Northwest Frontier ATTC
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Addiction Messenger

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SBIRT

Part 1 - Why Screen and Intervene?

Research shows that at critical moments just a brief screening and intervention can help someone reduce or stop risky substance use, in some cases before misuse crosses into addiction. Beginning with this issue the next three AM articles will review the processes and potential outcomes of Screening, Brief Intervention, and Referral to Treatment (SBIRT).

There are now brief, evidence-based SBIRT tools available for a variety of settings and needs. SBIRT is both a preventative strategy and a treatment approach that focuses on identifying and helping people who use drugs or drink alcohol at a risky level. While there are several excellent models available, the basics of SBIRT are similar: a quick pre-screen (often just 2-4 questions) may begin the process; then, as warranted, be followed by a more in-depth screening, a brief intervention (sometimes brief treatment), and/or referral to treatment.

The general flow of an SBIRT program is illustrated below (OHSU, 2010).

A Public Health Approach

"SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders." (SAMHSA, 2010)

Routinely conducting just one to a few brief meetings can have a huge impact on the health of individuals and ultimately on families and whole communities. A national effort is underway for broad implementation of SBIRT, involving multiple governmental agencies, policy makers, administrators, providers, community members, and others. Key to the success of efforts is creating a system or network of early intervention and referral activities conducted in medical and social-service settings with strong linkages to specialized treatment programs.

SBIRT is part of a larger shift toward a public health model for addressing problems related to substance use. In the future, substance abuse treatment, mental health, primary care, and related services will be increasingly integrated in an effort to reach more people and provide them with a more seamless recovery-oriented system of care. As the shift occurs addiction professionals may be called upon to work in and collaborate with primary care and other settings where services such as SBIRT and medication-assisted treatment are being offered. Brief Intervention/Treatment models can be used in addiction treatment settings with clients who are assessed but don't meet the diagnostic criteria for abuse or

"Any approach to addressing unhealthy alcohol and drug use that does not include attention beyond those with dependence who receive specialty treatment misses the majority of people affected"

~ Richard Saitz, MD, MPH (2007) ~

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Next Issue:

Core Processes of SBIRT

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dependence, or as part of relapse prevention during long-term continuing care. Providers in many settings – behavioral health, primary care, social service, criminal justice, and schools at all levels – can benefit from understanding and applying the instruments and processes of SBIRT.

Defining SBIRT

Screening refers to using a validated instrument to quickly assess the "risk level" of substance use and identify individuals who might benefit from intervention. A brief questionnaire or interview is often sufficient to identify patients with substance use problems. Screening differs from assessment in that it doesn't establish a *definite* diagnosis. An SBIRT provider might begin with a pre-screen (in some cases just one to four questions); then, as needed, initiate a more entailed screening. A number of validated screening instruments are available, including the ASSIST, AUDIT, DAST, or CRAFFT.

Brief Intervention (BI) occurs when initial screening indicates a risk level as moderate to high; the focus is on increasing insight and awareness regarding substance use and motivation toward behavioral change. During BI the individual receives education about substance use, possible consequences, and other personalized feedback and counseling based on the individual's risk level. This is often enough to encourage reduced alcohol intake. Motivational interviewing techniques are typically used to encourage the patient to modify their behavior. BI may range from a session conducted in minutes, with no follow-up required, to from 1 to 4 short counseling sessions with a trained interventionist. As distinguished from specialized treatment, BI goals generally don't focus on abstinence (though that may be encouraged), but rather on reducing consumption or negative outcomes (such as injuries, domestic violence, auto accidents, or damage to a developing fetus). Some high risk users will accept a referral to treatment, but even those who don't may experience significant improvement through repeat visits with a health or social service provider skilled in SBIRT.

Brief Treatment (BT) is similar to BI in emphasizing motivation to change and client empowerment. It may be used for those with moderate to high risk and be conducted over three or more sessions.

Referral to Treatment (RT) provides those at highest risk with access to specialty care. Referral can be made any time during the SBIRT process. A referral coordinator may help patients identify a program best suited to their needs.

BT and RT may be services especially suited to addiction specialists skilled at intervention and knowledgeable about available treatment options.

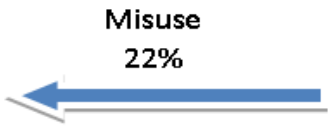
The Need for SBIRT

Substance use is one of America's top preventable health issues. The World Health Organization (2005) estimated that 20 major risk factors are responsible for almost half of the approximately 57 million annual deaths that occur worldwide; alcohol and tobacco ranked among the top ten preventable risks that collectively contributed to 40% of these deaths.

At-risk drinking and alcohol problems are common. About 3 in 10 U.S. adults drink at levels that elevate their risk for physical, mental health, and social problems; of these, about 1 in 4 currently has alcohol abuse or dependence (NIAAA, 2005).

