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Addiction Messenger

SERIES 39 - August 2010 Volume 13, Issue 8 *Ideas for Treatment Improvement*

SBIRT

Part 2 - Breaking the Model Down

The components of Screening, Brief Intervention, and Referral to Treatment (SBIRT) combine to create a powerful tool for substance abuse intervention and treatment. The model was developed as a way to engage people who are not seeking help for alcohol or drug-related problems, but who have behaviors or symptoms that might indicate problem use. To better understand SBIRT it is helpful to breakdown each of its core processes.

S = Screening

A brief pre-screen often starts the process and can be integrated into a routine history or interview. Typically three or four questions can quickly identify risk for substance misuse. One common pre-screen is the AUDIT-C, which uses the first three questions of the AUDIT. More detailed screenings identify levels of risky use. SBIRT screenings need to measure a spectrum of use, from low, medium, to high risk levels. Some traditional screens, such as the CAGE or MAST, do not measure lower levels of risky use. Three tools most commonly used in SBIRT programs include:

- AUDIT (Alcohol Use Disorders Identification Test): a 10-question screen developed by the World Health Organization (WHO) to measure adult alcohol use across a broad range of cultures and nations,
- ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test): eight multiple-item questions developed by researchers for WHO to screen a broad audience of adults for alcohol and other drug use (AOD), and
- DAST (Drug Abuse Screening Test): 28 questions designed to screen adults for drug use only.

Examples of screenings targeted for adolescents and used in SBIRT include the CRAFFT ("Car, Relax, Alone, Forget, Friends, Trouble" referring to question topics), which screens for AOD; and the ADIS (Alcohol Drug Involvement Scale).

Screening Resources. It is important to use screening instruments that accurately identify levels of use. A useful and reliable resource is the *Substance Use Screening and Assessment Instruments Database* maintained by the University of Washington Alcohol and Drug Abuse Institute at http://lib.adai.washington.edu/instruments/. The database is comprehensive, regularly updated, searchable, and descriptive of each instrument. Descriptions include length, administration time; measures of recent versus lifetime use; intended/validated audience(s); references/strength of supporting research; substances screened for (and any related risk factors); modes of administration; availability in other languages; links to the instruments, and more. Another useful publication includes a compendium of 25 recommended screening tools (Babor et al, 2007). These two resources combined identify about 40

"The whole is greater than the sum of its parts."

~ Aristotle (384 BC – 322 BC) ~

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Next Issue:

Applying SBIRT

Funded by Substance Abuse and Mental Health Services Administration

recommended tools (of about 140 listed by ADAI), based on research validity and clinical utility. Also, the AUDIT and DAST are available in several languages at http://www.sbirtoregon.org/screening.php (Oregon Health & Science University [OHSU], 2010).

BI = Brief Intervention

Key to SBIRT effectiveness is the BI. Individuals who screen at moderate to high risk levels of substance use are candidates for BI, which takes about 10 to 15 minutes on average, and is often delivered over 1-4 sessions. It may be as brief as five minutes or as long as 30-60 minutes. BI strategies range from relatively unstructured advice and information to more formal manualized approaches. Models have been developed based on behavioral self-control training, cognitive-behavioral psychotherapy, and motivational interviewing (MI).

Several research-based BI models are available for use. Many share similar elements in that they aim to investigate the impact of substance use and, based on the identified risk level, motivate an individual to begin taking action to reduce use through self-directed means and/or specialized treatment. Here we'll discuss the Brief Negotiated Interview, a model often used in SBIRT. BNI is an adaptation of MI and incorporates the following principles:

- Respect for an individual's autonomy, goals, and values,
- Readiness to change taken into account throughou process,
- Ambivalence expected (and considered an opportunity for "change talk"),
- Target goals selected by the patient, not the "expert",
- Expert is the provider of information (i.e., the patient), and
- Communication is empathic, non-judgmental, respectful, supportive, and includes reflective listening.

BNI Step 1– Raise the Subject

- Establish rapport to engage the individual.
- Ask permission to raise subject of alcohol/drug use; this formally communicates that a patient's wishes and perceptions are central to treatment. The completed screening acts as a conversation starter and helps set the "climate" or "tone" for a successful BNI. Example: *"Thanks for filling out this form. Would you mind taking a few minutes to talk with me about your alcohol use and how it might relate to your …(e.g., health issue, car accident, etc.)?"*
- Assess comfort. Example: *"How are you feeling right now?" "When is the last time you drank/used anything?"* Ask about withdrawal symptoms, if applicable. Acknowledging a person goes through periods of withdrawal and at other times feels "straight", "normal", or "good" following alcohol/drug use is an example of recognizing the reality of the individual's experience.

