Northwest Frontier ATTC
Unifying science, education and services to transform lives.

Addiction Messenger

SERIES 39 - September 2010 Volume 13, Issue 9 *Ideas for Treatment Improvement*

SBIRT

Part 3 - Taking It To The Field

The beauty of the Screening, Brief Intervention, and Referral to Treatment model (SBIRT) is that it is simple, brief, and can be integrated into regular check-ups or interviews to initially detect and subsequently monitor changes in substance use. The model can be used in a variety of settings from health to social service and education. Built on a solid base of research, science-based demonstration projects have proven so successful that SAMHSA CSAT Director, Dr. H. Westley Clark has announced that "promoting services like SBIRT…is a crucial part of SAMHSA's mission to reach everyone struggling with substance abuse issues" (SAMHSA News, 2009). Some of the settings in which SBIRT are proving effective are described in this article.

MEDICAL SETTINGS

An emerging consensus is that SBI (if not always RT) should be utilized across the spectrum of health care services. SBIRT is being successfully applied in 1) primary care clinics, 2) hospitals, and 3) emergency rooms/trauma centers. In addition, a current grant program in 11 medical schools is training resident physicians to integrate SBIRT into their practice.

Primary Care. SBIRT provides a non-stigmatizing way for patients to discuss and address substance use issues. It can be easily made a standard practice, offering low-cost intermediary care that has proven remarkably effective in reducing the use of alcohol and other drugs. Universal and targeted repeat screenings are possible because the model takes so little time to implement. Just a few short questions by a physician, nurse, or behavioral health provider can indicate the need for a more complete screen or brief intervention. Some settings use a written self-report, on-line screening, or "video doctor" technology to save even more time.

Tribal Cooperatives. Tanana Chiefs Conference, a tribal healthcare consortium serving more than 40 villages in Alaska's interior, is using the SBIRT model. Shannon Sommer, the project manager, notes the potential impact of such a simple and direct service when she says "a seed planted in 1 village will have far reaching effects." She recently received a heartfelt thank you letter from a parent whose son was screened as part of regular medical visit, after which SBIRT case management helped him access treatment. "His mom has seen an amazing change," said Sommer, "and it's not something he'd thought of before he got screened, he hadn't looked at it that way…He didn't realize his use patterns could be that problematic."

Emergency/Trauma Settings

The intensity and seeming chaos in Emergency Departments (ED) can present barriers to SBIRT utilization. Sometimes there are no billing codes for SBI services, ED personnel are not trained in the use of SBIRT, and staff may not see intervention with substance use as part of their role. At the same time EDs are arenas of opportunity for SBIRT. We know that up to 31% of patients treated in EDs and fully 50% of severely injured trauma patients screen positive; plus they are 1.5 to 3 times more likely to report heavy drinking, adverse consequences of drinking, or prior substance abuse treatment. Young people,

"The only man I know who behaves sensibly is my tailor; he takes my measurements anew each time he sees me. The rest go on with their old measurements and expect me to fit them."

~ George Bernard Shaw (1856-1950 ~

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Next Series:
Continuing Care

Funded by Substance Abuse and Mental Health Services Administration

lacking insurance, are more likely to seek treatment in an ED as their primary source of medical care. Finally, ED visits also offer "teachable moments" when people may be more open to SBIRT interventions.

Washington State's SAMHSA-funded project had great success in overcoming barriers to conducting SBIRT in EDs. In 9 different hospitals, chemical dependency professionals (CDP) conducted over 104,000 screenings for alcohol and illicit drug use. Subsequent brief interventions and referrals to treatment were associated with reduced substance use, reduced medical costs, increased employment, and improved mental status. For each 1,000 working-age, disabled Medicaid patients receiving SBIRT services, potential Medicaid cost savings, relative to subsequent costs for similar Medicaid ED patients who did not receive SBIRT services, were calculated to be approximately $2,000,000, due in large part to reductions in subsequent admissions to the hospital from the ED.

Referral to chemical dependency treatment (RT) was exceptionally powerful. At Harborview Medical Center, Medicaid and uninsured ED patients who received SBIRT services were more than twice as likely to enter treatment within the following year than comparable Harborview ED patients who did not receive SBIRT services. Similarly, across all 9 hospitals that participated in the project, patients covered by Medicaid and state-funded medical assistance were also over twice as likely to enter CD treatment within 90 days of receiving a BI than a statistically matched sample of patients who did not get SBIRT services. Receiving brief therapy in addition to a BI further increased the likelihood of entering formal CD treatment.

