Background: Current evidence suggests that screening and brief intervention (SBI) programs can be effective at reducing risky alcohol consumption. While validity and reliability have been demonstrated for existing screening instruments, little is known about how the diagnostic properties of an instrument influence the cost-effectiveness of SBI. We develop a decision theoretic framework to model this issue, and to investigate the sources of decision uncertainty.

Results: When QALYs are valued at a conservative $1,000/QALY our decision theory indicates an optimal AUDIT threshold score of 5. Our model indicates that employing the recommended threshold score of 8 results in about $4.50 per patient in foregone benefits. This suggests large aggregate foregone benefits with even modest sized patient populations. Gender-specific results are qualitatively similar, but reveal that the optimal SBI program is dramatically different across genders.

Conclusions: Despite the relatively sound psychometric properties of the AUDIT, small differences in the sensitivity and specificity can have large impacts on the cost-effectiveness of SBI. Differences in the AUDIT’s performance across males and females, as well as differences in the prevalence of risky drinking across genders, contribute heavily to the cost-effectiveness of SBI as well.

ORAL PRESENTATIONS

O1
Optimal use of the AUDIT in screening and brief intervention programs: a decision theoretic approach (part of Economics of SBI symposium)
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E-mail: aaldrige@rti.org
Addiction Science & Clinical Practice 2015, 10(Suppl 2)[]{O1}

Background: Current evidence suggests that screening and brief intervention (SBI) programs can be effective at reducing risky alcohol consumption. While validity and reliability have been demonstrated for existing screening instruments, little is known about how the diagnostic properties of an instrument influence the cost-effectiveness of SBI. We develop a decision theoretic framework to model this issue, and to measure the potential improvement in cost-effectiveness that could result from changes in screening instrument properties and other factors associated with SBI.

Material and methods: To make use of our decision theoretic model, we obtain estimates of the input parameters by conducting a comprehensive review of the literature. In particular, we review the literature on the sensitivity and specificity of the Alcohol Use Disorders Identification Test (AUDIT), and then synthesize this evidence using meta-analytic methods. We also compile evidence on the cost of SBI, the QALY gains of SBI, and the prevalence of risky drinking among primary care patients. We assess uncertainty via Monte Carlo analysis. Finally, we conduct expected value of perfect information (EVPI) analyses to investigate the sources of decision uncertainty.

Results: When QALYs are valued at a conservative $1,000/QALY our decision theory indicates an optimal AUDIT threshold score of 5. Our model indicates that employing the recommended threshold score of 8 results in about $4.50 per patient in foregone benefits. This suggests large aggregate foregone benefits with even modest sized patient populations. Gender-specific results are qualitatively similar, but reveal that the optimal SBI program is dramatically different across genders.

Conclusions: Despite the relatively sound psychometric properties of the AUDIT, small differences in the sensitivity and specificity can have large impacts on the cost-effectiveness of SBI. Differences in the AUDIT’s performance across males and females, as well as differences in the prevalence of risky drinking across genders, contribute heavily to the cost-effectiveness of SBI as well.

O2
Healthcare professionals, substance use and adverse childhood experiences
Agnieszka Baklazec, Elizabeth Pace
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Addiction Science & Clinical Practice 2015, 10(Suppl 2)[]{O2}

Background: Adverse Childhood Experiences (ACE) are a predictor to medical and mental health conditions, including substance use disorders. The ACE study, conducted by Kaiser Permanente and Center for Disease Control and Prevention, links childhood trauma to health and social consequences. [1,2] Peer Assistance Services, Inc, a Colorado nonprofit organization, implements Peer Health Assistance Programs (PHAP), for
Licensed healthcare professionals who have substance use and/or mental health disorders affecting public safety.

The objective is to understand the characteristics of clients living with substance use and/or mental health conditions, and to improve outcomes, PHAP identified characteristics of clients with an ACE score of 4 or higher. The likelihood of clients underreporting ACE scores was also studied.

**Material and methods:** The ACE questionnaire is administered to clients and a clinical ACE score is given by the clinician. The score assigns one point for each category of exposure to child abuse and/or neglect. Points are summed for a score from 0 to 10. The higher the score, the greater the exposure. [3] The PHAP hypothesized clients with higher ACE scores would be more likely to have a substance use or mental health diagnoses, evidenced by increased score on the AUDIT, DAST-10 or PHQ-9.

**Results:** Preliminary analysis of 171 clients shows that 78% with an ACE score of 4 or higher have a substance use and/or mental health condition. The ACE score did not always correlate with increased scores on the AUDIT, DAST-10 or PHQ-9. Also, 76% of clients aware of their trauma history had the same ACE score as the clinician’s ACE score, indicating that 24% of PHAP clients underreported their ACE score.

**Conclusions:** The data suggests ACE have an enormous impact on individuals and their careers. Screening for ACE in PHAPs, in addition to AUDIT, DAST-10 or PHQ-9, may impact long term recovery and safe return to practice.

**Acknowledgements:** None.

**References**


**O4**

**A screening and brief intervention for women in OB/GYN care**

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O4

**Background:** Alcohol consumption levels in Russia are among the highest in the world [1]. Fetal Alcohol Spectrum Disorders in children are completely preventable by avoiding alcohol use during pregnancy [2,3], yet substantial numbers of women around the world consume alcohol during pregnancy mostly prior to pregnancy recognition [3-5]. A U.S. prevention model, Project CHOICES, utilized a pre-conception approach consisting of four counseling sessions and a family planning clinic visit [6]. A brief intervention protocol [7] and the CHOICES were adapted by the research team to design a brief intervention for implementation in public OB/GYN clinics in two regions in Russia. The objective of this study was to evaluate impact of the adapted protocol in reducing the risk for alcohol-exposed pregnancies (AEP) and alcohol consumption in general.

**Material and methods:** A dual-focused (alcohol use and the risk for an unplanned pregnancy) brief physician intervention (DFBPI) was designed to be delivered by OB/GYN physicians (8). The intervention consisted of two face-to-face, 5-minute sessions incorporated into a routine clinic visit. A two- arm cluster-randomized controlled trial of the DFBPI was conducted at 20 district OB/GYN clinics. A total of 767 non-pregnant women, aged 18-44 years, at risk for an AEP (at-risk drinking, heterosexual intercourse, and the inconsistent use of contraception) were recruited for the study. Data included 90-day retrospective Time-Line Follow Back (TLFB) reports of daily alcohol consumption at baseline, 3, 6, and 12-months. Drinking trajectories were modeled using three-level semi-continuous piecewise latent trajectory models, with post-intervention intercepts and slopes conditional on treatment assignment. A subpopulation analysis was conducted for women who became pregnant during the 12 month interval for alcohol consumption prior to and after pregnancy recognition. Latent class transition models from baseline to post-intervention were tested to identify shifts in drinking patterns conditional on intervention condition.

**Results:** Physicians were able to implement, maintain skills, and deliver DFBPI. During the course of the study, 72 participants became pregnant. Participants in the DFBPI condition showed a larger decrease in alcohol consumption immediately following the intervention, which was maintained over the follow-up period. Newly pregnant women in the intervention condition showed a substantial drop in alcohol consumption in the weeks prior to pregnancy recognition, consistent with the targeted purpose of the intervention. Women in the intervention condition were more likely to transition out of a high alcohol use pattern and into a lower use pattern rather than into a binging pattern.

**Conclusions:** Results support the feasibility and efficacy of the DFBPI at OB/GYN clinics.

**Acknowledgements:** The study was supported by the National Institute on Alcohol Abuse and Alcoholism (NIAA) Grant R01 AA016234 and Fogarty International Center (Brain Disorders in the Developing World: Research Across the Lifespan). The authors wish to thank the study consultants Linda Sobell, PhD, of Nova Southeastern University for her invaluable contribution to the study; acknowledge contributions of the data base management team Nicholas Knowitz, MS, Sangeeta Agrawal, MS, and Som Bohora, MS; and thank graduate students from St. Petersburg State University, Nizhny Novgorod State Pedagogical University, and the University of Oklahoma Health Sciences Center who assisted with the study.

**Trial Registration:** NCT01961030.

**References**


**O5**

**Start-up costs of implementing Screening and Brief Intervention (SBI)** for Adolescents (part of Economics of SBI Symposium)

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O5

**Background:** Understanding the costs to implement SBI is important for providers in planning resource needs, and for decision makers considering
widespread implementation of SBI. Unfortunately, little is known about the initial costs to start an SBI program. The objective is to estimate the start-up costs of two models of SBI delivery to adolescents in primary health care settings: BI delivered by a behavioral health specialist (specialist model) and BI delivered by a primary care provider (generalist model).

Materials and methods: SBI was implemented in a multi-site, cluster randomized trial (N = 7) guided by Proctor’s model of implementation. The economic costs of starting SBI were calculated using an activity-based costing methodology. Data collection instruments were developed to collect staff time spent in identified SBI activities and non-labor resources. Start-up activities included: 1) administrative activities, such as changes to existing electronic medical record systems and planning meetings; 2) staff training; and 3) technical assistance.

Results: The average total cost for initial implementation of SBI was $5,017 and $3,838 for the specialist and generalist models, respectively. Planning activities had the greatest impact on costs for both models ($2,450 and $1,841 for the specialist and generalist models, respectively). This was followed by contracted services for training and technical assistance ($1,792 and $1,216 for the specialist and generalist models, respectively). The average cost of staff time spent in training was similar across the two models (approximately $770). Overall, more resources were devoted to planning activities in specialist sites, making this model of delivery slightly more costly than the generalist model, largely due to its increased complexity.

Conclusions: The initial resource investment for providers to implement SBI should not be ignored as these costs may present obstacles toward implementation. The level of resources depend on the delivery model and its integration in current practice.

Acknowledgements: The study was supported through National Institute on Drug Abuse (NIDA) GrantR01DA034258-01 (PI Mitchell). NIDA had no role in the design and conduct of the study; data acquisition, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript.

06
Implementing digital interventions in psychiatric outpatient units: a qualitative analysis of staff attitudes
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):06

Background: Up to one-third of patients in psychiatry use alcohol or drugs at a level that is problematic. A national survey of outpatient psychiatric clinic directors and staff in Sweden was carried out on guidelines and practices regarding screening, brief intervention and referral to treatment (SBIRT) for their patients, showing that national recommendations to offer SBIRT for problematic substance use (PSU) are not systematically followed [1]. The objective of this research is to investigate whether implementation of digital interventions for PSU in psychiatry could be a way of increasing treatment access for patients and supporting staff in offering treatment.

Material and methods: Clinic directors at seven psychiatric outpatient clinics in Stockholm, Sweden, were interviewed regarding their views on SBIRT for patients in psychiatry as well as the possibilities of implementing a digital stepped care model for offering SBIRT at their clinics. Interviews were transcribed verbatim and subjected to qualitative thematic content analysis.

Results: PSU complicates correct diagnostic assessment and effective treatment intervention in psychiatry, and patients with PSU are generally referred to the addiction treatment clinic. However, patients neglect to attend the addiction clinic or do not complete treatment, due to the stigmatic nature of problematic substance because attending parallel treatments at two different clinics is taxing for patients. Interviewees were positive to the digital stepped care concept for psychiatry patients. Implementation would be contingent on easy use and minimal expenditure of staff time and resources. A barrier is that treating PSU is not perceived as part of psychiatry’s mission and discipline.

Conclusions: Implementing a digital stepped care concept for PSU within psychiatry could improve patient access to SBIRT and positively influence psychiatric treatment outcomes. Facilitating factors for implementation are user-friendly design and minimal time and resource requirements. A potential barrier is that staff do not perceive PSU treatment as part of their mission and area of competence.

Acknowledgements: This research was funded by grant nr K2012-61X-22132-01-6 to AHB from the Swedish Research Council. We thank the clinic directors for their time and interest in this research.


07
Comparison of groups with different forms of problematic Internet use pro-actively recruited in the setting of vocational schools
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):07

Background: Previous studies found adolescents and young adults to have a higher vulnerability to develop problematic or pathological Internet use. The project PINTA-Diario revealed that in spite of the limitation on “Internet gaming” in the DSM-5, users of social networks showed criteria for problematic Internet use, too. The present study examines problematic Internet use and other harmful behavior in the setting of vocational schools.

