SC SBIRT FAQs

- **What is SBIRT?**
  SBIRT stands for Screening, Brief Intervention, and Referral to Treatment and is an integrated, evidence-based, early intervention model developed by the World Health Organization (WHO). SBIRT utilizes a public health approach to comprehensively identify and intervene with people who report patterns of risky substance use.

- **What does screening entail?**
  Screening involves briefly administering standardized, validated screening tools to all patients who enter the healthcare site. Screening universally will quickly identify patients who engage in unhealthy substance use.

- **What is a BI and how long does it take?**
  After screening, further assessment may be warranted in order to determine the level of risk in which a patient is engaging. A BI, or Brief Intervention, utilizes Motivational Interviewing (MI) techniques to provide feedback about the patient's substance use, offer education about the risks related to his/her use, and assist the patient in resolving ambivalence around using in order to enhance motivation towards healthy behavior changes. Within a busy setting, an effective BI can be provided in as few as 5 – 15 minutes.

- **What is motivational interviewing?**
  Motivational interviewing is an evidence-based, awareness-raising counseling method developed by William R. Miller and Stephen Rollnick. It is a compassionate patient-centered but clinician-driven approach that helps people resolve conflicting feelings by enhancing their motivation to accomplish positive goals via healthy behavior changes.

- **What does BT mean and what does it entail?**
  BT stands for Brief Treatment or Brief Therapy. Though similar in its goals, BT is more in-depth than a typical BI and often occurs over the course of several standard-length counseling sessions. These sessions may be offered onsite or offsite, depending on the capacity and scope of the healthcare practice.

- **What does RT mean and how is it done?**
  RT stands for Referral to Treatment. This step of the SBIRT process facilitates patient access to specialty substance use assessment and treatment services, offsite. In order to refer patients effectively, it is important to both review the current referral protocols that are in place as well as communicate with local substance use disorder (SUD) treatment agencies in order to agree on appropriate, optimal inter-agency procedures.

- **Where can SBIRT be implemented?**
  SBIRT can be implemented in many settings including, but not limited to, primary care, psychiatric clinics, inpatient care, urgent care, hospitals, emergency departments, Federally Qualified Health Centers (FQHCs), behavioral health clinics, community health centers, community mental health centers, senior services, veterans hospitals, detention centers, schools, homeless facilities, and trauma centers.

- **What are the benefits of implementing SBIRT?**
  There are many benefits to both SBIRT providers and SBIRT recipients. SBIRT offers clinicians with a means of identifying at-risk patients in advance of worsening substance-related problems. It provides clinicians with an opportunity to discuss substance use effectively and comfortably with patients. SBIRT also assists healthcare sites in securing and further developing close partnerships with community SUD treatment agencies and recovery capital resources. At the same time, patients gain an awareness of their substance use, education surrounding the impacts of their use, and improved confidence in taking care of their own health, without feeling targeted or punished.

- **Does SBIRT actually work?**
  SBIRT has been heavily researched for decades and is supported by a growing body of evidence. It is most effective for patients whose pattern of substance use is unhealthy but has not yet reached the diagnostic criteria for a substance use disorder[1]. Research has shown that these at-risk patients can be identified through screening[2]. Furthermore, SBIRT has also been found to reduce the frequency and severity of alcohol and drug use[3-5], lessen emergency department visits as well as days admitted to the hospital[6], and exhibit net-cost savings to healthcare sites[6-9]. SBIRT is endorsed by many organizations including, but not limited to, the WHO, the Substance Abuse and Mental Health Services Association (SAMHSA), the American Medical Association, the Emergency Nurses Association, The Centers for Medicare and Medicaid Services, the American College of Surgeons Committee on Trauma, the Centers for Disease Control and Prevention, the Office of National Drug Control Policy, and the National Institutes on Drug and Alcohol Abuse.

