SBIRT

Screening, Brief Intervention, Referral to Treatment

Land Acknowledgement

We acknowledge that this training is taking place on the land that was traditionally occupied by the Salish, Cayuse, Umatilla, and Walla Walla tribes and that they are the original stewards of the land.

Native-land.ca

What is SBIRT?

Screening to identify patients at-risk for developing substance use disorders or other medical problems due to their substance use.

Brief **I**ntervention to raise awareness of risks and consequences, internal motivation for change, and help set healthy lifestyles goals.

Referral to **T**reatment to facilitate access to specialized treatment services and coordinate care between systems for patients with higher risk and/or dependence.

SBIRT - Screening, Brief Intervention, Referral to Treatment

SBIRT is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. Risky substance use is a health issue and often goes undetected.

Why is Screening Important?

At least 38 million Americans drink too much— they are risky, hazardous or harmful drinkers.

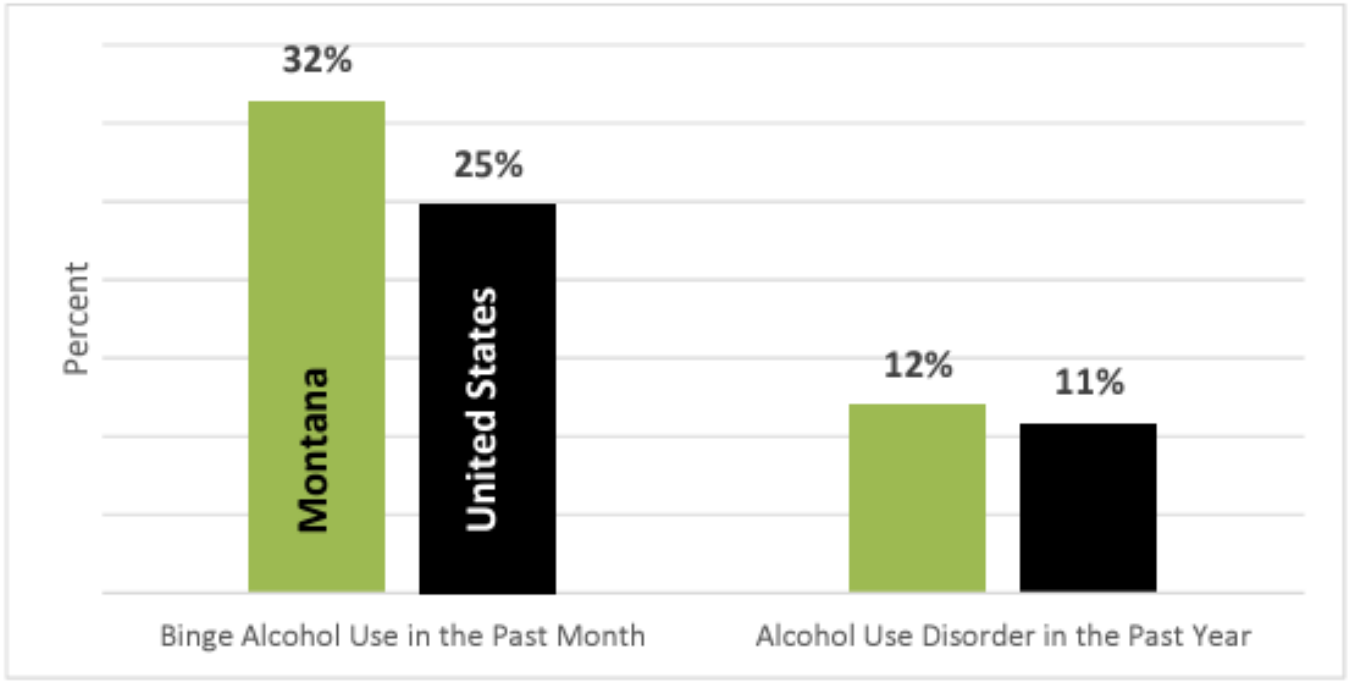
9.4% of Americans reported in the past month use of illicit drugs and 2.5% report use prescription drugs in a way that was not prescribed.

Brief intervention is effective and can reduce alcohol consumption by 10-30% in those who drink too much.

The US Preventive Services Task Force recommends alcohol screening and brief counseling (Grade B recommendation, same as flu shots and cholesterol screens).

Most healthcare professionals lack adequate training in SBI & rarely do it.

Figure 1. Self-Reported Binge Alcohol Use* and Percent Meeting Definition of Alcohol Use Disorder** Among Adults Aged 18+, **Montana** and the **United States**, 2019-2020

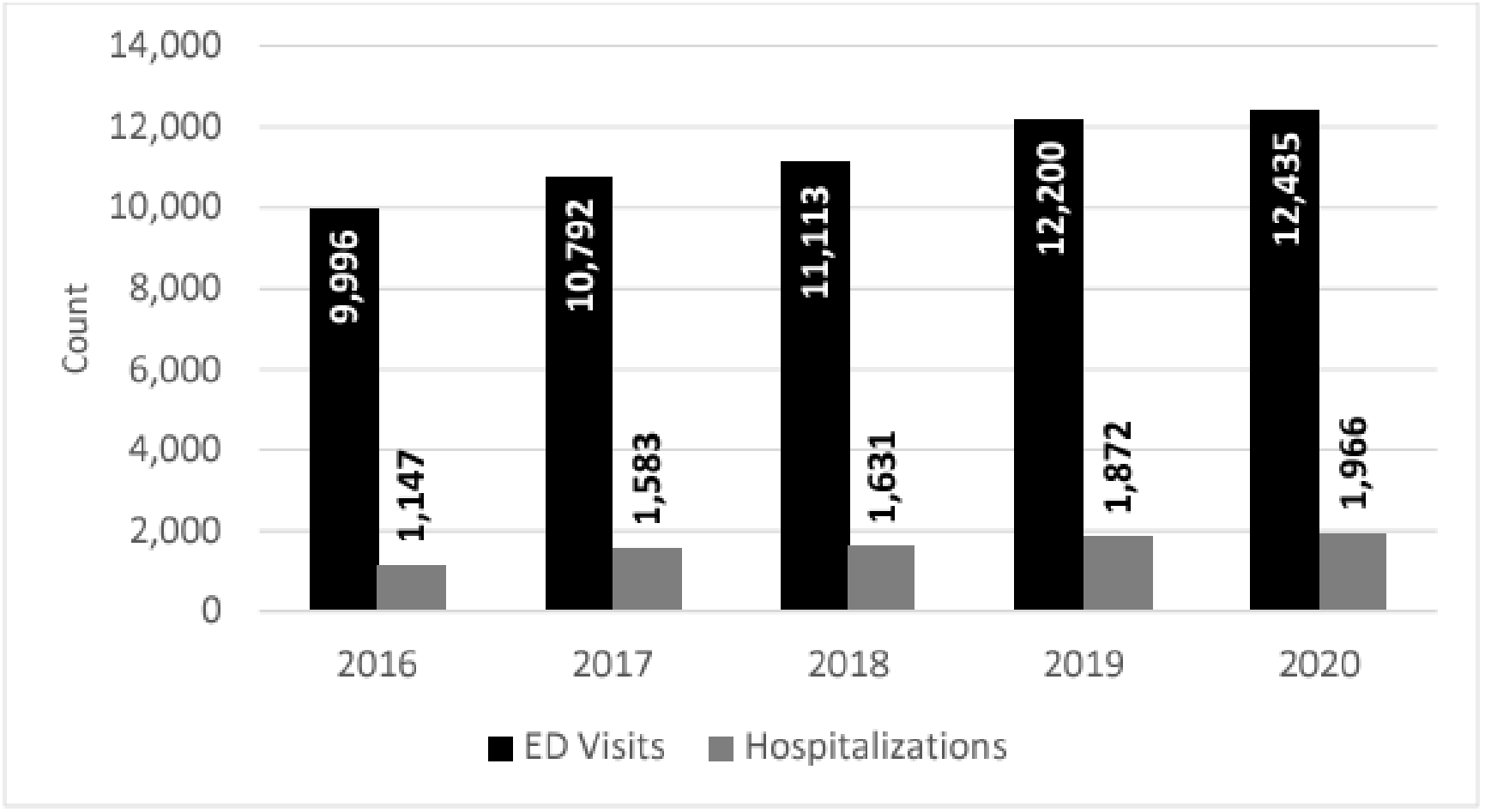


National Survey on Drug Use and Health, 2019-2020

**Binge alcohol use* is defined as consuming five or more drinks during a single occasion for men or four or more drinks during a single occasion for women

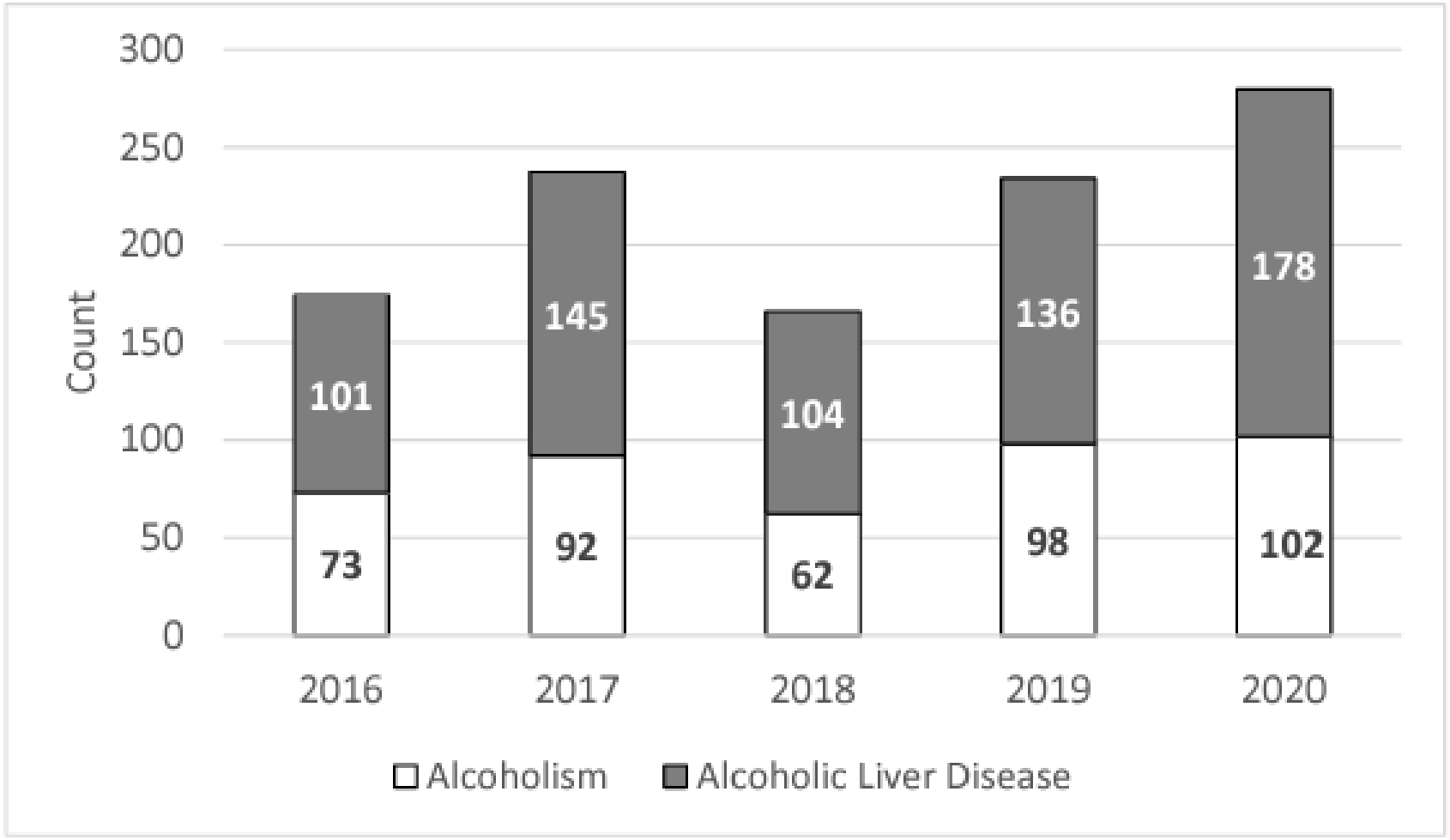
***Alcohol Use Disorder* is defined based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5). Symptoms include being unable to limit the amount of alcohol consumed, wanting to cut down on alcohol use but being unable to do so, and giving up or reducing social and work activities to use alcohol.