Material and methods: In two vocational schools in Luebeck, Germany, 1209 students were systematically screened with the Compulsive Internet Use Scale (CIUS), the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C), the Mental Health Inventory (MHI-5) and other validated questionnaires. Students were included in the analyses when scoring at least 21 on the CIUS-scale for problematic Internet use (n=313) and were split up in three groups: Online gamers (n=50), social networks users (n=135) and others (n=124).

Results: Of the sample, 32.3% with problematic Internet use were screening-positive on the AUDIT-C, 34.7% were daily smokers, 20% consumed marihuana and 8.7% other illegal drugs. The guidelines for fruit and vegetable consumption (“Five a day”) were met by only 11.2% of the students. No group differences between online gamers, social networkers, and users of other applications could be found except in mental health where online gamers performed better than users of other applications (MHI-5: gamers M 13.8 [SD 3.0]; others M 11.8 [SD 3.6], adjusted for sex: p=.021) but did not differ significantly from users of social networks.

Conclusions: Our data support recent findings that users of other Internet applications do not differ significantly from online gamers in a number of characteristics and that there is a need for further research and brief interventions. Students of vocational schools are a high-risk group concerning problematic Internet use and substance use. The problem groups can be easily identified in the setting by proactive screening measures.

Acknowledgements: The study was conducted without external funding. We want to thank the Emil Possehl School and the Dorothea Schloesser School for their cooperation.

08
Optimizing alcohol screening according to DSM-5 severity by adaptive testing using the AUDIT
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):08

Background: Due to unsatisfactory results of alcohol-related SBI in patients with severe Alcohol Use Disorders (AUDs), many studies aim to...
excluded severe cases by defining a cut-off in the upper range of the Alcohol Use Disorders Identification Test AUDIT. However, research focusing on optimal cut-offs is still insufficient. In addition, cut-off values of the AUDIT for DSM-5 substance use disorder criteria have not been analysed so far.

**Material and methods:** Data were collected in a general population sample (n=4,075). Alcohol consumption and alcohol use disorders were assessed using the Munich Composite International Diagnostic Inventory (M-CIDI) in all participants as the gold standard. Participants were then grouped according to M-CIDI into individuals without alcohol-related risks, at-risk consumers without AUDs and individuals with alcohol use disorders according to DSM-5. Alcohol Use data was dichotomized into belonging to the target group of SBI (at-risk drinking and/or moderate AUD) vs. not belonging to the target group (unhealthy drinking pattern or severe AUD).

**Results:** In both samples, the best inclusion criteria on the lower end was a cut-off value of 5 points in the AUDIT-C. Combining AUDIT-C with 5 points and the remaining AUDIT-items with a cut-off of maximum 6 points in order to exclude severe AUDs yielded the best performance. The Area under the Curve (AUC) for adaptive testing using these cut-off values was significantly better than using a single AUDIT in-exclusion rule of 5 and 11 points (AUC 77 vs. 73, p<0.1). Conclusions: Data suggest that adaptive screening can improve the identification of individuals with at-risk drinking and non-severe AUDs. Further research on the performance of adaptive screening in trials on SBI is warranted.

**Acknowledgements:** The data described in this paper are part of the project “Transitions in Alcohol Consumption and Smoking (TACOS)” funded by the German Federal Ministry of Education, Science, Research and Technology (grant no. 01 EB 9406).

**O9**

**Alcohol-related risk perception in primary care patients: screening positive for unhealthy alcohol consumption**

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**Addiction Science & Clinical Practice** 2015, 10(Suppl 2):O9

**Background:** Among unhealthy drinking patterns, drinking above recommended limits is the most prevalent one. Little is known to what extent lack of knowledge on risky amounts of drinking influences these drinking patterns.

**Material and methods:** In general practices in Luebeck, Germany, all consecutive patients aged 18-64 were systematically screened. Individuals screening positive on the Alcohol Use disorders Identification test AUDIT (AUDIT) or the Luebeck Alcoholism Screening Test (LAST) were asked to participate in an intervention study. Patients screening positive willing to participate (n=801; response rate: 54.3%) were diagnosed using the Munich Composite International Diagnostic Inventory M-CIDI. In addition to Alcohol Use Disorders (AUDs), at-risk drinking according to the British Medical Association (20/30 g/alc per day females/males) and binge drinking (50/60 g/alc in one sitting females/males) were assessed. As a part of an in-depth assessment, participants were asked to rate how many standard drinks one could drink on a daily basis without having to fear negative consequences. In the present analysis, participants were dichotomized according to BMA-recommendations into individuals with gender-specific adequate (ARP, n= 684) and individuals with inadequate (INARP, n=75) risk perception. These groups were compared.

**Results:** Patients with INARP had a lower degree of schooling, were more often male and reported more often at-risk drinking according to BMA but did not report higher levels of binge drinking or AUDs. Conclusions: Data suggest that in a subgroup of at-risk drinkers, lack of knowledge concerning health-related drinking limits might perpetuate unhealthy drinking patterns. This might in part also explain findings on the beneficial impact of minimal interventions (e.g. simple advice) on unhealthy drinking patterns.

**Acknowledgements:** This study is part of the German research network EARLiNT (Early substance use Intervention) and is funded by the German Federal Ministry of Research and Education. The present analysis is part of the project SIF (Stepped Interventions for Problem drinkers; grant no. 01 EB 0121).

**O10**

**How digital interventions on screening and BI might be applied to psychiatric ED settings**

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**Addiction Science & Clinical Practice** 2015, 10(Suppl 2):O10

**Background:** Unhealthy drinking and other drug use are common comorbid problems among individuals receiving treatment in psychiatric Emergency Departments (ED). Several studies have shown that systematic screening and motivational brief interventions (SBIRT) are promising approaches for reducing alcohol and drug use that can be implemented in Psychiatric ED settings. Recent digital screening and brief intervention trials have shown reductions in alcohol and other drug use among general (non-psychiatric) ED patients. These electronic approaches have yet to be tested for those receiving care in psychiatric ED settings. This presentation will provide an overview and framework for considering how SBIRT might be delivered electronically among psychiatric ED patients and how digital devices might be used to extend the impact of SBIRT beyond the psychiatric ED.

**Methods:** Systematic literature review of published literature on digital behavioral interventions for individuals with major mental disorders. Review of existing literature on electronic SBIRT approaches in the ED setting.

**Results:** Several studies have shown promising results for the use of tablet computers, wearable tracking devices and smartphone apps for individuals with mental disorders. The targeted behavioral interventions have typically focused on general fitness and weight loss. Several published studies have shown promise for digital SBIRT and computer-assisted SBIRT approaches (computer decision support) addressing alcohol and other drug use in general ED and other healthcare settings. However, the potential use of digital interventions for alcohol and other drug use among psychiatric ED patients have been inadequately explored.

**Conclusions:** Integrating digital SBIRT interventions initiated in psychiatric ED settings, with potential continuing care using mobile devices, could both improve patient access to SBIRT and provide alternative enhancements to psychiatric care to improve outcomes for these vulnerable patients. Electronic delivery of SBIRT, combined with the use of other digital technologies for patients with major mental disorders and concurrent substance misuse, should be explored.

**O11**

**Does brief intervention work for heavy episodic drinking? A comparison of emergency department patients in two cultures**

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**Addiction Science & Clinical Practice** 2015, 10(Suppl 2):O11

**Background:** Little has been reported on the efficacy of brief intervention (BI) among heavy episodic drinkers, although this drinking style is known to be especially harmful in relation to negative consequences including alcohol-related injuries. The objective is the comparative efficacy of BI is analyzed in two similar randomized controlled clinical trials of emergency department (ED) patients in two different cultures, both of which exhibit similar drinking styles of heavy episodic drinking: Poland and Mexican-Americans in the U.S.

**Material and methods:** Improvements in drinking and problem outcomes are analyzed at 3-month and 12-month follow-up, using random effects
Results: Preliminary results suggest that using MC to deliver the intervention is cheaper than MI. However, MC may not yield substantial cost savings because the MC cost was higher than anticipated. Reasons may include the considerable effort needed to locate and communicate with probationers to schedule and have them attend a second session as specified in the study protocol. If the MCs were delivered in “real world” settings, it is possible that the cost could be considerably lower. Findings on the effectiveness and thus the full cost-effectiveness for the study are pending at the time of submission.

Conclusions: Probation agencies are faced with both resource constraints and a high proportion of offenders needing substance abuse treatment. Given these constraints, a brief motivational intervention delivered by computer may be appealing on the basis of cost alone. Preliminary findings from this study may temper the appeal of MC when delivered in this format. Effectiveness estimates are needed to determine the degree to which MC is cost-effective.

Acknowledgements: This research was funded by U.S. National Institute of Health grant R01-DA029010-05.

O14 Brief motivational intervention for adolescents treated in emergency departments for acute alcohol intoxication - a randomized-controlled trial

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O14

Background: Rising numbers of adolescents receiving emergency medical treatment due to acute alcohol intoxication have been a major public health concern in a range of European countries in recent years. Brief interventions addressing this target population have been introduced in a number of emergency departments with the aim to reduce alcohol-related harm. The “HalT-Hamburg” trial evaluated effectiveness of a manualized brief motivational intervention addressing under 18 year-olds following alcohol intoxication in this setting. To our knowledge, we are the first to evaluate a brief intervention for the special target group of adolescents with acute alcohol intoxication in a randomized-controlled design.

Material and methods: The trial design is a parallel two-arm cluster randomized-controlled trial with follow-up assessment after 3 and 6 months [1]. Children and adolescents with the diagnosis acute alcohol intoxication (ICD-10 F10.0) were recruited in 6 urban emergency departments over a period of 30 months. Intervention condition was a manual-based brief motivational intervention with a telephone booster after 6 weeks and a manual-guided intervention for caregivers. Control condition was treatment as usual (information leaflet). Primary outcomes were intention-to-treat (ITT) and completers (per-protocol) principles to examine intervention effects.

Results: N = 316 adolescents with a mean age of 15.8 years (SD = 1.16) were included in the study. Both conditions resulted in reduced binge drinking episodes, quantity of alcohol use on a typical drinking day and alcohol-related problems (RAPi). Linear mixed models adjusted for baseline differences were conducted according to intention-to-treat (ITT) and completers (per-protocol) principles to examine intervention effects. Results: N = 316 adolescents with a mean age of 15.8 years (SD = 1.16) were included in the study. Both conditions resulted in reduced binge drinking episodes, quantity of alcohol use on a typical drinking day and alcohol-related problems at 3 month follow-up and stayed at a low rate at 6 month follow-up.

Conclusions: Intervention effects and subgroup analyses will be presented and clinical implications for the delivery of brief interventions to adolescents with acute alcohol intoxication will be discussed.

Trial registration: Current Controlled Trials ISRCTN31234060.

Acknowledgements: This work was a sub-project of psychenet - the Hamburg Network for Mental Health [2] which was funded by the German Federal Ministry of Education and Research (BMBF) (Ref: 01KQ1002B) and aims at strengthening health care regions in Germany by establishing new transsectoral cooperations and implement and evaluate selected innovations. Further information and a list of all project partners can be found at http://www.psychenet.de.
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http://www.ascpjournal.org/supplements/10/52
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Table 1 (abstract O16) Adjusted relative risk ratios (ARRR) comparing cSBA vs. TAU adolescent alcohol use rates at 3 and 12 months post-visit

<table>
<thead>
<tr>
<th></th>
<th>3 MONTHS</th>
<th></th>
<th>12 MONTHS</th>
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<td>ARRR</td>
<td>95%CI</td>
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<td>95% CI</td>
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<tr>
<td>Girl patient (n=546)</td>
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<td>0.25-0.87</td>
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<td>Boy patients (n=612)</td>
<td>0.54</td>
<td>0.26-1.19</td>
<td>0.71</td>
<td>0.45-1.11</td>
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<tr>
<td>Female doctors (n=658)</td>
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<td>0.22-0.76</td>
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<td>0.38-1.03</td>
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<tr>
<td>Male doctors (n=500)</td>
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<td>0.30-1.29</td>
<td>0.77</td>
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</table>

*p<0.05; ¹ Number of patients

Material and methods: We analyzed a subset of data from a quasi-experimental, asynchronous effectiveness trial of 12-18 y/o patients at primary care sites. An initial 18-month Treatment as Usual (TAU) phase was followed by a 1-hour physician training and an 18-month cSBA phase with computerized screening, immediate feedback and information on the health risks of drugs, follow by physicians brief advice. Adolescents rated their visit and physician immediately post-visit. Only data for physicians with >5 patients in each study arm were included. We conducted stratified multiple logistic regression modeling with adjustment for known covariates and within-site clustering. Endpoints were past 3- and 12-month alcohol at follow-ups.

