Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

July 23, 2015, 1-2:30 p.m. (ET)

"Alcohol Misuse in the Military: Screening Brief Intervention and Referral to Treatment"

Good afternoon and thank you for joining us today for the DCoE Psychological Health July webinar. My name is Dr. Vladimir Nacev. I'm a clinical psychologist and a senior program manager for the Deployment Health Clinical Center at the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. I will be your moderator for today's webinar on Alcohol Misuse in the Military, specifically screening brief, intervention, and referral to treatment.

Before we begin, let us review some webinar details. Live closed captioning is available through Federal Relay Conference. For Relay conference captioning, please see the pod beneath the presentation slides. Should you experience any technical difficulties, please visit dcoemil/webinars and click on the troubleshooting link under the monthly webinars heading. There may be an audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with the speaker's comments.

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I will now move to today's webinar topic, Alcohol Misuse in the Military: Screening, Brief intervention, and Referral to Treatment, or also known as SBIRT.

According to the Department of Defense 2011 Health-Related Behavioral Survey, approximately 33% of active duty service members reported binge drinking in the past 30 days, higher than the civilian estimated 27%. Several interventions for alcohol use exist, but many of these approaches are too intense for substance threshold alcohol misuse.

The Screening, Brief Intervention, and Referral to Treatment model promoted by the U.S. Preventative Services Task Force in 2013 is a comprehensive integrated public health approach to the delivery of early intervention and treatment services to persons with alcohol use disorders. The SBIRT model enables

health-care professionals to systematically screen patients with the goal of preventing the negative effects of alcohol use among service members and beneficiaries.

During this webinar, participants will; one, discuss policy and clinical issues related to alcohol use disorders in the military health system; two, identify and differentiate between alcohol use disorders; and, three, learn a comprehensive approach for screening brief intervention and referral to treatment for alcohol misuse in primary care settings.

I would now like to introduce our presenter. United States Public Health Commander David S. Barry is a clinical psychologist currently with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. He currently serves as the implementation division chief at the Deployment of Health Clinical Center overseeing a practical-based implementation network to rapidly translate research findings across DoD treatment facilities and of screening brief intervention and referral to treatment implementation pilot program that addresses problematic alcohol use in the DoD.

While at DCOE Commander Barry also served as a subject matter expert on alcohol and substance misuse contributing to the DoD report to Congress on substance use and the DoD instruction, which improved the delivery of care and military mission readiness. Commander Barry has over ten years of experience in the psychological health field. As a clinician and program director, he previously served as U.S. Public Health Service officer at MacDill Air Force Base. Welcome, Commander Barry.

Thank you, Dr. Nacev. I'm going to read my disclosure, but I have no relevant financial relationships to disclose, and the views expressed in this presentation are those of myself and do not reflect the official policy of the Department of Defense, and I do not intend to discuss any off-label or unapproved use of commercial products or devices. Trying to get -- the clicker's not working. There with we go. Okay.

So Dr. Nacev read through the objectives that we're going to accomplish today, so I first I'd like to just get into it. But before I get into the meat of what we're going to be discussing I just want to put a disclaimer out there that we're going to be primarily focusing on alcohol during this webinar today. We will not be addressing illicit drugs, nor will we be addressing prescription misuse. I'll get into a little bit of the reasons why we'll be going through that down the road but primarily the prevalence rate for alcohol use in the military is problematic, but also illicit drugs and prescription misuse is not supported by the SBIRT model.

During this presentation today, in this webinar, we're going to look at problematic alcohol use. We're going to define that. We're going to look at alcohol use in the military. We'll talk about the prevalence, special considerations, emphasis on intervention, and that will lead us up to discussing about screening, brief intervention, and referral to treatment, which from now hence I'll call it SBIRT.

We'll also talk about an SBIRT implementation pilot that we are working on from the Defense Centers of Excellence. We will talk about the overview of that pilot, some of the implementation challenges, but also some basic workflows and practices and best practices also evidenced from the civilian sector that we are using to back up our SBIRT pilot. And then at the end we'll leave some time for questions and answers.

So, starting off, we're going to just talk basically about problematic alcohol use. I know in the objectives we talked about maybe differentiating between disorders, but as I was finalizing this report, I thought maybe staying away from specific disorders would be a little bit more on point, because I don't want to get caught up on what is in DSM-4 and what is in DSM-5.

For the real reason is that we want to make sure that we are focusing on individuals that are engaging on alcohol use that may be harmful, and the real distinction between, to my opinion, of where you start to get into a disorder is when the alcohol use is clinically and functionally leading to significant impairments. That's role functioning with health. That's issues with roles and their ability to meet demand at school, work, and at home, and I think that's one of the bigger distinctions you're going to get between somebody who is engaging in problematic alcohol use and somebody who is meeting the criteria for a diagnosis.

And everything we're going to be going through today will be relevant to those that do meet diagnostic criteria, whether you're using DSM-4 or DSM-5 criteria, but one of the goals of SBIRT, one of the main themes that I want to touch upon throughout this webinar is intervening with individuals and recognizing problematic alcohol use before it gets to the point of a diagnosis and helping recognizing some warning signs, but also looking at different ways that we could educate and intervene with our patients, colleagues, co-workers, family member in a meaningful way before it gets to the point of having role-functioning impairment. That's why I'm going to focus much more on definitions of problematic alcohol use and not necessarily the traditional or current diagnoses that are out there.

So if we're looking at this slide for purposes of today and there are different ways of looking at it, but I like the one from the Centers of Disease Control, the CDC, heavy drinking is consuming, on average, two or more drinks per day. And also from the CDC, but this is also in NIAAA and a couple of other reputable organizations, binge drinks is consuming five or more drinks for men or four or more for women during a typical drinking period; that is one day, same day, over this single occasion.

And another way of looking at it is that this drinking during this period brings your blood alcohol content over .08 percent, which, in many states, is the legal limit. Some states it's less. Federal property is also less than that. And usually this is -- somebody who's binge drinking is doing this under a shorter period of time, but that two-hour period is by the CDC. But other definitions brought it into a greater time period.

