How Harm Reduction Fits into the SBIRT Model

Jim Winkle, MPH

SBIRT Oregon

Webinar for the
Institute for Research, Education, & Training in Addictions.
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Disclosures

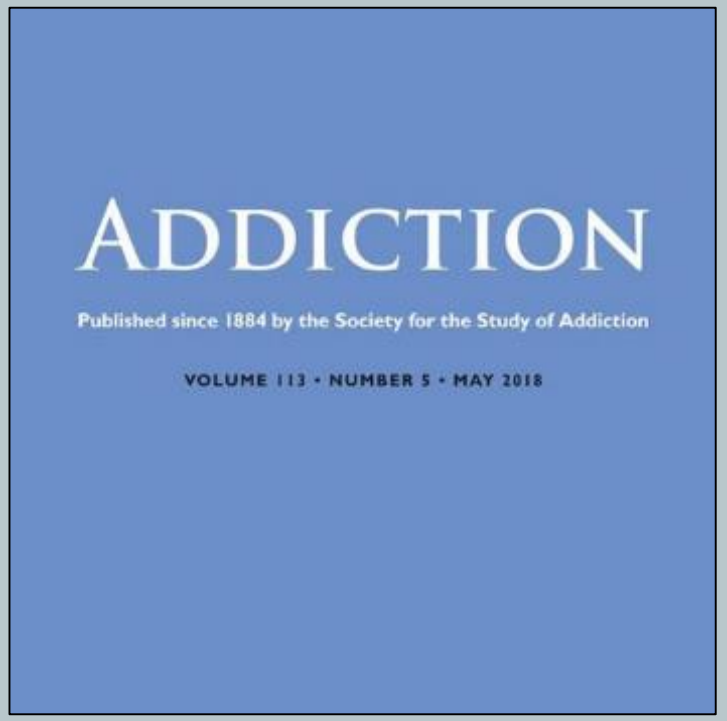
I have no financial conflicts of interest to disclose

My background

- Trained hundreds of clinical team members in SBIRT, 2008 – present
- Primary care, Pediatrics, women's heath clinics, ERs
- Built EHR tools, screening app
- Currently consult

New study

- Study question: is BI associated with treatment for AUD within 365 days?
- Analysis of VA pt records 2009-2013
- 830,825 outpatients screened positive for unhealthy alcohol use, 74% had documented BI within 0-14 days
- **Result**: BI was associated with lower likelihood of receiving specialty treatment



Frost MC, Glass JE, Bradley KA, Williams EC. "Documented brief intervention associated with reduced linkage to specialty addictions treatment in a national sample of VA patients with unhealthy alcohol use with and without alcohol use disorders". Addiction. 2019 Oct 22.

Table: Percent of VA pts who received treatment within 365 days

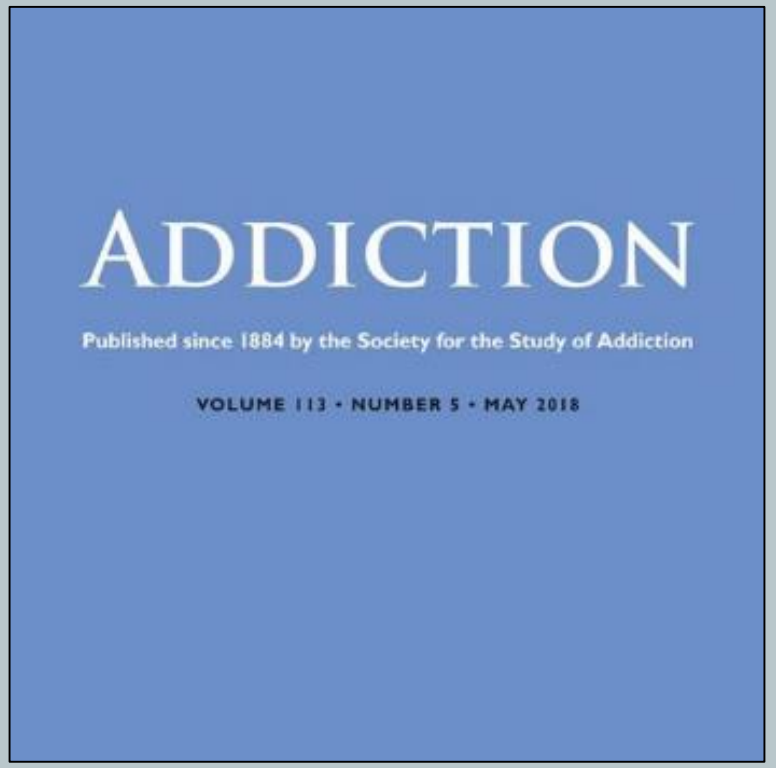
	Adjusted* %	95% CI	Rate ratio	P-value
Overall sample: (N= 1,172,606 positive screens)				
No documented BI	12.6	(12.5-12.7)	.84	<0.001
Documented BI	10.5	(10.4-10.6)		
AUD diagnosis in the past year: (N= 421,244 positive screens)				
No documented BI	19.9	(19.7-20.1)	.83	<0.001
Documented BI	16.5	(16.4-16.6)		

*"Adjusted for sex, age, race/ethnicity, marital status, VA eligibility status, mental health and drug use disorder diagnoses, tobacco use, AUDIT-C category, alcohol use disorder diagnosis, alcohol-specific condition, and fiscal year in which positive AUDIT-C screen occurred."

Frost, et al. Addiction. 2019

Study takeaways

- BIs were defined as giving information and advice
- Beware: poor BIs may cause harm with pts with SUDs?
- At a minimum, traditional BI+RTs don't seem to be cutting it



Frost, et al. Addiction. 2019

Evidence of SBIRT towards unhealthy alcohol use

	SBI (for self-reported reduced use)	SBI + RT (for receipt of specialty treatment)
Adults	Moderate evidence (USPSTF, 2018)	Meta-analysis: no evidence*
Adolescents	Insufficient evidence (USPSTF, 2018)	?
Pregnancy	Moderate evidence (USPSTF draft, 2018	?

*Glass, et al. Addiction. 2015

Evidence of SBIRT towards illicit drug use

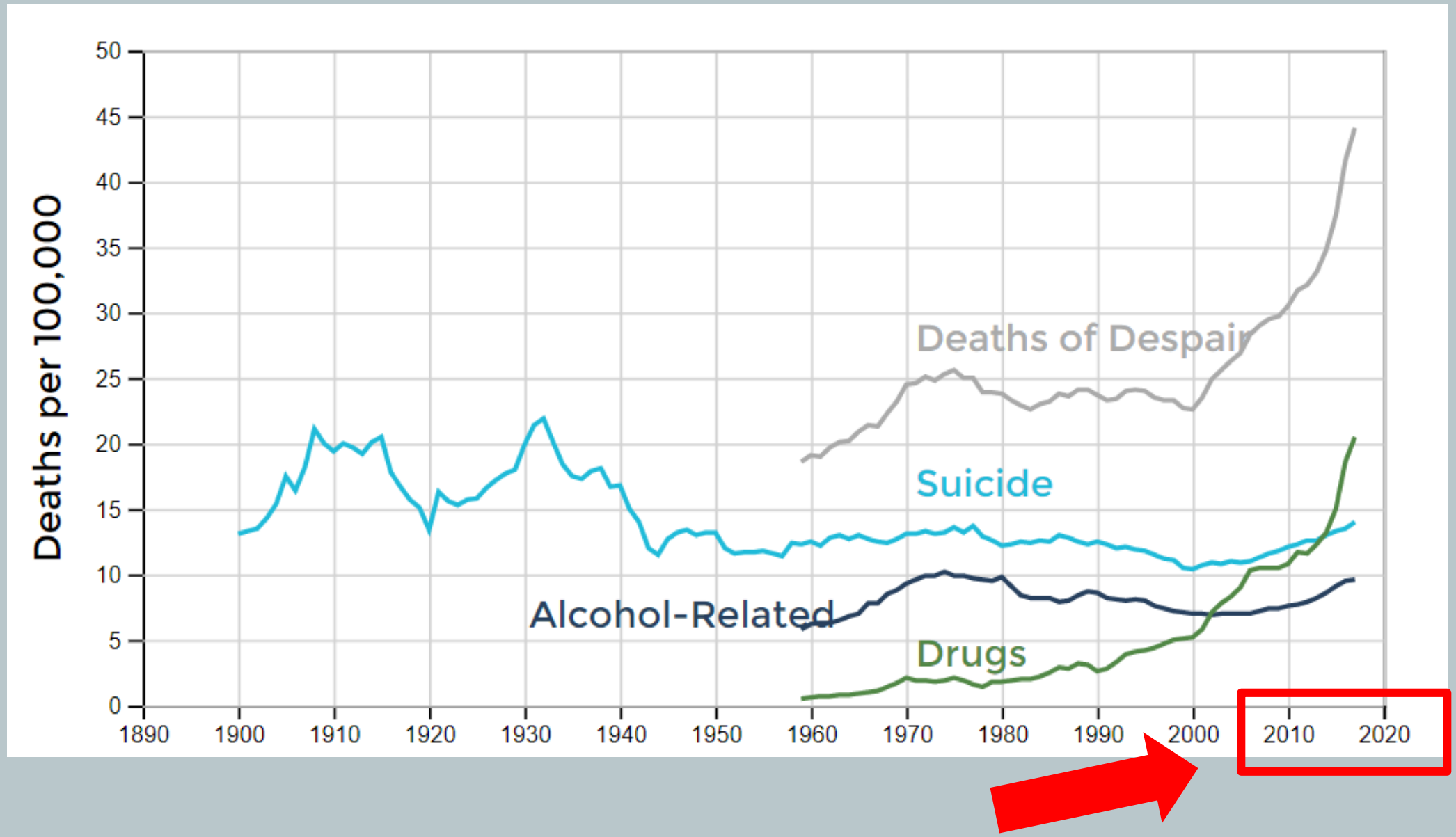
	SBI (for self-reported reduced use)	SBI + RT (for receipt of specialty treatment)
Adults	Moderate evidence (USPSTF draft, 2018)	?
Adolescents	Insufficient evidence (USPSTF draft, 2019)	?
Pregnancy	?	?

Meanwhile, in the U.S:

- 10% of adults have substance use disorder at some point in their lives
- 88,000 die from alcohol-related causes annually, making alcohol the third leading preventable cause of death
- Prevalence of injection drug use:
  Last 12 mths: 750,000. Lifetime: 6.5 million
- 42,000 die from opioid overdoses annually

National Institutes of Health; Lansky et al, 2014; DHHS.

Deaths of Despair*, 1900-2017, Age-Adjusted Rates



*among white non-Hispanic Americans in midlife

Social Capitol Project, 2019

Why this presentation?

- Recognize that traditional SBIRT isn't helping pts with SUDs access treatment
- Consider an alternative with promise: integrating HR into SBIRT.
  - Reduce harm
  - Provide pathways to treatment
- Counter some misunderstandings between HR advocates and SBIRT, MI

This presentation will . . .