Figure 5. Alcohol-Related Emergency Department Visits and Hospitalizations, 2016-2020



Montana Hospital Discharge Data System, 2016-2020

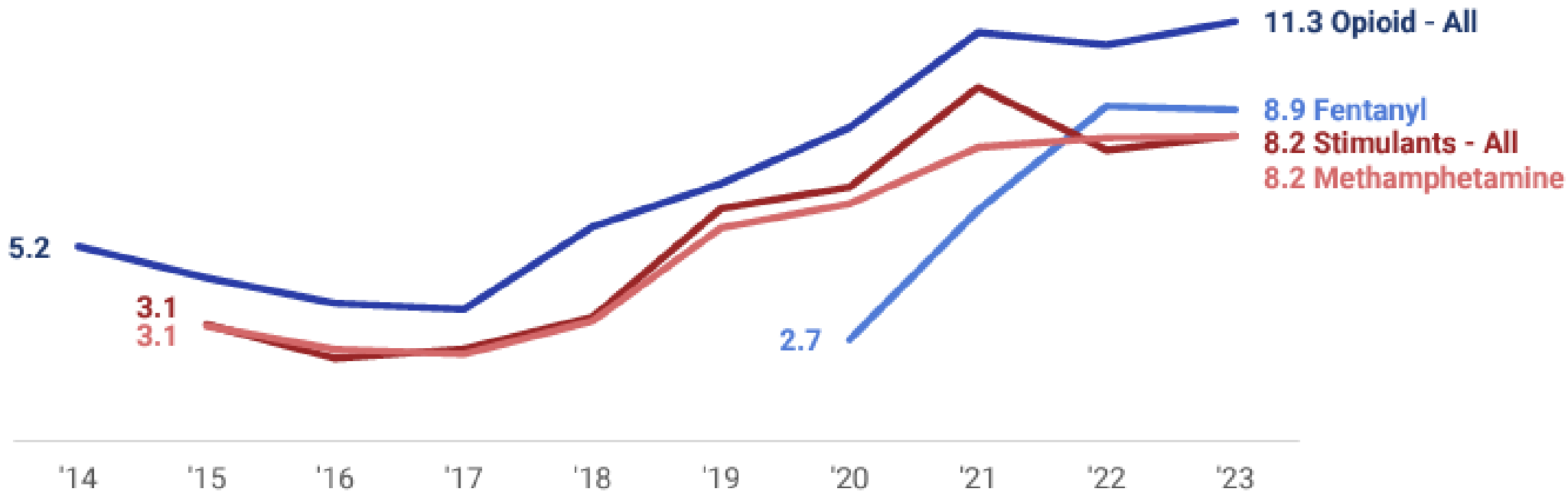
Figure 6. Montana Resident Deaths Attributed to Alcoholism and Alcoholic Liver Disease, 2016-2020



*Despite compromising only 6% of Montana's population, AI/AN individuals represent over one-third of alcoholic liver disease deaths in 2020.

Source: Montana Vital Statistics, 2016-2020

Figure 2. Drug overdose death rates increased primarily due to fentanyl and methamphetamine.
Age-adjusted drug overdose death rates by drug type per 100k residents, 2014-2023



Notes: Analysis used a multiple-cause approach, so the sum of individual drugs will not add up to the total for all drugs. For example, a drug overdose death involving both stimulants and opioids would be counted in both stimulant and opioid rates. Rates for all opioids, all stimulants, and benzodiazepines were identified using an "any mention" search of the relevant ICD-10 codes within the multiple cause of death fields. Fentanyl and methamphatamine deaths were identified using keyword searches of drug overdose death records. Rates for fentanyl and bezodiazepines are not presented for all years because counts were too low to caculate rates (n<20) in some years. Some drugs are excluded from this chart due to low counts of overdose deaths. Information on additional drugs can be found in Tables 2-3.

Source: Montana Vital Statistics

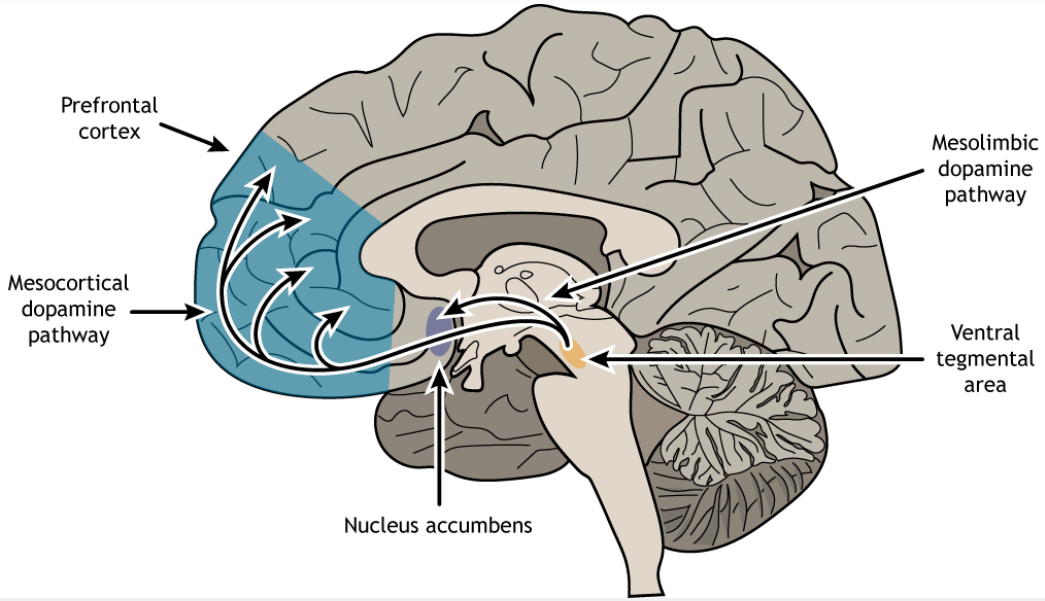
Substance Use Disorder

- "From a neurobiological perspective, drug addiction is a disease of the brain, and the associated abnormal behavior is the result of dysfunction of brain tissue." ~Christopher Cavacuiti – "*Principles of Addiction Medicine: The Essentials*"

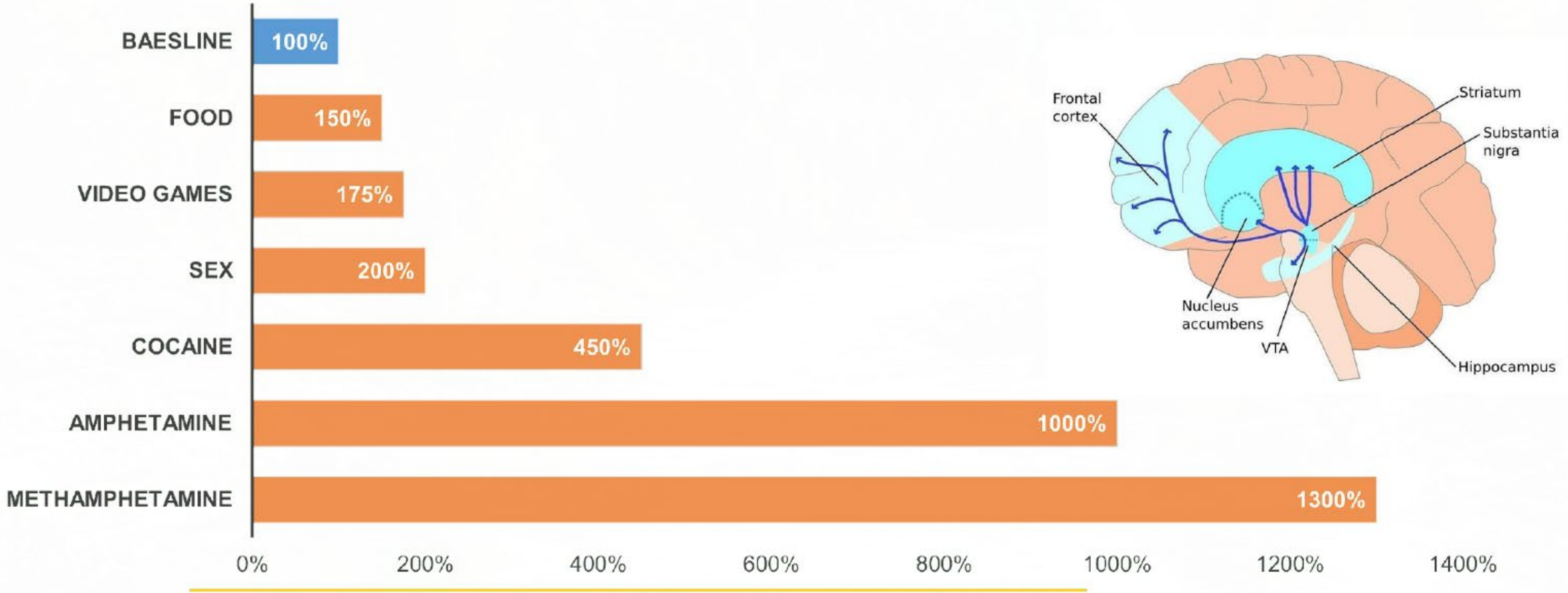
- *Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. ~American Society of Addiction Medicine*

Substance Use in the Brain

- Positive Reinforcement:
  - Release of dopamine
  - Pre-frontal cortex remembers and seeks the rewarding trigger (substance)
- Negative Reinforcement
  - Alleviates coexisting psychiatric disorders
  - Avoidance of withdrawal symptoms