So what is low-risk drinking? Low-risk drinking, according to NIAAA -- and I'll be saying that several times today, but that is NIH subsidiary called the National Institute on Alcohol Abuse and Alcoholism, and they look at the following limits as the boundary between low-risk drinking and those that may be at risk for problematic alcohol use. And for men, that is four or more drinks on a day. Women that is less, it's three or more. And the differentiation is the way we metabolize and hold alcohol within our body. And then per week for men it's no more than 14 drink, and for women, no more than 7 drinks.

Like I said before, there are many other definitions out there about alcohol use. Some are much more strict. Some are much more lenient. But this seems to be one that's widely accepted and has the evidence base behind it.

So things that could contribute to alcohol risky drinks or going beyond this is the rate of consumption, ongoing medical problems or medications. So if you're using Benzodiazepine or opiates, that is something you're going to have a drug-drug interaction, that should be very concerning; tolerance, and age. And I will get to a little later about some other considerations when we're talking about the SBIRT model itself.

So one thing to also note is that although this doesn't come into the patterns here, and it's a good side note to mention that if we have a male who is drinking four drinks in one sitting or one setting, that's not necessarily going to be going beyond this low-risk drinking pattern. But it should be noted that if this male is drinking all four drinks at one time; meaning that let's say they have one big Long Island iced tea and they put four shots of alcohol in there and they chug it, that's going to have more detrimental effects on your body than it would if you expand that over a period of time.

So this slide, to me, is probably going to be -- and the next slide, is going to be one of the most important things that I want you to take home from here. Not all drinks are created equal, and I'm sure many of you that are listening in today have been treated at MTS. And this point is incredibly important, for the reason is, what I define as a drink may not be the same as what my patient defines as a drink.

Using the picture here, one pint of beer does not equal one bottle of beer. And even that in itself, one is 16 ounces versus one is 12 ounces, is not as simple as just comparing the two, because different beers, especially nowadays, you have your microbrews and you have your Belgium imports, the alcohol content for a single beer can be 9 or 10%, which is very high for a beer.

So, when we are treating our patients, it's important to ask the question -- and I retrospectively want you to look back in your lives and retrospectively answer this question to yourself -- when you go see your

MTF provider, or any provider there, and a tech or the doc asks you the question, "Do you drink alcohol, yes, or no," do they also follow up with the question of "What does alcohol mean to you or what do you define, more importantly, as a drink?" Because that is not the question that's normally asked.

I may define a drink, for me, as a 12 ounce beer at 5% alcohol -- let's just say a Bud or Coors -- where somebody else may define a single drink as a Long Island iced tea, which, at that point, could be the equivalent of two-and-a-half drinks. So if you have a patient in front of you that defines a drink as that Long Island iced tea and they say they only have two drinks a couple days a week, well, compared to the beer, they're actually having more along the lines of maybe five or more drinks per occasion, because of the alcohol content. So it's really important to be asking that question. And when you are doing this, make sure you're doing it with the patients and asking the question in an open-ended manner.

So that brings me to the next question or the next point, is what is a standard drink? A standard drink is any drink that contains 14 grams of pure alcohol. That's about a little over a half an ounce of liquid, or to put it a different way, 1.2 tablespoons. So your glass of wine is typically five ounces for a drink. That's 12% alcohol. You're going to be having a shot, whether it's whisky or something, that would be 80 proof or 40% alcohol, that's 1.5 ounces, and the average beer is 12 ounces at 5% alcohol.

Now many beers, if you go to a bar, you're getting 16 ounces or maybe you're getting a tall of 20 ounces, or you're getting something with a much higher alcohol content. So when you're drinking for yourself or when you're interacting with your patients, what we define as a drink and what is a standard drink to a patient is very different, and that needs to be included in the context of with a patient, and that is often a question that is frequently missed. I think the clicker's batteries might be going.

So I know, you know, when I say if I told you alcohol had detrimental effects on an individual, everybody would be saying, "Of course it does." I mean, I don't think there's any one individual that would disagree and say, "No, alcohol is really good for you across the board." And that is even despite the research that shows out there that, hey, alcohol, having some red wine may be good for this or good for that. But, generally speaking, alcohol, especially if you're engaging in problematic alcohol use, is not good for you.

So talking about just some general health issues, and we could spend the remainder of the time just talking about the detrimental effects of alcohol on the body, but some basic health problems we are very familiar with are liver disease, cancers -- stomach, throat. Also, a lot of heart problems can be aggravated by alcohol use. Alcohol is a depressant. And not only does it depress our mood in some regards but it also depresses our biological systems, and that has negative effects.

In regards to personal injuries, DUIs are way up there on the list in regards to dangerous and how individuals are passing away or causing harm to others, and there's quite a few injuries. I know one individual, when I was running a substance abuse program, they drank alcohol. They occasionally engaged in binge drinking, and the way they self harmed themselves was they accidentally fell off a terrace on a third-floor building, and fortunately for them, they fell on some bushes. But a few broken bones and soft-tissue damage later, it wasn't as much fun drinking alcohol as it was before that. So alcohol is one of the leading contributors to accidents.

And alcohol, according to the World Health Organization in their 2014 Global Assessment, alcohol contributes to about 6% of deaths worldwide. It's the fourth leading cause of preventable deaths in the United States, so quite a few individuals that do fall off their terraces, or their proverbial terraces, some do not make it. This individual was lucky, this airman, but many are not, and this is something that could be very much avoided, especially with regards to DUIs, and the loss of life to those that are the victims of DUIs.

So another thing that should be pointed is that alcohol is expensive, and I'm not necessarily talking about the price at store. The cost of alcohol on the American public is very large for a variety of reasons. One, because we're dealing with DUIs and we're dealing with the legal ramifications of DUIs, which can be pricey. We're talking about loss of life. We're talking about loss of time away from employment. But we're also talking about the cost of treatment. So if an individual does have alcohol issues and does require

treatment, the number of bed days that a person is going to be at a treatment facility is very large compared to normal maladies. So a 28-day treatment program, where somebody is in resident is much longer than you would see for other individuals that may be staying at treatment programs or within a hospital setting. So that money does add up, and in regards to injuries, the number one reason why DUIs and injuries, and the costs that are associated with that, is with the binge drinking.

So this brings us to our first polling question. Which population engages in more problematic drinking behaviors? So our results right now, we have is 72% of you that responded have the military population as the higher level, and 28%-ish is talking about the civilian population.

So I'll answer this question a little bit more up front, coming when we start talking about prevalence and comparing military versus civilian. But the short answer is, general rule or generally speaking when you're looking at prevalence, the military rate is significantly higher than the civilian population.

