1 UD1 TI15962-05 from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to the Office of the Governor. Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA or http://www1.dshs.wa.gov/dasa

Research and Data Analysis Division Report Number 4.60.HMC.2009.2
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Providence Everett Medical Center (PEMC) is one of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient's level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients' levels of alcohol or other drug use, a sample of 979 out of 5,223 PEMC patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 718 individuals in the sample – a response rate of 80%.

Providence Everett Medical Center patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 8.6 to 3.9 days for drinking (p<.05).
- From 5.8 to 1.5 days for binge drinking (p<.05).
- From 6.9 to 3.0 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey:

- 79% of 487 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 44% stopped drinking altogether.
- 89% of 308 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 84% of 341 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 42% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 8.2 to 4.1 days (49% decrease) for patients who received a brief intervention only (p<.05).

From 10.2 to 3.2 days (68% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 8.6 to 3.9 days (54% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 5.3 to 1.5 days (71% decrease) for patients who received a brief intervention only (p<.05).

From 7.9 to 1.2 days (85% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 5.8 to 1.5 days (75% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 32% to 49% (54% increase) for patients who received a brief intervention only (p<.05).

From 28% to 66% (132% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 31% to 53% (71% increase) overall (p<.05).
Drug Use Outcomes

**Average days of drug use in the past 30 days decreased as follows:**

From 6.4 to 3.1 days (51% decrease) for patients who received a brief intervention only (p<.05).

From 8.5 to 2.6 days (70% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 6.9 to 3.0 days (56% decrease) overall (p<.05).

**Abstinence from drug use increased significantly:**

From 53% to 74% (39% increase) for patients who received a brief intervention only (p<.05).

From 47% to 79% (68% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 52% to 75% (44% increase) overall (p<.05).

**Abstinence from Alcohol and Drugs**

**Abstinence from alcohol and drug use increased significantly:**

From 16% to 40% (149% increase) for patients who received a brief intervention only (p<.05).

From 12% to 60% (417% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 15% to 44% (193% increase) overall (p<.05).
TECHNICAL NOTES

Six-Month Follow-up Survey Procedures

Out of the 5,223 PEMC patients who received at least a brief intervention, a sample of 979 patients was selected for the follow-up survey. Interviews were completed with 718 individuals in the sample—a response rate of 80% percent (excluding 21 people who died by the time the interview was due).

Analyses were based on 707 participants with complete data on alcohol use, 701 with complete data on binge drinking, and 709 with complete data on drug use. Analyses excluded 2 participants (0.3%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Analyses also excluded 5 participants (0.7%) who did not give permission for the use of chemical dependency treatment records needed to classify the level of intervention. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

Measures of Substance Use Outcomes

Changes in alcohol and other drug use were based on a person’s answers on the baseline screening survey compared to answers on the six-month follow-up interview, using the following questions:

During the past 30 days, how many days have you ...
- Used any alcohol?
- Had 5 or more drinks in one sitting? (This was used as a measure of binge drinking.)
- Used any illegal drugs? (Use of illegal drugs included misuse of prescription drugs.)

Classification of Risk and Intervention Groups

Outcomes’ risk levels were based on scores on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Two groups were used in analyses: (1) those who received only a brief intervention and (2) those who received a brief intervention plus brief therapy, CD treatment, or both within 120 days of the brief intervention. The receipt of brief therapy or CD treatment was identified from WASBIRT records or from the Division of Alcohol and Substance Abuse’s treatment data (TARGET) for the 713 participants who gave permission for the use of administrative records.

The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

<table>
<thead>
<tr>
<th>Criteria for Intervention</th>
<th>Screen Only (Not in follow-up survey)</th>
<th>Brief Intervention Only</th>
<th>Brief Intervention Plus Brief Therapy or CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT - Female</td>
<td>1</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>DAST</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>AUDIT - Male</td>
<td>Less than 7</td>
<td>7 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>DAST</td>
<td>Less than 8</td>
<td>8 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>0</td>
<td>1 - 4</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Drank alcohol before injury</td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

This report was funded through grant number 1 UD1 TI15962-05 from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to the Office of the Governor. Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA or http://www1.dshs.wa.gov/dasa
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Providence St. Peter Hospital (PSPH) is one of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient's level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients' levels of alcohol or other drug use, a sample of 412 out of 2,514 PSPH patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 329 individuals in the sample – a response rate of 85%.

Providence St. Peter Hospital patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 8.0 to 4.6 days for drinking (p<.05).
- From 4.7 to 1.7 days for binge drinking (p<.05).
- From 7.8 to 3.7 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey.

- 76% of 232 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 38% stopped drinking altogether.
- 84% of 150 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 89% of 159 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 37% stopped using drugs.
**Alcohol Use Outcomes**

**Average days of alcohol use in the past 30 days decreased as follows:**

- From 7.3 to 4.7 days (35% decrease) for patients who received a brief intervention only (p<.05).
- From 10.9 to 3.9 days (64% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).
- From 8.0 to 4.6 days (43% decrease) overall (p<.05).

**Average days of binge drinking in the past 30 days decreased as follows:**

- From 3.7 to 1.8 days (53% decrease) for patients who received a brief intervention only (p<.05).
- From 8.7 to 1.7 days (81% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).
- From 4.7 to 1.7 days (63% decrease) overall (p<.05).

**Abstinence from alcohol increased significantly:**

- From 25% to 41% (63% increase) for patients who received a brief intervention only (p<.05).
- From 24% to 66% (171% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).
- From 25% to 46% (84% increase) overall (p<.05).
Drug Use Outcomes

**Average days of drug use in the past 30 days decreased as follows:**

From 7.5 to 4.0 days (47% decrease) for patients who received a brief intervention only (p<.05).

From 9.3 to 2.7 days (71% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 7.8 to 3.7 days (52% decrease) overall (p<.05).

**Abstinence from drug use increased significantly:**

From 49% to 68% (40% increase) for patients who received a brief intervention only (p<.05).

From 48% to 83% (71% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 49% to 71% (45% increase) overall (p<.05).

**Abstinence from Alcohol and Drugs**

**Abstinence from alcohol and drug use increased significantly:**

From 12% to 32% (167% increase) for patients who received a brief intervention only (p<.05).

From 10% to 60% (483% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 12% to 37% (208% increase) overall (p<.05).
TECHNICAL NOTES

Six-Month Follow-up Survey Procedures
Out of the 2,514 PSPH patients who received at least a brief intervention, a sample of 412 patients was selected for the follow-up survey. Interviews were completed with 329 individuals in the sample—a response rate of 85% percent (excluding 4 people who died by the time the interview was due).

