SBIRT with Adolescent Patients

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SBIRT OREGON

Last updated: August, 2021
Outline

I. Why SBIRT?
   - Categories of use
   - Prevalence and morbidity
   - Relevance to medical care

II. Screening
   - Brief screen, AUDIT, DAST, CRAFFT, 5Ps

III. Reimbursement and EHR tools

IV. Brief intervention
   - Styles of communication
   - Brief intervention model
   - Role play practice

V. Referral to treatment
   - Harm Reduction
   - Treatment
Website: sbirtoregon.org

- Demonstration videos
- Screening forms
- Reimbursement information
- Pocket cards and tools
- Training curriculum
- Screening app
SBIRT

“A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders.”
I. Why SBIRT?
# SBIRT vs. business as usual

<table>
<thead>
<tr>
<th>SBIRT implemented</th>
<th>No SBIRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine and universal screening, regardless of medical complaint</td>
<td>Inconsistent, selective screening</td>
</tr>
<tr>
<td>Validated screening tools</td>
<td>Non-systemized narrative questions</td>
</tr>
<tr>
<td>Substance use defined as a continuum</td>
<td>Substance use defined as dichotomous</td>
</tr>
<tr>
<td>Interventions: evidence-based, patient-driven discussion</td>
<td>Ineffective, directive, or no discussion</td>
</tr>
<tr>
<td>Recognizes patient is more than their substance use</td>
<td>Patient is defined by their use</td>
</tr>
</tbody>
</table>
Relevance to medical settings

- Significant prevalence of unhealthy substance use among pts
- Substantial associated morbidity, mortality, and health care cost
- Valid screening instruments
- Interventions are effective, inexpensive, and feasible
Zones of use for adolescents

- Low risk: No use
- Risky: Use without current consequences
- Disorder: Ongoing use despite consequences
Low-risk alcohol limit for adolescents: 0

• Even first use can result in tragic consequences.
• Adolescence is a period of neurodevelopmental vulnerability
• Earlier use increases chance of later addiction.

AAP, 2016
“Abuse”, “dependence” or “alcoholism” are terms no longer used

Official term: Substance Use Disorder

Criteria: 11 consequences experienced in last 12 months

- 2 - 3 symptoms: mild
- 4 - 5 symptoms: moderate
- 6+ symptoms: severe

American Psychiatric Association, 2013
11 criteria that define SUDs

1. Taking the substance in larger amounts or for longer than you’re meant to.

2. Wanting to cut down or stop using the substance but not managing to.

3. Spending a lot of time getting, using, or recovering from use of the substance.

4. Cravings and urges to use the substance.

5. Not managing to do what you should at work, home, or school because of substance use.

6. Continuing to use, even when it causes problems in relationships.

7. Giving up important social, occupational, or recreational activities because of substance use.

8. Using substances again and again, even when it puts you in danger.

9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.

10. Needing more of the substance to get the effect you want (tolerance).

11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

American Psychiatric Association, 2013
Reasons teens use alcohol and drugs

• Desire for new experiences
• An escape from problems
• Desire to perform better in school
• Peer pressure
• To feel good
The adolescent brain

- Limbic system: responsive to rewards, and the first to mature during childhood.
- Prefrontal cortex: assesses situations, makes sound decisions, controls emotions and impulses
- Risk taking behaviors help develop independence from family

Negative outcomes associated with adolescent substance use

- Inhibits brain development
- Depressed cognitive functioning
- STDs, unplanned pregnancy
- Physical and sexual assaults
- Arrests & incarceration
- Psychiatric disorders
- Premature death
- Alcohol poisoning
- Addiction

Ryan and Kokotailo, 2019. Gray and Squeglia, 2018
Correlations of heavy cannabis use during adolescence

- Reduced memory, attention and learning abilities
- Poorer school performance
- Greater risk of addiction (1 out of 6)
- Increased risk of psychosis or schizophrenia
- Increased risk of criminal behavior
- Increased risk of car accidents

