Indian Health Service

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

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Presenter

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Objectives

At the end of this presentation, participants will be able to:

1. Examine the rationale for universal screening and information on SBIRT screening tools, procedures, and motivational interviewing.
2. Identify how SBIRT is conducted in primary care.
3. Apply screening tools for substance use and appropriate referral for patients to treatment.
4. Implement strategies and to sustain SBIRT at your site.

Epidemiology, Substance Use and American Indian and Alaska Native Populations

Epidemiology of Substance Use in U.S.

- In 2021, the percentage of people aged 12 or older with a substance use disorder (SUD) was highest among young adults aged 18 to 25 (25.6% or 8.6 million people), followed by adults aged 26 or older (16.1% or 35.5 million people), then by adolescents aged 12 to 17 (8.5% or 2.2 million people).[1]

- Untreated, SUDs may account for a disproportionate amount of medical and mental health concerns.

- Early detection of SUDs, particularly within the Primary Care setting, can lead to successful management, and may prevent progression of both mental health and medical concerns.

Scope of the Problem – AI/AN

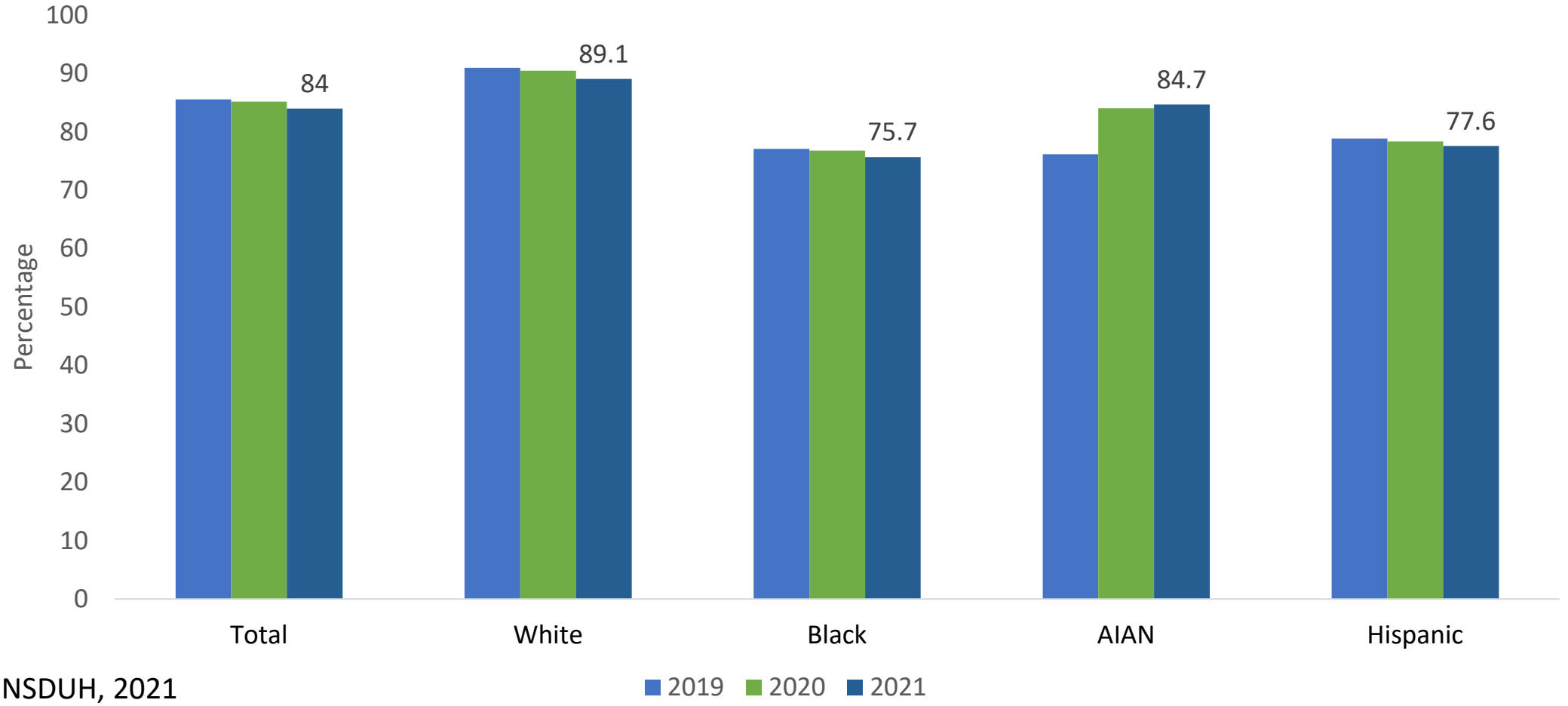
- In 2021, AI/AN (27.6%) were more likely to have a substance use disorder (SUD) in the past year compared with Black (17.2%), White (17.0%), Hispanic/Latino (15.7%).