Alcohol Misuse Among Primary Care Patients:

Alcohol:	Drinks per week	Drinks per day
Men	14	4
Women	7	3
All age >65	7	3
Drugs: Any illicit use		



National Institute on Alcohol Abuse and Alcoholism

A vast number of physical ailments are associated with alcohol use, including chronic liver disease, eight specific cancers, heart disease, pancreatitis, stroke, and injuries. Alcohol can also exacerbate a number of chronic medical conditions, including hypertension and diabetes. Co-occurring psychiatric conditions (such as anxiety, personality, and mood disorders) are more common in substance users. Undetected risky use can compromise medical or psychiatric treatment in numerous ways; for example, it may increase risk for adverse drug interactions and hamper adherence to medications and other treatment protocols. Some people simply don't know their level of substance use is risky; education and feedback may be enough to motivate change.

Cost savings in both health care and to society can be enormous. Citing a study by the National Center on Addictions and Substance Abuse, a NY Times article in May 2009 stated: "Government spending related to smoking and the abuse of alcohol and illegal drugs reached $468 billion in 2005.... Most abuse-related spending went toward direct health care costs…or for law enforcement expenses including incarceration.... Just over 2% of the total went to prevention, treatment, and addiction research." Per SAMHSA (2008) "literature reports a four to one savings with the SBIRT approach"; for example, one study (Fleming et al, 2002) suggests that every dollar invested in an SBIRT-like approach saved $4.30 in future health care costs, and benefits increase when other societal costs, such as motor vehicle accidents and legal fees, are factored in.

SBIRT: Broadly Recommended and Proven Effective

SBIRT has a solid base of support from multiple agencies and governmental groups. It became a public health strategy for addressing alcohol misuse as early as the 80s; and in 1990 the Institute of Medicine, in its report *Broadening the Base of Treatment for Alcohol Problems,* recommended broad deployment of SBI, stating that "suitable methods of identification and readily learned brief intervention

techniques with good evidence of efficacy are now available."

Other organizations support SBIRT. The Federation of State Medical Boards has set SBIRT as a universal goal. The American College of Surgeons Committee on Trauma has mandated the use of alcohol screening for all members, requiring that all Level I and II trauma centers conduct SBIRT with patients. The National Commission on Prevention Priorities ranked alcohol SBI with adults among its top five priorities, ahead of 20 other effective services including colorectal cancer screening, hypertension screening and treatment, and influenza immunization (Solberg et al 2008).

Research of SBI began more than 40 years ago, and multiple trials now provide evidence of SBIRT's effectiveness. Meta-analyses and reviews that included more than 34 randomized controlled trials of SBIRT (focused primarily on at-risk and problem drinkers) revealed an overall 10-30% reduction in alcohol consumption at 12 months (Moyer et al, 2002; Whitlock et al, 2004; Bertholet et al, 2005). There is less evidence for other drugs, but several studies show positive results. Listed below are some of the findings from a paper describing research over the past 25 years involving SBIRT conducted in a variety of settings and for tobacco, alcohol, and other drugs (Babor et al, 2007):

- "Brief Interventions (BI) can reduce alcohol use for at least 12 months in non-dependent heavy drinkers;
- The approach is acceptable to both genders and to adolescents and adults;
- Cost-effectiveness has been demonstrated in several countries;
- Brief interventions are effective with smokers and risky drinkers, and there is some evidence that they work well with marijuana users;
- Brief treatments are effective with persons who are dependent on alcohol, marijuana or other drugs; and,
- SBIRT risk reduction materials exist in diverse formats."

There are now large-scale SBIRT programs in Brazil, South Africa, Europe, and the U.S. In U.S. SAMHSA-funded programs (SAMHSA 2008), of 600,000 patients screened about 23% had substance use problems (with prevalence higher on college campuses) and many receiving SBIRT services made big changes: "At the 6-month follow up, for instance, almost half of the participants in the state and tribal SBIRT programs who were consuming alcohol at inappropriate levels reported they hadn't had a drink in the past 30 days. More than half of the participants who were using illicit drugs or misusing prescription medications had stopped that behavior."

Conclusion

Built upon a solid base of research and public support, a rich array of well-tested SBIRT tools and resources are now readily available. Next month's article will focus on each of the core processes of SBIRT.

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NFATTC WORKSHOPS AUGUST - SEPTEMBER

Cognitive Behavioral Therapy

August 30-31, 2010 – Wilsonville, OR
1.5 -day Course (10 CE Hours) – focuses on building skills in the use of cognitive behavioral therapy for counseling interventions. Participants will have the opportunity to develop or improve skills in the use of CBT appropriate for those clients with substance use disorders and mental health issues.

Enhancing Motivation in Group Counseling

September 27-28, 2010 – Honolulu, HI
2-day Course (14 CE Hours) - assumes a basic understanding of group counseling processes and designed to facilitate improvement in client readiness to change. Practice-oriented and focused on interventions that address change and improve group process.

Clinical Supervision II: Managing Supervisory Dilemmas

August 26-27, 2010 – Seattle, WA
2-day Course (14 CE Hours) - builds upon "Clinical Supervision I", taking participants to the next level in supervisory skill development by adding a conceptual framework and practice in correcting counselor performance problems.

Advanced Motivational Interviewing

September 20-21, 2010 – Honolulu, HI
2-day Course (14 CE Hours) – designed for those who have had introductory MI training and want to further develop and refine their MI skills in the areas of identifying and eliciting change talk and using strategies to decrease resistance.