Comparisons of Dopamine Release

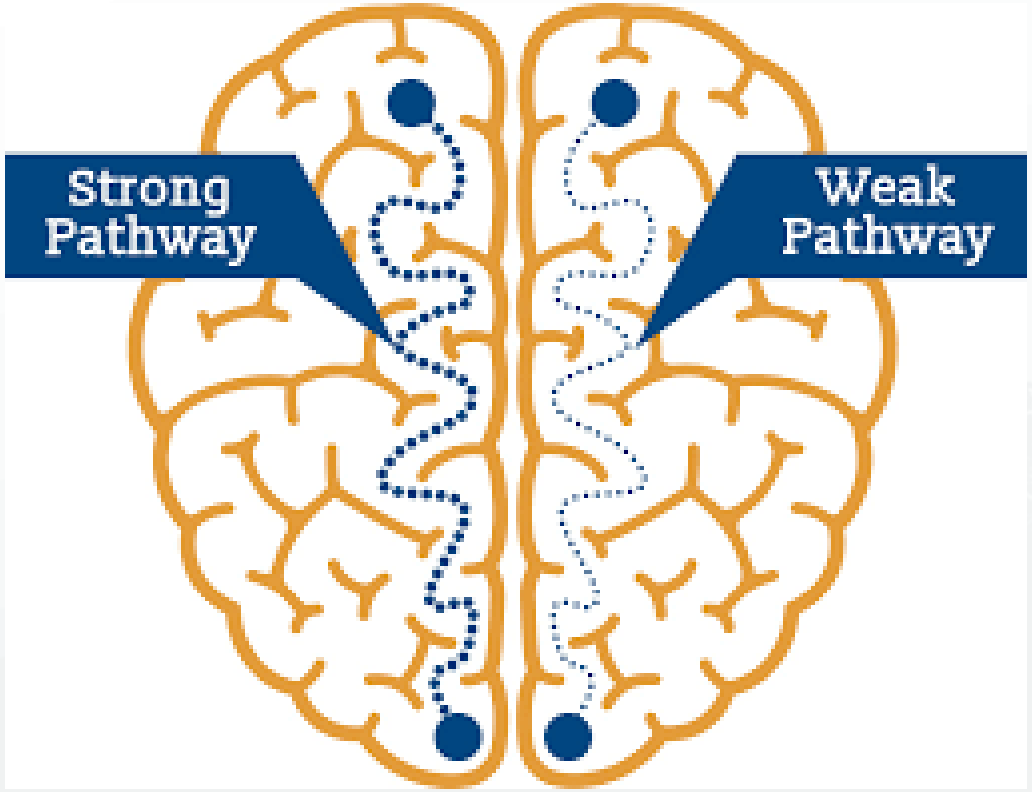


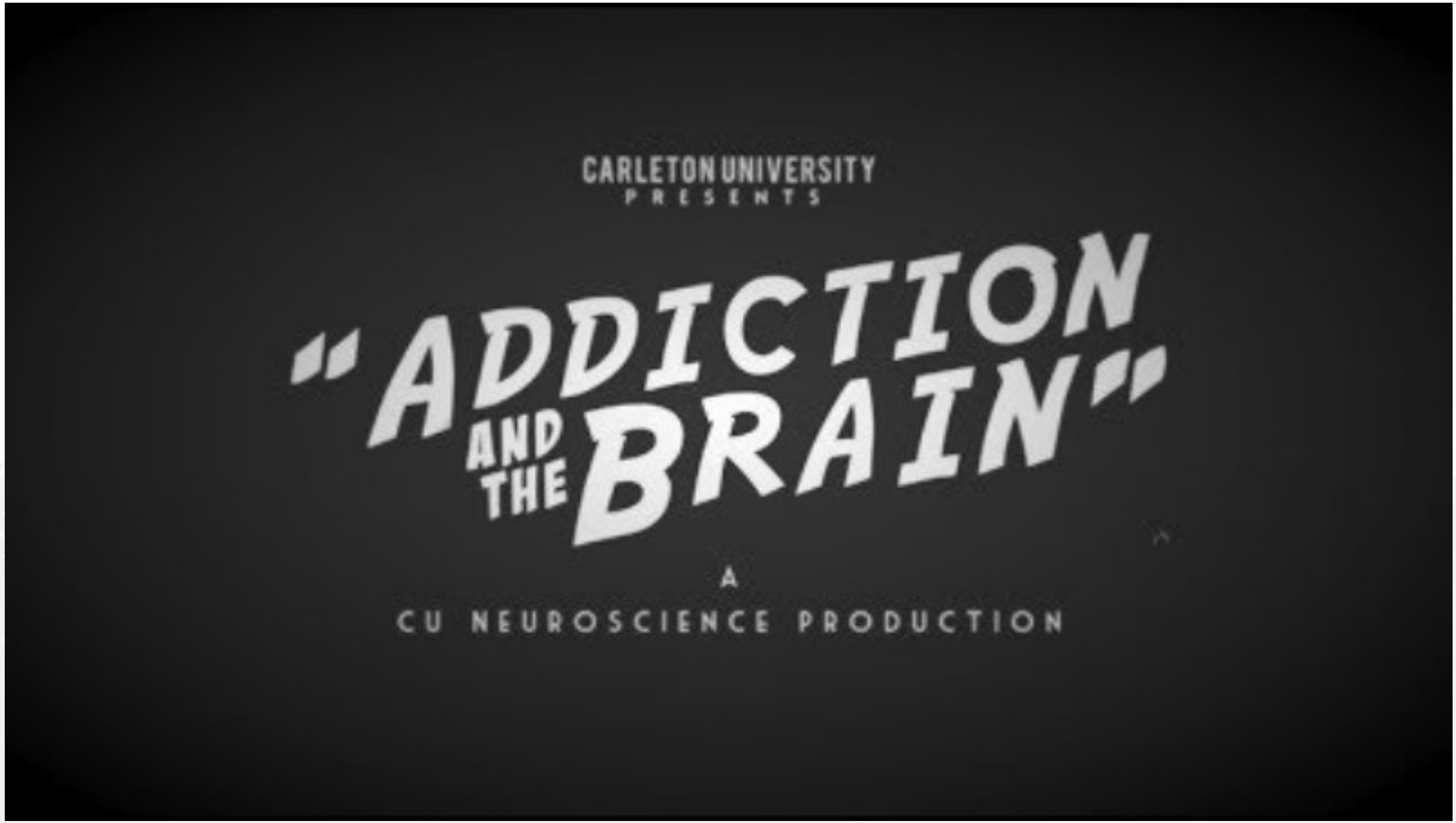
Di Chiara et al., Neuroscience, 1999.; Fiorino and Phillips, J. Neuroscience, 1997.; Ferguson, 2018.

Creating Brain Pathways

- After continual use:
  - Reward system pathways are reinforced
  - Tolerance increases (decrease in effect of dosage)
  - Sensitization increase (more intense cravings)

- Leads to increased risk of return to use, even after a long period of abstinence




CARLETON UNIVERSITY
PRESENTS
"ADDICTION AND THE BRAIN"
A
CU NEUROSCIENCE PRODUCTION

When is it a Substance Use Disorder?

Impaired control

- Substance is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control substance use
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance.

Social impairment

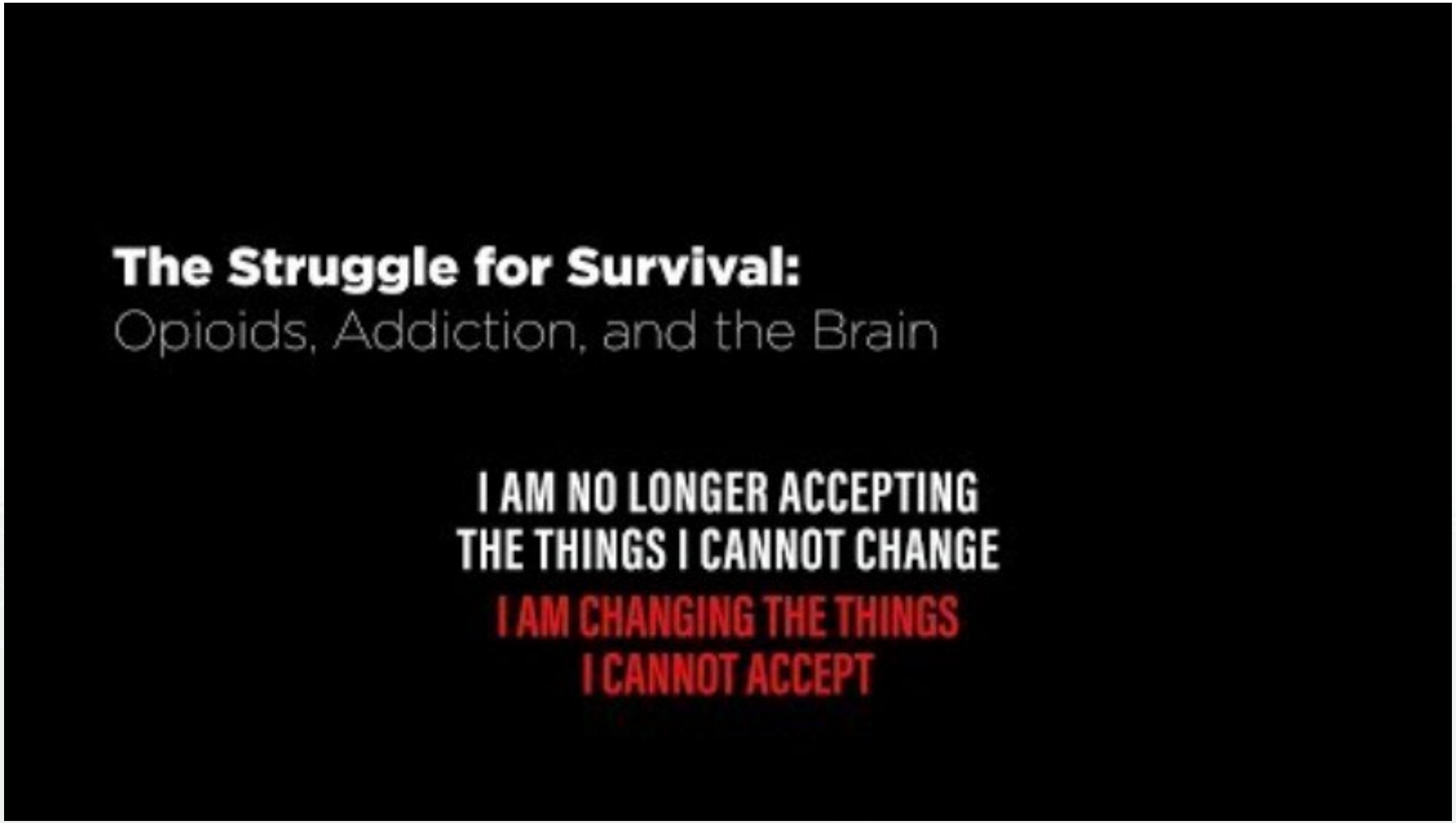
- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.

Risky use of substance

- Recurrent substance use in situations in which it is physically hazardous.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Pharmacological criteria

- Tolerance, as defined by either: a need for markedly increased amounts of the substance to achieve intoxication or desired effect OR markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either: the characteristic withdrawal syndrome for the substance OR the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.


The Struggle for Survival:
Opioids, Addiction, and the Brain
I AM NO LONGER ACCEPTING
THE THINGS I CANNOT CHANGE
I AM CHANGING THE THINGS
I CANNOT ACCEPT

Reflection

- How does this definition and explanation of Substance Use Disorders differ from how you have thought about them before?
- Does this change how you view people who have a Substance Use Disorder?

Bias

- Explicit versus Implicit bias
  - Explicit is known, and expressed – I know it to be true
  - Implicit occurs without conscious awareness – often in conflict with personal beliefs
    - Develops early in life from repeated social stereotypes
    - May unconsciously affect our understanding, actions and decisions
    - https://implicit.harvard.edu/implicit/takeatest.html

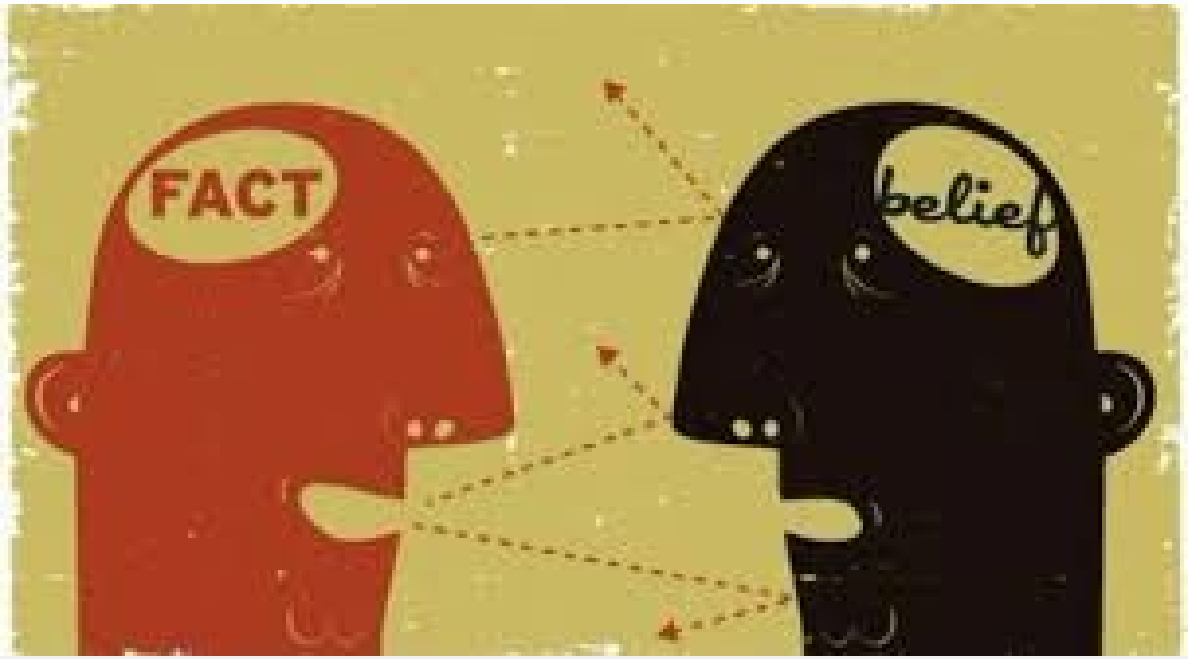
Bias contributes to stigma and discrimination

Stigma

- Stigma is shaped by our **thinking** – a bias and perception that substance users are “bad” and immoral rather than ill with a chronic condition requiring care and treatment. Often there is more than one chronic condition such as mental health disorders which also require care.
- Stigma is communicated by **tone, interpersonal attitude, body language.**
- Stigma is communicated by **words**.
- Stigma becomes **internalized** by the person with a Substance Use Disorder. The person views themselves as bad, as dirty, as weak which fuels the shame of stigma.