- In 2021, 8.0% AI/ANs reported heavy alcohol use in past month compared to 6.4% of the overall U.S. population.

- For years, unintentional injuries, chronic liver disease, and suicide are reported as leading causes of death for AI/AN, with an estimated 15-20% related to alcohol

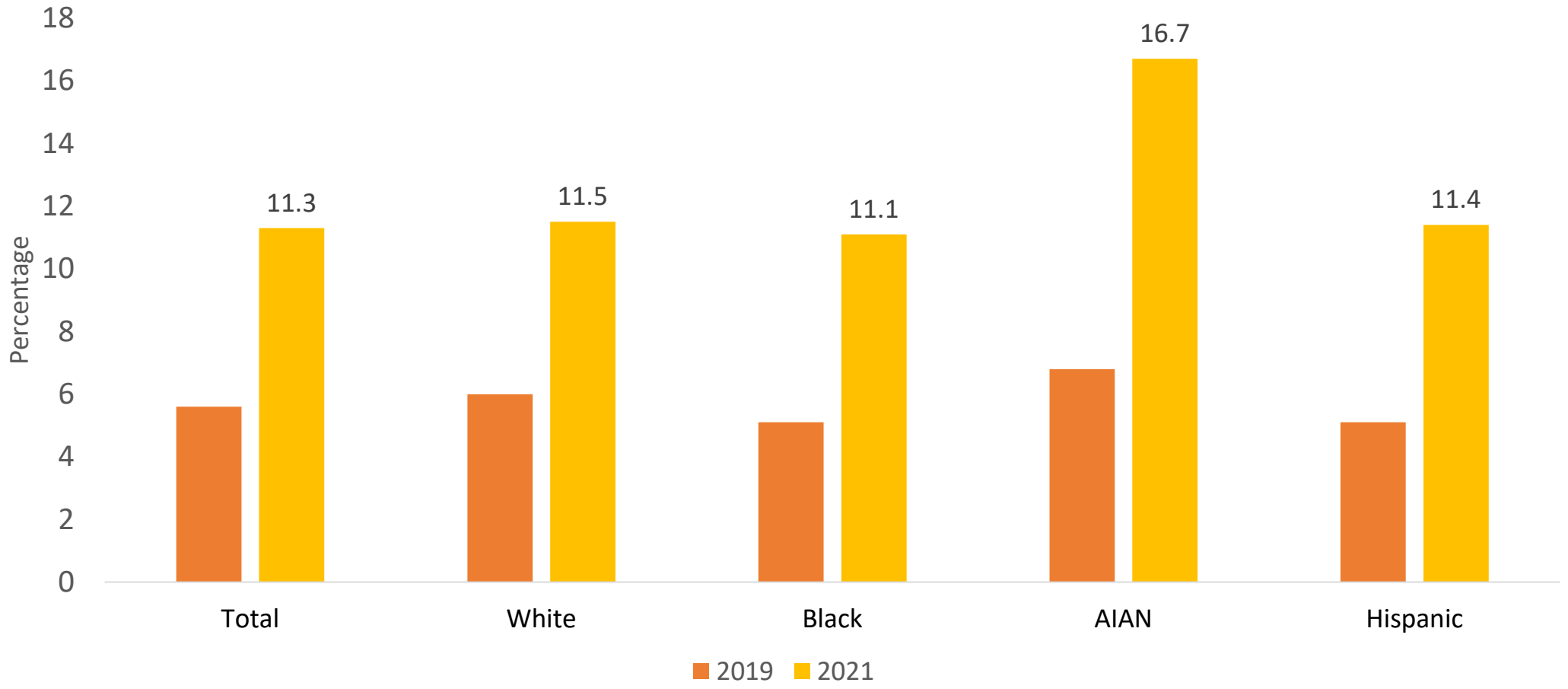
Source:
1. National Survey on Drug Use and Health (NSDUH) 2021 Report