Results: Subjects: 20 physicians (11 females; 85% pediatricians) and 1158 patients, mean age 15.6+2.0 yrs. Youth-provider connectedness was high (median score 32 [IQR 29-34] out of 35 max). However, female physicians’ patients scored significantly higher on youth-provider connectedness than patients of male physicians (p<0.0001), regardless of patient gender. The 3-month effect of cSBA on adolescent alcohol use was stronger among girls and female physicians (Table 1).

Conclusion: Physician advice regarding alcohol use may be particularly effective for girls within the context of an ongoing relationship with their physician, and when delivered by female physicians whose care is associated with higher patient-provider connectedness.

Acknowledgements: The authors thank the physicians and staff of The New England Partnership for Substance Abuse Research for their help in implementation of the original study, to the adolescent patients who participated and their parents who gave permission and the funding agencies: National Institute on Drug Abuse R01DA0188468 and R01DA01884860351; National Institute on Alcohol Abuse and Alcoholism K07 AA03289; CNPq 202418/2014; CAPES BEX 6951/14-7.

Reference

O17
The role of change facilitators in the implementation of alcohol SBI with public health nurses
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Addiction Science & Clinical Practice 2015, 10(Suppl 2)O17

Background: The University of Alaska Anchorage partnered with the State of Alaska, Section of Public Health Nursing (PHN) to pilot routine alcohol screening and brief intervention (aSBI) in three of their 22 public health centers (PHCs) prior to system-wide dissemination. During this two-year project funded by the Centers for Disease Control and Prevention, the university research team facilitated an SBI implementation through collaborative planning with PHN leadership, providing training for nurses to conduct aSBI, and maintaining contact with PHN staff. Nurses at the pilot sites participated in regular phone calls with members of the research team acting as change facilitators. A Plan-Do-Study-Act approach was used to refine implementation protocols throughout the pilot.

Materials and methods: A semi-structured protocol was used by change facilitators to identify challenges, successes, and fidelity issues. Each PHC participated in 12-16 calls over 14 months. Content from calls was iteratively discussed by the research team and key issues were presented to PHN’s aSBI implementation planning team in order to continuously refine protocols during pilot implementation. Thematic analysis of contact logs revealed key themes.

Results: Emerging themes included challenges with documentation procedures, on-going training needs, and adoption successes. Feedback from calls resulted in the refinement of PHN’s aSBI policies and procedures, supported booster training for nurses to improve brief intervention skills, and were used to develop local aSBI resources for nurses and clients. Throughout the project, nurses expressed increased acceptance of conducting aSBI as a routine part of client visits.

Discussion: Change facilitation calls provided a structured mechanism to involve nurses in piloting and improving aSBI implementation procedures, and to foster buy-in necessary for the adoption of practice change.

Conclusions: Change facilitation served as an important method for improving fidelity and feasibility of aSBI within the PHN health system.

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O18
Alcohol screening a brief intervention: a self-paced program for nurses
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Addiction Science & Clinical Practice 2015, 10(Suppl 2)O18

Background: Nurses are key positions to plan and implement alcohol screening and brief intervention (aSBI). To simultaneously advance aSBI of nurses in various roles, we developed a self-paced program for Clinical Nurse Leaders, Nurse Instructors, Nurse Administrators, and Registered Nurses including Advanced Practice Nurses. The content for the program is based on the Centers for Disease Control & Prevention (CDC) 2014 Planning and Implementation Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. The objective is to present the results of a cooperative agreement between the Centers for Disease Control & Prevention, Johns Hopkins School of Nursing, and the University of Pittsburgh School of Nursing. The framework used to design the aSBI Program and key aspects of the program will be demonstrated and discussed.

Material and methods: The aSBI Program flow, depicted in the CDC guide defined the modules for learning: patient population, assess alcohol consumption, negative screen (and subsequent conversation), positive screen (and assessment of harm and dependence), brief intervention and referral to treatment. The modules were developed using Articulate Storyline, the premier rapid e-learning development platform, and hosted on a learning management system. Special focus was given to the assessment portion of the e-learning modules to ensure learners are provided with authentic assessments that accurately measure their mastery of real-world skills needed to be successful when applying the module educational materials.

Results: When finalized, the self-paced aSBI Program, funded by the American Association of Colleges of Nursing through the CDC, will be widely disseminated to the nursing community across the U.S.

Conclusions: This easily accessible on-line educational program will bring evidence-based alcohol screening and intervention to current and future nurses.

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Reference

O19
Harm-reduction goals and safer-drinking strategies among individuals attending a new drop-in center
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O19

Background: Although socially marginalized individuals with alcohol-use disorders (AUDs) experience severe alcohol-related harm, few enter treatment. [1,2] Developing innovative, tailored interventions is therefore important to addressing this population needs. The Harm Reduction Treatment - Brief Intervention (HaRT-BI), designed to elicit self-generated harm-reduction goals and discuss safer-drinking strategies [3], was adopted for a new drop-in center that allows drinking in Switzerland. This study aimed to qualitatively document participants’ self-generated harm-reduction goals and safer-drinking strategies endorsement at the HaRT-BI baseline session.

Material and methods: Participants (N = 78; 16.7% female; mean age = 38) were socially marginalized individuals with AUDs participating in a larger study evaluating a new facility attendance and subsequent drinking outcomes. At baseline, study interventionists elicited participants’ harm-reduction goals with an open-ended question (‘What would you like to see happen for you in the next 4 weeks?’) and provided participants with a list of 12 safer-drinking strategies (e.g., taking vitamins, counting drinks). (3) Content analysis was used to categorize the goals and strategies participants endorsed.

Results: Seventy-six participants (97.4%) generated and endorsed at least one goal (Mdn = 2.1, IQR = 2) and one strategy (Mdn = 3, IQR = 1). The 5 most highly endorsed goals included drug and alcohol-related goals (e.g., reducing, connecting with treatment), basic-need goals (i.e., searching housing), health-related goals (i.e., improving health), and quality-of-life goals (i.e., engaging in meaningful activities). Changing manners of drinking (e.g., spacing drinks) was the most highly endorsed strategy type, followed by buffering the effects of alcohol on the body (e.g., eating) and reducing drinking.

Conclusions: Most participants did generate and endorse harm-reduction goals and safer-drinking strategies, which replicated US findings [4,5]. These results suggest that HaRT-BI may be used to help these individuals set harm-reduction goals and safer-drinking strategies. Future research is needed to test HaRT-BI effectiveness in decreasing alcohol outcomes.

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References
Material and methods: In year two of the project, students training began integrating SBIRT into their clinical experiences. Implementation packets were distributed to students with resources and instructions tailored to fit the varied needs of the programs and clinical sites. Clinical practice was supervised by SBIRT-trained clinical preceptors when possible or self-evaluated by students using the Brief Intervention Observation Sheet fidelity scale. Qualitative feedback was collected from faculty, clinical preceptors, and students to identify facilitators and barriers to integration of SBIRT into clinical experience.

Results: Preliminary data showed that 56 students (33 BSN, 23 MSW) practiced SBIRT at their clinical site during the first semester of implementation, with 91% completing screening only (no BI indicated) and 91% completing screening and BI. Fidelity ratings revealed strong completion of BI steps with no significant difference between the groups (BSN fidelity mean = 9.44/10, MSW fidelity mean = 9.30/10), although BSN students demonstrated stronger motivational style (t=2.47, p=.017). Qualitative data revealed institutional barriers to integrating SBIRT into some nursing clinical sites, while MSW clinical sites generally facilitated student practice and some adopted SBIRT agency-wide.

Conclusions: Students need opportunities to integrate SBIRT practice into clinical experience and receive supervised feedback to achieve competency. Plans must be tailored to meet the institutional needs of clinical sites, which can vary for BSN and MSW students.

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References

O22
The impact of billing/reimbursement structures on the integration of aSBIs into primary care practice: implementation experiences at five different types of clinics
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O22

Background: The purpose of the Screen-All Project was to promote adoption of alcohol SBI (aSBIs) in five primary care clinics within the University of Nevada School of Medicine Health System (System). Prior to this project, no formal aSBI activities were being conducted in these clinics or within the System. The five clinics included in the project provide healthcare services to adult men and women, including those at risk for alcohol-exposed pregnancies (e.g. women of reproductive age; college students). Two of the five clinics have non-Medicaid/Medicare/insurance funding sources for providing services, whereas three of the five clinics have Medicaid/Medicare/insurance funding sources. The objective is to determine how billing/reimbursement impacts implementation of aSBIs.

Material and methods: Meetings were held with the medical director and manager of each clinic to gather clinic-specific information (e.g., staffing, workflow, EMR, billing/reimbursement) and identify potential barriers to aSBI implementation. This information was used to inform development of aSBI training for each clinic.

Results: Medical personnel/staff at all five clinics participated in trainings. Four of the five clinics (two non-funding-dependent, two funding-dependent) successfully implemented aSBI. However, patient screening rates were higher at the two non-funding-dependent clinics (66% and 37%) compared to the two funding-dependent clinics (25% and 7%). Staff at the fifth clinic, which is dependent on Medicaid/Medicare/insurance funding, attended initial trainings and requested additional meetings/information but never implemented aSBI.

Conclusions: Although all five clinics received the same training and support throughout the project, only four implemented aSBI. The two clinics most successful with the implementation were not dependent on reimbursement. One barrier to implementation for funding-dependent clinics is that Nevada's Medicaid billing codes are not turned on for conducting aSBI. Efforts have begun to get those codes activated. Lessons learned from this project could be useful when systematizing aSBI as part of routine practice in other System clinics.

Acknowledgements: We would like to thank the physicians, nurses, and clinic staff who participated in this project from the following University of Nevada School of Medicine Clinics: Student Health Center (Reno); Student Outreach Clinic (Reno); Patient Care Center (Las Vegas); Women’s Healthcare Cetner (Las Vegas); and Patient-Centered Family Medicine Center (Reno).

O23
Computer self-administered screening for substance use in a university health center: a feasibility pilot
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Background: Unhealthy use of alcohol and drugs poses a significant health problem on college campuses, [1] and student health centers are an under-utilized resource for offering substance use screening and interventions [2,3]. As a strategy for increasing screening rates, we tested the feasibility of incorporating tablet computer self-administered screening into routine care at one university health clinic.

Materials and methods: During the 3-week study period, all patients presenting for a visit with a participating primary care provider were asked by the receptionist to fill out a ‘health screener’ in the clinic waiting area Screening tools were the 4-item Substance Use Brief Screen (SUBS), [4] followed by the ASSIST for those who screened positive [5]. Patients gave informed consent and completed screening on a tablet computer, then viewed their results and were given the option of delivering this information to the medical provider.

Results: Half of the patients presenting for an appointment received the tablet, of which 337 (90%) consented and completed screening. Rates of past-year unhealthy use were 73% for alcohol, 43% for illicit drugs, and 8% for prescription drugs. Among participants who screened positive for alcohol, 45 (21%) had moderate-risk use, and 4 (2%) had high-risk use, based on ASSIST scores. Of those screening positive for drugs, 53 (35%) had moderate-risk use, and one had high-risk use. Overall, 49% of all participants elected to disclose results to their primary care provider. Rates of disclosure were significantly lower for those with moderate-high risk drug or alcohol use (31%) than in those with low-risk use (59%), (P<0.01).

Conclusions: Our findings suggest that university health centers are a good venue for substance use screening and interventions, but there is also a need for interventions that can be delivered outside the health center, or that increase patient motivation to discuss substance use during the primary care visit.

