Implementation of a Brief Treatment Counseling Toolkit in Federally Qualified Healthcare Centers: Patient and Clinician Utilization and Satisfaction

Adam C. Brooks, Ph.D. [a,*], Jaclyn E. Chambers, M.S.W. [a], Jennifer Lauby, Ph.D. [b], Elizabeth Byrne, N.C.C, L.P.C. [a], Carolyn M. Carpenedo, M.H.S. [a], Lois A. Benishek, Ph.D. [a,c], Rachel Medvin, Psy.D. [a,d], David S. Metzger, Ph.D. [a,c], Kimberly C. Kirby, Ph.D. [a,c]

[a] Treatment Research Institute, 600 Public Ledger Building, 150 S. Independence Mall West, Philadelphia, PA 19106, USA
[b] Public Health Management Corporation, Centre Square East, 1500 Market St. 15th Floor, Philadelphia, PA 19102, USA
[c] University of Pennsylvania School of Medicine, Department of Psychiatry, 3900 Chestnut Street, Philadelphia, PA 19104, USA
[d] Widener University, The Institute for Graduate Clinical Psychology, One University Place, Chester, PA, 19013

ARTICLE INFO

ABSTRACT

Introduction: The need to integrate behavioral health care within medical settings is widely recognized, and integrative care approaches are associated with improved outcomes for a range of disorders. As substance use treatment integration efforts expand within primary care settings, training behavioral health providers in evidence-based brief treatment models that are cost-effective and easily fit within the medical flow is essential.
Methods: Guided by principles drawn from Diffusion of Innovations theory (Rogers, 2003) and the Consolidated Framework of Implementation Research (Damschroder et al., 2009), we adapted elements of Motivational Enhancement Therapy, cognitive–behavioral therapy, and 12-step facilitation into a brief counseling toolkit. The toolkit is a menu driven assortment of 35 separate structured clinical interventions that each include client take-away resources to reinforce brief clinical contacts. We then implemented this toolkit in the context of a randomized clinical trial in three Federally Qualified Healthcare Centers. Behavioral Health Consultants (BHCs) used a pre-screening model wherein 10,935 patients received a brief initial screener, and 2011 received more in-depth substance use screening. Six hundred patients were assigned to either a single session brief intervention or an expanded brief treatment encompassing up to five additional sessions. We conducted structured interviews with patients, medical providers, and BHCs to obtain feedback on toolkit implementation.
Results: On average, patients assigned to brief treatment attended 3.29 sessions. Fifty eight percent of patients reported using most or all of the educational materials provided to them. Patients assigned to brief treatment reported that the BHC sessions were somewhat more helpful than did patients assigned to a single session brief intervention ($p = .072$). BHCs generally reported that the addition of the toolkit was helpful to their work in delivering screening and brief treatment.
Discussion: This work is significant because it provides support to clinicians in delivering evidence-based brief interventions and has been formatted into presentation styles that can be presented flexibly depending on patient need.

© 2015 Elsevier Inc. All rights reserved.

1. Introduction

The need to integrate behavioral health care within medical settings is widely recognized among health care professionals (O'Donohue, Cummings, & Cummings, 2009; Robinson & Reiter, 2007) as well as government and international organizations (Agency for Healthcare Research Quality, 2008; President's New Freedom Commission on Mental Health, 2003; World Health Organization, 2008), as behavioral health conditions are at risk to be undiagnosed or undertreated (Hine, Howell, & Yonkers, 2008; Mitchell, Vaze, & Rao, 2009). In general, systematic reviews suggest that integrative care approaches are associated with improved physical, mental, and quality of life outcomes for a range of disorders including chronic illness (Bradford et al., 2013; Martinez-Gonzalez, Berchtold, Ullman, Busato, & Egger, 2014), mental illness (Bradford et al., 2013), substance use disorders (Fiellin et al., 2006; Oslin et al., 2006) as well as disorders that often co-occur with substance use disorders (SUDs) such as depression (Archer et al., 2012; Butler et al., 2008) and anxiety (Archer et al., 2012). The presence of on-site mental health providers is also associated with referral to off-site mental health care and a reduction in medications (Harkness & Bower, 2009). Support for integrated models, however, is tempered by clinical and implementation concerns. For instance, modest short-

