Strongly agree ☐
Agree ☐
Disagree ☐
Slightly disagree ☐

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

- SBIRT overview
- screening tools
- methods for enhancing motivation
- effective referrals
- additional resources
key terms

- **screening**: brief tool used to identify those at risk for substance use disorders
- **brief intervention**: brief interaction that serves to educate the client and motivate them to move in the direction of healthier behaviors
- **brief treatment**: ongoing intervention, 5-12 sessions, cognitive-behavioral in nature
- **referral for treatment**: referral to an offsite intensive substance abuse treatment program for individuals requiring more extensive treatment than the current setting can offer
part I: SBIRT overview
22 million Americans met the criteria for an alcohol or drug use disorder in 2010.

(National Survey on Drug Use and Health, 2011)
$235\ billion$
the annual cost of alcohol abuse in the United States in the form of healthcare costs, lost productivity, criminal justice costs, etc.

$193\ billion$
the annual cost of drug abuse in the United States in the form of healthcare costs, lost productivity, criminal justice costs, etc.

(US Dept. Health and Human Services, 2014; CDC, 2015; National Drug Intelligence Center, 2011)
The National Institute on Drug Abuse estimates only 11% of individuals requiring substance abuse treatment services receive them.
the substance use continuum

- non-use
- experimental/social/recreational use
- healthy use
- misuse
- abuse/dependence
history of SBIRT

- 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
- primary care settings
- emergency departments
- trauma centers
- public health settings
- dental clinics
- schools
- jails/prisons
- community health centers
- specialty clinics (i.e. HIV clinics)
- community behavioral health agencies
identifying the at-risk user

• at ‘moderate’ risk for a substance use disorder
• clients/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% risky
- 8% Harmful
- 5% Dependent

Low-risk Drinking Limits

<table>
<thead>
<tr>
<th>Category</th>
<th>Per Week</th>
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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 client? (i.e. health problems, marital problems, etc.)...

...just because it’s not dependence doesn’t mean it’s not a problem.
common practice: not intervening because the client is not dependent
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
Drinking Behavior

Intervention Need

- **75%** Low Risk or Abstinence
- **20%** Hazardous or Harmful
- **5%** Symptomatic

- **Brief Intervention and Referral for Additional Services**
- **Brief Intervention or Brief Treatment**
- **No Intervention or Screening and Feedback**

Developed by, and used with permission of Daniel Hungerford, Ph.D., Epidemiologist, Center for Disease Control and Prevention, Atlanta, GA
rationale for alcohol interventions

- alcohol is the 3rd leading cause of preventable death
- large body of evidence supporting brief interventions for alcohol misuse
- demonstrated reductions in:
  - consumption
  - binge drinking
  - risky behaviors
  - mortality/morbidity
  - accidents/injuries
- slowed progression toward/prevention of dependence
- dosage matters: more contacts=stronger effect
illicit drug use is increasing

in 2014, **10.2%** 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

47,055 prescription and illicit opioid-related deaths in 2014, double the rate of deaths from a decade earlier.

(Centers for Disease Control, 2015)
making sense of the SBIRT 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**
- 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 II: screening 101
screening decision tree

Low Risk
- No Intervention

Moderate Risk
- Brief Intervention

Mod-High Risk
- Brief Treatment

Severe Risk; Dependency
- Referral

or reinforce their healthy use
the case for universal screening

the research literature indicates 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

HAVE YOU EVER FELT INVISIBLE BEFORE?
screening candidates:

– college students
– adolescents
– clients with a mental health condition
– those with infectious diseases (HCV, HIV)
– those with a drug/alcohol offense (i.e. DUI)
– accident victims (i.e. MVA)
– pregnant women
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
- 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
• completed amongst intake paperwork
• completed by administrative staff
• completed during a medical exam
• completed during a behavioral health session
• administered following certain events (i.e. motor vehicle accident) or labs/tests (i.e. BAC indicates intoxication)
alcohol pre-screens

National Institute on Alcohol Abuse & Alcoholism (NIAAA) pre-screen

1) “On average, how many days per week do you drink alcohol?” (frequency)

2) “On a typical day when you drink, how many drinks do you have?” (volume)
   (multiply 1 & 2 to get weekly average; compare to weekly limits)

3) “What’s the maximum number of drinks you had on a given occasion in the last month?” (binge drinking)
   (4 drinks in 2 hrs for women; 5 drinks in 2 hrs for men)