- Assume attendees are familiar with SBIRT
- Assume there is a spectrum of understanding of HR among attendees
- Not assume to represent HR in any official capacity
- Focus on pts with SUDs
- Focus on primary care

Outline:

How harm reduction can inform how we address SUDs in clinic settings:

- The role of stigma
- The HR philosophy

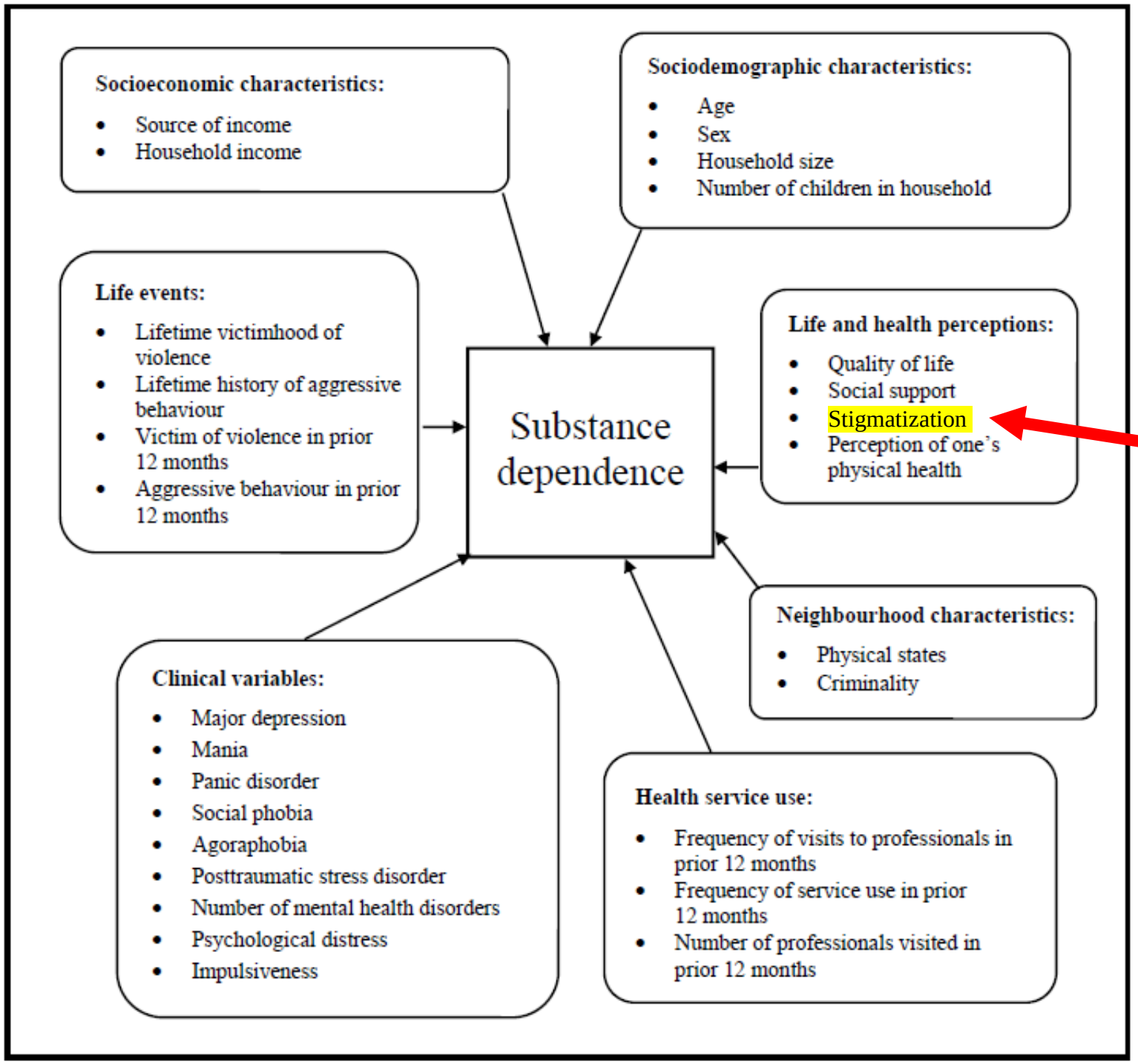
Implementing a HR-informed SBIRT model:

- Tailor the brief intervention
- Re-define referral to treatment

Acknowledgements

This presentation uses information from:

- Susan Collins, PhD, Harm Reduction Research and Treatment (HaRRT) Center, U. of Washington
- SBIRT Oregon training curriculum
- HOPE project, Oregon Health Authority
- Original content created for this presentation



Conclusion: "Stigmatization was the strongest predictor of substance dependence"

Figure from:

Fleury, M; Grenier, G; Bamvita JM, Perreault, M; Caron, J. Predictors of Alcohol and Drug Dependence. CanJPsychiatry 2014

Slide: OHA HOPE Project

Stigma:

"A social process which can reinforce relations of power and control. Leads to status loss and discrimination for the stigmatized."

- Link and Phelan, 2001

Slide: OHA HOPE Project

Stigma

- Originates from the Greek practice of branding people who were enslaved
- Based on attributes:
  - Housing, race, class, etc.
- Based on behaviors:
  - Substance use, sex, mental health issues, etc.
- Discrimination is an actualization of stigma

Harm Reduction Coalition, Slide: OHA HOPE Project

Social stigma and drug addiction

Many Americans:

- Indicate that they desire social distance from individuals addicted to drugs
- See them as unworthy of receiving assistance (e.g., finding jobs or housing),
- Regard them as dangerous, unpredictable, and lacking self-control

Biancarellia et al, 2019. Barry et al., 2014; Corrigan, Kuwabara, & O'Shaughnessy, 2009. Slide: OHA HOPE Project

Internalized stigma

- Acts as a barrier to seeking health care, disclosing use, harm reduction, and treatment.
- Diminishes self-worth and self-esteem
- Stigma may inflict greater psychological pain than SUD itself
- May increase substance use as a way of coping with internalized stigma and to boost self-esteem

Harm Reduction Coalition. Rivera et al, 2014. Slide: OHA HOPE Project

Stigma from providers

- Systemic review: stigma towards pts with SUDs common among providers
- More highly stigmatized than other health conditions

Linked to:

- Less likelihood of offering harm reduction services, ART
- Less personal engagement and diminished empathy
- Discouraging and marginalizing problematic substance use

van Boekel et al, 2013. Westergaard et al, 2012. Slide: OHA HOPE Project

Provider stigma: connected to generalizations

Pts with SUDs are more likely to be perceived by providers as:

- Less honest or trustworthy
- More likely to overuse system resources
- Less vested in their own health, adhere to recommended care
- More likely to abuse the system through drug-seeking and diversion

Biancarellia et al, 2019. Weiss et al, 2006. Henderson et al, 2008. Slide: OHA HOPE Project

Patient perspectives

"There's a stigma attached to it. Like, the fact that you maybe had cancer or you had heart disease, like you could say, well, that's not my fault. As opposed to the way the world looks at substance abuse as 'this is your fault, you did this to yourself' type of mentality."

- NY-2 Patient

Patients are sensitive to feeling accused of bringing their substance use upon themselves.

McNeely et al, 2019.
Slide: OHA HOPE Project

Patient perspectives

"The minute they find out that you're [an] injection user, the doctors, you can see it right in their face. They change their whole attitude. They don't want to help you. It's weird. I hate telling the doctor that I use drugs. Hate it. Their whole attitude changes…"

- Donna

Patients can perceive subtle changes in behavior from medical professionals after disclosing injection drug use.

Biancarellia et al, 2019.
Slide: OHA HOPE Project

Stigma conveyed non-verbally

Common theme in PWID focus groups: looks from clinicians and staff:

- Being “looked down on” by medical personnel
- “Look at [us] like we’re garbage.”
- “They give you dirty, snotty looks”

Paquettea et al, 2018. Slide: OHA HOPE Project

Impact on patients

Pts who perceive stigma are more likely to:

- Conceal their substance use from providers
- Report poor rapport with their provider
- Avoid or interrupt treatment
- Not come back for follow up

Neale et al, 2008. Ball et al 2006, Eaton et al 2004.
Image: SBIRT Oregon. Slide: OHA HOPE Project

Patient perspectives

"When you go to a hospital, and you're a drug addict – you are treated horribly. Your life isn't as valuable, you're a second
or third class citizen, and it's sad. Most people using a needle know. A lot of people just won't go. They'd literally rather die than face that. It's sad."

- Melissa

PWIDs often delay care rather than experience stigma from medical professionals.

Paquettea et al, 2018.
Slide: OHA HOPE Project

Patient perspectives

"When it comes down to it, a lot of the times that I need to get medical attention, I put it off and put it off and put it off, because I don't want to face the embarrassment that they make me feel, and that's not fair. It's not."

- Stacey

PWIDs often delay care rather than experience stigma from medical professionals.

Biancarellia et al, 2019.
Slide: OHA HOPE Project

Patient perspectives

"I don't want to tell them I'm a drug user if there's something really wrong with me. You know, I need that issue taken care of…It makes me want to lie and not be honest."

- Donna

"She wouldn't keep my appointments. She would care less. She wouldn't go the nine yards or go out the way for me."

- Richard

"There's just some things I wouldn't tell a doctor."

- Aaron

Not disclosing substance use can reflect an attempt to receive higher quality care

Biancarellia et al, 2019.
Slide: OHA HOPE Project

More reasons PWIDs may avoid disclosing

- Fear that their access to insurance may be threatened
- Fear that they will be reported to police
- May not be ready to admit openly to themselves

Patient perspectives

"Well it's so hard you know 'cause you're abusive, you're loud . . . you just walked 30, 40 blocks, three or four different places probably and finally you get to this point and you're trying to get to see him to help you out and they interrogate you and 'you're double doctoring'. You're this or you're that."

- Anonymous

Pts addicted to drugs acknowledged that people living with addiction can behave in ways that shape provider expectations.

Salvalaggio et al, 2013.

Slide: OHA HOPE Project

Patient perspectives

"I had an abscess on my head. My whole face was swollen. I was in a lot of pain. And they would not give me any pain medication because I have an opiate problem. Your arm has to be like ripped off before they'll give you a Tylenol."

- Megan

Assumptions about "med seeking" may result in lower quality of care and more rushed visits.

Biancarellia et al, 2019.
Slide: OHA HOPE Project

Factors that mitigate provider stigma

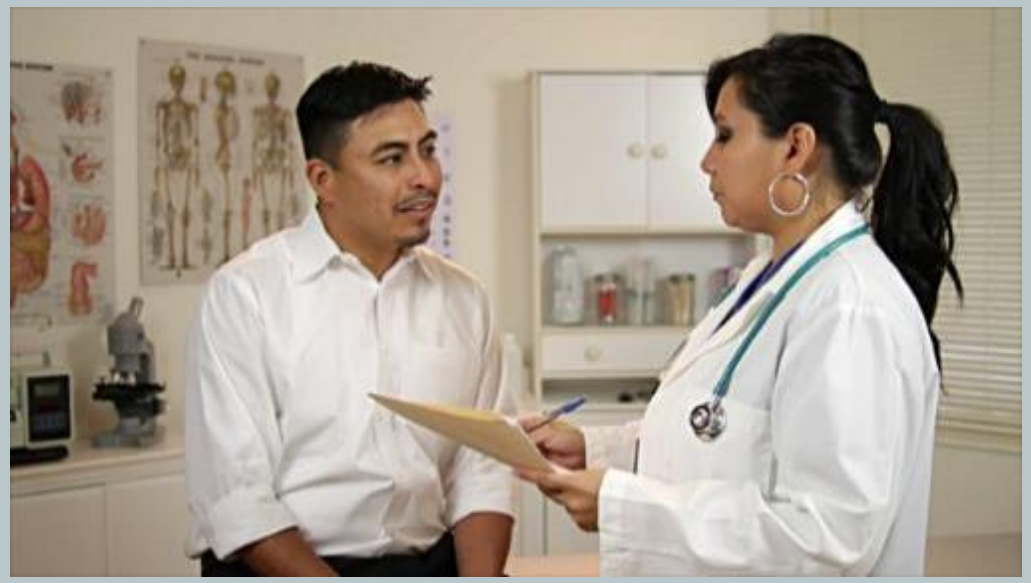
- Existing knowledge about SUDs
- Existing beliefs about attribution
- Personal experience working with PWIDs
- Training and education on attitudes and knowledge

Howard and Holmshaw, 2010. Ding et al., 2005; May et al., 2002. Slide: OHA HOPE Project