U. of Washington, 2020
Leading causes of adolescent death

- Alcohol major contributor to 74% of premature death among adolescents
Past year alcohol, tobacco, and marijuana use among U.S. adolescents, 2017

- Alcohol
- Marijuana
- Tobacco products

Age 12 – 13
Age 14 – 15
Age 16 – 17

SAMHSA
Past year illicit drug use among U.S. adolescents, 2017

SAMHSA

%
Risk factors for problem substance use among adolescents

- Presence of mental health disorders:
  - Depression, anxiety, bipolar, schizophrenia
- Living in the U.S. as a person of color
- Genetic predisposition
- Personality traits
- Influence of family and peers
### Study: clinical impressions have poor validity towards detecting teen substance use

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity (CI)</th>
<th>Specificity (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any use</strong></td>
<td>.63 (.58-.69)</td>
<td>.81 (.76-.85)</td>
</tr>
<tr>
<td><strong>Any problem</strong></td>
<td>.14 (.10-.20)</td>
<td>1.0 (.99-1.0)</td>
</tr>
<tr>
<td><strong>Any disorder</strong></td>
<td>.10 (.04-.17)</td>
<td>1.0 (.99-1.0)</td>
</tr>
<tr>
<td><strong>Dependence</strong></td>
<td>0.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Wilson et al., 2004
Adolescence is a critical time for preventing addiction

% of treatment admission, ages 18 - 30

SAMHSA 2011
Percent experiencing dependence in lifetime, based on age of first use, U.S.

Hingson et al 2006, SAMHSA 2010
Missed opportunities with adolescent pts

Survey of 363 U.S. pediatricians:

- 88% screen annually for substance use
- 26% use validated screening tools
- 40% perform BIs using motivational interviewing

Hammond et al 2021
Barriers to performing SBIRT with adolescents

Survey of 75 PCPs:

• Limited time
• Sensitivities of addressing substance use
• Lack of training
• Concerns about effectiveness of brief interventions
• Perceived barriers to patient accepting treatment.
<table>
<thead>
<tr>
<th></th>
<th><strong>SBI</strong> for reduced use, abstention</th>
<th><strong>SBI + RT</strong> for receipt of specialty treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td>Insufficient evidence (USPSTF, 2018)</td>
<td>?</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td>Moderate evidence for <strong>null</strong> effect (USPSTF, 2020)</td>
<td>?</td>
</tr>
</tbody>
</table>
II. Screening
Common workflow in primary care

Exam room

Screening

Medical Assistant

Response

Clinician
Screening in the ED

- Ideally delivered by behavioral health specialist
- When there’s a “break in the action” - waiting for x-rays, labs or ready for discharge
- Best case scenario: warm introduction to BHS
- Adolescent pts may be more receptive to BHS and answer more honestly than in triage
Two options for administering a screening tool remotely

**Patient portal**
- Secure website that gives patients 24-hour access to PHI

**Interview**
- Clinician reads screening questions to patients during tele visit
Screening via patient portal

Pros:
- Can be completed before visit
- Questions answered in private

Cons:
- Results may get lost in EHR
- Can’t ensure that pt privacy was ensured
- Proxy accounts for younger teens break confidentiality
Screening via online interview

Pros

• More likely to ensure privacy
• Can clarify questions in real time
• Results can be put in progress notes immediately
• An opportunity to build rapport, set the stage for BI

Cons

• Takes up time during visit
• Pt has to answer questions directly to clinician
Tips on screening through online interview

• Try to confirm that pt is in private space and can't be overheard
• Screening can be done as part of any visit
• During any portion of the visit
• Explain reason behind screening
• Raise the subject and ask permission
• Read validated questions as written
Adolescent preferences for preventative screening

