

# **WEBINAR VIDEO TRANSCRIPT**

## Opioid Addiction Treatment ECHO

### **Evidence-based screening and use of SBIRT techniques**

22 September 2017

MIRIAM: We're gonna take a quick trip through screening, brief intervention, and referral to treatment. This is an approach that has been strongly championed by SAMHSA and is being pretty widely implemented in primary care settings. As a way of identifying folks who have risky substance use. They may not qualify for a full fledged substance use disorder but they're drinking more than is recommended or using more in the way of other substances than is recommended and it's an attempt to intervene with them and help prevent them from continuing on progression to a substance use disorder.

The definition of SBIRT is really involved in trying to take a comprehensive and integrated widespread approach to the delivery of early intervention and treatment services, and as I mentioned, it's really for people who are using at a level that confers some degree of risk. It can also pick up folks that have a full blown substance use disorder and help to engage them in treatment. Brief intervention has really been shown to be effective for unhealthy alcohol use, it has not been shown, so far to be effective for other substances. But I will talk about screening for those other substances because screening is useful in everybody. It's just whether the brief intervention component is effective or not, that is, it's clear that it is effective for alcohol use disorder, but not clear that it's effective for other substances.

How do I get rid of this bar across the top? Oh there we go. So, in the past, before the SBIRT approach was widespread, interventions to address substance use disorders really focused on prevention and then on specialized treatment for people who met substance use disorder criteria, and the folks who had high risk use really were pretty much not being provided with specific services. So SBIRT was designed to really be implemented in a primary care setting to pick up people who are using at a high risk level. It is designed for use in a primary care setting, it's a little bit, takes a little bit of work to get it started, but then it can just pretty much be incorporated into regular routines.

For standard screening such as checking vital signs. Brief interventions are low cost, and as I mentioned effective for alcohol misuse, and the goal is to intervene early when someone's use is above recommended levels but they haven't developed a full blown substance use disorder. Core competencies within SBIRT are regarded as universal screening, asking everyone about use of substances, brief intervention, particularly for alcohol use disorder to help people who are using at a risky level to identify that fact, and to develop some other strategies to reduce their use.

And then for folks who have a substance use disorder, or who are unsuccessful in responding to just a brief intervention, to refer them to treatment or provide treatment directly in the primary care setting which is of course our focus here in this ECHO program. This complicated slide may be useful as a reference after the fact, the main things to notice here, are that the screening happens automatically



with all patients, if there's a negative screen, nothing more needs to happen. If there's a positive screen then the options are to have the patient complete a more extensive screen, to gather more information or go directly to interaction with a clinician. The clinician then needs to assess whether or not, a diagnosis of unhealthy use is in fact present.

So the screening is screening, the actual diagnosis is, still relies on a clinical assessment and then if indeed unhealthy use is present, a brief intervention is provided or if the patient has an actual substance use disorder, then a plan is made to manage to further provide services to that patient. Which can include harm reduction, management of withdrawal or engagement in actual treatment. A lot of sites use a sort of prescreening strategy, short screens that can pick up potential problems and then be followed up with more intensive assessment. In general using SBIRT in a primary care setting, 75% of screens will be negative and about 25 will require further followup overall.

So in thinking about prescreening for alcohol the question that's recommended is simply, do you sometimes drink beer, wine, or other alcoholic beverages? If the answer is no, you're done, you've done the prescreen and you don't need to go on. If it's yes then you move on to the NIAAA single item screener, how many times in the past year have you have five or more drinks in a single day? That's the number for men, for women it's four or more drinks in a single day.

Where did they come up with those? They really came up with those numbers from epidemiologic study showing the amount of drinking that is correlated with adverse physical or behavioral health outcomes in the population. That if someone answers yes to that screener, it is, has strong enough positive predictive value to suggest that you should then go on and do further assessment for unhealthy use. So you might find when you go on and do further assessment you know yes I did that on new years eve, and I don't drink heavily ever otherwise and then maybe you don't need to go further.

On the other hand the further evaluation may tell you that this person is drinking four or more drinks a day on a frequent basis and that they're really drinking at an unhealthy level and need further intervention. So if you get a positive answer to that single item screener, you're then going to go on to assess the frequency and quantity of use on a weekly basis. Or also assess for very heavy occasional use or bingeing. So for people who you find regularly exceed recommended limits or binge periodically, you're then going to go on to assess whether they have an alcohol use disorder.

So, looking at DSM criteria this would include things as you know such as using more than intended, or more frequently than intended. Unsuccessful attempts to quit or cut back, interference with usual social or professional roles, such as interfering with your ability to carry out your job or be a parent. Presence of withdrawal symptoms, presence of tolerance, et cetera.