SMART–ED. The success of SBIRT programs has contributed to the development of a new model tailored to acute care settings: "Screening, Motivational Assessment, Referral, and Treatment in Emergency Departments". Over the next year SMART-ED will be implemented in 6 EDs across the U.S. as part of the NIDA Substance Abuse Treatment Clinical Trials Network (CTN). In this model interventionists will provide follow-up or "booster" phone calls, "as a way to re-introduce awareness, facilitate commitment to change, and explore possible barriers to change," says Dennis Donovan, Director of the University of Washington Alcohol and Drug Abuse Institute. SMART-ED features 3 comparison groups, including 1 to "tease out" the results of screening alone, which preliminary research indicates can have positive impacts simply by raising awareness or knowledge related to substance use. The study will also gather data on the effectiveness of BI on drug use other than alcohol. To learn more about products developed from CTN research visit the on-line CTN Dissemination Library at http://ctndisseminationlibrary.org/.

Residency Programs

"Research shows that when you learn something at an early point in your career, you're more likely to adopt it once you're out in the wider medical community" (SAMHSA News, 2009). With that idea in mind, a number of residency programs have been funded to develop and implement SBIRT services in a variety of medical settings. Oregon Health & Science University (OHSU), in partnership with the Northwest Frontier ATTC and RMC Research Corporation, has developed a web-based training program flexible enough to be used by a broader audience. The program includes on-line training (3 1-hour modules with lectures, role plays, and video demonstrations) as well as tools for use in the field. The materials note that 25 to 30% of doctors reportedly fear discussing alcohol with patients because it may frighten or anger them, or appear to question their integrity; whereas more than 90% of patients surveyed felt that as part of medical care doctors should feel free to ask about alcohol consumption; and, if drinking may be affecting health, doctors should advise patients to cut down.

In addition to training residents, the OHSU project has implemented SBIRT in 7 residency clinics and expects to directly impact more than 400 family, preventive, and internal medicine residents, a significant proportion of the future primary workforce in Oregon.

OTHER SETTINGS

The SBIRT model has been cast far and wide, especially to settings where substance use is known to be high, such as higher education, mental health, and criminal justice.

- Behavioral Health – SBIRT has been integrated into psychiatric hospitals and other mental health settings, specialized addiction recovery programs (e.g., during pre-assessment and aftercare), and in the office practices of psychiatrists, psychologists, mental health and substance abuse counselors.
- College and other schools – Young adults have the highest prevalence of binge or hazardous drinking in the U.S., putting them at particular risk for alcohol-related injuries and accidents. SBIRT is being applied in campus health or counseling centers and incorporated into campus judicial systems.
- Criminal Justice – DWI programs, courts, jails, and prisons are using SBIRT. Given the extended period of time it takes for cases to move through the system, conducting SBIRT close to the time of arrest is beneficial.
- Employment/Workplace – Employee Assistance and Corporate Wellness Programs utilize SBI as an integral part of a preventive health program. Substance use questions can be integrated into screenings that include anxiety, stress, and other problems impacting worker productivity.
- Military – Active military personnel and veterans can be screened in the field and in healthcare centers.
- Social Services – Welfare, housing, child protection and other services can incorporate universal screening or target people exhibiting signs of impaired functioning.

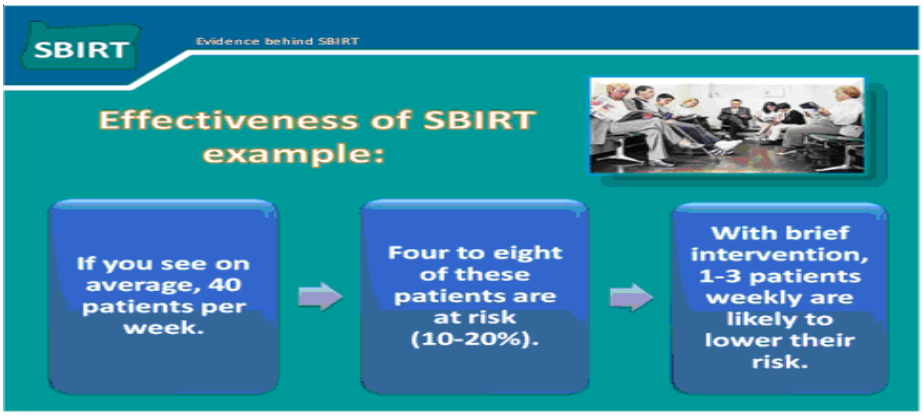
- Other – SAMHSA Access to Recovery projects; National Alcohol Screening Day; health fairs, and other venues can provide opportunities for using SBIRT, assuming that privacy and confidentiality needs can be met.