<table>
<thead>
<tr>
<th></th>
<th>Agree %</th>
<th>Neutral %</th>
<th>Disagree %</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper</td>
<td>57.0</td>
<td>35.1</td>
<td>7.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Provider interview</td>
<td>76.5</td>
<td>17.4</td>
<td>6.1</td>
<td>.034</td>
</tr>
<tr>
<td>Electronic</td>
<td>90.0</td>
<td>12.2</td>
<td>0.9</td>
<td>-----</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Agree %</th>
<th>Neutral %</th>
<th>Disagree %</th>
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<td>60.9</td>
<td>33.9</td>
<td>5.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Provider interview</td>
<td>73.9</td>
<td>20.0</td>
<td>6.1</td>
<td>.006</td>
</tr>
<tr>
<td>Electronic</td>
<td>88.7</td>
<td>10.4</td>
<td>0.9</td>
<td>-----</td>
</tr>
</tbody>
</table>

Study: 115 teens, 12-18 years old, racially diverse, university-based primary care clinics
Oregon consent and confidentiality laws for teens

- Pts ≥15 can consent to medical services. (ORS 109.640)
- Oregon law does not give minors a “right” to confidentiality or parents a “right” to disclosure.
- Providers are encouraged to use their best clinical judgment over whether to disclose (ORS 109.650)
When parents ask to review their minor’s records

Consider:

• Reviewing your confidentiality policy with parents
• Discussing the benefits of maintaining confidentiality
• Assuring parents that their teen has been screened

How does your clinic handle disclosure of records?
CRAFFT

• Validated for ages 12-21, across diverse populations

• Can be self-administered or through verbal interview.

• Version 2.1+N contains an additional question about tobacco and nicotine use.

• SBIRT Oregon website version features PHQ-2 and PHQ-9 Modified for Teens on back

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# CRAFFT questions #1 - 4

During the **PAST 12 months**, on how many days did you:

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drink more than a few sips of beer, wine, or any drink containing <strong>alcohol</strong>? Put “0” if none.</td>
<td></td>
</tr>
<tr>
<td>2. Use any <strong>marijuana</strong> (weed, oil, or hash by smoking, vaping, or in food) or “<strong>synthetic marijuana</strong>” (like “K2,” “Spice”)? Put “0” if none.</td>
<td></td>
</tr>
<tr>
<td>3. Use <strong>anything else to get high</strong> (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put “0” if none.</td>
<td></td>
</tr>
<tr>
<td>4. Use any <strong>tobacco or nicotine</strong> products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Say “0” if none.</td>
<td></td>
</tr>
</tbody>
</table>

If you put “0” **in ALL** of the boxes above, **ANSWER QUESTION 5, THEN STOP.**

If you put “1” **or higher in ANY** of the boxes above, **ANSWER QUESTIONS 5-10.**
<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Do you ever use alcohol or drugs while you are by yourself, or alone?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Do you ever forget things you did while using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Do your family or friends ever tell you that you should cut down on your drinking or drug use?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Have you ever gotten into trouble while you were using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
## CRAFFT answers and actions

<table>
<thead>
<tr>
<th>Answers</th>
<th>Risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No” to questions 1-4</td>
<td>No use</td>
<td>Positive reinforcement</td>
</tr>
<tr>
<td>“Yes” to Car question</td>
<td>Riding risk</td>
<td>Discuss alternatives (Contract for Life)</td>
</tr>
<tr>
<td>CRAFFT score = 0</td>
<td>Occasional use</td>
<td>Brief education</td>
</tr>
<tr>
<td>CRAFFT score = 1</td>
<td>Problematic use</td>
<td>Brief intervention</td>
</tr>
<tr>
<td>CRAFFT score ≥ 2</td>
<td>Likely SUD</td>
<td>Brief intervention (offer options that include treatment)</td>
</tr>
</tbody>
</table>
Percent with a DSM-5 SUD by CRAFFT Score

Mitchell et al, 2014
Motor vehicle fatality is the leading cause of accident death among teens.

Study: 17% of students have ridden in a vehicle in the last 30 days driven by someone who had been drinking alcohol.

Discuss safer alternatives.