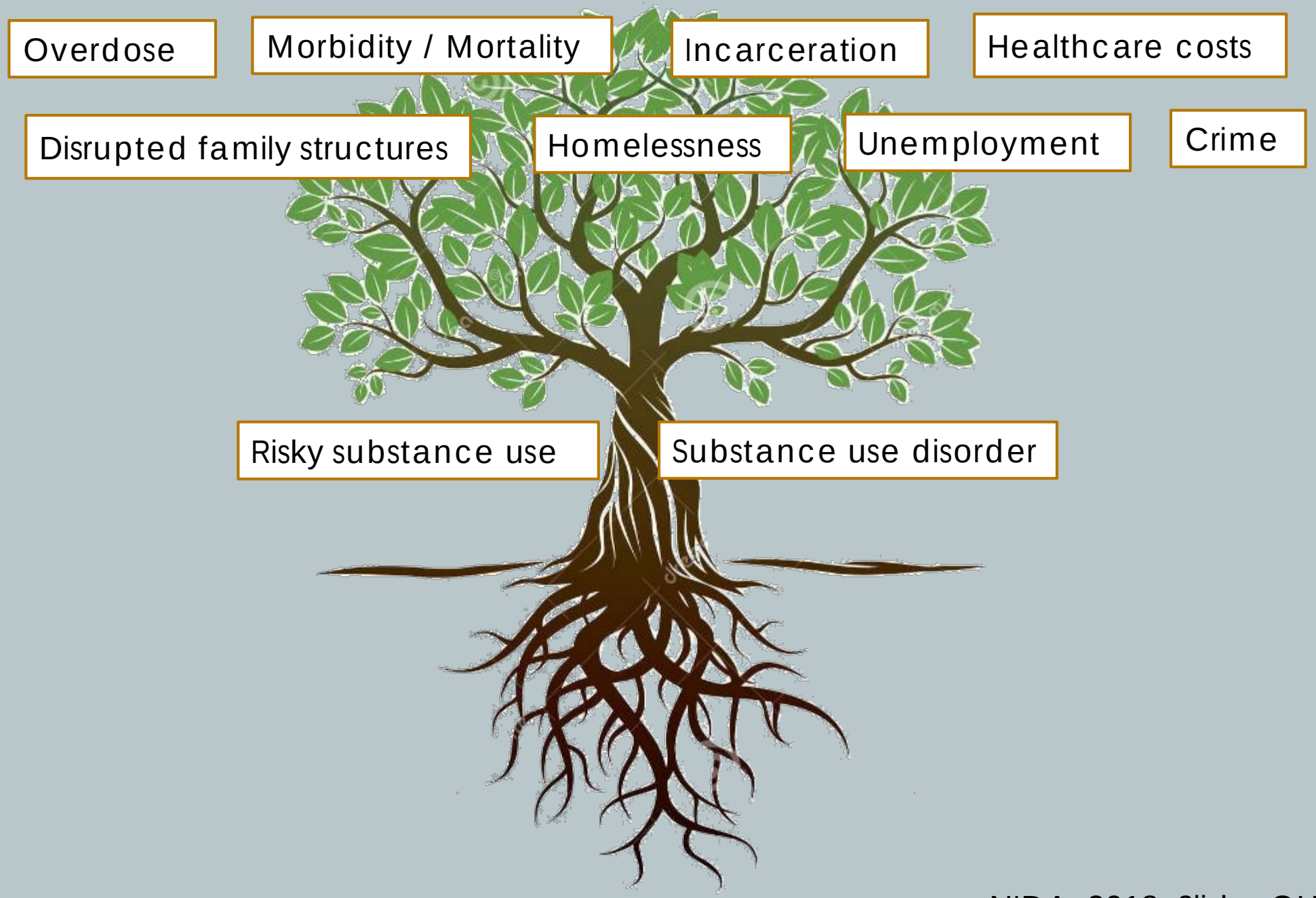
Roots of stigma: cause and control

Stigma associated with:

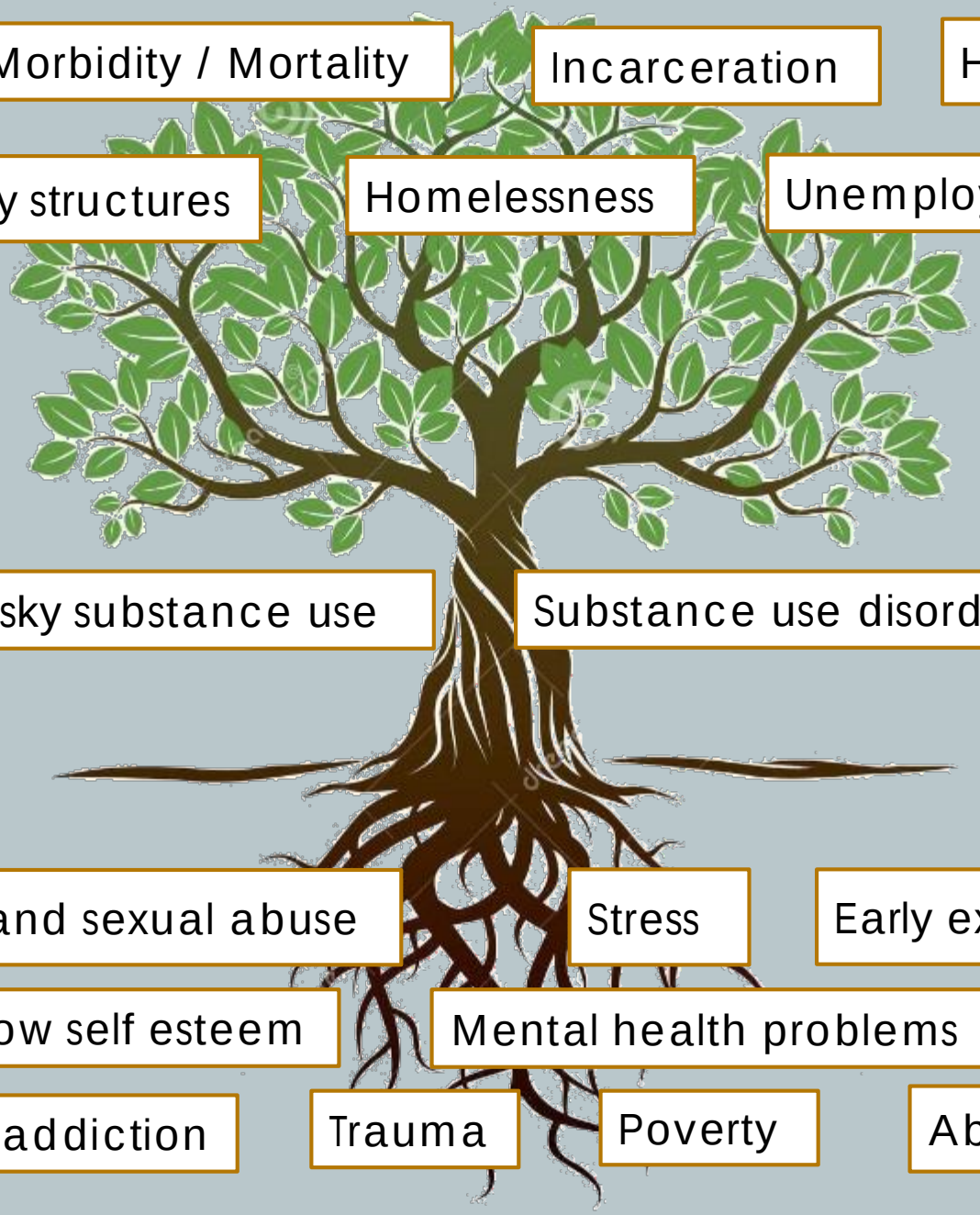
- The perception that an individual is responsible for **causing** their problem
- The perception that an individual is able to **control** their problem
- Using **language** that perpetuates stigma



Kelly et al, 2015. Slide: OHA HOPE Project



NIDA, 2018. Slide: OHA HOPE Project


Overdose
Morbidity / Mortality
Incarceration
Healthcare costs
Disrupted family structures
Homelessness
Unemployment
Crime
Risky substance use
Substance use disorder
Physical, emotional, and sexual abuse
Stress
Early exposure to substances
Genetics
Low self esteem
Mental health problems
Marginalized population
Family history of addiction
Trauma
Poverty
Absence of social support

NIDA, 2018.

Cause of OUDs: role of the drug industry

Original Investigation | Substance Use and Addiction

Association of Pharmaceutical Industry Marketing of Opioid Products With Mortality From Opioid-Related Overdoses

Scott E. Hadland, MD, MPH; MS, Ariadne Rivera-Aguirre, MPP; Brandon D. L. Marshall, PhD; Magdalena Cerdá, DrPH, MPH

Abstract

IMPORTANCE Prescription opioids are involved in 40% of all deaths from opioid overdose in the United States and are commonly the first opioids encountered by individuals with opioid use disorder. It is unclear whether the pharmaceutical industry marketing of opioids to physicians is associated with mortality from overdoses.

OBJECTIVE To identify the association between direct-to-physician marketing of opioid products by pharmaceutical companies and mortality from prescription opioid overdoses across US counties.

DESIGN, SETTING, AND PARTICIPANTS This population-based, county-level analysis of industry marketing information used data from the Centers for Medicare & Medicaid Services Open Payments database linked with data from the Centers for Disease Control and Prevention on opioid prescribing and mortality from overdoses. All US counties were included, with data on overdoses from August 1, 2014, to December 31, 2016, linked to marketing data from August 1, 2013, to December 31, 2015, using a 1-year lag. Statistical analyses were conducted between February 1 and June 1, 2018.

MAIN OUTCOMES AND MEASURES County-level mortality from prescription opioid overdoses, total cost of marketing of opioid products to physicians, number of marketing interactions, opioid prescribing rates, and sociodemographic factors.

RESULTS Between August 1, 2013, and December 31, 2015, there were 434 754 payments totaling $39.7 million in nonresearch-based opioid marketing distributed to 67 507 physicians across 2208 US counties. After adjustment for county-level sociodemographic factors, mortality from opioid overdoses increased with each 1-SD increase in marketing value in dollars per capita (adjusted relative risk, 1.09; 95% CI, 1.05-1.12), number of payments to physicians per capita (adjusted relative risk, 1.18; 95% CI, 1.14-1.21, and number of physicians receiving marketing per capita (adjusted relative risk, 1.12; 95% CI, 1.08-1.16). Opioid prescribing rates also increased with marketing and partially mediated the association between marketing and mortality.

CONCLUSIONS AND RELEVANCE In this study, across US counties, marketing of opioid products to physicians was associated with increased opioid prescribing and, subsequently, with elevated mortality from overdoses. Amid a national opioid overdose crisis, reexamining the influence of the pharmaceutical industry may be warranted.

JAMA Network Open. 2019;2(1):e186007

Corrected on March 22, 2019. doi:10.1001/jamanetworkopen.2018.6007

Key Points

Question To what extent is pharmaceutical industry marketing of opioids to physicians associated with subsequent mortality from prescription opioid overdoses?

Findings In this population-based, cross-sectional study, $39.7 million in opioid marketing was targeted to 67 507 physicians across 2208 US counties between August 1, 2013, and December 31, 2015. Increased county-level opioid marketing was associated with elevated overdose mortality 1 year later, an association mediated by opioid prescribing rates. per capita, the number of marketing interactions with physicians demonstrated a stronger association with mortality than the dollar value of marketing.

Meaning The potential role of pharmaceutical industry marketing in contributing to opioid prescribing and mortality from overdoses merits ongoing examination.

+ Invited Commentary

+ Supplemental content and Audio

Author affiliations and article information are listed at the end of this article.

JAMA:

- “The pharmaceutical industry invests tens of millions of dollars annually in direct-to-physician marketing of opioids.”
- “Marketing of opioid products to physicians was associated with increased opioid prescribing and, subsequently, with elevated mortality from overdoses.”

Hadland et al, 2019. Slide: OHA HOPE Project

Stigma and the perception of individual control

- SUDs reflect a person's "impaired ability to exert self-control. This impairment in self-control is the hallmark of addiction"
- People with SUDs often have to use just to feel 'normal'
- People with SUDs have difficulty controlling their need to use, despite the problems it causes for themselves and their loved ones.

