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Screening and Brief Intervention: A Framework for Effective Conversations with Your Patients

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Introduction

A long-time patient, who is a 56-year-old male, arrives for his annual exam complaining of excessive thirst, frequent urination, unplanned weight gain, and fatigue. His blood pressure, which was borderline hypertensive last year, is now 160/95. He reports no change in diet, job responsibilities, or family life. This year, you have added another screening to the standard vital signs. Before coming back to the exam room, your patient completes a one-page form that you have constructed with the following six questions:

1. In the past 3 months have you had more than:
(Men) 4 drinks in one day or 14 drinks in one week? Yes/No
(Women) 3 drinks in one day or 7 drinks in one week? Yes/No
(Age 65+) 3 drinks in one day or 7 drinks in one week? Yes/No

2. In the past 12 months, did you ever drink alcohol or use drugs more than you meant to? Yes/No

3. In the past 12 months, did you ever feel you should cut down on your drinking or drug use? Yes/No

In the last 12 months, did you use:
4. Marijuana? Yes/No
5. Another recreational drug? Yes/No
6. A prescription pain killer, stimulant, or sedative more than recommended? Yes/No

This patient answers "Yes" to the first question. As part of your review of the substance use screening with the patient, you find out that for the past two months he has been drinking 3-4 cans of beer nightly after dinner, 4-5 nights per week, and up to 8 cans of beer on most Saturdays during these two months when he has met up with his friends to watch the game. (You now have vitally important information, which may have been previously missed without this screening, that impacts on this patient's health: that is substance misuse, in this case alcohol misuse.)

Executive Summary

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention services for individuals with substance misuse.
- SBIRT provides proven, effective, and collaborative strategies that lead to healthier lifestyles.
- It is estimated that for every one person who meets criteria for alcohol abuse or dependence, there are six more people who fall into the category of substance misuse.
- The four key elements of patient-physician communications include patient comprehension, patient participation, physician listening skills, and physician empathy.
- Motivational interviewing is an evidence-based, client-centered, guided communication style used to enhance a patient's internal motivation, readiness for, and commitment to change.
- EARS-D is an acronym the embraces the principles that guide the process of motivational interviewing.

Trust. Acceptance. Hope. Change.

Do you run across any of these concepts in your daily life as a physician? Are they words that describe your patient interactions? How many times in an average week do you face the patient who has heard your diagnosis at his or her last office visit but has implemented virtually none of your recommendations to avoid the life-threatening disease you see occurring much sooner rather than later? You've been quite specific: "You're pre-diabetic; you must lose that extra 50 pounds you've packed on. You need to completely change your diet. Here is a diabetic diet to follow and a prescription for diabetic classes at the hospital that I want you to take." Or, "You've just dodged a bullet; that heart attack could easily have killed you. You've got to lower your cholesterol, quit drinking and smoking, and learn to manage your stress better. Contact the stress management clinic for classes; here are the ones I want you to take." What, you might ask yourself, is the problem? You feel as though you spend much more time with these patients than you should or than is economically feasible in your busy practice and it's as if they didn't hear you. This article will discuss the value of adding screening, brief intervention, and referral to treatment (SBIRT) and motivational interviewing to your clinical practice as a fiscally prudent and best practice concept.

SBIRT Definition

SBIRT (screening, brief intervention, and referral to treatment) is a comprehensive, integrated, public health approach to the delivery of early intervention services for individuals who are misusing substances and creating significant risk for medical, legal, and social consequences. SBIRT targets people with nondependent substance misuse and provides proven, effective, collaborative strategies such as motivational interviewing to promote self-responsibility and permanent positive behavior changes that lead to healthier lifestyles. SBIRT and motivational interviewing are also effective when used with multiple chronic conditions.[1] Realizing that 27% of Americans with multiple chronic diseases generate 66% of all health care costs[2] makes SBIRT and motivational interviewing compelling in the primary care setting.

Screening quickly assesses the severity of substance misuse and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance misuse and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings.[3] An intervention in the physician's office can take as little as 5-10 minutes, is billable to Medicare and some private insurances or Medicaid in some states, and is proven effective in increasing patients' compliance with your recommendations across a broad spectrum of diseases.

The SBIRT initiative through the Center for Substance Abuse Treatment (CSAT) and the Substance Abuse Mental Health Services Administration (SAMHSA) represents a paradigm shift in the provision of treatment for substance use and abuse. The services differ from, but are designed to work in concert with, specialized or traditional treatment. The SBIRT initiative targets those with nondependent substance misuse and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. Research has shown the SBIRT/motivational interviewing approach to be successful in the primary care setting. It has also shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screenings. Interventions such as SBIRT have been found to:

- Decrease the frequency and severity of drug and alcohol use;
- Reduce the risk of trauma; and
- Increase the percentage of patients who enter specialized substance abuse treatment.

