SBIRT (Screening, Brief Intervention, and Referral to Treatment): Core Curriculum

Alan Lyme, LISW – MINT Certified MI Trainer

alanlyme@gmail.com

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Introductions

- Name/Agency/Position
- What do you know about SBIRT and/or Motivational Interviewing?
- What do you want to get from this training?

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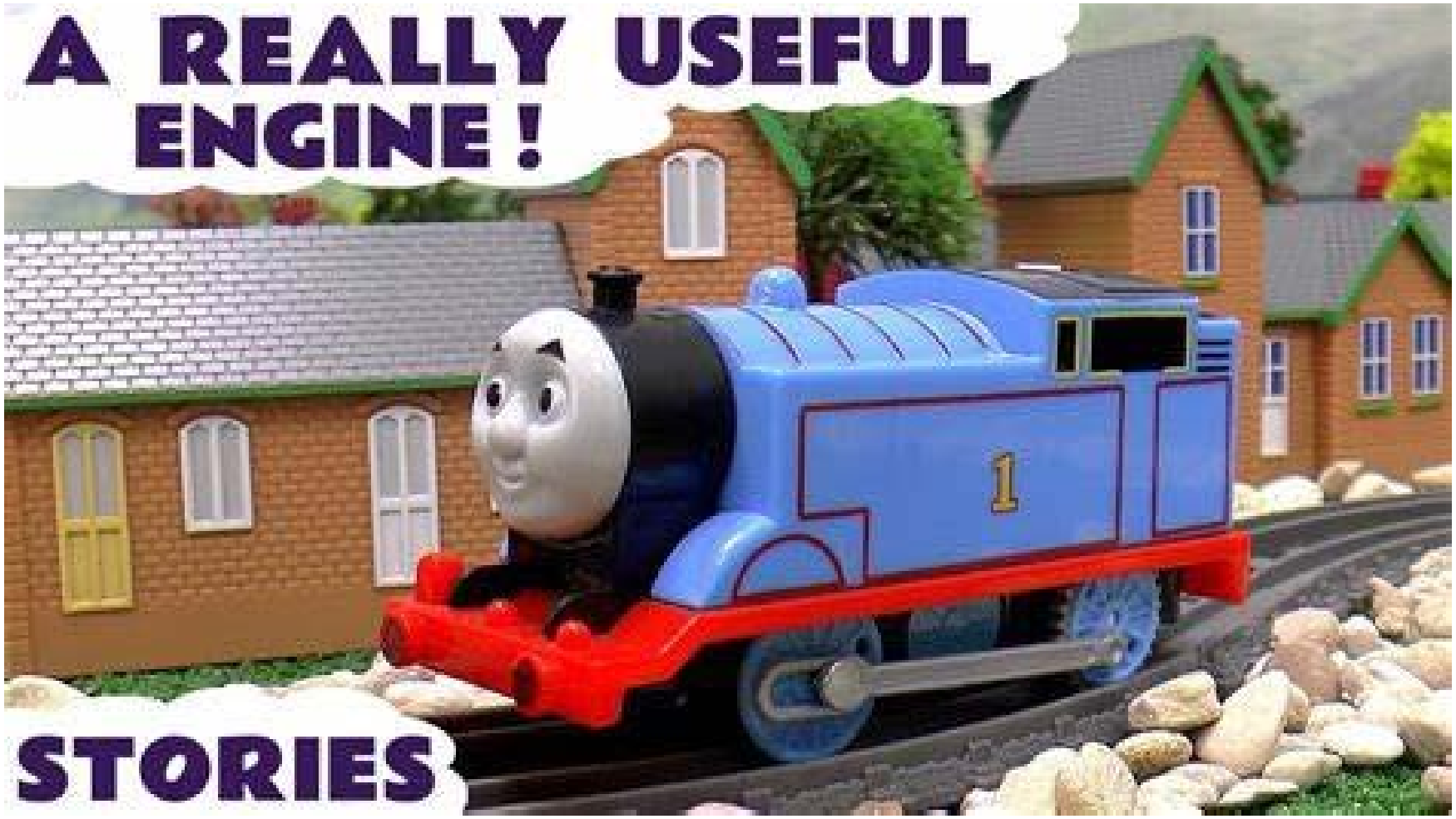
Your goals?