National Institute of Drug Abuse, 2018. Slide: OHA HOPE Project

Surgeon Generals report

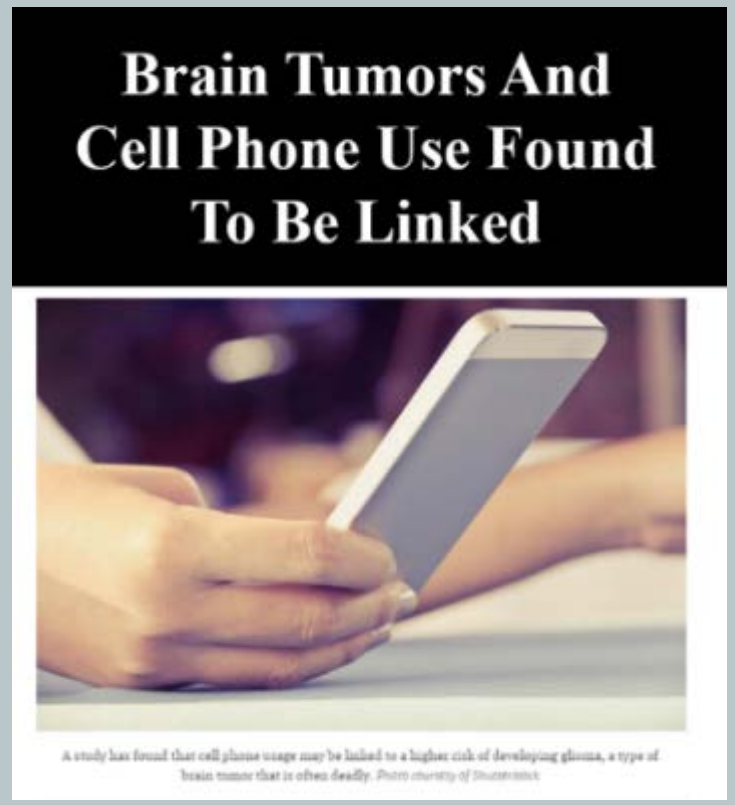
- Latest science defines SUDs as a chronic brain disease.
- “Brain imaging shows physical changes that are critical to judgment, decision-making, and behavior control”
- Changes in the brain persist long after substance use stops
- Influenced by genetic, developmental, behavioral, social, and environmental factors

Office of the Surgeon General, 2016.
Slide: OHA HOPE Project

How much do you control your own behavior?

Use of smartphones associated with:

- Reduced cognitive capacity
- Imbalance in the brain chemistry
- Lowered intelligence
- Insomnia
- Brain tumors



Ward et al, 2017. Hyung, 2017. Hardell and Carlberg, 2014.

Stages of change

- Patients typically move sequentially on their path to maintenance
- One session unlikely to immediately produce action
- Triggering events can set patient back to earlier stage

Stigma and the role of language

Research shows language can perpetuate or alleviate stigma

Characteristics of affirming language:

- Person-first
- Technical language with a single, clear meaning instead of colloquial definitions
- Non-sensational and non-fear-based

Kelly et al, 2015.
Slide: OHA HOPE Project

Examples

Outdated language	Person-first, affirming language
Injection Drug Users (IDU)	People who inject drugs (PWID)
Drug abuse, dependence, drug habit	Substance use disorder
Drug abuser, addict, alcoholic	Person with a substance use disorder
Clean and sober	Person in recovery
Dirty or clean needles	Used or new needles
Dirty or clean urine	Positive or negative urine drug screen
Medication-Assisted Treatment (MAT)	Medication for Opioid Use Disorder (MOUD)
High risk	Individuals at risk of acquiring HIV, Hep C, etc.

Office of National Drug Control Policy, 2017. Slide: OHA HOPE Project

Patient perspectives

"I go in to see my family doctor, when he comes through the door he's got a smile on his face 'How you doing [Bob]?'

You go in through the emergency, it's 'What's the problem?' it's not a person thing it's an object thing."

- Anonymous

PWIDs were more satisfied with visits during which they were treated as equals worthy of the same dignity as providers themselves.

Salvalaggio et al, 2013.

Slide: OHA HOPE Project

Patient perspectives

"I OD'd and I woke up 3 days later in intensive care . . . and one of the social workers there came through and asked the right questions and she got one of the [community health workers] . . .to come to see me 'cause I was suicidal, I wanted to check out. She came over 3 days in a row to see me and just she got me off [to treatment]. I spent three years out there, got my head back together, my life back together . . . but that was because I was being treated as an individual. And I felt cared for."

- Anonymous

A provider's commitment to rapport development can encourage PWIDs to commit to a long-term relationship and comply with recommendations

Salvalaggio et al, 2013.

Slide: OHA HOPE Project

Outline:

How harm reduction informs how we address SUDs in clinic settings:

- The role of stigma
- The HR philosophy

Implementing a HR-informed SBIRT model:

- Tailor the brief intervention
- Re-define referral to treatment

Harm reduction

- Both a philosophy and a series of interventions:

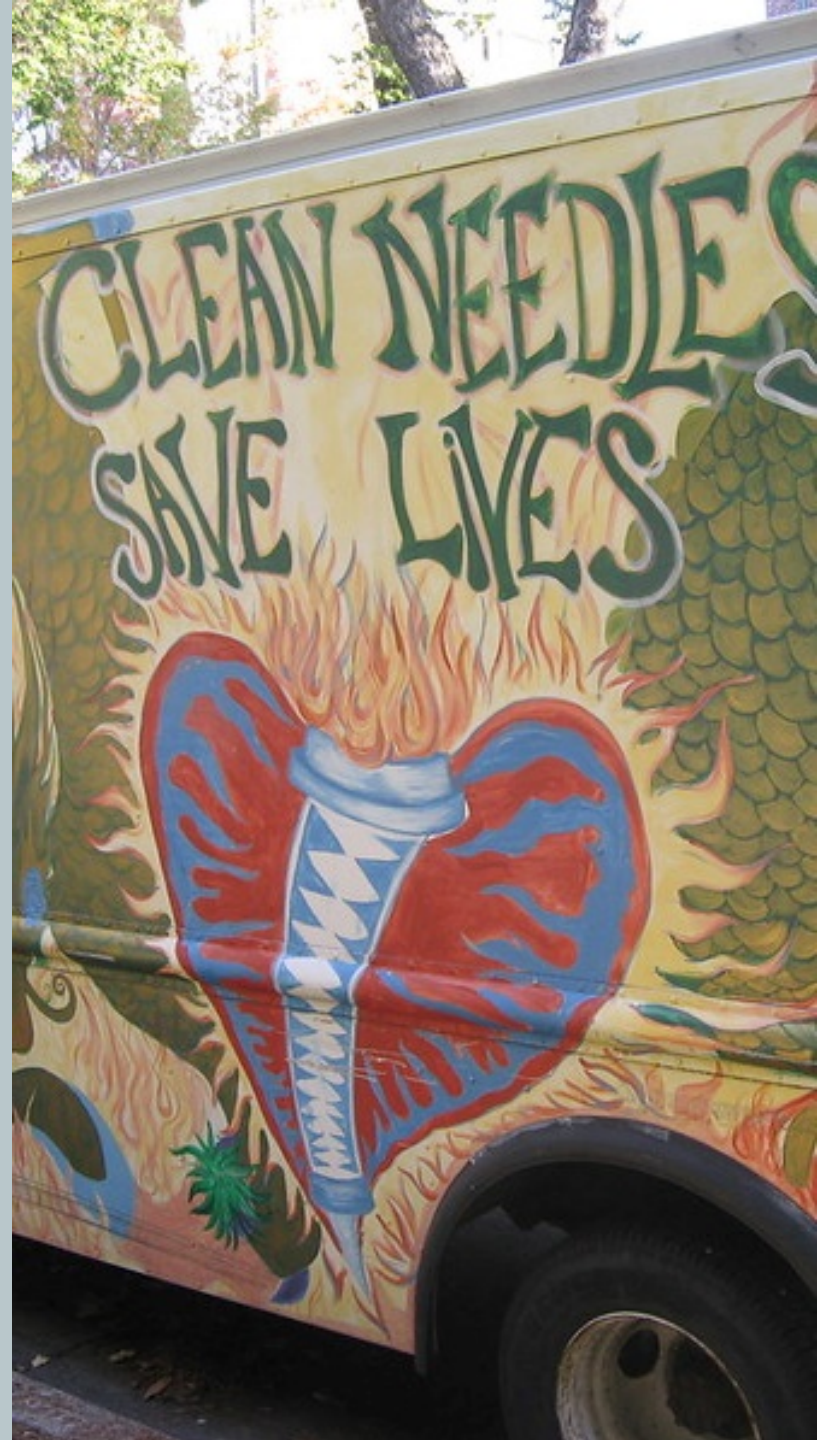
  "Aimed at reducing the negative effects without necessarily extinguishing the behavior."

- Rose in prominence in the 1970s and 1980s in response to Hep B and HIV
- Principles have been applied to other risk behaviors: sex work, IPV, eating disorders, tobacco use, etc.

Hawk et al, 2017. Slide: OHA HOPE Project

Harm reduction

- Applied on policy, population, community or individual levels
- Different than tolerating substance use. Instead: actively working with clients/pts
- More of an attitude than a fixed set of rules or approaches



Collins, et al, 2019. Collins et al, 2011.
Marlatt 1998. Slide: OHA HOPE Project

HR and substance use

- Abstinence is neither prioritized nor assumed to be the goal of the patient
- Result: HR broadens the spectrum of patients we can engage with and help
- “Meeting the patient where they’re at”

Hawk et al, 2017. OHA HOPE project

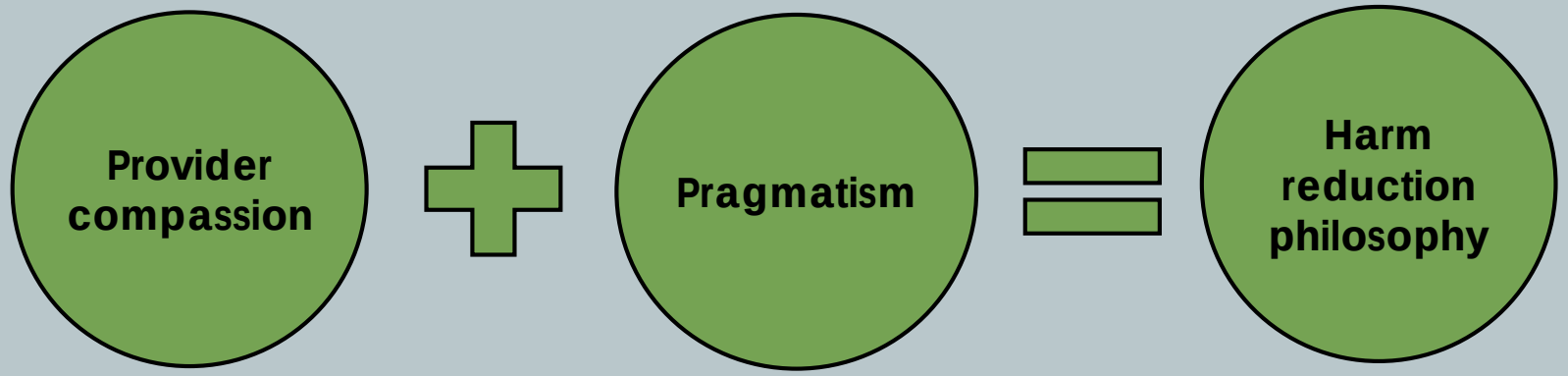
Some harm reduction beliefs

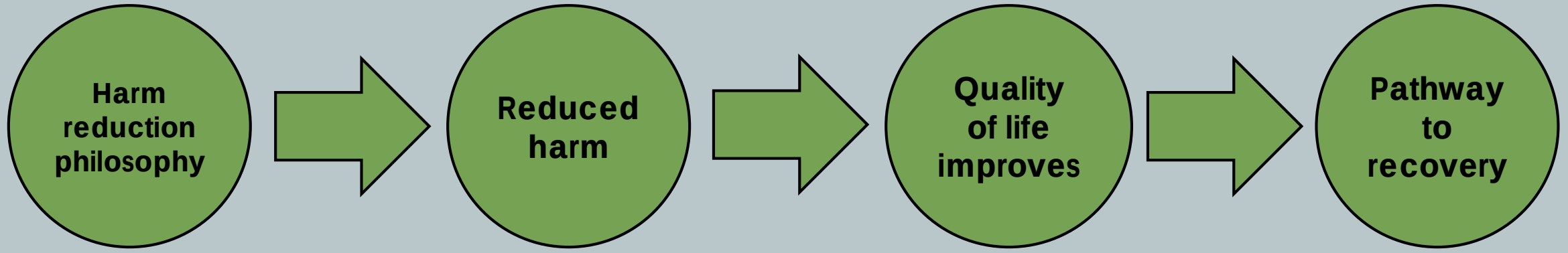
Substance use:

- Has pros and cons
- Is here to stay
- Is complex
- Exists in social context
- Is not the client

Slide: HaRRT Center

Harm Reduction theory and practice





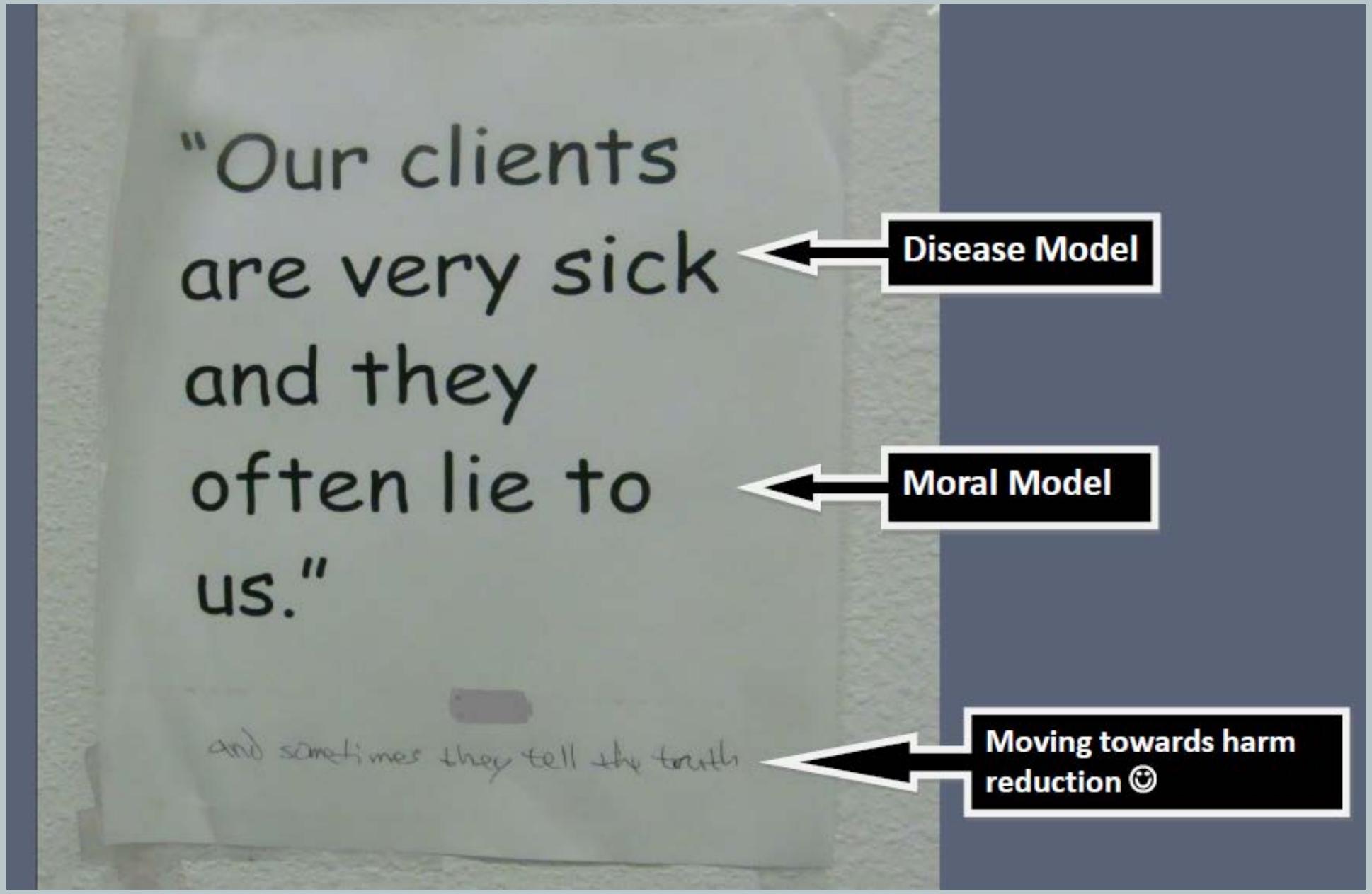
Slide: HaRRT Center

Different approaches with pts with SUDs

Traditional SBIRT	Harm reduction
Ultimate goal: abstinence	Goal: reducing harm
Perceives use and problems are in 1:1 agreement	Recognizes risk of problems is variable and individually based
Provider “prescribes” treatment	Provider offers science and knowledge to help patient assess their own risk of harm
Provider knows best	Patient knows better
Abstinence is the only, or best way forward	Keeping the pt alive and on a path towards reducing harm is the best way forward

More characteristics of a HR approach

- Respect for patient autonomy, goals, and values
- Accepting ambivalence
- Recognizing the patient is the expert
- Empathy, non-judgment, respect


"Our clients are very sick and they often lie to us."
and sometimes they tell the truth
Disease Model
Moral Model
Moving towards harm reduction ☺

Discussion

> “It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes.”

Does HR seem morally ambiguous?

Does HR fit into the medical model?

Hawk et al, 2017. Slide: OHA HOPE Project

Outline:

Describe how harm reduction informs how to address SUDs in clinic settings:

- The role of stigma
- The HR philosophy

Implementing a HR-informed SBIRT model:

- Tailor the brief intervention
- Re-define referral to treatment

Discussing substance use in primary care settings

- Clinicians typically have 15-minute visits
- Patients often present with multiple complaints, and often don't include substance use
- Behavioral health specialists may not be available
- Result: Clinicians may have 3-5 minutes to discuss substance use

Slide: SBIRT Oregon

Provider barriers to addressing substance use with primary care pts

- Lack of time/competing priorities
- Fear of opening “Pandora’s box”
- Inadequate training
- Lack of referral resources
- Lack of behavioral health providers
- Staff turnover

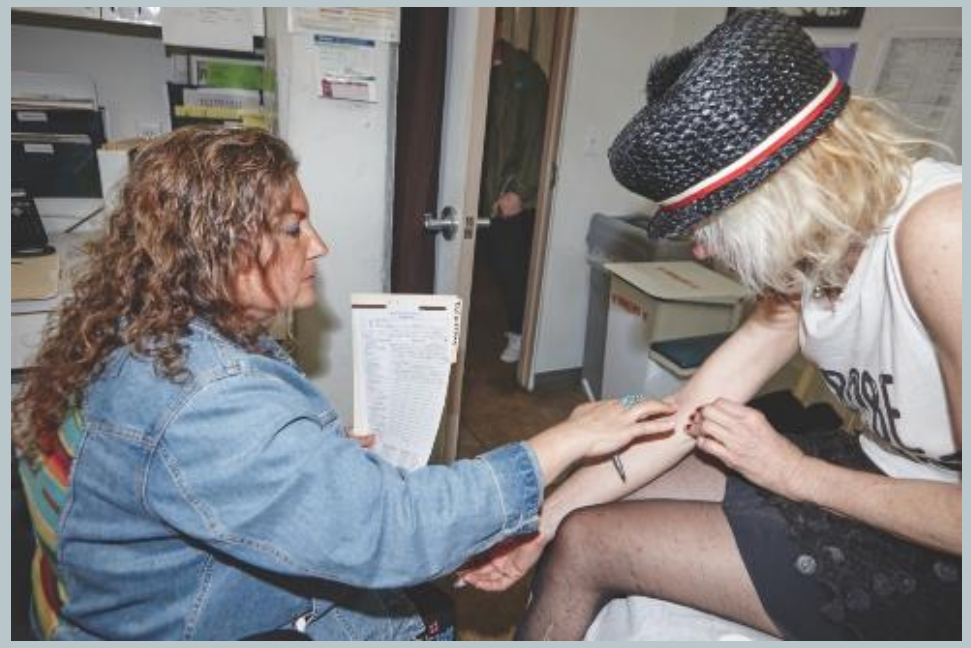
Vendetti et al 2017. Slide: SBIRT Oregon

Remedies to barriers

Barrier	Remedy
Lack of time/competing priorities	3-5 minute conversation can be effective
Fear of opening “Pandora’s box”	Pts with SUDs don’t want providers to solve their problems
Inadequate training	2-hour training can impact provider behavior
Lack of referral resources	Pts with SUDs not likely not ready to accept referrals
Lack of behavioral health providers	Using MI with PWIDs is an important provider skill
Staff turnover	Identify and use clinic champion

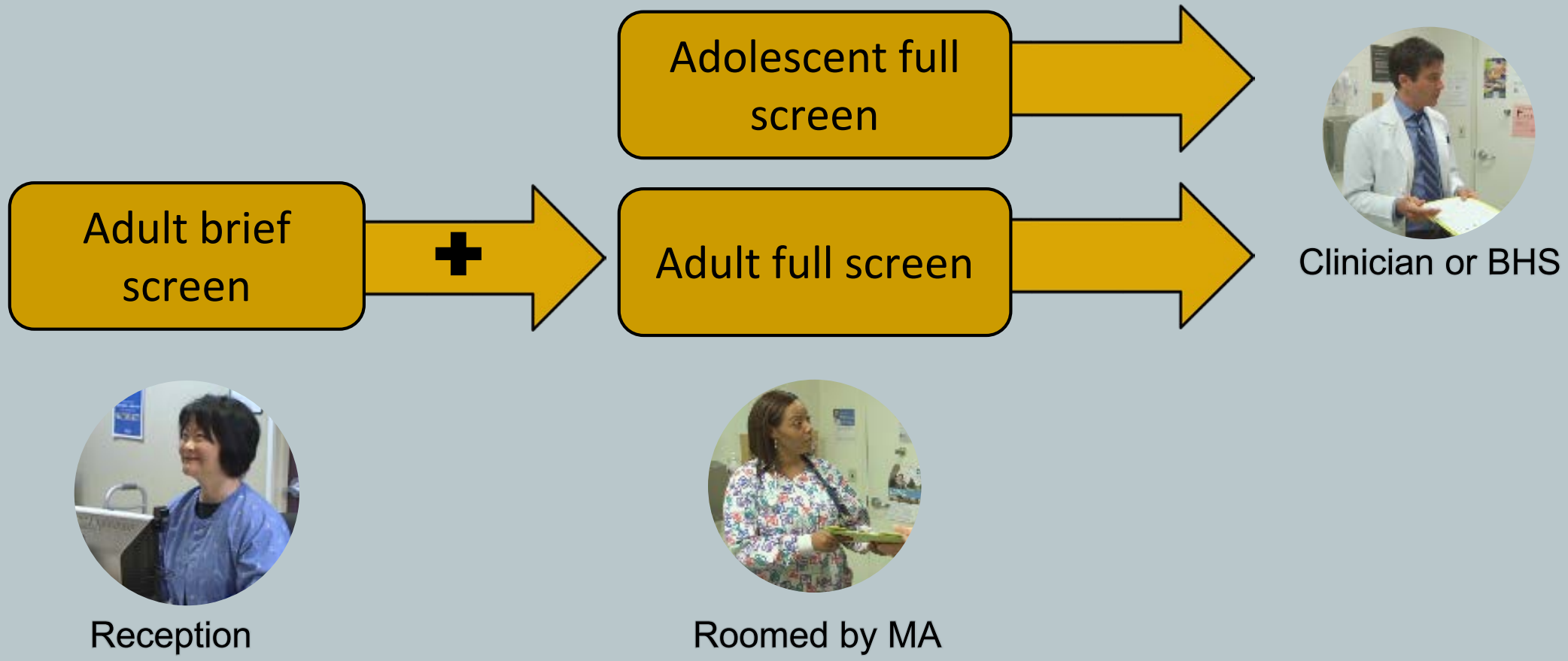
What primary care providers can do for pts with SUDs