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References

O24 Implementing adolescent SBIRT in an urban federally qualified health center: generalist vs. specialist service delivery models

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O24

Background: Little is known about how best to implement SBIRT services in pediatric health care settings or who, optimally, should provide brief interventions when on-site behavioral health is available. The objective of this presentation is to present results from a cluster randomized trial examining implementation of adolescent SBIRT services for substance use within a US federally qualified healthcare system. Two different implementation models for conducting brief interventions (BIs) were compared using randomization at the clinic level to either: the Generalist Model (BI provided by primary care provider) or the Specialist Model (BI provided by behavioral health specialist).

Material and methods: Multilevel logistic regression modeling was used to examine differences by Condition in rates of successful delivery and documentation of the following services: (a) screening (of all adolescent patients ages 12-17), (b) brief advice (for patients reporting alcohol or drug use but scoring ≥2 on the CRAFFT), and (c) brief intervention (patients scoring <2 on CRAFFT, delivered using either the Specialist or Generalist models). Due to the organization transitioning to a new electronic medical record (EMR) in month 6 of the study, data on BA and BI are currently limited to extractions from the new EMR.

Results: Multilevel logistic regression analyses taking into account the cluster-randomized design showed no significant differences between Generalist and Specialist conditions in rates of screening (OR=1.27; p=0.55), with significant volatility over time (<0.001) and variation by sites. In the post-EMR transition, Generalist sites were not significantly more likely to deliver appropriate BA (OR=1.34; p=0.70) or BI (OR=1.53; p=0.36) than Specialist sites. Site-level intraclass correlations were higher than anticipated. Future analyses will examine practices for the full implementation period and subsequent to the removal of implementation support resources.

Conclusions: Both service delivery models showed promise for delivering BIs but the high rates of variability within sites demonstrate a need for further examination.

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O25 Value of saliva testing when added to questionnaire screening for unhealthy drug use

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O25

Background: Unhealthy drug use (UDU), including both illicit drug use and misuse of prescription medications, is high among Americans 12 or older (9.4% past month; 48% lifetime), and is often 50-100% higher among emergency department (ED) patients (Cherpitel & Ye, 2008). While most screening, brief intervention and referral to treatment (SBIRT) projects focus on questionnaire screening for UDU, many clinicians are unaware of the potential of saliva testing (ST) to increase detection. The objective is to assess the added value of ST when added to comprehensive questionnaire screening for UDU.

Material and methods: Research assistants systematically approached adult patients receiving care in the medical-surgical area of an urban ED. After granting informed consent, patients completed a survey containing four different single-item screening questions (SDSQs) and the drug use section of the Mini International Neuropsychiatric Interview; then received a financial incentive. Patients granting separate consent then provided a saliva sample for drug testing and received a second incentive.

Results: Among 208 patients interviewed, only 111 (53.4%) agreed to saliva testing. Nine samples were positive in patients not reporting illegal/ recreational drug use. Six were positive for prescribed medications which they had reported (five for alprazolam, one for opioids). Two were positive for undisclosed cocaine. One was positive for barbiturates in a patient who did not report barbiturate use.

Conclusions: ST detected two patients (1.8% of those submitting samples) with unsuspected illicit drug use and one patient (0.9%) with unreported prescription psychotropic drug use. Despite financial incentives, 47% of patients refused ST, which could have disclosed more unreported drug use. Results confirm the ability of biomarker testing to detect small numbers of additional patients with potentially life-threatening UDU when added to questionnaire screening.

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Reference

O26 Vida PURA: results from a pilot test of culturally adapted screening and brief intervention for Latino day laborers

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O26

Background: The aim of this study was to assess the feasibility of culturally adapted screening and brief intervention to reduce heavy alcohol use among Latino day laborers.

Material and methods: We conducted qualitative interviews with Latino day laborers and social service to inform the cultural adaptation of screening and brief interventions. Case summaries and coded transcripts were reviewed for prevalent themes. Themes were used to identify sources of mismatch between traditional screening and brief intervention and the target population. The adapted intervention was then pilot tested to assess the feasibility and potential effectiveness. In the pilot test, 104 men were screened using the AUDIT and men with a score of 6 or greater were offered a brief intervention (56%). Those receiving an intervention completed follow-up surveys at 2 and 8 weeks. Alcohol use was assessed using the AUDIT and 14 day timeline follow-back.

Results: Findings from the qualitative interviews indicated that unhealthy drinking was related to and helped relieve immigration-related stressors. They identified many barriers to accessing health care and social services and few culturally-appropriate alcohol-related services existed. Based on these findings, we adapted SBI to incorporate the social and cultural context of Latino day laborers. SBI was provided in a community setting (at a day labor worker center) by bilingual community health workers. Men were receptive to SBI during the pilot test. Results from the pilot test confirmed that unhealthy alcohol use was prevalent (average of 8.5 drinks per day).
drinking day and 4 drinking days in past 14 weeks among intervention group). Mean AUDIT scores among those receiving the intervention went from 18.7 at baseline, to 13.5 at 2 weeks, and 14.8 at 8 weeks.

Conclusions: Our results suggest that screening and brief intervention may be more efficacious for Latino day laborers if conducted by community health workers in community settings. Our findings can be used to further test culturally adapted SBI to prevent and reduce unhealthy alcohol use in this vulnerable population.

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O27 Developing an implementation strategy for SBIRT in general hospital: first phase
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Addiction Science & Clinical Practice 2015, 10(1 Suppl 2):O27

Background: Following statement from Nilsen, Kaner and Babor [1], that motivation to address alcohol issues can be understood as a dynamic outcome between health professionals and patients embedded in the context, we follow a down-top implementation focus to work in partnership with all actors (professionals, patients and researchers) to understand ‘what’, ‘how’ and ‘why’ interventions can be carried out in everyday practice.

The objective is to develop an implementation strategy, grounded upon real conditions according Mexican healthcare settings in order to merge actors’ needs encompassed into public health perspective. First phase’s aims were: characterize actual practices oriented to reduce alcohol consumption over alcohol related disease inpatients, and to identify health professionals as key partners of implementation process.

Material and methods: We use an Action-Research framework which is a reflective process of progressive problem solving led by individuals within everyday practice context [2]. Also an ethnographic approach was used to further test culturally adapted SBI to prevent and reduce unhealthy alcohol use in this vulnerable population.

Results: Thirty focus groups were set up to discuss interviewing findings.

Consent to publish: Written informed consents were obtained from all interviewees.

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Addiction Science & Clinical Practice 2015, 10(1 Suppl 2):O29

O29 A randomized controlled non-inferiority trial of primary care-based facilitated access to an alcohol reduction website (EFAR-FVG): preliminary results
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Addiction Science & Clinical Practice 2015, 10(1 Suppl 2):O28

Background: The Screening, Brief Intervention, and Referral to Treatment (SBIRT) model has brought positive outcomes in addressing adult substance use, but its effectiveness during adolescence-a time of high-risk behavior-while promising, is less known. Under a three-year grant from the Conrad N. Hilton Foundation, Abt is evaluating more than two dozen health, school, and community-based settings providing SBIRT services to youth and young adults funded through the Foundation’s Youth Substance Use Prevention and Early Intervention Strategic Initiative.

Material and methods: Grantees’ quarterly reporting on the Initiative’s three objectives (expand training, increase implementation, and promote the evidence base) and individualized RE-AIM measures (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and key informant interviews with grant programs’ project directors using a structured interview guide provide early results on training and implementation challenges and successes, as well as initial results on screening tools and brief intervention methodologies.

Results: In any setting, implementing an innovation is difficult, time-consuming, and requires following specific steps that account for the intricacies of the environment, while maintaining fidelity to the evidence base. This is even more difficult with varying models of implementation, settings to which it is being implemented, and the black box of “brief intervention.” Grantees report key factors that cross implementation setting: engaging the right people, including an innovation early adopter or champion; modifying electronic health record and self-administering SBIRT into the medical, school, or community ‘record’; and ensuring confidentiality/privacy of youth.

Conclusions: Physicians’ judgments, rather than validated screening tools, tend to drive interventions for youth and young people. The study’s findings will be used to improve delivery systems aimed at youth, strengthen the evidence base for prevention and treatment, and improve school and workplace success as it helps policymakers, funders, and practitioners better understand substance use and its impact. Additional research will be conducted that reports on training model’s effectiveness and outcomes related to varying models of SBIRT implementation.

Acknowledgements: The authors wish to acknowledge the funding of the Conrad N. Hilton Foundation and contributions of Foundation staff and grantees and Abt colleagues.

O28 Preventing, screening, and intervening in youth substance use: examining implementation of SBIRT in diverse settings
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Addiction Science & Clinical Practice 2015, 10(1 Suppl 2):O28
Adapting SBIRT for Batterer Intervention Program groups using motivational approaches

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O30

Background: To present a public health initiative to adapt SBIRT for Batterer Intervention Programs (BIP) using Motivational Interviewing (MI) approaches. While studies concur that substance use is not the underlying cause of Interpersonal Violence (IPV), approximately 50% of men in BIP are reported to be using substances at unhealthy levels. The Massachusetts Department of Public Health (MDPH) initiated a pilot to address risky substance use in BIP participants, with the Institute for Health & Recovery (IHR), providing curriculum development, training, and technical assistance. The curriculum employs an innovative application of SBIRT designed for use in groups, allowing BIP group leaders to provide substance use health education to men in groups. Some studies indicate that MI can result in better engagement with participants than the typical directive, confrontational approaches often used with individuals involved with the criminal justice system. It uses MI strategies adapted to help the group members to improve the benefits and costs of substance use themselves, rather than a more traditional ‘health education’ lecture by a group leader. Validated single item screening tools, for alcohol and for other drugs, were completed in silence during the group, and open-ended questions were asked as the Brief Intervention; leaders were encouraged to ask permission before sharing information in order to give participants a greater sense of control and ownership of their place on the road to change.

Conclusions: This adaptive SBI approach was deemed successful/very successful by 85% of men (n=215). Group leaders found the material/implementation relevant and useful. Adapting SBIRT for Batterer Intervention Program (BIP) Groups Using Motivational (MI) Approaches is a cost-effective, non-threatening initiative to increase ambivalence to change amongst men who batter. Upon implementation in a second program, this curriculum will be used in BIPs across Massachusetts.

Utilization of standardized patients and case studies to evaluate effect of SBIRT training for APRN’s

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O31

Background: Research supports the efficacy of screening, brief intervention, and referral to treatment (SBIRT) in reducing unhealthy substance use, and demonstrates that nurses are effective SBIRT providers. The purpose of utilizing MI is to help clients to manage their health independently, while building their confidence and willingness to change behavior [1]. Identifying effective pedagogical methods for teaching and evaluating students’ proficiency in utilizing SBIRT is essential.

Methods: Family Nurse Practitioner (FNP) students (n = 36) received SBIRT and Motivational Interviewing (MI) didactic content and clinical practice during three consecutive semesters. The students’ skills were assessed during the 1st semester (Time One) and the 3rd semester (Time Two) using standardized patient case scenarios. Student encounters were recorded and evaluated by faculty, standardized patients and self-reflections. Debriefing sessions provided face to face feedback by faculty and MI trainers.

Results: The percentage of students who were able to demonstrate six specific SBIRT skills increased from Time One measure to Time Two measure in four areas: identifying risk (82.6% vs.100%), educating on low risk drinking limits (67.4% vs. 97.2%), recommendation to quit or cut back (78.3% vs. 97.2%), and enhancing motivation (67.4% vs. 77.8%). The remaining two areas showed a slight decrease in the percentage of students who demonstrated those skills: asking permission to raise the subject (97.3% to 94.4%) and explaining the connection between substance use and the reason(s) for patient’s current medical visit (89.1% vs. 88.9%). Student’s self-reflections accurately identified areas of strengths and weaknesses in their individual SBIRT skills and were consistent with faculty evaluations of their performance.

Conclusion: The use of standardized patient case scenarios was shown to be an effective venue for faculty to evaluate student proficiency at performing SBIRT. Educating the FNP student in SBIRT and MI will result in more clients being screened and treated for alcohol or drug misuse and to empower these clients to independently manage their health with success.

