



Are Healthcare Professionals Ready to Address Patients' Substance Use and Mental Health Disorders?

A National Survey of Physicians, Nurses, and Nurse Practitioners

Co-Authored by

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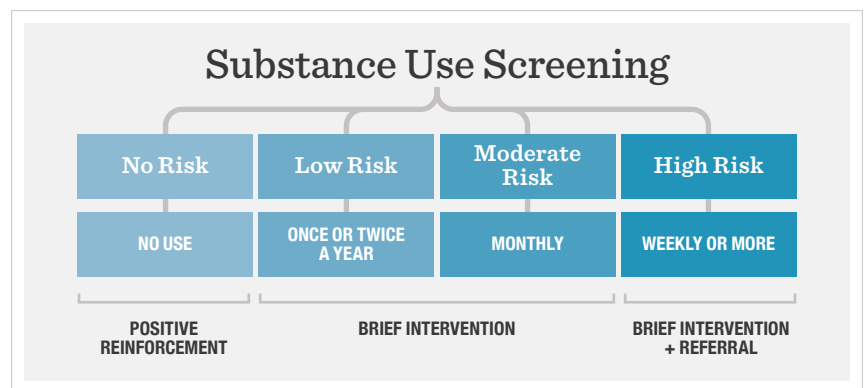
INTRODUCTION

Sixty-five million Americans will experience a mental health or substance use disorder in their lifetime, raising their risk of disease and mortality, and increasing healthcare costs.¹

Integrating behavioral health within routine care creates new opportunities for providers to assess every patient's mental health and substance use, intervene appropriately, and connect them to treatment and resources.

A number of evidence-based screening tools can be given verbally, electronically, or by paper questionnaires, and can be used to identify the severity of the problem. In turn, providing screening and brief behavioral interventions like motivational interviewing are evidence-based approaches to prevent, reduce, and treat substance use disorder, as well as address mental health concerns such as depression and suicide.^{2,3}

The U.S. Preventive Services Task Force (USPSTF) has endorsed screening and brief intervention (SBI) for adults who are at risk because of alcohol use⁴ or tobacco use.⁵ This set of clinical strategies is applicable to other health conditions and problems for which early detection and



timely interventions can be lifesaving. For instance, the USPSTF also recommends screening for depression, providing an accurate diagnosis, effective treatment, and appropriate follow-up.⁴

There are also strong economic indicators for the value of this health promotion and harm reduction approach. Research has shown that every dollar spent on screening and brief intervention for alcohol use can save over \$4 in future health care costs.⁶ Similarly, team-based care for depression (a condition that affects one in five Americans and accounts for more than \$200 billion per year in lost earnings),⁷ when integrated in primary care settings, has been found to save up to \$6 for every dollar invested while yielding improved patient outcomes.⁸

¹ Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.
² Deutekom, M., Vansenne, F., McCaffery, K., Essink-Bot, M. L., Stronks, K., & Bossuyt, P. M. (2011). The effects of screening on health behaviour: A summary of the results of randomized controlled trials. *Journal of Public Health*, 33(1), 71-79.
³ McCambridge, J., & Kypri, K. (2011). Can simply answering research questions change behaviour? Systematic review and meta analyses of brief alcohol intervention trials. *PloS One*, 6(10), e23748.
⁴ Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., ... & Landefeld, C. S. (2018). Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force

recommendation statement. *JAMA*, 320(18), 1899-1909.
⁵ U.S. Preventive Services Task Force. (2015). Tobacco smoking cessation in adults, including pregnant women: Behavioral and pharmacotherapy interventions. Retrieved from <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1>
⁶ Fleming, M.F., Mundt, M.P., French, M.T., Manwell, L.B., Stauffacher, E.A., & Barry, K.L. (2002). Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research*, 26, 36-43.
⁷ Insel, T.R. (2008). Assessing the economic costs of serious mental illness. *The American Journal of Psychiatry*, 165(6), 663-665.
⁸ Unützer, J., Katon, W. J., Fan, M. Y., Schoenbaum, M. C., Lin, E. H., Della Penna, R. D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American Journal of Managed Care*, 14(2), 95-100.

This approach is consistent with normalized practice for a broad range of medical conditions: screenings allow for their identification, followed by the development of a collaborative plan between provider and patient in order to address the risks associated with those conditions or behaviors, all at the point of care where the condition is identified.