Analyses were based on 310 participants with complete data on alcohol use, 309 with complete data on binge drinking, and 311 with complete data on drug use. Analyses excluded 18 participants (5.5%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

Measures of Substance Use Outcomes
Changes in alcohol and other drug use were based on a person’s answers on the baseline screening survey compared to answers on the six-month follow-up interview, using the following questions:

During the past 30 days, how many days have you ...
- Used any alcohol?
- Had 5 or more drinks in one sitting? (This was used as a measure of binge drinking.)
- Used any illegal drugs? (Use of illegal drugs included misuse of prescription drugs.)

Classification of Risk and Intervention Groups
Outcomes’ risk levels were based on scores on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Two groups were used in analyses: (1) those who received only a brief intervention and (2) those who received a brief intervention plus brief therapy, CD treatment, or both within 120 days of the brief intervention. The receipt of brief therapy or CD treatment was identified from WASBIRT records or from the Division of Alcohol and Substance Abuse’s treatment data (TARGET) for the 329 participants who gave permission for the use of administrative records.

The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

<table>
<thead>
<tr>
<th>Criteria for Intervention</th>
<th>Screen Only (Not in follow-up survey)</th>
<th>Brief Intervention Only</th>
<th>Brief Intervention Plus Brief Therapy or CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT - Female</td>
<td>Less than 7</td>
<td>7 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>AUDIT - Male</td>
<td>Less than 8</td>
<td>8 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>DAST</td>
<td>0</td>
<td>1 - 4</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>

This report was funded through grant number 1 UD1 TI15962-05 from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to the Office of the Governor. Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA or http://www1.dshs.wa.gov/dasa

Research and Data Analysis Division Report Number 4.60.PSPH.2009.2
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Southwest Washington Medical Center(SWMC) is one of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient's level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients' levels of alcohol or other drug use, a sample of 1,116 out of 5,253 SWMC patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 881 individuals in the sample – a response rate of 82%.

Southwest Washington Medical Center patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 7.9 to 4.0 days for drinking (p<.05).
- From 4.3 to 1.6 days for binge drinking (p<.05).
- From 6.5 to 3.1 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey.

- 80% of 651 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 35% stopped drinking altogether.
- 87% of 385 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 87% of 390 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 33% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 6.7 to 4.0 days (40% decrease) for patients who received a brief intervention only (p<.05).

From 13.2 to 4.1 days (69% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 7.9 to 4.0 days (49% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 3.0 to 1.3 days (56% decrease) for patients who received a brief intervention only (p<.05).

From 9.8 to 2.6 days (73% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 4.3 to 1.6 days (63% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 21% to 42% (96% increase) for patients who received a brief intervention only (p<.05).

From 26% to 62% (140% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 22% to 46% (109% increase) overall (p<.05).
Drug Use Outcomes

Average days of drug use in the past 30 days decreased as follows:

From 5.9 to 3.3 days (45% decrease) for patients who received a brief intervention only (p<.05).

From 8.8 to 2.5 days (72% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 6.5 to 3.1 days (52% decrease) overall (p<.05).

Abstinence from drug use increased significantly:

From 56% to 74% (32% increase) for patients who received a brief intervention only (p<.05).

From 41% to 77% (90% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 53% to 75% (42% increase) overall (p<.05).

Abstinence from Alcohol and Drugs

Abstinence from alcohol and drug use increased significantly:

From 10% to 34% (226% increase) for patients who received a brief intervention only (p<.05).

From 10% to 53% (413% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 10% to 37% (270% increase) overall (p<.05).
TECHNICAL NOTES

Six-Month Follow-up Survey Procedures
Out of the 5,253 SWMC patients who received at least a brief intervention, a sample of 1,116 patients was selected for the follow-up survey. Interviews were completed with 881 individuals in the sample—a response rate of 82% percent (excluding 5 people who died by the time the interview was due).

Analyses were based on 837 participants with complete data on alcohol use, 837 with complete data on binge drinking, and 832 with complete data on drug use. Analyses excluded 32 participants (3.6%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Analyses also excluded 8 participants (0.9%) who did not give permission for the use of chemical dependency treatment records needed to classify the level of intervention. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

Measures of Substance Use Outcomes
Changes in alcohol and other drug use were based on a person’s answers on the baseline screening survey compared to answers on the six-month follow-up interview, using the following questions:

During the past 30 days, how many days have you ...
- Used any alcohol?
- Had 5 or more drinks in one sitting? (This was used as a measure of binge drinking.)
- Used any illegal drugs? (Use of illegal drugs included misuse of prescription drugs.)

Classification of Risk and Intervention Groups
Outcomes’ risk levels were based on scores on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Two groups were used in analyses: (1) those who received only a brief intervention and (2) those who received a brief intervention plus brief therapy, CD treatment, or both within 120 days of the brief intervention. The receipt of brief therapy or CD treatment was identified from WASBIRT records or from the Division of Alcohol and Substance Abuse’s treatment data (TARGET) for the 873 participants who gave permission for the use of administrative records.

The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

<table>
<thead>
<tr>
<th>Criteria for Intervention</th>
<th>Screen Only (Not in follow-up survey)</th>
<th>Brief Intervention Only</th>
<th>Brief Intervention Plus Brief Therapy or CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT</td>
<td>1</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>DAST</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>Less than 7</td>
<td>7 - 15</td>
<td>16 - 40</td>
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<tr>
<td>Male</td>
<td>Less than 8</td>
<td>8 - 15</td>
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<tr>
<td>DAST</td>
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<td>1 - 4</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drank alcohol before injury</td>
<td>x</td>
<td></td>
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</tbody>
</table>

This report was funded through grant number 1 UD1 TI15962-05 from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to the Office of the Governor. Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA or http://www1.dshs.wa.gov/dasa

Research and Data Analysis Division Report Number  4.60.SWMC.2009.2
Tacoma General and Allenmore Hospitals

Six-Month Follow-up Survey of WASBIRT Patients
April 12, 2004 - March 31, 2008
Sharon Estee, Ph.D., Lijian He, Ph.D., Summer Yang, John Doane, Melissa Ford Shah

In collaboration with Division of Alcohol and Substance Abuse
Stephen O'Neil, Project Director; John Taylor, Acting Director

Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Tacoma and Allenmore Hospitals (TGH-AH) are two of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient's level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients' levels of alcohol or other drug use, a sample of 881 out of 4,971 TGH-AH patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 667 individuals in the sample – a response rate of 79%.

Tacoma and Allenmore Hospitals patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 6.9 to 4.0 days for drinking (p<.05).
- From 3.0 to 1.5 days for binge drinking (p<.05).
- From 4.5 to 2.7 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey:

- 78% of 474 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 36% stopped drinking altogether.
- 84% of 285 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 80% of 249 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 25% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 6.5 to 4.2 days (35% decrease) for patients who received a brief intervention only (p<.05).

From 10.6 to 2.4 days (78% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 6.9 to 4.0 days (42% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 2.5 to 1.5 days (40% decrease) for patients who received a brief intervention only (p<.05).

From 6.8 to 1.2 days (83% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 3.0 to 1.5 days (50% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 24% to 40% (69% increase) for patients who received a brief intervention only (p<.05).

