

Screening, Brief Intervention and Referral to Treatment in an Emergency Room

by

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Abstract

Background: Alcohol and substance use are leading causes of hospitalizations, injury and death. Individuals increasingly use the emergency room to seek help for their alcohol and substance use related concerns. The purpose of this quality improvement project was to implement a Screening, Brief Intervention and Referral to Treatment intervention (SBIRT) to effectively evaluate at-risk or current individuals with alcohol or substance use in a high-volume emergency room in rural Maryland.

Methods: The project was implemented over a 12-week period and included every adult 18 years and older with alcohol or substance use related concerns. All encounters were screened by the Behavioral Health Response Team (BHRT) using the Cut, Annoyed, Guilty, Eye (CAGE) screening tool. The Brief Intervention (BI) included Motivational Interviewing (MI) and was elicited with individuals scoring a 2 or higher on the CAGE screening. Individuals were asked their readiness to change score post-MI intervention. All encounters were referred or given information to access inpatient or outpatient substance use treatment facilities for the next level of care. An Excel spreadsheet and monthly run charts were performed to analyze trends towards percentages of patients receiving motivational interviewing, referrals to treatment and completed SBIRTs.

Results: There were 54 (62.7%) males compared to 32 (37.3%) females that completed the SBIRT protocol. The number of individuals who completed the SBIRT process was 86 out of 112 who were eligible (76.7%), a noted increase from the internal data indicating evidence of 54.0% that were properly enrolled in treatment.

Conclusion: Successful systematic implementation of an SBIRT can increase access to substance use programs, increase engagement and readiness to change and improve better outcomes in recovery management.

Introduction

Alcohol and substance misuse account for increased injuries, deaths, hospitalizations and health care costs in the United States within the last decade (Broderick, Kaplan, Martini, & Caruso, 2015). In 2009, the Drug Abuse Warning Network estimated 2.1 million emergency room visits from substance or alcohol misuse in the adult population (Broderick et al., 2015). Opioid overdoses have become a nationwide epidemic with over 28,000 opioid related deaths in the US in 2014 (Pringle et al., 2018). Relating to and compounding the problem, excessive alcohol consumption accounts for approximately 88,000 deaths annually in individuals over the age of 18 (Barata et al., 2017).

The internal evidence was collected from the implementation facility from a high-volume community hospital emergency room in a rural mid-Atlantic state. The community utilized substance use peer support specialists which consisted of lay individuals trained by the health department to counsel individuals with substance use. From June 2016 through August 2017, the specialists in the community have assisted 336 individuals who were consulted in the emergency room for substance or alcohol use related concerns. Of the 336 individuals served, only 183 or 54% were successfully enrolled in treatment.

Screening, brief intervention, and referral to treatment (SBIRT) is an intervention that can be used in an emergency room to assess increasing numbers of individuals that present with alcohol and drug misuse related problems (Broderick et al., 2015). SBIRT identifies at-risk or dependent users through screening, provides brief invention, and refers to specialty treatment if needed (D'Onofrio & Degutis, 2010). After at-risk or dependent users have been identified via SBIRT, brief interventions are provided to establish rapport, offer feedback to current use, enhance motivation to change, and begin setting goals for treatment (D'Onofrio & Degutis,

2010). Referrals are made after the brief intervention if the individual is interested in modifying behavior, changing lifestyle and further exploration of addictions treatment. (Agerwala & McCance-Katz, 2012). The purpose of this DNP project was to implement and evaluate the effectiveness of an SBIRT intervention in the emergency room setting.

Literature Review

There was significant evidence to support the use of a SBIRT intervention to simplify protocols when working with individuals at-risk for substance use disorders (SUDs). Major themes appeared in abundance throughout the literature, such as screening to increase individuals identified for at-risk or problematic substance use, brief interventions to engage the individual to treatment, and the facilitation of referrals to further improve health outcomes after the completion of the SBIRT intervention (Appendix A).

Barata et al. (2017), conducted a systematic review consisting of 35 articles of randomized controlled trials that took place in the emergency room. Individuals that used substances had a decrease in the frequency and amount used after SBIRT interventions, a reduction in alcohol consumption after brief interventions and a decrease in the amount of return emergency room visits. Desy, Howard, Perhats and Li (2010) did a quasi-experimental study of 94 individuals that were screened for alcohol use in the emergency room. Although the results were not statistically significant, there was a 70% decrease in alcohol frequency and amount amongst the intervention group using the SBIRT process compared to the control group. The intervention group also showed 20% lower occurrences of emergency room visits compared with the care group.