In addition to decreases in substance use, screening and brief interventions have also been associated with fewer patient hospital days and fewer emergency department visits. Cost-benefit analyses

Table 1: Health Risks of Substance Misuse

Regular use of each substance is associated with:

TOBACCO:

- Premature aging, wrinkling of the skin
- Respiratory infections & allergies/asthma in patients & often their children
- High blood pressure, diabetes
- Miscarriage, premature labor and low birth weight babies for pregnant women
- Kidney disease; variety of cancers
- Chronic obstructive airways disease
- Heart disease, stroke, vascular disease

ALCOHOL:

- Hangovers, aggressive/violent behavior, accidents/injury
- Reduced sexual performance, premature aging
- Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
- Anxiety & depression, relationship/money/work problems
- Difficulty remembering things & solving problems
- Deformities & brain damage in babies of pregnant women
- Stroke, permanent brain injury, muscle and nerve damage
- Liver disease, pancreas disease
- Cancers, suicide

CANNABIS:

- Problems with attention and motivation
- Anxiety, paranoia, panic, depression
- Decreased memory and problem-solving ability
- High blood pressure; asthma, bronchitis
- Psychosis in those w/personal or family history of schizophrenia
- Heart disease and chronic obstructive airways disease
- Cancers

COCAINE:

- Difficulty sleeping, heart racing, headaches, weight loss
- Numbness, tingling, clammy skin, skin scratching/picking
- Accidents and injury, financial problems
- Mood swings — anxiety, depression, mania
- Aggression and paranoia; Irrational thoughts
- Intense craving, stress from the lifestyle
- Psychosis after repeated use of high doses
- Sudden death from heart problems

AMPHETAMINE-TYPE STIMULANTS:

- Sleep problems, loss of appetite/weight, dehydration
- Jaw clenching, headaches, muscle pain
- Mood swings — anxiety, depression, agitation, mania, panic, paranoia; aggressive & violent behavior
- Tremors, irregular heartbeat, shortness of breath
- Psychosis after repeated use of high doses
- Permanent damage to brain cells
- Liver damage, brain hemorrhage, sudden death (ecstasy) in rare situations

OPIOIDS:

- Itching, nausea and vomiting
- Drowsiness
- Constipation, tooth decay
- Difficulty concentrating and remembering things
- Reduced sexual desire and sexual performance
- Relationship difficulties
- Financial and work problems, violations of law
- Tolerance and dependence, withdrawal symptoms
- Overdose and death from respiratory failure

SEDATIVES:

- Drowsiness, dizziness and confusion
- Difficulty concentrating and remembering things
- Nausea, headaches, unsteady gait
- Sleeping problems
- Anxiety and depression
- Tolerance & dependence after short period of use.
- Severe withdrawal symptoms
- Overdose & death if used w/alcohol, opioids, or other depressant drugs

Source: World Health Organization, ASSIST screening instrument

and cost-effectiveness analyses have demonstrated net-cost savings from these interventions.[1] This type of evidence has been collected partially through the various grants provided by SAMSHA/CSAT to universities, state consortiums, and physician training programs since 2003 in an effort to provide SBIRT training and services on a large scale.

The number of Americans with chronic medical conditions will increase by 37% between the years 2000 and 2030, an increase of 46 million people.[4] Leading the list of chronic conditions for people ages 18 to 64 are: hypertension (30%), cholesterol disorders (20%), respiratory diseases (19%), and diabetes (12%), all of which are known to be directly correlated to substance

Table 2: SBIRT Grantees

Medical Residency I Grantees	Medical Residency II Grantees
• Access Community, Chicago, IL	• Baylor College, Houston, TX
• Albany Medical Center, Albany, NY	• Indiana University, Indianapolis, IN
• Children's Hospital Boston, Boston, MA	• Mercer University, Macon, GA
• Howard University, Washington, DC	• University of California, SF, San Francisco, CA
• Kettering Medical Center, Kettering, OH	• University of Maryland Baltimore, Baltimore, MD
• Natividad Medical Center, Salinas, CA	• University of Missouri, Columbia, MO
• Oregon Health Services, Portland, OR	
• San Francisco General Hospital, San Francisco, CA	
• University of Pittsburgh, PA	
• University of Texas Health Services, San Antonio, TX	
• Yale University, New Haven, CT	

misuse.[5]