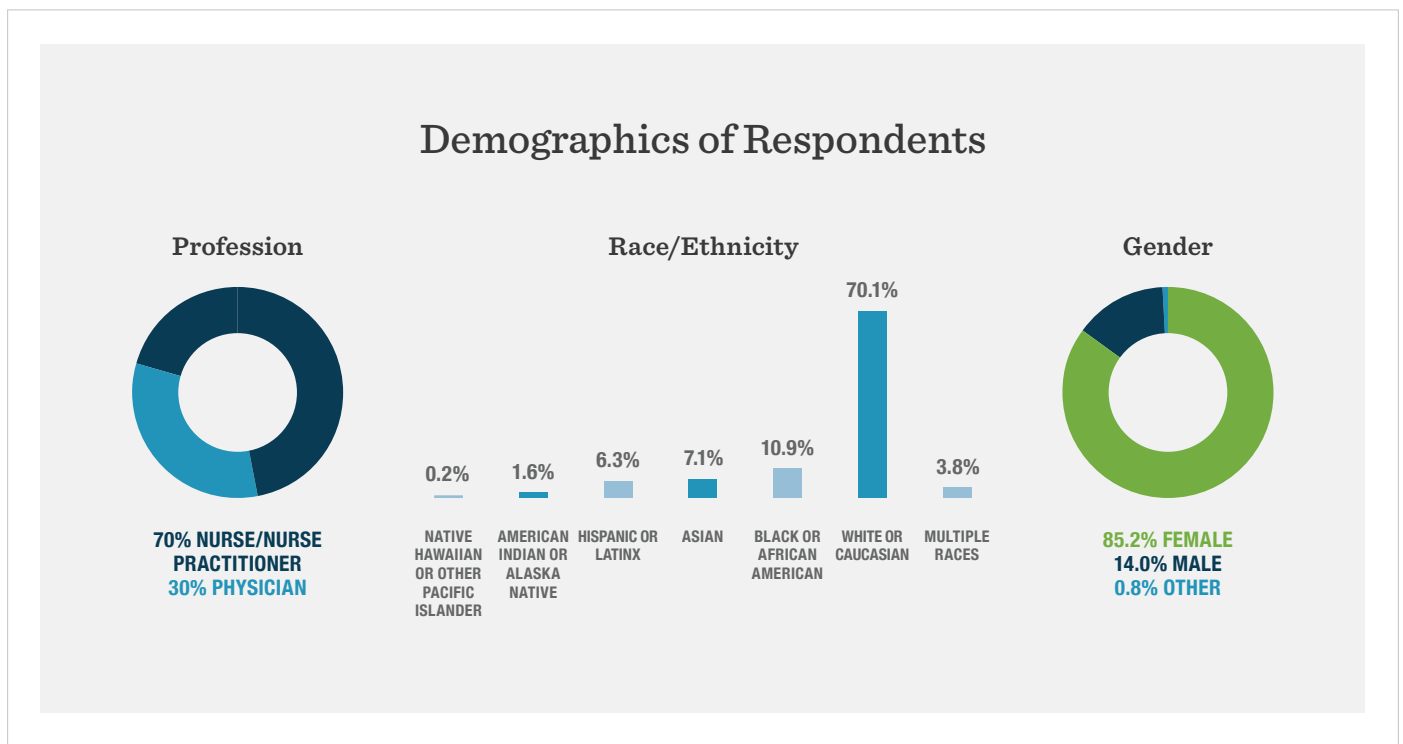
Implementing SBI may raise concerns about added time in patient visits, reimbursability of services, and initial cost of implementation.⁹ Yet the recent movement toward value-based care, parity legislation, and the high prevalence of opioid use and mortality have brought renewed impetus to arm all healthcare professionals with the skills to address patients' behavioral health in primary and acute care, community health centers, pharmacies, and other settings.

As primary and acute care practitioners are increasingly integrating substance use and mental health into routine care, we sought to answer the following questions:

1. Are healthcare professionals competent in delivering this set of clinical strategies for substance use and mental health?
2. How likely are they to carry out these activities as part of routine care?
3. How many patients do they currently engage in these activities?

THE SURVEY

Between August 2015 and September 2018, Kognito surveyed 676 healthcare professionals from over 50 organizations. Participants completed the survey immediately prior to enrolling in one of Kognito's online simulations on substance use and mental health SBI, which was implemented by their organization as a professional development activity. Participation in the activity was not mandatory. Participants were not compensated for taking the survey, but were offered 1.5 to 2.0 Continuing Medical Education (CME) credits or Continuing Nursing Education (CNE) credits, depending on their profession. On average, participants had 10.85 years of experience as healthcare professionals.