From 39% to 70% (78% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 25% to 43% (72% increase) overall (p<.05).
Drug Use Outcomes

**Average days of drug use in the past 30 days decreased as follows:**

From 4.2 to 2.7 days (36% decrease) for patients who received a brief intervention only (p<.05).

From 6.4 to 2.7 days (59% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 4.5 to 2.7 days (40% decrease) overall (p<.05).

**Abstinence from drug use increased significantly:**

From 62% to 74% (19% increase) for patients who received a brief intervention only (p<.05).

From 49% to 74% (50% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 61% to 74% (21% increase) overall (p<.05).

**Abstinence from Alcohol and Drugs**

**Abstinence from alcohol and drug use increased significantly:**

From 15% to 33% (118% increase) for patients who received a brief intervention only (p<.05).

From 22% to 60% (173% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 16% to 36% (125% increase) overall (p<.05).
**TECHNICAL NOTES**

**Six-Month Follow-up Survey Procedures**

Out of the 4,971 TGH-AH patients who received at least a brief intervention, a sample of 881 patients was selected for the follow-up survey. Interviews were completed with 667 individuals in the sample—a response rate of 79% percent (excluding 10 people who died by the time the interview was due).

Analyses were based on 634 participants with complete data on alcohol use, 627 with complete data on binge drinking, and 636 with complete data on drug use. Analyses excluded 8 participants (1.2%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Analyses also excluded 9 participants (1.3%) who did not give permission for the use of chemical dependency treatment records needed to classify the level of intervention. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

**Measures of Substance Use Outcomes**

Changes in alcohol and other drug use were based on a person’s answers on the baseline screening survey compared to answers on the six-month follow-up interview, using the following questions:

*During the past 30 days, how many days have you ...*
- Used any alcohol?
- Had 5 or more drinks in one sitting? (This was used as a measure of binge drinking.)
- Used any illegal drugs? (Use of illegal drugs included misuse of prescription drugs.)

**Classification of Risk and Intervention Groups**

Outcomes’ risk levels were based on scores on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Two groups were used in analyses: (1) those who received only a brief intervention and (2) those who received a brief intervention plus brief therapy, CD treatment, or both within 120 days of the brief intervention. The receipt of brief therapy or CD treatment was identified from WASBIRT records or from the Division of Alcohol and Substance Abuse’s treatment data (TARGET) for the 658 participants who gave permission for the use of administrative records.

The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

<table>
<thead>
<tr>
<th>Criteria for Intervention</th>
<th>Screen Only (Not in follow-up survey)</th>
<th>Brief Intervention Only</th>
<th>Brief Intervention Plus Brief Therapy or CD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Scores</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUDIT</td>
<td>1</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>DAST</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Criteria for Intervention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUDIT - Female</td>
<td>Less than 7</td>
<td>7 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>AUDIT - Male</td>
<td>Less than 8</td>
<td>8 - 15</td>
<td>16 - 40</td>
</tr>
<tr>
<td>DAST</td>
<td>0</td>
<td>1 - 4</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drank alcohol before injury</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

This report was funded through grant number 1 UD1 TI15962-05 from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to the Office of the Governor. Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA or http://www1.dshs.wa.gov/dasa

Research and Data Analysis Division Report Number 4.60.TGH-AH.2009.2
Use of alcohol and other drugs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT

Yakima Valley Memorial Hospital, Yakima Regional Medical Center and Toppenish Community Hospital are three of the nine hospitals in Washington State that agreed to participate in the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project which began in the spring of 2004. Through this project, chemical dependency counselors screen primarily emergency department patients for alcohol and drug use. Based on the patient’s level of risk for substance use disorders, the counselor provides brief interventions to anyone at moderate or high risk levels. They also refer patients with more serious disorders to brief therapy or more traditional forms of chemical dependency (CD) treatment.

To see whether brief interventions or additional counseling helps reduce patients’ levels of alcohol or other drug use, a sample of 811 out of 4,697 Yakima patients who received at least a brief intervention were selected randomly for a follow-up telephone interview six months later. Interviews were completed with 607 individuals in the sample – a response rate of 81%.

Yakima Hospital patients who received brief interventions through the WASBIRT Project as well as those who went on to receive additional forms of counseling for alcohol or other drug use have altered their substance use patterns significantly (p<.05). The following changes occurred:

- Number of days of drinking and other drug use declined.
- Abstinence from alcohol and other drug use increased.
- Binge drinking declined.

Among all patients who received at least a brief intervention, the average number of days of alcohol or drug use declined:

- From 6.4 to 3.1 days for drinking (p<.05).
- From 4.5 to 1.4 days for binge drinking (p<.05).
- From 4.6 to 2.4 days for drug use (p<.05).

Among the subset of patients who drank or used drugs in the 30 days before they were screened and received a brief intervention, a large proportion reported fewer days of drinking or drug use at the time of the follow-up survey.

- 83% of 379 patients who drank alcohol reduced the number of days of drinking in the past 30 days, and 41% stopped drinking altogether.
- 90% of 263 patients who reported bingeing in the past 30 days reduced the number of heavy drinking days.
- 88% of 213 patients who reported drug use in the past 30 days reduced the number of days of use, in part because 37% stopped using drugs.
Alcohol Use Outcomes

Average days of alcohol use in the past 30 days decreased as follows:

From 6.5 to 3.5 days (46% decrease) for patients who received a brief intervention only (p<.05).

From 5.7 to 1.6 days (71% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 6.4 to 3.1 days (51% decrease) overall (p<.05).

Average days of binge drinking in the past 30 days decreased as follows:

From 4.4 to 1.5 days (65% decrease) for patients who received a brief intervention only (p<.05).

From 4.9 to 0.8 days (84% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 4.5 to 1.4 days (69% decrease) overall (p<.05).

Abstinence from alcohol increased significantly:

From 35% to 48% (35% increase) for patients who received a brief intervention only (p<.05).

From 42% to 70% (65% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 37% to 52% (41% increase) overall (p<.05).
Drug Use Outcomes

Average days of drug use in the past 30 days decreased as follows:

From 4.3 to 2.5 days (42% decrease) for patients who received a brief intervention only (p<.05).

From 5.6 to 2.3 days (60% decrease) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 4.6 to 2.4 days (47% decrease) overall (p<.05).

Abstinence from drug use increased significantly:

From 67% to 79% (18% increase) for patients who received a brief intervention only (p<.05).

From 55% to 79% (43% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 65% to 79% (22% increase) overall (p<.05).

Abstinence from Alcohol and Drugs

Abstinence from alcohol and drug use increased significantly:

From 24% to 43% (80% increase) for patients who received a brief intervention only (p<.05).

From 29% to 62% (117% increase) for patients who received a brief intervention plus brief therapy and/or chemical dependency treatment (BT/CD Tx) (p<.05).

