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Screening and Brief Interventions: An Interview With Dr. Craig Field

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Holleran Steiker: More than 70% of drinkers aged 21 or older exceed the guidelines for what is referred to as “low-risk drinking” and therefore National Institutes of Health recommendations have included “rethinking drinking” among other alcohol interventions (Willenbring, 2012). Although those who are at risk might not pursue alcohol treatment, they often visit a primary care physician or other health care provider. Brief screenings and intervention techniques for alcohol were initially developed in Europe and have gradually become more widely used in the United States to address the growing problems of “risky drinkers.” SBIRT, which stands for Screening, Brief Intervention, and Referral to Treatment, has become a widely adopted interdisciplinary model for early identification of alcohol problems in primary health facilities, such as general medical practitioners, hospital emergency room, and, more recently, in Employee Assistance Programs (Straussner, 2012, p. 130).

As noted in an article by social work researchers Bliss and Pecukonis (2009), SBIRT models have utility in both substance abuse and non-substance-related settings and can be used by social workers in child welfare settings, family services, schools and colleges, and geriatric services (Bliss &
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Pecukonis, 2009). The SBIRT model is a time-limited, patient-centered counseling strategy focused on changing behaviors.

Over the past few decades, a strong body of research has grown to demonstrate the efficacy and effectiveness of brief interventions (BIs) across a variety of settings and populations. For example:

- Fleming, Barry, Manwell, Johnson, and London (1997) observed that men and women receiving two counseling visits of 10 to 15 min and two 5-min follow-up phone calls showed significant reductions in alcohol use during the preceding week, in episodes of binge drinking, and in frequency of excessive drinking. Sustained reductions in alcohol use have been observed at 48-month follow-up.
- A study of primary care physicians and nurse practitioners who received brief training in skills, attitudes, and knowledge regarding high-risk drinking found that they were able to significantly increase their counseling skills, their preparedness to intervene with at-risk drinkers, and the perceived usefulness of intervention (Adams, Ockene, Wheeler, & Hurley, 1998; Ockene, Wheeler, Adams, Hurley, & Hebert, 1999). At 6-month follow-up, alcohol consumption was significantly reduced for patients who had received BIs during the course of their routine primary medical care.
- Gentilello and colleagues (1999) showed that patients admitted for injuries to a Level 1 trauma center who received a single motivational interview (MI) decreased alcohol consumption significantly at 12 months.
- Another study evaluated the use of a 30-min MI in the emergency room to reduce alcohol-related consequences and use among adolescents following an alcohol-related event (Monti et al., 1999). Follow-up assessments at 6 months showed that patients who received the MI had a significantly lower incidence of drinking and driving, alcohol-related injuries, and alcohol-related problems than patients who received standard care.
- Longabaugh and colleagues (2001) found that patients treated for injuries in a hospital emergency department receiving both a 40- to 60-min MI intervention and a booster MI session 7 to 10 days later reported fewer negative consequences from drinking and fewer alcohol-related injuries at 1-year follow-up, as compared to patients receiving no MI treatment and those receiving the MI treatment with the booster session. Patients in all three groups reduced their days of heavy drinking (six or more drinks on one occasion).
- Social work researchers at the University of Texas at Austin Addiction Research Institute surveyed 141 community health programs to assess organizational readiness factors for SBIRT interventions and found that knowledge of organizational readiness for change leads to positive SBIRT outcomes (Bohman et al., 2008).
Although such findings are compelling, to some addictions practitioners they might be puzzling, or even counterintuitive. We have the pleasure of interviewing social work professor and expert in screening and brief interventions, Dr. Craig Field. Craig, to begin with, can you tell us about screening and brief intervention?

Field: First, let me thank you for the opportunity to be interviewed by you for the *Journal of Social Work Practice in the Addictions*. I guess the easiest way to begin is by describing brief intervention. In the studies our research team has conducted, brief intervention is based on motivational interviewing. Because brief motivational intervention can be provided in a single session, it is often applied in the medical setting. It is well suited to health care settings because it can be applied to wide array of mental health and substance abuse problems that affect patient health.

