Colorado Screening, Brief Intervention and Referral to Treatment

Services and Outcomes, May 2010

www.improvinghealthcolorado.org

Initiative of Gov. Bill Ritter, Jr.

Colorado's Screening, Brief Intervention, and Referral to Treatment initiative **(SBIRT Colorado)** aspires to make screening for alcohol and other substance use a routine practice, similar to blood pressure screening. Since April 2007, patients across Colorado have been screened using validated tools by healthcare professionals. When patients screen at risk for negative health consequences, healthcare professionals provide an immediate brief intervention (BI) and, if needed, a referral to additional substance use treatment services, including brief therapy (BT) or more extensive treatment (RT). The following provides information on data collected from SBIRT Colorado grant sites since April 2007. In general, results support the program's efficacy in reducing risky substance use behaviors.

SBIRT Services Provided to Date

SBIRT Colorado is currently providing services to a broad range of patients in urban, rural, and frontier healthcare settings across Colorado. This report presents data collected by health educators in 25 SBIRT Colorado healthcare sites. For more information about SBIRT models and settings throughout the state, visit the SBIRT Colorado website at:

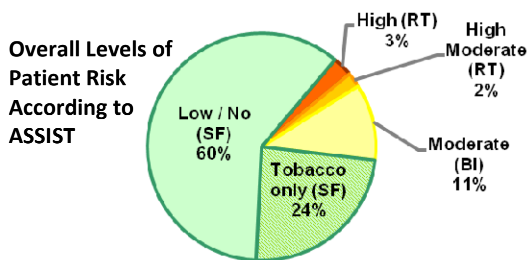
www.improvinghealthcolorado.org

As of May 1, 2010 over 80,000 screens have been completed. In 2009 and 2010, about 3,000 patients were screened each month throughout the state.[1]

About 44.7% (35,189) of patients screened to date were male and about 55.3% (43,558) were female. The most frequently screened age group was between 25 and 34 years old. About 56% (44,285) of patients identified as White, 10% (7,494) identified as Black/African American, and 31% (24,111) identified as Hispanic or Latino. Other races/ethnicities combined accounted for less than five percent of all screens.

SBIRT Patients Scoring at Risk

The SBIRT CO program uses the ASSIST[2], a screening tool developed by the World Health Organization, to assess patient use of substances and levels of risk associated with each substance. **The ASSIST tool defines patients as at risk if their pattern of substance use indicates hazardous or harmful use that puts them at risk for health and other problems.** Unless noted, at risk refers to alcohol and/or illicit substances.

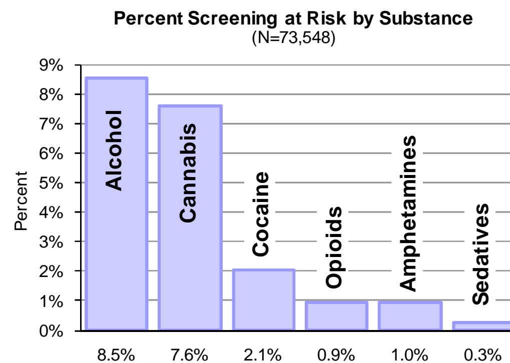


Percent at Risk by Gender and Race

About 21% of males and 10% of females scored at risk for alcohol and/or illicit substances. Males were about 2.5 times more likely than females to score at risk. Those who identified as White, Black/African American, and Hispanic/Latino scored at risk 15%, 21%, and 11% of the time, respectively.

Percent at Risk by Substance

The ASSIST screens for up to 10 substances. The top six substances, excluding tobacco, are included in the chart below. Of all completed screens about 8.5% of patients scored at risk for alcohol.



Tobacco Risk

According to ASSIST criteria about 35% of all patients scored at risk for tobacco. Approximately 41% of males and 30% of females scored at risk for tobacco. In every age group patients were more likely to be at risk for tobacco than any other substance.

Preliminary Outcomes

As of May 1, 2010, 907 six-month follow-up interviews had been completed.

Change in Use

Participants in the SBIRT Colorado follow-up study were asked the number of days they used alcohol and illicit substances in the last 30 days. It is possible that it is more difficult to locate patients to participate in the follow-up study who are using substances than those who reduced their use, which may affect the findings. In addition, we cannot compare change in use in these patients to change in use in patients with similar patterns of use who did not receive SBIRT services. Thus, we do not know whether these patients would have reduced their use in the absence of receiving SBIRT services.

Results for SBIRT Colorado are similar to national SBIRT findings[3] and indicate that patients experienced a significant drop in overall use during the 30 days prior to follow-up as compare to the 30 days prior to intake:

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[1] Data provided represent screens through April 30, 2010.

[2] In cases where a brief screen indicated no use and the ASSIST was not administered, all ASSIST substances were coded as 0. ASSIST data were not available for 5,243 cases.

