Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is designed for prevention, early intervention, and treatment of problem behaviours.[1,2] It involves screening all clients as they enter non-specialized settings, then referring them for the appropriate level of treatment based on their specific need. SBIRT sets up an opportunity to engage individuals in care for a problem for which they may not have necessarily sought help.[1] It has been used most widely to identify and treat risk and dependence for the use of alcohol and illicit drugs. More recently, it has been applied to other problem areas such as depression and anxiety.

Brief Summary of Intervention	
Population	Has been used in diverse communities for people with substance use disorders or other problem behaviours.
Gap addressed	Bridges the gap between early intervention and specialized treatment services.
Core integration/transition strategies	Includes screening and links across various levels of treatment, based on need (i.e., brief intervention, brief treatment, and referral to specialized treatment).
Services, sectors, levels of care involved	Delivered in a wide range of non-specialized settings (e.g., public health, primary care, emergency and trauma departments, community health clinics, schools, etc.).
Resource requirements, feasibility	Requires trained staff (e.g., peer health educators, substance abuse professionals, licensed behavioural health counsellors, etc.).
Readiness for implementation	Various materials are available to support training, implementation, and quality assurance.
Effectiveness evidence	Many high quality studies, mainly with adults. In primary care, reduced at-risk alcohol use; evidence growing for reducing at-risk drug use. In emergency rooms, results are mixed. Use with youth and in other settings is beginning to be evaluated. Study limitation: selection bias (i.e., who agrees to screening).

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Population

SBIRT has been implemented widely in the Canada, the U.S., and beyond. Investigators from a large U.S. national initiative to implement and evaluate SBIRT in 6 states reported reaching more than 500,000 people from a diverse range of ethnicities and racial backgrounds.[3]

While SBIRT has mainly been used to detect and respond to risky alcohol and substance use behaviours, researchers are now starting to evaluate its use for other problem health behaviours, such as depression, trauma, and anxiety.[1] Researchers have mainly studied its use with adults (18 years of age and older), but evidence on its use with younger populations is beginning to emerge.[4,5]

Key Components

SBIRT has been used in a wide range of non-specialized treatment settings, typically a public health or non-substance abuse treatment setting, such as primary care clinics, emergency departments, trauma centres, community health clinics, schools, and social service agencies.[3] Most common are primary care and emergency settings.[4]

The key components of SBIRT are[1]:

- Screening of all clients for problem behaviours or substance use –The organization screens all clients for problematic behaviours such as a substance use disorder, dangerous use of drugs and alcohol, and risk of developing dependence. Screening involves use of validated screening tools and takes about 5 to 10 minutes.
- Brief intervention (BI) and/or brief treatment (BT) – These interventions are intended for clients who are at moderate to high risk of problem behaviours.
  - BI is generally provided in person and involves giving the client information or advice to increase motivation and teach behavior change skills. These interventions are often based on the FRAMES model (feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy).[6] The number of conversations or meetings and the time spent conducting the intervention can vary,[4,7] but a 2011 white paper suggests 5 to 10 minutes as an appropriate duration for one BI session, and suggests it should be used for those at low or medium risk of problem behaviours.[8]

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- BT involves giving clients a time-limited treatment, such as cognitive behavioural or motivational enhancement therapies. This intervention is intended for clients who are at greater risk of, or already in the early stages of, dependence. It can also be provided to those with a more serious disorder. There are variations in duration of sessions and who administers the intervention. Although the Substance Abuse and Mental Health Administration (SAMHSA) white paper suggests 5 to 12 sessions by a trained clinician, the usual number of sessions is 4 to 8.[3]
- Referral to treatment (RT) – RT is intended for individuals with signs of more serious substance use or problem health behaviours, those at greater risk of dependence, and those who need more intensive treatment.
- Coordination and integration activities – Strong coordination and integration is integral to all components of the intervention. It ensures that a network of services links early intervention and referral to treatment with more specialized treatment services.[2]

Resources Required/ Feasibility

Human Resources

To implement SBIRT, it's necessary to have on staff service providers who are trained in the core components of the intervention, including[3]:

- Screening - Peer health educators, substance abuse professionals, general health care staff;
- Brief intervention - Peer health educators, licensed behavioural health counsellors, primary care providers, community health workers, case managers;
- Brief treatment - Licensed behavioural health counsellors.