Alcohol Use in Lifetime among Persons Aged 18 or Older by Race 2019-2021



SAMHSA, NSDUH, 2021

Alcohol Use Disorder in Past Year among Persons Aged 18 or Older, 2019 & 2021



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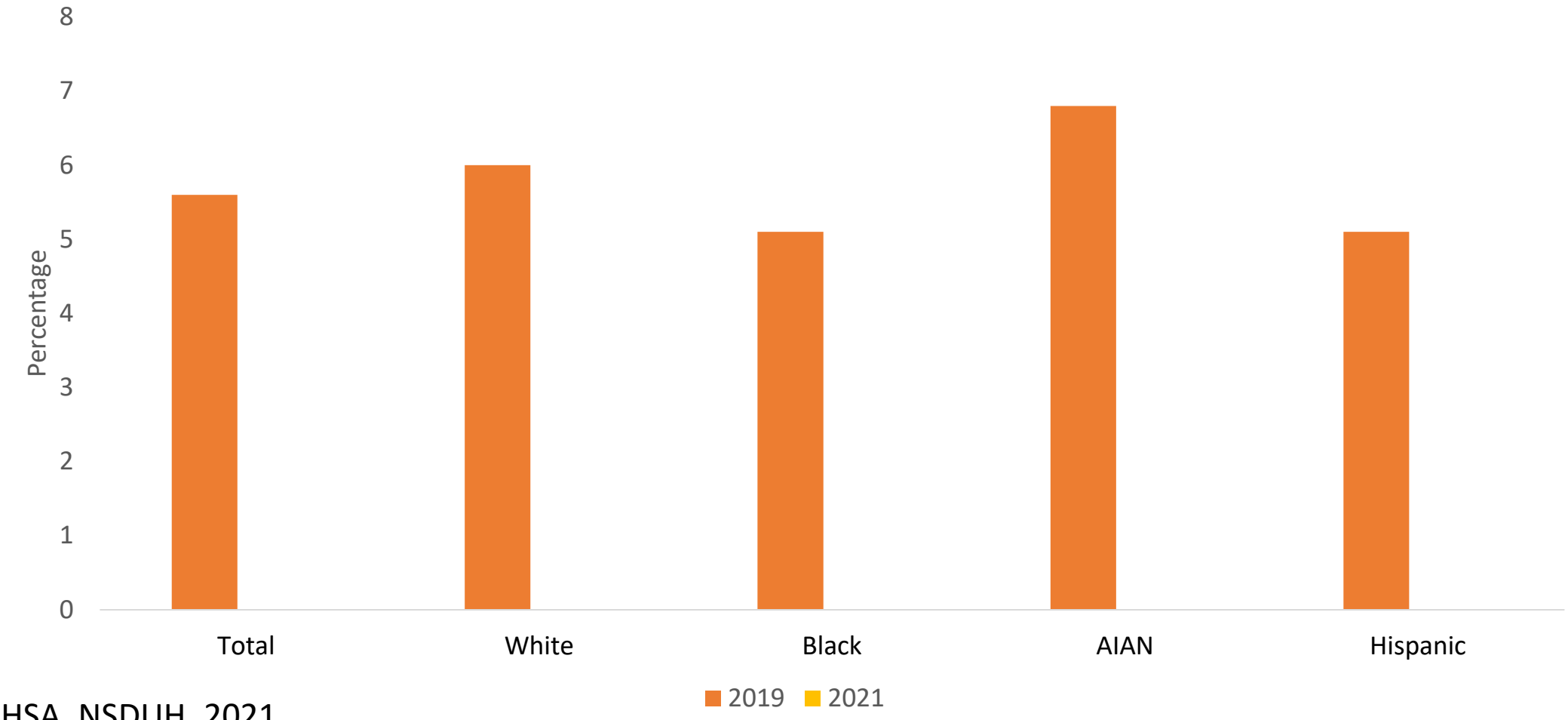
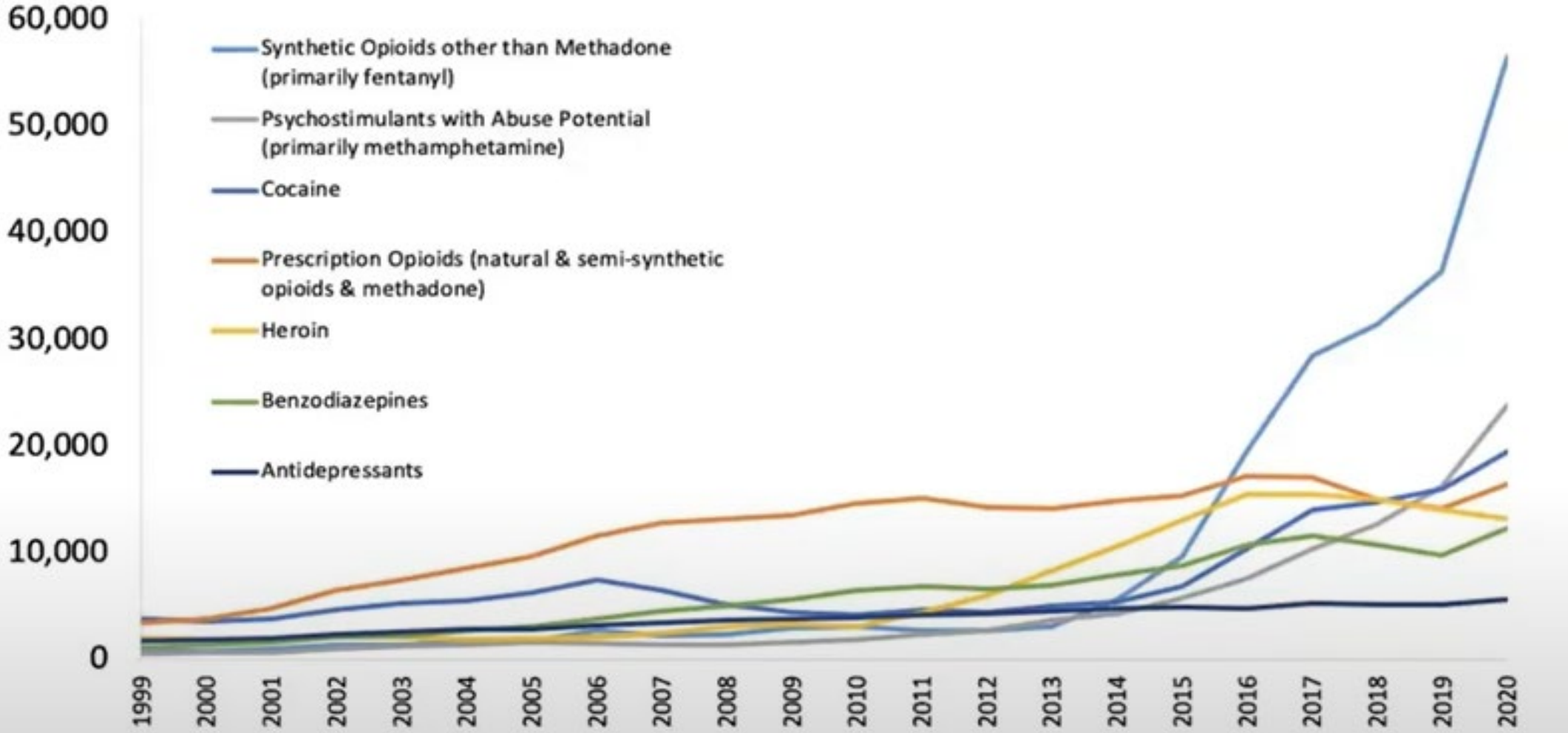