[3] Madras, B.K., Compton, W.M., Avula, D., Stegbauer, T., Stein, J.B., & Clark, H.W. (2009). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. Drug and Alcohol Dependence, 99(1-3), 280-295.

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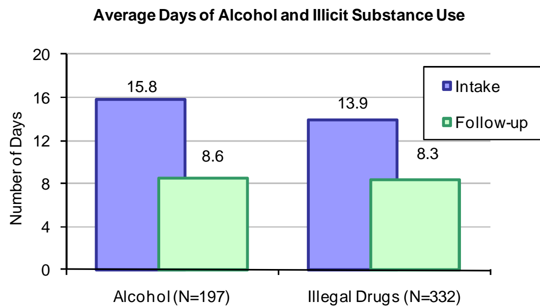
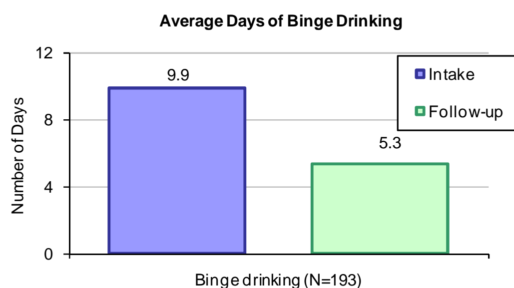
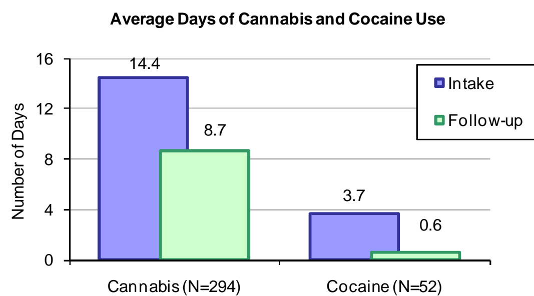
- **Days of alcohol use fell by 46% and overall days of illicit substance use fell by 40%.**



- **Days of binge drinking (consuming 5 or more drinks in a single sitting) fell by 46%.**



- **Days of cannabis and cocaine use fell by 40% and 83%, respectively.**



Summary

→ Approximately 16% of patients screened by SBIRT CO were at-risk for substance use. Only 5% of patients were identified as in need of additional services beyond a brief intervention.

→ Results to date support the SBIRT program's efficacy in reducing patients' substance use.

→ Reducing substance use can have dramatic positive effects on individuals' physical, mental, and social health.

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SBIRT Colorado Spotlight: Integrated Healthcare

An estimated 60-70% of visits to primary care are related to psychological issues and emotional distress, which often co-occur with issues related to substance use.[4] SBIRT screening in healthcare settings allows for early identification of patients at-risk for substance use problems. However, many barriers such as time, transportation, and cost prevent patients referred to behavioral health services from following through with treatment. Integrated care models that provide co-located behavioral health services in a primary care setting offer one solution to these barriers. While in the traditional referral system only 10% of referred patients enter treatment, integrated care systems result in 85-90% of patients entering treatment through a 'hallway hand-off.' One study examining integrated care found positive outcomes that were sustained for four years.[5] Specifically, the study found that in the integrated practice, compared to a solo mental health service practice, wait times for new appointments were shortened from an average of 33 days to 19 minutes, clinical productivity and evaluation of new referrals more than doubled, and 10% of the behavioral health providers were able to care for 75% of the patients. In addition, 99% of patients reported excellent satisfaction with overall care in the integrated model.

Integrated care is an economically viable model that benefits patients by increasing the likelihood they will receive appropriate treatment. It also benefits providers by allowing physicians to focus on medical care for which they are better trained, and offering behavioral care providers a more economically sustainable practitioner model.[4] In the shift toward integrated systems of care, SBIRT is uniquely positioned to bridge the gap between healthcare and behavioral health. Primary care practices that adopt SBIRT may be better prepared to move in the direction of integrated care than other primary care practices. In turn, integrated care practices are well equipped to effectively implement SBIRT because the 5% of patients who may need further behavioral health services are best served by a 'hallway hand-off' that greatly increases their chances of entry into treatment.

[4] Cummings, N.A., O'Donohue, W.T., & Cummings, J.L. (2009). The financial dimension of integrated behavioral/primary care. *Journal of Clinical Psychology Medical Settings,* 16, 31-39. DOI 10.1007/s10880-008-9139-2

[5] Pomerantz A., Cole B.H., Watts B.V., & Weeks W.B. (2008) Improving efficiency and access to mental health care: combining integrated care and advanced access. *General Hospital Psychiatry*, 30, 546-551. doi:10.1016/j.genhosppsych.2008.09.004