Substance Misuse in Primary Care

Substance misuse for the purposes of this article is defined as the use of any legal, prescription, or over-the-counter (OTC) substance for a purpose not consistent with legal guidelines or medical recommendations for dosage intervals or amounts. (This is not abuse of or dependence on substances.) Moderate alcohol consumption is defined by the National Institutes of Health (NIH) as: *For men younger than age 65: no more than 4 drinks in one day and no more than 14 drinks in one week; *for women of any age and men older than age 65: no more than 3 drinks in one day and no more than 7 drinks in one week. Approximately 3 of 10 adults in the United States drink in amounts that significantly increase their risk for physical, social, and emotional complications.[6]

Think this does not describe your practice population? Substance misuse is not yet a well-recognized concept, and this equates to many patients with significant risk factors that are routinely overlooked. According to Dan Hungerford, an epidemiologist at the Centers for Disease Control and Prevention, it is estimated that for every one person who meets criteria for alcohol abuse or dependence, there are six more people who fall into the category of substance misuse. In contrast to concerns expressed by physicians when asked to list their thoughts about substance use screening, most patients don't object to being screened for alcohol use by clinicians and are open to hearing advice afterward.[7] What this means is that approximately 3 out of every 10 patients a physician sees will have a substance misuse issue, including the 70-year-old grandmother who comes to you for a "sleeping pill," but who also has a few sherries after dinner each night to help her sleep.

Risky behaviors are at the top of the list of preventable causes of injury and death.[8] More than 20% of adult patients seen in primary care settings are categorized as being risky users/misusers of alcohol,[7] and the majority of them can be treated effectively by a single brief intervention within the primary care setting.[9] It is well documented that injury and death related to alcohol intake increase at consumption amounts well below that which would meet criteria for alcohol abuse or dependence. Stroke, several types of cancer, nonspecific gastrointestinal symptoms, hypertension, cardiomyopathy, and recurrent atrial fibrillation are all shown to be positively associated with alcohol misuse.[10] Progression of substance misuse can be halted and patients can be appropriately treated in the primary care setting if the misuse is identified and addressed early.[11] It would seem reasonable, then, that screening and brief intervention directed toward substance misuse actually improves the overall quality of care that patients receive. Yet this skill set is being underutilized in a setting that logically seems to be an ideal fit.

What seems a logical fit, however, does not equate to what is a functional fit. When given the challenges of time and patients with multiple medical problems, how does one primary caregiver address each of the equally pressing medical problems in one short visit?[12] One answer is to use a set of communication skills (known collectively as a brief intervention) as a standard of care in any patient interaction. Since time limitations are not likely to suddenly go by the wayside for primary care providers, methods of using time more effectively seem a productive focal point. A 2007 review of randomized controlled trials showed the efficacy of brief interventions with patients involved in risky consumption; patients reduced alcohol intake by an average of 3 standard drinks per week.[13] A focus on alcohol screening and brief intervention does not equate to lesser quality of care for other presenting problems.[14] Preventive screenings and brief interventions for misuse are likely to increase quality of care and carry the potential to lay a solid foundation for collaboration between you as the caregiver and the patient.

Patient-Physician Communications

Primary care providers command a compelling position in the health

care offensive strategy at the "tip of the spear." This vantage point becomes a powerful, essential focal point in regard to the current movement toward preventive health. The primary care setting is optimal for creating and continuing ongoing positive relationships between patients and clinicians. A key factor of these relationships is a focus on patients' active and informed participation in decision-making about their health and health care needs[15]; in essence, the acknowledgement that health behavior change is in the ultimate and final control of the patient rather than the physician. Preventive medicine puts this awareness at the top of the priority scale. Lasting behavior change is most likely to occur for ambivalent patients when they are active, collaborative partners with their healthcare providers. Honoring patients' autonomy and choices in making decisions, and providing a setting in which to speak about the whys and hows of any given change will facilitate movement from a position of automatically defending an acknowledged unhealthy behavior, to a position of voicing their own creative and specific paths to wellness. The physician maintains responsibility to provide expert consultation and guidance. The patient is in the driver's seat regarding the final decisions to implement recommended treatment protocols. The result is that both parties to this collaboration hold equal value and equal responsibilities. It is not the physician's responsibility to convince a patient to make changes. It is the physician's responsibility to be a trusted guide to patients as they consider health behavior changes.