Start-up and On-going Training

The Brief Negotiated Interview and Active Referral to Treatment (BNI-ART) Institute located at Boston University School of Public Health offers various materials to support SBIRT training, implementation, and quality assurance. Organizations are expected to have their staff attend a three-day training session before they implement SBIRT. The cost of training is $750 per person for a group of up to six participants.[1] Many resources are available for ongoing training.

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Financial Resources

Initial funds are required to cover staff training and ongoing professional development (see above).[2] Costs can be categorized by the core components, including costs associated with information packages, screening, counselling sessions, and case management. The costs will depend on the number of sessions needed for brief intervention and treatment, staff salaries, resources required to develop and implement the core components, and operational costs associated with the setting where SBIRT is implemented.

Data Systems

A database can track the need for specific core components, referrals made, and wait times for specialized treatment.

Administrative and System Supports

As with any intervention, successful implementation of SBIRT will depend on the commitment of senior-level management and of the organizations providing specialized treatment.

Evidence

SBIRT is a complex intervention that has been implemented in a variety of settings and with a broad range of populations. Implementations have included providers in diverse disciplines and differed in terms of target populations and/or problem (mental health or addiction related), number of components delivered (for example, just screening and brief intervention (SBI), or SBI/BT, or SBIRT), and number and focus of sessions. SBIRT has been studied extensively, but it's difficult to summarize results because the methods used and follow-up periods are so different.[7]

Most studies have evaluated SBIRT interventions in primary care and hospital emergency rooms for substance-related issues.[1] Evidence on use for other conditions (such as depression and anxiety) and in other settings (such as schools) is starting to emerge.[1] Currently, a systematic review of SBIRT interventions is underway for reducing substance use in adolescents and adults.[4] This section offers a high-level analysis of review studies in primary care and hospital emergency settings.

In primary care settings, research has more consistently shown SBIRT to be effective for reducing risky (versus dependence-level) alcohol consumption than for reducing other substance use problems.[5,9] But SBIRT results with drug use are promising and the evidence in its favour is growing.

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Evidence is less consistent for its use in hospital emergency rooms to address alcohol or drug problems.[10,11,12,13]

Some of this variation may be due to challenges in implementing it in both primary care and emergency settings.[7,9] In a recent national, large-scale demonstration of SBIRT across a range of service settings, the Substance Abuse and Mental Health Services Administration (SAMSHA) reported that implementation was feasible.[3] But the referral component can sometimes be challenging to implement for individuals with more severe alcohol or drug use problems due to the coordination and linkages that are needed.[1] Continued work is needed on best-practice solutions for offering more intensive services.[10,14,15]

Regarding the quality of SBIRT research, there have been many high-quality studies (including randomized, controlled trials). Main study challenges include selection bias in recruitment (engaging the most willing individuals), relying on outcome data based on participants' self-reports, and difficulty finding participants for follow-up.[13] However, research methods usually try to address these limitations. Also, the large SAMSHA study showed that many individuals are willing to receive screening and follow-up interventions, although some decline to participate or drop out.[3]

Regarding the effectiveness of SBIRT with youth and in other settings, a preliminary trial of SBI to promote marijuana abstinence and reduced consumption among youth 14 to 21 years old showed positive results on a number of outcome measures after one year.[16]

A systematic review of the effectiveness of SBIRT in schools and community settings is also underway.[4] Specifically, the review will look at the effects of BI (as part of the SBIRT protocol) on reducing non-medical use of substances in adolescents and adults (excluding alcohol, caffeine, and nicotine). The study will try to evaluate the potential moderating factors that may influence the effectiveness of SBIRT. Regarding other conditions, the US Preventive Services Task Force recommends screening for adolescents for major depressive disorder, with follow-up as needed.[1]

Two recent policy review documents endorsed SBIRT. A review of policies for reducing alcohol-related harms and costs in Canada concluded that use of screening, brief interventions, and referrals in health care settings is an effective method to reduce alcohol consumption and associated problems, particularly for individuals with early stage or less severe alcohol dependence.[17] Most of the studies in this review were for primary care settings. The review also supported SBIRT's potential to result in significant cost savings when used in a primary care setting.