References


O32 Developing alcohol SBI policy and procedures with Alaska Public Health Nursing Rebecca Porter1, D King, B Hanson, S Faulkner

Background: The Institute of Medicine recommends changing organizational policy as a key element of evidence-based practice (EBP) implementation; however, policy change alone may be insufficient to change provider practice behavior [1,2]. Engaging key organizational stakeholders in the policy change process may foster buy-in, particularly if the policy is piloted and refined alongside the new practice. As part of a two-year initiative funded by CDC to implement routine alcohol screening and brief intervention (SBI) into primary care settings, the Alaska Section of Public Health Nursing (PHN) collaborated with the University of Alaska Anchorage to pilot alcohol SBI policy and procedures in three clinics prior to system-wide dissemination.

Material and methods: Key PHN stakeholders and researchers formed a planning team to develop a draft alcohol SBI policy and nurse providers from pilot clinics were trained in the standardized procedures. Throughout the pilot, the university team maintained frequent contact with the clinics and monitored implementation through tracking data and contact notes. Findings were shared with the planning team regularly and the draft alcohol SBI policy and procedure was revised to balance fidelity to EBP with feasibility for PHN.

Results: Screening rates, one measure of implementation success, increased throughout the pilot as barriers and challenges were identified and addressed, with corresponding updates to organizational policy and procedure. Nurses also indicated increased confidence and ability to conduct SBI as outlined in the policy. After fourteen revisions, the universal alcohol SBI policy and procedure was finalized and disseminated throughout Alaska’s PHN system. Together, findings reveal that piloting and revising draft policy was an important implementation facilitator.

Conclusions: Piloting and refining an organizational policy and procedure for alcohol SBI was effective for feasibility purposes and to implement the EBP with fidelity. Including nurses, leadership, and researchers throughout the implementation process fostered engagement in practice change.

Acknowledgements: The authors would like to acknowledge Alaska Public Health Nurses who volunteered to participate the pilot project to implement the routine practice of alcohol SBI.

References

O36 Integrating adolescent substance abuse screening, brief intervention and treatment in health professionals education

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Background: Substance abuse remains one of the largest public health issues facing our society. Early alcohol and drug use is linked to a range of immediate and long-term consequences (e.g., academic, brain development, and later dependence). Although studies such as the Youth Risk Behavior Survey and National Survey on Drug Use and Health have recently shown stable or slight decline in the use of alcohol and certain drugs, alcohol remains the drug of choice, marijuana use has increased, and perceptions of harm has decreased. [1,2] Opportunities to address substance use exist in a range of settings where nurses, social workers and other health professionals work with youth yet training and adoption of adolescent screening and brief intervention has been slow. The cost of substance use disorders, in both adults and adolescents, could be reduced through the SAMHSA-backed prevention and early identification procedure of Screening, Brief Intervention, and Referral to Treatment (SBIRT), a cost-effective and widely-supported prevention framework. Research has shown SBIRT to be effective for the early identification of problematic alcohol use, with growing but inconsistent evidence for its effectiveness with other risky drug use. However, there is little substance use training in social work and nursing programs. SBIRT education is often optional or specialized, rather than being required coursework.

Material and methods: NORC at the University of Chicago has been funded by the Conrad N. Hilton Foundation to increase training opportunities in adolescent SBIRT within undergraduate and graduate social work and nursing programs. In October 2014, NORC partnered with the Council on Social Work Education, Center for Clinical Social Work, American
Association of Colleges of Nursing, and New York-based technology company Kognito to support the integration of adolescent SBI reporting education into required coursework for their students. Following the model established by the Institute for Healthcare Improvement, [3] NORC has assembled a Learning Collaborative comprised of faculty from schools of nursing and social work throughout the United States. Led by a Steering Committee including partnering organizations and experts on adolescent substance use, the Learning Collaborative has been developing curricular and technical assistance tools to integrate substance use education in nursing and social work education.

**Results:** To date, faculty from approximately 100 schools of nursing and social work have actively contributed to the initiative. Tools created include a virtual patient simulation that will allow students to learn specific skills and the delivery of tailored brief interventions based on motivational interviewing. [4] Developed by Kognito, the online simulation enables learners to practice brief interventions in conversation with realistic virtual patients, and facilitates assessment of competency by scoring learners' performance and providing elaborative feedback.

**Conclusions:** There is wide-ranging support among schools of social work and nursing for the integration of SBI training in curricula with support from professional associations and technical assistance providers. Further study underway will evaluate the initiative's effectiveness in developing substance use competencies among health professionals.

**References**


**O37**


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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O37

**Background:** Risky alcohol use can cause a range of negative consequences, including motor vehicle crashes, intimate partner violence, and medical conditions such as hypertension, gastritis, liver disease, and various cancers [1]. Alcohol use during pregnancy can result in miscarriage, stillbirth, and fetal alcohol spectrum disorders (FASDs) [2,3]. Over thirty years of research has shown that alcohol screening and brief intervention (SBI) is effective at reducing risky drinking. Yet, it has not been integrated widely into clinical settings.

In 2014, CDC released Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices [4]. The guide provides a practical process that primary care settings can use to implement alcohol SBI. Prior to publication, a draft version of the guide was tested with three CDC-funded FASD Regional Training Centers (RTCs) to implement alcohol SBI as routine care for all adults in 10 primary care clinics in Alaska, Nevada, and Tennessee.

**Materials and methods:** To assist the FASD RTCs in their implementation efforts, CDC provided them with a draft of the implementation guide. CDC hired Westat to evaluate the quality and effectiveness of the guide, using qualitative research methods, including site visit interviews with program and clinic staff.

**Results:** Data were obtained from 56 RTC and clinic respondents. Results showed that the guide was most useful for initial planning, engaging key clinic stakeholders, developing training and dissemination materials, and for additional resources and references. Multiple challenges with the draft guide were identified, including the need for protocols for brief interventions and information on billing and reimbursement codes.

**Conclusions:** Evaluation findings were used to revise the guide prior to its release. This presentation will highlight the evaluation, findings, modifications, and an overview of the guide as currently available from CDC.

**Acknowledgements:** The authors would like to acknowledge the team at Westat, led by Dr. Saloni Sapru, who conducted the evaluation of the alcohol SBI implementation guide for primary care.

**References**


**O38**

A scoping study of practitioner training in alcohol brief interventions as described and delivered in randomised controlled trials

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O38

**Background:** Good evidence for the efficacy of alcohol brief interventions (ABIs) delivered in primary care [1] has been insufficient to drive routine implementation [2] and may not translate to normal clinical settings, possibly due to a loss of fidelity [3]. Implementation efforts, and research trials, rely on practitioners being adequately prepared to deliver ABIs consistently with evidence or protocols (amongst other factors). Relatively little research attention has been paid to establishing optimal duration, content, methods, style, deliverer or format of training and the importance of heterogeneity in training provision in affecting trial outcomes is currently unknown.

This study aimed to ascertain how published trials of ABIs describe the training and related support provided to practitioners, what additional relevant information can be obtained from trial authors and how current frameworks or taxonomies can inform how best to analyse and describe training content and design.

**Materials and methods:** A systematic search identified published ABI trials involving frontline healthcare workers. Data on how training is reported in papers and supplementary materials was extracted so as to facilitate analysis of how clearly the design, duration, method and topics covered in training are described and reported. Corresponding authors were contacted to request further information on training content and design. Existing frameworks which might facilitate systematic description of ABI training will be critically appraised to assess usefulness for routine use in reporting.

**Results:** 780 records were identified from the Cochrane Drug and Alcohol group specialised register and relevant Cochrane systematic reviews. After de-duping and screening, 221 full text articles were being assessed for eligibility and data extracted on training and support provided to practitioners in eligible reviews.

**Conclusions:** Preliminary findings suggest that the quality of descriptions of training, as well as the duration and intensity of training and support provided to practitioners are highly variable and that in future standardised reporting would facilitate further analysis.

**Acknowledgements:** We wish to acknowledge small grant funding from Alcohol Research UK for this study.

**References**

Challenges and opportunities in alcohol screening and brief interventions in new settings: A Narrative Review of Implementation Initiatives
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Background: Alcohol screening and brief interventions (SBI) have a history and robust evidence of efficacy in primary care settings. [1]. Efficacy evidence is variable across other settings and much is unknown including mechanisms of action, and optional screening or implementation approaches [2,3]. Despite this, implementation outside of primary care has had much attention including in non-health settings, particularly in the UK [4-6].

This study aimed to discuss, and present for debate, challenges and opportunities relating to alcohol SBI in new settings from published and previously unpublished studies of recent SBI implementation in Scotland and England.

Material and methods: A narrative review was conducted of evidence from diverse studies including research into training and implementation of alcohol SBI outside of primary care (accident and emergency; antenatal; social care; community/mental health; homelessness and multidisciplinary teams).

Results: The challenges and opportunities can be conceptualised in terms of questions that should be asked before considering implementation of alcohol brief interventions in a new setting: (1) Is there a need for SBI delivery in this service? (2) How are practitioners currently addressing alcohol use - how when, where does SBI fit in? (3) Will SBI work/do harm in this setting? (4) Will SBI be perceived as legitimate by practitioners and acceptable to service-users? (5) Will practitioners have the ability to deliver SBI? (6) What support will be needed? (7) What will support routine implementation of SBI in this setting?

Conclusion: Careful consideration should be given to every aspect of the design, purpose, context and evaluation of alcohol SBI in any given setting preferably by robust stepwise research prior to widespread implementation. Avoiding assumptions, including about screening methods and intervention goals, is likely to be important for effectiveness, implementation and avoiding unintended harms.

Acknowledgements: This paper is based on material first presented to an expert seminar organised by Middlesex University which was funded by Alcohol Research UK.

References
programs for the treatment of the abuse of alcohol and other drugs [3,4] at addiction treatment centers in Mexico. On the basis of the experience of experts in the implementation and dissemination of programs, a number of actions are established to address them and advance the transfer process.

It is a qualitative study using interviews. The results reported several barriers to the adoption of programs in clinical scenarios. The study discusses the fact that the technology transfer process requires a deliberate, combined effort to ensure the implementation of programs in clinical scenarios. The barriers identified by the actors involved in the process should be considered in the development of strategies to disseminate brief intervention programs.

Material and methods: The team used an interview guide that included:
1. Knowledge about brief intervention programs.
2. Knowledge about working with brief intervention programs based on scientific evidence.
3. Training and supervision got during the transfer process about brief interventions.
4. Modifications to programs.
5. Barriers on the implementation of programs.
6. Advantages and limitations of brief intervention programs.
7. Other important information.

Sixteen interviews were conducted and recorded for about two hours each in the working place of the participants (therapists), who were informed about the recording, the confidentiality and the use pretended for the information. The interviews were transcribed, read, analysed, organized in categories.

Results: The participants reported three types of barriers to the brief programs operation: Institutional barriers, Therapist barriers, Barriers in the researcher himself and barriers in the program users.

Regarding the Institutional barriers therapists report bureaucracy, lack of budget for material or for adequate working areas.

Among all ED patients screening positive in 5,805/14,561 (39.9%) for alcohol and 2,454/14,494 (16.9%) for drugs. We collapsed the free-text chief complaints into 50 usable categories. To identify 75% of all ED patients having positive assessments using the first strategy we would require including 19 chief complaints for alcohol screening and 20 chief complaints for drug screening. Adapting the second strategy, we would need to screen at least 71% and 68% of all ED patients for alcohol and drugs respectively to identify 75% of those having positive assessments.

Conclusions: Based on this large, multicenter study, chief complaints provide little assistance in targeting SBIRT for alcohol or drug use in the ED.

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References


O44 A new methodology for examining the efficacy of SBIRT protocols on reducing healthcare utilization and costs
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O44

Background: There is increasing interest in deploying Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices in emergency departments (ED). However, the current literature is inconclusive on whether or not SBIRT practices are cost effective and cost beneficial. In order to answer this question, new analytical methods need to be developed.

The objective of the following study was to pilot a new experimental methodology - modeling costs using a multilevel generalized linear model (GLM) - for studying the impact of SBIRT on healthcare utilization and costs.