⁹ Rahm, A. K., Boggs, J. M., Martin, C., Price, D. W., Beck, A., Backer, T. E., & Dearing, J. W. (2015). Facilitators and barriers to implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care in integrated health care settings. *Substance Abuse*, 36(3), 281-288.

SURVEY HIGHLIGHTS

The survey revealed significant gaps in clinicians' assessment of their own skills to identify patients who might benefit from behavioral health services and to collaborate with these patients on accessing treatment.

Below are the survey findings, organized by type of learning outcome:

Competency

See Appendix Table 1

Overall, participants reported feeling largely unprepared to conduct SBI:

- **57% don't feel adequately prepared** to screen patients for substance use or mental health disorders, or to provide their patients with information about the impact of substance use and mental health.
- **64% don't feel adequately prepared** to use motivational interviewing to enhance their patients' motivation to change their behavior or seek help.
- **62% don't feel adequately prepared** to collaborate with their patients to create an action plan.

Behavioral Intent

See Appendix Table 2

Despite lack of preparedness, participants did report a strong likelihood to conduct SBI with patients:

- **84% are likely or very likely** to provide substance use or mental health screening, brief interventions, and referrals to treatment to their patients.

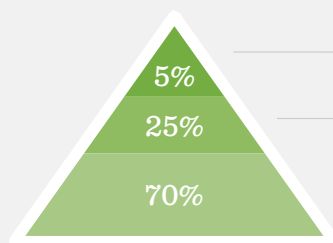
Current Behavior

See Appendix Table 3

Participants were asked how many patients they screened, engaged in brief interventions, and referred to additional help in the prior two months:

- On average, **physicians screened 17.6 patients, engaged in brief intervention with 5.6** (32% of those screened) and **referred 1.3** (7% of those screened).
- On average, **nurses/nurse practitioners screened 8.5 patients, engaged in brief intervention with 4.7** (55% of those screened) and **referred 3.5** (41% of those screened).

Alcohol Use Prevalence and Interventions



High Risk Use
Brief Intervention and Referral

Risky/Harmful Use
Brief Intervention

Low Risk Use/Abstinence
Positive Reinforcement

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). The alcohol use disorders identification test (AUDIT): Guidelines for use in primary care. Geneva, Switzerland: World Health Organization.

NEED AND DEMAND FOR SBI TRAINING

Overall, healthcare professionals responding to this survey report not feeling adequately prepared to address the needs of patients with potential substance use and mental health problems. Such lack of preparedness means that patients will

recognize the value of addressing the behavioral needs of patients, and that they would do so if they knew how. Having a workforce that is willing to translate evidence into practice is an important facilitator for implementation.¹⁰

The findings make it clear that considerable investment in preparing the healthcare professional workforce is needed to address the behavioral health needs of patients.

go undetected for common behavioral health problems for which screening measures and intervention models exist and can be feasibly administered in most healthcare settings.

Also of concern is that over 60% of healthcare professionals did not feel adequately prepared to engage in motivational conversations with their patients to promote health behavior change - skills that are also relevant in supporting patients in managing their chronic health and following treatment recommendations.

Less than half of respondents felt adequately prepared to collaborate with patients on treatment plans. The findings make it clear that considerable investment in preparing the healthcare professional workforce is needed to address the behavioral health needs of patients.

Despite their overwhelming lack of preparedness, it is encouraging that over 80% of respondents reported an intent to utilize these clinical skills with their patients. It seems that these healthcare providers

The total number of patients for whom the healthcare providers delivered any component of SBI suggests that they are provided to only a fraction of their patients. The absence of data on the total number of patients seen in the past two months precluded the ability to calculate the proportion of patients who were screened.

Screening

Despite this, respondents reported fairly small numbers of patients whom they screened in the prior two months. This low number is not surprising since a high proportion of providers reported not feeling adequately prepared to do so, though it is not known whether they were working in systems where universal screening was implemented. Further unknown is whether these providers knew what screening entails, whether they were using established screening measures or even knew such measures exist, or whether they were relying on non-evidence-based methods of detection.

