EMERGENCY NURSES ASSOCIATION

IntNSA
International Nurses Society on Addictions

Position Statement

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Expanding Roles and Responsibilities for Nurses in Screening, Brief Intervention, and Referral to Treatment (SBIRT) For Alcohol and Other Substance Use

Description

Alcohol and substance use disorders are global public health concerns. The U.S. National Institute on Drug Abuse states that alcohol, tobacco, and other substance use disorders cost more than $740 billion annually in crime-related costs, lost work productivity, and health care expenses (NIDA, n.d.). Overall costs in the U.S. are $249 billion for alcohol use, $193 billion for illicit drug use, $300 billion for tobacco use, and $78.5 billion for prescription opioid use (NIDA, n.d.). The National Survey on Drug Use and Health from the Substance Abuse and Mental Health Services Administration reported that 19.7 million Americans aged 12 and older had a substance use disorder (SAMHSA, 2017a). Of those, 74% suffered from a combination of an alcohol and other substance use disorder, and 38% had a drug use disorder only (SAMHSA, 2017a; American Addiction Centers [AAC], 2019). When viewed as chronic medical conditions, relapse rates (noncontinuous abstinence) for substance use disorders after one year (40–60%) are similar to recurrence rates of other chronic diseases, including asthma (50–70%) and hypertension (50–70%), although an additional 15 to 30% of persons with a substance use disorder do not resume dependent use in that time period (McLellan et al., 2000). Effective prevention, identification, and early intervention are essential to supporting effective treatment and recovery from substance use disorders.

The 2013–2014 National Roadside Survey (NRS) of Alcohol and Drug Use by Drivers reported on the alcohol and drug prevalence among 11,100 drivers (Benning et al., 2015) in data collected during weekday daytime and weekend nighttime. The national prevalence rates for alcohol and drug use by drivers revealed a decreasing trend in the percentage of drivers that were alcohol-positive from 7.5% (1973) to 1.5%, an increase in drug-positive drivers using medications from 3.9% (2007) to 4.9%, and an increase in the prevalence of illegal drugs detected in drivers from 12.4% (2007) to 15.1% (Benning et al., 2015). The NRS is the only nationwide data set regarding alcohol and drug use by drivers. Challenges persist in this line of research; factors include testing across a wide array of substances, psychomotor and behavioral functions, sensitivity and tolerance, absorption and metabolism, and acute versus chronic consumption (Benning et al., 2015).

Currently, there are no national standards for “drugged driving” as there are for drunk driving (0.08 g/ml blood alcohol concentration). “Drug-impaired driving” and “marijuana-impaired driving” laws need to be referred to in applicable cases; existing state laws include the zero tolerance law, per se law, driving under the influence of drugs (DUID), and permissible inference law (National Conference of State Legislatures [NCSL], 2019). Several states have legalized recreational marijuana, revealing gaps in substance use testing technology and practices. This affects reporting and detection of traffic crashes by drivers impaired

by marijuana (Ghosh et. al., 2017). There is little evidence to link drug concentrations to driver performance (Benning et al., 2015). Caution must be exercised by authorities regarding the presence of a drug, as presence alone does not necessarily imply impairment (Benning et al., 2015). There is an opportunity for authorities to explore additional methods by which they collect traffic accident and citation data. Further research on "drugged driving" is necessary due in part to the public health trend toward legalization of marijuana.

Alcohol use disorders alone are responsible for more than 5% of the global disease burden. According to the World Health Organization (WHO) (2018), more than 3 million people died as a result of an alcohol use disorder in 2016. There are over 7.6 million emergency department (ED) visits per year in the U.S. for alcohol-related illnesses and injuries (Institute for Research, Education, and Training in Addictions [IRETA], n.d.). Research has shown that alcohol use disorder is a highly prevalent, comorbid, and disabling disorder that frequently goes untreated in the U.S. (Grant et al., 2015; Mellor et al., 2019; Connor et al., 2016; Hasin et. al., 2017). Based on the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) Wave 2 (2003–2005) data, researchers recommended that the general public and policy-makers be educated about alcohol use disorders and treatment options, destigmatize the disorder, and encourage treatment and ongoing recovery support (Hasin & Grant, 2015).