- Screen for unhealthy substance use
- Treat complaints related to use
- Discuss reducing harm from use
- Offer medications for SUDs, PrEP, treat HIV, treat HCV
- Provide general care
- Help patients forge a path to recovery
- Enhance the pt's motivation to change behavior



Slide: OHA HOPE Project

Common SBIRT workflow in primary care



SBIRT:
Adult Brief Screen

One alcohol question ➔

One drug question ➔

Annual questionnaire
Once a year, all our patients are asked to complete this form because drug use, alcohol use, and mood can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

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

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

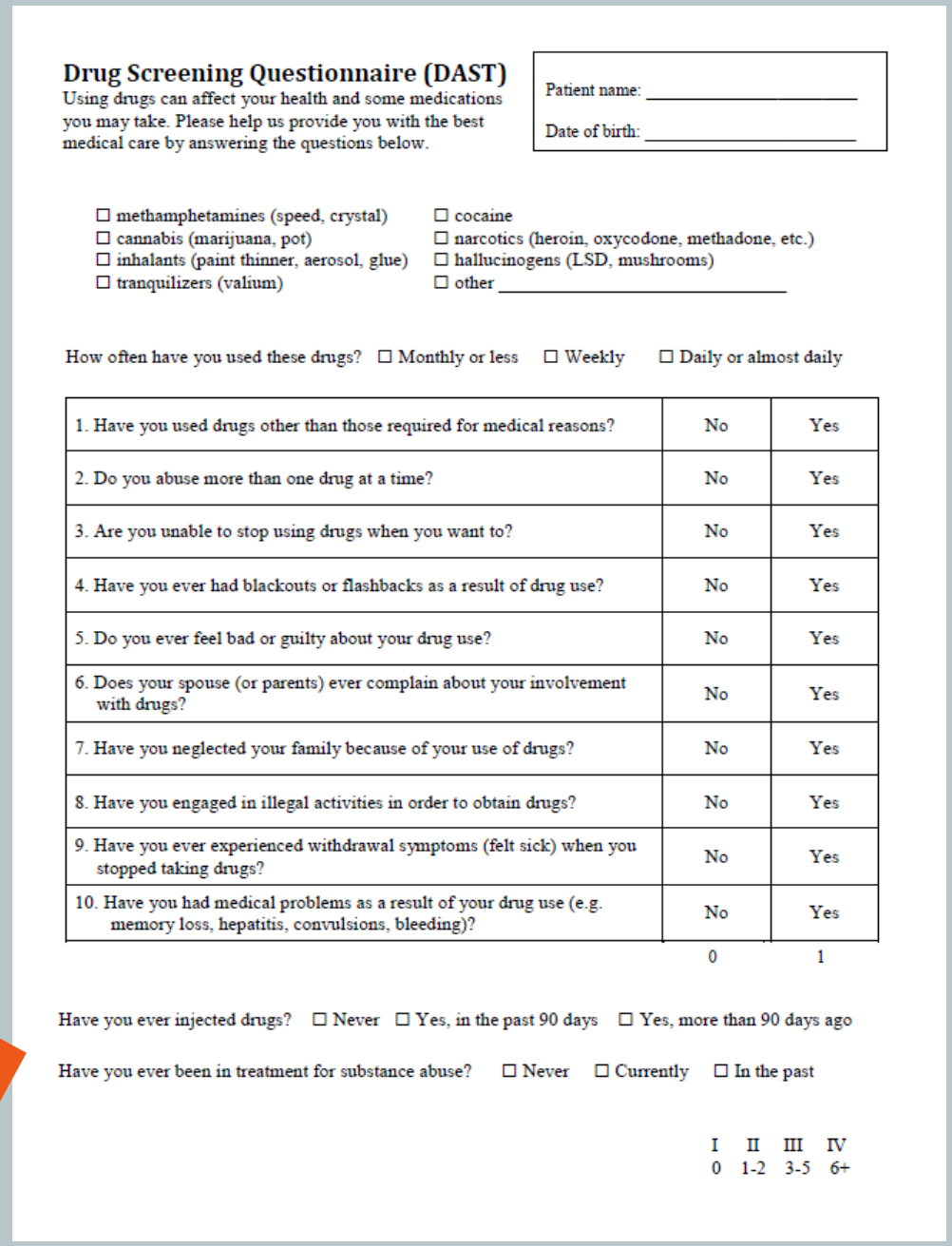
Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

SBIRT:
Full DAST Screen

- **D**rug **A**buse **S**creening **T**est
- DAST-10 version
- Validated for adults
- Cut-off score of 3 has high validity for consequences associated with drug use



Drug Screening Questionnaire (DAST)

Using drugs 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.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

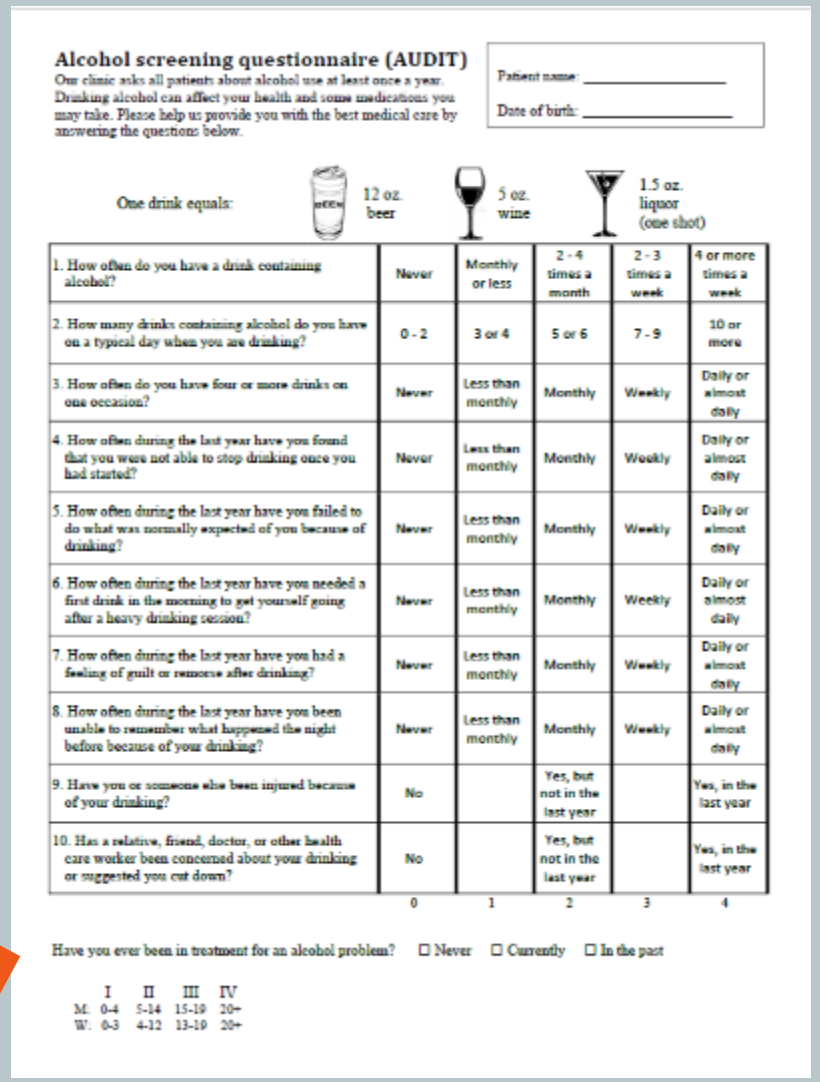
Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

SBIRT:
Full AUDIT Screen

- **A**lcohol **U**se **D**isorders **I**dentification **T**est
- Created by WHO, accurate across many cultures/nations
- 10 questions - multiple choice
- Addresses alcohol only



Alcohol screening questionnaire (AUDIT)

One 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.

Patient name: _____

Date of birth: _____

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 an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M.	0-4	5-14	15-19	20+
W.	0-3	4-12	13-19	20+

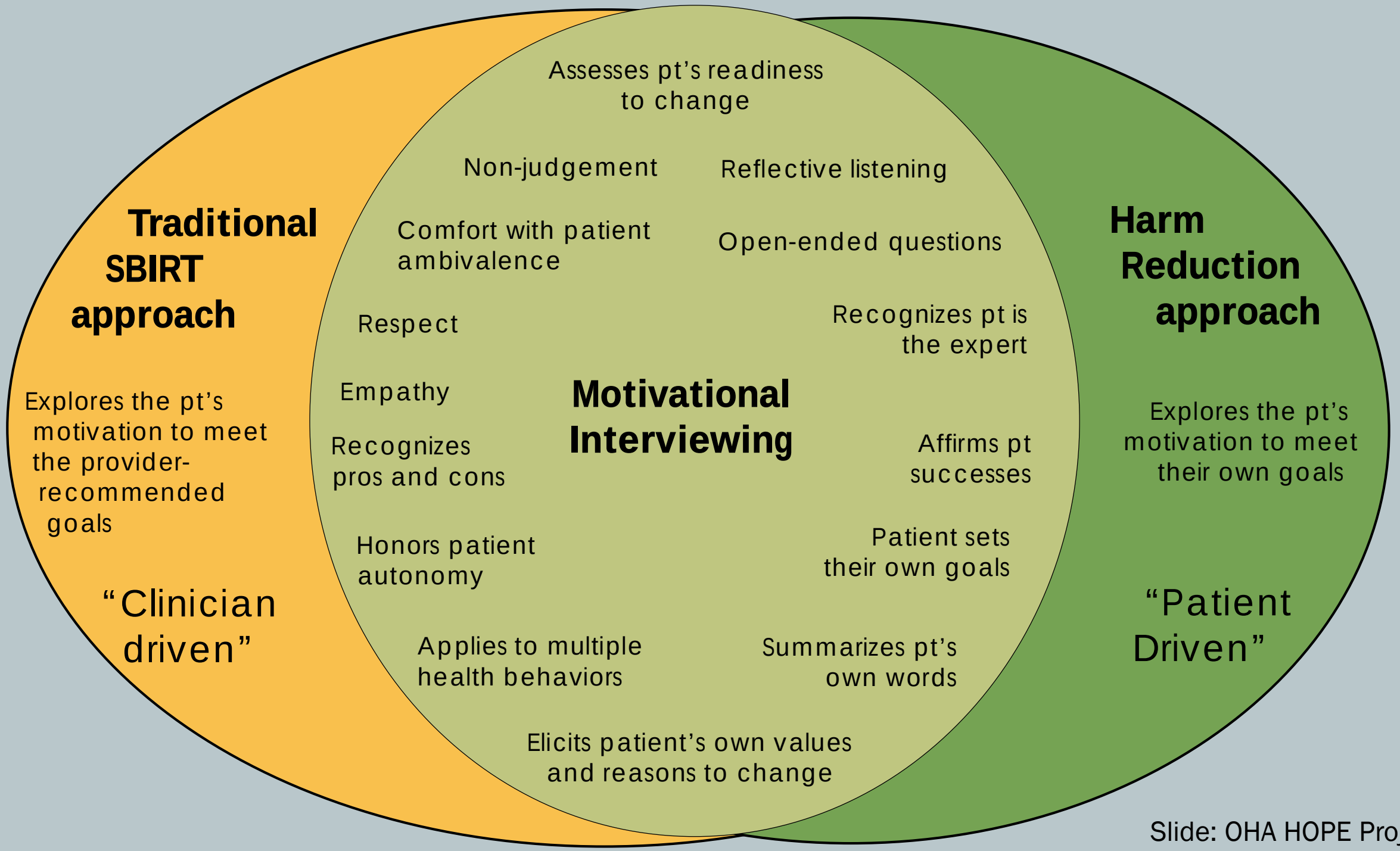
Traditional brief intervention: "Brief Negotiated Interview"

Raise subject

Provide feedback

Enhance motivation

Negotiate plan



Slide: OHA HOPE Project

HR-informed brief intervention

Raise subject

- Ask permission to discuss health behavior
- Be transparent about your role

Transparency example

Thank you for giving me permission to discuss your substance use with you. Just so you know, I will not ask or advise you to stop or cut down your substance use or change your use in any way you do not want to. Instead, my focus is to understand what **your** goals, intentions, or visions for your future are. I can help you assess the relative risks of your substance-use behavior so you can make your own informed decisions about your substance use. Ultimately, I want to help you improve your quality of life on your own terms and on your own timeline.