REIMBURSEMENT & HEALTHCARE COVERAGE

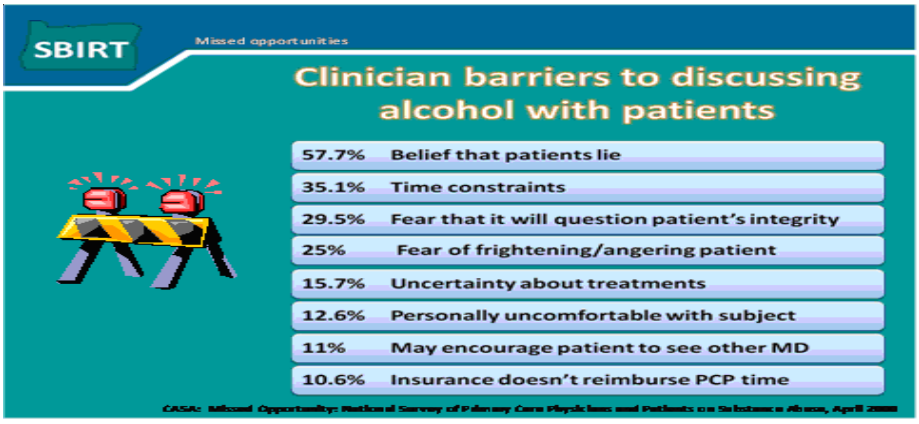
Reimbursement codes (commercial insurance CPT, Medicare "G", and Medicaid "H" codes) were introduced in 2007 and 2008 and many states are in the process of adoption. Allowing reimbursement represents a meaningful shift toward a broader public health approach to preventing and intervening with substance use disorders.

TRAINING & TECHNICAL ASSISTANCE

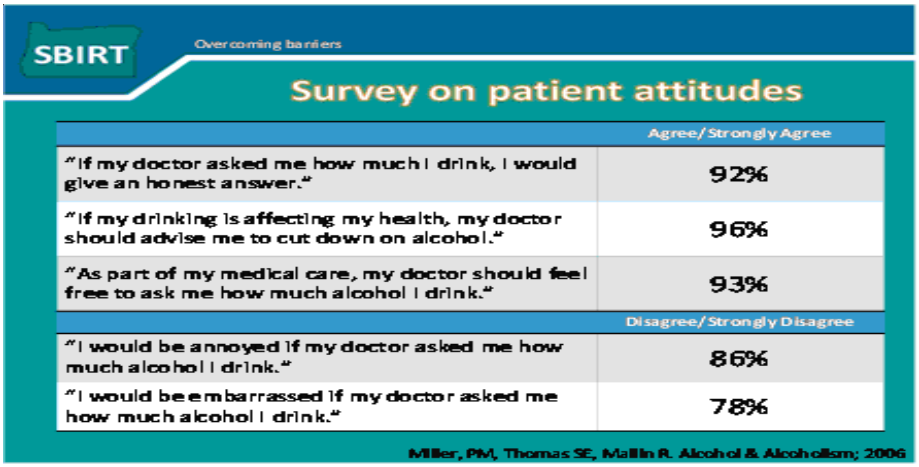
A broad array of SBIRT applications have been developed and evaluated. Tools, models, and resources are readily available. All are important steps in technology transfer. Regional ATTCs may be able to help plan and navigate all phases of implementation. For more information about training and technology transfer, contact your regional ATTC through www.attcnetwork.org.



Brief Interventions result in reduced consumption of alcohol and other drugs.



What physicians say about discussing alcohol use with their patients.



What patients say about discussing alcohol use with their doctor.

Source: OHSU SBIRT Primary Care Residency Initiative: www.sbirtoregon.org

SBIRT Resources

Primary Care Models

National Institute on Alcohol Abuse and Alcoholism (NIAAA). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 Edition): http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm

National Institute of Drug Abuse (2009). Screening for Tobacco, Alcohol, and Other Drug Use: http://www.drugabuse.gov/nidamed/screening/

ED/Trauma Models

Washington DSHS Division of Behavioral Health and Recovery (May 2010). Screening, Brief Intervention, and Referral to Treatment for Substance Abuse: http://www.dshs.wa.gov/pdf/hrsa/dasa/SBIRT_TrainManual2010.pdf

College of Emergency Physicians, Committee on Trauma, Quick Guide (2007). Alcohol Screening and Brief Intervention (SBI) for Trauma Patients: http://sbirt.samhsa.gov/documents/SBIRT_guide_Sep07.pdf