Patients Who Experience Stigma

- Often develops medical trauma
- Are less likely to seek or access services, do not follow-up for care
- Drop out of treatment early
- Have poor health outcomes
- Can sense it from providers



Words Matter

- “Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward others.” ~Otto Wahl

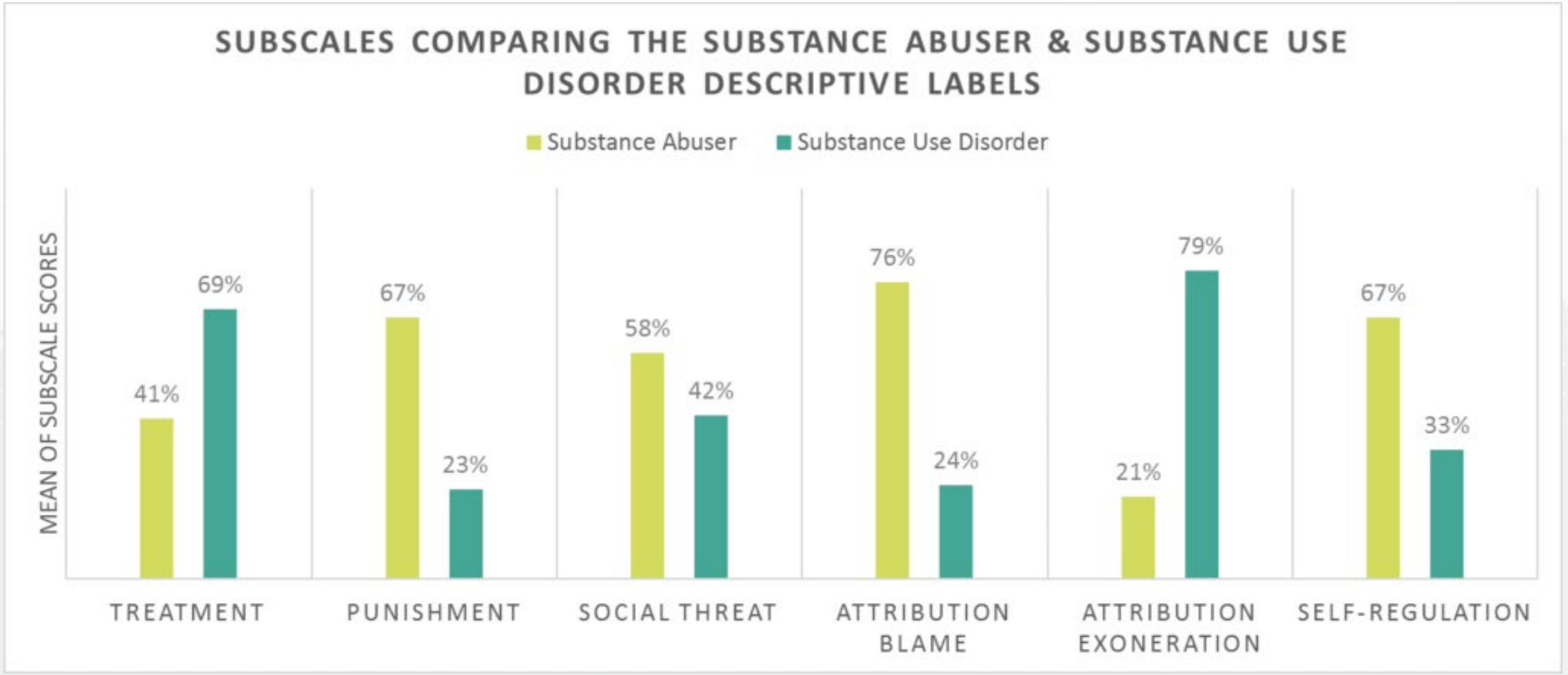
- If we want to nurture something, we call it a flower. If we want to kill something, we call it a weed. ~Unknown

Language in Treatment

- Dr. John Kelly, Harvard-MGH Recovery Research Institute published a 2010 study & 2015 editorial in American Journal of Medicine which showed an impact on clinical care

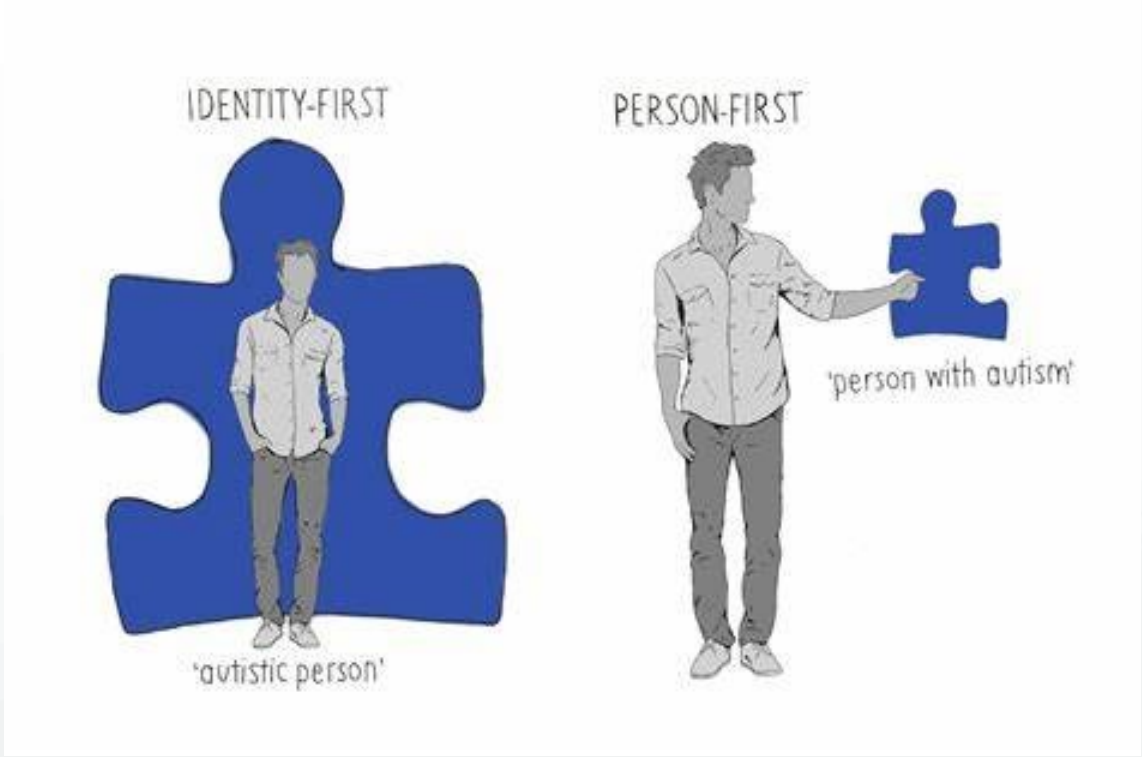
- Trained clinicians were given identical scenarios about someone with a substance use disorder and the only thing changed was in one scenario the person was called a 'substance abuser,' and in the other scenario, a 'person with a substance abuse disorder.' Dr. John Kelly found that when you called someone a substance abuser, it elicited, even from trained clinicians, a **much more punitive response**.

Results


SUBSCALES COMPARING THE SUBSTANCE ABUSER & SUBSTANCE USE DISORDER DESCRIPTIVE LABELS
Substance Abuser
Substance Use Disorder
MEAN OF SUBSCALE SCORES
41%
69%
67%
23%
58%
42%
76%
24%
21%
79%
67%
33%
TREATMENT
PUNISHMENT
SOCIAL THREAT
ATTRIBUTION BLAME
ATTRIBUTION EXONERATION
SELF-REGULATION

Person First Language

- A person is a person first and behavior is something that can be changed, addict or user implies that someone is “something” instead of describing a behavior
- Stigma is a barrier to care and we want people to feel comfortable when accessing services
- People are more than their drug use and harm reduction focuses on the whole person



WORDS TO AVOID	ALTERNATIVE/PREFERRED
Addict, Alcoholic, Junkie, Abuser Problem with the terms: It can be demeaning because the person is labeled by their illness and can imply a permanency to their condition, leaving no room for a change in their condition.	**Person with a Substance Use Disorder, Mental Health.** First person language is the accepted standard for discussing people with disabilities and/or chronic medical conditions. The person has, or the person with.....
Clean (When referring to recovery) Problem with the term: It implies that when the person was in active addiction, they were dirty, unclean and unwanted (stigmatizing, pushing away)	**In remission (partial-sustained)** Remission is a medical term that describes a period of time in which signs and symptoms of the illness have disappeared and that addiction is indeed a medical condition
Clean/Dirty (When referring to urine screen) Problem with the terms: Treats the urine of a person with a SUD differently than a person with any other medical condition.	**Positive/negative for (substance)** Treats the urine of the individual with a SUD in the same way that they would any other chronic illness.
Drug Overdose Problem with the terms: Implies that the individual caused the condition.	**Drug Poisoning** According to the CDC report, 86% of drug poisoning deaths were unintentional. Approximately 8% were suicides, while there is no precise determination of the real intent in 6% of cases.
Relapse Problem with the term: Can imply a moral failing as the origin of the word states that there is a return to heresy or wrongdoing.	**Recurrence/Return to Use** The terms tend to be less moralizing and carry greater hope.

***Having versus Being**

What Can You Do?

- Get comfortable talking about substance use and discrimination
- Recognize and remedy through modeling appropriate language
- Chart review and documentation
- Be kind to ourselves and each other
- Become aware of our own biases
- Continue to increase personal knowledge about mental health and SUDS


TIME FOR
A BREAK!

How Do I Ask?

- It is a Matter of Health – If we don't ask, it is assumed that we don't want to know.

- How do the patients react to being asked?

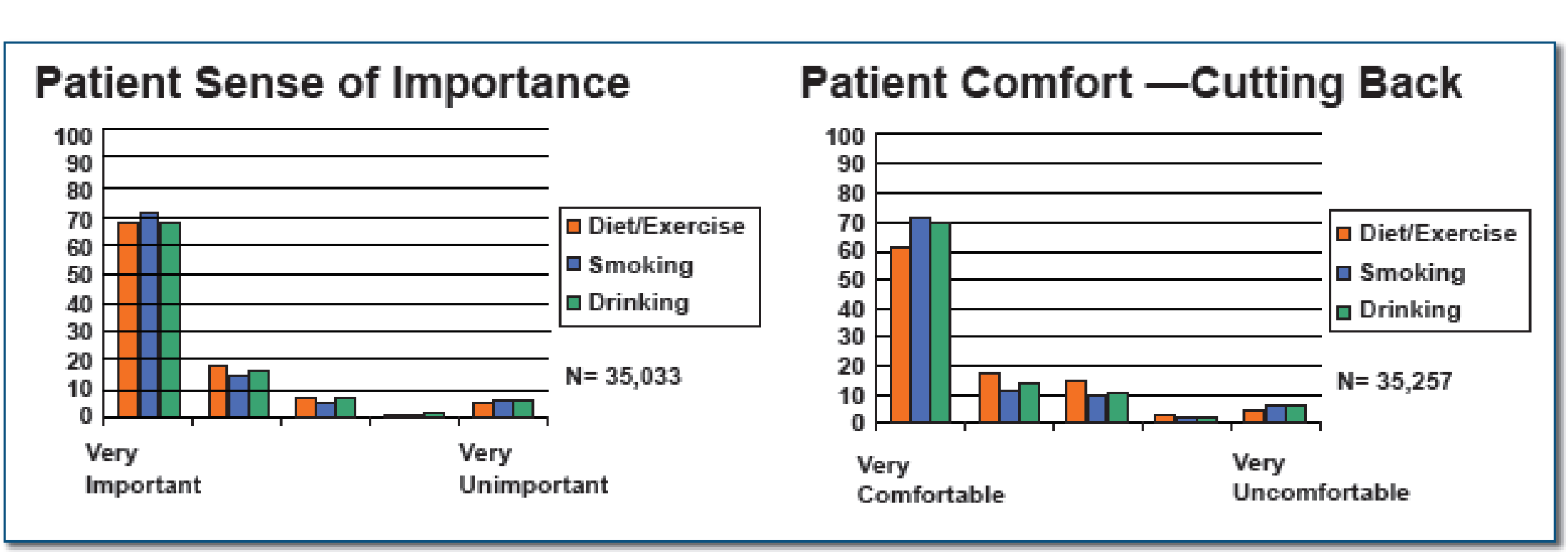
"Cutting Back Study"

- The University of Connecticut School of Medicine
- Screened primary care patients in five states for smoking, diet/exercise, and alcohol use.

- Patients were asked two questions:
  - How comfortable do you feel answering these questions?
  - How important do you think it is that your healthcare provider knows about these health behaviors
  - They were asked to express their views on a 5-point scale

Results

FEWER THAN 9% OF PATIENTS INDICATED ANY DISCOMFORT OR ANY THOUGHT THAT SUCH INFORMATION WAS UNIMPORTANT TO THEIR HEALTHCARE PROVIDERS.