BNI Step 2 – Provide Feedback

- Use screening data and other tools (e.g. a pyramid of risk zones; an illustration showing standard drinks; informational handouts) to review the individual's pattern of use and explain their "zone of misuse". Throughout feedback, ensure information is delivered in an interactive "give and take" discussion.
- Explore the connection to health issues if there is one (e.g., hypertension, an STD); and/or express concern for other acknowledged problems, such as financial, family, employment, or legal issues. For example: *"Can you see any relation between your use of (alcohol or drug) and what brought you here today?"*
- Compare individual's use to national guidelines or "norms" for drinking (or drug use).

BNI Step 3– Enhance Motivation

- Assess readiness to change. Use strategies (e.g., a readiness ruler) to help individuals identify what motivation already exists toward making change. For example: *"On a scale of 0-10, with 10 being very ready, how ready are you to change any aspect of your drinking (drug use)?"*
- Develop discrepancies. For example: *"Why did you choose number 4 and not a lower one?"* The goal is for the client to express reasons they might be ready to change. Explore pros and cons, e.g., *"What are some things you like about your drinking?" "What are some things you don't like about your drinking?"* Use reflective listening, e.g., in the context of discussing drinking less, a patient's comment, *"It's difficult to cut down around friends"*, might be followed by, *"So it's difficult because you're worried about what your friends think,"* delivered with downward intonation to encourage response.

BNI Step 4– Negotiate and Advise

- Negotiate to secure an agreement regarding changes the patient is willing to make to reduce use, abstain, or seek referral. Use a drinking/drug use agreement form, or a referral agreement, and informational handouts. For example: *"What are your options?" "Where do you want to go from here?" "This is what I have heard you say…"*
- Assess readiness to change as the plan is

negotiated, providing clear advice and expressing concerns; exploring discrepancies around behavior and expressed goals; and providing a menu of options, including a referral to treatment if needed.

- Summarize. Provide an agreement for the client to take home. For example: *"Here is a drinking agreement that can reinforce your new drinking goals." "This is really an agreement between you and yourself."*
- Schedule follow-up as needed, determining who will initiate it and how it will occur (e.g., in-person, phone, email, or mail).
- Thank the individual for their time and willingness, expressing optimism for their intent to make changes.

Sources used here for BNI information include downloadable treatment manuals (Yale, 2008; APHA 2008) and an on-line resource that includes training modules, helpful video demonstrations, and other tools (OHSU, 2010). Also, Merlo Lab has created videos that juxtapose effective and ineffective BI's to reduce smoking, conducted by physicians, dentists, and pharmacists at http://www.youtube.com/user/MerloLab.

RT = Referral to Treatment

Referrals to higher levels of care may be necessary for individuals with more severe substance use problems, or for those insufficiently motivated through BI to reduce use. Making effective referrals may include some of the following suggestions:

- *Gather Information/Developing Linkages.* Contact state or county authorities for information about treatment services, financial resources, and available referral networks; meet with representative of local recovery programs to get acquainted with staff, services, and preferred methods of referral (and collect handouts); and identifying useful on-line resources such as SAMHSA's Substance Abuse Treatment locator at http://findtreatment.samhsa.gov/.
- *Compile a Referral List.* Many people are unaware or misinformed about treatment options. A list might include community treatment agencies, mental health providers with addictions expertise, peer-support groups (such as AA), social service agencies, and even some general information about treatment. Where possible, provide names and description of services along with contact information. Ensure lists are updated.
- *Pharmacotherapy.* Physicians might consider using medications adjunctive to psychosocial treatment for patients with strong cravings, who have difficulty abstaining, and/or have had previous relapses. (For more information see the Addiction Messenger, January – March 2010.)
- *Facilitating Referrals.* Some individuals may need more intensive referral support, including repeat follow up, assistance accessing treatment, or even comprehensive case management. Longer term BI (or BT) might be used as a "bridge" to engage individuals who might eventually accept referrals to more intensive treatment.

RT is the least researched component of SBIRT, but is important in the development and delivery of a balanced SBIRT program. A referral specialist can facilitate the process, though cost versus benefit will need to be weighed. Determining when to refer can be tricky. Using substance abuse specialists can enhance the process of SBIRT, given their expertise in treatment delivery and recovery. However SBIRT is approached, developing strong referral networks will benefit not only patients but service providers, since knowing one another will increase and facilitate bi-directional referrals and continuity of care.

A tool potentially useful to clinicians that summarizes much of the information included in this breakdown of the SBIRT model is illustrated on page 4. Developed by OHSU, it has been useful to clinicians learning to implement SBIRT in health care settings.