* Corresponding author. Tel.: +1 215 399 0980; fax: +1 215 399 0987.
E-mail addresses: abrooks@tresearch.org (A.C. Brooks), jchambers@tresearch.org (J.E. Chambers), jennifer@phmc.org (J. Lauby), ccarpenedo@tresearch.org (C.M. Carpenedo), lbenishek@tresearch.org (L.A. Benishek), rmedvin@tresearch.org (R. Medvin), dsm@mail.med.upenn.edu (D.S. Metzger), kkirby@tresearch.org (K.C. Kirby).

term improvements in mental health outcomes and social functioning resulting from integrated care are not always maintained over time (Bower, Knowles, Coventry, & Rowland, 2011; Jonas et al., 2012). Without well-conducted effectiveness trials, integration strategies can be prematurely adopted and then discarded.

The integration of SBIRT for SUDs in primary care is one potential example wherein systems might be moving forward with broad adoption ahead of the evidence for broad effectiveness. Medical patients are briefly *Screened* for risky substance use; patients with risky use are provided with a *Brief Intervention* (BI) to help them reduce substance use; and patients with moderate to severe substance use are *Referred* to specialty *Treatment* (SBIRT; Babor et al., 2007). Early efficacy trials demonstrated moderate-to-high efficacy of BIs for reducing hazardous drinking in primary care settings (Bien, Miller, & Tonigan, 1993). Additional reviews have demonstrated comparable treatment outcomes for patients treated with BIs and patients treated with more extensive and traditional treatments, adding support for this model (Ballesteros, Duffy, Querejeta, Arino, & Gonzalez-Pinto, 2004; Kahan, Wilson, & Becker, 1995; Moyer, Finney, Swearingen, & Vergun, 2002; Whitlock, Polen, Green, Orleans, & Klein, 2004; Wilk, Jensen, & Havighurst, 1997) and leading to widespread calls for broad implementation. Furthermore, the majority of research examining the effectiveness of SBIRT has been conducted with hazardous drinking; fewer studies have supported its utility with illicit drug use. While initial early results were promising (Bernstein et al., 2005), the most recent well controlled studies have not demonstrated BI efficacy for illicit drug use (Hingson & Compton, 2014; Marsden et al., 2006; Roy-Byrne et al., 2014; Saitz et al., 2014). In this case, SBIRT for addressing risky alcohol use is supported by an evidence base, particularly when the interventions are brief but include multiple contacts (Jonas et al., 2012) while using the techniques to address illicit drug use is not.

Additionally, SBIRT for alcohol use may not be the easiest prevention strategy to implement, and elements of the approach do not always work as advertised. Three recent effectiveness trials attempting to implement SBIRT using standard strategies in medical settings demonstrated little evidence for SBIRT in reducing hazardous or harmful drinking (Butler et al., 2013; Kaner et al., 2013; van Beurden et al., 2012). Furthermore, SBIRT interventions are intended to motivate more moderate and severe patients to engage in additional specialty SUD care, but a recent meta-analysis demonstrated that patients receiving a brief intervention are no more likely to participate in specialty care (Glass et al., 2015). These studies and others have also raised implementation concerns. For example, van Beurden et al. (2012) noted difficulties in recruiting physicians and motivating them to participate in the patient-tailored parts of the program. Other studies have shown that concerns about SBIRT implementation exist among providers, patients, and administrators alike. Medical providers worry about the logistics of fitting SBIRT into their busy daily clinical flow and lack confidence about their knowledge related to substance abuse problems (Broyles et al., 2012). Patients may have concerns about privacy and confidentiality when discussing their substance use with a medical provider (Rahm et al., 2014). On a broader level, integrating substance abuse screening and treatment with primary care can pose financing and documentation problems for health systems, as administrators may struggle with sustainability financing these interventions and integrating them with electronic health records (Padwa et al., 2012).