Turning now to thinking about assessment for use of other substances, again you can start with a prescreen. So your prescreen might be how many times in the past have you used an illegal drug or used a prescription medication for nonmedical reasons. Such as for the feeling it caused. If the response is never, your screening is done. If the response is positive you're gonna go on to inquire further. And this, screen has been shown to have a sensitivity of 100%, if someone is answering honestly and 74% specificity for a drug use disorder. You can then move on again to either a more extensive screen to assess further their drug use patterns, or you can move directly to clinical assessment. A clinical



interview to assess their use. So in terms of key points for screening, it's recommended that we screen everyone. Everyone whose seen in a primary care setting is obviously at risk for unhealthy use of alcohol or other substances, and universal screening can pick up a lot of folks who you may not have developed any level of clinical concern about.

It's recommended to use a validated tool and if possible incorporate this screening into other health screening in order to reduce the stigma. It is important to explore each substance if you get a positive prescreen to do a pretty careful cataloging of what substances these patients are using since as we all know, co-occurring substance use disorders are common and then to follow up positive screens with formal assessment for substance use disorder. And as always motivational interviewing skills are our friend because this is the main way, that you're going to follow up on a positive screen, is using motivational interviewing skills.

To encourage the patient to talk with you about the problem and then to explore the patient's interest in, or motivation to make a change, if they have unhealthy behaviors. So, I think I've already covered this, down at the bottom of this slide, one thing that can be useful that we've talked about before in some of our case discussions is the use of the readiness ruler. So if you are detecting that the patient that has use that exceeds recommended guidelines, you can use that readiness ruler to assess how prepared they are to really make a change and so after you've engaged in dialogue with them and used some of your motivational interviewing techniques to evoke motivation and promote change talk. You can then say, thinking about how ready you are to make a change in your alcohol use on a scale of 1-10? Can you tell me where you fall on that scale, you know maybe the patient says I'm on a, I'm at a level of six in terms of my readiness to change and then a followup question might be, tell me about why you're at a six and not at a two in terms of your readiness to change. Because again that evokes the patient telling you about reasons why they're actually ready to make a change now, when you're asking them to compare it with a lower level of readiness.

So, let's talk a little bit about what to do if the patient expresses really very limited desire to make a change or is frankly not super excited about the whole conversation. One strategy to use is kind of asking them to think more broadly about the situation, asking them to think down the line about whether they have concerns in the long run, about the impact of their drinking. Or if they can imagine with you what might, negative consequences might happen if they continued to use at this level or more. Another strategy with motivational interviewing is to really promote change talk, to sort of engage the patient in talking about why they might wanna make a change.

So let's say that we're talking with a patient whose drinking more than is considered healthy, it's ideal if you can identify some particular conditions that are tied to that. Let's say this is a patient that is seeing you for hypertension and you learn through the screening that they're drinking more than is recommended. You might be talking with them about the link between hypertension and drinking more than is recommended and then you can try to promote some change talk around that. So, what might be a way that you would, that you might do that? Use motivational techniques, motivational interviewing techniques to actually query the patient in a way to get them talking, in a way that evokes change talk, any thoughts about that? Go ahead Laurel.



LAUREL: I think you have to figure out, what is most important to them. Like for some of my patients, it's getting off of medication and so it's you know trying to figure out what it is that they want to, what would be most meaningful to them and then work from that perspective well if we change this, maybe we could decrease this or get you off this or do something from that perspective, and that's what I try, that's how I try to work thing you know maybe we can you know that, I don't know.

MIRIAM: Uh huh, yeah, I like that. Anybody else want to add to that? Or have an additional suggestion or thought? Sherry you're muted if you're trying to talk to us, I'm not sure if you are.

SHERRY: I am, I always forget to do it on the screen. You know be it a lot of times people have motivation during pregnancy that they don't have themselves outside of pregnancy, so when it comes to you know alcohol, drug use and you know actually cigarette use as well you know the idea is that it's, the window which we'll have some motivation they don't have normally so you just kind of talk about, benefits the baby but also the benefits to them long term as well. Because they have a window where they are actually motivated to make change for the baby where they may not feel motivated normally.

MIRIAM: Great, yeah that's terrific, any thoughts about how you would promote change talk in talking with a patient whose pregnant and drinking, you know more than you think is appropriate? Which is probably much at all.

SHERRY: Well I think that we often will talk about you know what can you do in general, for healthy pregnancy and healthy baby you may start off with generalized things, like you know diet and vitamins. And then narrow in on specific things like, you know the alcohol and how its associated with fetal alcohol syndrome, and what that means and the opiod situation with neonatal abstinence syndrome. And how you know, what you know, and there, and kind of their motivation towards trying to make this baby as healthy as possible, and so a lot of times we'll start off like, just talking about general health and then also then more specifically you know, the issues which are involved.

MIRIAM: So, it sounds like maybe asking something like what are thing that you could do to have the best possible outcomes for your baby? Or the healthiest pregnancy possible. And then prompting around alcohol if she doesn't go there, or around cigarette smoking, is that right?

SHERRY: Right, exactly.



MIRIAM: Good.

SHERRY: What are the concerns of the pregnancy?

MIRIAM: Yeah, great. Other people want to chime in?