From 25% to 47% (88% increase) overall (p<.05).
TECHNICAL NOTES

Six-Month Follow-up Survey Procedures

Out of the 4,697 Yakima patients who received at least a brief intervention, a sample of 811 patients was selected for the follow-up survey. Interviews were completed with 607 individuals in the sample—a response rate of 81% percent (excluding 12 people who died by the time the interview was due).

Analyses were based on 599 participants with complete data on alcohol use, 597 with complete data on binge drinking, and 600 with complete data on drug use. Analyses excluded 3 participants (0.5%) who did not receive a brief intervention because the patient was not willing to talk to the counselor, was already in treatment, or for some other reason. Analyses also excluded 2 participants (0.3%) who did not give permission for the use of chemical dependency treatment records needed to classify the level of intervention. Beginning in July 2005, sample selection criteria were refined such that only those with moderate or high risk for substance use disorders were eligible for the follow-up survey.

Follow-up interviews were conducted at the Research and Data Analysis Division using standard survey techniques that included mailing advance contact letters and multiple attempts to call hard-to-reach respondents. Contact information was gathered from the patient at baseline and augmented by administrative records to update contact information if the patient gave permission for this.

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The average AUDIT and DAST scores are shown below for patients who received a screen only, a brief intervention only, or a brief intervention plus brief therapy or CD treatment. The table also shows the recommended level of intervention based on the degree of risk for a substance use disorder.

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<tbody>
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<td><strong>AUDIT</strong></td>
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<td>4</td>
<td>15</td>
</tr>
<tr>
<td><strong>DAST</strong></td>
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<td>4</td>
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Research and Data Analysis Division Report Number 4.60.Yakima.2009.2
APPENDIX G

Evaluation of the Washington State Screening, Brief Intervention, and Referral to Treatment Project: Cost Outcomes for Medicaid Patients Screened in Hospital Emergency Departments

PLEASE GO TO:
http://journals.lww.com/lww-medicalcare/pages/default.aspx
APPENDIX H

The Use of Administrative Data as a Substitute for Individual Screening Scores in Observational Studies Related to Problematic Alcohol or Drug Use

PLEASE GO TO:
http://www.elsevier.com/wps/find/journaldescription.cws_home/506052/description#description
APPENDIX I

Legal Authorities:
Washington Administrative Code (WAC)

WAC 388-805-005
What definitions are important throughout this chapter?

WAC 388-805-010
What chemical dependency services are certified by the department?

WAC 388-805-85
What are the requirements for screening and brief intervention services?
WAC 388-805-005
What definitions are important throughout this chapter?

"Added service" means the adding of certification for chemical dependency levels of care to an existing certified agency at an approved location.

"Addiction counseling competencies" means the knowledge, skills, and attitudes of chemical dependency counselor professional practice as described in Technical Assistance Publication No. 21, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services 1998.

"Administrator" means the person designated responsible for the operation of the certified treatment service.

"Adult" means a person eighteen years of age or older.

"Alcoholic" means a person who has the disease of alcoholism.

"Alcoholism" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Approved supervisor" means a person who meets the education and experience requirements described in WAC 246-811-030 and 246-811-045 through 246-811-049 and who is available to the person being supervised.

"Authenticated" means written, permanent verification of an entry in a patient treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If patient records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a patient's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

(1) Full printed name;

(2) Signature including the first initial and last name; and

(3) Initials and abbreviations indicating professional designation or job title.
“Bloodborne pathogens” means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

“Branch site” means a physically separate certified site where qualified staff provides a certified treatment service, governed by a parent organization. The branch site is an extension of a certified provider’s services to one or more sites.

“Certified treatment service” means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the department of social and health services, as evidence the provider meets the standards of chapter 388-805 WAC.

“Change in ownership” means one of the following conditions:

(1) When the ownership of a certified chemical dependency treatment provider changes from one distinct legal owner to another distinct legal owner;

(2) When the type of business changes from one type to another such as, from a sole proprietorship to a corporation; or

(3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

“Chemical dependency” means a person’s alcoholism or drug addiction or both.

“Chemical dependency counseling” means face-to-face individual or group contact using therapeutic techniques that are:

(1) Led by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP;

(2) Directed toward patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and

(3) Directed toward a goal of abstinence for chemically dependent persons.

“Chemical dependency professional” means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

“Child” means a person less than eighteen years of age, also known as adolescent, juvenile, or minor.

“Clinical indicators” include, but are not limited to, inability to maintain abstinence from alcohol or other nonprescribed drugs, positive drug screens, patient report of a subsequent alcohol/drug arrest, patient leaves program against program advice, unexcused absences from treatment, lack of participation in self-help groups, and lack of patient progress in any part of the treatment plan.

“Community relations plan” means a plan to minimize the impact of an opiate substitution treatment program as defined by the Center for Substance Abuse Guidelines for the Accreditation of Opioid Treatment Programs, section 2.C.(4).
“County coordinator” means the person designated by the legislative authority of a county to carry out administrative and oversight responsibilities of the county chemical dependency program.

“Criminal background check” means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.

"Critical incidents" includes:

(1) Death of a patient;

(2) Serious injury;

(3) Sexual assault of patients, staff members, or public citizens on the facility premises;

(4) Abuse or neglect of an adolescent or vulnerable adult patient by another patient or agency staff member on facility premises;

(5) A natural disaster presenting a threat to facility operation or patient safety;

(6) A bomb threat; a break in or theft of patient identifying information;

(7) Suicide attempt at the facility;

(8) An error in program administered medication at an outpatient facility that results in adverse effects requiring urgent medical intervention.

“CSAT” means the Federal Center For Substance Abuse Treatment, a Substance Abuse Service Center of the Substance Abuse and Mental Health Services Administration.

“Danger to self or others,” for purposes of WAC 388-805-520, means a youth who resides in a chemical dependency treatment agency and creates a risk of serious harm to the health, safety, or welfare to self or others. Behaviors considered a danger to self or others include:

(1) Suicide threat or attempt;

(2) Assault or threat of assault; or

(3) Attempt to run from treatment, potentially resulting in a dangerous or life-threatening situation.

“Department” means the Washington state department of social and health services.

“Determination of need” means a process used by the department for opiate substitution treatment program slots within a county area as described in WAC 388-805-040.

“Detoxification” or “detox” means care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.
"Disability, a person with" means a person whom:

1. Has a physical or mental impairment that substantially limits one or more major life activities of the person;
2. Has a record of such an impairment; or
3. Is regarded as having such an impairment.

"Discrete treatment service" means a chemical dependency treatment service that:

1. Provides distinct chemical dependency supervision and treatment separate from any other services provided within the facility;
2. Provides a separate treatment area for ensuring confidentiality of chemical dependency treatment services; and
3. Has separate accounting records and documents identifying the provider's funding sources and expenditures of all funds received for the provision of chemical dependency treatment services.

