Screening, Brief Intervention & Referral (SBIR)

Presentation provided by
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Canadian Centre on Substance Abuse (CCSA)
Disclosures

No financial or pharma conflict of interest.
Objectives

- Review the genesis of Canada’s SBIR initiative.

- Explore the process of SBIR for various risk categories.

- Critique the approach and discuss practice implementation.
Alcohol SBIR

CCSA and CFPC
Development and Background
Canada’s National Alcohol Strategy

- Led by the Canadian Centre on Substance Abuse.

- Developed a comprehensive, collaborative, stakeholder endorsed set of 41 recommendations:

- Reducing Alcohol Related Harm in Canada: Toward a Culture of Moderation (CCSA 2007)
Alcohol SBIR: NAS Recommendations

- #7 Develop integrated, culturally sensitive screening, brief intervention and referral (SBIR) tools and strategies

- #9 Improve access to addiction services in isolated, rural and remote regions of Canada, and for vulnerable populations.
Development and Implementation

- CCSA contracted Dr. David Brown PhD to develop and pilot test a prototype

- Prototype refined through IT consultants, focus groups and beta testing in conjunction with the College of Family Physicians of Canada (CFPC)

- CFPC now maintains the site, with open access, and have assumed responsibility for further KE activity
Challenges to Primary Care SBIR Uptake

- Need for national Low Risk Drinking Guidelines
- Credible information and endorsement
- Time: seamless inclusion in busy practices
Challenges to Primary Care SBIR Uptake

- Comfort with the process and inclusion of Motivational Interviewing
- Ability to address alcohol abuse and dependency
- Appropriate technology and resources for both the practice and patients

(Lit Review and Practitioner Feedback)
The Site

- College of Family Physicians of Canada, open source [www.sbir-diba.ca](http://www.sbir-diba.ca)
Alcohol SBIR

The site, LRDG and Standard Drinks
Screening, Brief Intervention and Referral

A Clinical Guide

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1. Screening and Assessment
   Identify patients who drink alcohol beyond low-risk consumption levels and further assess their at-risk status based on reported alcohol use and other relevant clinical information.
   - Screen for at risk drinking
   - Determine level of risk

2. Brief Intervention and Referral
   Communicate patient’s risk status, help patient identify goals and readiness to change, make referrals as appropriate.
   - Conduct brief intervention
   - Assess readiness to change
   - Refer to appropriate resources

3. Follow-up and Support
   Follow up with patients, monitor withdrawal symptoms, and review goals and progress.
   - Assess progress towards goals
   - Monitor and manage withdrawal

Canada’s Low-Risk Alcohol Drinking Guidelines

The first-ever pan-Canadian set of drinking guidelines.

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Safer drinking tips

- Set limits for yourself and stick to them.
- Drink slowly. Have no more than 2 drinks in any 3 hours.
- For every drink of alcohol, have one non-alcoholic drink.
- Eat before and while you are drinking.
- Always consider your age, body weight and health problems that might suggest lower limits.
- While drinking may provide health benefits for certain groups of people, do not start to drink or increase your drinking for health benefits.

Organizations officially supporting Canada’s Low-Risk Alcohol Drinking Guidelines:

- Association of Canadian Distillers
- Association of Local Public Health Agencies
- Brewers Association of Canada
- Canadian Association of Chiefs of Police
- Canadian Centre on Substance Abuse
- Canadian Medical Association
- Canadian Paediatric Society
- Canadian Public Health Association
- Canadian Vintners Association
- Centre for Addiction Research of British Columbia
- Centre for Addiction and Mental Health
- College of Family Physicians of Canada
- Council of Chief Medical Officers of Health
- Educa’lcool
- MADD Canada
- Nova Scotia Department of Health and Wellness
- Society of Obstetricians and Gynaecologists of Canada

Reference:

Have feedback? Email alcohol@ccsa.ca
www.ccsa.ca

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Canada’s Low-Risk Alcohol Drinking Guidelines

Drinking is a personal choice. If you choose to drink, these guidelines can help you decide when, where, why and how.