So, going into alcohol prevalence, so substance abuse is a leading health problem, and we're looking at the DSM-4 diagnosis for this specific bullet where the information was pulled from. 22.5 million Americans with substance abuse dependence last year, and this is in 2008. 15.4 million Americans abuse alcohol; 3.9, illicit drugs; 3.2 use alcohol and drugs. So 7.1% of veterans meet past criteria of substance use disorder, versus 4.7 in civilian population meeting this criteria.

Now I do want to point out you can be looking at this is 2008, and this data is old now we're in 2015. However, the differences between the civilian and military population do remain about the same, and I think this is a good illustration of the differences between the two populations. We could also look at, below, the civilian rate for heavy drinking is 5.1%, and the civilian rate for binge drinking is 15.6%. That's also at that same timeframe. But that's compared to a previously 20% rate with active duty for binge drinking.

And I'm going to just take a little side note here, and we will get back to prevalence rates again in a few slides from now. But first I wanted to just talk about alcohol use in the military a little bit and the implications for the military, and some implications for the providers.

So implications for military is problematic. You know, substance use takes an individual away from their unit. It takes them away from their fellow battle buddies, airmen, wingmen, and it disrupts military mission readiness. Alcohol misuse also impacts service member welfare, their ability to meet military mission requirements. It impacts their ability to meet social requirements to be able to be home, to be able to be there for their family, to be able to take care of their own financial interests. So alcohol has significant impacts on the military and the service member that can really impair the overall mission for us to be ready for any contingency or readiness for deployment.

The implications for providers are, you know, they're looking at the context of treatment. There is a lot of things that we need to consider with alcohol. And if we're not necessarily considering it, we may miss diagnoses, or we may miss critical points that we wanted to touch upon in our treatment planning.

So alcohol use in the military, according to the most recent behavioral health survey that was published in 2013, but speaks to 2011 data, identifies alcohol consumption as remaining a huge concern for the DoD. And if you're looking at the surveillance data, in 2010 versus 2001/2002, the number of individuals requiring treatment or having medical encounters for alcohol has increased by 50%. Looking at the DoD in the most recent behavioral health surveys, and I'll get this a little bit further on, 9% of service members drink heavily and approximately one-third of active duty service members binge drink. That means they drink over that five period or four amounts in a single period in at least once over a 30-day period.

So this brings us to our second polling question, which service branch has the highest rate of binge drinking? So do they see the results? Okay, so right now we have the Army in the lead, followed up by the Marines, then the Navy and the Air Force. And close, but no cigar. But I'm going to answer this in -- not right now. As we go through the next slides the answer will become a little bit more apparent. So we're looking at the next slide. There we go.

So looking at the next slide, this is also old data, but what I like about it, for the purposes of today, and the next several slides, will come from the National Defense Authorization Act from 2010, Section 596. Why I chose to keep these slides in here is because it shows a nice illustration of the uptick, and from year to year, about where we're drinking and the percentages of how things are going.

So the first one we have here is the trend of substance use disorders in active duty. The next one is the trend of substance use disorders as well. This is for drug-related disorders. I know most of our folks think alcohol, but I thought this was something that would be interesting to show.

Once again, though, I want to point out that, although you can could see a trend here, and if you're looking at the far-left hand corner, left side, it's the number of individuals here are less, and that this is still a significantly smaller rate compared to the civilian sector.

So looking at our reserve component, you also see a similar trend. And there's also, although less, a trend with the dependence as well. So I'm going to get into this. So right now, those that did the polling questions that have Army as you one with the highest -- service with highest amount of binge drinking is -- you might think that you're -- thinking that your choices are correct right now, but I'm going to get into that and show that, actually, the army comes in second with regards to binge drinking, and the Marines have, actually, taken over in regards to percentage of alcohol use.

So looking at this slide here, this is also from the Behavioral Health Survey in 2013, and this, over here, just showing the overall DoD percentages of infrequent drinkers, moderate drinkers, heavy, and those that don't drink. So talk about drinking classification levels for all services, the Marines have the higher rate at 15.5% for heavy drinkers, and that is greater than what you would compare to other services, which are lower percentages.

But getting into the binge drinking question, so the overall civilians is 28.3% rate for binge drinking. For the Marines, according to the most recent survey, 48.2% of Marines actually engage in bing drinking, which is a significantly higher number than the civilian rate. The Army is also higher, with 32.2%, and the Navy is 36.1%. And as your polling questions indicated, the Air Force is actually the lowest, and their numbers come below the civilian rate at 22.7%.

So what are some of the risk factors for problematic drinking? There's several different socio-demographic variables that we could look into and that are pretty common across many behavioral health diagnoses or behavioral health service issues, and that would be what service branch you're coming from, what's your gender, your race and ethnicity, education, marital status, and age.

And it should also be noted that a problematic drinking risk factor is deployment. Those that have been in deployment and experienced combat-related traumas and deployment-related psychological stress, and deployment-related psychological stress, from this article that's cited here, does not necessarily mean that you are under fire or you were actually in a fire base and actually saw engagement. It is just what the individual defines as psychological stress related to the deployment. So those individuals that had these experiences did have a higher rate of alcohol use and problematic alcohol use upon return to the states.

So the following information that will pop up there shortly is also from the 2013 Behavioral Health Survey. And, you know, talk about all services, women are drinking 8.1%, and that's drinking heavily, compared to 8.4% of males. And if we're looking at the civilian sector, females, overall, have a higher rate than the civilian sector. And I'm pointing this out and singling out women because there is that stereotype that men engage in alcohol use and that men are the ones with the problem, and that women don't have this problem as much as men do. And although that may be generally true in certain circumstances, but it's also not true. And it's something that when we have individuals in front of us, especially with women, we need to be mindful of their alcohol use as much as we'd be of any other individual.

So as we mentioned, military service could be a precursor, those, like we said, in the Marines are 48% binge drinking, and 16% heavy drinking. This is followed by the Coast Guard, the Navy, and the Army, and looking at deployment status.