Option: Ask teen to take home the “Contract For Life” to discuss with parent(s) or adult. Offer to facilitate conversation.
# Screening-only billing codes

<table>
<thead>
<tr>
<th>Service</th>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening only</td>
<td>Medicaid</td>
<td>CPT 96160</td>
<td>Administration and interpretation of a health risk assessment instrument.</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>G0442</td>
<td>Screening for alcohol misuse in adults once per year.</td>
</tr>
</tbody>
</table>

- 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. Two options:
  - Z13.89: “Encounter for screening for other disorder”
  - Z13.9: “Encounter for screening, unspecified”
## Screening + BI codes

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Payer and amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening plus brief intervention</strong></td>
<td></td>
<td></td>
<td>• 5-14 minutes of aggregate clinic time spent administering and interpreting a validated alcohol or drug screening tool, plus performing a face-to-face brief intervention the same day.</td>
</tr>
<tr>
<td>G2011</td>
<td>Medicare $16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT 99408</td>
<td>Medicaid $23-27</td>
<td></td>
<td>• Same as above, only 15-29 minutes</td>
</tr>
<tr>
<td>G0396</td>
<td>Medicare $33-35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT 99409</td>
<td>Medicaid $47-53</td>
<td></td>
<td>• Same as above, only ≥30 minutes</td>
</tr>
<tr>
<td>G0396</td>
<td>Medicare $64-66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• CRAFFT
• S2BI
• __________

The patient completed the _______________ screening tool, and their responses indicate
___________________________.

• no risk of related health problems related to substance use
• a low risk of related health problems related to substance use
• an increased risk of health problems, as well as current consequences related to substance use that suggest a possible substance use disorder

I briefly educated the patient about risks associated with adolescent substance use, and discussed how to avoid driving after using or riding with an impaired driver. [Medicaid CPT 96160 can be billed]
Discussing this further, we reviewed options that would reduce the patient’s risk of health problems related to substance use. The patient agreed to: ________________.

- __________________
- reduce their use
- abstain from use
- accept a referral to ________________
- accept medication for substance use disorder

The patient’s readiness to change was ______ on a scale of 0 - 10. We explored why it was not a lower number and discussed the patient’s own motivation for change.

Total clinic time administering and interpreting the screening form, plus performing a face-to-face brief intervention with the patient was ________________ minutes.

- Less than 5
- 5 – 14
- 15 to 30  [CPT 99408 can be billed]
- greater than 30  [CPT 99409 can be billed]
Who’s allowed to independently bill for SBI

<table>
<thead>
<tr>
<th>Oregon Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (MD, DO, ND)</td>
<td>Physicians (MD, DO)</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Physician Assistants</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>Nurse Practitioners</td>
</tr>
<tr>
<td>Licensed Clinical Psychologists</td>
<td>Licensed Clinical Psychologists</td>
</tr>
<tr>
<td>Licensed Clinical Social Workers</td>
<td>Licensed Clinical Social Workers</td>
</tr>
<tr>
<td>Licensed Professional Counselors</td>
<td>Certified Nurse Midwives</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapists</td>
<td>Clinical Nurse Specialists</td>
</tr>
</tbody>
</table>
Incident-to billing

- Any clinic employee under supervision can bill for SBI

- Examples:
  - CADCs, Health Educators, Registered Nurses, Clinical Nurse Specialist, Students or Graduates entering medical profession, Community Health Workers

- Some limitations apply to certain clinic settings
Oregon CCO metric: SBIRT

RATE 1:
Patients with either a negative brief screen or a full screen.

