

Screening, Brief Intervention, and Referral to Treatment – SBIRT – *Who are we missing?*

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A question that has often crossed my mind, while working in the substance abuse field for over thirty years, is “What if we could have identified the problems sooner and found a way to intervene with the father, mother, son, or daughter; could we have saved his or her marriage, career, family or life?” I did not have an answer until about eight years ago when I first became involved with a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) called Screening, Brief Intervention, and Referral to Treatment – SBIRT. The approach was different from my formal clinical education and practice, but it fit well with my broad services research experience. SAMSHA’s SBIRT program is a paradigm shift from the traditional Substance Use Disorders (SUD) model of treating those with diagnoses, usually with an acute care model, and providing prevention strategies to those who have not ever used tobacco, alcohol, or other substances. This model left out a very large group of people who use substances at risky levels but for whom use or misuse has not yet caused serious problems.”

SBIRT is a comprehensive, integrated public health approach for providing early identification and intervention for people with risky alcohol and drug use and referral to more intensive treatment for those with SUDs. SBIRT has been around for over twenty five years and an ever growing body of evidence supports its efficacy for reducing tobacco and alcohol use. Current research shows that SBIRT is also effective in reducing illicit drug use.

SBIRT targets those who are drinking at harmful or hazardous levels but do not have an SUD diagnosis. The pyramid below shows the percentage of the U.S. population which fall into each category¹ of alcohol use. The terms “hazardous drinking” and “harmful drinking” refer to drinking amounts that *increase the risk of causing* serious problems and amounts that *actually cause* serious problems, respectively. These risky behaviors and problems include motor vehicle crashes, physical health and/or mental health problems, violence, injuries, unsafe sex, and serious issues involving

The Drinkers' Pyramid



Who are targets for SBIRT?

Note: Represents the general US adult population. The % of high-risk drinkers is likely to be much higher in certain settings such as emergency or trauma departments.

work, school, family, social relationships, and finances. If we only continue to treat those with SUD diagnoses, we will continue to miss the majority of people with risky alcohol use. In the table above, The NIAAA guidelines for moderate drinking specify the upper limits of low-risk drinking. Risky drinking levels are presented in the table below:

| How Much Is Too Much? | Drinks per Occasion | Drinks Per Week |
|-----------------------|---------------------|-----------------|
| Men | More than 4 | More than 14 |
| Women | More than 3 | More than 7 |
| Age 65+ | More than 3 | More than 7 |

However, there are people who should not drink alcohol at all: individuals in recovery from or who have ever been diagnosed with alcoholism or addiction; children and adolescents; women trying to get pregnant or are pregnant; people who operate machinery and are required to drive, to name a few. Other screening tools available to help identify misuse of other substances include the Drug Abuse Screening Tool (DAST), Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), and the Car, Relax, Alone, Friends, Forget, Trouble (CRAFFT) for adolescents.

SBIRT’s core elements provide a model for and guide clinical practice: 1) Universal **Screening** in non-treatment settings identifies the level of use, problems experienced as a consequence of this use, and indicates the needed level of intervention for patients unaware of their risky use and not seeking treatment; 2) A five to ten minute **Brief Intervention** raises awareness and motivates the patient toward acknowledging the problem and making changes. These sessions are patient-centered with shared decision making for which motivation to change must come from the patient, and the counselor must ask permission before providing clear, respectful advice without judgment or blame; 3) **Brief Treatment** uses cognitive behavioral techniques with those patients who acknowledge their risky behavior(s) and seek help; and 4) **Referrals to Treatment** are for patients

with more serious SUD problems. SBIRT is relatively easy to learn for various providers, it can be integrated into current practice, and evaluations from SAMHSA cohorts demonstrate cost savings in potential health care utilization, automobile accidents, work absences, and criminal justice involvement.

The goal of this approach is to spread SBIRT services throughout the entire health care system. SAMHSA’s grantees are part of the expansion of SBIRT services into other venues: hospital trauma units, primary care offices, school-based health centers, community health centers, and FQHCs. In New York, SAMSHA awarded the Office of Alcoholism and Substance Abuse Services (OASAS) an \$8.3 million grant for five years (2011 to 2016) to implement SBIRT. The NYSBIRT project has sites in six New York City’s STD clinics and two sites in Watertown that target the active military, veterans, and their families in two hospital emergency departments. SBIRT programs and models provide the mechanism to identify patients who are unaware of their problematic use and not seeking out treatment, intervene early, increase problem awareness, prevent disability and premature death, and reduce cost to individuals, families, and their communities.

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Source: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B. and Monteiro, M.G. AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care. Second Edition. World Health Organization, Geneva, 2001.2. Heather, N. Treatment

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