So one thing I'll point in regards to age, we all would pretty much agree that the 18 to 25 risk is a high-risk group for age. Those, however, in the age 21 to 25 had a higher rate of heavy drinking than the other ages, and one could guess this is for a variety of reasons, but access, also less likely to get in trouble with command for underage drinking and a variety of things. But the 21 to 25 had the highest rate. And marital status, so this is where you're having your wife or your husband is a saving grace in many regards. And education, the higher educated you were, the less likely you would have problems; however, if you look at some of the data that came from the colleges, other people may think otherwise. Because college and drinking, in some people's experiences, go hand in hand.

So I touched upon this before, so I won't really go too much into the implication for providers. But it's really important, and that's why I introduced it before and follow up here, of including alcohol use in the context of clinical treatment planning. And I'll give an example. If you have a patient that has diabetes and you're not sure why they're taking -- well, why they're responding to their medication or what their issues are, and they say, "Well I drink alcohol here and there," and you find out what they're drinking, and you find out what their definition of a drink is, it's something that you really need to keep in mind with their treatment planning. It's true for individuals with diabetes, those with heart disease. So really keep it in context of the patient that you're treating.

And this is true for behavioral health providers who are seeing individuals who may be having episodes of depression or anxiety. Where does alcohol use come to play in here? How is this impacting the treatment? And this way you know this information, you could then reach out to the evidence-based practices that are out there and address salient or poignant points with your patients so you could move forward in a healthy way.

These are implications for command. I won't necessarily go through that again. I just wanted point out, it's worth pointing out again now that we have discussed the prevalence rate and seeing that there are some significant issues go forward.

One thing I didn't mention before here that's worth here now is implications for patients. Early intervention and prevention of more complex problems improve chances for lower rate of reoccurrence, and improves patient prognosis adherence to treatment. So addressing that elephant in the room is going to have more benefit than not, and it can be a very awkward conversation to talk to individuals about their alcohol use, but it's something that needs to be done as much as we would talk about anything else that could be uncomfortable, such as their sexual activity or otherwise. And when we start getting into SBIRT there will be some techniques and tools that we could talk about in regards to how to be able to address and interact with patients.

So looking at the emphasis of early intervention, should we be doing this, why should we be doing this? Well, in the DoD the Institute of Medicine had a recent report recommending that substance use needs to be addressed in the primary care settings, and SBIRT, or something like SBIRT, needs to be addressed.

The clinical practice guidelines -- which was a link at the earlier part, prior to the starting, I think the link might still be up there -- does talk about screening. brief intervention, and referral to treatment. And it's also something that is being heavily watched by the Interagency Task Force and other organizations in the civilian sector for making sure this evidence-based practice is being used, because intervening with patients before they get to the point of a diagnosis or require those 28-day bed stays is not only good for the patient, you're helping them intervene, doing course corrections in their lives, or health or social issues come up, but you're also going to be saving the institute, the patient, and a variety of individuals, of course, some money.

And one of the things that is really important is that if we're focusing on the individual before this becomes a problem, it's much easier to take a solution-focused approach with the patient rather than doing damage

control. So if you have a patient that's in your office and they're having some problematic alcohol use, it's easier to engage them at that level, than when they are later down the road and you're talk about them and they have maybe a DUI under their belt or some other problematic issues and now they're looking at a diagnosis. So that, superficially, is one of the reasons why there's benefits to early intervention.

And doing it in this circumstance, before they have diagnoses, you could address this in a way that is not necessarily stigmatizing or something that is going to be putting up a barrier towards them getting an intervention. It provides the opportunity to reach the service members and patients who may not be aware that they're engaging in alcohol use that is unhealthy or putting themselves at risk. And it also supports the readiness of our deployment capabilities.

So, for the provider and early intervention, it provides the opportunity to talk openly with the patient. It's addressing that elephant in the room, better treatment planning. Potentially reduces the reservation about approaching the topic with alcohol, and it's an opportunity to incorporate evidence-based approaches for screening and brief intervention in the moment before there are any other issues that that may arise.

So SBIRT, SBIRT has been defined by the Substance Abuse Mental Health Service Administration, SAMHSA, as a comprehensive integrated public health approach to the delivery of early intervention for individuals with risky alcohol and/or drug use and the timely referral to more intensive substance abuse treatment for those who have substance abuse disorders.

I do want to make a side disclaimer here. So, in this definition from SAMHSA, they talk about how SBIRT is evidence-based for drug use. Recent studies have come out that have shown that SBIRT is less effective in circumstances with illicit drug use and prescription drug use, but the evidence for alcohol remains strong. So that's another reason why we are focusing primarily on alcohol.

So SBIRT has shown promise in a range of medical settings and facilities. This includes primarily your gateways into care; primary care, internal medicine, emergency rooms. These settings where individuals are coming in and getting the first look at for health care. Those are some of the best locations to be engaging in SBIRT. Elements of SBIRT could be applied elsewhere, but the majority of the evidence does support those settings that I mentioned. It's intended to use for a broader population, those that may be at risk. It could be flexible and could be delivered in the settings that I mentioned, and can be adapted elsewhere. And most of the research that has been done on SBIRT has been done in non-military settings.

So this is our next polling question, and we really want to get at is what screening are you using to assess alcohol? So which screen do you use at your clinic to assess alcohol use? So we have the results here, and the Audit C came out as being the primary one in the clinic, which is fortunate, according to the DoDI 1010.4, which addressing alcohol and substance use in the military. The AUDIT C was identified there as a screening tool of choice.

The CAGE, I see a lot of individuals have mentioned the CAGE, and that is not a bad screen, but it is something that is a bit on the outdated and addresses more alcohol dependence from the DSM-4 than what we would get from the AUDIT C, which addresses more alcohol consumption.

So I just wanted to just point out here, before I start going into SBIRT itself, because this will help ground some of the slides that are coming up next, is that, currently one of our projects we're work on here is an SBIRT implementation pilot. And we're looking to adapt and contextualize for the military setting evidence-based approach for SBIRT that can be applied to primary care and to internal medicine settings. And right now we're pretty much looking at patient-centered medical home. That's a special -- it's a model where we have integrated behavioral health specialists within the clinics that could help intervene. So you'll see some of the slides may represent that.

But I do want to point out, although this implementation pilot, there's some elements here that I'm going to be talking to, SBIRT could be modified, it could be adapted. This is one of the things that we were talking about from SAMHSA, it is very flexible and could be adopted and adapted in many ways to the

environments of the clinic. What our goal right now is to be looking at several clinics across the military to see how they are doing alcohol interventions in their clinic, how can SBIRT be incorporated, and be incorporated in a way that it follows the evidence base but does not necessarily touch upon one of the more difficult aspects of a provider in these type of settings, which is the lack of time that a provider has with a patient.