- **What is considered unhealthy "at-risk" drinking and drug use?**
  The National Institute on Alcohol Abuse and Alcoholism (NIAAA) developed low-risk substance use guidelines based on decades of population-based evidence. Risk is determined by substance use patterns that are linked with a greater likelihood of health consequences. The NIAAA has determined that healthy men under 65 years of age should drink no more than 4 standard drinks in a day as well as no more than 14 drinks in a week; and healthy women as well as healthy men over 65 should drink no more than 3 drinks in a day and no more than 7 drinks in a week[10]. Any alcohol use by unhealthy individuals is considered risky. Similarly, any use of illicit drugs as well as any misuse of prescription medications is considered both unhealthy and risky.

- **Why should I screen every patient every time they come in?**
  Universal screening is important because alcohol and drug use is not limited to any specific gender, age, race, ethnicity, religion, or socioeconomic status. It is common for unhealthy alcohol and drug use to go unrecognized without universal screening. It is also constructive to screen every patient each time they present to the healthcare site, because as with blood pressure, blood sugar levels, and other health screens, things can change from visit to visit.

- **What screening tools do you recommend?**
  There are many screening tools in the public domain that can be used for assessing alcohol and drug use, however it is recommended to use validated, evidence-based tools. It is also helpful to take into account the population each healthcare site serves. For example, some tools may be better suited for adolescents, such as the CAGE, whereas other tools like the ASSIST, AUDIT, and DAST-10 may be a better fit for adults.

- **Do any of these tools come in other languages, such as Spanish?**
  Though SBIRT is used internationally, not all screening tools are easily found in other languages. The CAGE, ASSIST, AUDIT, and DAST-10, however, are available in Spanish within the public domain.

- **Won't patients just lie when self-reporting substance use?**
  It is a common misconception that patients will not be honest in reporting their alcohol and drug use. Research, however, indicates that patients are not only honest when asked by medical staff about their use, they also feel that providers should counsel them if their use is affecting their health[11]. Patients are in favor of both being screened and advised. SBIRT providers can assist with eliciting honest responses by using MI skills and spirit as well as by being comfortable with asking substance-related questions.

- **How would SBIRT fit in to the flow where I work?**
  Each healthcare practice has its own unique workflow and capacity, so there is no fixed way of implementing SBIRT models. Unless already present, sites will need to add at least two prescreen questions to their triage protocol – one for alcohol use and one for drug use. Then, they will need to choose which validated alcohol and drug screens they prefer to add to their workflow. Next, the site should determine which staff will be trained to effectively deliver the BI to patients, when warranted by the screening results. Last but not least, procedures should be developed to facilitate a warm hand-off in cases where referral to treatment is clinically indicated. Staffing, training, workflow, documentation, and accountability are determined on a site by site basis.

- **Where do I begin if I want to implement SBIRT where I work?**
  To implement SBIRT effectively, it is crucial to first gain a realistic understanding of the site's interest and commitment to embedding the model within their existing workflow.

It is also helpful to determine the site's familiarity with SBIRT components such as screening tools and motivational interviewing skills, in order to identify the types and extent of training necessary to move forward with implementation. Successful implementation always begins with sustainability, desired outcomes, and inter-agency collaboration in mind.

- **How should SBIRT services be documented?**
  Effective and sustainable SBIRT models are documented within the healthcare site's electronic medical record (EMR) to ensure accountability, reporting capacity, and billing opportunities. Elements that should be documented in each patient record include, but are not limited to pre-screen responses, types of substances the patient uses, full screen scores, whether or not a BI was completed and the length of session time, the patient's goal-oriented plan, and whether or not a referral to specialty SUD treatment was made. Privacy protection per federal regulation 42 CFR part 2 should be upheld, where appropriate.

- **Is SBIRT billable?**
  Currently, SBIRT may generate revenue for the healthcare site via screening and brief intervention. It may also generate revenue for partnering SUD treatment agencies via assessment and treatment. The types of billing codes used depend on the type of healthcare site, personnel credentials, and length of session times.

References

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