The Age of SBIRT

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The Age of SBIRT

What if we could, in less than 30 minutes…

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- cut alcohol use in half for all patients using emergency room services in the U.S., and keep it there over 6 months without resorting to coercion, proselytizing, or threats?
- save $4 in future health care costs for every $1 put into prevention of alcohol or drug related problems in any given year?
- lower use of emergency rooms for any reason in a 12 month period by over 40%?

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- reduce Medicaid costs by -$185 (or more) per enrollee per month?
- reduce both alcohol and illicit drug use by 96% over six months *without* having to send users to treatment or to jail?

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All this, and much, much more, in less than 30 minutes?

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IT'S REALLY TRUE!

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"The data from SBIRT is not merely impressive; within the framework of most medical interventions, the impact of SBIRT is astounding, knock-your-socks-off, nearly too good to be true…." Timmen Cermak, MD, California Society of Addiction Medicine

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By 2009 there were 17 states with active SBIRT programs, and more than 658,000 persons had been screened, over 17 medical residencies had trained over 100 resident physicians in SBIRT screening techniques

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Programs are funded with state and Federal Substance Abuse Prevention and Treatment Block Grants, but the cost effectiveness makes SBIRT projects good business for primary health care facilities regardless of funding source or location

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Screening and
Brief
Intervention and
Referral to
Treatment

It is exactly what the name says it is.

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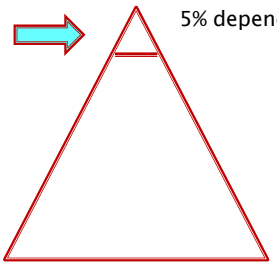
It is a whole new way of looking at health care delivery:



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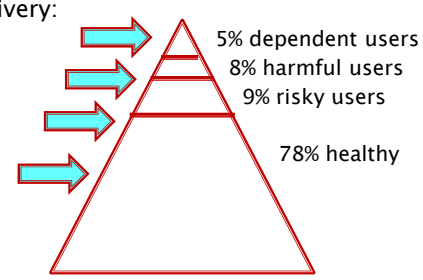

Traditional Approach to Addictions	SBIRT Approach to Addictions
Concentrates resources on the few on the treatment end of the spectrum	Spreads resources to the many before problems develop, eliminating the need for treatment
Costs money	Saves money
Creates more demand for services by case finding only	Lowers demand for services by focusing on PREVENTION
Ignores the natural history of SUDs and treats them as discrete dx's	Considers the natural history of SUDs as spectrum-based disorders
Targets problem cases	Targets high risk populations
Meets with maximum resistance	Meets with no resistance—"striking while the iron is hot" in an MI-based approach
Produces the weakest results—recidivism, health care costs, etc.	Produces strongest results
Often philosophically based	Evidence-based, appealing across all philosophies of care

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- Providers can choose from several models of care
  - Multiple approaches, adaptable to any setting
    - Emergency rooms, workplaces, clinics, hospitals, jails, schools, tribal settings
  - Use of Addiction Therapists, Social Workers, Trained Workers, nurses, etc. using evidence-based approaches, well trained at every step
  - Integrated into existing systems as part of the treatment team

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- A variety of screening tools and approaches are available on-line
  - University of Washington's Alcohol and Drug Abuse Institute web site contains a comprehensive database that is regularly updated and searchable
  - University of Oregon's SBIRT web site has the AUDIT and DAST translated into several languages
  - Several SBIRT projects based in states and universities across the country have web sites with a wealth of information available to start-up projects

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- It has been applied and validated in:
  - Urban and rural populations
  - Caucasian, Native American, Hispanic, African American, and other population groups
  - Men as well as women
  - Teens, adults of all ages
  - Alcohol and drug users, smokers, other high-risk groups
  - Thousands of people from several states

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What if we could, in less than 30 minutes….

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We can!