So one of the things that, you know, we are working also here a DCoE is the Practice-Based Implementation Network, and what we're doing with this network is we have established several sites that we are testing the implementation of evidence-based practices. And it's worth pointing this out is what we are doing with the SBIRT pilot in our site is we are, right now, testing implementation approaches, looking at the implementation barriers, facilitators, and what tools could be used for the adoption of SBIRT, and we are following an evidence-based and best practice approach for implementation science, which is the essence of the practice-based implementation network, which also has a lot of resources and online capabilities that is being developed and has been developed for other circumstances and other innovation pilots.

So looking at SBIRT in the military setting, so, first, SBIRT as simple as it is, it's screening, brief intervention, and referral to treatment. So I'll be talking about these three parts in different components. The first screening I'll do, and I'm going to be focusing on the AUDIT C. And once again, some of this may be tailored to a specific use at our pilot, but this is generic that can be adapted in military settings, and also mirrors what a lot of civilian settings are doing as well.

So the AUDIT C is something that could be completed by a physician, it could be completed by the PCM, the nurse or the tech, and the screening AUDIT C, which is, you know, the AUDIT, the alcohol use disorders identification Consumption. It is three questions. It could be accomplished in a very short amount of time, and it gives a basic understanding of what the individual's drinking. I'll get into brief intervention and referral to treatment in a little bit.

So going into the screening right here, so if you look at this, some of you -- and I'm guessing by at least 50% that answered the polling question -- are very familiar with this already and may not necessarily have seen it in this specific format. But this is the AUDIT C, and the AUDIT C's scoring. And, you know, if you notice underneath, there's a couple of questions that we have included as part of our screening if a person does admit to drinking, and that goes back to the earlier slides where I said it was really important to determine what is your definition of a drink, asking that patient what the definition of drink is.

And then if you see a two other questions; how many drinks do you have per week, and how many drinks do you generally have in one sitting, those are questions that get at the NIAAA drinking low risks to standards, and this is to really get a flush out what the person's drinking is on a regular basis, in addition to the AUDIT C, and this all focuses on consumption.

At this point, then, the tech would provide the information, or the nurse would provide the information to the PCM, or the PCM would have this information themselves if they engaged. And then it's up to the PCM to determine the risk level. And we have broken it out here in several different ways. But the real important piece of look at this is the context to the patient really, and looking at what the normal drinking levels are.

So if a person is drinking 20 drinks a week and they have a history of alcohol misuse, these are things that you'd want to look contextually at the patient, and you may want -- you know, although an AUDIT C may say one thing, because of context of their past history and context to other comorbid mental health or medical issues, the provider, you need to use their clinical judgment to really determine the risk level. These are things to just be mindful of, but, really, what it comes down to is the provider's opinion and their clinical judgment when sitting with the patient themselves.

So one thing I will point out also, is that at the beginning there is some areas where you could see links. One of the links there was for the 2009 DoD VA CPG. And that's something that is going to be updated in

the future. But nonetheless, they do talk about screening and brief intervention in there, and it's really worth knowing. It behooves us to have a good understanding of the CPGs.

So the role to have doc would be to review the technician's documentation; that would be the audit C and the follow-up questions, and then to intervene with the patient and educate the patient on alcohol use, and advise the patient to stay within drinking limits. You could always have the use of a full audit if that's necessary. And then, at this point, refer to the IBHC -- that would be your behavioral health specialist within the clinic -- to a specialty care, that would be alcohol specialty care or other services, depending upon if the individual is active duty or a beneficiary.

So the PCM, depending upon what resources they have in the clinic, they may not have a behavioral health specialist. So it may be up to the PCM to engage in some intervention themselves, which I will get into the brief negotiated interview in a few minutes, and that's something that is not only good to know for the behavioral health specialists in the clinic but also for the PCM, given that there may be some need to intervene with the patient themselves.

So if you are fortunate enough or you are an IBHC, if the patient has come to you, you know, provide the patient with the information that would be necessary to move forward. But if the patient agrees to meet with the IBHC, have the IBHC consult with the patient sooner than later. If you identify an issue at the immediate, it's easier to intervene with them then in the moment than wait a week later or schedule appointment there out.

So, if you have the opportunity, although it may not necessarily be an emergency to have this person be seen by behavioral health specialist or by the person within your clinic, but the sooner they are to admitting things and actually getting intervention will have a greater success rate than letting the situation get a little cold over a period of time while the individual waits for another appointment. Provide the patient with education materials and, you know, always, always document.

The IBHC role is, you know, they can always follow up with them for several appointments over a span of one to four appointments, 20 or 30 sessions, and they'll engage in brief intervention. The brief negotiated interview as well -- I'll get into a little more -- is one of the ones I am really favorable of. And also provide resources. And it's also important that the IBHC also engage in regular screening as well.

So if you have somebody who is in front of you and has any of these special considerations, you may really want to consider referring or having lower threshold for tolerance in regards to a person doing alcohol use. And these are some of them that make perfect sense. I mean if a woman is coming to your office and they're pregnant and they're engaging in alcohol use, you're definitely going to want to intervene. If they're taking medications, as we mentioned earlier, opiates or Benzodiazepines, and there's a concern for a drug-drug interaction, that's something else you're really going to want to consider. And health conditions where alcohol is contraindicated. Many health issues, you should not be doing that.

So going into the brief negotiated interview -- and this is another link that we had earlier on to the Yale Brief Negotiated Interview, they have a manual. The manual is primarily for the civilian sector. But although it's not been geared for military, there's a lot of lessons learned in there and a lot of great information that could be gleaned by providers and applied to their patients.

So the brief negotiated interview could conducted by the PCM or the IBHC, and the focus is on the patient-centered counseling. The focus is also on utilization of motivational interviewing. Now motivational interviewing -- and I'm not going to get into that because that in itself could be a webinar of its own -- is a form of collaborative conversations for strengthening a person's own motivation and commitment to change. It's a client-centered person, patient-centered style for addressing the problem, and the goal is to strengthen the individual's motivation for a movement towards a specific goal by eliciting and exploring the person's reasons for change, and this is in context to their environment and their willing for acceptance and compassion. And we do that in a way that is non-judgmental.