Many Americans and healthcare workers are unaware of the drinking guidelines established by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) (2015). In the United States, a standard drink is defined as a 12-ounce glass of beer, a 5-ounce glass of table wine, or 1.5 ounces of 80 proof distilled spirits (HHS & USDA, 2015). If alcohol is consumed in moderation, nonpregnant women should consume no more than 1 drink per day, and healthy men no more than 2 drinks per day. Heavy alcohol use is defined as drinking on 5 or more days within a month (HHS & USDA, 2015). For certain individuals, there is no safe drinking limit. Per the Centers for Disease Control and Prevention (CDC) Guidelines, persons should abstain from alcohol if they are or may become pregnant, are younger than age 21, have certain medical conditions, and/or are in recovery from a substance use disorder (CDC, 2019).

Healthcare professionals have been slow to implement a comprehensive SBIRT approach in relation to alcohol and other substance use. Despite more than 50 years of research evidence, SBIRT remains under implemented in many settings for a variety of reasons (Fornili, 2016a Rahm et al., 2015; Saitz, 2007). Currently, there is a movement to expand the use of SBIRT as an interprofessional, public health approach (Wamsley et al., 2018). Research supports the expansion of SBIRT to diverse populations (e.g., pediatric, adolescent, maternity, and geriatric), and in various settings (e.g., primary care, middle/high schools, academia, healthcare professions), rather than being limited to trauma or emergency departments (American College of Surgeons [ACS], n.d. IRETA, n.d.).

However, the general consensus among professionals supports a comprehensive SBIRT approach. Not all studies have deemed SBIRT to be effective (e.g., Roy-Byrne et al., 2014; Saitz, 2014). *Brief intervention* alone may be inadequate for persons with frank substance use disorders, with complex medical conditions, and/or psychiatric disorders; these individuals require effective referral to specialty treatment and follow-up support after treatment (SAMHSA, 2013; Fornili, 2016b). SBIRT is not a cure for alcohol and other substance use disorders; however, an SBIRT approach can positively contribute to reduced risk, remission, and recovery. Potential benefits of SBIRT include reductions (or abstinence) in substance use, risky behaviors, morbidity and mortality; improvements in health outcomes; and holistic well-being.

ENA Position

It is the position of the Emergency Nurses Association (ENA) and the International Nurses Society on Addictions (IntNSA) that:

1. Nurses support the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol use and other substance use and related disorders.

2. Nurses are prepared to deliver SBIRT across all clinical specialties and in practice settings across the lifespan.

3. Academic institutions integrate SBIRT into the curricula of undergraduate and graduate nursing programs.

4. Healthcare institutions provide SBIRT education, training, implementation, and outcomes evaluation.

5. Nurses participate in research, evidence-based practice, and clinical quality improvement initiatives in the implementation of SBIRT.

Background

SBIRT is a comprehensive and systematic public health approach for screening, delivering early intervention services, and referring persons who have alcohol use and/or other substance use disorders to treatment (SAMHSA, 2020). Screening involves the use of one or more valid and reliable instruments that professionals and healthcare students, across disciplines, can use to quickly identify a potential issue and determine whether further treatment is indicated (SAMHSA, 2020). Based on principles of motivational interviewing, brief intervention includes an individualized conversation about risky behavior, professional feedback, health advice, and healthy lifestyle practices (SAMHSA, 2020). During referral to treatment, efforts are made to facilitate appropriate specialty care (SAMHSA, 2020).