Low-risk drinking helps to promote a culture of moderation.
Low-risk drinking supports healthy lifestyles.
For these guidelines, “a drink” means:

- 341 ml (12 oz.) glass of 5% alcohol content (beer, cider or cooler)
- 142 ml (5 oz.) glass of wine with 12% alcohol content
- 43 ml (1.5 oz.) serving of 40% distilled alcohol content (rye, gin, rum, etc.)

**Your limits**
Reduce your long-term health risks by drinking no more than:

- 10 drinks a week for women, with no more than 2 drinks a day most days
- 15 drinks a week for men, with no more than 3 drinks a day most days

Plan non-drinking days every week to avoid developing a habit.

**Special occasions**
Reduce your risk of injury and harm by drinking no more than 3 drinks (for women) or 4 drinks (for men) on any single occasion.

Plan to drink in a safe environment. Stay within the weekly limits outlined above in Your limits.

**When zero’s the limit**
Do not drink when you are:

- driving a vehicle or using machinery and tools
- taking medicine or other drugs that interact with alcohol
- doing any kind of dangerous physical activity
- living with mental or physical health problems
- living with alcohol dependence
- pregnant or planning to be pregnant
- responsible for the safety of others
- making important decisions

**Pregnant? Zero is safest**
If you are pregnant or planning to become pregnant, or about to breastfeed, the safest choice is to drink no alcohol at all.

**Delay your drinking**
Alcohol can harm the way the body and brain develop. Teens should speak with their parents about drinking. If they choose to drink, they should do so under parental guidance; never more than 1–2 drinks at a time, and never more than 1–2 times per week. They should plan ahead, follow local alcohol laws and consider the Safer drinking tips listed in this brochure.

Youth in their late teens to age 24 years should never exceed the daily and weekly limits outlined in Your limits.
Alcohol SBIR

Menu Orientation
Alcohol Screening, Brief Intervention & Referral
Helping patients reduce alcohol-related risks

Screening, Brief Intervention and Referral
A Clinical Guide
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- Screen for at-risk drinking
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Communicate patient’s risk status, help patient identify goals and readiness to change, make referrals as appropriate.
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3 Follow-up and Support
Follow up with patients, monitor withdrawal symptoms, and review goals and progress.
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Drinking Guidelines
The first-ever pan-Canadian set of drinking guidelines.
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A Clinical Guide

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Canada’s Low-Risk Alcohol Drinking Guidelines
for more information...

The first-ever pan-Canadian set of drinking guidelines.
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Alcohol Screening, Brief Intervention & Referral
Helping patients reduce alcohol-related risks

Overview

Brief Intervention and Review Protocol
Motivational Interviewing
Readiness for Change
Referral

1. Screening and Assessment
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Alcohol SBIR

Screening and Assessment
Screening Alternatives

- Evidence based LRDG’s

- Waiting room screening alternatives:
  1) Primary level AUDIT-C, CRAFFT, or PHQ 4
  2) Secondary level GAINS-SS

- Potential for App and EMR migration of broader lifestyle and mental health screening, with focused intervention.
ALCOHOL SCREENING, BRIEF INTERVENTION & REFERRAL: A CLINICAL GUIDE

This resource provides an overview of a simple 3-step alcohol screening, brief intervention and referral process.

1 SCREENING AND ASSESSMENT
2 BRIEF INTERVENTION AND REFERRAL
3 FOLLOW-UP AND SUPPORT

It incorporates Canada’s Low-Risk Alcohol Drinking Guidelines into your routine alcohol screening.

More details and related resources can be found at WWW.SBIR-DIBA.CA

SCREENING FOR AT-RISK DRINKING

ASK ABOUT ALCOHOL USE

QUESTION 1
DO YOU DRINK BEER, WINE, COOLERS OR OTHER ALCOHOLIC BEVERAGES?

NO
ASK WHY NOT?

- Religious / Cultural
- Family History
- Medications or other issues
- In Recovery

• Explore possible history of trauma
• Refer to health care or community resources

YES
PROCEED TO QUESTION 2 
& QUESTION 3

QUESTION 2
ON A TYPICAL DRINKING DAY, HOW MANY DRINKS DO YOU CONSUME?