"Domestic violence" means:

1. Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;
2. Sexual assault of one family or household member by another;
3. Stalking as defined in RCW 9A.46.110 of one family or household member by another family or household member; or
4. As defined in RCW 10.99.020, 26.50.010, or other Washington state statutes.

"Drug addiction" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Drug addiction is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Essential requirement" means a critical element of chemical dependency treatment services that must be present in order to provide effective treatment.

"Established ratio" means using 0.7 percent (.007) of a designated county's adult population to determine an estimate for the number of potential patients with an opiate diagnosis in need of treatment services as described in WAC 388-805-040.

"Faith-based organization" means an agency or organization such as a church, religiously affiliated entity, or religious organization.
“First steps” means a program available across the state for low-income pregnant women and their infants. First steps provides maternity care for pregnant and postpartum women and health care for infants and young children.

“Governing body” means the legal entity responsible for the operation of the chemical dependency treatment service.

“HIV/AIDS brief risk intervention (BRI)” means an individual face-to-face interview with a patient, to help that person assess personal risk for HIV/AIDS infection and discuss methods to reduce infection transmission.

“HIV/AIDS education” means education, in addition to the brief risk intervention, designed to provide a person with information regarding HIV/AIDS risk factors, HIV antibody testing, HIV infection prevention techniques, the impact of alcohol and other drug use on risks and the disease process, and trends in the spread of the disease.

“Medical practitioner” means a physician, advanced registered nurse practitioner (ARNP), or certified physician's assistant. ARNPs and midwives with prescriptive authority may perform practitioner functions related only to indicated specialty services.

“Offsite treatment” means provision of chemical dependency treatment by a certified provider at a location where treatment is not the primary purpose of the site; such as in schools, hospitals, or correctional facilities.

“Opiate substitution treatment program” means an organization that administers or dispenses an approved medication as specified in 42 CFR Part 8 for treatment or detoxification of opiate dependence. The agency is:

1. Certified as an opioid treatment program by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration;

2. Licensed by the Federal Drug Enforcement Administration;

3. Registered by the state board of pharmacy;

4. Accredited by an opioid treatment program accreditation body approved by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration; and

5. Certified as an opiate substitution treatment program by the department.

“Outcomes evaluation” means a system for determining the effectiveness of results achieved by patients during or following service delivery, and patient satisfaction with those results for the purpose of program improvement.

“Patient” is a person receiving chemical dependency treatment services from a certified program.

“Patient contact” means time spent with a patient to do assessments, individual or group counseling, or education.
“Patient placement criteria (PPC)” means admission, continued service, and discharge criteria found in the patient placement criteria for the treatment of substance-related disorders as published by the American Society of Addiction Medicine (ASAM).

“Probation assessment officer (PAO)” means a person employed at a certified district or municipal court probation assessment service that meets the PAO requirements of WAC 388-805-220.

“Probation assessment service” means a certified assessment service offered by a misdemeanor probation department or unit within a county or municipality.

“Progress notes” are a permanent record of ongoing assessments of a patient’s participation in and response to treatment, and progress in recovery.

“Qualified personnel” means trained, qualified staff, consultants, trainees, and volunteers who meet appropriate legal, licensing, certification, and registration requirements.

“Registered counselor” means a person registered by the state department of health as required by chapter 18.19 RCW.

“Relocation” means change in location from one office space to a new office space, or moving from one office building to another.

“Remodeling” means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

“SAMHSA” means the Federal Substance Abuse and Mental Health Services Administration.

“Screening and brief intervention” means: a combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions to enhance patient motivation to change, and make appropriate referral as needed.

“Self-help group” means community based support groups that address chemical dependency.

“Service provider” or “provider” means a legally operated entity certified by the department to provide chemical dependency services. The components of a service provider are:

(1) Legal entity/owner;

(2) Facility; and

(3) Staff and services.

“Sexual abuse” means:

(1) Sexual assault;

(2) Incest; or

(3) Sexual exploitation.
“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment or treatment; or

2. Such conduct interferes with work performance or creates an intimidating, hostile, or offensive work or treatment environment.

“Substance abuse” means a recurring pattern of alcohol or other drug use that substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.

“Summary suspension” means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

“Supervision” means:

1. Regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give directions and require change; and

2. “Direct supervision” means the supervisor is on the premises and available for immediate consultation.

“Suspend” means termination of the department's certification of a provider's treatment services for a specified period or until specific conditions have been met and the department notifies the provider of reinstatement.

“TARGET” means the treatment and assessment report generation tool.

“Treatment plan review” means a review of active problems on the patient's individualized treatment plan, the need to address new problems, and patient placement.

“Treatment services” means the broad range of emergency, detoxification, residential, and outpatient services and care. Treatment services include diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other drugs, and intoxicated persons.

“Urinalysis” means analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the department of health:

1. “Negative urine” is a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and
(2) “**Positive urine**” is a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

“**Vulnerable adult**” means a person who lacks the functional, mental, or physical ability to care for oneself.

“**Young adult**” means an adult who is eighteen, nineteen, or twenty years old.

“**Youth**” means a person seventeen years of age or younger.
(1) The department certifies the following types of chemical dependency services:

(a) Detoxification services, which assist patients in withdrawing from alcohol and other drugs including:

   (i) Acute detox, which provides medical care and physician supervision for withdrawal from alcohol or other drugs; and

   (ii) Subacute detox, which is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

(b) Residential treatment services, which provide chemical dependency treatment for patients and include room and board in a twenty-four-hour-a-day supervised facility, including:

   (i) Intensive inpatient, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families;

   (ii) Recovery house, a program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities; and

   (iii) Long-term treatment, a program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

(c) Outpatient treatment services, which provide chemical dependency treatment to patients less than twenty-four hours a day, including:

   (i) Intensive outpatient, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families;

   (ii) Outpatient, individual and group treatment services of varying duration and intensity according to a prescribed plan; and

   (iii) Opiate substitution outpatient treatment, which meets both outpatient and opiate substitution treatment program service requirements.

(d) Assessment services, which include:

   (i) ADATSA assessments, alcohol and other drug assessments of patients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment; and
(ii) **DUI assessments**, diagnostic services requested by the courts to determine a person's involvement with alcohol and other drugs and to recommend a course of action.

(e) **Information and assistance services**, which include:

(i) **Alcohol and drug information school**, an education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who may have been assessed and do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs;

(ii) **Information and crisis services**, response to persons having chemical dependency needs, by phone or in person;

(iii) **Emergency service patrol**, assistance provided to intoxicated persons in the streets and other public places;

(iv) **Screening and brief intervention services**, a combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions and make appropriate referral as needed. These services may be provided in a wide variety of settings.

(2) The department may certify a provider for more than one of the services listed under subsection (1) of this section when the provider complies with the specific requirements of the selected services.
What are the requirements for screening and brief intervention services?

(1) Screening and brief intervention service providers must be governed under:

(a) WAC 388-805-001 through 388-805-135, 388-805-205 and 388-805-640; and

(b) This section.