There are four key elements to patient-physician communications to be discussed at present: patient comprehension, patient participation, physician listening skills, and physician empathy. Traditionally, physicians have been taught to approach health behavior change from the "expert/direct persuasion" perspective, operating under the principle that patients simply lack knowledge, insight, skills, or facts about their situation, and if these deficits are adequately addressed by the medical community, patients will be able to make the difficult transition that allows them to change their target behavior. Research about effective behavior change shows that this approach results in patient resistance and a continuation of the status quo.[13] In other words, it doesn't work in achieving the goal of helping people to be healthy. We tend to believe what we hear ourselves say. The more patients verbalize the disadvantages of change, as a "counterattack" to the physician's push for them to make change, the more committed they become to keeping things the way they are. There is a vital aspect of human nature that resists being coerced and told what to do. Ironically, by acknowledging the patient's right and freedom not to change, change becomes possible.[16]

Influencing the Patient's Motivation to Change

Many times, patients consult physicians about health issues that can be tied to their lifestyles and behavioral choices over which they often feel they have little power or control. A variety of challenges may lead to patients' feelings of powerlessness or being out of control, such as emotional reactions to coping with chronic conditions, complying with medical therapies and/or medications, building and maintaining personal life roles that hold meaning for them, adjusting to changes in their lives or routines, and even facing issues of their own mortality.[17] Through the use of the motivational interviewing, physicians can collaborate with patients in their choices to take self-directed steps toward better health for many conditions, in a variety of areas such as smoking, poor diet, medication compliance, lack of exercise, obesity, diabetes, heart and liver disease, and various cancers.[18] While this issue specifically addresses substance misuse, motivational interviewing techniques work in all phases of the medical setting where changes must be made if health is to improve.

Motivational interviewing was rooted in, and has been found effective in, the area of addiction counseling. Over time, much interest has also arisen for its use to help facilitate other health behavior changes with patients in primary care and community-based settings.[19] Motivational interviewing is an evidence-based, client-centered, guiding communication style used to enhance a patient's internal motivation, readiness for, and commitment to change. A key focus is on facilitation of a patient's exploration and resolution of ambivalent feelings.[18]

Another significant component involves eliciting change talk from patients.[20] Patients are thought to unconsciously monitor their speech, and if they find themselves verbalizing their own reasons for change and/or their own plans for making changes, they are more likely to be self-influenced in making specific, adaptive behavioral changes.[20]

A key assumption of motivational interviewing is that behavioral changes are more affected by a person's internal motivation than by the information that a physician provides. Motivational interviewing is considered to be an empathetic, egalitarian way of being with others. It is a communication style that emphasizes development of a good rapport between the physician and the patient, and it conveys encouragement and an attitude of non-judgment. The motivational interview process differs from traditional medical approaches in which medical professionals typically emphasize persuasion, directives, and expert information. Instead, motivational interviewing provides a framework within which the patient, not the physician, does the bulk of the work.[21]

Motivational interviewing has been shown to outperform other types of interventions, especially the traditional approach of advice giving, resulting in an increase in productive patient health behavior changes.[22] Based on the motivational

Table 3: Coding for SBI Reimbursement

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00
Source: http://sbirt.samhsa.gov/coding.htm			

interviewing approach, the use of SBI (screening and brief intervention) can increase the likelihood of identifying risky substance misuse behaviors among patients and health-related factors that may have previously gone undetected. Patients who might react negatively if interviewed and advised solely in relation to substance usage have been found to engage more successfully in response to this type of "health promotion approach."[23] Resulting benefits can help the physician provide early and brief interventions, and aid in the facilitation of outside patient referrals as needed, improving the quality of care provided to patients. Additionally, patients have reported increased satisfaction in their overall medical care and in their communications with physicians and staff based on this approach.[23] Importantly, the physician's ability to quickly and effectively customize a motivational interviewing intervention to a particular patient brings added strength and value to the interaction.[24]

Utilizing the basic principles and techniques of motivational interviewing alone cannot afford success in helping patients move toward making healthy behavior changes. Instead, it is crucial to first understand and embrace the spirit of motivational interviewing. Research has indicated that the spirit of motivational interviewing "is an important predictor of practitioner skill with motivational interviewing, which in turn predicts client behavior and treatment outcome."[25]

There are three important elements involved in the spirit of motivational interviewing. First is collaboration with the patient. The physician uses him- or herself as a resource with areas of expertise on behalf of the patient. The patient is respectfully acknowledged as the expert of his or her own life, and the physician and patient partner together, each as experts, as the patient moves toward health behavior change.[25] The physician seeks to understand the patient from his or her own perspective, goals, and issues. The physician avoids prescriptive advice, but as a part of the collaborative process offers concerns, information, and guidance.

The second element involves evocation. Here, the physician understands and acknowledges that there are many ways a patient may make changes. The physician is aware that the patient knows what has and has not worked for him or her in the past, and the physician creates a positive environment in which the patient will candidly discuss these issues. Seek to evoke from the patient his or her reasons for potential changes and possible means for making those changes. The patient is self-influenced by giving voice to the whys and hows of making changes.