SAMHSA, NSDUH, 2021

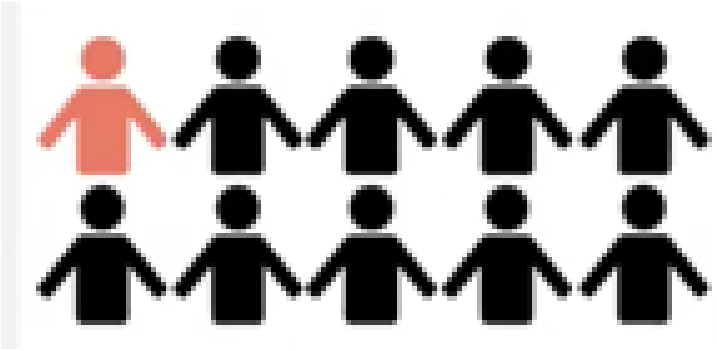
National Drug-Involved Overdose Deaths, 1999-2020



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

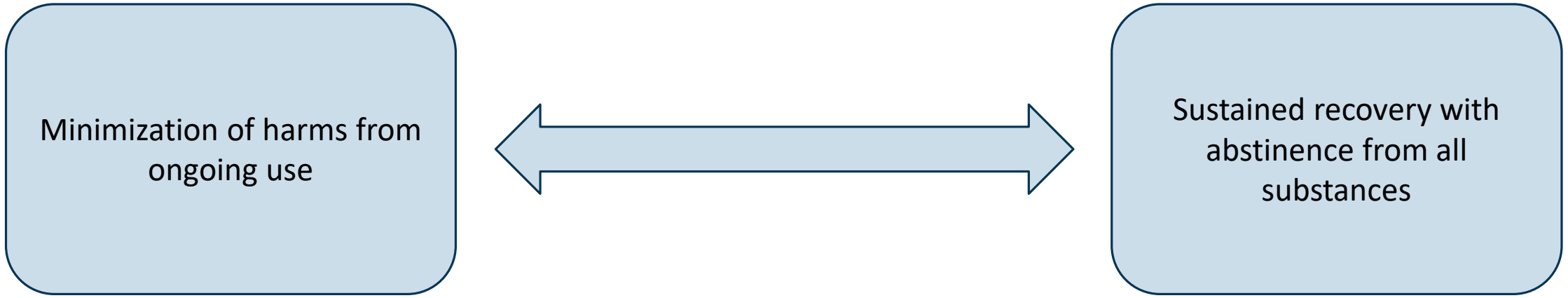
Treatment Gap for Substance Use Disorders

- Approximately 41 million individuals aged 12 or older (15%) needed substance use treatment in 2020.
- Only 10% of those with SUDs received any type of substance use treatment
- Primary care and health care providers see many patients with untreated substance use disorders and have the opportunity to link patients to treatment.