So going into the next parts of the brief negotiated interview, there are some things that we need to keep in mind when we're engaging with alcohol, because alcohol can be a very touchy subject, we want to generate respect. We do not want to be judgmental. We do not want to go, "Are you crazy, do you drink that much," or anything along those lines, which does happen. So we want to try to demonstrate respect. One of the things that may be helpful as a tool to engage the patient initially is go, "Hey, you know, I would like to discuss your alcohol use with you," and kind of elicit their permission, especially if this is a topic that could be really sensitive. And we do that -- and I know when I go to my medical appointments, we do that with a lot of other things. Provide some context why we're asking those questions, or the PCM or doc themselves may go, "Hey, is it already if we talk about this?" That might be, with certain patients, really helpful for opening that front door and starting to address that elephant.

Really, do not be confrontational, avoid arguing, and be mindful of the patient's physical discomfort. So take a look at their non-verbal cues and see how they are responding. That may give you an idea of their comfort level in regards to discussing this specific topic.

So the first step bringing up the subject, establishing rapport. If you have patients you already have, then that might be easier. If it's not, when I first did this, I was a behavior health specialist integrated in an emergency room in Florida, and frequently when I saw patients, they were not known to me. So in these circumstances, I really tried to introduce myself, explain my role, gave them some context to why I was there, and some rationale to the questions that I was going to be asking. I was non-judgmental, and I often acknowledged the circumstance they were in and tried to, to the best of my ability, establish an environment where they felt comfortable and at ease and something they could address with me.

So bringing up the question, bringing up the subject -- this is recommended from the Yale BNI I mention before -- is asking permission and just engaging the patients, and assessing the discomfort. And use reflective listening. That is taking the patient's words and using them in a manner to reflect back to them and saying, well, I know you just mentioned this is really hard. You know, I appreciate that you're bringing up this difficult subject with me, and use that type of language and reflective listening to really help interact with the patient.

When you're engaging with the patient you're going to want to review their drinking patterns. This goes back to the screening. Once again, non-judgmental. Sometimes it's really hard not to be judgmental. I had patients in my office and I asked them how often they drink, and they told me three times a week. And then when I find out what your definition of a drink was, it was about five ounces of vodka per drink. And so try to keep your poker face and not be judgmental, because it would be really easy to raise some eyebrows when you have a patient in front of you giving you those type of drinking levels.

And be honest, express concern. Don't say, "Okay, well very nice, you drink three five-ounce drinks a day, okay, no worries there." No, let them know your concern. You know, it's okay to go back to what the drinking levels are. You know what, really, unhealthy drinking is beyond five drinks per day and one of your drinks is equivalent to what I would be concerned with by itself. And always, context, look at the reviewing and screening data, review the medical records and try to relate the person's drinking of the context of why they're there. Is it because they're there because of a broken arm and you're in the ER and maybe they hurt themselves when they were drinking, or are they there because they are constantly getting the flu, and you may want to say, "Hey, your drinking is maybe suppressing your immune system." So depending on what the circumstances are, you want to relate it to the patient's medical issues and, you know, compare him or her to what would be healthy drinking, because it's very frequent you'll have a individual in front of you that does not understand what is healthy drinking versus what is unhealthy drinking, and that's mere intervention in its own right for a lot of individuals is enough to set a course correction

So step three is enhancing motivation. You want to assess their readiness to change. Ask motivational questions. Use motivation interviewing and answers. Discuss the pros and cons. Work with their goals, find out what their goals are and work with those things. But, also, you want to assess their readiness to change, and that's whether you want to use the Likert scale, like we have over here as an example of one through five, or the Trans-Theoretical Model of Change, that's with your stages of change. People may

know it that way, as your pre-contemplation, your contemplation, your prep stage, action stage, and your maintenance relapse prevention stage.

But getting an idea of the patient's readiness to change and where they are could be a great tool and helpful when intervening. So the next step would be step four, negotiating and advising, you know, work with the patient's goals. Work in the context of what they are trying to accomplish. If their goal is to reduce the number of drinks because their wife says, "Hey, I don't like it when you have over six drinks per week," and if their goal is to reduce it to four, then work within the context of their goal. The their goal may not necessarily be abstinence, it may be reduction. And depending upon what their drinking levels are and where they're at health-wise, that may be more than an acceptable goal, so work within their constraints and work within their definitions of what they can, to the best of your ability, and to what is relevant or appropriate.

So additional motivational strategies: So refrain from giving resistance, focus on the less resistant aspects, restate positives, and encourage the patient to reflect upon previous times when they were abstinent or they were able to cut back. Now there may be times where you may go against this. I could think of one time where I was working with one of my patient's goals, and there goal was -- and this is true -- to stay alive. And they had an extreme case of Korsakoff syndrome; that is a syndrome that people have when they're drinking alcohol for a tremendous amount of time, and it has severe detrimental effects on their body.

And the person in front of me looked very much like Homer Simpson. Their skin was that color of yellow. And at that point, I was not necessarily restating positive. I was very clear, told him that, you know, if he continued these patterns he is going to die. So there are always exceptions. Just keep in mind what the context is and in reducing your clinical judgments and in lieu of all the medical issues that may or may not be going on with this individual.

And this will bring us to our last polling question. In your opinion, what is the most significant barrier to substance use care or intervention? Okay, so in your opinions what is the most significant barrier to substance use care or interventions? And it's a little bit mixed. We have stigma, and we also have patients lie about their alcohol use. And we also have some that are getting into alcohol use interventions are not prioritized, and lack of confidentiality came down to the lowest. So I'm going to speak to each of these briefly.

So, yes, our patients do lie about their alcohol use. That's why it's important to frequently ask the question, because it's not something that patients are going to necessarily readily reveal. So that is definitely a barrier. Confidentiality could be a barrier, depending upon if this is a service member and they're reporting an alcohol-related incident or alcohol use level, that is really concerning, that, according to DOD service regulations, requires the provider to refer the patient to alcohol specialty care. That is where confidentiality definitely comes into play.

Alcohol use interventions not prioritized due to lack of provider time during a session, this is something that, you know, frequently comes up. And as we're working with our pilot, we're noticing that frequently the providers in PCMs are overtaxed, they are seeing a tremendous amount of patients per day. Patients show up late. Patients show up in circumstances that are not conducive towards intervening. And this is one of the bigger barriers that we are coming across.