WELL
- Reinforce and support continued abstinence
- Review current steps to maintain abstinence

NOT WELL
- Acknowledge that change is difficult
- Support efforts to change and address barriers
- Reevaluate goal and plan to achieve abstinence
- Consider engaging additional or different supports
- Reassess diagnosis: is there a concurrent mental illness?
- Offer support: detox, rehab, community addiction services, medication, etc.
- Refer to health care or community resources as indicated

CALCULATE DRINKS PER WEEK

(days/week X drinks/day)

ARE THE DAILY AND WEEKLY AMOUNTS ABOVE THE LIMITS IN CANADA’S LOW-RISK ALCOHOL DRINKING GUIDELINES?

2 drinks/day
10 drinks/week
3 drinks/day
15 drinks/week

Determine Level of Risk

ELEVATED RISK
Patient drinks at levels above alcohol limits set in Canada’s Low-Risk Alcohol Drinking Guidelines and does not meet the criteria for either Alcohol Abuse or Alcohol Dependence.

ALCOHOL ABUSE*
In the past 12 months, patient’s drinking has caused or contributed to:
- Role failure (i.e., failed work or home obligations)
- Injuries or risk of injuries
- Drinking while driving or operating machinery
- Legal issues (e.g., arrested, charged)
- Relationship issues (e.g., spouse or friends complained about patient’s drinking)
- Does not meet criteria for Alcohol Dependence

ALCOHOL DEPENDENCE*
In the past 12 months, patient’s drinking has caused or contributed to:
- Increased tolerance (i.e., need to drink more to achieve the same effect)
- Withdrawal (e.g., tremors, sweating, nausea or insomnia when trying to quit or cut down)
- Failed attempts to stick to limits
- Failed attempts to cut down or quit
- More time spent anticipating or recovering from drinking
- Less time spent on other activities that had been important or pleasurable
- Continuation of drinking despite problems (e.g., personal, work, social, physical, psychological, and/or legal)


WHAT IS THE PATIENT’S AT-RISK STATUS?

ELEVATED
GO TO STEPS 2-AD & 3-AD

ALCOHOL ABUSE
GO TO STEPS 2-ER & 3-EA

ALCOHOL DEPENDENCE
GO TO STEPS 2-AD & 3-AD

ER
AA
AD

GO TO STEP 3-AD
Canada’s Low-Risk Alcohol Drinking Guidelines
Communicating Alcohol-Related Health Risks

This resource was developed to assist healthcare providers in discussing with their clients the risks of several serious illnesses associated with various levels of alcohol consumption.

Tables 1, 2 and 3 below—taken from the technical, scientific report1 that provided the basis for Canada’s Low-Risk Alcohol Drinking Guidelines2—show changes in the risk for a selected number of serious alcohol-related illnesses based on how many drinks a person consumes on average per day. These estimates were based on an analysis of a comprehensive database of scientific studies commissioned as an internal document by the Centre for Addiction and Mental Health.3

Table 1 summarizes the risks for 12 serious illnesses, including seven types of cancer, which apply equally for both men and women under 70 years of age. Of note from this table:

- Drinking just one drink per day increases, by up to 4.2%, a person’s risk of getting any one of the nine listed conditions identified in yellow. For these nine conditions, a person’s risk rises as the number of drinks consumed per day increases.
- Tuberculosis was the only condition for which there was no significant change in risk until a particular ‘threshold’ drinking level (namely, at three or more drinks per day).
- A person is 14–19% less likely to get ischemic heart disease when drinking up to 3–4 drinks per day, with zero risk at 5–6 drinks per day and increased risk with greater consumption.

Table 1. Percentage changes in risks for males and females of premature death from 12 alcohol-related illnesses according to typical daily alcohol intake