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An international review of interventions for drug policy concluded that brief intervention reduces drug use by at-risk drug users when implemented in primary care settings.[18]

Readiness for Replication

The BNI-ART Institute offers various materials to support the training, implementation, and quality assurance of SBIRT:

- Training includes a focus on SBIRT and motivational interviewing skills with the use of role-playing and videotaped sessions. Training for trainers, introductory lectures, and additional sessions are also available;
- A manual and handouts for health promoters has detailed information on SBIRT, including the program rationale, key components, human resource requirements, screening tools, scoring sheets, and case studies. A video illustrates how program principles can be implemented;
- Support is available to develop, implement, and evaluate the program;
- Various tools for quality assurance and outcome measurement are also available.

Specific resources include**:

- Program website: http://www.bu.edu/bniart/;
- BNI-ART Institute. Health promotion advocate: SBIRT training. Boston, MA; 2011;
- Medical Record Template/Checklist;
- SBIRT Program Implementation Guide;
- Training Narrative;
- BNI-ART Institute. Training of trainers: Sample binder. Boston, MA; 2011;
- BNI-ART Institute. (n.d.). Interactive cases: SBIRT in action [DVD]. Boston, MA;
- Boston Medical Center job description and posting: Health promotion advocate;
- Grant application;
- Training of Trainers Narrative (NREPP Summary).

**Use the contacts listed below to solicit these materials.

A Step-by-Step Implementation Guide on Screening and Brief Interventions for Trauma Centers, published by the U.S. Centers for Disease Control and Prevention, provides a detailed list of resources available for the screening and brief intervention components of SBIRT, including[19]:

- SBIRT ToolKit, with screening tools and materials used for brief intervention;
- Website with links to clinical tools;

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- Guides for mental health and primary care professionals;
- The Substance Use Screening and Assessment Instruments Database

In its intervention summary, the National Registry of Evidence-based Practices and Programs (NREPP) rates the readiness for dissemination of the SBIRT intervention as high, based on the availability of quality assurance tools, implementation resources, and training and supports.

Sustainability

There are several issues for consideration when looking at the sustainability of SBIRT. These include:

- Ability to ensure staff have necessary skills and expertise in the different components of SBIRT;
- Continued support within the organization and from the wider community;
- Financial resources to support staff costs, training, administrative requirements, and ongoing evaluation.

Contacts:

References:

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The SAMHSA website identifies the following contacts for SBIRT:

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Contacts included on the National Registry of Evidence-based Practices and Programs (NREPP) summary of the ASSERT program (an SBIRT intervention) include:

To learn more about implementation :
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We welcome your feedback!

This summary is one of a number of transition/continuity of care practice summaries developed by EENet and the Performance Measurement and Implementation Research (PMIR) team, which are part of the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH). The purpose is to support the selection of an evidence-informed intervention by Ontario's Systems Improvement through Service Collaboratives (SISC) initiative. It was designed to give the reader a starting point in understanding the intervention along a number of dimensions.

The intervention summarized in this document was identified through a targeted search of the scholarly and grey literature, and key informant suggestions. The summary was developed from a selected review of reports and journal articles. The evidence review section examined quantitative effectiveness studies only. Other issues, such as acceptability to users and cost effectiveness, are also important to examine but were out of scope to review in the available time frame.

This summary is a living document and the information on which it is based may evolve over time. While great care was taken to prepare this summary, we acknowledge the possibility of human error due to search limitations and rapid timelines. Therefore, we do not warrant that the information contained in this document is fully current, accurate, or complete. If you have any comments or suggestions to improve its content, please contact us at eenet@camh.ca.