Pts ≥12 years visit in last year

RATE 2:
Pts who received a brief intervention, or referral to treatment within 48 hours

Pts with a positive full screen.
Oregon CCO metric: IET

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Initiation rate:
Pts who received AOD Treatment within 14 days
Pts ≥13 years with a new AOD dx

Engagement rate:
Pts who received 1 or 2 AOD treatments within 34 days of initiating treatment
Pts ≥13 years with a new AOD dx

A brief intervention with a BHS counts as satisfying the numerator in both rates
Keys to implementing a sustainable SBIRT workflow

• Secure buy-in from leadership
• Identify workflow
• Train all staff and implement ongoing training
• Identify champions
• Optimize EMR
• Use clinic tools
IV. Brief intervention
Characteristics of a guiding style of communication

- Respect for autonomy, goals, values
- Readiness to change
- Ambivalence
- Patient is the expert
- Empathy, non-judgment, respect
How do **you** discuss behavior change with your patients?
Video:

The Ineffective Clinician

https://www.youtube.com/watch?v=cSBsgmgYm8o
Characteristics of a directive style of communication

- Explaining why the pt should change
- Telling how the pt should change
- Emphasizing how important it is to change
- Trying to persuade the pt to change
Common patient reactions to the directive style

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>Afraid</td>
</tr>
<tr>
<td>Agitated</td>
<td>Helpless, overwhelmed</td>
</tr>
<tr>
<td>Oppositional</td>
<td>Ashamed</td>
</tr>
<tr>
<td>Discounting</td>
<td>Trapped</td>
</tr>
<tr>
<td>Defensive</td>
<td>Disengaged</td>
</tr>
<tr>
<td>Justifying</td>
<td>Not come back – avoid</td>
</tr>
<tr>
<td>Not understood</td>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Procrastinate</td>
<td>Not heard</td>
</tr>
</tbody>
</table>

Rollnick and Miller, 2008
Brief intervention

- 3-5 minute conversation that employs motivational interviewing
- Well suited for adolescents (desire for autonomy, resistance to authority)
- Evidence accumulating on effectiveness

Brief Interventions in medical settings

- Should employ motivational interviewing (evidence-based)
- Even three minutes can have effect
- Can be performed by any trained clinic employee
- 2 hours of training can make difference

Warm introduction principles

- In-person introduction to behavioral health specialist
- Referred to as “colleague” or “specialist”
- Brief intervention delivered during same visit
- Avoid “counseling” label
Steps of the brief intervention

- Raise subject
- Share information
- Enhance motivation
- Identify plan
Steps of the brief intervention

- Ask permission to discuss patient’s substance use
- Be transparent about your role
- Ask the patient to describe their use
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 change your use in any way you do not want to. Instead, my focus is to understand what your goals or visions for your future are. I can share information with you so you can improve your quality of life on your own terms and on your own timeline.

How does that sound to you?
Steps of the brief intervention

- Explain any association between substance use and health complaint
- Share information about the risks of use. Ok to express concern
- Ask the pt what they think of the information
Pitfalls of giving advice or recommendations

- Implies judgement, risks furthering stigma
- Clinician-driven rather than patient-driven
- Patients with SUDs may already feel trapped
- Advice is different than offering options
Steps of the brief intervention

- Ask patient what they like about their use, and what they don’t like, then summarize
- Ask what change the pt would like to see
Examples that elicit patient 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?”
Goals are more achievable when they are:

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

• Considers cutting down to 1 drink when out with friends.

• Will not get in a car with any driver who is intoxicated.

• Agrees not to have sex when he/she is intoxicated

• Agrees to return for follow-up.
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?”
Steps of the brief intervention

- Ask patient what they like about their use, and what they don’t like, then summarize
- Ask what change the pt would like to see
- Gauge readiness/confidence to reach goal
Readiness Ruler

- Gauge readiness by asking, “On a scale of 0 to 10 . . .”
- “Why not a lower number?”
- Answering this question enhances motivation
Steps of the brief intervention

- If patient sounds ready, ask: “What would 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 goals
- Sharing information about risks
- Eliciting pt-driven harm reduction goals
- Discussing safer-use strategies

HaRRT Center
Raise the subject

• “Thanks for filling out this form – is it okay if we briefly talk about your substance use?”
• “My role is to help you assess the risks so you can make your own decisions. I want to help you improve your quality of life on your own timeline.”
• “What can you tell me about your substance use?”

