

## **How to Implement Screening, Brief Intervention, Referral to Treatment (SBIRT)**

**Live CHAMPS/CCGC/SBIRT CO Webcast, 05/28/08  
Presented by Dr. John Higgins-Biddle**

### **Webcast Follow-Up: Responses to Questions Posed During the Live Event**

#### **1. What is the definition of “acute intoxication” (referenced on slide #15)?**

Acute intoxication is the term in ICD-10 for intoxication of clinical significance. Complications may include trauma, inhalation of vomitus, delirium, coma, and convulsions, depending on the substance and method of administration.

The ICD-10 definition is as follows: “A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behavior, or other psychophysiological functions and responses.”

#### **2. What is the reference for the 87% figure in slide #16 (87% of people who need treatment don’t want it)?**

Please refer to the attached SAMHSA slide presentation, “SBIRT Grantee Orientation – Program Overview”, slide 3.

#### **3. In your practice do you currently utilize the skills of a licensed addiction counselor and if so in what capacity? At what level would you refer the patient?**

I am not in practice as a medical provider, but I know some practices—mainly large community health centers and staff model HMOs—that do employ licensed alcohol and drug counselors. Some large staff-model HMOs also have separate mental health or behavioral health facilities. Unfortunately, such services often go under-utilized due to the lack of experience among primary care providers and the lack of systems to connect such services to all patients in need—at least until the need is so severe that the patient takes the initiative to seek such care. We need better integration of primary and behavioral medicine so that both can work more effectively together—not only to bring behavioral health services to patients but also to assure that patients who are receiving such services also receive appropriate medical care.

#### **4. It seems like rural areas go unnoticed. What can we do to serve the rural areas that have no resources?**

The expansion of medical services in rural (and some urban) areas that have no medical resources is a tragedy of enormous proportions, but since our country has no real medical system it is unclear who is responsible or how the problem can be approached or addressed. However, where there are even minimal services it is critical to incorporate a broad array of capacities. This includes SBI, which can be done by nursing staff even when working alone if a system is established and training is provided. The expansion of tele-health holds promise for providing consultation and specialized services for patients with severe conditions. An example of how progress can be made is evident in the recent efforts to disseminate SBI within the Indian Health Services system. With strong leadership, a great deal can be accomplished at very little cost.

**5. I'm a Certified Addictions Counselor III and work in a medical clinic where the doctors are becoming more accepting of my screening of patients for drug/alcohol use, abuse, misuse. Why would there not be more doctors/clinics accepting of hiring professional counselor, i.e., substance abuse counselors in their practices?**

A lack of medical interest and support in this area is usually a result of inadequate education and experience on the part of physicians and nurses, who have traditionally received little training in this field and whose consequent experience often leads them to conclude that the only problem is addiction that is (by them) untreatable. However, medical and residency education is changing as SBI research is disseminated. Nevertheless, cost constraints are likely to preclude having full-time behavioral health counselors in every medical practice. It will be far more cost effective to have medical providers provide SBI services to the majority of patients at risk and link those who are most severe to counselors either in-house or in a linked specialty practice.

**6. In Utah we often have a problem when patients are acutely intoxicated and may be a danger to self or society. Jails often don't want them nor do hospitals. Is anything being done to alleviate this problem, i.e. detox facilities etc.?**

States deal with this problem differently. Many provide public ambulance transport to public detoxification services for those who qualify. Others also offer low-cost sobering centers, without medical supervision, to allow intoxicated patients to "dry out". There are advantages and disadvantages of each system besides the variant costs. SAMHSA can provide information about how states deal with the issue.