– Single question screen from NIAAA
  • “How many times in the past year have you had X or more drinks in a day?” (X=4 for women, 5 for men) (response of 1 or more is a positive screen)
alcohol screening tools

Alcohol Use Disorders Identification Test (AUDIT)

- identifies problem drinkers or those with alcohol 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
- domains: poly-substance use, relational problems, withdrawal, etc.
- 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)
adolescent screen - CRAFFT

- **C** – Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?
- **R** – Do you ever use drugs or alcohol to **RELAX**, feel better about yourself, or fit in?
- **A** – Do you ever use drugs or alcohol while you are by yourself, **ALONE**?
- **F** – Do you ever **FORGET** things you did while using alcohol or drugs?
- **F** – Do your family or **FRIENDS** ever tell you you should cut down on your drinking or drug use?
- **T** – Have you gotten into **TROUBLE** while you were using drugs or alcohol?
Alcohol, Smoking and Substance Involvement Screening Test 3.0 (ASSIST)

- Developed by the World Health Organization
- Developed for use in primary care
- 5-10 minutes to administer
- Intended to be an interview
- Covers most substances (alcohol, tobacco, most illicit drugs)
- Available in Spanish
part III: enhancing motivation
brief interventions

• for moderate risk clients
• 15-30 minutes; 1-5 sessions
• assist clients 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 (i.e. drinking and driving, combining sedatives & alcohol, overuse of pain medication)
brief interventions (cont’d)

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

might incorporate:
  – the **stages of change** to match intervention with readiness
  – **motivational interviewing** to enhance intrinsic motivation
patient education

You may want to...

• review results of screener
• ask permission to provide information
• provide pamphlets, brochures, or have a verbal exchange
  – provide factual information about the health consequences of engaging in the use of that particular substance
• check back in with the patient…what do they think?

You may want to avoid...

– advising, warning, utilizing scare tactics (if they want to be consistent with a motivational approach)
– educating without permission
employing a motivational approach

• minimize closed-ended questions
• avoid advice and scare tactics
• 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
  – “You’re worried about how your alcohol use might be negating the impact of your antidepressants.”
readiness rulers

SBIRT | Screening, Brief Intervention, and Referral to Treatment

cabhp.asu.edu

Categories of Drinking

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

Low-risk Drinking Limits

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<td>Audit</td>
<td>0-7 DAST: 0</td>
<td>8-15 DAST: 1-2</td>
<td>16-19 DAST: 3-5</td>
<td>20+ DAST: 6+</td>
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<td>Raise the Subject</td>
<td>“If it’s okay with you, let’s take a minute to talk about the annual screening form you’ve filled out today.”</td>
<td></td>
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<td>Provide Feedback</td>
<td>“As your doctor, I can tell you that drinking (drug use) at this level can be harmful to your health and possibly responsible for the health problem you came in for today.”</td>
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| Enhance Motivation| “On a scale of 0-10, how ready are you to cut back your use?”  
- If >0: “Why that number and not a ___ (lower one)?”  
- If 0: “Have you ever done anything while drinking (using drugs) that you later regretted?” | | | |
| Negotiate Plan  | “What steps can you take to cut back your use?”  
- “How would your drinking (drug use) have to impact your life in order for you to start thinking about cutting back?” | | | |
brief treatment

• brief treatment: **5-12 sessions** (per SAMHSA)
  – seen onsite for an extended period of time
  – often utilizing a **cognitive behavioral** approach
  – might be more appropriate for clients with a long-term substance use problem or higher level of risk
part IV: making effective referrals
who requires a referral?

_only 3-4% of those screened will require a referral_

who should be referred:

• those meeting criteria for a substance use disorder (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 client to ensure they attended intake
- schedule follow-up with referring clinician
• Medicare/Medicaid Screening & Brief Intervention (SBI) codes not billable in Arizona
• for SBIRT billing in Arizona utilize Health & Behavior 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
• reimbursement map: http://my.ireta.org/sbirt-reimbursement-map
video demonstration
part V: additional resources
additional resources

- Screening tools: http://www.integration.samhsa.gov/clinical-practice/sbirt/screening
- 1.5 hour online training, Foundations of SBIRT: https://www.thedatabank.com/dpg/423/donate.asp?formid=mee tb&c=8121495
- 4 hour SBIRT training http://psattcelelearn.org/courses/4hr_sbirt/
Avatar practice:
https://training.simmersion.com/Launch/Free/3f9f4dde-c68c-44d3-a143-041e6604aaf5
Thank you!

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