Material and methods: In the study, healthcare utilization and costs were quantified for patients who received emergency department (ED) services and participated in an SBIRT program entitled Safe Landing. The healthcare and utilization costs of patients who underwent the Safe Landing program were compared using a multilevel GLM to patients in three control groups where no SBIRT protocol was implemented.

Results: The study found that SBIRT was associated with 24% lower health care costs from the 12 months preceding the index ED visit to the 12 months following the index ED visit. This translates to approximately $2,600 per patient per year. This reduction in healthcare costs could be linked mainly to decreased inpatient use. The study found a reduction in inpatient claims and visits, suggesting that the reduction in health care costs was driven mainly by a decrease in inpatient visits.

Conclusions: This study provides further support that SBIRT programs are a cost-effective and cost-beneficial approach to substance use disorder management. The study also contributes to important literature on the impact of SBIRT implemented in real world settings, rather than traditional randomized clinical trials.

O43 Collaborative implementation of screening, brief intervention, and referral to treatment within the medical community of Blair County, PA
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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O43

Background: This report provides an overview on the planning and implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT) training programs in one community healthcare system so that it can be a model for other systems who wish to implement similar programs.

The goal was to reduce the impact of substance use disorders (SUD) on the criminal justice system and community by implementing SBIRT in local medical clinics to improve the early identification of and evidence-based intervention on SUD by the medical community.

Material and methods: Two leading healthcare organizations in the community formed a committee that managed and spearheaded the SBIRT training program implementation. An Innovation Model used by the authors guided implementation. The committee completed organization assessments and business analyses for each training site. The committee and training sites became knowledgeable of SBIRT protocols, training program implementation, and infrastructure development. Once the program began, quality metrics were compiled and reviewed on a weekly basis.

Results: Infusing SBIRT practices into clinics increased in difficulty as the complexity of the system increased, however, benefits were still obtained. Through the screening of over 280 new patients, training sites found that SBIRT exposed problematic substance use within their patient population that previously would have gone unnoticed. Identification presented opportunities to improve patient care. Knowledge and skills developed on screening, brief interventions; medical and psychiatric complications; and community D&A resources, were fundamental to implementation.

Conclusions: The project revealed key factors relevant to the Innovation Model that related to successful implementation: champion preparedness; a highly specified protocol; a cultural shift signifying a reduction in negative stigma attached to working with patients with SUD; clear role definition for each member of the team; continuous activity tracking; and regular contact between physical and behavioral health providers and institutions.

O45 Screening and brief intervention for low risk drug use in primary care: a pilot randomized trial
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Background: Universal screening and brief intervention (SBI) for drug use among primary care (PC) patients lacks efficacy but the efficacy of SBI for low risk drug use is unknown. This 3-arm pilot study tested the efficacy of two brief interventions (BIs) for drug use compared to no BI in PC patients with low risk drug use identified by screening.

Material and methods: We randomly assigned participants identified by screening with Alcohol Smoking and Substance Involvement Screening
Test (ASSIST) drug specific scores of 2 or 3 (consistent with low risk drug use) to: no BI, a brief negotiated interview (BNI), or an adaptation of motivational interviewing (MOTIV). BNI was a 10-15 minute structured interview conducted by health educators. MOTIV was a 45 minutes with an optional booster conducted by trained master’s-level counselors. Primary outcome was number of days use of self-identified main drug in the past 30 as determined by validated calendar method at 6 months. Analyses were performed using negative binomial regression adjusted for baseline use and main drug.

Results: Of 142 eligible adults, 61(43%) consented and were randomized. Participant characteristics were: mean age 41; 54% male; 77% black. Main drug was marijuana 70%, prescription opioid 10%, cocaine 15%; 7% reported injection drug use and mean days use of main drug (of 30) was 3.4. At 6 months, 93% completed follow-up and adjusted mean days use of main drug were 6.4 (no BI) vs 2.1 (BNI) (Incidence rate ratio (IRR) 0.33, 95% CI 0.15-0.74) and 2.3 (MOTIV) (IRR 0.36, 95% CI 0.15-0.85).

Conclusions: BI (both BNI and MOTIV) appears to have efficacy for preventing an increase in drug use in primary care patients with low risk use identified by screening. These findings raise the potential that less severe patterns of drug use in PC may be uniquely amenable to brief intervention and warrant replication in a larger trial.

O46

Does screening and brief intervention for drug use in primary care increase receipt of substance use disorder treatment?

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O46

Background: Little is known about the efficacy of “RT” (referral to treatment) for increasing receipt of substance use disorder (SUD) treatment by patients with unhealthy drug use identified by screening. We compared receipt of SUD treatment between baseline and 6 months across three randomized groups: no intervention and two different types of brief interventions.

Material and methods: Adults presenting to a hospital-based primary care clinic with recent drug use (Alcohol, Smoking and Substance Involvement Screening Test [ASSIST] drug specific scores of ≥4) were enrolled in a randomized clinical trial comparing: (1) a 10-15 minute structured interview conducted by health educators (BNI), (2) a 30-45 minute intervention based on motivational interviewing by Masters-level counselors (MOTIV), or (3) no brief intervention. All received information on treatment resources. We assessed receipt of any SUD treatment in a statewide database. Logistic regression analyses adjusted for main drug (self-identified), drug dependence, and past SUD treatment.

Results: Among 528 participants the main drug was marijuana (63%), cocaine (19%), and opioids (17%); 46% met 12-month drug dependence criteria (Composite International Diagnostic Interview Short Form); 18% had ASSIST scores ≥27 consistent with dependence (past 3 months). At 6 months, 14% (73/528) received any SUD treatment. There were no significant differences in SUD treatment receipt: BNI vs control (adjusted odds ratio [AOR] 1.16, 95% Confidence Interval [CI] 0.59-2.30, Hochberg adjusted p-value=0.66); MOTIV vs control (AOR 0.45, 95%CI 0.21, 0.97, Hochberg adjusted p-value=0.89). There were no significant interactions between intervention and main drug, severity (ASSIST), or prior SUD treatment.

Conclusions: Brief intervention did not increase receipt of SUD treatment in primary care patients. Future research should address how to make referral to treatment successful among screen-identified patients who could benefit from it.

O47

Incorporating validated alcohol and drug screening instruments in the electronic health record

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O47

Background: We sought to implement validated alcohol and drug use screening tools into the Electronic Health Record (EHR) without the aid of specialized information technology (IT) support.

Material and methods: Since October 2012, when our outpatient clinic transitioned to an EHR, we implemented the AUDIT and DAST-10 questionnaires as Epic SmartPhrases.

A high score on either questionnaire prompts a “brief intervention” (BI), which includes offering the patient a printed brochure. To our SmartPhrases, we added hyperlinks (to http://www.sbhintonline.org and http://www.drugabuse.gov) to make pertinent brochures immediately available.

To “charge capture” and retrieve BIs, we used the Current Procedural Terminology (CPT) codes for alcohol and drug counseling.

Results: Of 155 randomly selected patient encounters prior to using the EHR, there were no encounters with a validated alcohol use screening instrument, and in only 1 encounter (0.6 %) was there a valid BI. After transitioning to the EHR and educating residents, 43 of 97 (44.3%, p < 0.05) randomly selected patient encounters included a validated alcohol use screening instrument, but only 4 of 97 (4.1%) contained evidence of a BI. Over time, with continued training, including conferences and reminders from attending physician “champions,” residents performed more BIs. For the year April 2014 through March 2015, documented BIs averaged 11 per month (1.3% of total monthly patient encounters).

Conclusions: Though the resulting workflow process may not be “seamless,” EHR users can independently implement validated screening questionnaires. With proper IT expertise, Best Practice Advisory/Health Maintenance Reminder (BPA/HMR) “pop-ups” can increase the automaticity of screening, enforce the necessity of screening, and minimize the chances of “losing” documentation of screening (such as when residents fail to “charge capture.”) The BPA/HMR method, with automatic periodic reminders which the provider must address - in perpetuity - before moving to the next step in encounter documentation, should aid sustainability of alcohol and drug use screening and intervention programs.

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O48

SBI and EHR: understanding, adoption, and implementation in family medicine clinics

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):O48

Background: Alcohol screening and brief intervention (SBI) programs have been shown to be effective in reducing risky alcohol consumption among primary care patients [1-3]. Although various implementation protocols exist, it can be difficult to launch and sustain SBI programs. A number of barriers exist, including those related to clinical workflow, the intake process, and the incorporation of protocols into electronic health records (EHR) [4-6]. This study aims to present challenges and potential solutions to incorporating SBI as a standard of care into an existing EHR of a family medicine system.

Material and methods: An SBI program was piloted in two underserved family medicine clinical teaching practices. Physicians, residents, nurses, medical assistants and patient service representatives (PSR’s) were trained on the protocol for adopting this practice into daily clinic work. Through
this implementation, an EHR template was created to complement the workflow.

Results: Utilization of the screening tool provided a mechanism to better assess risky drinking within a regular patient encounter. High rates of completion were appreciated throughout the grant period prior to leadership changes. The EHR template facilitated the intake process, the clinical encounter, and provided a mechanism for billing.

Conclusions: The incorporation of a dedicated EHR template may mitigate providers’ concerns about time constraints and establishes a more effective mechanism for billing for the service.

Strong support from organizational leadership and the use of clinic champions were shown to positively contribute to the success of the SB programs in this health system by addressing common barriers to implementation.

Acknowledgements: We would like to thank the Fetal Alcohol Syndrome Prevention Team, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention for their support of this project.

References

POSTER PRESENTATIONS

P1 Psychoactive substances: screening for brief intervention in primary health care, Rio de Janeiro/Brazil

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):P1

Background: About 10% of the populations in urban centers all over the world misuse psychoactive substances, independently of age, gender, education level and purchasing power. The use of these substances is directly and indirectly related with a series of health problems, among which traffic accidents, aggression, clinical depressions and conduct disorders are highlighted, besides sexual risk behavior and the risk of HIV transmission due to injectable drug use and other health problems. We analyzed the profile of a population attended in the Family Health Strategy, considering the consumption of psychoactive substances in the last three months.

Material and methods: Quantitative, Cross-sectional descriptive survey, conducted in a community located in the north of Rio de Janeiro. The sample consisted of 1489 users of the Service, using a structured questionnaire (Alcohol, Smoking and Substance Involvement Screening Test). Data collection was conducted within one year. The analysis was performed with SPSS software using statistical measures appropriate (t test, ANOVA and Pearson correlations), respectively to evaluate mean differences for two and more than two groups, Pearson correlations, using the Statistical Package Social Science (SPSS) version 22.0 and we have established a level statistical significance at p < 0.05. The ethical study procedures were represented by the approval of the Ethics Committee of the Municipal Secretaria of Health and Civil Defense of Rio de Janeiro number 132/09.

Results: The male population was prevalent in consumption over life and in the last three months, more frequently for tobacco use 56.4%, alcohol 75.8%, cannabis 16.9% and cocaine / crack 10.1%. Religion showed as a protective factor for drug use.

Conclusions: We emphasize the relevance of the inclusion of the model of Brief Interventions, a low-cost and gentle technology in this area and in the nursing practice.

Acknowledgements: National Council of Technological and Scientific Development/ CNPq, Brazil.

References

P2 Screening of problems related to alcohol, tobacco and cannabis in primary care settings: a comparative study between Brazil and Portugal

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):P2

Background: The consumption of psychoactive substances is a global health problem. The objectives are to identify the sample socio-demographic profile and use pattern of alcohol, tobacco and cannabis throughout life and in the last three months. Also, to discuss the application of Brief Intervention procedures for problems related to psychoactive substances in patients assisted at the primary health care, in Brazil (Rio de Janeiro) and Portugal (Coimbra).

Material and methods: The sample included 1700 individuals (Brazil, n=1489; Portugal, n=211). All participants filled the instrument Alcohol, Smoking and Substance Involvement Screening Test. Analyses were performed (Student’s t-test, ANOVA and Pearson’s correlations) using the Statistical Package Social Science (SPSS) version 22.0. A level of statistical significance of 0.05 was established.