(2) The screening and brief intervention administrator must:

(a) Ensure a chemical dependency professional (CDP), or a CDP trainee under the supervision of a CDP, provides the services;

(b) Maintains a current list of local resources for legal, employment, education, interpreter, and social and health services;

(c) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:

(i) Chemical dependency screening and brief intervention techniques; and

(ii) Motivational interviewing.

(d) Have policies and procedures for the provision of screening and brief intervention services, such as:

(i) Screening;

(ii) Motivational interviewing; and

(iii) Referral.

(e) Ensure the individual patient records contain:

(i) A copy of a referral;

(ii) Demographic information;

(iii) Documentation the patient was informed and received a copy of the requirements under 42 C.F.R Part 2;

(iv) Documentation the patient received a copy of the counselor disclosure information;
(v) Documentation the patient received a copy of the patient rights;

(vi) Properly completed authorization for the release of information;

(vii) A copy of screening documents including outcome and referrals; and

(viii) Progress notes summarizing any contact with the patient.
Washington State Screening, Brief Intervention, and Referral to Treatment Program (WASBIRT)

NO COST EXTENTION FINAL REPORT: April 1, 2009 through September 30, 2009

PROJECT MANAGEMENT:
David Dickinson, Director, Division of Behavioral Health and Recovery, Aging and Disability Services Administration
John Taylor, Chief, Office of Program Services
Alice Huber PhD, Supervisor, Evaluation and Quality Assurance

PROJECT EVALUATION:
Sharon Estee, PhD, WASBIRT Research Director, Research and Data Analysis Division, Planning, Performance and Accountability

GRANT NUMBER: 4 TI015962-05-1

Reporting Period: April 1, 2009 through September 30, 2009
Completed by: Sharon Estee, PhD, Chief, Program Research and Evaluation Section and WASBIRT Evaluation Project Director, Research and Data Analysis Division, Washington State Department of Social and Health Services (360) 902-7655
Alice Huber, PhD, Supervisor, Evaluation and Quality Assurance, Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services (360) 725-3739

I. Identification information

Grantee Federal identification Number: 5 UD1 TI15962-05 (No Cost Extension)
CSAT Project Officer’s Name: Reed Forman, CSAT Project Officer
Project Name: Washington State SBIRT Program
Grantee Organization: Office of the Governor Washington State Legislative Building
Post Office Box 43113
Olympia, WA 98504-0002
Project Director’s Name: John Taylor, Chief
Office of Program Services
Department of Social and Health Services
Division of Behavioral Health and Recovery
Address: Post Office Box 45330, Olympia, Washington 98504-5330
Telephone Number: (360) 725-3726 E-mail address: tayloje@dshs.wa.gov
Fax Number: (360) 438-8078
Project Evaluator’s Name: Dr. Sharon Estee
WASBIRT Research Director
Research and Data Analysis Division
Department of Social and Health Services
Address: Post Office Box 45204, Olympia, Washington 98504-5204
Telephone Number: (360) 902-7655 E-mail address: esteesi@dshs.wa.gov
Fax number: (360) 902-0705
II. Changes in and development of key personnel during reporting period

A. New Staff Information, (changes in project director, evaluator, and key clinical or outreach staff require prior CSAT approval). The following information is needed on new key staff.

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION/TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen O’Neil</td>
<td>Project Director, left to take a new position, April 2009</td>
</tr>
<tr>
<td>John Taylor</td>
<td>Chief, Office of Program Services assumed WASBIRT Project Director responsibilities upon Steve O’Neil’s departure</td>
</tr>
</tbody>
</table>

B. The following information is needed on any other new staff that was hired during this reporting period.

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION/TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

C. The following information is needed on any staff vacancies during this reporting period.

<table>
<thead>
<tr>
<th>VACANCIES</th>
<th>POSITION/TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

D. List any training or professional development activities staff has participated in.

<table>
<thead>
<tr>
<th>STAFF NAME/POSITION</th>
<th>TRAINING/PROFESSIONAL DEVELOPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>NA</td>
</tr>
</tbody>
</table>

E. Please list any licensing/certification obtained for new services. (If none, please note that.)

<table>
<thead>
<tr>
<th>NEW SERVICE</th>
<th>LICENSING/CERTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>NA</td>
</tr>
</tbody>
</table>

III. Project information

A. Coordination and Collaboration

List all organizations to which you referred clients for additional treatment or ancillary (i.e., wraparound) services, April 1, 2009 – September 30, 2009.

Note: Treatment services paid for through this grant ended January 31, 2009.

B. Client Information

1. Annual goal from grant application:

   How many clients do you plan to serve during the No Cost Extension? 2,049

   The Client Targets in the no-cost extension period equal the difference between the targets shown on CSAT’s GPRA website as of September 30, 2008 and the overall targets for the project as shown on the website in February 2009 (see table for details by modality). The difference between these two targets equals 2,049 which represents the total number of clients that were to be screened during the no-cost extension period.
Client Targets for No-Cost Extension Period

<table>
<thead>
<tr>
<th>Modality</th>
<th>CLIENT TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Through September 2008</td>
</tr>
<tr>
<td>Screening and Feedback (SF)</td>
<td>71,319</td>
</tr>
<tr>
<td>Brief Intervention (BI)</td>
<td>44,606</td>
</tr>
<tr>
<td>Brief Treatment (BT)</td>
<td>3,720</td>
</tr>
<tr>
<td>Referral to Treatment (RT)</td>
<td>1,211</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>120,856</strong></td>
</tr>
</tbody>
</table>

If this number is not the same as what is in your grant application, please indicate that CSAT approved and revised number in 1a.

1a. See C-2 below

**How many clients do you plan to serve this year (October 1, 2008 through September 30, 2009)?**  
2,049

Screening patients through this project ended on January 31, 2009. Thus, from October 1, 2008 through the end of January 2009, WASBIRT provided intakes to 2,691 new clients, which was 131 percent of the targeted number (2,049) for this period. The coverage rates by modality are shown in the table below, which ranged from 84 percent for clients receiving a brief intervention to 316 percent for those in the brief treatment (BT) category.