SAMHSA, 2021

Range of Treatment Goals



- Treatment Options
  - Behaviorally-Oriented Treatment
  - FDA approved treatment for Medications for Opioid Use Disorder include:

<u>Ultimate goal: Maintain long-term recovery with or without medication</u>

Changing the Language of Addiction

VIEWPOINT

Changing the Language of Addiction

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Words matter. In the scientific arena, the routine vocabulary of health care professionals and researchers frames illness[1] and shapes medical judgments. When these terms then enter the public arena, they convey social norms and attitudes. As part of their professional duty, clinicians strive to use language that accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.

However, history has also demonstrated how language can cloud understanding and perpetuate societal bias. For example, in the past, people with mental illness were derided as "lunatics" and segregated to "insane asylums." In the early days of human immunodeficiency virus, patients were labeled as having "gay-related immune deficiency," with public discourse dominated by moral judgments. Other examples apply to disability and some infectious diseases. In all of these cases, stigma and discrimination can arise when patients are labeled, linked to undesirable characteristics, or placed in categories to separate "us" from "them."

Today, these complex themes have special relevance for addiction. Scientific evidence shows that addiction to alcohol or drugs is a chronic brain disorder with potential for recurrence. However, as with many other chronic conditions, people with substance use disor-

Stigma isolates people, discourages people from coming forward for treatment, and leads some clinicians, knowingly or unknowingly, to resist delivering evidence-based treatment services. The 2014 National Survey on Drug Use and Health[4] estimates that of the 22.5 million people (aged ≥12 years) who need specialty treatment for a problem with alcohol or illicit drug use, only an estimated 2.6 million received treatment in the past year; of the 7.9 million specifically needing specialty treatment for illicit drug use, only 1.6 million received treatment. The survey noted that reasons for not seeking treatment included fears that receiving it would adversely affect the individual's job or the opinion of neighbors or other community members. Lack of insurance coverage, cost concerns, and not perceiving a need for treatment also contributed. Among health care professionals, negative attitudes regarding people with SUDs have led to diminished feelings of empowerment among patients, lower levels of empathy and engagement among health care professionals, and poorer outcomes.[5] Not surprisingly, medication-assisted treatment remains isolated within SUD treatment systems, which in turn have historically been separated from the rest of health care.

To help address these concerns, the American Medical Association has called on physicians across

ONDCP, 2017

Words Matter. Using Patient Centered Language

Words are powerful…they can contribute to stigma and create barriers to accessing effective treatment

Use person-first language; focus on the person, not the disorder

When discussing substance use disorders…

Avoid these terms:

- Addict, user, drug abuser, junkie
- Addicted baby
- Substance abuse or substance dependence
- Problem
- Habit
- Clean or dirty urine test
- Relapse
- Treatment failure
- Being clean

Use these instead:

- Person with substance use disorder, patient
- Baby born with neonatal abstinence syndrome
- Substance use disorder
- Disease
- Drug addiction
- Negative or positive urine drug test
- Return to use
- Treatment attempt
- Being in remission or recovery

What is SBIRT and Why Use It?

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

- Excellent opportunities to intervene early in: outpatient BH, primary care, emergency departments, hospitals, community health, women's health, pediatrics

SBIRT and USPSTF

- The U.S. Preventive Services Task Force (USPSTF) has recommended that all adults in primary care be screened to identify unhealthy alcohol use, and that those with unhealthy use receive a brief counseling intervention

- Brief Intervention (BI):
  - Based on a Harm-Reduction Model – emphasizes reduction in use rather than abstinence
  - Time-listed, client-centered counseling session designed to reduce substance use
  - Generally delivered by health care professional
  - Average duration 5-20 minutes
  - Multiple BI sessions are more effective than a single session
  - Third party reimbursement

SBIRT: A View From Above

- Clinicians, staff, and patient advocates can enhance a patient's willingness to start treatment using evidence-based techniques
  - Physicians
  - PAs, APRNs
  - Nurses
  - Social Workers
  - Health Promotion Advocates
  - Peer Navigators

- Most effective techniques to enhance motivation to enter treatment are based on Motivational Interviewing.