D'Onofrio and Degutis (2010) performed a descriptive program evaluation in the emergency room. A convenience sample of 22,534 individuals were screened for substance use over a five year period. A significant amount of substance misuse determined by the screening process of SBIRT was revealed. The study permitted follow up of the individuals that completed the SBIRT intervention and at one month 65% of these individuals were enrolled in the referred facility.

Landy, Davey, Quintero, Pecora, and McShane (2016) completed a systematic review that consisted of 34 articles primarily based in the emergency room to examine the effectiveness of brief interventions. All studies showed a decrease in alcohol consumption in 3 months after the SBIRT intervention but had mixed results in the decrease in alcohol use following 3 months; however, brief interventions decreased the likelihood of alcohol related injuries. Brief interventions did not have a direct impact on emergency room visits but a decrease in risky behaviors related to alcohol potentially decreasing emergency room visits were demonstrated.

Madras et al. (2009) completed a randomized controlled trial of 459,599 individuals that were screened for substance use in a variety of healthcare settings, including an emergency room. SBIRT was able to identify risky or problematic substance users, provide brief interventions to those individuals identified, and refer the individuals to treatment. A 67.7% decrease in illicit substance use and 38.6% alcohol use was reported in individuals at a 6-month follow up.

Evidence supports the use of the SBIRT intervention as an effective tool that can be utilized in the emergency room setting, which holds significance for the implementation project. Although different methods were used for screening, the literature demonstrates an increase of identification of SUDs after any screening tool was used. Furthermore, the screening methods

are typically easy to use, which makes the SBIRT intervention feasible (Madras et al., 2009). Brief intervention (BI), following the identification of substance users, has shown to decrease use of substance, increase engagement and readiness to change and explore options with the individuals. Individuals that are referred to treatment have a decrease in alcohol consumption and emergency room visits (Desy et al., 2010). Individuals that have used referrals have better outcomes in their recovery management when compared to those who did not utilize referrals.

Theoretical Framework

The Recovery Management model (RM) is a specialty model specifically taken from the Recovery-Oriented Systems of Care (ROSC) to address adults who are at-risk or already have a SUD. The RM model engages those identified as at-risk or harmful users of alcohol or substances and assists them with management of long-term recovery from a community approach (White, 2008). The major concepts of the model include Pre-Recovery Identification, Engagement and Recovery Stabilization (Fornili 2016; White, 2008). Pre-Recovery Identification includes early interventions such as screening and person-centered assessments (White, 2008). Engagement includes the patient, family and clinician which are empowered through brief intervention and support through individualized needs. Recovery Stabilization offers follow-up check-ups and community support services to sustain recovery management (White, 2008).

The RM model was the framework used to implement a SBIRT in the emergency room setting. The three concepts identified in the RM model correspond to the three interventions used in the SBIRT protocol. Pre-Recovery Identification corresponds to the screening phase including the tool that was used to identify the individual. Engagement corresponds with the brief intervention in which motivational interviewing was used to engage the client's readiness for

treatment. In addition, engagement was applied to screening and referral to treatment steps of the SBIRT, as there will be a certain level of engagement between the clinician, client and family. Recovery Stabilization included the referral to treatment and decides the level of care for the client.

Methods

This quality improvement project was designed to implement an SBIRT intervention for adults 18 years and older presenting to a rural community emergency room with alcohol or substance use related concerns. When the client entered the emergency room, the individual was triaged by a registered nurse. If the client had a self-identified mental health concern, the emergency room physician ordered a Behavioral Health Response Team (BHRT) consult for the patient to be assessed. Inclusion criteria included every encounter a patient is assessed by BHRT over the age of 18. Exclusion criteria included patients that were not medically cleared for treatment, were positive for suicidal or homicidal ideations and unable or unwilling to answer intervention questions (i.e. autism, intellectual disability, communication barriers).

After the initial BHRT consult, each patient was assessed for alcohol and substance use using the CAGE scale (Appendix B) and responses 0-4 will be recorded (D'Onofrio & Degutis, 2010; Madras et al., 2009). The CAGE scale was already used during the BHRT assessment for both alcohol and substance use and decreased training time for staff. If the patient receives a 0-1, the patient received counseling regarding risks of increasing intake and number to local health department if needed in the future.

If the patient scores a 2-4, the MI was elicited with the individual as a brief intervention. A brief training occurred with staff that details the steps of MI and role playing which allowed

for evaluation of competency for each member of the implementation team (Appendix C). After the MI was completed, patient was asked to rate their readiness to change score. After the patient rated their engagement score, patient was referred to an outpatient or inpatient substance or alcohol treatment facility to determine further level of care (Appendix D). The outcome measure was the number of patients who were referred to treatment following the completion of the SBIRT protocol.