While brief counseling for patients at risk for illicit drug use has not delivered on its early promise and has posed some implementation problems, it is possible that more intensive integration of SUD care with medical treatment might yield more consistent results. Research trials that have integrated more intensive treatments such as medications for addiction into medical care have typically yielded more robust findings (Center for Integrated Health Solutions, 2013; Fiellin et al., 2006; Hesse, 2009; O'Malley et al., 2003; Oslin et al., 2014). Furthermore, studies that have brought primary care into treatment settings have also resulted in improved health outcomes for patients with SUDs (Saxon et al., 2006; Weisner, Mertens, Parthasarathy, Moore, &

Lu, 2001). However, the efficacy of intensive integrated care for SUD in primary care is not a settled matter, as one well-designed and intensive trial yielded no patient improvements (Saitz et al., 2013).

As SUD treatment integration efforts expand within primary care settings, training behavioral health providers in evidence-based brief treatment models that easily fit within the medical flow is essential. Reductions in resources for training and counselor turnover necessitating frequent re-training have left the field searching for more cost-effective training strategies. Continuing education workshops, the most widely used method of training counselors on evidence-supported treatments (ESTs), are insufficient to significantly change clinical practice unless followed by coaching, feedback, or supervision (Baer et al., 2004; Beidas & Kendall, 2010; Carroll et al., 2002; Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001; Schoener, Madeja, Henderson, Ondersma, & Janisse, 2006; Sholomskas et al., 2005; Smith et al., 2007; Walters, Matson, Baer, & Ziedonis, 2005). To counter the workforce training burden and improve patients' understanding of their treatment choices in specialty care SUD settings, we have developed EST "toolkits" consisting of multimedia tools (e.g., videos, colorful posters) and brief, flexible counselor guides. The "toolkit" strategy enables trainers to introduce an EST to counselors, provides concrete tools and immediate in-session prompts (i.e., graphic novels) to maintain its use, and promotes active learning on the part of the counselor and patient (Beidas & Kendall, 2010).

In our past work, our team developed toolkits focused on group delivery of cognitive behavioral relapse prevention (CB/RP) and 12-Step Facilitation (12SF), and tested these training strategies in specialty care substance treatment settings. Our EST Toolkits have been created with significant end-user and patient feedback. We conducted numerous focus groups and end-user interviews (Brooks, 2013; Brooks et al., 2012; Brooks, Laudet, et al., 2013) to adapt evidence-based approaches (Carroll, 1998; Marlatt & Gordon, 1985; Nowinski & Baker, 1992) into counselor/patient friendly presentations that would require minimal counselor training. We prioritized formats and communication strategies that were important to the patients (e.g., using serial, fictional narratives and maximizing the multimedia presentation) while carefully focusing on counselor usability (i.e., developing products that fit the workflow). In two NIDA-/NIAAA-funded counselor training trials, Toolkit training resulted in significant, enduring counselor improvement after only brief training (Brooks, Carpenedo, et al., 2013; Brooks, Laudet, Carpenedo, Carise, & Kirby, 2014; Brooks et al., 2012). Additionally, our 12-Step Toolkit changed counselor practice, resulting in some marginal improvement (i.e., non-significant trends in days of heavy drinking) among exposed patients (Brooks et al., 2014).

In the current project, in order to implement brief intervention and augment it with practical brief treatment approaches in primary care settings, our team adapted elements of Motivational Enhancement Therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1995), cognitive–behavioral therapy (CBT; Carroll, 1998) and 12-Step Facilitation (12SF; Nowinski & Baker, 1992) into a brief counseling toolkit appropriate for use to address mild and moderate substance use over multiple interventions. The SBIRT + Toolkit™ is a menu driven assortment of 35 separate structured clinical interventions that each include client takeaway resources to reinforce brief clinical contacts. The materials are designed to address neutral habit behaviors (e.g., breaking bad habits, setting positive habits) so that the Toolkit can be flexibly applied to multiple problems that present in primary care (e.g., medication adherence, smoking cessation). We designed the SBIRT + Toolkit™ to be implementable after modest clinician training, and also developed a self-help graphic novel to accompany the clinician interventions as an additional resource for primary care clinicians to provide to clients to jumpstart behavioral change between sessions. This Toolkit approach incorporates patient-centered health communications strategies that facilitate evidence-based practice with sustainable fidelity, and promote dissemination and transportability.