The 5 A's of SBIRT

ASK

- Screening and Assessment of Risk Level
  - Can include screening questionnaire, lab or physical findings

ADVISE

- Direct advice from the Clinician about the patient's substance use
  - Review results in an objective manner
  - Convey concerns with a strong, clear, and personalized language

ASSESS

- Evaluate patient's willingness to change the unhealthy behavior after hearing the Clinician's advice. If patient is NOT willing to change substance use then:
  - Clinician should restate concerns
  - Convey support and a willingness to help when the patient is ready
  - Encourage patient to reflect about perceived benefits of continued use vs. decreasing or stopping use
  - Explore barriers to change

ASSIST

- Help agreeable patient develop a treatment plan in accord with their goals
  - Use behavior change techniques e.g. Motivational Interviewing
  - Start with small, achievable steps
  - Articulate a concrete and specific plan

ARRANGE

- Follow-up visits, specialty referrals, and educational materials

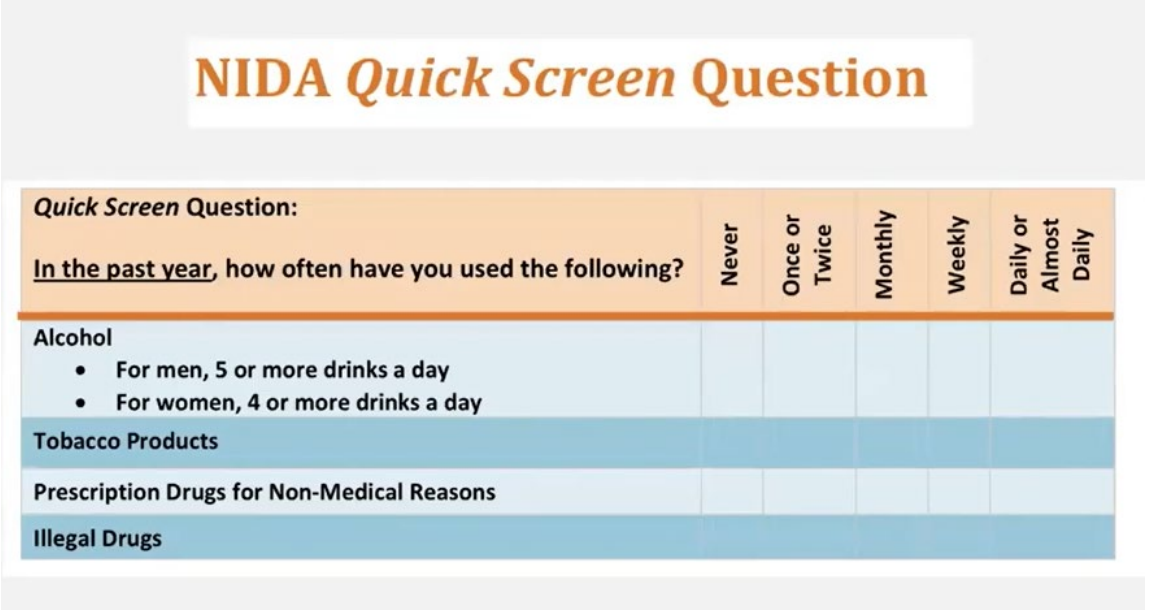
SBIRT Screening Tools

- There are a wide variety of screening tools with different sensitivity and specificity to varying levels of substance use involvement

- For SBIRT practice, the trend is toward screening tools that identify the risky and hazardous population impacted by substance use.

SBIRT Screening Tools: Most Common

- AUDIT (Alcohol Use Disorder Identification Test)
- CRAFFT (adolescents)
- NIDA- Quick Screener
- TAPS



NIDA *Quick Screen* Question

***Quick Screen* Question:** In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Motivational Interviewing (MI)

"Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

(Miller & Rollnick, 2013, p.29).

Motivational Interviewing (MI)

- Developed by William Miller and Stephen Rollnick in the 1980's
  - Clinical tool conceptualized for individuals "less ready" for change
- Over 25,000 articles using MI
- 200 Randomized Controlled Trials
- Effectiveness of MI varies widely across counselors, studies, and sites within studies
- Fidelity of delivery affects outcomes
- Can be done in primary care and health care settings to enhance willingness to enter treatment.

MI Definitions and Skills

- A person-centered counseling that helps people ***resolve ambivalent feelings*** **and** ***insecurities*** to find the ***internal motivation*** they need to ***change*** their behavior.

- A ***practical, empathetic, and short-term process*** that takes into consideration how difficult it is to make life changes.