The physician gives voice to the nature and power of the patient's internal motivation for change and knows that sustained change cannot be externally forced.[25]

Autonomy is the third element of the spirit of motivational interviewing. The prevailing wisdom is that the physician does not choose the ultimate change a patient may make. The patient always holds complete and final power and responsibility for making choices and decisions about health behaviors and/or changes. The physician has no power to force change upon another person. It is also important to acknowledge that while the spirit of motivational interviewing reinforces patient autonomy and responsibility for choices and changes, this in no way interferes with the physician's responsibility to appropriately express professional concerns or take required actions regarding potential abuse, neglect, or imminent risk. During the motivational interviewing-based interaction with a patient, the physician provides information and guidance that can influence and support the patient as he or she makes a personal decision for change.[25] What many view as ironic is that by the very acknowledgement of a patient's right to decide not to make a change, the physician actually is increasing the possibility that the patient may make a desired change.[18]

Guiding Principles

There are a number of principles that guide the process of motivational interviewing. One group of principles is commonly referred to with the acronym EARS-D. The "E" stands for expressing empathy. Here, the physician conveys an attitude of acceptance of the patient, which means understanding and accepting a person's views/position even if — especially if — the physician doesn't agree with or endorse it.[16] An accepting demeanor with the patient helps to facilitate change. View and discuss a patient's ambivalence as being normal. Use reflective listening as a key means of following this principle of expressing empathy.

The "A" refers to avoiding arguments. As noted earlier, people are more likely to seek change when they find themselves voicing their own reasons for change. Becoming caught up in some type of argument or debate with a patient over a potential behavioral change often will result in the patient arguing for maintaining a current behavior and/or against change. One author noted that people may fail to change not because they can't change, but because they may not yet have decided they want to change. In this regard, the more a patient argues with the physician against change, the greater likelihood he or she will definitively decide not to change.[26]

Rolling with resistance reflects the "R" in the EARS-D acronym. Resistance is often rooted in ambivalence, and ambivalence is normal when a person is considering making a change. This principle emphasizes that when encountering resistance from a patient, the physician changes the strategy and chooses a different approach. Do not directly oppose a patient's resistance. Instead, move in conjunction with the patient's momentum. How the physician chooses to respond to a patient's resistance will influence whether the resistance grows or recedes.[16] You might select an element of the patient's resistance to focus upon for a bit. You could point out both sides of the ambivalence he or she senses as underlying the resistance and discuss this with the patient. Reshaping the patient's resistant statement into a different perspective might move the interaction forward in a more productive fashion. Sometimes letting the patient know you understand that now might not be the right moment for him or her to make a change can be the right approach to diminishing the patient's resistance. Shifting the focus from the resistance by using a question, a reflection, or a summarization can open up new channels of communication.

The "S" means supporting the self-efficacy of the patient. Your encouragement and support of a person's belief in the possibility for change influences the patient's belief in self, which, in turn, can increase internal motivation for change. It is important that you genuinely convey your own belief in the patient's ability to make successful changes. The physician's belief can have a powerful effect, and it can serve as a self-fulfilling prophecy for the patient.[16] A patient's perception of hope and empowerment can lead him or her to become actively engaged in choosing to make healthy behavior changes.[17]

Finally, the "D" in the acronym involves talking with the patient to help develop discrepancy for purposes of discussion. This means to present and amplify, from the patient's own perspective, any discrepancies that are seen between the patient's present behaviors and his or her goals or values.[16] More simply put, developing discrepancy involves guiding the patient in a discussion about how it is right now and how the patient wants it to be in the future. Then support the patient as he or she presents a rationale or argument for change. If the physician does this in a skillful manner, the physician is likely to influence a person in changing his or her perceptions without feeling that he or she is being lectured or pressured. Ultimately, the emphasis is on you helping the patient to help him- or herself.[27]

Another acronym is also commonly associated with the principles of motivational interviewing known as "RULE." It stands for:

"R" – resisting the righting reflex. Don't give in to the tendency to want to fix the other person or the problem, as this reduces the chances of a patient making change;

"U" – understanding the client's motivation. Actively seek information from the patient about his or her goals, beliefs, and aspirations and use the knowledge to help him or her explore discrepancies and make decisions about change;

"L" – listen to the client. From a patient-centered perspective, create an atmosphere of safety in which a patient can explore and discuss

