introduction to SBIRT
screening, brief intervention, & referral to treatment

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part I: the substance abuse continuum
the substance abuse continuum

- non-use
- healthy use
- experimental/social/recreational use
- misuse
- abuse/dependence
identifying the at-risk user

- at ‘moderate’ risk for a substance use disorder
- patients who are not dependent
- at increased risk for health problems (i.e. hypertension, liver damage, etc.)
- at increased risk for mental health problems
- may be sufficient to provide brief intervention without a referral (i.e. education)

*Primary target for the SBIRT model*
safe drinking limits

Categories of Drinking

- 78% Low Risk or Abstain
- 9% II Risky
- 8% III Harmful
- 5% IV Dependent

Low-risk Drinking Limits

<table>
<thead>
<tr>
<th></th>
<th>Per Week</th>
<th>Per Day</th>
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</thead>
<tbody>
<tr>
<td>Men</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Women</td>
<td>7</td>
<td>3</td>
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<tr>
<td>over 65</td>
<td>7</td>
<td>3</td>
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A Standard Drink

- 12 oz beer
- 5 oz wine
- 1.5 oz liquor

Any drink containing about 14 grams of alcohol
illicit drug use

• is it ‘problematic’ because it is illegal?
• some argue minimal use is ‘experimental’ or ‘social’
• some argue all adolescent use is problematic

think of problem use in terms of: What problems is the use causing for the patient? (i.e. health problems, marital problems, etc.)…

…just because it’s not dependence doesn’t mean it’s not a problem.
common mistake: not intervening because the client/patient is not dependent
part II: substance abuse prevalence
National Institute on Drug Abuse researchers estimate only 11% of individuals requiring substance abuse treatment services receive them.
alcohol use/abuse

- **20%** of adult US population might be considered high risk drinkers
  - **5%** of population is dependent
- prevalence in young adults
  - **34%** of 19-28 year olds engaged in binge drinking in the past month
- prevalence in adolescents
  - half of HS seniors report alcohol use in previous month
  - nearly **30%** report binge drinking in previous 2 weeks
alcohol-related deaths & injuries

- more than **100,000** alcohol-related deaths annually
- problem drinkers have 2 accidents/injuries per year on average
- 14/100 ED visits for injuries/accidents are alcohol related; other studies note higher rates
- **10%** of alcohol-related ED admissions are older adults
  - medication interactions; self-medicating depression; increased sensitivity to alcohol
drug use/abuse

- illicit drug use is increasing
- in 2012, 9.2% of population reported using illicit drugs in the previous month
- most commonly used illicit substance – marijuana
  - followed by prescription pain medication
  - marijuana use & prescription drug abuse are increasing
- in 2009, 21.2% of ED visits were related to illicit substances
most commonly abused drug by high school seniors (after marijuana)

in 2009, nearly 30% of ED visits (27.1%) involved the misuse of pharmaceuticals (OTC & prescription) (often combined with other drugs & alcohol)

– from 2004-2009 ED visits due to or involving pharmaceutical misuse increased by 98.4%
tobacco use

• leading cause of preventable death in the U.S.
• health consequences
  – smoking tied to 90% of lung cancer cases
  – nearly 50,000 people die annually from second hand smoke related illnesses
• usually require multiple attempts to quit
• 5% success rate when smokers try to quit ‘cold turkey’ with no external support
• brief interventions for tobacco use have been shown to be effective
part III: the evidence for brief interventions
World Health Organization conducted an international study of brief interventions with high-risk alcohol users

- 10 countries; over 1,200 participants
- Treatment interventions: advice giving/education, brief interventions, ongoing counseling
- Results:
  - 27% reduction in use with a 15 minute intervention
  - 21% reduction in use with only a 5 minute intervention
the evidence for alcohol interventions

• Gentilello et al. (1999)
  – injury patients (n=732) coming into the ER
    • screening + BI for alcohol were provided
  – reduction in consumption from 21.8 drinks/week to 6.7
  – strongest effect with moderate drinkers: 21.6 drinks/week to 2.3
  – injuries reduced by 48% by 3 year follow-up**

**not replicated
Fleming and colleagues treated alcohol use in primary care (Fleming et al., 1997; Fleming et al., 2000) intervention: brief intervention, patient workbook, two 15 min. visits, 2 nurse follow-up calls

results:

- reduced weekly drinking from 19/week to 11.5 (at 12 mos)
- reduced binge drinking from 5.7x/month to 3.1 (at 12 mos)
- 6:1 cost savings for treatment group; $56K saved for every $10K spent
the evidence for drug abuse interventions

- data less robust for drugs than alcohol
- strong evidence for screening & referrals
- weaker/inconclusive evidence for brief interventions
- exception: tobacco
making sense of the literature

- reduction in **volume & frequency** of substance use
  - reduces risky drinking by about 12%
  - reduces consumption by about 15%
- **multiple** contacts more impactful than single contacts
- poorer outcomes with heavy/high risk users; stronger outcomes with **moderate risk users**
- poorer outcomes for those with **co-occurring disorders**
- better outcomes in **primary care** than hospitals
- few people show up when we make a **referral**

(SAMHSA white paper, 2011; National Council SBIRT Brief, n.d.; Jonas et al., 2012; Beich et al., 2013; Saitz, 2015)
part IV: SBIRT model overview
history

• stems from the public health arena
  – identify risky use prior to dependence
  – intervene with individuals engaging in risky behaviors

• SAMHSA definition:
  “…comprehensive, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, and the timely referral to more intensive substance abuse treatment for those who have substance abuse disorders.”