The data plan consisted of a 12-week period in which categorized data was collected by the author once at the end of every week from the implementation team member. Every two weeks, the data was discussed with the clinical site representative. The limited data set included the following data points CAGE screenings (No or Yes), brief intervention initiated by CAGE score (2 or greater or less than 2), referral to treatment (No or Yes) and total number of encounters that completed the SBIRT intervention (No or Yes). Data collection occurred by using a check-list that tracked screening, motivational interviewing, patient engagement scores and referral to treatment (Appendix E). Encounters were collected monthly by counting the total number of encounters on the check-list to determine completion. Additionally, demographic data (gender and age) were tracked on the same checklist.

Approval was obtained through the University of Maryland (UMB) Institutional Review Board for a Non-Human Subjects Research (NHSR) determination. All data was analyzed through an Excel spread sheet. Monthly (September, October, November) run charts were performed to analyze trends towards the percentages of patients that were screened, provided with MI and referred to treatment to determine if goals were achieved. Descriptive statistics were utilized to determine the results of the different components of the SBIRT protocol including the outcome measure.

Results

The SBIRT implementation project took place over a 12 week period in the emergency room. Throughout the 12 weeks, the sample consisted of 272 individuals (Table 1). All 272 (100%) individuals were screened using the CAGE score. The majority of screened individuals were male (54.4%) and in the age range 18-39 (60.2%) (Table 1). Of those individuals, 112 (65.1%) were eligible for the SBIRT protocol. The eligible individuals were mostly male (63.3%) (Table 2). From the 112 eligible individuals, 96 (85.7%) individuals received MI. Nine of the twelve weeks, 80% or more of eligible individuals received MI (Figure 1). Of the 96 individuals that received MI, 86 (89.5%) individuals were referred to treatment. Eleven of the twelve weeks, 75% or more individuals that received MI were provided with a referral to treatment (Figure 2). There were 54 (62.7%) males compared to 32 (37.3%) females that completed the SBIRT protocol. Finally, of the 112 eligible individuals, 86 (76.7%) completed the SBIRT protocol. Nine of the twelve weeks, 75% or more of the eligible individuals completed the entire SBIRT protocol (Figure 3). The quality improvement project had a 76.7% completion rate, which is statistically significant compared to internal evidence of 54.0%.

Changes in practice included developing a step by step process for individuals identified as at-risk or current substance users. In addition, reviewing MI with the BHRT helped enhance patient engagement to accept treatment referrals. Enhanced engagement is evident by the increase in completion rate compared to the existing internal evidence. An unexpected benefit of this quality improvement project to the emergency department included an updated list of referral sources in the community (Appendix D). An initial barrier to implementing the SBIRT protocol was a lack of referral sources but was minimized by contacting local facilities indicating

a variety of options actually available. A strong facilitator was the ease of the recording of the data for the BHRT members, which assisted in the abundance of data collected (Appendix E).

Discussion

The quality improvement project provided preliminary support regarding the likelihood of implementing an SBIRT in an emergency room setting. All individuals entering the emergency room with a BHRT consult (100%) were initially screened using the CAGE scale. Although the CAGE scale is not always used for both substance and alcohol use, it supported an effective screening process to identify at-risk or current substance users. Support was evident by the high number of eligible individuals from total screened. Through 12 weeks, an average of 85.7% completed MI and nine of the twelve weeks achieved an average completion rate of 80% or above. The increased number of individuals that received MI supports the likelihood of patient engagement and adherence to treatment. An average of 89.5% of eligible individuals were referred to treatment and eleven of the twelve weeks above 75% of individuals were referred to treatment. An average of 76.7% of individuals completed the SBIRT protocol and nine of the twelve weeks achieved the outcome of above 75%. The average percentage of individuals completing the SBIRT protocol was increased from the original internal evidence of 54.0% of individuals receiving treatment after an emergency room visit.

The data supports SBIRT as an effective protocol for obtaining appropriate treatment for individuals with substance use, which showed to decrease hospital recidivism by 47% when using the SBIRT protocol (Agerwala & McCance-Katz, 2012). Additionally, the results showed that having a collaboration between social workers and peer support advocates improves patient flow and community relations with increasing success in finding appropriate referral placement (Agerwala & McCance-Katz, 2012). The use of MI as a brief intervention showed strong support

amongst social workers and nurses. Social workers and nurses receiving training in MI build a strong skill set that enhances engagement and relapse prevention in those who are at-risk or currently using substances (Wamsley, Satterfield, Curtis, Lundgren & Satre, 2018).