Table 4: Principles of Motiviational Interviewing

RULE
R: Resist the righting reflex
U: Understand the patient's motivation
L: Listen to the patient
E: Empower the patient
OARS + E
O: Open-ended questions
A: Affirmations
R: Reflections to the patient (verbal)
S: Summaries
E: Elicit change talk in the patient's communications
EARS-D
E: Expressing empathy
A: Avoiding arguments
R: Rolling with resistance
S: Supporting self-efficacy of the patient
D: Develop discrepancy

difficult issues. You should convey empathy and acceptance of the patient so he or she feels heard; and

"E" – empower the patient. Support the patient's confidence in her or his ability to make successful changes, sharing your own confidence that he or she can change. Guide the patient through discussions about discrepancies and reasons for change in a manner that fosters active patient participation/collaboration.[25]

Before moving on to the basic motivational interviewing techniques to use during communications with patients, it is helpful to consider the issue of change itself. Ambivalence regarding change is normal. We all experience this, regardless of our perception of a change as positive or negative. In interactions with patients, using motivational interviewing-consistent behaviors (asking permission to discuss the subject, expressing empathy, affirming and supporting the patient, and emphasizing the patient's right to choose) makes the physician more likely to effectively guide the patient through exploration and resolution of ambivalent feelings about change. Motivational interviewing-inconsistent behaviors (giving prescriptive advice or advice without permission, being confrontational, emphasizing and restating negative information or opinions) have been shown to significantly increase resistance and decrease exploration and resolution of ambivalence.[28]

Recognize that change is many times a nonlinear process, which can involve many steps forward, backward, or even staying stuck in the same place for awhile before an initial or maintained change occurs. Likewise, a patient's readiness to change is not static; the physician can influence a person's readiness to consider making changes all the way through actively making (or not making) changes by choices of verbal and non-verbal behaviors during communications. It is to the physician's benefit to talk with the patient and discuss/assess the patient's status related to readiness to change and confidence about making changes.[25]

The operational techniques or skills of motivational interviewing are known by the acronym OARS+E: "O" is the use of open-ended questions, which helps to gather and clarify information, helps the patient explore issues, and assists the physician in guiding the communication in a desired direction.[25]

"A" is the use of affirmations with your patient, which helps you support a patient in developing hope, accessing a sense of personal empowerment, and building self-efficacy. An affirmation is a genuine statement the physician makes about appreciation of the patient as an individual and his or her strengths.[25]

"R" is the use of verbal reflections the physician makes to the patient (from simple to complex) in response to something he or she has verbally or non-verbally conveyed. Through reflections, you enable the patient to feel heard and understood, and help him or her participate in the interaction in ways that promote personal growth and discovery.[25] A skillful choice of reflections can help a patient build self-efficacy through a review of past successes in making healthy behavioral changes, or through reframing unsuccessful past attempts to emphasize them as "practice runs" instead of failures.[21]

"S" involves providing verbal summaries to the patient of what the patient has directly stated (or implied) to you. Summaries help the physician collect, clarify, and reflect back information to the patient. Summaries help link information, issues, and patterns together in ways that may enhance patient insight, often by tying something said in the present to information previously discussed, or by pointing out some relationship (or lack thereof) between issues or ideas. They can also help transition from one point in an intervention to another.[25]

"E" involves eliciting change talk in a patient's communications. Learning to recognize a patient's words that indicate a desire to change, the ability to change, a reason to change, and/or a need to change are all cues to help the physician guide the patient along a continuum of change talk to commitment talk. (This process is also referred to as DARN-C.) This process of listening for and responding to change talk, and guiding the discussion toward a patient's commitment to change, increases the chances that actual health behavior changes will occur.[19]

During an motivational

interviewing brief intervention, the physician will typically shift between three communication styles: following, directing, and guiding. In the following style, the physician will generally open the discussion with open-ended questions. This encourages the patient to provide an expanse of information that is relevant to the patient's concerns and needs. The physician may use the directing style to provide information to the patient. The third style, guiding, is most motivational interviewing-consistent. When using this, the physician relies less on providing information and using professional persuasion and much more on supporting and encouraging the patient to explore motivations and goals, develop discrepancies, discuss and resolve ambivalence, and make health behavior choices.[21]

There are a number of ways in which a brief intervention can be approached. In one approach, known as the brief negotiated interview (BNI), four distinct steps are taken. First, the subject of the patient's problematic behavior or condition is raised with the patient. One might say, "I'd like to take a few minutes to discuss your use of alcohol. Would that be okay with you?" Next, provide feedback to the patient, which involves a review of the substance use screening outcomes, helping the patient make a connection (if possible) between his or her substance usage and the reason for the current office visit, and a discussion of what is considered to be the low to high risk categories of usage (e.g., norms and guidelines).[29]

