



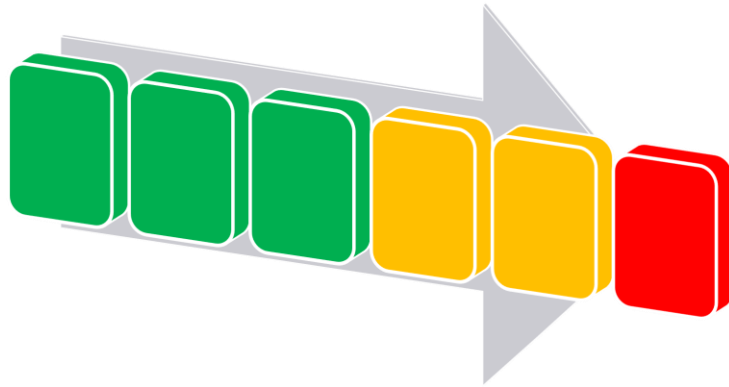
# SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

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# WHAT IS AN ALCOHOL OR SUBSTANCE USE PROBLEM?



## THE RANGE VIEW OF SUBSTANCE USE



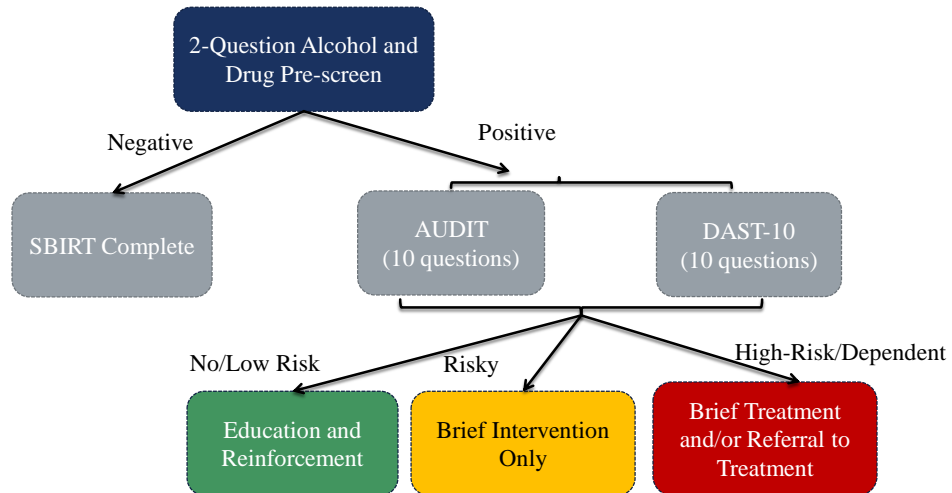
## WHAT IS SBIRT?

SBIRT stands for:

- **S**creening
- **B**rief **I**ntervention
- **R**eferral to **T**reatment



## SBIRT PROCESS



## ADULT PRE-SCREENING

- How often in the past 12 months have you had 5 or more drinks (4 or more for females) in a day?
  
- How many times in the past 12 months have you used an illegal drug or used a prescription drug for nonmedical reasons?

# ADULT SCREENING TOOLS

## AUDIT-10

- Validated for adults 18 and older
- Alcohol screening
- 10 questions on full screening

## DAST-10

- Validated for adults 18 and older
- Drug screening
- 10 questions on full screening

**Alcohol Use Screening (AUDIT)**

PATIENT: Because alcohol use can affect your health and can interfere with other medications and treatments, it is important that we ask some more questions about your use of alcohol. Your answers will remain confidential or phone be heard. Please do it as soon as you have had time to describe your pattern to each question.

QUESTIONS	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	5 or more times a week
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8
3. How many drinks containing alcohol do you have on your most drinking day in a week?	Never	Less than monthly	Monthly	Weekly
4. How often during the last year have you found that you were not able to stop drinking when you had wanted?	Never	Less than monthly	Monthly	Weekly
5. How often during the past year have you failed to do what you expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly
6. How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly
8. How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly
9. Have you or someone else been injured because of your drinking?	No	Yes, but not in the past year	Yes, but not in the past year	Yes, during the past year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No	Yes, but not in the past year	Yes, but not in the past year	Yes, during the past year

PROBLEMS USE ONLY	1	2	3	4	Total
	0	0	0	0	

**Drug Screening Questionnaire (DAST)**

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_

Which of the following drugs have you used in the past year?

<input type="checkbox"/> methamphetamines (speed, crystal)	<input type="checkbox"/> cocaine
<input type="checkbox"/> cannabis (marijuana, pot)	<input type="checkbox"/> narcotics (heroin, oxycodone, methadone, etc.)
<input type="checkbox"/> inhalants (paint thinner, aerosol, glue)	<input type="checkbox"/> hallucinogens (LSD, mushrooms)
<input type="checkbox"/> tranquilizers (valium)	<input type="checkbox"/> other _____

How often have you used these drugs?  Monthly or less  Weekly  Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parent) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

0 1

Have you ever injected drugs?  Never  Yes, in the past 90 days  Yes, more than 90 days ago

Have you ever been in treatment for substance abuse?  Never  Currently  In the past

I II III IV  
0 1-2 3-5 6+

## SCORING THE SCREENINGS

AUDIT-10 Score	DAST-10 Score	Modality
0-7	0	Education and Positive Reinforcement
8-15	1-2	Brief Intervention
16-19	3-5	Brief Treatment
20-40	6-10	Referral to Treatment

## BRIEF INTERVENTIONS: THE NEXT STEP

- Short conversation or counseling session (5-15 minutes).
- Often focuses on barriers to changing behavior and benefits to changing.
- Assess readiness to change behavior.
- Motivational Interviewing vs. Education Only



### Establish Rapport

- Raise the subject
- Ask permission

### Thoughts and Feedback

- Discuss results
- Pros and cons
- Health Education (when needed)

### Enhance Motivation

- Ideas for change
- Barriers to change
- Validate control over the decision

### Negotiate a Plan

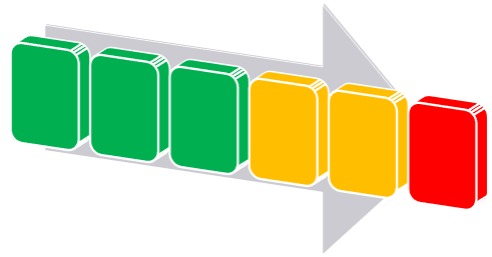
- Set goals
- Discuss follow-up as needed

## REFERRAL TO TREATMENT

Screening **locates** someone on the range of substance use.

Usually, a BI is used for **risky/harmful** use.

Referral to treatment occurs when a patient uses at the **heavy or dependent level**, or when a BI reveals more serious use.



## SBIRT OUTCOMES

Screening and Brief Interventions **reduce**...

- Drinking and illicit drug use<sup>1, 3, 4</sup>
- Emergency room costs<sup>2, 3</sup>
- Injuries and emergency dept. visits<sup>3</sup>
- Length of hospital stays, sick days & mortality<sup>3</sup>
- Unnecessary risks (e.g. driving under the influence, legal consequences, physical injury)<sup>3</sup>

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# THANK YOU!

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