Trauma Centers Prove Good Venues for SBIRT

The cohort members had received funding from SAMSHA to set up services in diverse settings.

BY RENÉE MATTHEWS

BETHESDA, MD. — Screening, brief intervention, and referral to treatment programs in large-volume general medical settings captured a range of patients at risk for alcohol, tobacco, and other drug use disorders that otherwise might not have been detected, findings in an evaluation of data from a cohort of centers that implemented the program show.

Emergency/trauma centers, in particular, are effective as screening, brief intervention, and referral to treatment (SBIRT) venues, because they serve high proportions of at-risk individuals, Francis K. Del Boca, Ph.D., reported at the annual conference of the Association for Medical Education and Research in Substance Abuse.

Forty-five percent of patients who screened positive for tobacco or at-risk alcohol use also reported using an illicit drug, said Dr. Del Boca of the University of Connecticut Health Center in Farmington. She noted that those who screened positive "often had ancillary physical, medical, and mental health issues that required consideration in the treatment referral process" and that being able to do so at an earlier stage could have an impact on patient outcomes.

The centers in the current analysis were based in California, Illinois, New Mexico, Pennsylvania, Texas, Washington State, and Cook Inlet in Alaska—together referred to as cohort 1 in the analysis. The cohort members had received funding from the Substance Abuse and Mental Health Services Administration in 2003 to set up SBIRT services in several diverse settings.

Other centers have since received funding as well, but the current analysis was based on data from the first cohort.

The researchers sought to establish the effectiveness, availability, and efficiency of the program by reviewing documents from the centers and conducting site visits that included interviewing and observing program providers and administrators.

There were three service delivery models—in-house generalist, in-house specialist, or contracted specialist—and when the researchers broke down the services into the categories of prescreening, screening, brief intervention (BI), or brief treatment (BT), the contracted specialist model seemed to work well across all of the categories, especially for screening, BI, and BT.

Providers in the hospital-outpatient setting recommended screening and feedback to 87% of patients, but BI, BT, and referral to treatment (RT) to only 8%, 3%, and 3% of patients, respectively. Likewise, federally qualified community health center providers recommended screening to most patients (85%), but their rates for BI, BT, and RT were also notably lower—11%, 3%, and 1%, respectively. By comparison, although only 70% of emergency/trauma patients were recommended for screening and feedback, the corresponding percentages for BI, BT, and RT recommendations were 18, 5, and 8. In the hospital-inpatient setting, only 65% of patients were recommended for screening, but the rates for BI, BT, and RT were 23%, 6%, and 7%.

The researchers found that the SBIRT programs could be implemented successfully and that both patients and medical staff found the programs acceptable. In fact, most patients were willing to participate in SBIRT after screening, with 86% proceeding to BI, 93% to BT, and 93% to RT.

Screening, brief intervention, and referral to treatment programs are effective in emergency/trauma centers because they serve large numbers of at-risk individuals.

Over time, most SBIRT facilitators found that the programs needed to be adapted to real-world settings, and the researchers noted a migration from early service delivery models, settings, and implementation models, Dr. Del Boca said. Delivery models migrated from full-length screening to shorter prescreening; traditional substance abuse treatment to on-site delivery of treatment; and from a focus on alcohol and drug risk factors to a focus on tobacco, comorbid psychiatric disorders, and other health risk factors.

In addition, hospital and emergency/trauma settings supplanted clinic settings, and a shift was seen away from the early in-house generalist model to contracted specialist model.

The effects of these migrations resulted in an overall shift in program emphasis from treatment to prevention, from alcoholism to heavy drinking, addiction to recreational drug use, disease conditions to risk factors, and from a focus on the individual to a broader public health perspective, said Thomas Babor, Ph.D., also of University of Connecticut Health Center, and who co-presented with Dr. Del Boca at the meeting, which was also sponsored by Brown Medical School.