Approximately halfway through 12 weeks, there was an increase in all three outcomes measures including completions of MI, referrals to treatment and completed SBIRTs. During this time, there appeared to be more engagement between staff and one to one meetings were arranged with each team member. During this engagement process, increased data collection and improved morale from the implementation team to support the project. Otherwise, there were no differences between observed and anticipated outcomes.

The analysis of strengths and limitations of the SBIRT protocol were assessed. One particular strength of the project was the collaboration between the clinical site representative (CSR), sponsor and implementation team. Strong ongoing communication and support between the CSR and sponsor allowed for adequate development, planning and implementation of the project. The BHRT was adequately prepared and all had a novice skill set in using MI as a brief intervention. Another strength was the ease and clarity of the protocol. Each BHRT member was given a guide which provided a step by step process for screening, MI and referrals to treatment. One limitation of the project included the CAGE screening tool which was unreliable for substance use and at-risk drinkers. Efforts were made to replace “drinking” or “drink” with “substance use” or “illicit drug” and was discussed with BHRT members and CSR after implementation. Another limitation to the study was the amount of time spent with MI during the BHRT assessment. Due to the high volume of the emergency room, individuals received various times of the brief intervention. Time constraints impacted the amount of time the BHRT could spend providing brief intervention after the screening was completed. This could certainly

decrease an individual's engagement and readiness to change. Several BHRT members stated they had an uncomfortable response working with SUDs. The increased stigma initiated a bias towards working with those individuals limiting internal validity of the project. There were no follow-up calls to determine if individuals received treatment or returned to the emergency room within 30 days. Lack of follow-up was discussed with the CSR and implementation team and would warrant further studies.

Conclusion

The primary purpose of this quality improvement project was to implement and evaluate the effectiveness of an SBIRT protocol in the emergency room setting. Observed outcomes indicate the implementation of an SBIRT protocol is an effective treatment plan for individuals who are at-risk or current alcohol or substance users. The project assured that individuals can be identified early by screening, counseled regarding changing behaviors and referred to appropriate levels of care from the emergency room. The high number of individuals who completed MI, referred to treatment and subsequently completed the protocol supports the idea of future sustainability within the organization. Future plans will be discussed with the emergency room manager, director and CSR to gradually expand the protocol throughout the whole emergency room. In order to have a collaborative SBIRT protocol in the emergency room, future implications should address monitoring of adherence to treatment after referrals are made and continued education of social workers, nursing staff and physicians to decrease stigma, promote engagement and assist those into recovery management.

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<http://homeless.samhsa.gov/ResourceFiles/White.2008.pdf>

Table 1. Demographic Characteristics of the Sample (n=272)

Gender (number, percent)	
Male	148 (54.4%)
Female	124 (45.6%)
Age (number, percent)	
18-39	164 (60.2%)
40-65	94 (34.5%)
65 and over	16 (5.3%)

Table 2. Demographic Characteristics

Eligible Individuals (n=112) (number, percent)	
Male	71 (63.3%)
Female	41 (36.7%)
Individuals Completed (n=86) (number, percent)	
Male	54 (62.7%)
Female	32 (37.3%)

