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

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Disclosure

• The presenter has no financial relationship to this program.
Objectives

At the end of this presentation, participants will be able to:

1. Administer brief screening tools to assess for problem substance use
2. Employ a motivational approach during brief interventions
3. Provide referrals to higher levels of substance abuse treatment in a manner that enhances follow-through
Acknowledgements & Disclaimer

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

### Low-risk Drinking Limits

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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
substance abuse is prevalent and undertreated
undertreated condition

*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
• 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
prescription drug abuse

- 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 be effective
part III: the evidence for brief interventions
the evidence for alcohol 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
the evidence for alcohol interventions

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
key terms

• **screening**: brief tool used to identify those at risk for substance use disorders

• **brief intervention**: brief interaction that serves to educate the patient 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
screening decision tree

Chart 1. FLOW CHART FOR SBIRT PROCESS

Screening

- 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
S - screening

- 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
screening candidates:

– young adults
– adolescents
– patients 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)
B – brief interventions

• 15-30 minutes; 1-5 sessions
• might include:
  – educational intervention
  – motivational enhancement
• goal: abstinence or cutting back
• target 1-2 risky behaviors
• assist patients in seeing a connection b/w their substance use and their health/wellbeing
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
95% of patients requiring alcohol treatment are unaware of their treatment needs (National Survey on Drug Use and Health, 2007)
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 \textit{and} alcohol use (preferably)
• publically available (i.e. free!)
• utilize self-report

\textit{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)
considerations

• assure them their responses are confidential
  – be specific about what this means at your site
• use visual aids (calendar, standard drink visuals)
• ask objective/measurable, nonjudgmental questions (i.e. How many drinks have you had in the last 7 days? Versus: Do you think you have a drinking problem?)
• interview/screen when the patient is not intoxicated:
  “Insight is soluble in drugs and alcohol.”
  -Nicholas Cummings
considerations for adolescents

• ask about friends’ use first:
  – “Do you have any friends who drank beer, wine or any drink containing alcohol in the past year?”

• then transition into asking about teen’s personal use

• ask about frequency and quantity (i.e. binge drinking)

• ask about risky behaviors

• screening tool: CRAFFT
considerations for pregnant women

Fetal Alcohol Spectrum Disorders

• risk factors:
  – maternal binge drinking
  – maternal heavy alcohol use

• effects on the infant:
  – premature birth
  – structural facial differences
  – cognitive deficits
  – immunodeficiencies
  – coordination deficits

• higher rates of FASD amongst NA infants
  – (1.5 per 1,000 live births vs. .02-1.0 in the general population)
screening pregnant women

- TWEAK
  - Tolerance
  - Worried
  - Eye Opener
  - Amnesia
  - Cut down

- self-administered or an interview
- sensitivity: 79%; specificity: 83%
- 5 minutes to administer; 2 minutes to score
- \( \leq 2 \) = ‘at-risk drinker’
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)
Practice makes progress, not perfect.
Drug screening tools

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)
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 substance use
  – “You’re worried about how your alcohol use might impact your diabetes.”
• **Don’t Tell, Ask** (R. Rhode)
readiness rulers

- review drinking limits and/or review their score from the screening tool
- ask permission to engage in a conversation about their score
- provide the visual aid (ruler)
- 3 domains
  - Importance?
  - Confidence?
  - Readiness?
- ask why they selected the number they chose
- inquire about the number they selected and why they did not select a lower number (pulls for change talk)
- set goals
readiness rulers

SBIRT | Screening, Brief Intervention, and Referral to Treatment

cabhp.asu.edu

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<td>IV Dependent</td>
<td>Audit: 20+ DAST: 6+</td>
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### Raise The Subject
- “If it’s okay with you, let’s take a minute to talk about the annual screening form you’ve filled out today.”

### Provide Feedback
- “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.”

### 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?”
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.)
using a motivational approach

• precede referral with a motivational interaction:
  – “How do you think you might benefit if you attend the initial intake appointment and perhaps some follow-up appointments? What do you have to gain from engaging in a treatment program?”
  – “What would prevent you from following through on this referral? What barriers do you anticipate? How can I help you address these?” (don’t end with sustain talk)
  – “Who will hold you accountable for showing up for your appointment?”
  – “When I follow-up with you how can we determine if you’ve been successful?”
warm handoffs

- arrange transportation
- call together to make initial intake appointment
- provide written for the provider
- address barriers (i.e. insurance)
- call patient to ensure they attended intake
- schedule follow-up with referring clinician
considerations for rural areas

if it appears a referral is warranted, but no provider is available in the immediate vicinity, provide a brief intervention or brief treatment onsite
part VIII: practice
one person plays the patient; the other person plays the clinician

remember the SBIRT steps:
1) ask permission to conduct the screen
2) administer the screening tool
3) discuss the results of the screening tool
4) provide the brief intervention
   - primarily: discuss the patient’s use using a motivational approach (open-ended questions, reflections)
   - use the readiness ruler if you prefer
5) provide a referral if necessary

if time permits....switch roles
part IX: implementation strategies
In what ways is your site well poised to implement SBIRT?

What challenges might you experience? What adaptations might need to be made for Native American clients?

- how do we address confidentiality in small communities?
- language barriers?
- referral barriers in rural areas?
additional resources

• Native American Motivational Interviewing manuals:
  
  *Native American Motivational Interviewing: A Manual for Counselors in Native American Communities*
  

  *Enhancing Motivation for Change: A Learner’s Manual for the American Indian/Alaskan Native Counselor*
  

• 1.5 hour online training, Foundations of SBIRT:
  

• SBIRT booster training
  
  [http://psattcelearn.org/courses/4hr_sbirt/](http://psattcelearn.org/courses/4hr_sbirt/)