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2009). Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers: http://www.cdc.gov/InjuryResponse/alcohol-screening/pdf/SBI-Implementation-Guide-a.pdf

Primary Care Residency

Oregon Health & Science University (2010). SBIRT Primary Care Residency Initiative – On-line Training and Tools. http://www.sbirtoregon.org/

Public Health

American Public Health Association and Education Development Center, Inc. (2008). Alcohol Screening and Brief Intervention: A Guide for Public Health Practitioners. Washington DC: National Highway Traffic Safety Administration, U.S. Dept. of Transportation. http://www.apha.org/programs/additional/progaddNHTSI.htm

Settings and Populations

NIAAA (April 2005). Alcohol Alert: Screening for Alcohol Use and Alcohol-Related Problems. http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm

NIAAA (July 2005). Alcohol Alert: Brief Interventions. http://pubs.niaaa.nih.gov/publications/aa66/aa66.htm

NFATTC WORKSHOPS for September & October

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.

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.

Problem Gambling Awareness & Co-Occurring Substance Abuse/Mental Health
October 5, 2010 – Honolulu, HI
October 6, 2010 – Honolulu, HI
1-day Course (6 CE Hours) – provides information on signs & symptoms, etiology, treatment modalities and the correlation with substance abuse and mental health issues.

Integrated Treatment Planning for Individuals with Co-Occurring Disorders
October 14, 2010 – Honolulu, HI
1-day Course (6 CE Hours) – provides information on understanding co-ocurring disorders and the development of treatment plans that are client centered.

LGBT
October 15, 2010 – Honolulu, HI
1-day Course (6 CE Hours) – designed to enhance familiarity with the issues and barriers faced by LGBT persons and to increase professional effectiveness and competencies in addressing LGBT issues.

Cognitive Behavioral Therapy
October 19-20, 2010 – Anchorage, AK
1.5-day Course (10 CE Hours) – Focuses on building skills in the use of cognitive behavioral therapy for counseling interventions.

Working with Latinos: Cultural Considerations
October 21-22, 2010 – Portland, OR
1.75-day Course (12 CE Hours) – Focuses on increasing awareness and building of culturally sensitive skills for working with Latinos.

Clinical Supervision I: Building Chemical Dependency Counselor Skills
October 21-22, 2010 – Juneau, AK
2-day Course (14 CE Hours) - designed to increase understanding and skill in assessing the clinical skills of counselors in addiction treatment settings and building learning plans for their continued professional growth and development.

Buprenorphine Treatment for Adults and Adolescents
October 22, 2010 – Portland, OR
.5-day Course (4 CE Hours) - aims to increase understanding of the role of Buprenorphine in medication-assisted treatment of opioid dependence. Content is focused on treatment strategies and philosophy, the role of Buprenorphine in recovery, and the value of coordinated client care.

Earn 2 Continuing Education hours for $20
NAADAC Approved

by reading a series of three Addiction Messengers (AM)

If you wish to receive continuing education hours for reading the AM:

- fill out the registration form below, and complete the 2-page test on the following pages,
- return both to NFATTC with a fee **payment of $20** (make checks payable to: NFATTC, please).

You will receive, by return mail, a certificate stating that you have completed 2 Continuing Education hours.
You may complete any of the past series you wish. You can download issues by clicking on the Addiction Messenger button on our website: **http://www.attcnetwork.org/regcenters/c1.asp?rcid=10&content=CUSTOM1**