- A collaborative conversation style for strengthening a person's own motivation and commitment to change in a spirit of acceptance and compassion

Miller & Rollnick, 2013

Practical Aspects of MI

- Be open minded
- Listen > ask > give advice
- Do not ask more than 3 consecutive questions
- Avoid wordiness
- Avoid interrupting
- Cooperate, do not force knowledge
- Use patient as consultant
- Be open, be direct
- Work together
- Communicate compassion, acceptance, partnership, and respect

Miller & Rollnick, 2013

Enhancing MI using the Brief Negation Interview

Raise the Subject/Establish rapport

- Introduce yourself
- Raise the subject of to discuss problem behavior
- Assess readiness to change

Provide feedback

- Review patient's substance use and patterns
- Ask the patient about and discuss substance use and its negative consequences
- Make a connection (if possible) between substance use and visit or medical issues
- Provide feedback on substance use diagnosis and treatment option (e.g., medication, behavioral, outpatient, 12 step

Enhancing MI using the Brief Negation Interview

Step 3. Enhance Motivation

- Assess readiness to change – with regard to starting preferred treatment
  - "On a scale of 1-10, how ready are you to start treatment right now?"
- Enhance motivation
  - Ask a series of open-ended questions designed to evoke "Change Talk" (or motivational statements) about their target behavior
  - Reflect or reiterate the patient's motivational statements regarding entering treatment

Step 4. Negotiate & Advise

- Negotiate goal regarding the target behavior (e.g., starting treatment)
- Give advice
- Complete a referral/treatment or goal agreement, and secure and provide the actual referral for treatment

SBIRT - Motivational Interviewing Skills

SCREENING

Promptly identifies patients who need further assessment for unhealthy levels of drinking or drug use (risky, mild/mod use)

BRIEF INTERVENTION

Increases patient's awareness of unhealthy use and enhances motivation to change

REFERRAL TO TREATMENT

Assists ready patients with an action plan for change, e.g., behavioral, pharmacologic, or referral to specialized care

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Historic Response to Substance Use

- In the past, substance use intervention and treatment focused primarily on substance abuse universal prevention strategies and on specialized treatment services for those who me the abuse and dependence criteria (DSM-IV).

- There was a significant gap in service systems for at-risk populations.

DSM-5 Criteria for Substance Use Disorders

Loss of Control

- More than intended
  - Amount used
  - Time spent
- Unable to cut down
- Giving up activities
- Craving
- Repeated Attempts to quit or control use

Physiology

- Tolerance
- withdrawal

formerly dependence (DSM-IV)

Consequences

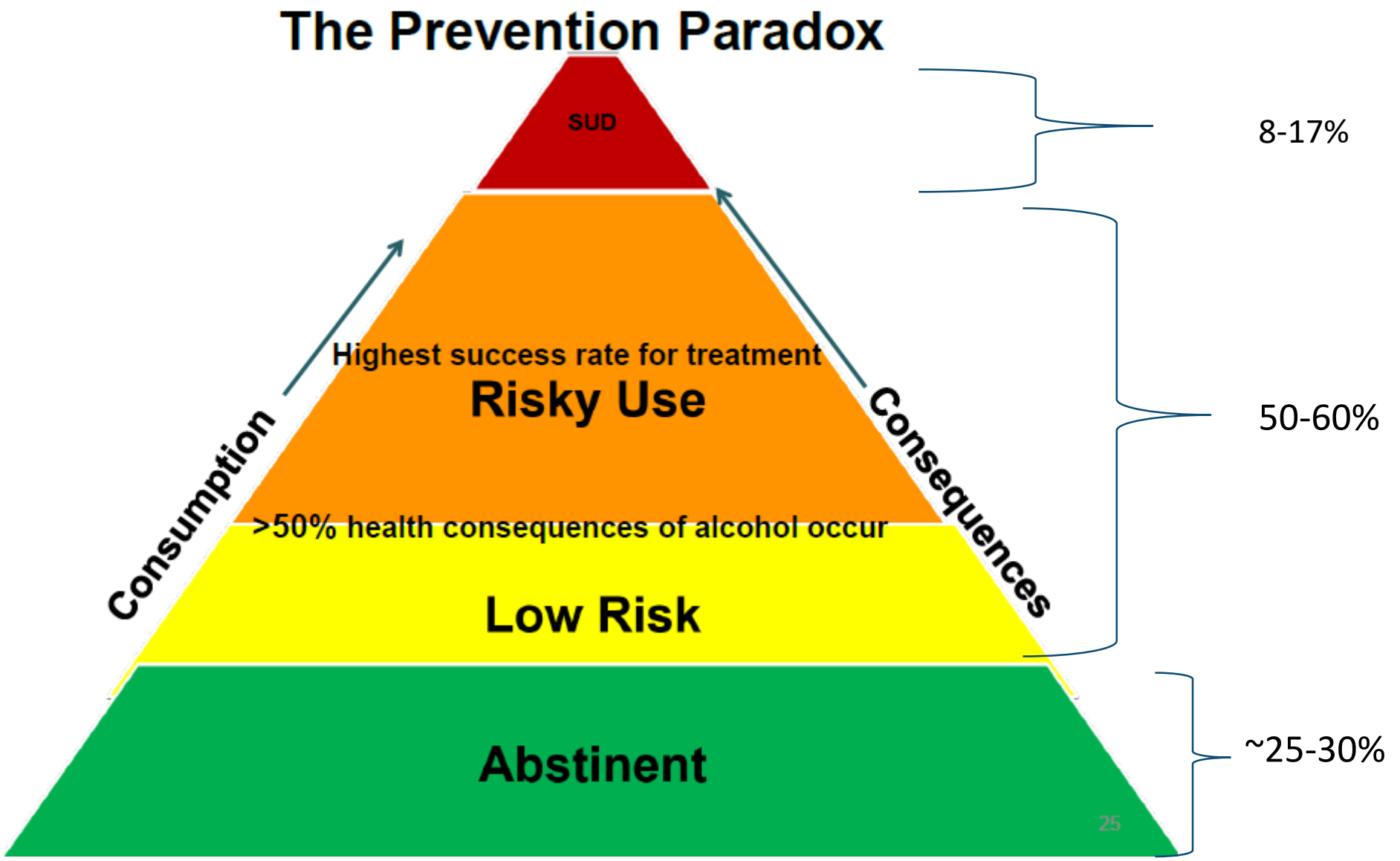
- Unfulfilled obligations at work, school, home
- Interpersonal problems
- Dangerous situations
- Medical problems