<table>
<thead>
<tr>
<th>Type of Illness or Disease</th>
<th>Proportion of All Deaths, 2002–2005</th>
<th>Percentage Increase/Decrease in Risk</th>
<th>1 Drink</th>
<th>2 Drinks</th>
<th>3–4 Drinks</th>
<th>3–5 Drinks</th>
<th>+ 6 Drinks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>1 in 2,500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1.94</td>
<td>-1.94</td>
<td>-1.94</td>
</tr>
<tr>
<td>Oral cavity &amp; pharynx cancer</td>
<td>1 in 200</td>
<td>-42</td>
<td>-0.06</td>
<td>-1.07</td>
<td>-3.83</td>
<td>-4.07</td>
<td>-4.07</td>
</tr>
<tr>
<td>Oral esophagus cancer</td>
<td>1 in 150</td>
<td>-20</td>
<td>-0.43</td>
<td>-0.87</td>
<td>-3.64</td>
<td>-3.67</td>
<td>-3.67</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>1 in 40</td>
<td>-3</td>
<td>-0.5</td>
<td>-1.13</td>
<td>-4.08</td>
<td>-4.08</td>
<td>-4.08</td>
</tr>
<tr>
<td>Rectum cancer</td>
<td>1 in 200</td>
<td>-5</td>
<td>-1.0</td>
<td>-1.18</td>
<td>-4.30</td>
<td>-4.30</td>
<td>-4.30</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>1 in 200</td>
<td>+10</td>
<td>+0.21</td>
<td>+0.38</td>
<td>+0.90</td>
<td>+0.90</td>
<td>+0.90</td>
</tr>
<tr>
<td>Larynx cancer</td>
<td>1 in 500</td>
<td>+21</td>
<td>+0.47</td>
<td>+0.95</td>
<td>+3.99</td>
<td>+3.99</td>
<td>+3.99</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>1 in 13</td>
<td>-19</td>
<td>-0.18</td>
<td>-0.14</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1 in 1,000</td>
<td>+19</td>
<td>+0.41</td>
<td>+0.81</td>
<td>+1.92</td>
<td>+1.92</td>
<td>+1.92</td>
</tr>
<tr>
<td>Dysthymias</td>
<td>1 in 250</td>
<td>-3</td>
<td>-0.17</td>
<td>-0.54</td>
<td>-1.02</td>
<td>-1.02</td>
<td>-1.02</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>1 in 750</td>
<td>-3</td>
<td>-0.22</td>
<td>-0.44</td>
<td>-1.33</td>
<td>-1.33</td>
<td>-1.33</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>1 in 1,000</td>
<td>0</td>
<td>0</td>
<td>0.29</td>
<td>-0.64</td>
<td>-2.07</td>
<td>-6.05</td>
</tr>
</tbody>
</table>

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Tables 2 and 3 present separate risk estimates for males and females for conditions where these are significantly different. Of note from the estimates in these tables:

- At the lower levels of alcohol consumption, women experience greater benefits for some conditions such as stroke and diabetes (in green). However, with increasing alcohol intake, women's risk for these conditions increases more rapidly than that of men.
- At even one drink per day on average, a woman's risk of getting liver cirrhosis increases by 139% compared with 26% for males.
- The risk levels from drinking for all the listed illnesses are also significant for persons 70 years of age or older, with similar patterns of protection and increased risk.

Table 2. Percentage changes in risks for men of premature death from five alcohol-related illnesses according to typical daily alcohol intake

<table>
<thead>
<tr>
<th>Type of Illness or Disease</th>
<th>Proportion of All Deaths, 2002-2005</th>
<th>Percentage Increase/Decrease in Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Zero or Decreased Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1% to -24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-25% to -50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to +49%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+50% to 99%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+100% to 199%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Over +200%</td>
</tr>
<tr>
<td>Hemorrhagic stroke (morbidity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhagic stroke (mortality)</td>
<td>1 in 30</td>
<td>-10%</td>
</tr>
<tr>
<td>Ischemic stroke (morbidity)</td>
<td></td>
<td>-13%</td>
</tr>
<tr>
<td>Ischemic stroke (mortality)</td>
<td>1 in 80</td>
<td>-13%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1 in 30</td>
<td>-12%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1 in 150</td>
<td>-13%</td>
</tr>
<tr>
<td>Liver cirrhosis (morbidity)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver cirrhosis (mortality)</td>
<td>1 in 90</td>
<td></td>
</tr>
</tbody>
</table>

* Note: Rehm and colleagues (2010) estimate reduced risk of liver cirrhosis morbidity at these levels of consumption (at one or two drinks per day). Given that there is no known biological reason for such a result, the relative risk has been artificially put at zero.
Table 3. Percentage changes in risks for women of premature death from five alcohol-related illnesses according to typical daily alcohol intake

