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Commentary on Kim *et al*. (2017): Staying focused on non-treatment seekers

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Abstract

Negative results for screening, brief intervention and referral to treatment (SBIRT) trials continue to build. These findings should accelerate rather than suppress research regarding how best to identify and intervene proactively with non-treatment seeking samples.

Keywords

Addiction treatment; brief intervention; drug use; primary care; technology

Kim *et al*.'s rigorous secondary analysis in this issue [1] finding no effect for screening, brief intervention and referral to treatment (SBIRT) on receipt of addiction treatment is the latest example of the challenges facing SBIRT research. It comes on the heels of other recent trials finding little to no effect for SBIRT [2–4], particularly with respect to drug use outcomes and receipt of addiction treatment. The decline effect—namely, that effect sizes decrease routinely over multiple study replications [5,6]—appears to be on full display. Implementation challenges such as provider workload, provider willingness, negative attitudes regarding substance use, poor fidelity, time constraints and referral source limitations continue the assault [7–9]. These issues are uniquely difficult to weather for an intervention approach that is predicated on the power of small effects when multiplied across a large proportion of affected individuals.

Kim *et al*. call for '…greater effort and new methods' (p. 826). We agree. The vast majority of people needing treatment for substance use neither seek treatment nor feel that they need it [10]; we thus cannot achieve a significant population impact on addiction by focusing only on interventions that are of interest to just a small minority of identified treatment-seekers.

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We, as a field, must not ignore this reality and should give tremendous credit to the SBIRT pioneers who have led the way thus far. But how should we move forward?

Part of the answer may lie in Kim *et al.*'s analyses of interactions between study condition and substance dependence. Although the authors appropriately caution against over-interpretation of these findings, their study is not the first to show that the efficacy of brief and motivational interventions may be moderated partially by participant characteristics [11,12]. Evidence of stronger effects among subgroups would narrow but not negate the applicability of proactive screening and brief intervention. Additionally, brief interventions are insufficiently optimized. We have spent far too little time identifying the mechanisms through which such approaches elicit behaviour change [13]. Similarly, the field is only beginning to understand how to achieve and measure fidelity: multi-level modeling analyses indicate that fidelity may vary as much within interventionists as between them, suggesting that enhanced training may be needed to address varying patient presentations [14]. Finally, there is reason to reconsider the frequency as well as the structure of brief interventions. Most SBIRT research, including the Assessing Screening Plus brief Intervention's Resulting Efficacy to stop drug use (ASPIRE) trial analyzed by Kim *et al.*, involves just a single session. However, clear evidence from brief smoking cessation intervention research suggests that efficacy increases with greater frequency or duration of sessions (e.g. odds ratios of 1.4 for total contact time of 1–3 minutes; 1.9 for 4–30 minutes; and 3.0 for 31–90 minutes, with a notable plateau at or below 90 minutes) [15]. Reviews of SBIRT for alcohol have also reported advantages for more than one contact [16,17].

Technology may be the ideal platform from which to pursue these directions. Computer-delivered SBIRT, or e-SBIRT, has shown acceptability and promising efficacy in a number of studies [18]. Its modular nature can facilitate optimization and examination of mechanisms, and it is likely to be much easier to implement than traditional SBIRT—a notable advantage, given the implementation challenges described above, and evidence of better outcomes for SBIRT in efficacy versus effectiveness trials [19]. Its low cost also means that even very small effect sizes may be cost-effective. Further, technology has the ability to increase total contact time following a health-care encounter using text messages, invitations to complete additional sessions from home or connections to mutual support via social media. Finally, making e-SBIRT widely available could facilitate large-scale pragmatic trials, with highly representative samples, through which even small effects could be verified and moderators/mediators could be identified.

As with other recent research regarding SBIRT, Kim *et al.*'s findings must not be overlooked or explained away. At the same time, it is critical that efforts to identify and intervene effectively with the non-treatment-seeking majority be accelerated rather than abandoned. There are multiple promising avenues for doing so.