WOMAN: A lot of times one way we'll talk about it with patients is we'll have patients that are engaged in psychiatric medication management and they're also using alcohol and we identify that discrepancy and kind of work in that ambivalence and talk with them about you know, it sounds like you're using alcohol in a manner to try and manage your symptoms of anxiety, depression, trauma, et cetera, and with that you know it's really hit or miss in terms of how you're able to manage your symptoms with that. Your medications however are designed and being prescribed in order to successfully medicate those things for you. So help me understand, how the alcohol use is at this point outweighing the benefit of maybe trying out some of these prescribed medications that in the past have worked really well for you.

MIRIAM: Okay Angela, or Adam do either of you wanna chime in with any thoughts? Suggestions?

ADAM: I like the suggestions so far, Angie anything to add?

ANGELA: Yeah I mean, I would ditto everything everyone said, I, for me one of the most important things is pulling from the patient's narrative. Sometimes if I find myself where a lot of sustain talk is happening I might try to pull up a chair where they are next to them, and ask them to share with me like some of the positives before we move into some of the, their concerns about the future. And after, sometimes after you do that, pull up a chair next to them where they are and why they want to continue before you move into some of the reasons to stop it brings out some more of that narrative so you can hang on to that change talk from their narrative.

WOMAN: I love the suggestion of physically pulling up a chair next to them and sitting next to them literally as well as figuratively, that's great.

MIRIAM: Great, maybe one last comment? Mariah were you trying to unmute?

MARIAH: Yeah, I just thought I would put in there how important it is to quantify what they're doing, 'cause then of course you know people sometimes surprise us and make a lot of progress. So it's good to know either way if the use is more frequent less frequent, or increasing, decreasing.

WOMAN: Great, I do I like that.

MARIAH: I think is a really important element of the history.

WOMAN: Ah ha, yeah because if someone comes back and you ask, you know are they drinking more or less it really is helpful if you have quantified how much they were drinking before and how much they're drinking now, so that you have another kind of a marker, that's excellent.

MIRIAM: Okay, so we're all familiar I think with this concept of rolling with resistance I think this term is not so much being used in teaching motivational interviewing now but it still can be a helpful way of framing it to ourselves. The you know, when someone isn't in tune with making a change it can be very tempting to go into our lecturing and explaining mode and it's pretty clear that that's not likely to result in the patient suddenly seeing the light and agreeing to do what we think they should do. It's much more likely to create resentment, resistance, them telling us the reasons why we're wrong and their approach is right.

So this can be a good opportunity to ally with the patient to reflect what you're hearing them say, about why this is important to them and in particular to make it clear that you recognize that it is their choice, that nothing you can say or do is going to make them change their behavior, they have to decide what is best for them and what choice they wanna go with. Yeah these are things, just some additional pointers in using motivational interviewing techniques when you detect some readiness, some hint that the patient is thinking about making a change. Opening things up and having an attitude of curiosity, you know questions such as if you were going to be completely successful making the changes you're talking about how would things be different for you? Just allowing the patient an opportunity to really use their imagination and expand on what the impact of that would be in their life.

If you get to the point where the patient is actually ready to move into the action stage, it can be helpful to work with them around a very specific and particular plan, such as the patient says, I think I'll try going to an AA meeting. Then maybe working with them on okay, you know what meeting, what date, where can I help you to find a specific meeting that you're going to attend and problem solving with them around if they don't have a ride, you know how can you help make it really feasible to do what they're talking about doing. If someone says you know I'm prepared to go to counseling, jumping on that



willingness and openness to make a specific plan and helping them to turn that into reality and have an actual plan for who they're going to meet with and when.

A treatment plan can obviously include a lot of different elements, medication treatment, is ideally provided in the primary care office in order to promote adherence and reduce stigma. Its important to think about what's culturally appropriate for the patient, do they have a particular set of cultural beliefs that are going to make one type of treatment more acceptable than another. One treatment setting more acceptable than another, are there elements of their culturally defined beliefs in what will be helpful for treatment that you can weave in to things that might not be familiar to them. But that you are recommending that they participate in. Self help groups and peer support are extremely helpful for a lot of patients, and thinking about the kinds of lifestyle changes that can really help promote recovery such as diet, exercise and meditation, and finally formal counseling and psychosocial rehab programs can be very very helpful.

Last, point is just to think about if you think specialty treatment is needed, there are various different types of treatment setting and thinking through those before you make a referral can be very helpful. The ASAM criteria help to guide that based on the severity of the patient's substance abuse disorder, co-occurring disorders, their home environment, potential for self harm et cetera. So thinking about in patient treatment which is most appropriate for every severe and complex substance use disorders, often with co-occurring disorders, residential options, and then outpatient care, and outpatient services are where most people are going to get their treatment and primary care as you all are engaged in is a great place for that to happen. I think I'll stop there just wanted to point out SAMHSA has a national treatment facility locator, online that can help if you're looking for inpatient or rehab programs that can be a really helpful resource. So let's stop there.