Brief Intervention

On average, healthcare providers reported a smaller number of patients who received a brief intervention (BI) than those screened. The level of risk identified through screening should be used to guide the intervention. About 70% of the US population is at low risk due to abstinence or low-risk alcohol consumption. The remaining 30% of the US population falls into at-risk use (25%) or potential alcohol dependence (5%), groups that merit a BI.

What is not known from this survey is whether the patients engaged in a BI were previously identified by a screening tool to be at a risk level that merits a BI. Providers may have delivered a brief intervention to patients who were not screened, or to patients who were screened but did not present harmful use. Further, providers may have different notions of what constitutes a BI or brief motivational counseling.

Some may believe that a BI entails giving advice and lecturing patients about alcohol, as opposed to using a collaborative communication style such as motivational interviewing.

Referral to Treatment

About 5% of the total population should necessitate a BI and a referral to a specialist for diagnostic evaluation and treatment. Not known from this survey is whether providers based the decision to refer on the level of risk identified from the screening. These providers referred approximately 25% of the number

¹⁰ Johnson, M., Jackson, R., Guillaume, L., Meier, P., & Goyder, E. (2010). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: A systematic review of qualitative evidence. *Journal of Public Health, 33*(3), 412-421.

of patients they screened, more than five times what would be expected based on population estimates (and approximately 50% when examining adult patients only). This high rate of referral for additional treatment services may be because providers, as reported above, do not feel adequately prepared to create an action plan, such as when a referral is indicated.

Systematically referring patients to specialist treatment settings who could otherwise receive a BI and treatment in primary care raises concerns around unnecessary costs and patient burden for specialty care settings...

Some providers may fear upsetting patients or otherwise abdicate their role in addressing substance use as part of primary care and thus, believe that referring patients to a specialist is the best approach.¹⁰

Systematically referring patients to specialist treatment settings who could otherwise receive a BI and treatment in primary care raises concerns around unnecessary costs and patient burden for specialty care settings, and the potential for patients not receiving that treatment because of long wait times or other barriers to accessing specialty care. Since patients appear to expect more discussion about substance use with their healthcare providers,¹⁰ enhancing competency to deliver this set of evidence-based strategies is imperative.

While physicians engaged in screening more patients than nurses, they engage a much smaller percentage of patients in a brief intervention (32% vs. 55%) and referral to treatment (7% vs. 41%).

CONCLUSION

Efforts have been undertaken to incorporate SBI into education for future healthcare providers including medicine¹¹ and nursing.¹² However, as the integration of this content into curricula has occurred only recently, the healthcare professionals responding to this survey may not have had this advantage. This lack of core education may explain the gap between low preparedness but high willingness to conduct SBI reported in the survey.

At a time when the prevalence of drug overdoses are contributing to a reduction in life expectancy, when alcohol accounts for one in every ten adult deaths in the U.S.,¹³ and depression and suicide rates continue to rise at an unprecedented rate,¹⁴ there is renewed impetus to treat substance use and mental health like other health conditions. This approach begins with the detection of risk in primary care with calls now to extend to those at risk because of opioid use. That is, primary care providers can be mobilized to reach the millions of Americans with opioid use disorder including identifying patients who are at risk because of opioid and providing evidence-based actions in primary care that can have an immediate lifesaving effect.¹⁵

There is also evidence that people with substance use disorders are more willing to enter treatment in a primary care setting than in a specialty setting.¹⁶ For healthcare providers to keep pace with this need, they must have the knowledge and skills to address the needs of patients with behavioral health conditions as part of routine practice and on par with any physical illness.

¹¹ Tetrault, J. M., Green, M. L., Martino, S., Thung, S. F., Degutis, L. C., Ryan, S. A., ... & Fiellin, D. A. (2012). Developing and implementing a multispecialty graduate medical education curriculum on screening, brief intervention, and referral to treatment (SBIRT). *Substance Abuse*, 33(2), 168-181.

¹² Finnell, D. S., Savage, C. L., Hansen, B. R., Sanchez, M., White, K. M., Johnson, J. A., & Seale, J. P. (2018). Integrating substance use content in an "overcrowded" nursing curriculum. *Nurse Educator*, 43(3), 128-131.

¹³ Centers for Disease Control and Prevention. (2018). Fact Sheets - Alcohol Use and Your Health. Retrieved from www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm.

¹⁴ Hedegaard, H., Curtin, S. C., & Warner, M. (2018). Suicide mortality in the United States, 1999-2017. (NCHS Data Brief No. 330). Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/nchs/data/databriefs/db330-h.pdf>.