- What do you want from today?
- What would make this worth your time?
  - To not fall asleep?
  - Snacks and coffee?
  - For it to not suck?
  - To be left alone to play Candy Crush?



A really useful engine….

Housekeeping Items

"Larry's presentation wasn't so bad. After the third hour, my spirit left my body and went to the beach!"

ICE BREAKER

I like my trainings to be……

Complete the statement with only one (1) word.

* must be quick and same word cannot be used twice.

Ready…. Set…. Go….

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First……

A message from our sponsor.

Acknowledgments

- The material included in this course is based largely on the works of previously funded **SAMHSA** (Substance Abuse and Mental Health Services Administration) grantees, such as **GA BASICS**
- Other information sources will be noted within the course narration.

Learning Objectives

By the end of this module, you will be able to

1. Understand basic terms used when discussing substance use
2. Describe the components and goals of SBIRT
3. Define the rationale and purpose of SBIRT

Terms Used

Clients, Patients

Terms Used Continued

- Substance: Alcohol, illegal drugs, prescription drugs
- Use: to take
- Misuse: use (something) in the wrong way or for the wrong purpose
- Abuse: improper or excessive use
- Risk (y): the chance of loss to health or wellbeing
- Hazard (ous): level of certain danger or loss

Your typical patients/clients:

- How does alcohol or drugs factor into your cases?

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Core Curriculum
5 Modules

1. What Is SBIRT and Why Use it?
2. Essential Motivational Interviewing Skills
3. Screening for Substance Use Disorders
4. Brief Intervention
5. Referral to Treatment

What Is SBIRT and Why Use It?

SBIRT Defined

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services. It is used for—

- Persons with substance use disorders
- Those whose use is at moderate and higher levels of risk
- As a prevention and education model for everyone else

What Is SBIRT?

An intervention based on “motivational interviewing” strategies

- **Screening:** Universal screening for quickly assessing use and severity of alcohol; illicit drugs; and prescription drug use, misuse, and abuse
- **Brief Intervention:** Brief motivational and awareness-raising intervention given to risky or problematic substance users
- **Referral to Treatment:** Referrals to specialty care for patients with substance use disorders

Treatment may consist of brief treatment or specialty AOD (alcohol and other drugs) treatment.

Question?

Why might I choose to support SBIRT implementation?

Questions you may be asking

Q: Do I really *have* to do this thing?

A: It's your choice and we hope you will find your own personal reasons for doing it.

Q: How much hassle is involved?

A: There are a few challenges with starting up, but it can be made easy and routine, as with taking a blood pressure.

Q: Will it annoy my patients?

See next slide

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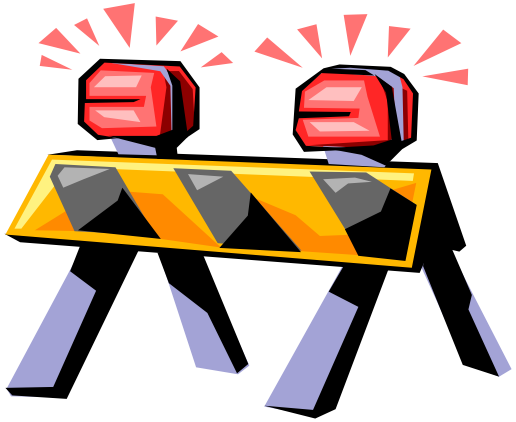
Clinician Barriers to Discussing Alcohol with Patients



- **57.7%** Belief that patients lie
- **35.1%** Time constraints
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CASA: Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse, April 2000