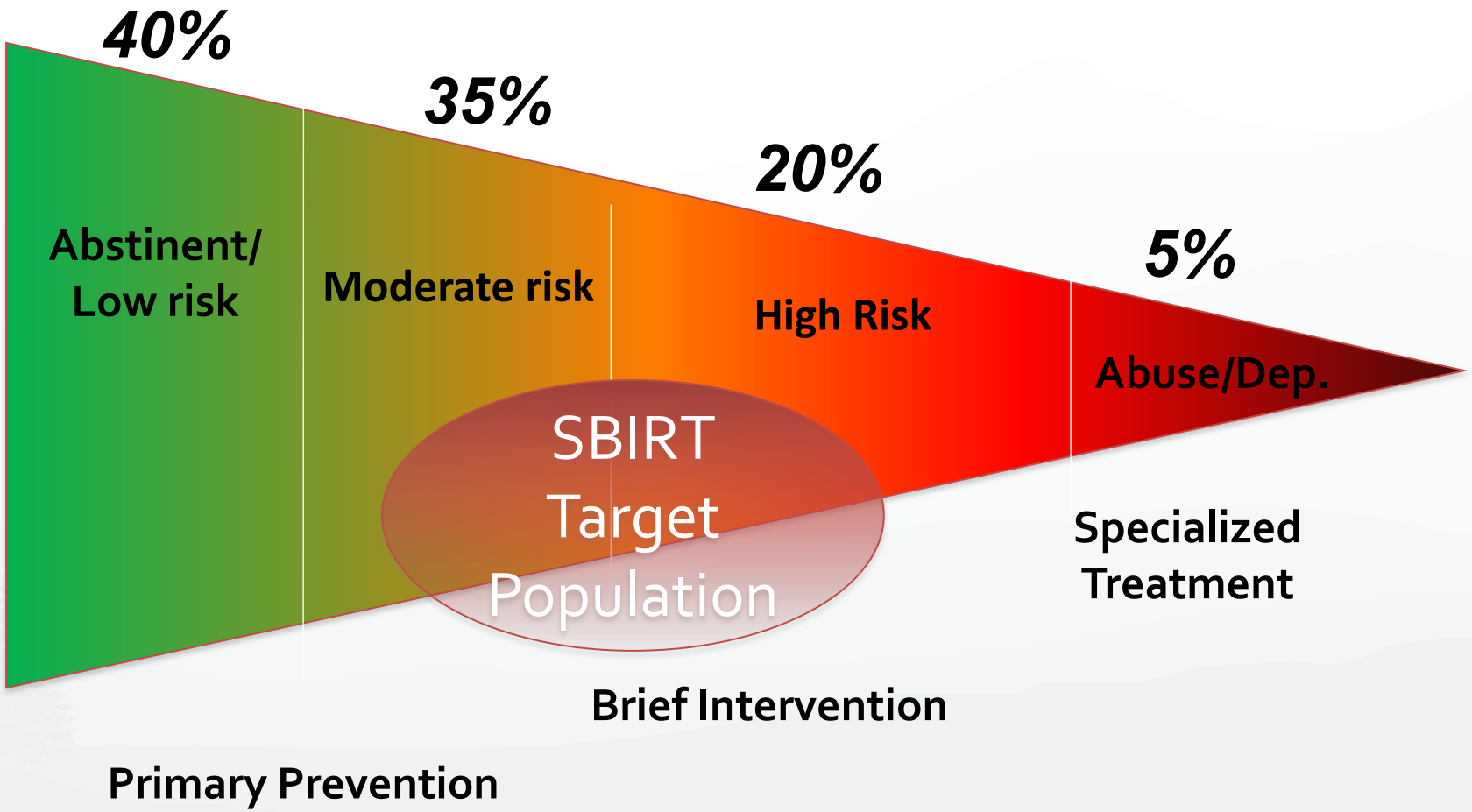


Screening:

Goal: **Identify patients at-risk for developing Substance Use Disorders**

- Early Identification of risky use and early intervention.
- Normalize discussing substance use as part of your healthcare – BECAUSE IT IS!
- We are meeting people where they are with an appropriate intervention.
- Not trying to identify Substance Use Disorder.

Continuum of Alcohol Use



Dawson, Alcohol Clin Exp Res 2004;
Grant, Drug Alcohol Dep 2004

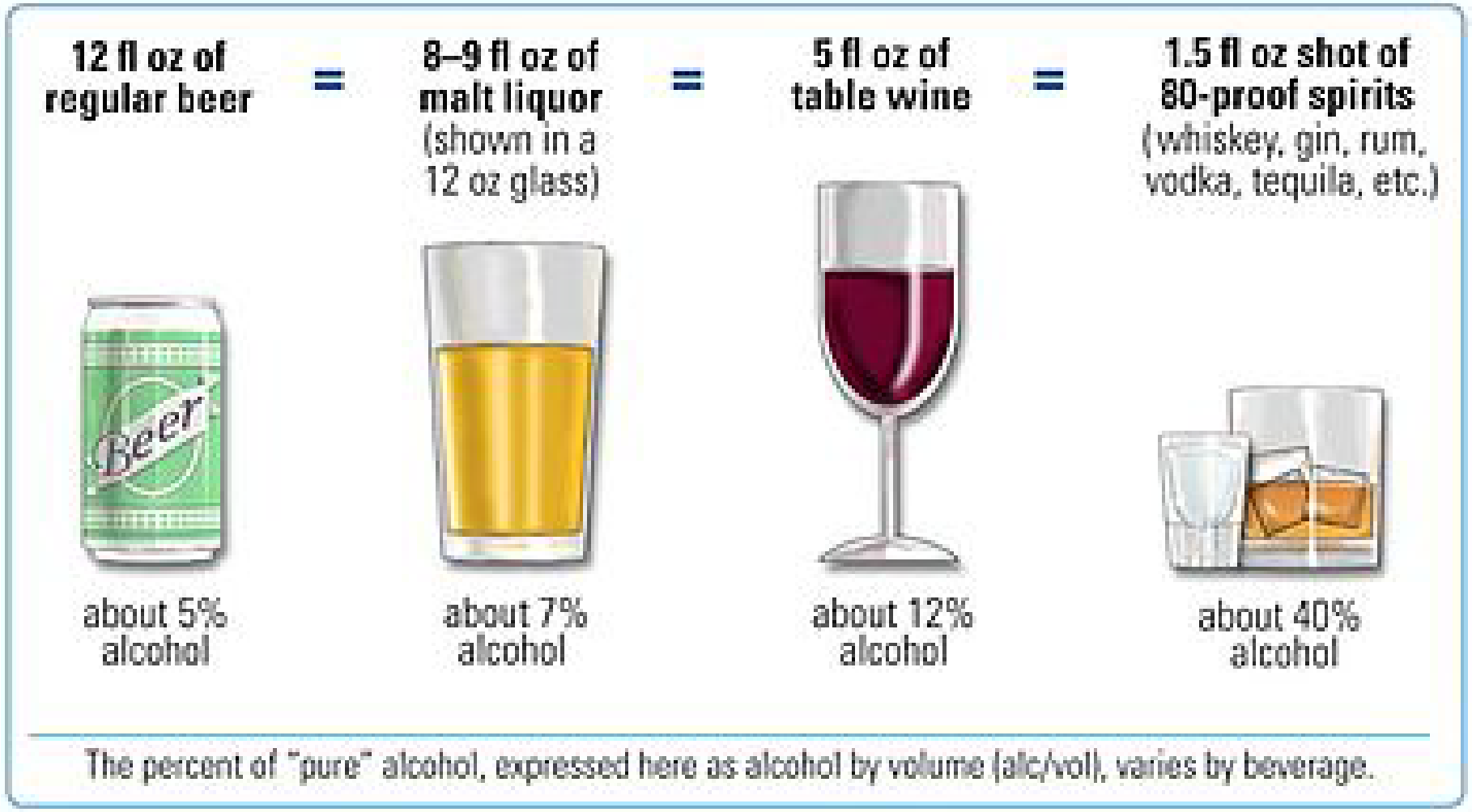
At Risk Drinking

How Much is Too Much?

Males <65 yrs. old: more than 14 drinks per week or more than 4 drinks/day.

Females & males age 65 and older: more than 7 drinks per week or more than 3 drinks per day.

What is a Standard Drink?



Screening Strategy

Prescreen

Alcohol:

Do you sometimes drink beer, wine, or other alcoholic beverages?

NO

YES

NIAAA Single Screener: *How many times in the past year have you had five (men) or four (women or patients over age 65) drinks or more in one day?*

Positive score=one or more times→ ask quantity and frequency, do full AUDIT.

Drugs:

In the last 12 months, on how many days did you use pot, use another street drug, or use a prescription medication 'recreationally' (just for the feeling, or using more than prescribed)?

NONE

ANY

Positive score=one or more times→ ask quantity and frequency, do full DAST-10.

Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2009). Primary care validation of a single-question alcohol screening test. J Gen Intern Med 24(7), 783–788

AUDIT – Alcohol Use Disorders Identification Test

- Developed by the World Health Organization.
- 10 Questions.
- Valid across cultures, sensitivity/specificity vary w/population.
- Takes less than 5 minutes.
- Consider self-administration using pen and paper or e-tablets.

AUDIT

Alcohol screening questionnaire

0 to 7 points: Low risk

8 to 15 points: Medium risk

16 to 19 points: High risk

20 to 40 points: Addiction likely

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

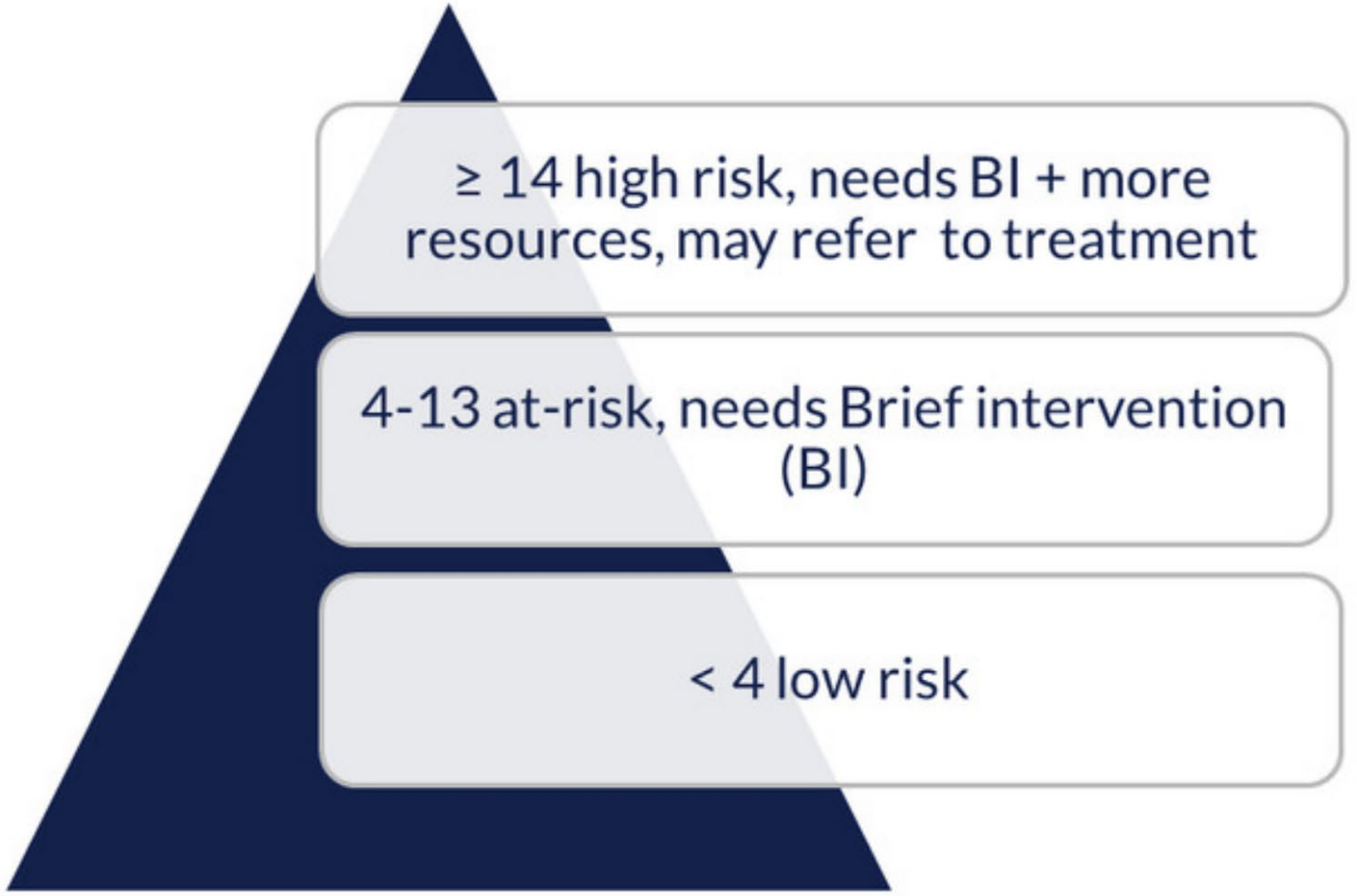
One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for alcohol use? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W, GM, ≥65:	0-3	4-12	13-19	20+

Screening the AUDIT



Johnson, Lee, Vinson & Seale, 2013; McGinnis, Justice, Kraemer, Saitz, Bryant & Fiellin, 2013; Rubinsky, Kivlahan, Volk, Maynard, & Bradley, 2010.