Share information

• Explain any association between the patient’s use and their health complaint, then ask, “Do you think your use has anything to do with your [anxiety, insomnia, etc,]?”
• Share information about the risks of using alcohol, drugs, and misusing prescription drugs. Ask the patient: “What do you think of this information?”

Enhance motivation

• Ask pt about perceived pros and cons of their use, then summarize what you heard.
• “Where do you want to go from here in terms of your use? What’s your goal or vision?
• Gauge patient’s readiness/confidence to reach their goal. If using Readiness Ruler: “Why do did you pick ___ on a scale of 0-10 instead of ____ [lower number]?”

Identify plan

• If patient is ready, ask: “What steps do you think you can take to reach your goal?”
• Affirm the patient’s readiness/confidence to meet their goal and affirm their plan.
• “Can we schedule an appointment to check in and see how your plan is going?”
Remember:

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.
Some risks of adolescent alcohol and marijuana use:

- 22% of teenage drivers in fatal car crashes were drinking. Car crashes are the leading cause of teen deaths.
- Marijuana affects a number of skills needed for safe driving, like reacting to sounds and signals on the road.
- Teens who use marijuana tend to get lower grades and are more likely to drop out of high school.
- High school students who use alcohol are five times more likely to drop out.
- Marijuana’s effects on attention and memory make it difficult to learn something new or do complex tasks.
- Heavy use of marijuana as a teenager can lower IQ later in life as an adult.
- Teens who binge drink every month damage their brains in a way that makes it harder to pay attention and understand new information.
- Alcohol poisoning and suicide are major causes of alcohol-related teen deaths.
- Teen drinking and marijuana use raise the risk of unprotected sex, sexual assault, STIs, and unintended pregnancy.
- Drinking increases the risk of injuries - the third leading cause of death among teens.

A standard drink of alcohol equals:

- Beer 12 oz.
- Wine 5 oz.
- Malt liquor 8 oz.
- Liquor 1.5 oz.

One party cup 16 oz.

Readiness ruler:

Not ready 0 1 2 3 4 5 6 7 8 9 10 Very ready

Reference sheet

Front acts as a visual aid for the patient during a brief intervention
Reference sheet

Back provides guidance to the health professional.
Patient handouts

- Download at sbirtoregon.org
- English and Spanish
- Separate handouts based on substance and population
- Should not replace brief interventions
Case study: “Natasha”

- 16-year old presenting for a physical
- Vapes cannabis 2-3x month
- No medical complaints
Video demonstration: “Natasha”

http://www.sbirtoregon.org/video-demonstrations/
Discussion

What worked well?
What could have gone better?
Case study: “Erin”

- 16-year old following up after STD test
- Occasionally binge drinks at parties
- No medical complaints
- Telehealth visit
Video demonstration: “Erin”

http://www.sbirtoregon.org/video-demonstrations/
Discussion

What worked well?

What could have gone better?
Role play practice

Groups of three:

- Clinician
- Patient
- Observer
OARS skills

- Open-ended questions
- Affirmations
- Reflective listening
- Summaries
### Examples of open-ended questions

<table>
<thead>
<tr>
<th>Closed</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you in pain?</td>
<td>How do you feel?</td>
</tr>
<tr>
<td>How often do you use drugs?</td>
<td>What role do drugs play in your life?</td>
</tr>
<tr>
<td>Don't you want to stop using and be sober?</td>
<td>What advantages do you see in changing your drug use?</td>
</tr>
</tbody>
</table>
Open-ended questions

- Invites the patient to “tell their story” without leading them in a specific direction
- Should be used often, but not exclusively
- Important to listen to the person’s response
Examples of affirmations

<table>
<thead>
<tr>
<th>Affirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>You really care a lot about your health</td>
</tr>
<tr>
<td>This is hard work you’re doing</td>
</tr>
<tr>
<td>You were successful in changing in the past</td>
</tr>
<tr>
<td>That’s a good idea</td>
</tr>
<tr>
<td>You are clearly very resourceful</td>
</tr>
<tr>
<td>I appreciate that you are willing to talk honestly with me about this</td>
</tr>
</tbody>
</table>
Affirmations