**Intake Coverage Report**

**Performance Period:** October 1, 2008 – March 31, 2009

<table>
<thead>
<tr>
<th>Modality</th>
<th>CLIENT TARGET</th>
<th>NEW CLIENTS</th>
<th>COVERAGE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 2008</td>
<td>October 2008</td>
<td>October 2008</td>
</tr>
<tr>
<td></td>
<td>through March</td>
<td>through March</td>
<td>through March</td>
</tr>
<tr>
<td></td>
<td>March 2009</td>
<td>March 2009</td>
<td>March 2009</td>
</tr>
<tr>
<td>Screening and Feedback (SF)</td>
<td>1,209</td>
<td>1,463</td>
<td>121%</td>
</tr>
<tr>
<td>Brief Intervention (BI)</td>
<td>756</td>
<td>632</td>
<td>84%</td>
</tr>
<tr>
<td>Brief Treatment (BT)</td>
<td>63</td>
<td>199</td>
<td>316%</td>
</tr>
<tr>
<td>Referral and Treatment (RT)</td>
<td>21</td>
<td>397</td>
<td>189%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,049</strong></td>
<td><strong>2,691</strong></td>
<td><strong>131%</strong></td>
</tr>
</tbody>
</table>

2. During the past reporting period (April 1, 2009 – September 30, 2009):

2a. **How many new clients did you plan to serve (conduct an intake/admissions Government Performance and Results Act (GPRA) assessment on—what was your goal)?**  
0

No screening, brief interventions, or referrals to treatment were planned during the last six months of the no-cost extension period. Funds for providing SBIRT services in the participating hospitals were expended by the end of January 2009. After that date, the remaining funds were used for the preparation of final analyses and grant close-out activities. Therefore, client target was zero (0) in all SBIRT service modalities for the six-month period from April 1, 2009 through September 30, 2009.
Screening, Brief Intervention, and Referral to Treatment
Performance Period: April 1, 2009 – September 30, 2009

<table>
<thead>
<tr>
<th>Modality</th>
<th>CLIENT TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Feedback (SF)</td>
<td>0</td>
</tr>
<tr>
<td>Brief Intervention (BI)</td>
<td>0</td>
</tr>
<tr>
<td>Brief Treatment (BT)</td>
<td>0</td>
</tr>
<tr>
<td>Referral to Treatment (RT)</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
</tr>
</tbody>
</table>

2b. How many new clients did you actually serve? 0

2c. How many intake/admissions GPRA assessments did you complete? 0

2d. How many intake/admissions GPRA assessments did you enter in the GPRA database? 0

Note that b, c, and d should be the same number. If not, please explain in the narrative section.

2e. How many clients completed the intake/admissions GPRA assessment but did not receive treatment from project staff? 0

Semi-Annual Intake Coverage Report
Performance Period: April 1, 2009 – September 30, 2009

<table>
<thead>
<tr>
<th>Modality</th>
<th>CLIENT TARGET</th>
<th>NEW CLIENTS</th>
<th>COVERAGE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Feedback (SF)</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Brief Intervention (BI)</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Brief Treatment (BT)</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Referral and Treatment (RT)</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
</tbody>
</table>

2f. How many clients were discharged from your project before completion? (Clients who left the program for any reason without completing)? 0

2g. How many clients graduated from the project? (Clients who successfully completed the program)? 0

2h. How many GPRA 6-month follow-up assessment surveys did you conduct? (Follow-up conducted six months after intake/admissions)? 0

2i. How many GPRA 6-month follow-up assessment records did you enter into the GPRA database? 0

2j. How many GPRA 12-month follow-up assessments did you conduct? (Follow-ups conducted 12 months after intake/admissions)? NA

2k. How many GPRA 12-month follow-up assessments did you enter into the GPRA database? NA

2l. How many clients were referred for additional services not provided by your project? 0

Note: For some of these individuals the additional treatment may have been paid for by SBIRT.

3. During the next semi-annual reporting period: How many new clients do you plan to serve? NA

4. Additional data you may wish to provide (e.g., number of outreach contracts)
C. Project Narrative

Provide a narrative section of no more than three to five pages, including the following:

1. Describe project successes since the last reporting period.

The following activities were completed:

New Certified Service: Screening and Brief Intervention (SBI)

The Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) revised Washington Administrative Code (WAC) 388-805 effective January 1, 2009, to include the new certified service of Screening and Brief Intervention (SBI). SBI is defined in Section 005, described in Section 010, and specific requirements for SBI services are listed in Section 855. WAC 388-805 is located at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805. (See Appendix I for copies of Sections 005, 010, and 855 which contain details pertaining to the SBI services.)

DBHR decided to develop this new certified service — SBI — in order to put in place regulations to ensure consistency within the chemical dependency field for agencies that want to provide this service. In addition, when reimbursement mechanisms for SBI services are in place, agencies would be able to bill for DBHR certified services.

DBHR has been working with the Washington State Medicaid Program on a Medicaid state plan amendment which will include SBI services. We are hopeful that SBI will become part of the state plan.

Publication of an SBIRT Training Manual for Acute Care Medical Settings

An SBIRT training manual for staff in acute care medical settings was prepared by Chris Dunn, PhD, as a culmination of Dr. Dunn’s training program for the WASBIRT Project. He specializes in using effective motivational interviewing techniques to provide feedback to patients and in conducting brief interventions in emergency departments and trauma centers.

During the course of this project, Dr. Dunn trained all of the chemical dependency counselors in how to use standard screening tools to identify potential risk for substance disorders among emergency department patients. He also trained counselors in how to use motivational interviewing techniques to conduct brief interventions and brief treatment and to motivate patients to act upon referrals to treatment. Dr. Dunn provides similar trainings nationwide and employs these techniques routinely in his own clinical practice at Harborview Medical Center.

As a result of Dr. Dunn’s knowledge and experience in this field, the training manual that he prepared as a final product of the WASBIRT project is clear and easy to use. The Division of Behavioral Health and Recovery anticipates using this manual to train professionals throughout the state in the use of SBIRT for patients, particularly in acute care medical settings, although the manual would also be very useful to those who plan to provide SBIRT services in primary care as well. (See Appendix C for a copy of the training manual.)

Publication of Medical Cost Outcomes Paper in Medical Care

A paper, entitled “Evaluation of the Washington State Screening, Brief Intervention, and Referral to Treatment Project: Cost Outcomes for Medicaid Patients Screened in Hospital Emergency Departments,” was accepted by the journal Medical Care (Volume 48, Number 1, January 2010, pp. 18-24, see Appendix G). This publication contains the results of analyses pertaining to Medicaid-reimbursed medical costs for working-age disabled clients who received a BI through WASBIRT relative to costs for a statistically matched comparison group of similar clients. We found an estimated reduction in Medicaid costs per member per month (ppmm) of $366 (p = .05) for those who received at least a brief intervention compared to those who did not. The primary factor contributing to reduced costs appeared to be a reduction in inpatient hospital days of 0.12 ppmm (p = .04) which amounts to a reduction of approximately 1.2 hospital days per person in a year.
Publication of a Paper on the Impact of SBIRT on Admission to Chemical Dependency Treatment

A paper, entitled “Impact of Brief Interventions and Brief Treatment on Admissions to Chemical Dependency Treatment,” was accepted for publication in Drug and Alcohol Dependence (currently in press, see Appendix E). The article was prepared collaboratively by researchers at the University of Washington at Harborview Medical Center and the WASBIRT Evaluation Project team at the Department of Social and Health Services, Research and Data Analysis Division and the Division of Behavioral Health and Recovery. The paper reports on analyses conducted for patients who were screened by the WASBIRT project at Harborview Medical Center and who received at least a brief intervention (BI). Some patients also received a series of brief treatment sessions as well.