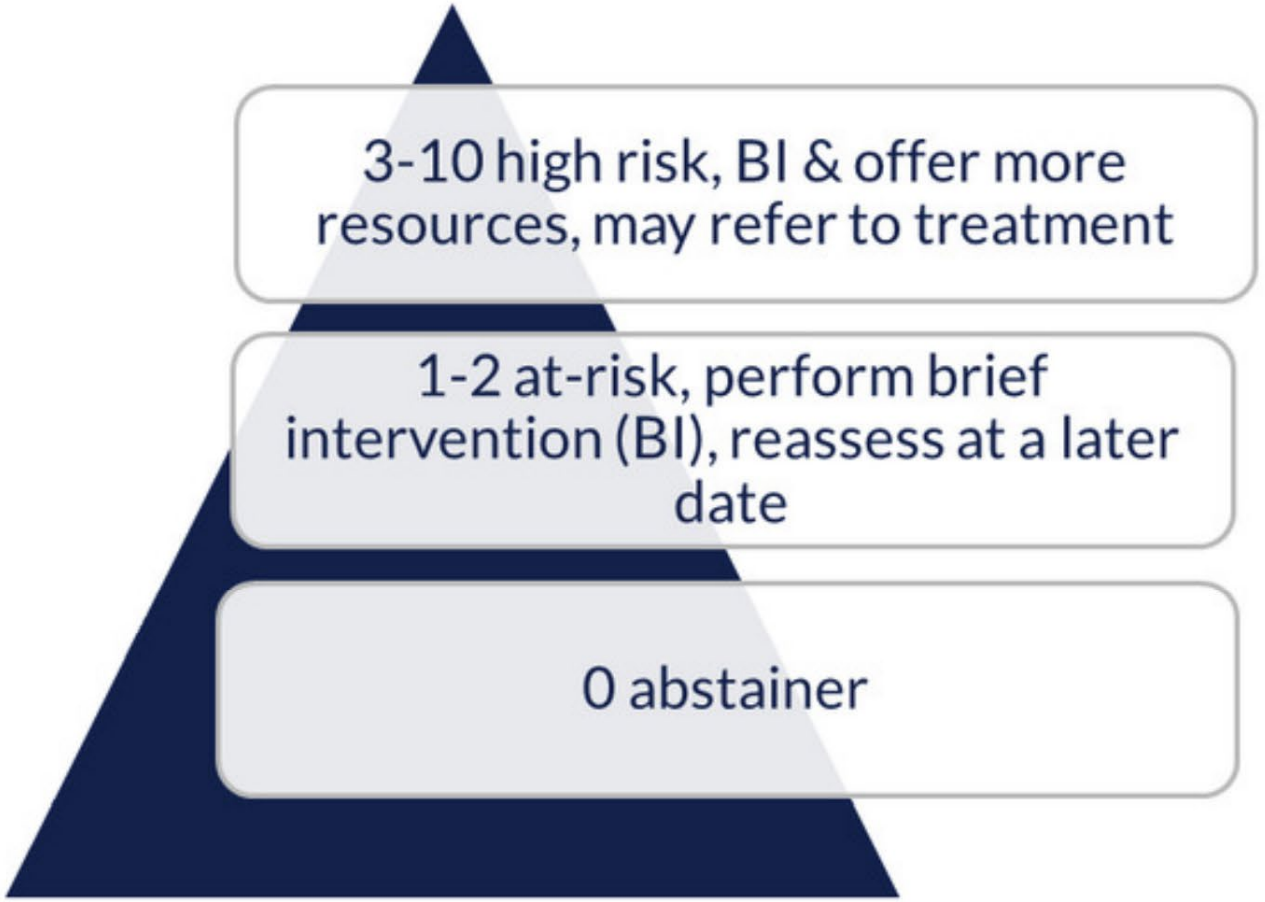
I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed, hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions **do not include alcohol or tobacco**.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parent) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?	0	1

DAST-10



Scoring the DAST-10

Discussion

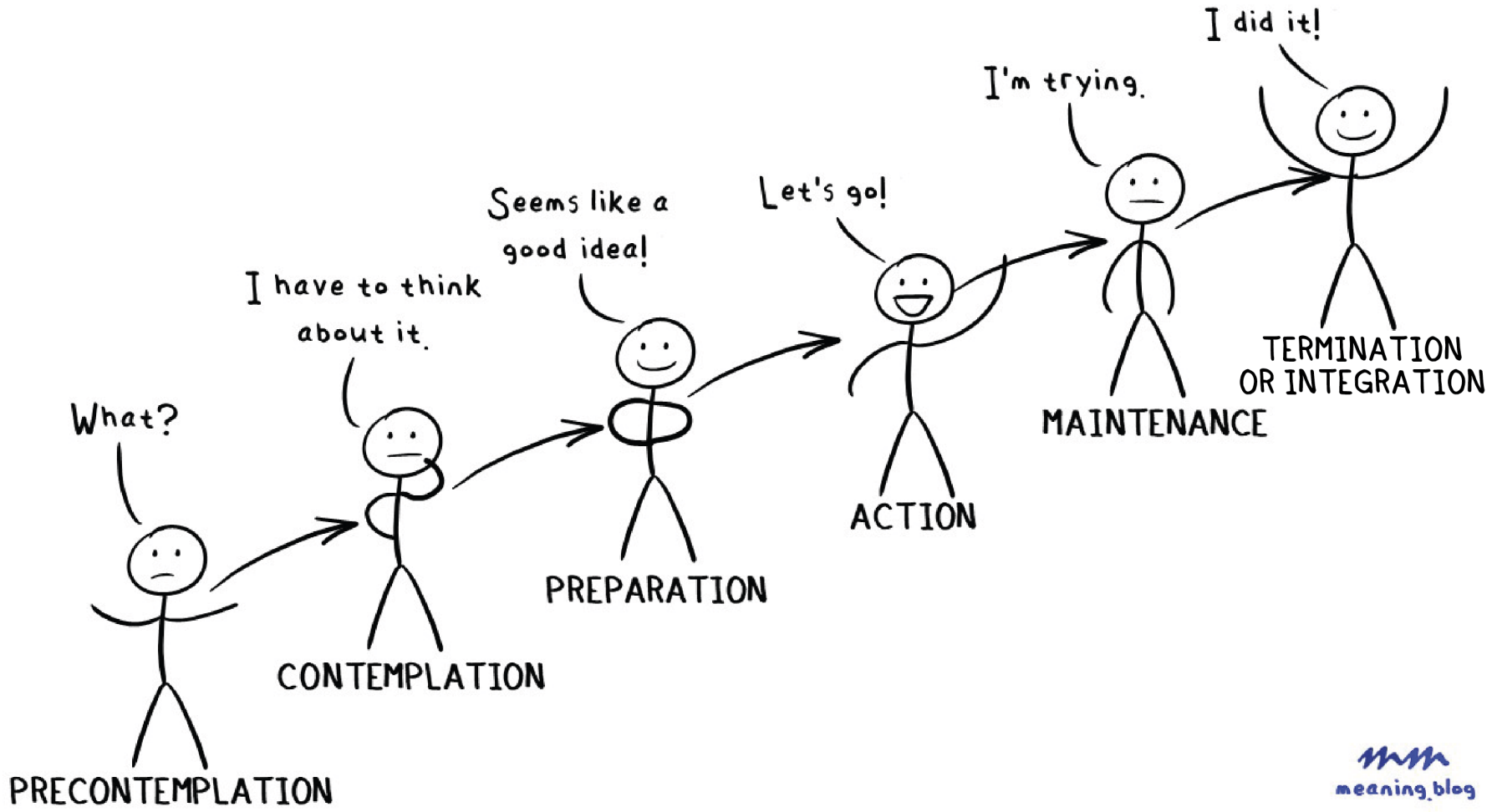
- Does your practice setting currently use screeners? What ones do you use?
- Who and how is the screener administered?

Brief Intervention:

Brief Interventions:

- Engaging a patient that has risky substance use behaviors in a short conversation, providing feedback, motivation, and advice.
- Could be a conversation that happens only once.
- Could be a conversation that happens annually at their Wellness Visit.
- The conversation is guided by the patient's answers to the validated screener using Motivational Interviewing.

The 6 Stages Of Change

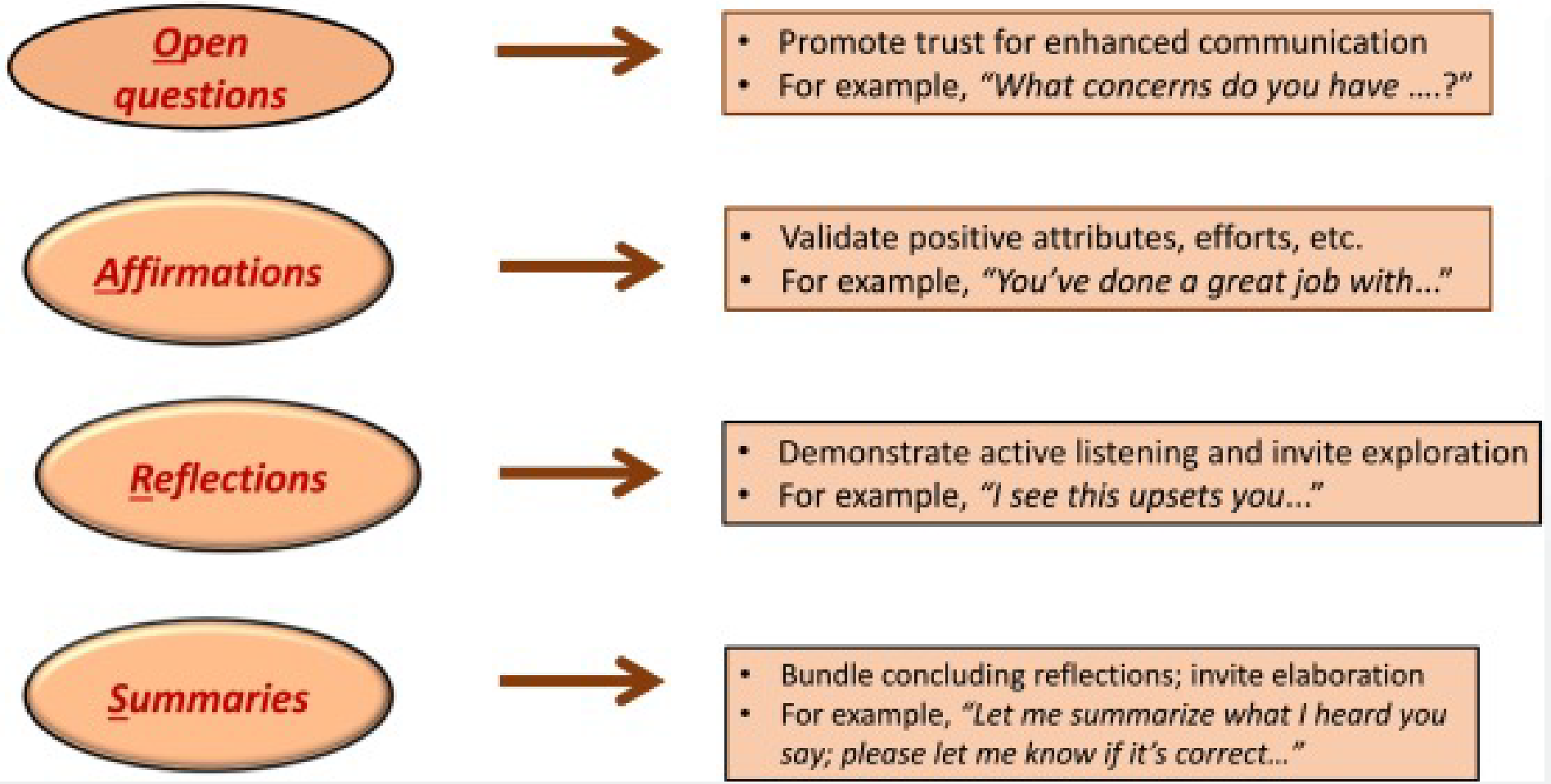


What is MI?

- A particular way of talking with people about *change and growth* to strengthen their own motivation and commitment.
- Directional and Purposeful
- Compassionate attention to the person while watching/listening for change and growth

- MI is a way of doing what you already do.
- It is **not** primarily seeing deficits, diagnoses or problems to be solved.
- It sees a person with strengths, hopes, and relationships who wants to be heard, valued, and viewed as competent.