Patients **Are** Open To Discussing Their Substance Use To Help Their Health

Survey on Patient Attitudes

	Agree/Strongly Agree
"If my doctor asked me how much I drink, I would give an honest answer."	92%
"If my drinking is affecting my health, my doctor should advise me to cut down on alcohol."	96%
"As part of my medical care, my doctor should feel free to ask me how much alcohol I drink."	93%
	Disagree/Strongly Disagree
"I would be annoyed if my doctor asked me how much alcohol I drink."	86%
"I would be embarrassed if my doctor asked me how much alcohol I drink."	78%

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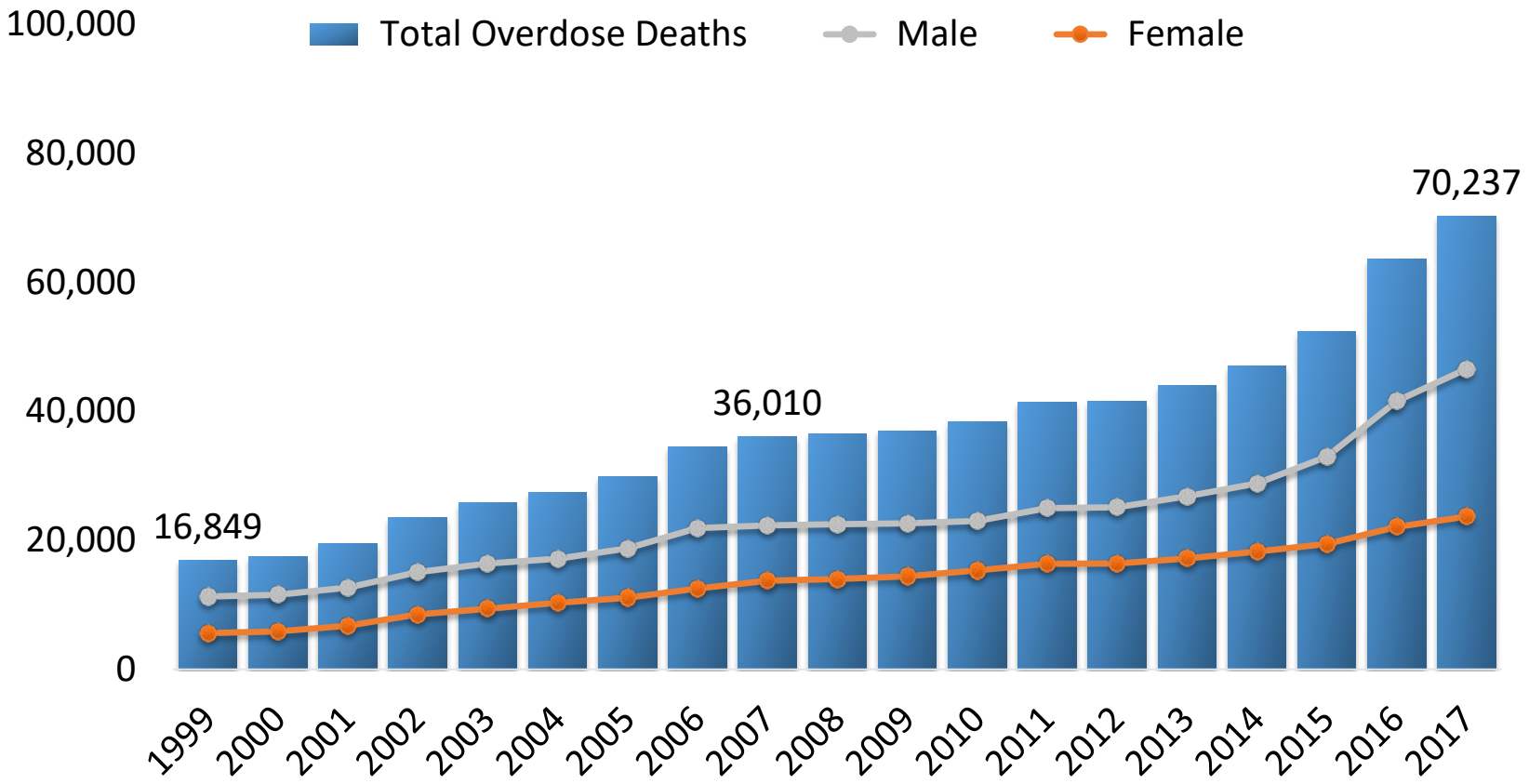
Source: Miller, P. M., et al. (2006). *Alcohol & Alcoholism*.
Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

Why Is SBIRT Important?