¹⁵ Wakeman, S. E., & Barnett, M. L. (2018). Primary care and the opioid-overdose crisis—Buprenorphine myths and realities. *New England Journal of Medicine*, 379(1), 1-4.

¹⁶ Barry, C. L., Epstein, A. J., Fiellin, D. A., Fraenkel, L., & Busch, S. H. (2016). Estimating demand for primary care-based treatment for substance and alcohol use disorders. *Addiction*, 111(8), 1376-1384.

AUTHOR BIOS

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Dr. Deborah S. Finnell has specialized in mental health and addictions for most of her career. Her 30-year tenure in higher education has been grounded on her professional practice as a registered nurse, psychiatric/mental health clinical nurse specialist and nurse practitioner. With funding awards from the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Finnell and her team integrated substance use-related content, including SBIRT into prelicensure and graduate nursing curricula. Her current work focuses on SAMHSA-funded curricular enhancements related to safe prescribing of opioids and opioid-agonist/antagonist treatment and supports for persons with opioid use disorder. As a fellow in the American Academy of Nursing, Dr. Finnell focuses on mental health and substance use policy-related initiatives.

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Co-Founder and Director of Research, Kognito

Dr. Glenn Albright is a clinical psychologist and former chair of the Department of Psychology at Baruch College, City University of New York. He is also co-founder and director of research at Kognito where his research evaluates the efficacy of game-based health simulations designed to bring about changes in health and mental health behaviors and can cost-effectively impact large numbers of geographically dispersed people that would benefit the most from such training. In his spare time, Dr. Albright volunteers his time running an equine psychotherapy practice for veterans with PTSD.

For Questions about the Survey:

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Kognito is a developer of role-play simulations designed to prepare people to lead conversations in real life that result in measurable improvements in social, emotional, and physical health. Kognito's suite of mental health simulations for PK-12, higher education, primary care, and acute care settings has been utilized by over 500 organizations. Its higher education programs are also listed in the National Registry of Evidence-Based Programs and Practices. **Learn more at kognito.com.**

APPENDIX

Table 1: Please rate your preparedness to:

	Very Low, Low, Medium	High, Very High
A. Screen patients for substance use and mental health disorders	57.2%	42.8%
B. Engage patients who screen positive in a conversation about substance use and mental health	59.1%	40.9%
C. Provide information about the impact of substance use and mental health on patients' health	57.2%	42.8%
D. Use motivational interviewing techniques to enhance patients' motivation to lower their substance use and seek help	63.9%	36.1%
E. Collaborate with patients to create an action plan	61.5%	38.5%
F. Schedule a follow-up visit or refer patients to additional support services when needed	52.3%	47.7%

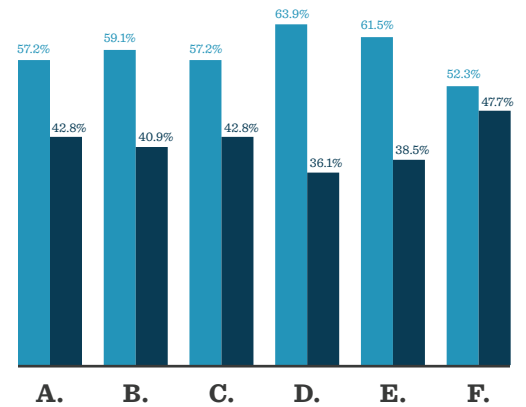


Table 2: How likely are you to conduct substance use or mental health screening, brief interventions, and referrals?

A. Very Unlikely	3.5%
B. Unlikely	12.6%
C. Likely	50.2%
D. Very Likely	33.7%

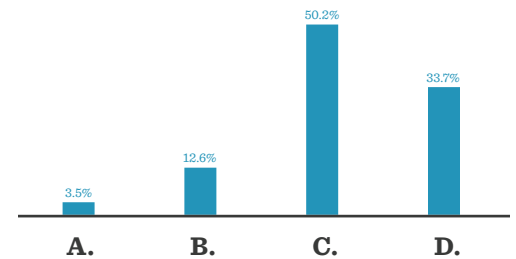


Table 3: In the past two months, approximately how many patients have you:

	Physicians (n=205)	Nurses/NPs (n=471)
A. Screened for substance use	17.6	8.5
B. Engaged in brief motivational counseling	5.6	4.7
C. Referred to additional treatment services	1.3	3.5