OARS: Four Core Skills of Motivational Interviewing



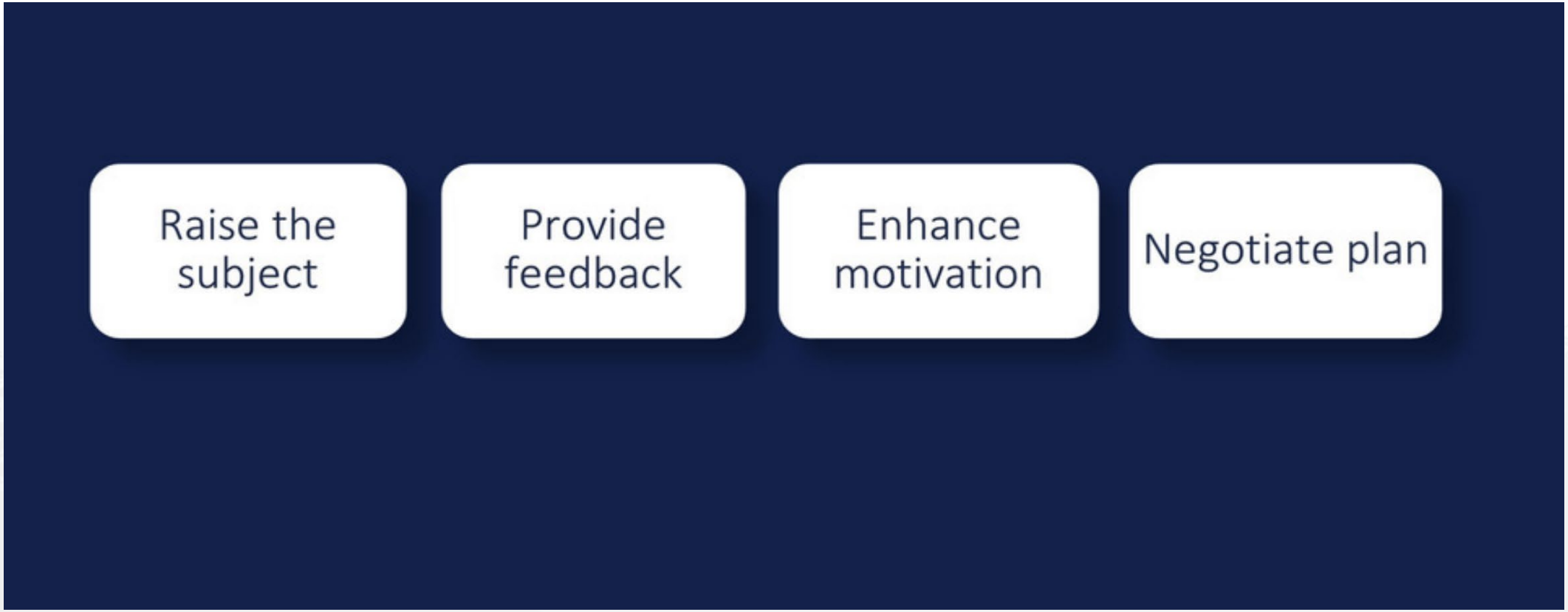
Our Role:

- We are not responsible for the individual's decision to change or not.
- We are like a tour guide…
  - Listen well to where they want to go
  - Don't just follow them around.
  - Don't push them where you want them
  - Share your knowledge.
  - Combine your expertise with what they care about and want.

Brief Intervention

- Can take as little as 5 minutes, or as long as 30 minutes is to educate individuals and increase their motivation.
- Using Motivational Interviewing techniques, individuals are provided information specific to their use.
- Brief intervention consists of:
  - The clinician will have a brief motivational conversation with a patient to guide the person through the standard drink sizes and Safer Drinking Guidelines.
  - The clinician gauges the patient's readiness to change and motivation for change or offers a warm hand off to a behavioral health consultant.

Brief Intervention



Raise the Subject

1. Ask Permission
2. “Thank you for completing the screener.”
3. “Can I share some information about the screener you took today?”
4. “Is it okay if I share what I know about the results of the alcohol screen you did today?”
5. “Is it alright with you if I tell you what I am concerned about?”
6. If they say, “Yes” then continue.
7. If they say, “No” then be respectful.

PROVIDE FEEDBACK

- **Set the stage, Discuss the Screening Results**
- **Range** – "Scores on the AUDIT range from 0-40. Most people who are social drinkers score less than 8." (Or whatever screener you used)
- **Results** – "Your score was 18."
- **Interpretation of results** – "That is the moderate to high use range. At this level, your use is putting you at risk for a variety of health issues (physical, mental) now or sometime in the future."
- **Norms** - "A score of 18 means that your drinking is higher than 75 percent of the adult population."
- **Patient Reaction** – "What are your thoughts?"

Enhance Motivation

- Listen to understand – Not to respond.
- They will give us our road map.
- If you find the thing THEY want to do, you have had a successful intervention.

Preparatory Change Talk:

- Desire – “I want…”
  - Want, wish, like, and love
- Ability – How confident they are that they could make the change
  - Can, could, able, and possible
- Reasons – “if, then…” Advantages and disadvantages
  - Changing my diet would help me manage my diabetes.
- Need – Emphasizes urgency to change; it is important, but doesn’t specify *why* it is
  - “Have to, need to, must, etc.”

Change Talk

1. I want to quit smoking.
2. I think it's possible for me to quit.
3. My kids are begging me to quit.
4. I have to quit smoking.
5. I'm willing to try to quit smoking.
6. I'm going to quit.
7. I bought nicotine gum today.

Sustain Talk

1. I enjoy smoking.
2. I don't think I can stand the withdrawal.
3. Smoking is how I relax.
4. I need to smoke.
5. I plan to continue smoking.
6. I've decided to keep smoking.
7. I bought cigarettes today.

We opened the can of worms…

NOW WHAT DO I DO!?

Evoking Skills:

- What makes you want to do this?
- How much does it matter to you?
- What reasons are there for you to do this?
- How important is this?
- ***The change must be important, and they must have confidence.***

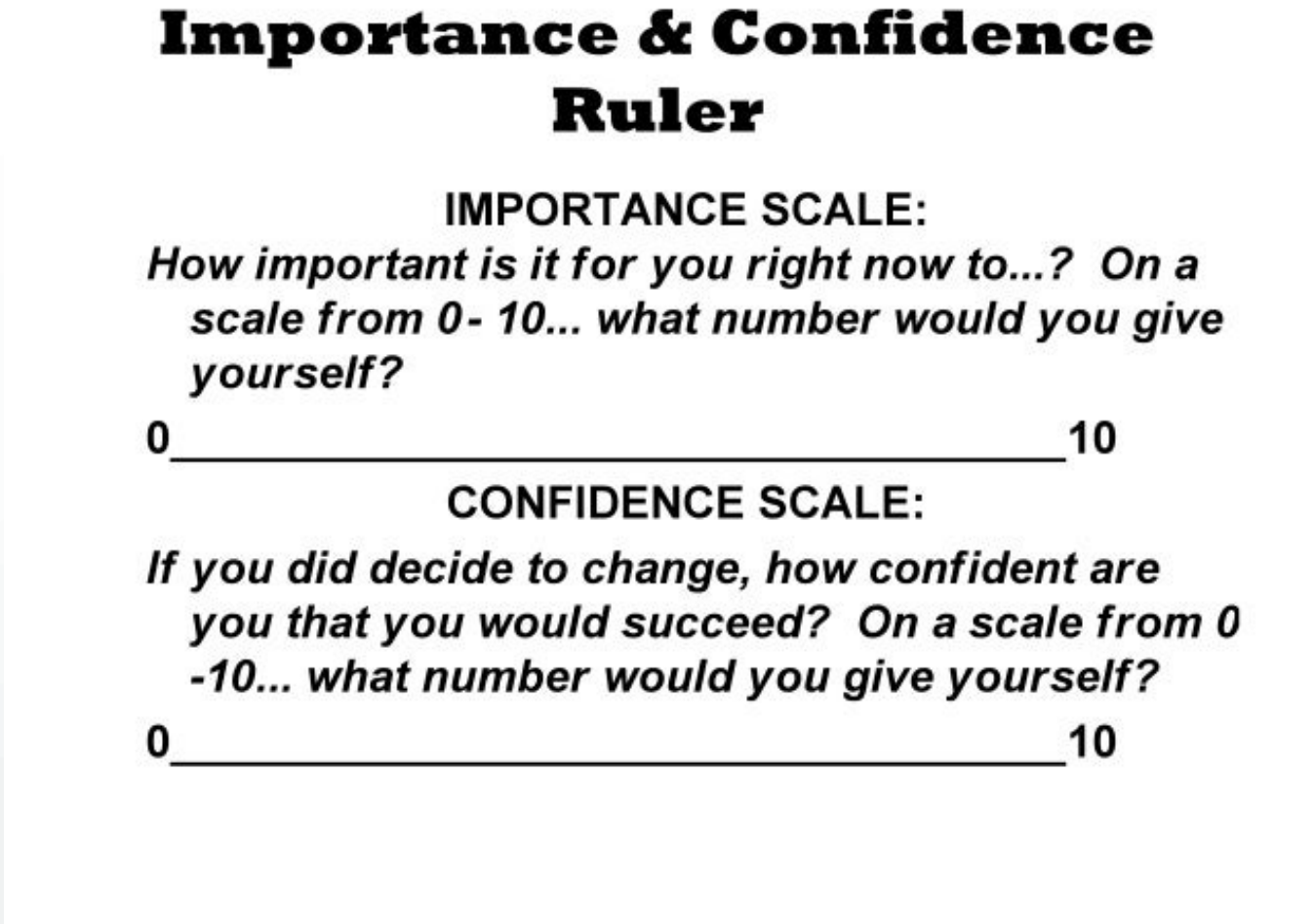
Directional Questions

- Elicit Change Talk
  - **How would you like things to be different…(Desire)**
  - **How might you…(Ability)**
  - **What are your reasons…(Reason)**
  - **How important is it… (Need)**

- Reflect what you've heard them state
- "You would like to cut back on your alcohol use for your kids. It's impacting your relationships."

Importance and Confidence

- "How important is it for you right now to cut back on your alcohol use?"
- Why a 4 and not a 1?
  - Notice you get change talk
- Why a 4 and not a 7?
  - Notice you get sustain talk.
- On the confidence scale, we want the patient to rate themselves 7 or higher.



Importance & Confidence Ruler

IMPORTANCE SCALE:

How important is it for you right now to...? On a scale from 0- 10... what number would you give yourself?

0_____10

CONFIDENCE SCALE:

If you did decide to change, how confident are you that you would succeed? On a scale from 0 -10... what number would you give yourself?

0_____10

Sustain Talk

- *“Smoking is how I* has become a
- **Ask** - elicit what ll.” (Reflection)
  know. what conc nat is helpful about
  have about smol Jse reflections.
- **Offer** - ask perm
  share advice or f ot so helpful about
  consent then off
- **Ask** - what do yc
  would you want you what I know?”
  that? etc

you think?”

What if they say….

I don't know…

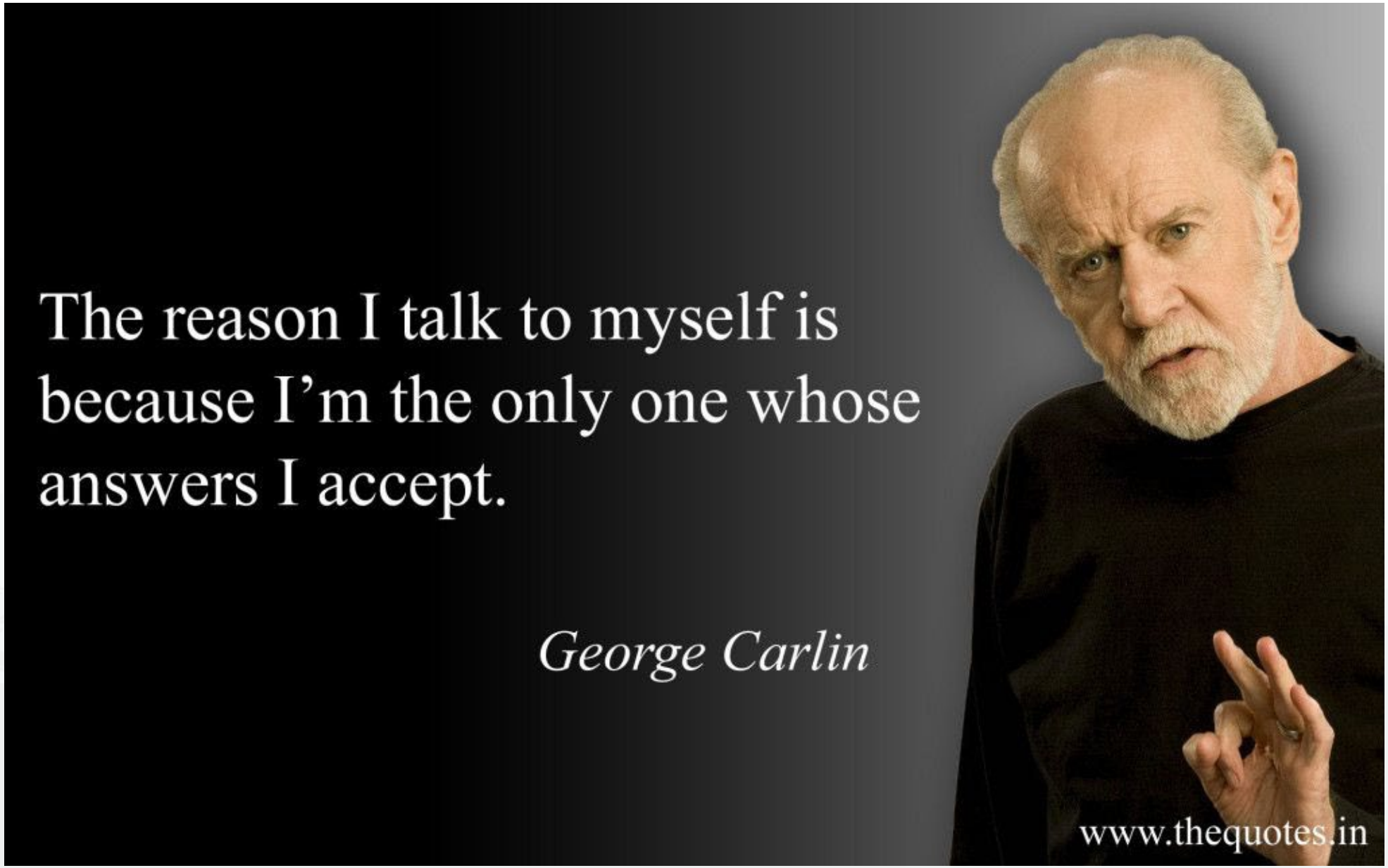
- **Ask Permission**
  - " I have some ideas about things that have worked for other people and I'd like to share those with you to see if it generates any ideas for you. Would that be OK?"