I have studied the use of brief motivational intervention for alcohol problems with seriously injured patients in the emergency department of a hospital setting. The medical treatment of an alcohol-related injury provides a window of opportunity to talk with patients about their drinking and what they are motivated to change about their drinking. Patients who receive brief motivational intervention for heavy drinking are identified through universal, standardized screening procedures. All patients are screened using the same assessment tools. We ask patients about their recent use of alcohol. Because they are presenting for medical treatment of a serious injury, we know whether they had a positive blood alcohol concentration at the time they were admitted, which suggests they were drinking at the time they were injured. We talk with patients who drink too much or have a positive blood alcohol concentration. Some of these patients might meet the diagnostic criteria for alcohol dependence but many do not. This may be the first time they’ve experienced any problems as a result of their drinking.

Holleran Steiker: What brought you to study this aspect of addictions work?

Field: It seemed like an unrecognized opportunity to help patients who drink too much. Often these patients either do not have access to treatment or have not yet considered treatment. Early in my career, I had the privilege of working with a trauma surgeon who was alarmed at how often injuries including car crashes, assaults, and falls are related to drinking. He believed it was important to talk with patients about their drinking when they were admitted to the hospital but didn’t know the best way to do that. He hired me to help him figure that out. We decided to focus our attention on injured patients because injuries are commonly associated with heavy drinking. Moreover, their drinking also placed them at increased risk of being injured again. We found ourselves talking with patients who didn’t necessarily see themselves as having an alcohol problem. We naturally wondered
how helpful the intervention was for them. Ultimately, our curiosity got the best of us and we began to study whether or not it was effective in terms of reducing drinking and alcohol problems.

Holleran Steiker: Thank goodness for curiosity! What role do social workers play in brief motivational interventions and your work in the medical setting?

Field: I think social workers are well positioned to be able to effectively provide this level of care to patients. Social workers are well integrated into the medical care of patients. Unfortunately, they have often been relegated to the essential, but time-consuming task of case management. Social workers can play a much larger role in the health care setting. This is truer now than ever before. Hospitals are becoming increasingly concerned about the mental health problems that are common in their patients and may negatively affect their medical outcomes. They are realizing more and more that they need not only to treat the medical problem for which the patient presents, but also the mental and behavioral health of the patient. I’ve trained a lot of different health professionals in brief motivational intervention throughout the country. As a professor in a school of social work it is my distinct impression that this work fits most naturally with the training, values, and background of social workers. In addition, social workers’ perspective on diversity and health disparities is a critical piece in the puzzle (for more detail, see Field, Caetano, Harris, Frankowski, & Roudsari, 2010).

Holleran Steiker: Can you explain the existing efforts, settings, unmet needs, and related challenges with regard to SBIs?

Field: I think one of the biggest challenges for brief motivational intervention is that we, in the field of social work, are not being as proactive as we could in terms of taking on this role. Many trauma and emergency departments have committed themselves to identifying patients with alcohol problems and are providing brief motivational intervention targeting heavy drinking. But the strategy can be widely applied to many other settings and with many health and social problems. There are, of course, other challenges that present themselves. We often talk with patients who are interested in longer treatment of their alcohol or drug problems and not just in brief interventions.

Although Alcoholics Anonymous (AA) is ubiquitous and clearly beneficial for many, some have been mandated to AA in the past and weren’t ready or able to acclimate for one reason or another. We are almost always able to facilitate patients’ commitment to change their drinking by getting them access to community treatment centers and providing them with a broader array of services that might be beneficial for patients at varied levels of readiness for embracing vehicles for change. Many patients are committed
to changing their drinking especially after a serious injury and they may need a counselor or therapist to help them successfully navigate the change process. The evidence suggests that we may be able to quicken their eventual recovery by working with them early on.

Holleran Steiker: Will you tell some anecdotes as illustrations of your experiences, successes, or challenges with screening and brief interventions?

Field: We are always asking ourselves whether or not the services we provide to patients are helpful, especially because we don’t often have contact with the person once they are discharged from the hospital. In our program, we don’t allow ourselves to blame the patient; we challenge ourselves to work effectively with these patients where they are at or pave the way for the next person who will talk with them about their substance abuse problem. I recall one time that a colleague expressed some disappointment in being able to effectively help a patient. After talking with the patient, the therapist returned to the office and was feeling frustrated that she could not have done more. She said the patient emphatically denied having a drinking problem and saw no reason to consider changing his drinking. While she came alongside the patient and rolled with resistance, she did not feel she had been as helpful as she could have been. When, as we sometimes do, she called the patient a month later to check in and see how he was doing, especially with his drinking, he thanked her profusely for how helpful she had been to him. While she didn’t think they were communicating very well, he had a different experience of the conversation. He talked about how he had returned to AA after he was discharged and was able to quit drinking. While this may seem like an unusual scenario, our research demonstrates that early conversations illuminate the issues and often “plant seeds” for changes later on.