- According to NIDA (2012):
  - Since the 2000 mortality related to drug use has more than doubled.
  - Substance use (alcohol, drug and tobacco) is attributable to one in four deaths, more than from any other preventable health condition.
  - http://www.drugabuse.gov/related-topics/medical-consequences-drug-abuse/mortality

Figure 1. **National Drug Overdose Deaths** Number Among All Ages, by Gender, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Why Is SBIRT Important?

- Unhealthy and unsafe alcohol and drug use are major preventable public health problems resulting in more than 100,000 deaths each year.
- The costs to society are more than $600 billion annually.
- Effects of unhealthy and unsafe alcohol and drug use have far-reaching implications for the individual, family, workplace, community, and the health care system.

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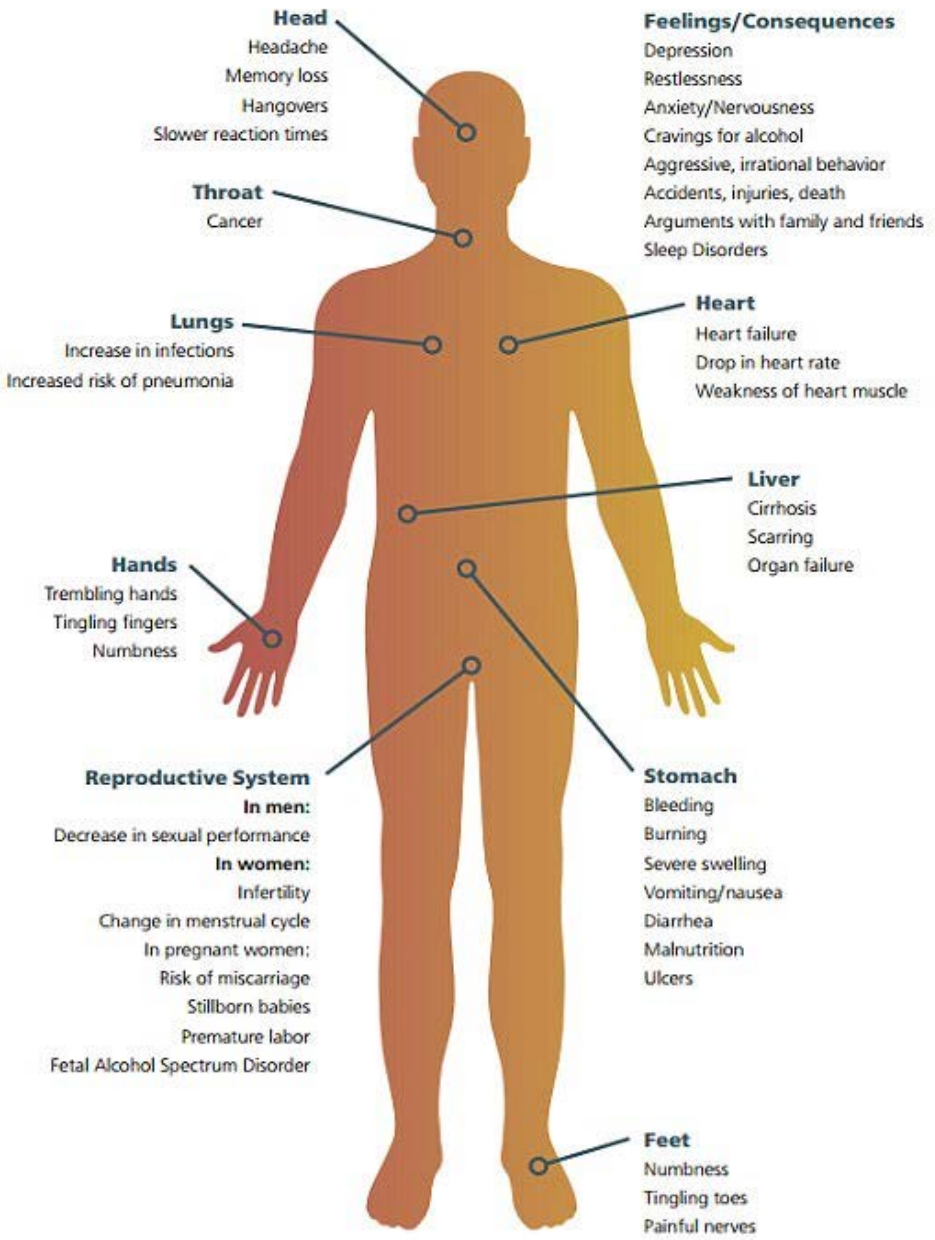
Harms Related to Hazardous Alcohol and Substance Use