- o **Series 5** Vol. 5, Issues 1-3 "Methamphetamine: Myths & Facts"
- o **Series 6** Vol. 5, Issues 4-6 "Co-Occurring Disorders"
- o **Series 7** Vol. 5, Issues 7-9 "Trauma Issues"
- o **Series 8** Vol. 5, Issues 10-12 "Cultural Competence"
- o **Series 9** Vol. 6, Issues 1-3 "Engagement & Retention"
- o **Series 10** Vol. 6 Issues 4-6 "Co-Occurring Disorders"
- o **Series 11** Vol. 6 Issues 7-9 "Integrated Services for Dual Disorders"
- o **Series 12** Vol. 6 Issues 10-12 "Infectious Diseases"
- o **Series 13** Vol. 7 Issues 1-3 "Contingency Management"
- o **Series 15** Vol. 7 Issues 7-9 "Research and the Clinician"
- o **Series 16** Vol. 7 Issues 10-12 "Recovery Support"
- o **Series 17** Vol. 8 Issues 1-3 "Family Treatment"
- o **Series 18** Vol. 8 Issues 4-6 "Cognitive-Behavioral Therapy"
- o **Series 19** Vol. 8 Issues 7-9 "Counselor As Educator"
- o **Series 20** Vol. 8 Issues 10-12 "Recovery Support"
- o **Series 21** Vol. 9 Issues 1-3 "Problem Gambling"
- o **Series 22** Vol. 9 Issues 4-6 "Treatment Planning"
- o **Series 23** Vol. 9 Issues 7-9 "Methamphetamine"
- o **Series 24** Vol. 9 Issues 10-12 "Using and Building Motivational Interviewing Skills"
- o **Series 25** Vol. 10 Issues 1-3 "Nicotine Cessation"
- o **Series 26** Vol. 10 Issues 4-6 "Improving Agency Process"
- o **Series 27** Vol. 10 Issues 7-9 "Motivational Incentives"
- o **Series 28** Vol. 10 Issues 10-12 "Recovery Oriented Systems of Care"
- o **Series 29** Vol. 11 Issues 1-3 "Family Treatment In Addiction Treatment"
- o **Series 30** Vol. 11 Issues 4-6 "Implementing Recovery Management"
- o **Series 31** Vol. 11 Issues 7-9 "The Returning Veterans Journey"
- o **Series 32** Vol. 11 Issues 10-12 "LGBTQ Issues in Addiction Treatment"
- o **Series 33** Vol. 12 Issues 1-3 "Prescription Medication Abuse"
- o **Series 34** Vol. 12 Issues 4-6 "Conflict Management"
- o **Series 35** Vol. 12 Issues 7-9 "Twelve Step Facilitation"
- o **Series 36** Vol. 12 Issues 10-12 "Integrating SA & MH Services"
- o **Series 37** Vol. 13 Issues 1-3 "Medication-Assisted Treatment
- o **Series 38** Vol. 13 Issues 4-6 "Cognitive Behavioral Therapy"

Registration Form for Series 39
"SBIRT"

Name_____

Address_____

City/State/Zip_____**Phone**_____

Email_____

Return your Pre-test and Registration form by mail or FAX at (503) 373-7348

Make checks payable to NFATTC and send to NFATTC, 810 D Street NE, Salem, OR 97301

Name_____

TEST Series 39

1. Please describe the three essential steps involved in utilizing the "SBIRT" approach
   1. _____
   2. _____
   3. _____

2. What are some of the reasons that SBIRT can be beneficial when used within primary care and other settings
   a. Identifying risky use of alcohol or drug use and its potential association with other physical health problems
   b. Potential cost savings to health provider and client
   c. Both a and b
   d. None of the above

3. Screening differs from assessment in that screening doesn't establish a definite diagnosis. (circle)

   True False

4. Meta-analyses and reviews of multiple trials of SBIRT revealed an overall _____ to _____ % reduction in alcohol consumption at 12 months. (Fill-in the blank)

5. Some of the tools most commonly used for screening in SBIRT programs include (list three):
   1. _____
   2. _____
   3. _____

6. Describe the four steps of the "Brief Intervention" stage of SBIRT discussed in Part II: Breaking Down the Model.
   1. _____
      _____
   2. _____
      _____
   3. _____
      _____
   4. _____
      _____

7. In some cases education and feedback as part of "brief intervention" is enough to motivate change in behavior. (circle)

   True False

8. What are some steps that can be taken to ensure that a referral to treatment is successful?
   a. Compile a list of possible referrals ahead of time
   b. Consider using pharmacotherapy as a part of the continued treatment in addition to referral
   c. Follow-up often with client
   d. All of the above

9. _____ settings have been the largest focus of SBIRT implementation to date. (Fill-in the blank)

10. List three possible settings for SBIRT:
    1. _____
    2. _____
    3. _____

Mail or FAX your completed test to NFATTC
Northwest Frontier ATTC, 810 D Street NE, Salem, OR 97301 FAX: 503-373-7348
You can register for continuing education hours for Series 1 through 38.
Contact Mary Anne Bryan at 503-378-6001

NAME_____

We are interested in your reactions to the information provided in **Series 39** of the ***"Addiction Messenger"***. As part of your 2 continuing education hours we request that you write a short response, approximately100 words, regarding Series 39. The following list gives you some suggestions but should not limit your response.

What was your reaction to the concepts presented in Series 39?
How did you react to the amount of information provided?
How will you use this information?
Have you shared this information with co-workers?
What information would you have liked more detail about?