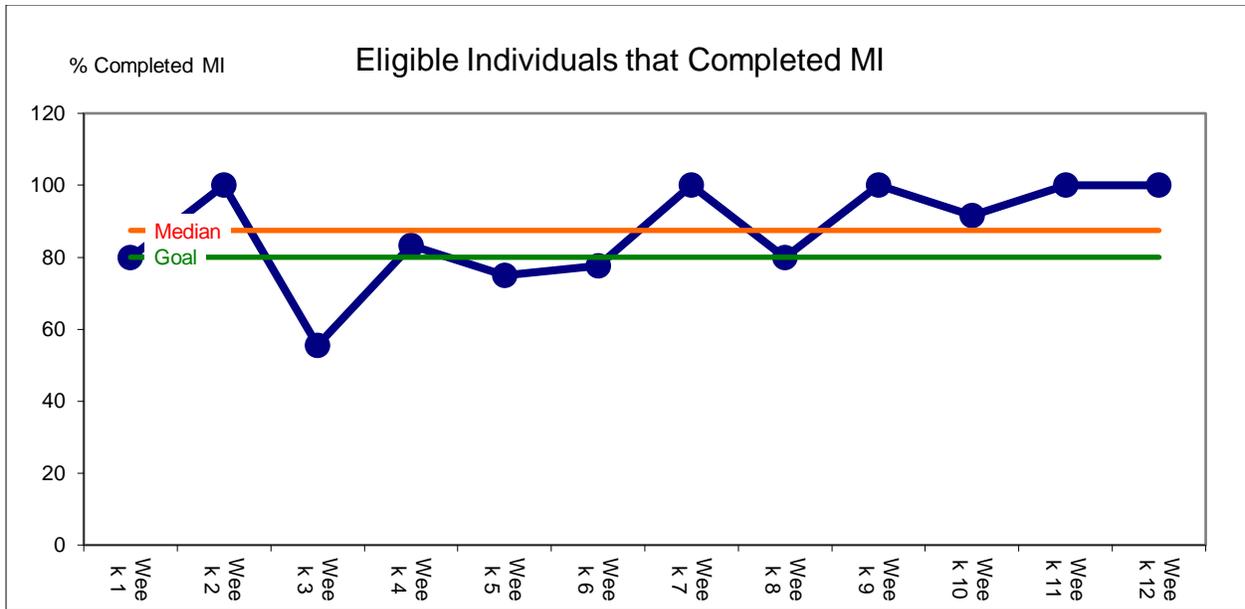


Figure 1. Eligible Individuals that Completed MI

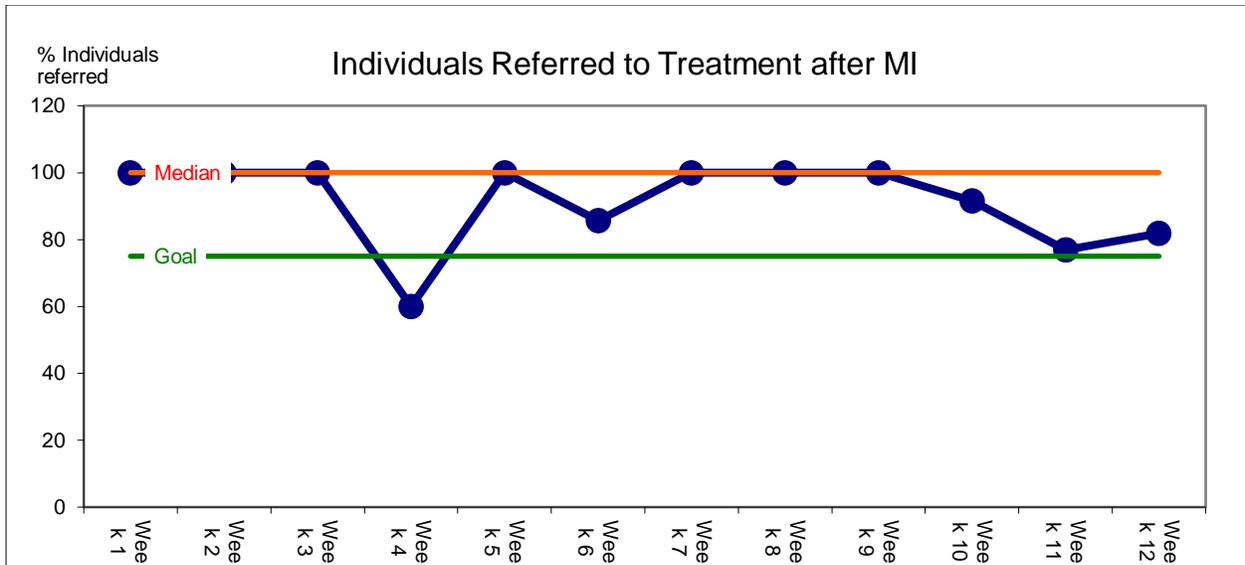


Figure 2. Individuals Referred to Treatment after MI

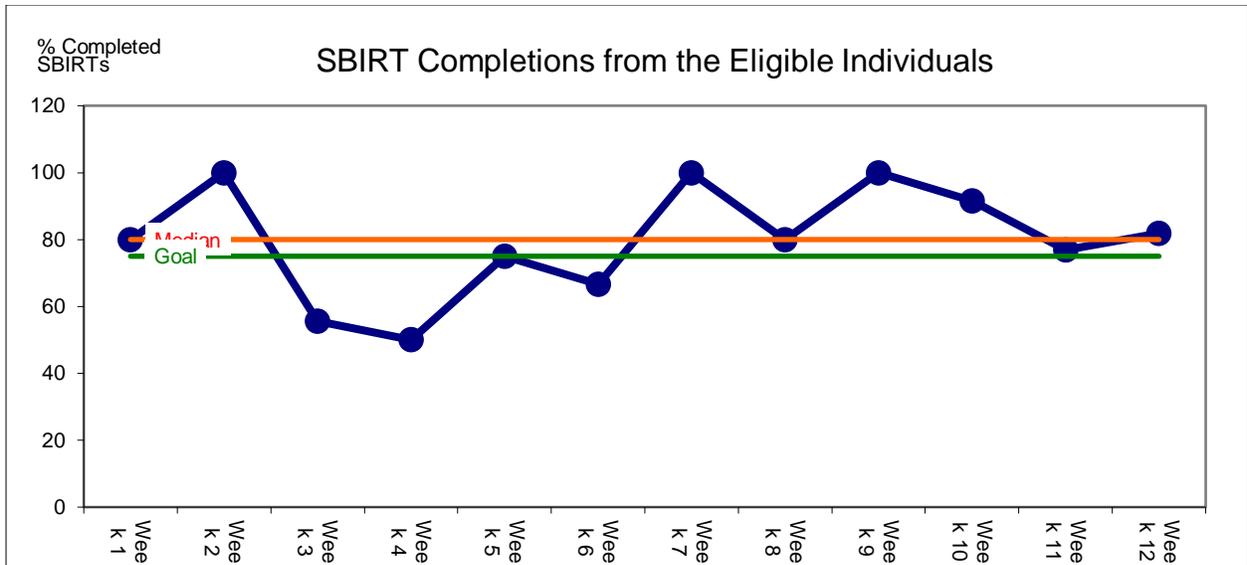


Figure 3. SBIRT Completions from the Eligible Individuals

Appendix A

Evidence Table

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Barata et al., 2017	To evaluate the evidence of the efficacy of emergency room brief interventions for patients identified through alcohol screening and the effectiveness of interventions at lowering alcohol intake and injury	Systematic Review	N=35 articles that were randomized controlled trials of SBIRT from January 1966 to April 2016	Alcohol use reduction, alcohol related injury, emergency room visits, and brief intervention impact; measurement methods vary depending on individual RCTs	1) 13 studies with a total of 5,261 individuals showed a decreased frequency and amount used after SBIRT was used 2) Moderate-quality evidence, which consisted of 16 studies showed a reduction in alcohol consumption after using brief interventions 3) One study showed that individuals referred to treatment had a mean of 0.5 fewer emergency room visits over 12 months	1B
Desy, Howard, Perhats, & Li, 2010	To evaluate the effectiveness of a nurse led SBIRT intervention on alcohol consumption and alcohol related injury	Quasi-experimental study	N= 94 individuals that were positively screened for alcohol in the emergency room, 42 of the individuals were in the control group and 49 were in the intervention group	1) Alcohol consumption through self-reporting on frequency and quantity 2) Recurring emergency room visits through 3 month follow up phone calls 3) Traffic violations and crashes related	1) There was a 70% decrease in the average amount of alcohol per week in the intervention group compared to a 20% decrease in amount used per week in the control group, but the results were not statistically significant due to the baseline drinking amount reported in each group 2) Reduction in alcohol frequency was not statistically significant with a 35% decrease in the intervention group and 42% decrease in the intervention group	3B