Results: It was observed in both countries higher prevalence in attendance of female participants, married, income between 1 and 2 minimum wage (in Brazil). Considering lifelong use of substances, the Brazilian sample showed 45.5% of tobacco use, 67.6% of use of alcoholic beverages and 8.6% of cannabis use. In Portugal, tobacco (59.3%), alcoholic beverages (88.1%) and cannabis (13.5%). Considering the daily frequency of use in the last three months in Brazil: tobacco (14.7%), alcoholic beverages (2.8%), cannabis (0.7%); and in Portugal: tobacco (22.7%), alcohol (32.7%) and cannabis (0.5%). Individuals classified as “moderate risk” were selected to receive Brief Intervention: in Brazil, tobacco use (score 4-25) 16.6%, alcoholic beverages (score 1-29) 8.8%, cannabis 1.5%; Portugal tobacco use (score 3.0%), use of alcoholic beverages (19.3%) and cannabis use (12.7%).

Conclusions: It was observed the use of psychoactive substances both countries and the importance of the primary health care in the early detection of health problems associated to the use of those substances. The scenario is responsible for health promoting/protection.

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Mental health and substance misuse 7 years following an Emergency Department admission for alcohol intoxication

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Addiction Science & Clinical Practice 2015, 10(Suppl 2):P3

Background: How young adults evolve at a distance of being admitted for alcohol intoxication in the Emergency Department (ED) is not well characterized.

Objective: Assess the prevalence of alcohol use disorder (AUD), substance use and health status 7 years following an ED admission for alcohol intoxication.

Methods: In 2006-2007, 631 patients aged 18-30 were admitted for alcohol intoxication at the ED of a tertiary Swiss hospital. In 2014, they were re-contacted and interviewed to complete: demographics, alcohol use disorders identification test-consumption (AUDIT-C), Mini International Neuropsychiatric interview (MINI) for AUD, SF12 mental and physical component summary scores (MCS, PCS), Patient Health Questionnaire (depression and anxiety disorders), past year use of illegal drugs/tobacco, if they remembered the admission and discussing their drinking while admitted.

Results: In 2014, 318/631(50.4%) patients completed the questionnaire: 32.1% were women, 36.5% unemployed, 73.6% remembered the admission and 34.6% discussing their drinking; 65.1% had AUDIT-C≥4 (i.e. positive screen for AUD). According to the MINI, 15.1% had alcohol dependence and 13.2% harmful use. 18.6% had depression, and 15.4% an anxiety disorder. Mean (SD) PCS and MCS were 52.2(9.3) and 42.7(11.7).

Prevalence of any use (past year) was 80.2% for tobacco, 53.1% for cannabis, 22.6% for cocaine, 13.5% for sedatives, 11.0% for stimulants, 7.2% for opioids, and 6.0% for hallucinogens. At least once a week use was 7.2% for opioids, and 6.0% for hallucinogens. No differences were found between those who completed the questionnaire and those who did not on 2006-2007 alcohol intoxication admission data (age, gender, blood alcohol concentration, presence of disruptive behavior in the ED).

Conclusions: Young patients admitted for alcohol intoxication are likely to develop substance misuse, mental health disorders, and social problems, suggesting they should be offered secondary prevention measures.

P4

Formative content development and evaluation of a text message intervention for excessive alcohol consumption among university students

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Background: Previous studies have highlighted the magnitude of risky drinking among Swedish students; finding that at least 50% of the students could be classified as risky drinkers [1]. Human resources are not sufficient to offer all risky drinkers face-to-face brief interventions. Text messaging is the least advanced but also the least expensive eHealth technology that virtual works on all mobile phones [2]. Thus text messaging have strong potential as a tool for healthy life style interventions since it is available on all mobile phone, the cost is low and is widely applicable to other health behaviours [3]. The objectives are to develop a new text message based alcohol intervention using a formative qualitative research approach.

Material and methods: The content development will be an interactive process in which theory guided content is modelled and qualitatively evaluated by the users in line with guidance on the development of complex intervention. The process will begin with a revisit of the literatures on theory-based approaches to behaviour change across behavioural targets, with focus on alcohol. In the next step the structure and content of tentative text messages will be discussed by students in focus group interviews.

Results: Three focus group interviews will be conducted during spring 2015 in three regions in Sweden in order to investigate the students reasoning on the theoretical informed content. The students will be asked to formulate new messages and disregard existing messages. Preliminary results from the interviews will be presented.

Conclusions: The responses of the students will enable us to understand how students think about the structure and content of a text message based alcohol intervention in order to increase uptake, compliance and effectiveness of the intervention.

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References

P5

Screening for alcohol consumption for a worker health intervention

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Background: The World Health Organization has been pointing out that alcohol consumption is one of the serious public health problems at present, ranking third among leading health risk factors in the world. The consumption pattern of heavy and sporadic alcohol reaches 11.5% of alcohol consumers, accounting for serious health problems. In Brazil, the pattern of alcohol use has shown alarming rates in general on average are consumed six liters of pure alcohol per capita per year. So many workers abusively consume alcoholic beverages, due to lack of knowledge of its pattern of alcohol consumption and its consequences. In this context early detection of the pattern of alcohol consumption among workers, requires further investigation in order to enable better strategies for prevention and health promotion.

The objectives are to identify the pattern of alcohol consumption and to analyze the association between social and occupational profile of workers.

Material and methods: A descriptive study with 322 subjects who responded to the AUDIT (Alcohol Use Disorders Identification Test) and
It was observed that 87.3% were consumption of low risk and 2014, 2013, Of respondents, 42% were enrolled in 4-year, 25% in community intervention trial [1] indicated that Mortalidade nos acidentes de transito na cidade do e on Drug Abuse (NIDA). Contract # Drinking National Institute of Child 2 10(Suppl 2): m o n i t o r i n g )w a se f f e c t i v ea tr e d u c i n gd r i n k i n gi nH I Vp a t i e n t s .A l s ou s i n g m o n i t o r i n g and discussion of drinking data collected through self- monitoring and discussion of drinking data collected through self-monitoring) was effective at reducing drinking in HIV patients. Also using this data, Elliott et al. [2,3] showed that patients’ drinking motives at baseline were associated with both past-year and end-of-treatment results. This data, Elliott et al. [2,3] showed that patients’ drinking motives at baseline were associated with both past-year and end-of-treatment drinking. However, it remains unknown: (a) whether motivational interventions also decreased drinking motives, and (b) whether the predictive validity of motives extended to end-of-study (i.e., 12-months post-baseline). Materials and methods: The sample consisted of 254 HIV-infected patients with past-month heavy drinking (78% male; 94.5% minority), participating in a randomized trial of brief alcohol interventions [1]. Participants completed one of three conditions: (a) a DVD educational control; (b) MI only; (c) MI+HealthCall. Patients reported motives, drinking, and alcohol dependence symptoms at baseline, end-of-treatment, and end-of-study. Results: The intervention conditions evidenced few differences in motives at end-of-treatment (MI+HealthCall evidenced higher drinking due to social pressure, p<0.05), and no differences at end-of-study. However, baseline motives remained predictive of drinking at end-of-study (drinking to cope with negative affect associated with more past-month drinks and dependence symptoms, ps<0.05; drinking due to social pressure with fewer drinks, p<0.01). Conclusions: Although MI+HealthCall reduces drinking, it does not reduce drinking motives. Individuals participating in MI+HealthCall were more likely to transition to drinking due to social pressure, an indicator of lower-risk drinking (2). However, motives (particularly drinking to cope) were predictive of alcohol consumption and dependence up to a year later, suggesting their importance in understanding and predicting drinking. Further work should increase attention to drinking motives in alcohol interventions for HIV patients. Acknowledgements: Financial support for this research was provided by the National Institutes of Health grants R01AA014323, K05AA014223, K23AA027353, and R01DA024606, and the New York State Psychiatric Institute. No conflicts of interest are declared. Trial registration: ClinicalTrials.gov: NCT00371969. References 1. Hasin DS, Aharonovich E, O’Leary A, Greenstein E, Pavlickova M, Arunagadai S, Wainberg M, Hasin DS. Drinking motives among HIV primary care patients. AIDS Behav 2014, 18(7):1315-23. 2. Elliott JC, Aharonovich E, O’Leary A, Wainberg M, Hasin DS. Drinking motives among HIV primary care patients. AIDS Behav 2014, 18(7):1230-40. 3. Elliott JC, Aharonovich E, O’Leary A, Wainberg M, Hasin DS. Drinking motives as prospective predictors of outcome in an intervention trial with heavily drinking HIV patients. Drug Alcohol Depend 2014, 134:290-5.
P8

Implementation of single-item alcohol screening and brief intervention in a primary care clinic in western Colorado

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Background: The U.S. Preventive Task Force recommends screening and brief intervention (SBI) as an effective strategy to address risky alcohol use [1]. Yet, only about 25% of binge drinkers have talked to a health care professional about alcohol use [2]. Perceived lack of time, difficulty implementing SBI protocols into clinic flow, and staff buy-in have been identified as barriers to successful implementation. We conducted a pilot study in a 3-physician primary care practice to evaluate successes and challenges in implementing a simple approach to alcohol SBI in primary care.

Materials and methods: A primary care clinic in Colorado implemented a single-item alcohol screening question. Screening was only implemented among patients who scored negative were provided a brief intervention (SBI) as an effective strategy to address risky alcohol use [1]. Yet, only about 25% of binge drinkers have talked to a health care professional about alcohol use [2]. Perceived lack of time, difficulty implementing SBI protocols into clinic flow, and staff buy-in have been identified as barriers to successful implementation. We conducted a pilot study in a 3-physician primary care practice to evaluate successes and challenges in implementing a simple approach to alcohol SBI in primary care.

Results: Of the 1190 patients with designated appointments types, only 10 (n=10) of patients who scored negative were provided a brief intervention (SBI) as an effective strategy to address risky alcohol use [1]. Yet, only about 25% of binge drinkers have talked to a health care professional about alcohol use [2]. Perceived lack of time, difficulty implementing SBI protocols into clinic flow, and staff buy-in have been identified as barriers to successful implementation. We conducted a pilot study in a 3-physician primary care practice to evaluate successes and challenges in implementing a simple approach to alcohol SBI in primary care.

Conclusions: Results suggest that there are benefits in implementing a single-item screening question for alcohol use. Nonetheless, challenges exist in consistently administering the question and following up on positive screens, and in identifying appropriate resources for referrals, were noted.

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References

P9

“The intervention piece…that’s still the hardest part of it all.”

Enhancing brief intervention skills among public health nurses

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Background: Nurses are likely to encounter opportunities to engage patients in alcohol interventions, yet few have received preparation for this work. Although screening procedures are relatively straightforward and easily utilized by nurse professionals, developing a personalized, brief, and effective response to promote behavior change for indicated cases is a clinical skill that, for many nurses, requires deliberate effort to acquire [1,2]. To support development of alcohol screening and brief intervention (SBI) skills among nurses and implement alcohol SBI as a routine practice, Alaska Public Health Nursing (PHN) collaborated with the Arctic FASD Regional Training Center at the University of Alaska Anchorage.

The objective is to describe ongoing training needs for nurses conducting alcohol SBI.

Material and methods: The university team and PHN leadership jointly planned policies and procedures for alcohol SBI implementation and PHN staff were trained. PHN shared quantitative tracking data and the university team collected qualitative data from contact notes and interviews to assess implementation processes and identify ongoing needs. Findings were iteratively discussed by the university team, presented to PHN leadership, and used to refine processes.

Results: Initial findings revealed nurse confidence and ability to conduct alcohol screening along with nurse hesitation and challenges with conducting brief interventions. The university team identified a need for additional nurse education and provided follow-up training and clinical tools specific to brief intervention skills. Following additional training and practice, nurses reported increased understanding of brief intervention components and importance. Nurses identified clinical tools as helpful resources to support adoption and, over time, nurses demonstrated increased confidence and ability to conduct both screening and brief intervention activities.

Conclusions: With planning, training, and commitment to continuous improvement, PHN staff, public health nurses were able to consistently incorporate alcohol SBI as a new practice. Follow-up training and customized resources proved to be important components for brief intervention skill development among nurses.

Acknowledgments: Authors would like to acknowledge Alaska Public Health Nurses who volunteered to participate the pilot project to implement the routine practice of alcohol SBI.