How does that sound to you?

HR-informed brief intervention

Raise subject

- Ask permission to discuss health behavior
- Be transparent about your role
- Elicit the pt's own description of their use, including perceived pros and cons

Eliciting the pt's own description of their use

"Tell me a little bit about your substance use"

- Info: what people are using, how, when, with whom, what effects it has, and how they feel about it.
- Elicit pros and cons: "I'm curious: what do you like about your use? What worries you about your use?

Traditional brief intervention: “Brief Negotiated Interview”

Raise subject

Provide feedback

Traditional brief intervention: “Brief Negotiated Interview”

Raise subject

Share information

HR-informed brief intervention

Share information

- Explain any connection between risk behavior and health complaint
- Share information about of risks of use, low-risk limits. Ok to express concern
- Ask the pt what they think of the information
- ~~Give recommendation or advice~~

Pitfalls of giving advice

- Patients with SUDs already feel trapped – they want options
- Traditional SBIRT only offers two: reduce use or abstain
- Giving advice or recommendation implies judgement, risks furthering stigma
- A HR approach expands the number of options a patient my choose from

Does not giving advice conflict with funders?

BRIEF INTERVENTIONS

SBIRT: Brief Intervention

Brief interventions are evidence-based practices design to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.

In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two.

Does not giving advice conflict with reimbursement?

Service	Payer	Code	Description
Full screen + brief intervention	Med & Com.	CPT 99408	• 15-30 minutes spent administrating and interpreting a full screen, plus performing a brief intervention.
	Medicare	G0396	
	Med & Com.	CPT 99409	• Same as above, only ≥ 30 minutes.
	Medicare	G0397	

- Codes above should be appended to E/M service with modifier 25
- ICD-10 diagnosis codes are poorly suited for most SBIRT patient scenarios and can break confidentiality with adolescent patients. Two options:
  - Z13.89: “Encounter for screening for other disorder”
  - Z13.9: “Encounter for screening, unspecified”

Possible documentation

The patient completed a AUDIT screening tool and the total score suggests an increased risk of health related problems related to substance use. In discussing this issue, the pt disclosed that they drink approximately 20 drinks per week. **I shared the low-risk guidelines** of no more than 4 drinks in one session and no more than 14 drinks per week.

The patient's readiness to change was 3 on a scale of 0 – 10. We explored why it was not a lower number and discussed the own patient's motivation for change. The patient identified a plan of counting his drinks and not keeping alcohol at home. Total time administering the screening tool, plus delivering a face-to-face brief intervention with the patient was greater than 15 minutes

Traditional brief intervention: “Brief Negotiated Interview”

Raise subject

Share information

Enhance motivation

HR-informed brief intervention

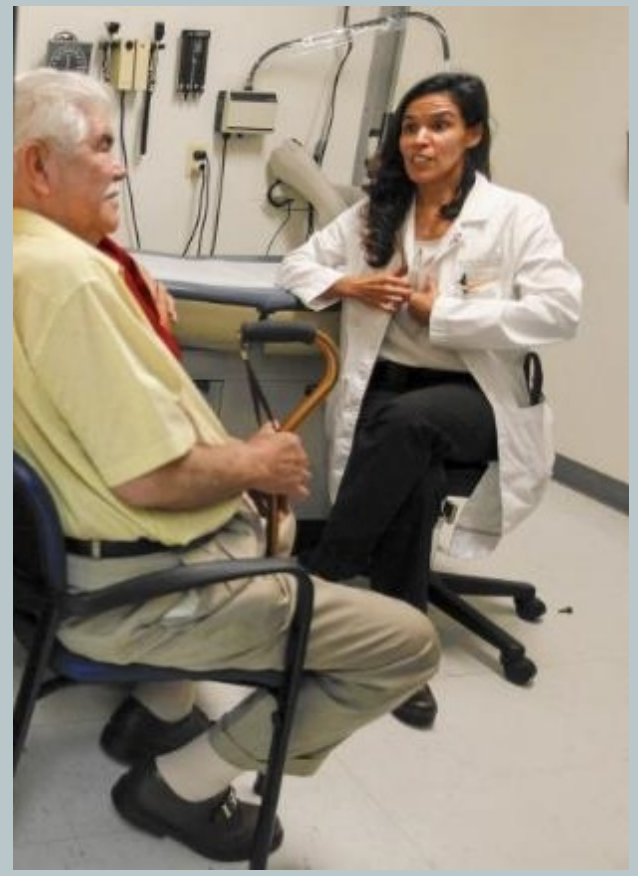
Enhance motivation

- Summarize pt's opinion, perceived pros and cons of use
- Ask what the pt wants to change, if anything.

Replace advice with an open-ended question

Questions that elicit pt's own goals:

- Over the next few (weeks, months) what would you like to see happen for yourself?
- What would you like to do about your use?
- Is there anything you'd like to change about your drinking/drug use?
- Where would you like to go with your drinking/drug use?



Examples of pt-driven HR goals

For PWIDs:

- Inject more safely
- Minimize sharing works or needles
- Carry Naloxone
- Use less
- Accept MOUD or other treatment
- Learn abscess care
- Get more regular medical care and/or mental health care

Example: relative-risk hierarchy of injection sites

Goal: reduce risk of returning to the hospital

Upper arm	Lower arm	Hands	Feet	Legs	Groin	Neck
• Safest • Closer to heart		• Harder to spot • Use small needle gauge	• Slower healing • You need them!	• Greater risk of clots • Hit downstream	• Harder to "hit blind" • Can puncture femoral artery/nerve	• Risk of hitting carotid artery makes this a last resort • Could cause death

Slide from: HaRRT Center

Survey of Infectious Disease physicians:

N = 672

	Comfortable / Very comfortable	Neutral	Uncomfortable / Very uncomfortable	Not sure
"How comfortable are you assessing patient injection practices and offering counseling regarding safe practices to offset infection risk?"	**43%**	**27%**	**23%**	**7%**

	Yes	No
"Have you ever prescribed naloxone for opioid overdose reversal?"	**22%**	**78%**

Rapoport et al, 2018.
Slide: OHA HOPE Project

Examples of pt-driven HR goals

For pts with AUDs:

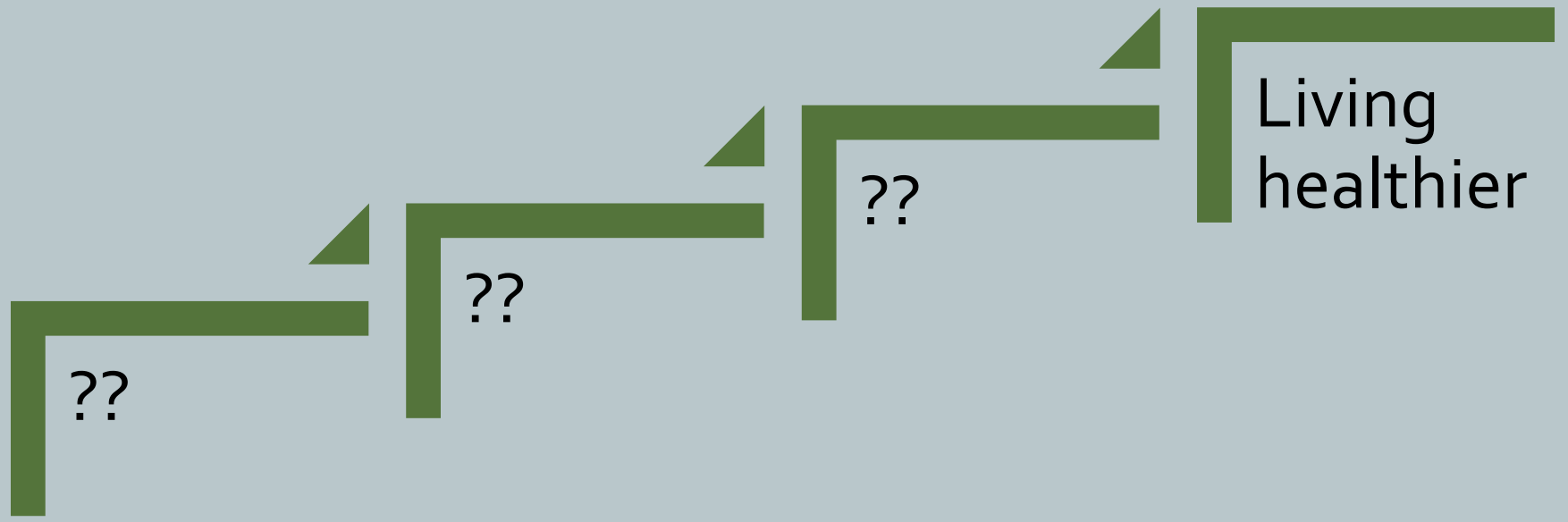
- Count your drinks
- Eat before you start drinking, and during
- Avoid non-beverage alcohol
- Space your drinks
- Accepting meds for AUD or other treatment
- Avoid mixing drugs with alcohol
- Drink in a safe place
- Choose periodic abstinence
- Choose lower-alcohol content beverages

Goals are more achievable when they are:

- Well defined
- Focused on reducing harm or quality of life
- Doable in a timeframe
- Patient-driven

Helping pts with abstract, or large goals

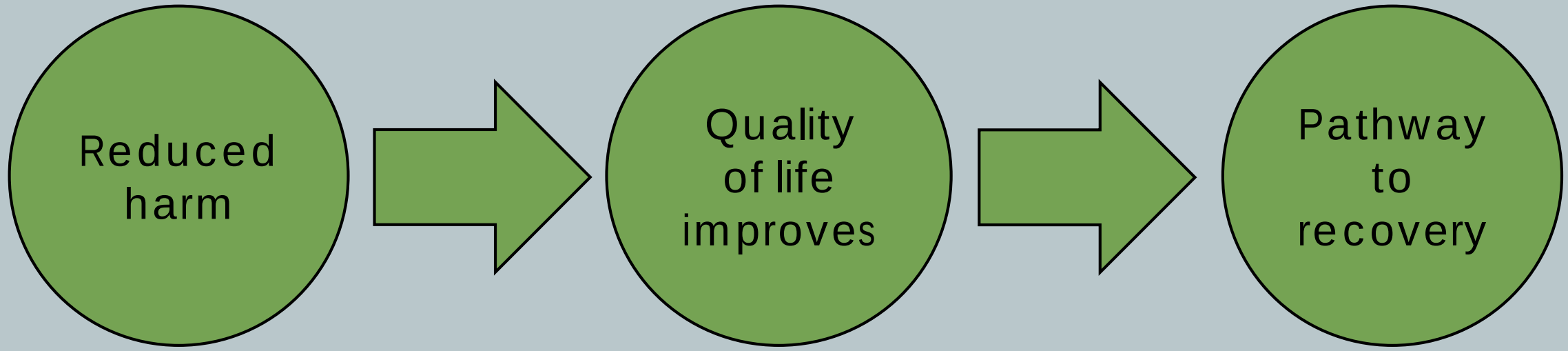
Patient: "I want to live healthier."