Increased risk for—

- Injury/trauma
- Criminal justice involvement
- Social problems
- Mental health consequences (e.g., anxiety, depression)
- Increased absenteeism and accidents in the workplace

Medical and Psychiatric Harm of High-Risk Drinking

Figure 1. Health Consequences of Hazardous and Harmful Alcohol Use



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SBIRT 2020

Historic Response to Substance Use

- Previously, substance use intervention and treatment focused primarily on substance abuse universal prevention strategies and on specialized treatment services for those who met the abuse and dependence criteria.
- There was a significant gap in service systems for at-risk populations.

Learning from Public Health

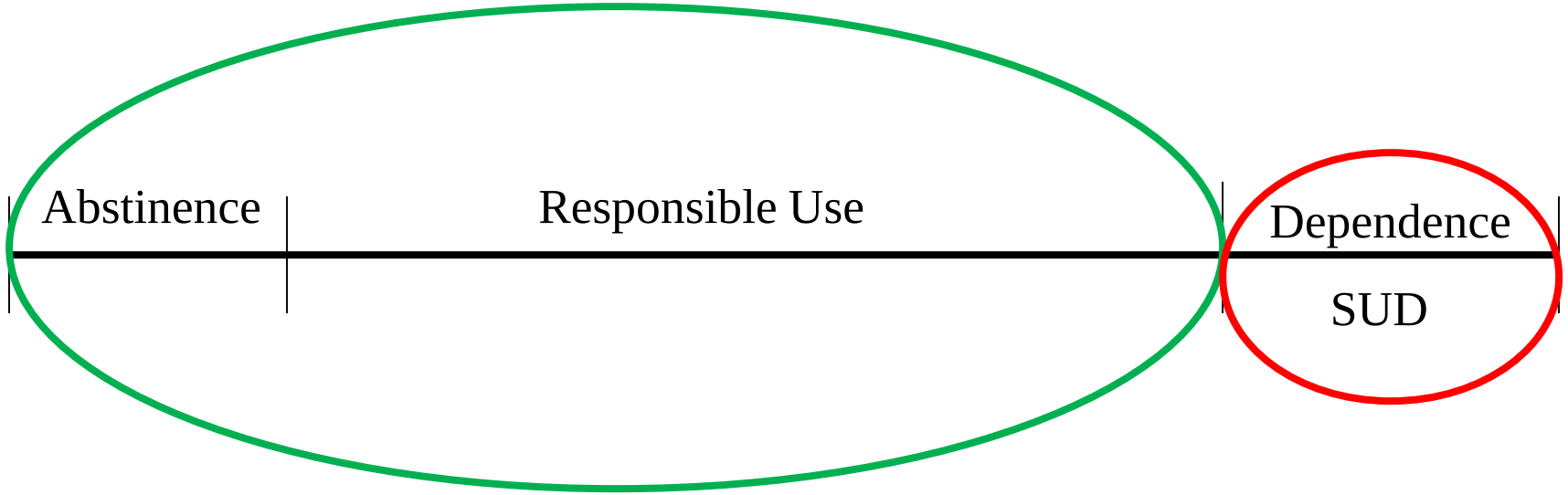
- The public health system of care routinely screens for potential medical problems (cancer, diabetes, hypertension, tuberculosis, vitamin deficiencies, renal function), provides preventative services prior to the onset of acute symptoms, and delays or precludes the development of chronic conditions.