				to alcohol through 3 month follow up phone calls	<p>3) There was a decreased amount of emergency room visits in the intervention group (20%) compared to the control group (31%); one patient from the intervention group had a recurring visit with injury compared to 4 patients with recurring visits for injury in the control group</p> <p>4) One traffic violation was reported from the intervention group.</p>	
D’Onofrio & Degutis, 2010	To evaluate an emergency room intervention that screens, provides brief intervention, and referrals to treatment for alcohol and drug use.	Descriptive program evaluation	Convenience sample N= 22,534 individuals screened in one emergency room over a five year period (1999-2004) during the available hours of the trained implementation team	<p>1) Amount of identified individuals with substance misuse through self-reporting symptoms during screening (using CAGE scale and frequency/amount questions)</p> <p>2) Brief intervention and referral to treatment of the identified users through one month follow up self-reports</p>	<p>1) Of the individuals that were screened, 10,246 (45.5%) reported alcohol use in the past 30 days and 5,533 (54%) exceeded the guidelines for low-risk drinking; the use of at least one illicit drug was reported by 3,530 (15.7%) of the screened individuals</p> <p>2) 6,266 (27.8%) of the screened individuals received brief interventions. Of these individuals, 3,968 (68%) were referred to specialized treatment</p> <p>3) 83% of the patients were followed at one month and 2,159 (65%) were enrolled in the referred facility</p> <p>4) Direct admissions to the specialized facilities were 30 times more likely to enroll than indirect admissions</p>	6A
Landy, Davey, Quintero, Pecora, &	To offer an updated systematic review on the efficacy of brief interventions for	Systematic Review	N=34 studies that included mostly pre/posttest designs and randomized control	Alcohol reduction at 3, 6, and 12 months, alcohol related injuries,	1) All studies showed a decrease in alcohol consumption at 3 months after brief interventions were provided but there were mixed	1B

