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2012

Screening, Brief Intervention, and Referral to Treatment: A Nursing Perspective

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Recommended Citation

Ong-Flaherty, C. (2012). Screening, brief intervention, and referral to treatment: A nursing perspective. *Journal of Emergency Nursing: JEN : Official Publication of the Emergency Department Nurses Association*, 38(1), 54-56. <http://dx.doi.org/10.1016/j.jen.2011.09.009>

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1 Screening, Brief Intervention and Referral to Treatment (SBIRT):
2 A Nursing Perspective

3
4 Introduction

5
6 Screening, brief intervention and referral to treatment (SBIRT) was first initiated by the
7 World Health Organization (WHO) in the mid 1980's in recognition of alcohol as an important
8 contributor of ill health, mental health issues, injuries from trauma, and social problems .¹ For
9 example, in 2002, 3.2% of deaths worldwide were attributed to alcohol use.¹ SBIRT has been
10 successfully implemented in primary care and emergency departments and globally.¹⁻¹¹ In
11 emergency medicine, SBIRT has been mandated by the American College of Surgeons
12 Committee on Trauma for all Level I trauma centers in the United States.⁸ There are a few
13 studies, however, with results that question the efficacy of SBIRT to reduce alcohol use at longer
14 term, at 12 months of follow-up.^{7, 9-10}

15 Advantages and challenges of SBIRT

16 Advantages of SBIRT include:

- 17 1. Flexibility in its implementation
- 18 2. Simple screening
- 19 3. Raising awareness in general among all alcohol users
- 20 4. Allowing for data collection on the extent of alcohol use
- 21 5. Contribution to larger public health implications of alcohol use
- 22 6. Potential cost-savings and positive return on investment

23
24 The flexibility of the SBIRT allows its components to be molded for local needs from choosing
25 the appropriate screening test to defining the most efficient way to conduct the brief intervention.
26 Screenings have been effectively conducted by different levels of providers either by
27 incorporating the screening in the larger health assessment or by approaching the topic of alcohol
28 use separately.²⁻¹¹ Similarly, brief intervention can be conducted following the screening or done
29 outside of the visit through coordination with other providers . The advantage of screening using

30 motivational interviewing is that it has been found to raise overall awareness on alcohol use as
31 seen in the drop in alcohol use by controls in the short-term.^{4,6-8,11}

32 The most important contribution to SBIRT is that universal screening allows for the
33 collection of data on the extent of alcohol use in a community in the form of a needs assessment.
34 With this data, public health policies can be more effectively tailored to the needs of the
35 community. The power of information can also apply political pressure to fund preventive care
36 versus shifting the money towards expensive down-stream care of trauma and chronic medical
37 issues directly caused by alcohol use.

38 Among the challenges in SBIRT are

- 39
- 40 1. The flexibility in the interpretation of the components
 - 41 2. Long-term efficacy
 - 42 3. Staff buy-in of the concepts
 - 43 4. Difficulty in following patients
 - 44 5. Cost of staff education
 - 45 6. Consequences of screening
 - 46 7. The lack of recognition of other contributory factors in the use of and abstention from
 - 47 alcohol

48

49 While flexibility is an asset of SBIRT, numerous questions have been raised by the many
50 studies conducted with variations to the interpretation of the SBIRT components. For example,
51 it is still unclear how variations in the screening and brief intervention process might affect
52 validity of the screening and its results: would patients be more inclined to self-report accurate
53 alcohol use if the screening is done within a larger health assessment by a physician versus a
54 separate “survey” by a non-physician? Does it matter if brief intervention is conducted at
55 screening or in a separate appointment with another provider? Do the variations explain the lack
56 of long-term efficacy of SBIRT identified? Another challenge identified is assuring staff training
57 and buy-in of screening SBIRT.^{4,6-7} The results of motivational interviewing depend on who
58 does it and how it is done. Do discriminative views of “alcoholics” wasting precious emergency
59 room time affect screener’s interactions with patients? The challenge of tracking patients and

60 attrition is also acknowledged by most authors contributing to the decreasing sample size as
61 studies progressed.^{7-9,11} The usefulness of SBIRT may be in “closed” integrated systems where
62 electronic health records are shared and accessible across provider groups and referral sites.

63 Beyond the issues above, there is the concern of cost. In the environment of scarcity facing the
64 U.S. health care system, who is to provide the training of staff, and who is to fund the long-term aspects
65 of SBIRT to collect and analyze data, and to conduct follow-up interviews? If and when a patient is ready
66 for treatment, is there a place readily accessible or will a long waiting period diminish the readiness of the
67 patient to comply with recommended follow-up?

68 The final challenge of SBIRT is that it is not intended to address the wide spectrum of causes of
69 alcohol use nor the many factors that contribute to sobriety. There is much to be learned on the
70 pathophysiology of alcohol use, on the psychological aspects of addictive behaviors and personal
71 readiness to change, and why certain cultures are more prone to the misuse of alcohol. Complex
72 multivariate analysis within SBIRT has yet to include biological and social factors such as family history
73 of drinking; supportive relationships/family life; state of employment; and other stresses or support
74 systems contributing to the use of or abstinence from alcohol.

75 Clinical implications: to SBIRT or not to SBIRT

76 There are clearly concerns facing the implementation of SBIRT: mainly, its lack of long-
77 term efficacy and uncertainty regarding realization of projected cost savings across different
78 provider groups . In light of the U.S. health care situation of sky-rocketing costs, should SBIRT
79 be universally implemented in emergency departments while long-term efficacy studies are still
80 being conducted? Will future studies show that, “brief” interventions have limited success for
81 patients with high-risk alcohol use, and further assessment and treatment are actually needed?
82 The other ethical concern is accessibility to treatment—is it harmful to screen, raise hopes for
83 treatment, and deny that hope when treatment is not available? Should funding target the causes
84 of alcohol misuse, or be shifted to making treatment more available?

85 Contrary to these challenges are the positive public health aspects that can come from
86 universal screening and learning the patterns of alcohol use within communities. The
87 significance of preventive screening cannot be overstated in the management of any disease—and,
88 there are many routine preventive services that have much less supporting evidence than SBIRT.
89 We do know that an upstream high-risk screening early can prevent a critical trauma or chronic
90 liver disease costing millions of dollars downstream.

91 The intentions of SBIRT are worthy but the long-term picture is incomplete. The decision
92 to implement SBIRT must be carefully considered within the context of the overall burden of
93 care due to alcohol-related injury and illness, the community needs assessment, and the resources
94 available. The results of long-term studies will be a welcomed addition to help decide if SBIRT
95 is suitable for every emergency department. In the meantime, those emergency departments
96 already implementing SBIRT will also help contribute to that body of knowledge.

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