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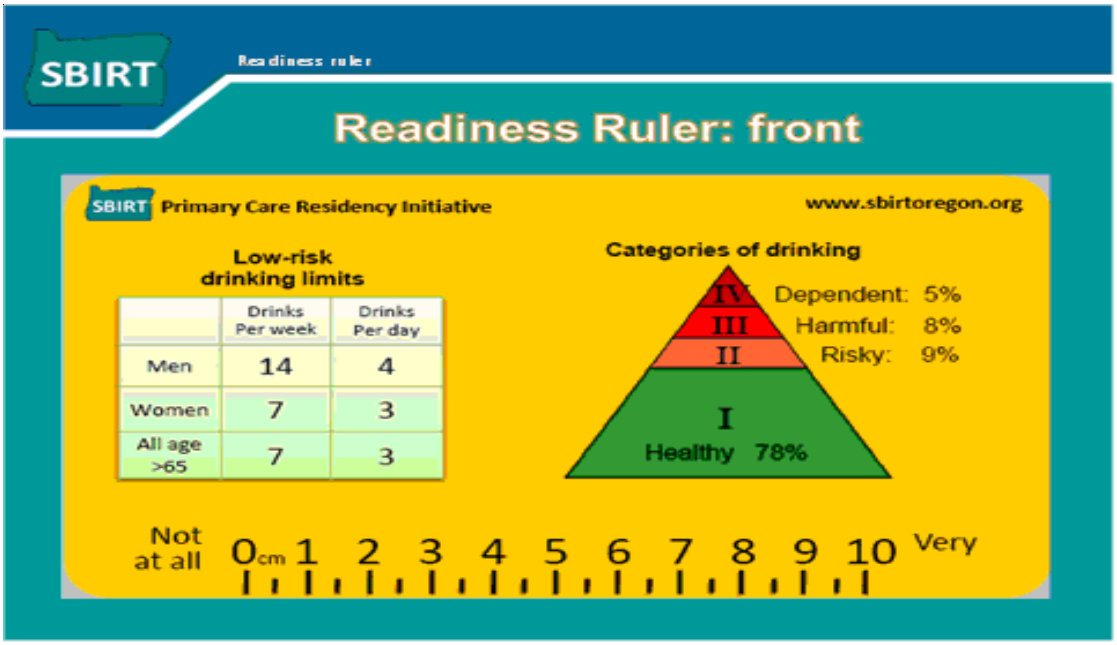

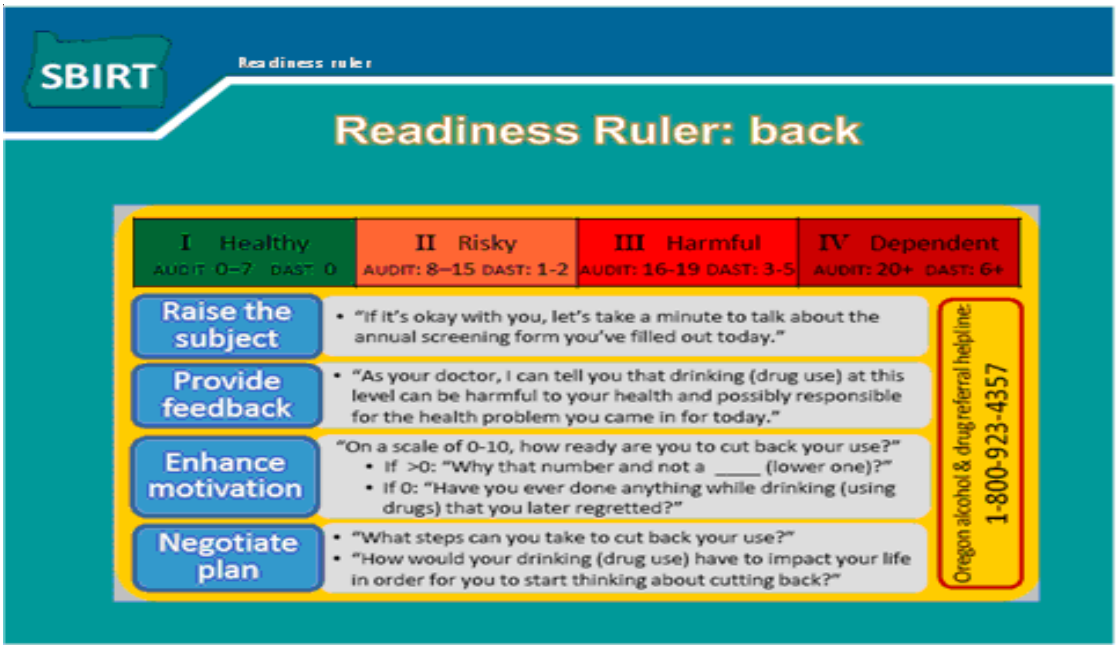

NFATTC WORKSHOPS AUGUST - SEPTEMBER

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.