Holleran Steiker: In terms of your research, what have been some of the most surprising findings?

Field: In retrospect, they are not necessarily surprising or counterintuitive, but unexpected findings. Often the findings you don’t expect are the most informative. The first study our research team conducted was to evaluate potential ethnic or racial differences in response to a brief intervention. Up to that point, these types of interventions had largely been evaluated in nonminority populations. From a general population perspective, ethnic minorities are more likely to drink heavily and less likely to have access to treatment. For that reason, we anticipated that brief intervention may not be sufficient for ethnic minorities. We were proven wrong. We found that our Latino patients benefited the most from brief intervention even when they had more severe substance abuse problems. We have gone on to better
understand why this might be the case and hope to expand on this important research in the near future.

*Holleran Steiker:* What other types of research are you proposing that will move brief intervention for substance abuse forward?

*Field:* While there is more research that needs to be done about who benefits from brief intervention and how it works, it is generally accepted that these approaches are effective and that they are clearly favored by patients and clinicians alike. Given that, I think the next question becomes how we best train clinicians to effectively provide brief motivational interventions. I am most often asked to provide 1-day training for providers. While I’m eager to support the dissemination of brief intervention, I have no idea how helpful these trainings are or how long participants in the training are able to retain the skills they do learn. I have also provided more extended trainings and augmented trainings with supervision. In our clinical trials, we have exhaustive training and supervision of the clinicians that may be cost prohibitive outside of the context of federally funded research. Ultimately, I think it’s an empirical question and we need research on the benefits and types of training.

In translating research into practice, we must be as sure as possible that we are setting providers up for success. The field as a whole could potentially lose some ground if we prematurely adopt and implement brief intervention without knowing how best to train clinicians in doing it in a way that is consistent with the research that supports its effectiveness.

*Holleran Steiker:* What are your visions for behavioral health research and substance abuse interventions in the future?

*Field:* As I mentioned, trauma centers and emergency departments throughout the country are implementing brief motivational intervention for heavy drinking. I think this is a “Trojan horse” opportunity for social work. Medical settings need and want to address the alcohol problems that affect the health of their patients. But we know that there are many other mental health and substance abuse problems that affect the overall well-being of patients. My hope is that social work as a field sees this opening and practitioners establish themselves as key stakeholders in the provision of these types of services in the medical setting. Social work can lead these efforts and change the face of health care through the widespread adaptation and implementation of screening and brief intervention.

*Holleran Steiker:* What recommendations can you make to social workers who want to create, aid, or research SBI programming for substance abusers in their agencies and communities?
In terms of research, small steps can lead to great gains. There are a number of cost-effective ways to evaluate the day-to-day services that are provided. For example, with forethought and planning, providers can conduct program evaluation research of screening and brief intervention. Earlier I mentioned that brief motivational intervention can be applied to a variety of mental and behavioral health problems and be provided in a wide array of contexts. By conducting programmatic-level research, social work practitioners can provide insight into how to effectively implement these programs with different patient populations and settings. Because much of our research in the field has been done in the framework of federally funded research, we have not been able assess how well the programs work in the “real world.” Those working in the field can, however, provide these important insights.

In terms of practice or implementation, there are a number of training resources and consultants that are available to discuss different strategies for implementation screening and brief intervention. For example, I’ve worked with groups who wanted to use brief motivational intervention to help their patients improve the management of their diabetes. I’ve also worked with treatment centers to provide brief motivational intervention to clients to help them shore up their commitment for completing treatment. Similarly, I’ve worked with other substance abuse treatment centers to use brief motivational intervention to help clients from ending treatment prematurely. There are trainers and consultants who are familiar with the use of brief motivational interventions in different settings with a focus on different mental health and behavioral health challenges.

Holleran Steiker: Thank you so much, Dr. Field, for your contributions to social work and substance abuse practice. Can our readers contact you if they would like to learn more? If so, what is the best way to reach you?

Field: Of course, I’d be happy to help anyone who is interested in finding out more. The readers are free to contact me via e-mail at E-mail: craig.field@austin.utexas.edu. I will try to answer any questions they may have or can put them in contact with another expert in the field.

REFERENCES