References

1. Kim TW, Bernstein J, Cheng DM, Lloyd-Travaglini CA, Samet JH, Palfai T et al. Receipt of addiction treatment as a consequence of a brief intervention for drug use in primary care:a randomized trial. Addiction 2017;112: 818–27. [PubMed: 27886657]

2. Kaner E, Bland M, Cassidy P,Coulton S, Dale V, Deluca P et al. Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ 2013; 346: e8501. [PubMed: 23303891]

3. Saitz R, Palfai TP,Cheng DM, Alford DP, Bernstein JA, Lloyd-Travaglini CA et al. Screening and brief intervention for drug use in primary care: the ASPIRE randomized clinical trial. JAMA 2014; 312: 502–13. [PubMed: 25096690]

4. Bogenschutz MP, Donovan DM, Mandler RN, Perl HI, Forcehimes AA, Crandall C et al. Brief intervention for patients with problematic drug use presenting in emergency departments: a randomized clinical trial. JAMA Intern Med 2014; 174: 1736–45. [PubMed: 25179753]

5. Schooler JWTurning the lens of science on itself: verbal overshadowing, replication, and metascience. Perspect Psychol Sci 2014; 9: 579–84. [PubMed: 26186759]

6. Ioannidis JP Contradicted and initially stronger effects in highly cited clinical research. JAMA 2005; 294: 218–28. [PubMed: 16014596]

7. van Beurden I, Anderson P,Akkermans RP, Grol RP, Wensing M, Laurant MG Involvement of general practitioners in managing alcohol problems: a randomized controlled trial of a tailored improvement programme. Addiction 2012; 107: 1601–11. [PubMed: 22372573]

8. Beich A, Gannik D, Malterud K Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. BMJ 2002; 325: 870. [PubMed: 12386040]

9. Howard MO, Chung SS Nurses' attitudes toward substance misusers. I Surveys, Subst Use Misuse 2000; 35: 347–65. [PubMed: 10714451]

10. Substance Abuse and Mental Health Services Administration (SAMHSA)—Center for Behavioral Health Statistics and Quality The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD: SAMHSA; 2014.

11. Palfai TP, Tahaney K, Winter M, Saitz R Readiness-to-change as a moderator of a web-based brief intervention for marijuana among students identified by health center screening. Drug Alcohol Depend 2016; 161:368–71. [PubMed: 26948755]

12. Stotts AL,Schmitz JM, Rhoades HM, Grabowski J Motivational interviewing with cocaine-dependent patients: a pilot study. J Consult Clin Psychol 2001; 69: 858–62. [PubMed: 11680565]

13. Bertholet N, Palfai T, Gaume J, Daeppen JB, Saitz R Do brief alcohol motivational interventions work like we think they do? Alcohol Clin Exp Res 2014; 38: 853–9. [PubMed: 24125097]

14. Imel ZE, Baer JS, Martino S, Ball SA, Carroll KM Mutual influence in therapist competence and adherence to motivational enhancement therapy. Drug Alcohol Depend 2011;115: 229–36. [PubMed: 21227601]

15. Fiore MC, Jaen CR, Baker TB, Bailey WC, Benowitz NC, Curry SJ et al. Treating Tobacco Use and Dependence: 2008 Update Clinical Practice Guideline. Rockville, MD:US Department of Health and Human Services, Public Health Service; 2008.

16. Jonas DE, Garbutt JC, Amick HR, Brown JM, Brownley KA, Council CL et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med 2012; 157: 645–54. [PubMed: 23007881]

17. Alvarez-Bueno C, Rodriguez-Martin B, Garcia-Ortiz L, Gomez-Marcos MA, Martinez-Vizcaino V Effectiveness of brief interventions in primary health care settings to decrease alcohol consumption by adult non-dependent drinkers: a systematic review of systematic reviews. Prev Med 2015; 76: S33–S38. [PubMed: 25514547]

18. Donoghue K, Patton R, Phillips T, Deluca P, Drummond C The effectiveness of electronic screening and brief intervention for reducing levels of alcohol consumption: a systematic review and meta-analysis. J Med Internet Res 2014; 16: e142. [PubMed: 24892426]

19. Saitz R Lost in translation: the perils of implementing alcohol brief intervention when there are gaps in evidence and its interpretation. Addiction 2014; 109: 1060–2. [PubMed: 24903285]