<table>
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<tr>
<th>Type of Illness or Disease</th>
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<th>Percentage Increase/Decrease in Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Drink</td>
<td>2 Drinks</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>1 in 49</td>
<td>-13%</td>
</tr>
<tr>
<td>Hemorrhagic stroke (morbidity)</td>
<td>-</td>
<td>-9%</td>
</tr>
<tr>
<td>Hemorrhagic stroke (mortality)</td>
<td>1 in 20</td>
<td>-22%</td>
</tr>
<tr>
<td>Ischemic stroke (morbidity)</td>
<td>-</td>
<td>-13%</td>
</tr>
<tr>
<td>Ischemic stroke (mortality)</td>
<td>1 in 66</td>
<td>-34%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1 in 30</td>
<td>-34%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1 in 85</td>
<td>-13%</td>
</tr>
<tr>
<td>Liver cirrhosis (morbidity)</td>
<td>-</td>
<td>-21%</td>
</tr>
<tr>
<td>Liver cirrhosis (mortality)</td>
<td>1 in 160</td>
<td>-130%</td>
</tr>
</tbody>
</table>

* Each cause of death in the above tables is reported in the second column as a proportion of total deaths for four years from 2002–2005, using Statistics Canada data.

Other conditions caused by alcohol includes:
- alcohol dependence syndrome (alcoholism)
- alcoholic psychosis
- nervous system degeneration due to alcohol
- alcoholic polyneuropathy, myopathy and cardiomyopathy
- alcoholic gastritis
- alcoholic liver diseases and hepatitis
- alcohol-induced pancreatitis
- fetal alcohol spectrum disorder
- alcohol toxicity and poisoning

References


Canadian Centre on Substance Abuse
Centre canadien de lutte contre l’alcoolisme et les toxicomanies
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ASK ABOUT ALCOHOL USE

DO YOU DRINK BEER, WINE, COOLERS OR OTHER ALCOHOLIC BEVERAGES?

NO

ASK WHY NOT?

Yes

PROCEED TO QUESTION 2 & QUESTION 3

ON A TYPICAL DRINKING DAY, HOW MANY DRINKS DO YOU CONSUME?

WELL

REINFORCE AND SUPPORT CONTINUED ABSTINENCE

REVIEW CURRENT STEPS TO MAINTAIN ABSTINENCE

NOT WELL

ACKNOWLEDGE THAT CHANGE IS DIFFICULT

SUPPORT EFFORTS TO CHANGE AND ADDRESS BARRIERS

RENEGOTIATE GOALS AND PLANS TO ACHIEVE ABSTINENCE

CONSIDER ENGAGING ADDITIONAL OR DIFFERENT SUPPORTS

NECESSITY DIAGNOSIS: IS THERE A CONCURRENT MENTAL ILLNESS?

OFFER SUPPORT: DETOX, DETOX, REHAB, COMMUNITY ADDICTION SERVICES, MEDICATION, ETC.

REFER TO HEALTH CARE OR COMMUNITY RESOURCES AS INDICATED

CALCULATE DRINKS PER WEEK

(days/week x drinks/day)

ARE THE DAILY AND WEEKLY AMOUNTS ABOVE THE LIMITS IN CANADA’S LOW-RISK ALCOHOL DRINKING GUIDELINES?

2 drinks/day

10 drinks/week

3 drinks/day

15 drinks/week

WHAT IS THE PATIENT’S AT-RISK STATUS?

ELEVATED

GO TO STEPS 2-AD & 3-AD

ALCOHOL ABUSE

GO TO STEPS 2-ER & 3-ER

ALCOHOL DEPENDENCE

GO TO STEPS 2-AD & 3-AD

NEW!

ALCOHOL SCREENING, BRIEF INTERVENTION & REFERRAL: A CLINICAL GUIDE

This resource provides an overview of a simple 3-step alcohol screening, brief intervention and referral process.

1 SCREENING AND ASSESSMENT

2 BRIEF INTERVENTION AND REFERRAL

3 FOLLOW-UP AND SUPPORT

It incorporates Canada’s Low-Risk Alcohol Drinking Guidelines into your routine alcohol screening.