formerly abuse (DSM-IV)

- A **substance use disorder** is defined by having 2 or more criteria above in the past year resulting in distress or impairment.
- **Tolerance** and **withdrawal** alone don't necessarily imply a disorder.
- **Severity** is rated by the number of symptoms present.

2-3 = Mild
4-5 = Moderate
6+ = Severe

APA, 2013


The Prevention Paradox
SUD
Highest success rate for treatment
Risky Use
>50% health consequences of alcohol occur
Low Risk
Abstinent
Consumption
Consequences
25
8-17%
50-60%
~25-30%

IHS Clinical Measures: Alcohol and Substance Abuse – GPRA and GPRA Developmental

GPRA

- Alcohol Screening – 2023 Target Rate is 32.3% for the proportion of patients ages 9 – 75 years of age who receive screening for alcohol use.
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) – 2023 Target Rate – Establish a baseline for the proportion of patients ages 9 – 75 years of age who screened positive for risky or harmful alcohol use and who received a Brief Negotiated Interview or Brief Intervention within 7 days of screen.

GPRA Developmental

- Screening for Substance Use – will start July 2023 to screen for substance use, namely illicit drugs for patients between 12 and older.

SBIRT AI/AN Cultural Considerations

RELATIONSHIP is paramount, treat everyone with respect

REMEMBER that substance use, suicide, and violence are more frequently seen together; assess for this

HISTORICAL TRAUMA and traumatic stress is a huge factor and different for each person

Understand the definitions of traditional vs. non-traditional medicine within the Tribe and location within which you are working

Do they have access to providers, SUD counselors, peer support workers, traditional healer or traditional medicine.

Structural/institutional barriers

- SUD treatment primarily outside the IHS system of care
- Historically, Tribal 638 activity in the health care setting began with community driven programs such as SUD treatment services.

- Many cases in the Tribal 638 structure
- Warm hand offs having to happen between programs: Federal, Tribal, Urban, other (private, non govt, not for profit)

Potential Barriers to Practitioner Implementation

- Lack of basic knowledge and skills
- Limited training opportunities
- Inadequate time to learn new therapies
- Negative practitioner attitudes toward EBPs reduce use of EBPs in SUD practice
- Question of applicability of research supporting EBPs
- Want greater emphasis on the therapeutic relationship
- Need for flexibility within treatment protocols
- Unsure of where to refer

Potential Barriers to Clinic Implementation

- No support from administration and/or leadership
- Lack of collaborative care team knowing their individual roles and how these fit in the overall system
- Lack of clinic process
- Lack of evaluation/feedback of implementation of SBIRT

Strategies to Overcome Barriers

- Important for WHOLE TEAM to understand importance of SBIRT
- Education and continued support regarding model and efficacy
- Tailoring SBIRT to specific needs of the clinic and population served
- Clinical learning group in person on virtual
- Brief SBIRT workshops
- Brief MI training, ongoing support and opportunity for practice
- Examine SBIRT evidence and ease of use
- Develop procedures and flow of work for each person
- Develop referral list and relationships
- Linking back to medical importance
- Taking these steps to do warm hand offs when required to Tribal systems
- SUD have parity with any other health related referral

The Long Haul

- You may not see the results of your efforts right away or during a single encounter
- Think of SBIRT as planting a seed
- Do not underestimate the value of building a therapeutic relationship (which may be particularly important if patients feel stigmatized or have had prior poor experiences
- Someone else down the road may see the fruits of your labor.

Questions?

- Please send me your questions and comments. JB.Kinlacheeny@ihs.gov
- Feel free to let me know of your successes and challenges in implementing SBIRT in your community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