- Statements that recognize patient strengths
- Acknowledging positive behaviors, no matter how big or small
- Help build confidence and self-efficacy
- Must be genuine
Examples of reflective listening

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Clinician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t think I’m really addicted to pot.</td>
<td>Being told you may have a substance use disorder doesn’t seem right to you.</td>
</tr>
<tr>
<td>I’ve never not used drugs – I think it’s just who I am.</td>
<td>Using drugs feels normal to you.</td>
</tr>
<tr>
<td>I don’t like being kicked off the basketball team</td>
<td>Being able to play basketball is important to you.</td>
</tr>
<tr>
<td>I know I probably shouldn’t smoke pot every day, but I haven’t cut down yet.</td>
<td>You know all the reasons to not use cannabis, but it’s been hard to find the motivation change.</td>
</tr>
</tbody>
</table>
Reflective listening

• Understanding what your patient is thinking and feeling, and then saying it back to the patient

• Engages your patient, conveys empathy, builds trust, and fosters motivation to change

• Allows you to see the world through your patient's eyes
Summarizing example

Patient

I don’t want to go to treatment

I’m worried about withdrawal

My parents would feel better

I’d feel safer if I got help

I’d have to find a ride
“If I hear you right, it sounds like you’re not interested in treatment right now. There’s a challenge in that you’d have to find transportation and you’re worried about going through withdrawal. But you also think it would be safer in the long run and your relationship with your parents might improve.”
Summarizing

• Special applications of reflective listening
• Particularly helpful at transition points, or when you’re not sure what to say next
• Good way to help patient analyze pros and cons
IV. Referral to Treatment
Traditional referral to treatment

• Delivered through the brief intervention – good!
• But, the referral comes from the clinician rather than the pt
• Patient-centered is not the same as patient-driven
• Traditional RT remains clinician-driven
# Evidence of SBIRT towards unhealthy alcohol use

<table>
<thead>
<tr>
<th></th>
<th>SBI (for self-reported reduced use)</th>
<th>SBI + RT (for receipt of specialty treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td>Moderate evidence (USPSTF, 2018)</td>
<td>Meta-analysis: no evidence*</td>
</tr>
<tr>
<td><strong>Adolescents</strong></td>
<td>Insufficient evidence (USPSTF, 2018)</td>
<td>?</td>
</tr>
<tr>
<td><strong>Pregnancy</strong></td>
<td>Moderate evidence (USPSTF draft, 2018)</td>
<td>?</td>
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</table>

Evidence of SBIRT towards illicit drug use

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</tr>
<tr>
<td>Pregnancy</td>
<td>?</td>
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</table>
Experts propose replacing RT

- 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
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
Harm Reduction 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
Harm Reduction theory and practice

Provider compassion + Pragmatism = Harm reduction philosophy

Harm reduction philosophy → Reduced harm → Quality of life improves → Pathway to recovery
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
Where does stigma come from?

Two main factors:

• When people perceive an individual is responsible for *causing* his/her problem

• And when he or she is able to *control* the problem

• Another contributory factor: the type of language we use

Kelly et al, 2015.
Substance Use Disorder

Risk factors:
Physical, emotional, sexual abuse; stress; early exposure to substances; low self esteem; mental health disorders; marginalized population; family history of addiction; trauma; poverty; absence of social support

Main Problem

Consequences

NIDA, 2018.
## Language

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

Evidence-based outpatient treatment for adolescent SUD

Strongest evidence associated with:

• Cognitive behavior therapy
• Motivational enhancement
• Family-based treatment
• Contingency management

Medications for SUDs

- Not substitutions of one drug for another
- Instead, they relieve withdrawal symptoms and psychological cravings
- Effective if used alone, or with behavioral therapy
- Can help pts initiate and sustain recovery from SUDs
## Medications for AUDs