<p>McShane, 2016</p>	<p>alcohol use in the emergency room</p>		<p>trials, one meta-analysis, one review article, one retrospective observational descriptive study, one paper, one symposium that summarized results from several studies, and a few studies that involved secondary analyses</p>	<p>alcohol related risky behaviors, and emergency room visits after brief interventions were delivered; measurement methods vary depending on individual studies</p>	<p>results in a decrease of alcohol consumption at 6 and 12 months 2) Individuals that were provided brief interventions had a decreased likelihood of alcohol related injury at 6 and 12 months after brief interventions 3) Brief interventions did not decrease emergency room visits but may decrease risky alcohol use behaviors that could lead to hospitalizations</p>	
<p>Madras, Compton, Avula, Stegbauer, Stein, & Clark, 2009</p>	<p>To compare alcohol and illicit drug use at intake and 6 months after drug and alcohol interventions were completed</p>	<p>Randomized Controlled Trial</p>	<p>N= 459,599 individuals screened in six facilities with a variety of healthcare settings (trauma centers, emergency rooms, outpatient clinics, and primary care centers)</p>	<p>1) Drug and alcohol use at 6 month after SBIRT interventions were used compared to intake through patient self-report 2) Functionality in the community at 6 months after SBIRT interventions were used compared to intake through patient self-report</p>	<p>1) Of the 459,599 individuals screened, 22.7% were identified as problematic or risky substance users 2) Of the identified substance users, 15.9% were given brief interventions 3) 3.2% were referred to brief treatment and 3.7% were referred to specialty treatment 4) There was a 67.7% decrease in illicit drug use and 38.6% in alcohol use from baseline at 6-month follow up 5) After referral to treatment all outcomes improved ($p < 0.001$) in general health, mental health, employment, housing status, and criminal behavior</p>	<p>2A</p>

Rating System for Hierarchy of Evidence

<u>Level of the Evidence</u>	<u>Type of the Evidence</u>
I (1)	Evidence from systematic review, meta-analysis of randomized controlled trials (RCTs), or practice-guidelines based on systematic review of RCTs.
II (2)	Evidence obtained from well-designed RCT
III (3)	Evidence obtained from well-designed controlled trials without randomization
IV (4)	Evidence from well-designed case-control and cohort studies
V (5)	Evidence from systematic reviews of descriptive and qualitative studies
VI (6)	Evidence from a single descriptive or qualitative study
VII (7)	Evidence from the opinion of authorities and/or reports of expert committees

Melnyk, B.M. & Fineout-Overholt, E. (2014). *Evidence-based practice in nursing & healthcare: A guide to best practice* (3rd ed.). New York: Lippincott, Williams & Wilkins.

Rating Scale for Quality of Evidence

- A: High – consistent results with sufficient sample, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific literature
- B: Good – reasonably consistent results; sufficient sample, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
- C: Low/major flaw – Little evidence with inconsistent results; insufficient sample size; conclusions cannot be drawn

Newhouse, R.P. (2006). Examining the support for evidence-based nursing practice. *Journal of Nursing Administration*, 36(7-8), 337-40.

Appendix B

CAGE

- C** Have you ever felt you should **cut down** on your drinking?
- A** Have people **annoyed** you by criticizing your drinking?
- G** Have you ever felt bad or **guilty** about your drinking?
- E** **Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.

*Team member will replace the word “drink” or “drinking” in each question with “substance use” or “illicit drug”

Appendix C

BHRT Teaching Plan

- I. What is SBIRT?
 - a. Explanation of steps
 - i. Screening- explanation/review of CAGE assessment tool
 - ii. Brief interventions-give motivational interviewing overview and teach techniques
 - iii. Referral to treatment-review current resources in the community and solidify which resources will be used in the referral process (local walk in times, inpatient rehab centers)
 - b. Significance for the ER
- II. BHRT team responsibilities
 - a. Encounter Information
 - i. Record date, gender and age
 - b. Screening
 - i. Administer CAGE tool after the BHRT consult is placed
 - ii. Obtain a score from the CAGE assessment, a score of 0 or 1 provide brief education and encouragement of maintaining proper usage, a score of 2 or greater will receive the brief intervention (motivational interviewing)
 - iii. Record how many patients were screened using the CAGE assessment and what their score was
 - c. Brief interventions
 - i. Begin motivational interviewing
 - ii. Assess the patient's readiness to change on a scale from 1 to 10 after the motivational interviewing
 - iii. Record post-MI readiness to change scores
 - d. Info/Referral to treatment
 - i. After patient rates engagement score, they will be referred/given information to treatment from the list of local resources
 - ii. Provide education to patient on treatment options (i.e. inpatient & outpatient services, medication assisted therapy, community support)
 - iii. Record how many patients were referred to treatment or given the information
 - iv. Record patient disposition
- III. Overview
 - a. Individual role-play as needed per need
 - b. Review how the data will be recorded
 - c. Questions?