In the third step of the BNI, work with the patient to enhance his or her motivation to make a behavioral change. Discuss a patient's level of readiness to change. For instance, one might ask the patient, "On a scale of 0 to 10, with 0 meaning you are in no way ready to consider making a change in your (drinking, smoking, etc.), and with 10 meaning you are absolutely ready to make a change, how ready do you believe you are to make a change?" Whatever the number the patient may pick, then move to develop discrepancy. Here, one might say, "You chose a 4. How did you come to choose a 4 instead of a 2?" An additional response could be, "What do you think would have to happen in your life for you to choose a number higher than a 4?" Then guide the patient to verbally discuss the pros and cons of making (or not making) a behavior change.[29] One might ask the patient, "What do you like about your use of alcohol?" Or, "What are some reasons you think it might be helpful to make changes in your use of alcohol?" The key to this step is for the patient to verbalize his or her own reasons for change.

In the last step of the BNI, negotiate a goal with the patient and advise the patient on this goal. Here, one might ask, "Okay, so what's your next step?" The physician can support the patient while providing advice on this goal, "Successfully taking the steps you just talked about will lower your risk of injury or illness." Summarize back to the patient his or her plan for change, emphasizing that the plan is based on the patient's choice and willingness to change. Also provide written information as adjunct resources for helping the patient meet his or her goal. A follow-up appointment is typically recommended. Lastly, express appreciation to the patient for the willingness to talk about the usage and for the collaboration and commitment to the plan for behavioral change.[29]

Another approach to doing a brief intervention with a patient based on the motivational interviewing approach involves following a sequence of tasks. This sequence follows what some refer to as the 5 As: Assess, Advise, Agree, Assist, and Arrange.[30]

In the first task, work to assess problematic behaviors by asking about the patient's behavior and discussing with the patient any issues that might affect behavioral change. Second, advise the patient on recommendations for making a behavioral change — from your perspective as the primary care physician — but do so in a way that conveys encouragement and support to the patient about making the change. Next, help the client explore his or her level of readiness to change the behavior, as well as discuss and move to resolve ambivalence the patient may be feeling about changing. Based on these activities, collaborate with the patient on setting goals for change (which is known as the agree task). The assist task follows, which involves helping the patient help him- or herself move to make the agreed-upon change. Through a brief discussion, promote the patient's development of the confidence, skills, and outside resources/support to help facilitate successful change. Finally, work with the patient to arrange for his or her needs, which may simply involve orchestrating a follow-up appointment or perhaps necessitate providing an outside referral.[30]

Regardless of the ultimate choice in approach to conducting a brief intervention with patients, the use of motivational interviewing provides a solid foundation for the interaction and can greatly enhance effectiveness in fostering health promotion activities.[31]

Conclusion

To bring this topic full-circle, think back to the opening example of the 56-year-old male patient who has been misusing alcohol for the past 2 months. With new-found knowledge of SBIRT and motivational interviewing, how might you intervene differently?

Doctor: "Good to see you again, Mr. Smith. I see on the questionnaire we gave you that you indicated you drink 12 to 20 cans of beer a week, plus an additional 4 to 8 on Saturdays when you watch football games with your friends. Is that correct?"

Mr. Smith: "Well, I never added them up before, but I guess so."

Doctor: "Would it be okay with you if we talk about your use of alcohol?"

Mr. Smith: "Yes, it's okay."

Doctor: "I just want you to know I'm concerned about your level of

drinking and the increase you indicated in the last several months. We know that excessive drinking can make medical problems worse and can actually cause some health issues. I was wondering if you've thought about your drinking and the relationship between your increase in beer and the increase in your blood pressure that you came in with today? Actually most of the symptoms you are concerned about today may have some relationship to your increase in alcohol use."

Mr. Smith: "No, I didn't know there was a connection."

Doctor: "Well the reality is that excessive drinking is associated with an increase in blood pressure as well as cholesterol changes, respiratory diseases, diabetes, and even certain cancers."

Mr. Smith: "I don't think I drink THAT much!"

Doctor: "Let me show you a chart here. For your age, this is what amount of drinking is considered a low-risk level. It's no more than 14 drinks in a week and no more than 4 drinks in any one day. A drink is defined as no more than 12 ounces of beer, 5 ounces of wine, or an ounce and a half of distilled spirits. You're right, you aren't drinking as much as some people, but your responses on the questionnaire indicate you are actually are at high risk."

Mr. Smith: "I didn't think my drinking was so bad!"

Doctor: "That's why I wanted to show you this. On a scale of 1 to 10, and with the knowledge you now have, what do you think your readiness to change your drinking habits would be? One means "I'm not going to change at all" and 10 is "I'm completely ready to change."