Clinician: "That's a great goal. It's also a big goal. So, let's put that up here on the top step. What could be the first step towards living healthier?"

Slide: HaRRT Center

Remember:



HR-informed brief intervention

Enhance motivation

- Ask and summarize pt's perceived pros and cons of use
- Elicit a goal
- Use the Readiness Ruler (0 – 10 scale) "Why not a lower number?"

Traps to avoid when discussing behavior change

- Explaining why the patient should change
- Telling the patient how to change
- Repeatedly emphasizing the importance of changing
- Reacting to ambivalence with persuasion

Slide: SBIRT Oregon

Common patient reactions to the directive style

Angry	Afraid
Agitated	Helpless, overwhelmed
Oppositional	Ashamed
Discounting	Trapped
Defensive	Disengaged
Justifying	Not come back – avoid
Not understood	Uncomfortable
Procrastinate	Not heard

Rollnick and Miller, 2008 Slide: SBIRT Oregon

Traditional brief intervention: “Brief Negotiated Interview”

Raise subject

Share information

Enhance motivation

Negotiate plan

Traditional brief intervention: “Brief Negotiated Interview”

Raise subject

Share information

Enhance motivation

Identify plan

HR-informed brief intervention

Identify plan

- If patient sounds ready, ask: “What would carrying out a plan of change look like for you?”
- Affirm pt’s readiness to change
- Ask to schedule follow-up

Follow up

A continuing cycle of:

- Collaborative tracking of patient-selected metrics
- Eliciting pt-driven harm reduction goals
- Discussing safer-use strategies

HaRRT Center. Image: WASBIRT

A HR-informed brief intervention

Raise subject	Ask permission to discuss use. Be transparent about your role. Elicit the pt's own description of their use, including perceived pros and cons.
Share information	Explain any connection between use and health complaint. Share information about of risks of use, low-risk limits. Ok to express concern. Ask the pt what they think of the information.
Enhance motivation	Summarize pt's perceived pros and cons of use. Ask what the pt wants to change. Use the Readiness Ruler (0 – 10 scale) Ask, "why not a lower number?"
Identify plan	If patient sounds ready, ask: "What would carrying out a plan of change look like for you?" Affirm pt's readiness to change and their plan. Ask to schedule follow-up

HR philosophy:

Defer to the patient's wisdom

The more responsibility, autonomy and respect people feel they have, the more they will step up and forge their own pathway to recovery.

Slide from: HaRRT Center

OARS skills: HR approved!

- **O**pen-ended questions
- **A**ffirmations
- **R**eflective listening
- **S**ummaries

OARS Example

Clinician What brings you here today? **[open-ended question]**

Patient Well, I don't really know. I guess I want to try to do something different with my drinking.

Clinician You are interested in making a change in your drinking, but you are unsure what that would look like. **[simple reflection]**

Patient Yeah, it's just I have been drinking for so long, I am not sure whether I can really make a change. It's really hard to imagine doing things differently at this point. I also really like drinking to help me wind down. Drinking makes me feel good—so much more relaxed. But I don't want to go out of this place in a body bag.

Clinician You know your drinking is harming you, but it's hard to know where to start. **[complex reflection]**

Patient I am worried about my health. I am also worried about my relationship with my girlfriend. We get into fights when we have been drinking too much. I don't want to hurt her. Sometimes I wake up and I am not sure what I did the night before. I want to maybe get a little more control over it.

Clinician You have a lot of good things in your life that are important to you—your girlfriend, your health--and you want to protect those. You don't want your drinking to threaten those. That said, you are a little unsure exactly what kinds of changes you want to make. Feeling more in control of your drinking is one option you have considered. Does that sound about right? **[summary]**

Slide from: HaRRT Center

Outline:

How harm reduction informs how we address SUDs in clinic settings:

- The role of stigma
- The HR philosophy

Implementing a HR-informed SBIRT model:

- Tailor the brief intervention
- Re-define referral to treatment

Traditional referral to treatment

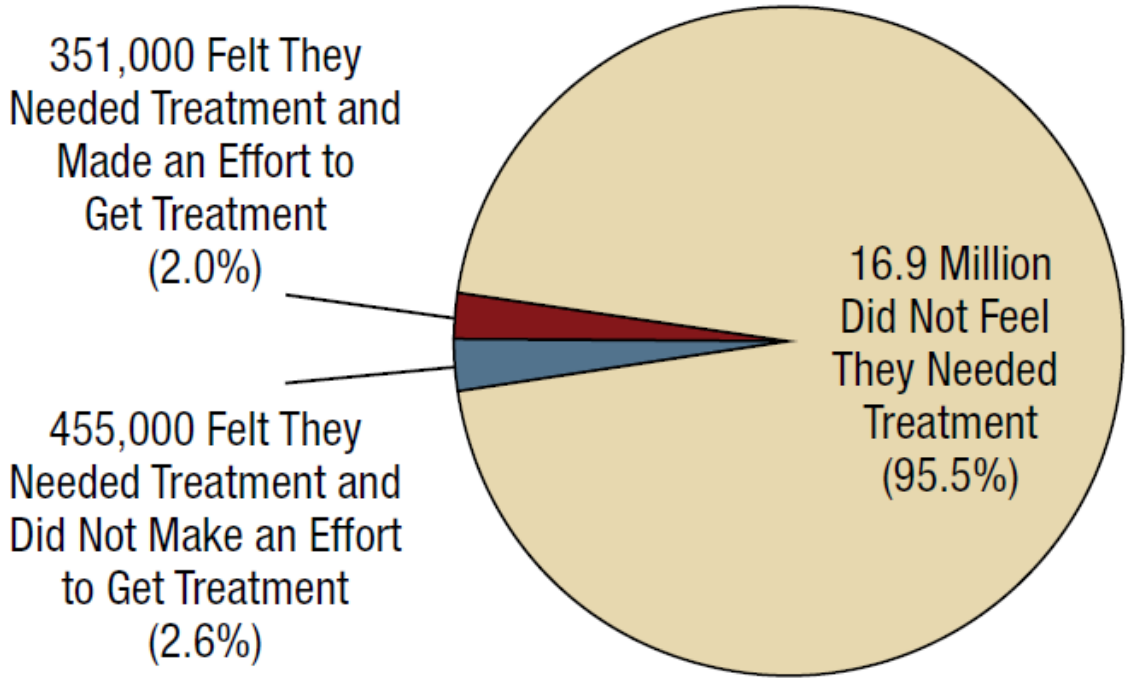
Delivered through the brief intervention – good!

But, the referral comes from the clinician – not HR-informed.

Patient-centered is not the same as patient-driven

Traditional RT remains clinician-driven

Figure 14. Perceived Need for Substance Use Treatment among Adults Aged 18 or Older Who Needed but Did Not Receive Substance Use Treatment in the Past Year: 2016



17.7 Million Adults Needed but Did Not Receive Substance Use Treatment

Note: The percentages do not add to 100 percent due to rounding.

Most people with SUDs do not believe they need treatment!

Park-Lee et al, 2017.

More reasons pts with SUDs may not accept treatment

Want to keep use hidden from partner

Privacy concerns

Excessive paperwork

Fear of losing job while in treatment

Long waiting lists

Language barriers

Costs

Fear stigma from society, friends and loved ones

Fear of withdrawal

Fear of relapse

Treatment not available

Lack of child care

Lack of transportation

Instable housing

The pros of use outweigh the cons

Not ready to quit

Time conflicts

HEDIS measure: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment:* Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis.
- *Engagement of AOD Treatment:* Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.

Consider replacing the RT with continued follow up, management, etc.

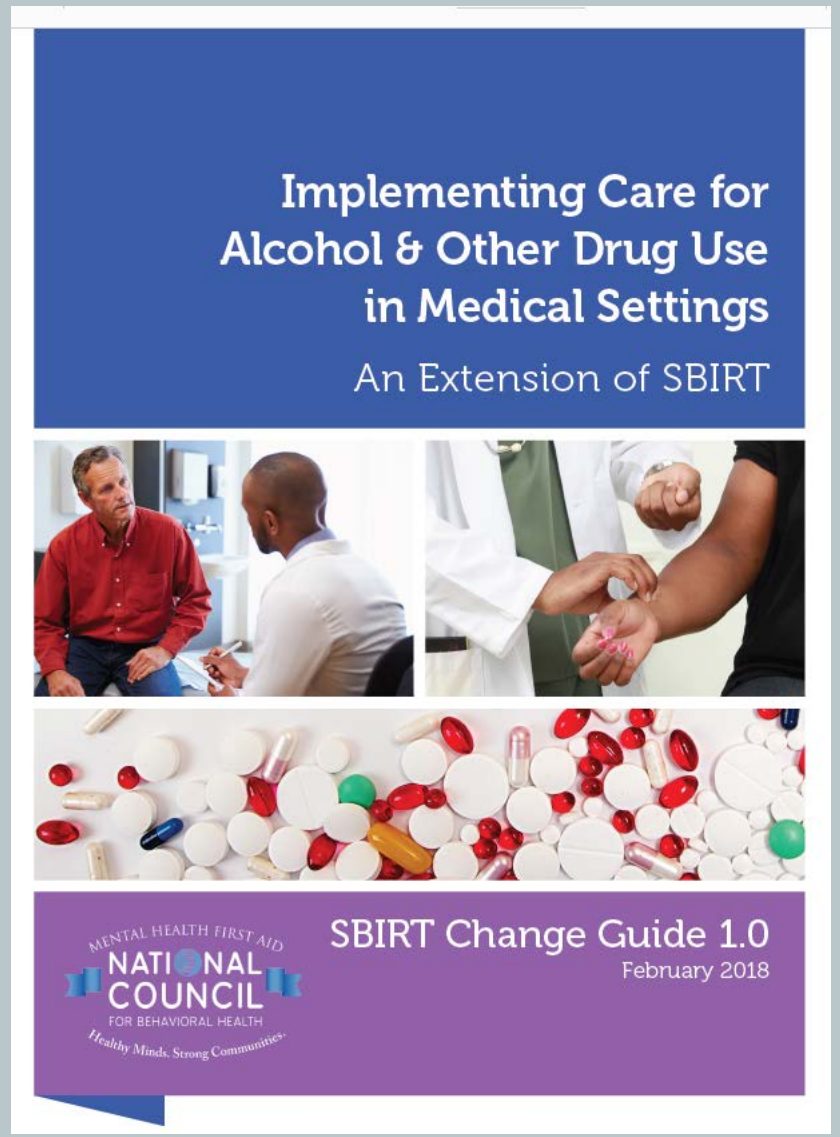
A continuing cycle of:

- Collaborative tracking of patient-selected metrics
- Eliciting pt-driven harm reduction goals
- Discussing safer-use strategies

HaRRT Center. Image: WASBIRT

Example of RT reform:

- SBIRT Change Guide renames RT "Management of SUDs"
- Defined as "offering patients shared decision-making about five types of options":
  - Medications for SUDs, one-on-one therapy, peer support groups, group-based treatment, 'possible self-management' with monitoring and support
- Proposes metric of a follow up visit within 90 days



National Council for Behavioral Health

Takeaways

We can use SBIRT to help pts with SUDs by:

- Being mindful of stigma
- Adopting a HR philosophy
- Use a HR-informed brief intervention
- Replace the RT with ongoing support and follow up

Thanks!

Questions or comments?

Jim Winkle
jimwinkle@gmail.com

SBIRT OREGON

T-shirt for sale
Iowa Harm Reduction Coalition