Analyses were based on a quasi-experimental design using hospital medical records to select a comparable set of hospital emergency department patients with evidence of possible substance use disorders to those who received at least a BI through WASBIRT. Patients who received at least a BI were significantly more likely to enter chemical dependency treatment in the following year than the statistically selected comparison group who were not screened and did not receive any intervention for substance abuse through WASBIRT counselors. Findings also indicated that participation in brief treatment appeared to facilitate admission to chemical dependency treatment.

A companion paper was also submitted to Medical Care on the effects of the WASBIRT project on entrance into chemical dependency (CD) treatment for Medicaid patients who were screened and received at least a brief intervention at any of the nine hospitals participating in WASBIRT. These analyses used administrative records for working-age disabled Medicaid clients. We found that the odds of entering chemical dependency treatment within a year of an emergency department visit were twice as high for Medicaid clients who received at least a brief intervention for substance use disorders through WASBIRT as those who did not get a brief intervention, with differences between the treatment and comparison group controlled through statistical matching algorithms. The journal editors offered us the option of combining these results with the paper on medical cost outcomes (shown in Appendix G). We chose to withdraw the paper on CD treatment from that journal rather than combine it with the cost outcome analyses. Since then, we have updated the CD treatment analyses with a broader set of Medicaid clients that included working-age disabled with medical coverage through either Medicaid or a state-funded General Assistance Program for the Unemployed and generally younger patients with families who were covered under Temporary Aid to Needy Families. We also used more refined methods for defining CD treatment episodes. The analyses have been completed and confirm the earlier findings of significantly higher odds of entering CD treatment for not only working-age disabled clients but for recipients of General Assistance-Unemployable (GA-U) and Temporary Aid to Needy Families (TANF) as well. The results of these analyses have been presented in a WASBIRT Fact Sheet and published on the Research and Data Analysis Division’s website at http://www.dshs.wa.gov/rda/. (See Appendix D.) A draft of the paper is in process and will be submitted to another journal in the near future. Once published, the paper will be sent to the CSAT SBIRT Project Officer in the future.

Acceptance of a Paper on the Comparison of Administrative Indicators of Substance Use Disorders to AUDIT and DAST Scores from WASBIRT Data

A paper entitled, “The Use of Administrative Data as a Substitute for Individual Screening Scores in Observational Studies Related to Problematic Alcohol or Drug Use,” was accepted by Drug and Alcohol Dependence (see Appendix H). This paper presents the results of statistical analyses on how well alcohol or drug (AOD)-related administrative indicators predicted self-reported AOD use based on screening scores obtained from the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Administrative records from Medicaid data, Harborview Medical Center medical records, publicly funded chemical dependency treatment data from the Division of Behavioral Health and Recovery’s TARGET system, and from Washington State Patrol arrest data were used by the WASBIRT evaluation teams at the University of Washington (UW) and the state’s Department of Social and Health Services (DSHS) to create indicators of potential AOD problems.
These AOD indicators derived from administrative data were found to discriminate, at acceptable statistical levels, self-reported AOD use that indicated the potential need for moderate or more intensive levels of intervention. This methodological paper may be useful to other SBIRT evaluations that are interested in using similarly created administrative indicators of the potential need for AOD interventions in their own research. These administrative AOD-need flags could prove to be useful for selecting comparison groups using propensity score matching methodology. This paper helps to demonstrate the validity of the AOD indicators created from administrative data.

Completion of Fact Sheets on Substance Use Outcomes

Results of the Six-Month Follow-up Survey that were published in a series of fact sheets in January 2009 were updated in September 2009 with data from the final WASBIRT database described above. The results were consistent with those from the earlier analyses of six-month follow-up substance use outcomes that revealed statistically significant declines in days of alcohol use, binge drinking and drug use and significant increases in abstinence from both alcohol and other drugs. These fact sheets are published on the website maintained by the Research and Data Analysis Division at [http://www.dshs.wa.gov/rda/](http://www.dshs.wa.gov/rda/). (See Appendix F for fact sheets for all WASBIRT sites combined and by individual site.)

Database and Documentation

The database administrator for the WASBIRT project prepared a final project database that includes baseline screening data, the six-month follow-up survey data, and brief therapy data. The database is maintained at the Department of Social and Health Services’ Research and Data Analysis Division that was responsible for the WASBIRT Evaluation. The final database will be stripped of confidential identifiers as required under conditions of the Institutional Review Boards that oversaw the WASBIRT evaluation. The documented version of the database (without identifiers) will be maintained for use by the Division of Behavioral Health and Recovery if any further analyses of WASBIRT effectiveness are undertaken in the future.

2. If you received approval from CSAT to change your target numbers, identify who approved these changes and when they were approved.

DBHR (formerly DASA) received written notification from Captain Ann G. Mahony on April 18, 2005 that CSAT approved revised targets that differed from those in the original Washington State SBIRT proposal. From thence forward, WASBIRT used the revised targets as accepted in April 2005.

3. Explain any differences between the number of planned and actual clients seen and between the number of clients served and the number of GPRA intakes.

The Division of Behavioral Health achieved 78.2 percent of its overall goal of 122,905 client intakes by reaching a total of 96,090 clients by the close of the project.

3a. If there are differences in Item #3, explain how the project will catch up to the annual goal for the number of clients seen during the year.

- Not applicable

4. Describe any plans for corrective actions from III.C.3

- Not applicable

5. Describe any successes and challenges related to follow-up.

- Not applicable
6. Describe any changes in goals or objectives.
   • None

7. Describe any changes in the delivery of services.
   • None

8. Describe any efforts to expand the project’s capacity.
   • None

9. Describe any changes in, or concerns about financial status.
   • None

10. Note changes in local conditions that may affect continued project success.
    • None

11. Provide information you gave to others about your project.
    Between March 1, 2009 and September 30, 2009, no formal presentations were made. The project focused on the preparation of publications described in Section C.1 above.

12. Describe any challenges your project encountered and strategies for overcoming them.
    • None

13. Note any Technical Assistance (TA) needs your project may have.
    • None

14. Note anything else that you would like your GPO to know.

    The Division of Behavioral Health and Recovery (DBHR) is continuing work on long-term, state-level support for SBIRT services. The most notable achievements in the close-out period were:

    1. Modification of Washington Administrative Code to include the new certified service of Screening and Brief Intervention,
    2. Completion of the SBIRT training manual for providers in acute care settings,
    3. Continuation of locally funded SBIRT services by a number of the hospitals that participated in the WASBIRT project and expansion of these services to several more hospitals in King County,
    4. Publication of several papers in peer-reviewed journals demonstrating that SBIRT improves admissions to chemical dependency treatment and is associated with lower medical costs for high-cost, fee-for-service Medicaid clients, and
    5. Continued collaboration with the Washington State Medicaid Program to develop a Medicaid state plan amendment that will include SBI services.