• uniqueness of SBIRT: focus on universal screening
settings

- hospitals
- community health centers
- primary care settings*
- emergency departments
- trauma centers
- public health settings
- dental clinics
- schools
- specialty clinics (i.e. HIV clinics)
- community behavioral health agencies
- jails/prisons
screening decision tree

- Low Risk: No Further Intervention
- Moderate Risk: Brief Intervention
- Moderate to High Risk: Brief Treatment
- Severe Risk, Dependency: Referral to Specialty Treatment

*or reinforce their healthy use*
• SAMHSA model promotes **universal** screening
• may utilize pre-screening (often shorter versions of existing screening tools)
• preferably validated screening tools
• screening tools you can repeat to capture changes are ideal
• screening tools may identify those needing a full assessment
BI – brief interventions

• 15-30 minutes; 1-5 sessions
• assist patients in seeing a connection b/w their substance use and their health/wellbeing
• might include:
  – educational intervention
  – motivational enhancement
• goal: abstinence or cutting back
• target 1-2 risky behaviors
BI – brief interventions (cont’d)

• brief treatment: **5-12 sessions** (per SAMHSA)
  – for those you can see on an ongoing basis at your site
  – often utilizing a **cognitive behavioral** approach
  – might be more appropriate for patients with a long-term substance use problem or higher level of risk
RT – referrals to treatment

• high risk or dependent patients
• referral to an outside specialty provider
• precede the referral with a motivational approach to ensure follow through
• warm hand-off
• importance of building linkages with the substance abuse treatment provider
part V: screening 101
message from NIDA Director
the case for universal screening

the research literature shows we’re not very good at identifying those with substance abuse problems…

– over-identify disenfranchised groups

– over-identify dependent users; under-identify risky users

– there may not be overt signs of one’s use
types of screening tools

• questionnaire (self-report)
  – perhaps completed in the waiting room
• interview (3-5 questions the clinician asks)
• biological markers
  – i.e. breathalyzer, urine analysis, blood alcohol content
screening tools should be….

- brief
- easily scored
- validated
- capture drug and alcohol use (preferably)
- publically available (i.e. free!)
- utilize self-report
- indicative of risk level
- available (and preferably validated) in different languages
administering a screen

screens can be completed....

• in the waiting room/lobby
• amongst intake paperwork
• by administrative staff
• during a medical exam
• during a behavioral health session
• following certain events (i.e. motor vehicle accident) or because certain labs/tests (i.e. BAC indicates intoxication)
alcohol screening tools

Alcohol Use Disorders Identification Test (AUDIT)
  – identifies problem drinkers or dependence
  – appropriate for adults or adolescents
  – 10 items
  – domains (e.g. frequency, quantity, morning drinking, guilt)
  – sum the scores
  – scoring: 0-7 (low), 8-15 (low-moderate), 16-19 (moderate), 20+ (high)
Drug Abuse Screening Test-10 (DAST-10)

- 10 items
- captures drug use/misuse
- **does not** capture alcohol & tobacco use
- self-administered or interview
- appropriate for adults
- yes = 1 point (except #3, no = 1 point)
- scoring: 1-2 (low risk); 3-5 (moderate risk); 6-8 (substantial risk), 9-10 (severe)
• **Alcohol, Smoking and Substance Involvement Screening Test 3.0 (ASSIST)**
  – expansion of the AUDIT
  – developed by the World Health Organization
  – 5-10 minutes to administer
  – intended to be an interview
  – covers most substances (alcohol, tobacco, most illicit drugs)
  – available in Spanish
part VI: brief interventions
brief interventions

- educational brochures or handouts
- education using visual aides (standard drink sizes, risky drinking levels, etc.)
- recommendations for cutting back
- readiness rulers/scaling questions

tips & hints:
- use the **stages of change** to inform your approach
- ideally, the conversation would incorporate a **motivational interviewing** style
employing a motivational approach

• minimize closed-ended questions & advice
• utilize open-ended questions that provoke the patient to explore why or how they may want to change their substance use
  – “What might be some of the good things about cutting back on your alcohol use?”
• reflect back some of the things the patient is saying about changing their substance use
  – “Your worried about how your alcohol use might impact your diabetes.”
• Ask, Don’t Tell (R. Rhode)
part VII: referrals
who requires a referral?

**only 3-4% of those screened will require a referral**

who should be referred:

- dependent users (those meeting DSM-5 criteria)
- those with a comorbid mental health disorder
- high-risk users (e.g. drunk drivers, those who have contracted an infectious disease, etc.)
warm handoffs

• arrange transportation
• call together to make initial intake appointment
• provide written information for the provider
• address barriers (i.e. insurance)
• call patient to ensure they attended intake
• schedule follow-up with referring clinician
part IX: implementation strategies
billable

- Medicare/Medicaid Screening & Brief Intervention (SBI) codes not billable in Arizona
- for SBIRT billing in Arizona utilize Health & Behavior codes (see handout for codes)
- must be tied to a medical diagnosis
- must focus on functioning (how their behavioral health, i.e. substance use, impacts their physical health)
- bill 15 min. increments, for a total of 1 hour per visit
discussion:

In what ways is your site well poised to implement SBIRT?

What challenges might you experience and how might you combat them?
ongoing training

• 1.5 hour online training, *Foundations of SBIRT*:  

• 4 hour online SBIRT training:  
  http://psattcelearn.org/courses/4hr_sbirt/

• IRETA, SBIRT Addiction Technology Transfer Center:  
  http://my.ireta.org/ATTC

• *Introduction to SBIRT* – @ Arizona State University  
  Tucson campus, 9/1/15, 9am-12pm (complimentary registration; sponsored by Health Choice Integrated Care and the Governor’s Office for Children, Youth & Families)

https://cabhp.asu.edu/events