More details and related resources can be found at WWW.SBIR-DIBA.CA

ELEVATED RISK

Patient drinks at levels above alcohol limits set in Canada’s Low-Risk Alcohol Drinking Guidelines and does not meet the criteria for either Alcohol Abuse or Alcohol Dependence.

ALCOHOL ABUSE

In the past 12 months, patient’s drinking has caused or contributed to:

• Role failure (e.g., failed work or home obligations)
• Injuries or risk of injuries
• Drinking while driving or operating machinery
• Legal issues (e.g., arrested, charged)
• Relationship issues (e.g., spouse or friends complained about patient’s drinking)
• Does not meet criteria for Alcohol Dependence

ALCOHOL DEPENDENCE

In the past 12 months, patient’s drinking has caused or contributed to:

• Increased tolerance (i.e., need to drink more to achieve the same effect)
• Withdrawal (e.g., tremors, sweating, nausea or insomnia when trying to quit or cut down)
• Failed attempts to stick to limits
• Failed attempts to cut down or quit
• More time spent anticipating or recovering from drinking
• Less time spent on other activities that had been important or pleasurable
• Continuation of drinking despite problems (e.g., personal, work, social, physical, psychological, and/or legal)

Alcohol SBIR

Brief Intervention and Referral
Factors Related to Improvement

- Relationship 30%
- Expectancy 15%
- Technique 15%
- Extra-Therapeutic 40%

(Asay & Lambert 1999)
Stages of Change

- Pre-contemplation
- Contemplation
- Planning
- Action
- Maintenance
- Relapse
- Success

(Prochaska & DiClemente, Transtheoretical Model of Change)
A Motivational Approach

• Start wherever the person is at: acknowledge their reality

• Roll with resistance

• Avoid arguments or a power struggle

• Be persuasive, not confrontational or abusive (From Miller)
CONDUCTING A BRIEF INTERVENTION

BRIEF INTERVENTION FOR ELEVATED RISK

STEP 2 ER

ADVERTISE AND ASSIST
Advise patient of at-risk status
Advise cutting down to low-risk drinking
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO

- Restate your concern
- Encourage reflection
- Address barriers to change
- Reassure your willingness to help

GO TO STEP 3 ER

YES

- Help set a goal
- Agree on a plan
- Provide educational materials
- Refer to health care or community resources

GO TO STEP 3 AA

BRIEF INTERVENTION FOR ALCOHOL ABUSE

STEP 2 AA

ADVERTISE AND ASSIST
Advise patient of at-risk status
Advise abstinence or cutting down
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO

- Restate your concern
- Provide follow-up and support
- Go to Step 3 AA

YES

- Negotiate a goal and develop a plan
- Refer to health care or community resources

GO TO STEP 3 AD

BRIEF INTERVENTION FOR ALCOHOL DEPENDENCE

STEP 2 AD

ADVERTISE AND ASSIST
Advise patient of at-risk status
Advise abstinence with medication support
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO

- Confirm your support
- Monitor for withdrawal
- Prescribe appropriate medications (but be careful with potential for drug abuse)
- Refer to health care or community resources

GO TO STEP 3 AD

YES

- Restate your concern
- Provide follow-up and support
- Go to Step 3 AD

FOLLOW UP AND SUPPORT FOR ELEVATED RISK

STEP 3 ER

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

- Acknowledge that change is difficult
- Support efforts to change and address barriers.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

YES

- Reinforce and support continued adherence to recommendations.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

FOLLOW UP AND SUPPORT FOR ALCOHOL ABUSE

STEP 3 AA

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

- Acknowledge that change is difficult
- Support efforts to change and address barriers.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

YES

- Reinforce and support continued adherence to recommendations.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

FOLLOW UP AND SUPPORT FOR ALCOHOL DEPENDENCE

STEP 3 AD

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

- Acknowledge that change is difficult
- Support efforts to change and address barriers.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

YES

- Reinforce and support continued adherence to recommendations.
- Coordinate care with involved specialists.
- Maintain medications for alcohol dependence at least three months or longer.
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually

For these guidelines, “a drink” means:

- 341 ml (12 oz) glass of 5% alcohol content (beer, cider or cooler)
- 142 ml (5 oz) glass of wine with 12% alcohol content
- 43 ml (1.5 oz) serving of 40% distilled alcohol content (vodka, gin, rum, etc.)