References
Background: There is a high prevalence of alcohol use among adolescents, especially among Hispanic teens in middle adolescence. This emphasizes the need for developmentally appropriate and culturally sensitive underage drinking brief interventions. Texting (i.e. SMS) is extremely popular among U.S. teenagers, and its advantages as a brief intervention includes wide reach, low cost, easy standardization, automation of health message delivery, and the ability to include multiple recipients concurrently.

Material and methods: We conducted an RCT to examine the effectiveness of preventive text messaging for underage drinking among a sample of predominantly (77.0%) Hispanic youth. Participants (n = 375) were recruited from a large, urban adolescent medicine setting. After completing the baseline intake survey, each participant was randomly assigned to either intervention (i.e. 2 times/week alcohol-related prevention SMS’s for 16 weeks) or control (assessment-only) groups. Follow-up assessments were conducted for all participants at post-treatment and 1-month post-treatment. In the present study, we analyzed baseline data to examine the association between psychosocial risk factors and past month alcohol use.

Results: The sample included females between 12 and 18 years old (M=15.90, SD=1.49). 42% reported lifetime alcohol use and 24% reported past month use. Regression analyses (MPLUS; version 5) revealed that past month alcohol use and future drinking intentions were significantly associated with (a) alcohol availability (β = 0.315 and β = 0.115 respectively), and (b) the CRAFFT (screening tool for substance use risks and consequences; ß = 1.312, ß = 0.174 respectively).

Conclusions: These findings highlight the importance of considering factors such as availability of substances and drinking intentions in the development of underage drinking brief interventions for minority populations.

Acknowledgements: Funding for this research was provided by the Ware Foundation.

Background: The study is focused on prevalence of risky and harmful drinking in Czech adults and on opinions of Czech GPs about the impact of alcohol on health of their patients. Self-assessment of doctors’ effectiveness in reduction of patients’ alcohol consumption was also addressed.

Material and methods: The results presented are based on the National Survey on Tobacco Smoking and Alcohol Consumption (N = 1,802) [1,2] and on a survey of 294 Czech GPs carried out within the ODHIN project [3-4].

Results: Risky or harmful alcohol consumption was found in one in five Czech adults. 34% of respondents reported their doctor asked them about alcohol consumption and 8.6% received advice to reduce or stop drinking. This advice was more common for respondents over 45 years of age. In contrast with this only 22 respondents (1.2%) felt they would need professional help [1,2]. About one third of the sample of Czech GPs considered None or very low drinking as very important for good health. Greater importance doctors attributed to other risk behaviors. The study identified lack of time, lack of professional training and lack of funding for preventive activities as barriers to broader implementation of alcohol consumption screening and brief intervention (SBI). Only 8.5% of GPs reported they were very effective in influencing drinking habits among their patients. 32% subjectively believe their efficiency in this area would be increased with adequate specialized training [3].

Conclusions: Only eight to nine percent of PHC patients receive recommendation to reduce drinking. GPs feel insecure regarding SBI to reduce alcohol consumption in patients, which could be changed if adequately provided. To overcome major barriers of wider implementation of SBI in PHC joint efforts and common interest of GPs, health insurance agencies and the Ministry of Health are needed.

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P13
Discovering SBIRT implementation and training priorities: The National SBIRT ATTC Needs Assessment
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Background: In the summer of 2013, the National Screening, Brief Intervention and Referral to Treatment Addiction Technology Transfer Center (National SBIRT ATTC) launched a national Needs Assessment focusing on the implementation of SBIRT services. The objectives are to the purpose of the Needs Assessment was to assess the current use of SBIRT in various settings, to examine SBIRT implementation models, and to determine training and technical assistance needs.

Material and methods: The target audience for the Needs Assessment was past and present SBIRT grantees, including SAMHSA, NIH, HRSA and other federal organizations. These individuals would be more likely to have the ideal circumstances (i.e., funding) to implement SBIRT, and having had substantial experience implementing SBIRT, would be most able to reflect on SBIRT needs for the future. The National SBIRT ATTC compiled the recruitment list from the database of past and awarded grants with SBIRT as a keyword on grants.gov, filtered for relevance. The final recruitment list was 182 organizations.

The Needs Assessment instrument was developed by members of the National SBIRT ATTC staff and reviewed by several individuals from the Advisory Board. The survey was administered electronically using FluidSurveys. Results: The top three identified areas of need for both training and technical assistance were “Reimbursement and coding for SBIRT,” “Sustainability of SBIRT,” and “Reporting Joint Commission performance measures.” The survey identified the typical respondent as in a University setting and currently funded either by SAMHSA or NIH to conduct training, conduct technical assistance, and/or implementation of SBIRT at a system level.

Conclusions: The Needs Assessment yielded critical information that will be utilized in the development of future National SBIRT ATTC initiatives focused on SBIRT implementation at the systems level, and ultimately increasing the number of settings that are using SBIRT. Future assessments will target other specific populations within the SBIRT community.

P14
Implementing Screening and Brief Intervention in Community Pharmacies to Improve Medication Adherence
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Background: Improving medication adherence across the health care system is a vital component to improving patient outcomes and reducing downstream health care costs. Research suggests that pharmacists can be a highly effective tool for improving medication adherence when equipped with knowledge and skills on conducting adherence screenings and interventions.

The objective of this large scale pharmacy demonstration study is to evaluate the impact of a pharmacy-based intervention on adherence to five chronic medication classes.

Material and methods: 283 pharmacists from a national community pharmacy chain were assigned to the intervention group. Collectively, they screened 29,042 patients for poor adherence risk and provided brief interventions to individuals with an elevated risk. Results from these screenings and interventions were compared to those of a control group consisting of 295 pharmacists who screened 30,454 but did not provide any brief interventions.

Results: Patients in the intervention group significantly improved adherence for all medication classes. Adherence for oral diabetes medications improved 4.8 percent. Adherence for beta-blockers improved 3.1 percent. Additionally there was a significant reduction in per patient annual health care spending for patients taking statins ($241) and oral diabetes medications ($341).

Conclusions: This study demonstrated that interventions are a cost-effective tool that can be applied in health care sites across the country. Furthermore, pharmacists provide a yet untapped source of health care professionals who can perform screening and brief interventions with patients.

P15
Primary care patients with drug use identified by screening self-medicate with alcohol and other drugs for chronic pain
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Background: Chronic pain is common among patients with drug use disorders. The prevalence of chronic pain and its consequences in primary care patients who use drugs is unknown and deserves further study.

The objectives are to determine the prevalence of chronic pain and pain-related dysfunction among primary care patients who screen positive for drug use. To examine the prevalence of substance use to self-medicate chronic pain in this population.

Material and methods: Cross-sectional analysis of adult patients who screened positive for any illicit drug use or prescription drug misuse, recruited from an urban, hospital-based primary care practice. Both pain and pain-related dysfunction were assessed by numeric rating scales, and grouped as: (0) None, (1-3) mild, (4-6) moderate, (7-10) severe. Questions were asked about the use of substances to treat pain.

Results: Among 589 participants, chronic pain was reported by 87%, with 13% mild, 25% moderate and 50% severe. Pain-related dysfunction was reported by 74% of participants, with 15% mild, 23% moderate, and 36% severe. Among those who used marijuana, cocaine, and/or heroin, 51% (283/576) reported using to treat pain. Of the 121 with prescription drug misuse, 81% used to treat their pain. Of the 265 participants who reported drinking any alcohol, 38% did so to treat pain compared to 61% of the 114 with heavy alcohol use.

Conclusions: Chronic pain and pain-related dysfunction were the norm for primary care patients who screened positive for drug use. Almost half of...
these patients reported severe pain and approximately a third reported both severe pain and severe pain-related dysfunction. Many patients using illicit drugs, misusing prescription drugs and using alcohol reported doing so in order to self-medicate their pain. Pain needs to be addressed when patients are counseled about their substance use.

P16
The implementation in Europe (EU) of the drinking guidelines for the Early Identification and Brief Interventions (EBI) for Hazardous and Harmful Alcohol Consumption (HHAC): results from the RARHA survey
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Background: RARHA (REDUCING ALCOHOL RELATED HARM) is a Joint Action (JA) (2014-2016) funded under the EU Health Programme and by EU Member States to address some commonly identified priorities to reduce levels of alcohol related harm in the EU. The work package 5 contributes towards increased understanding among public health policy makers of the scientific basis and practical implications of the use of low risk drinking guidelines as a public health measure. The objectives are to evaluate the presence (or not) of low risk drinking guidelines (GL) or recommendations (R) in Europe on the basis of the existing and available EU documents (Drug and Alcohol Review; WHO additional survey 2012; WHO Status report on alcohol and Health in 35 EU countries; OECD Collection on national drinking guidelines) (1-4) and by additional information based on ad hoc survey across European Union Member States.

Material and methods: A country specific questionnaire has been developed by the National Observatory on Alcohol on confirming the available sources of EU projects or documents and for collecting and/or upgrading information on drinking guidelines used in the context of EBI. The form has been submitted by email to the country representatives of the Committee on National Alcohol Policy and Action as members with qualified experience and competence. Participants have been asked to check the validity of the information provided by the country questionnaire reported as “review of available sources” and to provide the most updated and reliable information for their Country (The survey started on May 2014).

Results: Twenty-nine out of 31 European countries selected (all RARHA associated and collaborating countries + 3 additional countries), replied to the RARHA questionnaire. Twenty countries have a governmental organization responsible for preparing clinical guidelines for managing HHAC, twenty-two countries have multidisciplinary guidelines approved or endorsed by at least one health care professional body or scientific society and 22 countries have guidelines or recommendations for B/treatment.

Conclusions: The collected information represent the scientific basis and practical implications of the use of drinking guidelines as a public health measure. It serves to clarify the science underpinnings and practical/policy implications concerning low risk drinking guidelines, and work towards consensus on good practice principles in the use of drinking guidelines as a public health measure to help reduce HHAC. This activity, finalized to provide a more aligned messages to the general population, subgroups and health professionals, is ongoing (Rarha Delphi survey).

Acknowledgements: WPS Joint Action RARHA team work.

References

P17
The implementation in Europe (EU) of the low risk drinking guidelines: results from the RARHA survey
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Background: RARHA (REDUCING ALCOHOL RELATED HARM) is a Joint Action (JA) (2014-2016) that is funded under the EU Health Programme and by EU Member States to address some commonly identified priorities to reduce levels of alcohol related harm in the EU. The RARHA work package 5 contributes towards increased understanding among public health policy makers of the scientific basis and practical implications of the use of low risk drinking guidelines as a public health measure. The objectives are to evaluate the presence (or not) of low risk drinking guidelines (GL) or recommendations (R) in Europe on the basis of the existing and available EU documents (Drug and Alcohol Review; WHO additional survey 2012; WHO Status report on alcohol and Health in 35 EU countries; OECD Collection on national drinking guidelines) (1-4) and by additional information based on ad hoc survey across European Union Member States.

Material and methods: A country specific questionnaire has been developed by the ONA. The form has been submitted by email to the country representatives of the Committee on National Alcohol Policy and Action (CNAPA) to check the validity of the information provided by the Country questionnaire and to provide the most updated and reliable information for their Country.

Results: Twenty-eight countries have a definition of Standard Drink (SD) expressed as grams of pure alcohol but there isn’t a consensus on how much alcohol is contained in one standard drink. Twenty-two countries have GL or R on low drinking guidelines for daily or weekly consumption and twenty countries have GL or R on binge drinking. Six countries have GL or R specific for the elderly and 15 countries for the youth. The majority of Member States have GL or R for alcohol consumption during pregnancy. In Europe the general drink driving limit is 0.5mg, but there are differences from country to country and in some countries there are specific limitations for young/novice drivers or professional/commercial drivers.

Conclusions: The collected information represent the scientific basis and practical implications of the use of drinking guidelines as a public health measure. It serves to clarify the science underpinnings and practical/policy implications concerning low risk drinking guidelines, and work towards consensus on good practice principles in the use of drinking guidelines as a public health measure to help reduce HHAC. This activity, finalized to provide a more aligned messages to the general population, subgroups and health professionals, is ongoing (Rarha Delphi survey).

Acknowledgements: WPS Joint Action RARHA team work.

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4. OECD Collection on national drinking guidelines (provisional version 19 May 2014).

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