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In 1980, the World Health Organization called for improved treatment of alcohol use disorders, which evolved into the development of SBIRT (WHO, 2016; Bray et al., 2017). An SBIRT approach to address alcohol use in emergency settings began in the 1990s (Gentilello et. al., 1999; Bien et al., 1993) and has advanced in recent decades. Alcohol screening and brief intervention (SBI) is required of all Level 1 trauma centers, although the American College of Surgeons Committee on Trauma (ACSCOT) recommends that all trauma centers incorporate SBI as part of routine trauma care (American College of Surgeons, U.S. Department of Health and Human Services, & Department of Transportation, n.d.; ACSCOT, 2014; Fornili, 2016a). There have been more than 50 randomized, controlled trials in various healthcare settings, as well as meta-analyses and systematic reviews that have reported the efficacy of SBIRT (WHO, 2016; Bray et al., 2017). Its use has been endorsed by the World Health Organization (2003), several U.S. governmental agencies, and numerous medical and nursing organizations (ENA, 2013).

According to the Gallup Ethics Survey, nurses have consistently been ranked as the most trusted professionals for nearly two decades (Brenan, 2018; American Hospital Association [AHA], 2019) making them uniquely positioned to identify when a patient is in need (SAMHSA, 2014) and deliver SBIRT (Neft et al., 2017; Vipond & Mennenga, 2019). Hospitals, trauma centers, outpatient centers, primary care centers, schools, and colleges provide unique opportunities to identify at-risk users during early stages of use, and to intervene to prevent negative consequences (SAMHSA, 2020; Agerwala & McCance-Katz, 2013; Barbosa et. al., 2015).

The efficacy of SBIRT has been reported in primary care settings (Sterling et al., 2015; Mertens et al., 2015; Strobbe, 2014; Monico et al., 2019; Fornili, 2016a), medical schools (Carlin-Menter et al., 2016; Whittle et al., 2015), and middle/high schools (Harris, 2016). Studies have also reported the efficacy of SBIRT in pediatric and adolescent populations (Whittle et al., 2015; Harris, 2016; Schram et al., 2015), as well as older adults (Schonfeld et al., 2015), obstetric services (Wright et al., 2016), and educational settings (Pringle et al., 2017; Knopf-Amelung et al., 2018). Multiple studies have reported that an interprofessional approach to the implementation of SBIRT can achieve high levels of adherence (Zimmerman et al., 2018; Neft et al., 2017).

Evidence supporting SBIRT is now in its sixth decade (Saitz, 2007). The largest U.S. multi-site study reported the feasibility of implementation and improved patient outcomes, including significant improvements over baseline at 6 months for risky and hazardous use of alcohol and illicit substances (Madras et al., 2009; Aldridge et al., 2017). Moreover, many randomized control studies have reported statistically and clinically significant outcomes from the use of SBIRT, including high screening rates by non-physician providers and medical assistants (Mertens et al., 2015), a 10% rise in adolescent screening (Monico et al., 2019), a 35.6% reduction of any alcohol use in the past 30 days, and a 75.8% reduction in illicit drug use (Aldridge et al., 2017).

Research indicates barriers to the implementation of SBIRT such as a lack of resources (Barbosa et al., 2017), outdated policies, lack of funding, staff turnover, implementation climate (Stanhope et al., 2018), competing priorities, leadership involvement (Rahm et al., 2015), staff time (Cowell et al., 2017), and reimbursement for the delivery of SBIRT (Nunes et al., 2017). However, lessons learned from successful implementation of SBIRT based on 50 years of research include strong support from clinicians and other leaders, full integration into practice workflow, an interprofessional approach, cannabis screening that accounts for the legalization of marijuana in some states, the incorporation of SBIRT into standard healthcare personnel training, and reimbursement through private and public payers for SBIRT services (Nunes et al., 2017). Important research opportunities remain in certain areas including, but not limited to, the effectiveness of SBIRT among diverse populations, as well as its effectiveness in improving short- and long-term health outcomes.

Resources

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Centers for Medicare and Medicaid Services. (2019). *MLN Booklet: Screening, Brief Intervention, and Referral to Treatment (SBIRT) services*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

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