<table>
<thead>
<tr>
<th>Medication (Brand name)</th>
<th>Route</th>
<th>Effect</th>
<th>Adverse effects</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acamprosate (Campral)</td>
<td>Oral</td>
<td>Can decrease the craving for alcohol.</td>
<td>Anxiety, Diarrhea, Vomiting</td>
<td>Non habit-forming. Safe to take with alcohol and opiates. In event of relapse, will not cause an adverse reaction or exacerbate withdrawal symptoms.</td>
</tr>
<tr>
<td>Naltrexone (Vivitrol)</td>
<td>Oral, injection</td>
<td>Can discourage alcohol use by producing adverse reactions when alcohol is consumed.</td>
<td>Dizziness, Nausea, Vomiting</td>
<td>Non habit-forming. May reduce the feeling of intoxication and the desire to drink more, but it will not cause a severe physical response to drinking.</td>
</tr>
<tr>
<td>Disulfiram (Antabuse)</td>
<td>Oral</td>
<td>Can decrease the craving for alcohol.</td>
<td>Drowsiness</td>
<td>Non habit-forming. Should not be administered until patient has abstained from alcohol for at least 12 hours.</td>
</tr>
<tr>
<td>Topiramate (Topamax)</td>
<td>Oral</td>
<td>Can decrease the craving for alcohol.</td>
<td>Loss of appetite, Drowsiness, Hair loss</td>
<td>Non habit-forming. An anti-seizure medication used off-label for the treatment of alcohol use disorders (not FDA approved for this purpose).</td>
</tr>
</tbody>
</table>
# Medications for Opioid Use Disorders

<table>
<thead>
<tr>
<th>Medication (Brand name)</th>
<th>Route</th>
<th>Effect</th>
<th>Adverse effects</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Oral</td>
<td>An opioid agonist that eliminates withdrawal symptoms and relieves drug cravings.</td>
<td>Constipation, hyperhidrosis, respiratory depression, sedation</td>
<td>Only federally certified, accredited opioid treatment programs can dispense methadone.</td>
</tr>
<tr>
<td>Buprenorphine (Suboxone)</td>
<td>Tablet, Injection, implant</td>
<td>A partial opioid agonist that reduces cravings and withdrawal symptoms without producing euphoria.</td>
<td>Constipation, nausea, withdrawal, excessive sweating, insomnia</td>
<td>Usually tolerated well by patients. Only physicians, nurse practitioners, and physician assistants can prescribe buprenorphine for OUD and must get a federal waiver to do so.</td>
</tr>
<tr>
<td>Naltrexone (Vivitrol)</td>
<td>Oral, injection</td>
<td>Blocks the euphoric and sedative effects, prevents feelings of euphoria</td>
<td>Nausea, anxiety, insomnia, depression, dizziness</td>
<td>Any prescriber can offer naltrexone</td>
</tr>
</tbody>
</table>
Oregon laws towards minor consent and treatment

- Youth 14 years or older may initiate treatment without parental consent (ORS 109.6750)
- Providers are to involve the parents before end of treatment unless parents refuse or there are indications not to involve parents (ORS 109.6750)
- Providers may advise the parent /guardian of diagnosis of treatment of chemical dependency or mental disorder when clinically appropriate and if condition has deteriorated (ORS 109.680)
Referral to treatment

- Should be delivered through the brief intervention
- Offered as an option
- Followed through if the pt agrees to accept treatment
- Patient-centered is not the same as patient-driven
Confidentiality and the referral

Consider:

• May be difficult for teen to manage treatment requirements without parent knowledge.

• Teens respond better to treatment when parents are involved.

• Insurance carrier may notify parent if insurance is under their name.
Involving parents or trusted adults

• An adolescent who discloses heavy drug use may be looking for help.

• Ask patient if parents or trusted adults are aware of drug use. If so, inviting parents into conversation may be easy.

• Special considerations when parents themselves use substances
Side with the teen when presenting information:

• “Terra has been very honest with me and told me about her marijuana use. She has agreed to see a specialist to talk about this further. I will give you the referral information so that you can help coordinate”.
Thank you

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