Mr. Smith: "Well, Doc, I'm pretty healthy except for my high blood pressure and some of those things I told the nurse about today. On the other hand, I don't want my blood pressure to keep going up and I sure don't want some of those other things you mentioned! But I'd miss drinking with the guys … maybe a 5?"

Doctor: "You don't have to miss the games, you know. What kept you from saying a 1 or a 2?"

Mr. Smith: "Well it's obvious that I need to make some changes. I guess I've kind of known I was drinking more and more, but it just got away from me. I don't want to stop altogether, but I sure don't like being in that at-risk category. To tell you the truth, my family has mentioned my drinking more too. I don't see myself as an alcoholic, but I probably should cut back. That's why I chose a 5 — you know, middle of the road."

Doctor: "Well, that's a good place to start. I heard you say your health is important and so is your family. You're surprised your drinking fell into the high-risk category, although you were aware on some level that your drinking had increased. Is that right?"

Mr. Smith: "Yeah."

Doctor: "So based on that information, what are you willing to change right now? What would that change look like for you?"

Mr. Smith: "I think I need to cut back — maybe drink a time or two less a week and a beer or two less when I do drink. I also think I should watch how much I'm drinking with the guys during the game. At the end of the game I look down and there a lot more empties than I remember drinking."

Doctor: "Well, that sounds good. It's certainly an improvement over what you're drinking now and a great start. I'll check with you at your next visit to see how it's going. Now let's talk about what else we can do for that rising blood pressure and some of the other symptoms you are having."

Let's consider the possible outcomes of your brief intervention with this patient:

Three months later, Mr. Smith returns to your office for a check-up and completes another SBIRT screening. This time he indicates he's cut his drinking down to 2 beers twice a week, and he limits his game-time consumption with his friends to 3 or 4 beers per game. He's lost some weight, too, and while he is still hypertensive, his blood pressure is significantly lower than it was at his last visit, plus some of his symptoms of diabetes have moderated. He is happy with the changes he has made, "even though I didn't think I had a problem," and he states his family is also pleased.

You might find yourself thinking, "Now that's a pretty good outcome for such a brief intervention. It only took a few extra minutes instead of all that time I used to spend that often didn't work."

Trust. Acceptance. Hope. Change. How do these concepts apply to your patients in your daily life as a physician? Are they words that describe outcomes from your patient interactions? These words describe the communication skills that are central to SBIRT and that have been proven to be effective in increasing the likelihood that your patients will choose healthier behaviors. In combination with these communication skills, the emphasis on screening and early intervention for a substance misuse problem, a largely unrecognized but widespread health risk factor, creates a powerful tool for primary care physicians in the work of guiding patients toward healthy living.

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Physician CME Questions

1. The SBIRT initiative targets what type of patients?
   A. those who meet criteria for substance abuse
   B. those with nondependent substance use
   C. patients who do not use alcohol at all
   D. patients in recovery from substance abuse
   E. patients who rarely seek medical attention

2. What percentage of patients seen in primary care settings can be categorized as substance misusers?
   A. less than 1%
   B. 1-5%
   C. 5-10%
   D. 10-20%
   E. more than 20%

3. The number of Americans with chronic medical conditions will increase by what percent between the years 2000 and 2030?
   A. 7%
   B. 15%
   C. 25%
   D. 37%
   E. 44%

4. A 2007 review of randomized controlled trials showed that patients involved in risky consumption who received brief interventions reduced alcohol intake by an average of 3 standard drinks per week.
   A. true
   B. false

5. According to the CDC, for every one person who meets criteria for alcohol abuse, how many more fall into the category of substance misuse?
   A. 1
   B. 4
   C. 6
   D. 10
   E. 15

6. One of the guiding principles of motivational interviewing is:
   A. persuading the patient to change
   B. expressing empathy with your patients
   C. arguing with your patients if necessary to help them understand the risks
   D. expressing doubt about the patient's ability to make changes
   E. the physician should be working harder than the patients to make healthy behavior change happen

CME Answer Key

1. B; 2. E; 3. D; 4. A; 5. C; 6. B

In Future Issues

COPD Update

Corrections

In the December 2010 issue, please note the following corrections:

In Table 1 on page 127, in the section on arm preparation, the text should read, "Rolled up sleeve should not restrict blood flow."

In Table 3 on page 132, under antihypertensive pharmacotherapy for pheochromocytoma, the text should read, "Adequate alpha-blockade followed by beta1-blockade."

Primary Care Reports

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Upon completion of this activity, participants should be able to:

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