Appendix D

Referrals to Treatment

Inpatient**1. Warwick Manor Behavioral Health**

-Address: 3680 Warwick Rd, East New Market, MD 21631

-Phone: (410) 943-8108

-Intake Information: Call and an intake will be scheduled

2. Hudson Health Center

-Address: 1505 Emerson Avenue, Salisbury, MD 21801

-Phone: (410) 219-9000

-Intake Information: Walk in Monday-Friday 8AM-11AM

Outpatient**1. Wicomico County Health Department**

-Address: 108 E Main St, Salisbury, MD 21801

-Phone: (410) 742-3784

-Intake Information: For walk-in assessments, please report any day Monday - Thursday at 8 AM.

2. J. David Collins & Associates

-Address: 540 Riverside Dr Ste 8, Salisbury, MD 21801

-Phone: (410) 548-3333

-Intake Information: Call office or walk in at any time to schedule an intake.

3. Eastern Shore Psychological Services (ESPS)

-Address: 1113 Healthway Dr, Salisbury, MD 21804 OR 11559 Somerset Ave, Princess Anne, MD 21853

-Phone: (410) 334-6961 OR (410) 621-0889

-Intake Information: Monday-Friday at 12PM (Princess Anne); Monday-Friday 8-9am (Salisbury)

4. Peninsula Addiction Services

-Address: 102 W Market St, Salisbury, MD 21804

-Phone: (410) 860-2673

-Intake Information: Call to schedule intake appointment.

5. Worcester Addictions Cooperative Service Center (WACS Center)

-Address: 11827 Ocean Gateway, Ocean City, MD 21842

-Phone: (410) 213-0202

-Intake Information: Mon-Thurs @ 12-1pm

6. Worcester County Health Department

-Address: 6040 Public Landing Rd Snow Hill, MD 21863

-Intake: Mon-Fri 0800-0930 (Walk-in)

7. Chesapeake Health Care (CHS)

-Address: 560 Riverside Drive, Suite A-204, Salisbury, MD 21801 OR 12145 Elm St., Princess Anne, MD 21853 OR 305 10th Street, Suite 104, Pocomoke City, MD 21851

- Phone: (443)358-6193 OR (410) 651-1000 OR (410)957-1852
- Intake Information: Monday-Friday at 10AM or call for a scheduled appointment

8. Chesapeake Treatment Services

- Address: 1322 Belmont Ave. Salisbury, MD 21804 OR 12417 Ocean Gateway Suite 7, Ocean City, MD 21842 OR 402 Marvel Court, Easton, MD 21601
- Phone: (410)831-3904 OR (410) 651-2204 OR (410)822-7150
- Intake Information: Tuesday, Wednesday, or Friday at 5:45AM or call to schedule an appointment

9. Delmarva Counseling Center

- Address: 28 East State St Delmar, MD 21875
- Intake: Mon-Fri 8am-6pm (by appointment)

10. Focus Point Behavioral Health

- Address: 11672 Somerset Ave Princess Anne, MD 21853 Phone: 410-621-5858; 803 N. Salisbury Blvd Suite 2200 Salisbury, MD 21804 Phone: 443-978-7838
- Intake: Mon-Thurs 9am-8pm Friday 9am-5pm (by appointment or walk-in)

11. Life Mark Inc.

- Address: 28672 Old Quantico Rd. Salisbury, MD 21801
- Intake: Mon-Thurs 8am-630 pm, Fri 8am-4 30 pm (by appointment)

12. Lighthouse Counseling Christian Ministry

- Address: 10026 Main St Bldg 1 Berlin, MD 21811 Phone: 410-973-2211; 120 B Arlington Rd. Salisbury, MD 21801 Phone: 410-973-221
- Intake: Monday-Friday 8am-8pm (Appointment Only)

13. McCready Health Addictions

- Address: 201 Hall Hwy Crisfield, MD 21817 Phone: 410-968-1801
- Intake: Mon & Tues (2-3pm) Weds-Fri (1-2pm) Please bring ID and health insurance

Peer Support

1. Community Outreach Addictions Team (COAT)

- Phone: (443) 783-6875
- Intake Information: Available 24 hours a day, calls are answered or returned promptly. Offers peer support to support and guide treatment choices. Offers support until intake assessment is completed or can be placed in an inpatient facility.