Another presenter, Jeremy Bray, Ph.D., of the nonprofit research and development organization, RTI International, reported on the costs and financing of SBIRT. Among the components that the researchers examined were the cost per patient of screening, and the cost of a BI or BT in a medical care setting, compared with a specialty care setting.

In regard to screening, they found that support activities took as much time as—or sometimes more time than—services activities, with the total screen and service time ranging from about 4 to 14 minutes at a per patient cost of $1.50 to $6.00. For BI, service and support activities took about the same amount of time—from 12 to 22 minutes, with cost ranging from $4.50 to $9.00.

However, service time for BT was considerably longer, compared with the support time, with total time ranging from 40 to 52 minutes, and translating into total labor costs ranging from $16.50 to $22.50.

Dr. Del Boca, Dr. Babor, and Dr. Bray had no financial disclosures. The study was funded by the Center for Substance Abuse Treatment. ■

Economic Woes Are Taking Toll on Addiction Services

BY RENÉE MATTHEWS

BETHESDA, MD. — The current economic downturn has had a substantial impact on the prevalence and treatment of addiction in the United States, according to preliminary findings of data gathered from treatment program administrators.

Stress as a result of job loss or being in a family affected by job loss has led to an increased demand for addiction treatment services, which are themselves under siege because of a drop in funding, cuts in management and counselor slots, and the ripple effects of hiring freezes, Paul Roman, Ph.D., said at the annual meeting of the Association for Medical Education and Research in Substance Abuse, which was sponsored by Brown Medical School.

Dr. Roman and Amanda J. Abraham, Ph.D., both of the University of Georgia, Atlanta, collected data during face-to-face and follow-up telephone interviews with treatment program administrators in the Clinical Trial Program (198), privately run programs (345), and the National Institute of Alcohol Abuse and Alcoholism (350).

A reduction in the number of treatment slots was reported by 11.9% of the interviewees, and there was a mean overall increase of 18.2% in patients.

The administrators reported a mean reduction of 12.6% in overall budget, 21.8% in grant funding, 16.9% in Medicaid income, and 12.4% in insurance payments.

The dip in grant allocations alone correlated with an increase in uncollectible revenues, a decrease in staff and treatment slots, and the implementation of hiring freezes, he said.

Staff losses and hiring freezes cut across the management, counselor, and support staff categories: 14.1% of interviewees reported cuts at management level, 27.1% reported counselor losses, and 24.6% support staff losses.

One-third of those interviewed said there had been hiring freezes across all three staff categories.

Commensurate with these staff cuts, particularly at the counselor level, was a reduction in the number of treatment slots, which was reported by 11.9% of the interviewees.

At the same time, there was a mean overall increase of 18.2% in patients.

"The American substance abuse treatment system is under considerable economic stress," Dr. Roman said. Smaller, nonprofit, nonhospital-associated programs have been hardest hit, as have programs with a higher percentage of Medicaid patients, a lower percentage of counselors with master's degrees, and more injection drug users and unemployed patients.

From a regional perspective, almost half of the programs in the Pacific coast region were stressed, compared with 23.1% in the South Atlantic, 15.4% in the East North Central, and 7.7% in the Mid-Atlantic regions.

Dr. Roman said programs might capitalize on four "great opportunities" to bolster their bottom lines and treatment services: the growth of substance abuse problems in the elderly, the fact that Baby Boomers are aging into the high prevalence years of substance abuse, the implementation of parity for substance and alcohol use disorder treatment, and health care reform.

He emphasized, however, that leadership will be critical if providers are to join together to take advantage of these factors. "The most successful treatment programs ... engage in concrete, measurable, identifiable, systemic strategic planning," he said. Programs should therefore consider how they could attract clients to and keep them in treatment, work to shed the chronic disease stigma associated with substance abuse, and tap new sources of referral, such as the workplace.

Dr. Roman said he had no financial disclosures to make. The study was funded by National Institute of Drug Abuse and the NIAAA. ■