However, although time is a big barrier, the intervention for SBIRT can be broken down in a way where the onerous is on the tech that can ask a couple questions upfront. You're already asking the questions "do you drink or not," expanding upon that for a few more questions can only take a few seconds and provide valuable information. So my counterargument would be, although it can take away from time, it can be done in a manner that is minimally invasive for the time sensitivity, but also can be done in a way that already may supplant or override some of the interactions you're doing in a clinic that may not necessarily be evidence-based.

But also if you find somebody who is drinking alcohol the wealth of knowledge or information that can come into there in regards to engaging your patient may be a tremendous boon, as compared to lack of time, or a time issue. But it is -- yeah, I feel for the PCMs and those out there seeing many patients. I know this is a big factor, not just with alcohol but with many different issues that are out there.

I do want to talk a little bit about stigma. And stigma barrier of care is one thing that is really alive and well with alcohol use. People are concerned that if they go that their command's going to know or they're going to lose their careers or there's a variety of issues that are going to happen from negative repercussions for admitting some level of alcohol use. So that's one of the importance of doing SBIRT in the primary care setting and doing it at those gateways, because not being a mental health clinic initially could allow for the conversation to happen a little bit more freely in regards to the alcohol use, especially since the context may be in their other medical issues.

But also, according to the DoDI 6490.08, the dispel stigma in providing mental health care, command is notified when the service mentor has entered or being discharged from formal outpatient treatment program consistent with DoDI 1010.4 for the treatment of substance abuse or dependence. Command notification is not required if the patient self-refers for substance misuse education. The keyword there being "education."

So if a patient has some issues and they're engaging in education, whether it be for an IBHC to learn more about the behaviors, and they don't meet a diagnostic criteria, this is somebody who does not have role functioning issues, this is somebody who may be on the path to having difficulties. They could be intervening with in SBIRT in a non-invasive way, and remain confidential because they're maintaining these specific guidelines, and they're within these specific DoDI guidelines here and 1010.4 also with their service regulations. So stigma can be a tremendous barrier, but doing it in the primary care setting could help reduce this. And it really just comes down to education and spending time with our patients to help dispel some of the fallacies and concerns in regards to stigma. So diagnosis of an alcohol disorder or alcohol-related incident such as a DUI, domestic violence, and many others, that will require command notification.

So I'll end close to here is that referral to alcohol specialty care considerations, and this is not the be-all, end-all, nor is this to be used as canon. This is just some considerations to keep in mind when referring patients. And now this may be whether referring a patient to interactive duty to specialty care, such as ADAPT, or referring beneficiaries to the civilian sector for further care. But this is something that, you know, just to keep in mind.

So you may want to consider referring if the person has tried to or has been unable to change their alcohol behaviors on their own; has a known history of substance dependence; has had prior treatment for alcohol or substance use disorder; alcohol-related incidence; have role-functioning impacts, whether it be at home or work or other settings; has had recent alcohol counseling, meaning this is somebody who keeps recurring, keeps coming back up; has issues with alcohol that are being counseled for. Chances are if they're being counseled, then they're actually having some alcohol-related incident problems in regards to their role functioning. And also has an AUDIT-C score of greater than equal to eight. Once again, the AUDIT C is not the be-all, end-all, but it's a great way of sticking your finger up in the air and seeing which way the wind's blowing. And also if this is somebody that requires further evaluation or alcohol use.

What I have always stated to PCMs and doctors, whether it's been in the military setting or in alcohol circumstances beforehand, if you have a patient in front of you and when they leave your office and you're concerned about them and their alcohol use, then that is something you should really start considering some type of referral and some type of level of intervention. If you already have the concerns in your mind and you're documenting it also, then it's probably worthwhile addressing it with your patient and doing some type of referral to get them some extra care.

So, in a nutshell, these are the things that we have touched upon. We talked about what is problematic alcohol use, alcohol use in the military, and then we talked about the fundamentals and overview of

SBIRT. I have several references here, some are cited within the webinar and some are extra here for personal references and personal information. And I'll leave it open now to some questions and answers.

Very well. Thank you very much, Dr. Barry. It is now time to answer questions from the audience. If you have not done so, please submit your questions via the question pod located on the screen. We will respond to as many questions as time permits. The first question that I have is, "How often would you screen for problematic alcohol use?"

So this goes back to that question in regards to time. So if you're in a primary care setting and the patient comes late or they're getting a number of measures up front, you may want to be inclined to limit the number of times you're doing an alcohol screen. DoDI 1010.4 does not mandate a lot of AUDIT-C screening, but my recommendation is to screen for alcohol use as frequently as possible. And if not, then I would recommend every single session.

I look at the use of the AUDIT C as an opportunity to intervene with the patients. The patients may lie. They may not necessarily be ready to address these issues. They may be there for other health issues, but each time the AUDIT-C is given, each time those questions are asked, it is an opportunity for the primary care team or for the medical or mental health to be able to intervene with the patient. You never know when you're going to be able to catch an individual who may be in a pre-contemplative phase or ready or preparing to make some changes, and you're catching them at that moment. So, really, the key is to give as many opportunities as you can for the patients to be able to disclose and be able to get the help they need.

Okay, another question that was posted was, "What are some of the obstacles in implementing SBIRT?"

So we've come across several obstacles, and one we've already kind of touched upon. One of the biggest obstacles is lack of time. We find that providers are overtaxed and overwhelmed with their patients. With our pilots, we find that providers are able to do SBIRT much more in the morning than they are in the afternoon, because as they get by in the day patients may be coming in late, providers may feel like they're behind the eight-ball in regards to time, and SBIRT may be pushed aside. But I know SBIRT's not the only intervention or the only screening or important questions that need to be asked that are not being asked when time if constrained. So one would definitely be time.

The other would be it's just access to screening and access to the patient, the level of comfort with the patient to be able to address alcohol issues. Many providers have preconceived notions of what they feel alcohol use is acceptable or not, and may not necessarily address the appropriate norms with patients because they, themselves, may be engaging in alcohol use that may be unhealthy. So knowledge, access, and time are probably some of the three biggest barriers that we come across. There are many others, but those would be the three largest ones.