I don't want to do anything…

- **Reflect –** "You aren't ready to do anything right now."
- **Ask Permission –** "Could I run an idea by you?"
- "How about you do nothing and observe. Just notice what you use, maybe how much or when you tend to drink. Notice and make a note and then let's talk about it the next time we see each other."
- It is a win/win

Moving from Why to How…

- Summarize – Bouquet of Change Talk
- And ask…"What next?"
  - What are you considering?
  - What might you try?
  - How do you want to move forward?
- "You know yourself best, how do you think you could move forward?"
- "How **important** is this to you? How **confident** are you?"
  - Not "are you ready?"


The reason I talk to myself is because I'm the only one whose answers I accept.
George Carlin
www.thequotes.in

Planning

How will you get there?

- Evoking the “how” of their change
- Focusing on the specifics of the plan
- Must fit into the person’s lifestyle – their daily patterns and routines
- Only the individual knows what will work for them
- What are they ready, willing, and able to do?

Evoke Hope and Confidence

- The change plan is an **experiment** – "Let's try and see how this goes..."
- If this doesn't work, we will try something different next time.
- Their belief that this is possible is a predictor of change happening.
- Affirm strengths to boost confidence!

An Example…


Elicit/Evoke change talk using open-ended questions, reflections

Discuss:

- Did the interviewer hit all the steps:
  - Raise the Subject
  - Provide Feedback
  - Enhance Motivation
  - Negotiate a Plan

How do you think she did? How did the patient respond?

What would you do differently?

Practice the Skills

- In breakout groups, pick one person to be the patient and one person to be the clinician, and the third person to be the observer
- “Patient” should pick a behavior that needs to change and the “clinician” should use motivational interviewing skills to help assess their readiness for change and a plan going forward
- Observer should pay attention and give feedback to “clinician”
- Rotate roles after 5 minutes

Paradigm Shift

Acute Care Model:

- Enter treatment.
- Complete assessment.
- Receive treatment.
- Discharge.

Goal of Treatment

- Help patients **stop all substance use.**

Chronic Care Model:

- Prevention
- Early Identification
- Referral to Treatment
- Recovery Supports

Goal of Treatment

- **Reduce** morbidity and mortality.
- **Maximize** function.
- **Improve** wellness.

Plan with Harm Reduction Principles

Harm Reduction Principles

- Design and promote public health interventions that minimize the harmful effects of drug use.
- Drug use is a reality. Abstinence-only will not work for everyone.
- Accessible + Low Threshold Services for people who use drugs. Abstinence is NOT a requirement for services.
- Understand that drug use is complex and can include a range of behaviors from habitual, chaotic drug use to abstinence.
- Meets people where they are in their use and in their lives.

Negotiate a Plan for Safety

- **Track what you drink.** Become aware of how much, how often, where and with whom you drink
- **Buy less so you use less.** Buying large amounts of a drug may be cheaper, but you could end up using more than you want to simply because it's there.
- **Set a time limit before you start.** If you choose, say, to stop drinking at 10:00 p.m., watch the time, remind yourself of your time plan, and stick to it. Have some juice ready.
- **Eat a meal before you start**, and avoid snacking on salty foods, especially if you're drinking. You may drink more out of thirst.
- **Lower your dosage and frequency.** In other words, drink, smoke or inject in smaller amounts—and less often—than you do now. When it comes to alcohol, this could mean choosing light beer or other low-alcohol drinks, or alternating drinks with water or pop.
- **Choose the least harmful method of use.** Injecting a drug carries more risk than smoking, snorting or swallowing it. (If you do inject drugs, avoid the neck area.) When it comes to cannabis, using a vaporizer or smoking a joint (with a rolled-up cardboard filter) is safer than using a bong and some pipes.
- **Plan out some drug-free days.** The fewer days in a row you use a drug, the better. If you use the drug every day, try cutting back your use to every other day, and try not using it at all for two to three days. (Make sure you have in mind other ways to spend your time and energy, so you don't end up sitting around and thinking about how you miss getting "buzzed".
- **Use at your own speed** and don't feel pressured from others to pick up the pace.
- **Find someone caring and understanding** to talk to when you're struggling to stick to your reduced use plan.

Another Example:

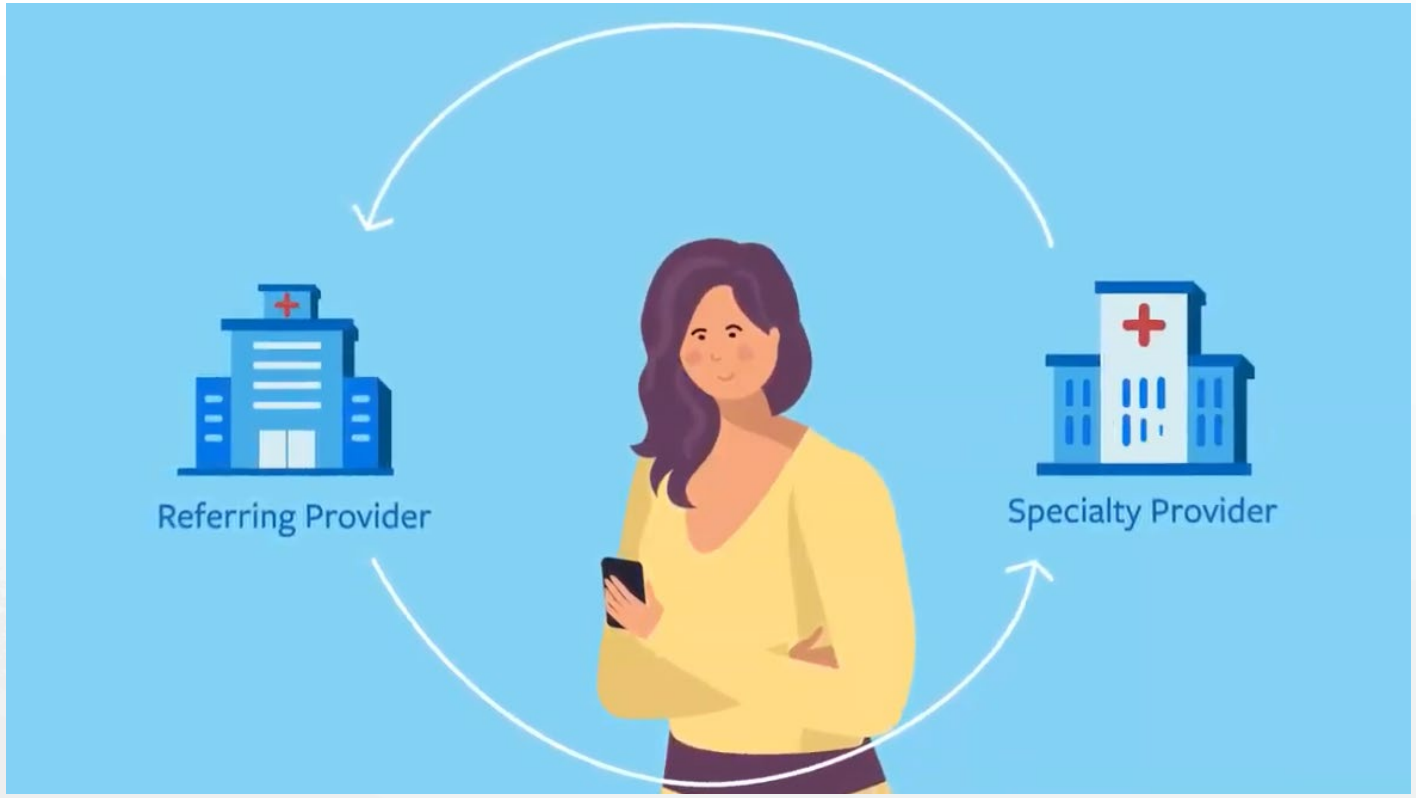
Discuss:

- Did the interviewer hit all the steps:
  - Raise the Subject
  - Provide Feedback
  - Enhance Motivation
  - Negotiate a Plan

What strategies did you hear the interviewer use? How did the patient respond?

What would you do differently?

Referral to Treatment:



Referral to Treatment

- About 5% of patients screened could be referred to SUD evaluation and treatment.
- An appropriate referral is when the patient's responses to the screening reveals serious medical, social, legal, interpersonal consequences associated with their substance use
- Know local and state resources.
  - Have a well-developed workflow that is easily accessible to your patient!
  - Use the entire team
- Develop relationship with professionals and the patient.

Warm Hand Off

- "I have a co-worker, Jamie, who is great at helping people plan for how they want to make lifestyle changes and cut back on alcohol use. I'm going to have her visit with you for just a few minutes. Then I'll be back to finish up our appointment."
- "You have a lot on your plate right now, and it seems like using is your only option. My coworker, Camille, is an expert at helping people manage their stress and improve their health. She is going to visit with you for a minute, then I'll be back."

Follow up

Negotiating a time frame for follow-up with the patient may enhance the likelihood that the patient returns.

Studies indicate that just one additional visit can significantly improve the effectiveness of your intervention (Rubak et al., 2005).

Monitoring

Whether or not patients treated with medications or counseling in primary care are benefiting and if not, does their treatment need to be changed or augmented?

Monitoring

- At a minimum, monitor the frequency of use with AUDIT-C +2 every three months.
- Repeated visits should include repeated brief intervention with MI, tracking symptoms, and patients' self assessment.
- Plant a seed and show you accept the person as they are!

Referral to Higher Level of Care

- Could be Treatment Center
  - In-Patient, Outpatient, Intensive Outpatient
- May require a Substance Use Assessment (ASAM)
  - Create a workflow
  - When the patient is ready, this should be an easy to engage workflow that meets the patient's needs where they are.

Putting it Together

- 1. Use a validated Screener
  - Provided at check in by the front desk
  - Completed in Waiting Room
- 2. Brief Intervention
  - Raise the Subject
  - Provide Feedback
  - Enhance Motivation
  - Negotiate a Plan
- 3. Referral to Treatment
  - A Warm Hand Off

Getting Started…

- 1. Identify a champion
- 2. Choose screening tool
- 3. Develop Reasonable Workflow
- 4. Train Staff
- 5. Practice
- 6. Normalize!
- 7. PDSA
  - Plan, Do, Study Act

Billing SBIRT

- Time spent face-to-face with the patient conducting SBIRT must be specified
- SBIRT must be at least 15 minutes
- There are many, many regulations and caveats so please read carefully
- Detailed CME billing guidelines available:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

Requirements for SBIRT – Policy 514

Montana DPPHS Medicaid Billing requirements:

- Medical Necessity Criteria
  - (1) The member must present with patterns of substance use that puts their health at risk.
- Provider Requirements
  - (1) SBIRT may be provided by a licensed behavioral health professional, a physician, a midlevel, or a supervised unlicensed staff.
  - (2) Appropriate staff providing this service must have a minimum of four hours training approved by the department related to SBIRT services that is documented in the staff's personnel file.

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