Adapted with permission from:

Brief Intervention, Follow up and Support for Elevated Risk
BRIEF INTERVENTION FOR ELEVATED RISK

ADVISE AND ASSIST
Advise patient of at-risk status
Advice cutting down to low-risk drinking
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO
• Restate your concern
• Encourage reflection
• Address barriers to change
• Reaffirm your willingness to help

YES
• Help set a goal
• Agree on a plan
• Provide educational materials
• Refer to health care or community resources

GO TO STEP 3-ER
FOLLOW UP AND SUPPORT FOR ELEVATED RISK

STEP 3 ER

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

- Acknowledge that change is difficult
- Support efforts to change and address barriers.
- Renegotiate goal and plans: consider a trial of abstinence
- Consider engaging additional or different social supports
- Reassess diagnosis if patient is unable to either cut down or abstain.

YES

- Reinforce and support continued adherence to recommendations
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking)
- Encourage to return if unable to maintain adherence
- Rescreen at least annually
Brief Intervention, Follow up and Support for Alcohol Abuse
BRIEF INTERVENTION FOR ALCOHOL ABUSE

STEP 2

ADVISE AND ASSIST
Advise patient of at-risk status
Advise abstinence or cutting down
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO
• Restate your concern
• Provide follow-up and support
• Go to Step 3-AA

YES
• Negotiate a goal and develop a plan
• Refer to health care or community resources

GO TO STEP 3-AA
FOLLOW UP AND SUPPORT FOR ALCOHOL ABUSE

STEP 3

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

- Acknowledge that change is difficult
- Support efforts to change and address barriers.
- Renegotiate goal and plans: consider a trial of abstinence
- Consider engaging additional or different social supports
- Reassess diagnosis if patient is unable to either cut down or abstain.
- Address co-existing physical and mental health conditions
- Refer as needed

YES

- Reinforce and support continued adherence to recommendations
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or an abstaining patient wishes to resume drinking)
- Encourage to return if unable to maintain adherence
- Rescreen at least annually
Brief Intervention, Referral, Follow up and Support for Alcohol Dependency
ADVISE AND ASSIST

Advise patient of at-risk status
Advise abstinence with medication support
Assess patient's stage of change
Engage in motivational interviewing

IS PATIENT READY TO CHANGE?

NO
- Restate your concern
- Provide follow-up and support
- Go to Step 3-AD

YES
- Confirm your support
- Monitor for withdrawal
- Prescribe appropriate medications (but be careful with potential for drug abuse)
- Refer to health care or community resources

GO TO STEP 3-AD
FOLLOW UP AND SUPPORT FOR ALCOHOL DEPENDENCE

STEP 3

WAS PATIENT ABLE TO MEET AND SUSTAIN DRINKING GOAL?

NO

• Acknowledge that change is difficult
• Support efforts to change and address barriers.
• Relate drinking to existing health/social problems as appropriate
• Consider engaging additional or different social supports
• Consider prescribing medication for alcohol dependence
• Refer as needed
• Address co-existing physical and mental health conditions

YES

• Reinforce and support continued adherence to recommendations
• Coordinate care with involved specialists
• Maintain medications for alcohol dependence at least three months or longer
• Encourage to return if unable to maintain adherence
• Follow-up regularly
• Renegotiate goals as needed
• Address concurrent disorders
• Rescreen at least annually
Objectives Accomplished

- Review the genesis of Canada’s SBIR initiative
- Explore the content and format
- Critique the approach
References & Recommended Reading

• American Society of Addiction Medicine, www.ASAM.org

• Canadian Society of Addiction Medicine, www.CSAM-SMCA.org

• Canadian Centre on Substance Abuse, www.CCSA.ca

• National Institute of Drug Abuse, www.NIDA.org

• National Native Addiction Partnership Foundation, www.nnapf.org

• Wellbriety Movement, www.whitebison.org

• Mate, Gabor. In The Realm of Hungry Ghosts. A.A.Knopf Canada. 2008