Okay. The question is, "Do you know what agencies or outside organizations are adapting the SBIRT model?"

So I'll speak to -- I mean, there are numerous academic -- or agencies that follow SBIRT. You know, as you've seen through this webinar, I've used Yale as my examples. I think the reason why I've used Yale is because they have fantastic resources on their website, and it's put together in a way that is very easy for a provider or technician to digest. But SAMHSA and the CDC, if you're looking at federal organizations, highly endorse the use of SBIRT within the clinical settings. And if you go on both of their websites you could find increased information about it.

The CDC recently, within the past year or so, has put out a manual on screening and brief intervention. It is very relevant to a lot of things we do in the military, but it doesn't necessarily take into context some of the environmental circumstances or special considerations that need to be considered for active duty. So when you look at some of these things, just please note that this has not been put together with the military in mind and that special considerations need to be considered, given the ramifications of alcohol use in regards to the mission and adherence to regulations and DoDIs.

Okay, a more clinical question this time. "How do you deal with a colleague who is engaged in problematic drinking?"

How do you engage with a colleague?

Colleague, yes.

First I would say it depends upon your relationship and what you've been observing, but I think, in many regards, you could treat it like how you treat ethical issues. I would approach the provider, colleague, in a closed room, just you and the other individual, do it in a non-invasive way, and let them know, "Hey, I got some information" or "I see that X, Y, and Z" or "I observed such," and try to do it very much similar to the brief negotiator interview they went through. I would take some of the pages from there and really be non-judgmental --don't know what's going on in their lives that's leading towards this alcohol use or their history -- and try to do it in a manner that you're not going to be alienating the provider.

But also if your provider and their provider, you might have some actual ethical issues in regards to their treating a patient. And this is a broad question, but if the person's coming to treat their patient and they're inebriated themselves, that may be an ethical issue that you may want to address with them. Or this is something that's maybe happening outside the work area and you know of it and you want to be able to intervene. And I would use the brief negotiated interview, I would be non-judgmental, but I would also call in some of your clinical stuff and human decency and say, "Hey, Dr. So-and-so, I'm really worried about you. I've noticed X, Y, and Z stressors in the clinic, and this is what I observed," and try to do in that regards, one on one.

But if this is a provider -- and I will put this caveat out there -- if this is a provider who's treating patients and they are engaging in alcohol use, and it's something that is impacting patient care, you may need to go beyond provider themselves and look -- you know, approach your hospital ethics board for advice, call up the APA or any other ethical body you could have to get additional advice, because you may want to, or you may need to, actually report higher up because there might be some potential harm to patients.

Yeah, I think that's the critical component there is that the potential harm to the patient by the provider. In a similar vein, a follow-up question to that is, "How do we deal with a commanding officer who is having alcohol-related problems, and they're not addressing them?"

That's a little trickier.

Yeah.

That's a lot trickier. What I would do, and it depends upon where you sit in the chain. If the commander, and you're the deputy, then that might be -- a different interaction than you'd have if as compared to maybe being his provider and noticing the squadron commander or somebody higher level engaging in alcohol behaviors. If it is a patient-client interaction, I would encourage you to engage them as your patient. If it's something that you observed outside of patient relationship, then I probably would engage the next person in your command. If you, depending upon where you sit, if you're a captain or a lieutenant and you see your squadron commander engaging in risky alcohol behaviors on a regular basis, I would not necessarily go to my commander straightaway. I would definitely go to my supervisor and get some assistance there. This is not something I would just go out there on my own and do.

That's a very good suggestion. I think that's very important. Last question for today, what level of training does one need to have in order to implement or practice SBIRT?

There's several different ways to answer that. If you have a professional degree already in mental health counseling, social work, or clinical psychology, you may already have the necessary skills to be able to engage in this. If you're a PCM, or otherwise, you could -- you know, you have many of these similar techniques as well, but it's not something I would just necessarily go off the cuff about, unless this is

something that is -- motivational interviewing is very familiar to you. And I'm going to harp a little bit on motivational interviewing, because that is the key component to SBIRT in regards to engaging in the brief intervention. And there are many different programs out there, face to face or computer-based, that will allow you to acquire the skills for motivational interviewing.

I think many of the other techniques that we mentioned in regards to the brief negotiated interview are things that you can incorporate and be mindful of, but there's a specific art and practice to motivational interviewing, and how you would specifically talk. And even there's a practice you would require for reflective listening. So if this is not something that is already in your bailiwick as part of your profession, I would recommend, you know, approaching those that do have that within your clinic and ask them to do a training on it.

I would seek some training outside, but also what I would really recommend doing, if this is a skill that you want to acquire and be able to exercise, is to practice. It is a skill much like, if anything else, the more you practice it, the easier it's going to be to engage with your patients and something that will become more natural into those interactions.

So, you know, frequently in clinical psychology schools and social work as well, when you're learning these techniques, you'll break up into groups and you'll practice using motivational interviewing or reflective listening while the teacher goes around and provides recommendations and comments. And I would really recommend doing something similar, because the better you are at this skill, the easier you're going to find to intervene with your patient and be able to engage in those uncomfortable conversations. So you'll be a lot more comfortable with the uncomfortable.

All right, thank you very much. After the webinar, please visit dcoe.cds.pesgce.com to complete the online CE evaluation and post-test and obtain your CE certification and certificate of attendance. The online CE evaluation will be open through Thursday, August 6th, 2015. Thank you again to our presenter, Commander David Barry. Today's presentation will be archived in the monthly webinar section of the DCoE website.

To help us improve future webinars, we encourage you to complete the feedback tool that will open in separate browser on your computer. To access to presentation and resource lists for this webinar, visit the DCoE website at dcoe.mil/webinars. A downloadable audio podcast and edited transcript of the closed captioned text will be posted to that link. The chat function will remain open for an additional ten minutes after the conclusion of the webinar to permit attendees to continue to network with each other.

The next DCoE traumatic brain injury webinar topic "Returning to College After Concussions and Mild Brain Injuries" is scheduled for August 13, 2015 from 1:00 to 2:30 PM Eastern Time. The next DCoE psychological health webinar health topic, "Health Care Management of Sexual Assaults and Sexual Harassment" is scheduled for 27, August, 2015, again, from 1:00 to 2:30 PM Eastern Time. Thank you again for attending and have a great day.