Advertising regarding alcohol use

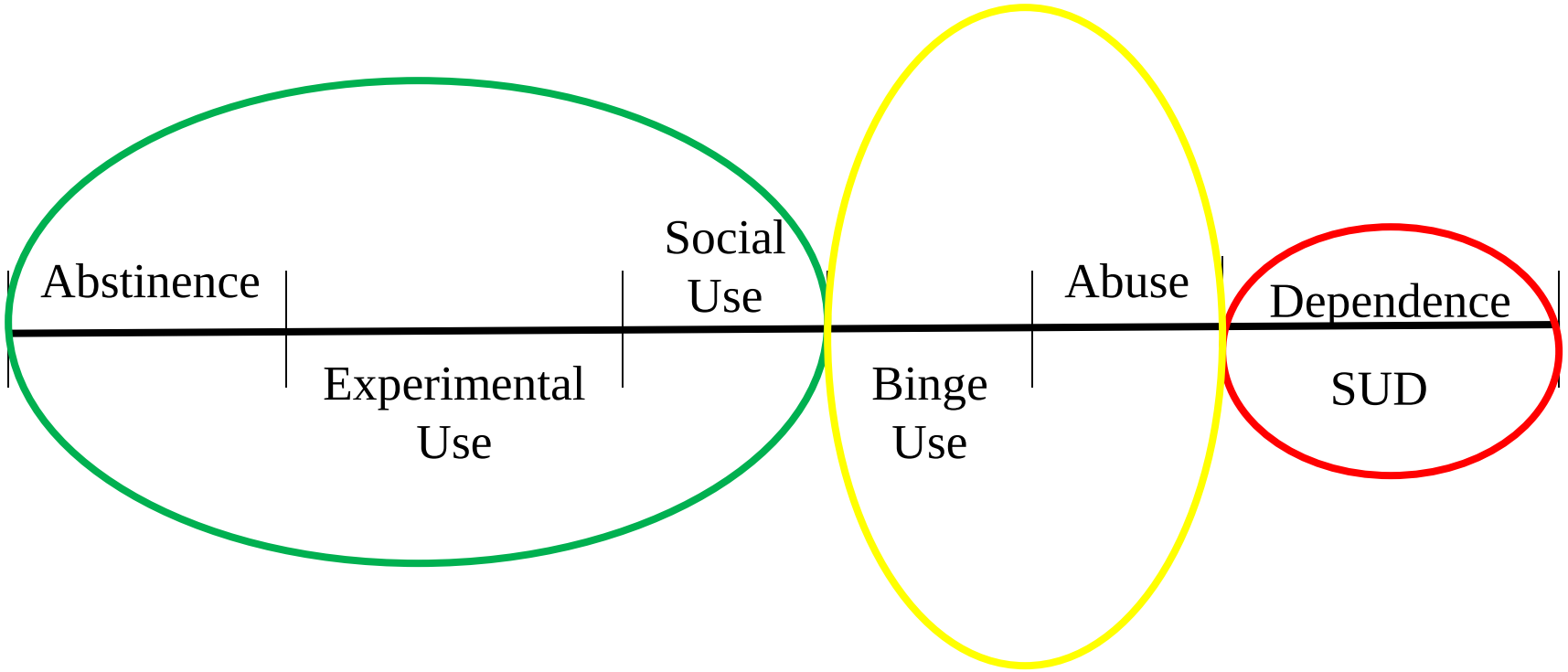
- Who drives the information?
- What is the message they convey?


Jose Cuervo
Especial
Who is this “Moderation” people keep telling me to drink with?

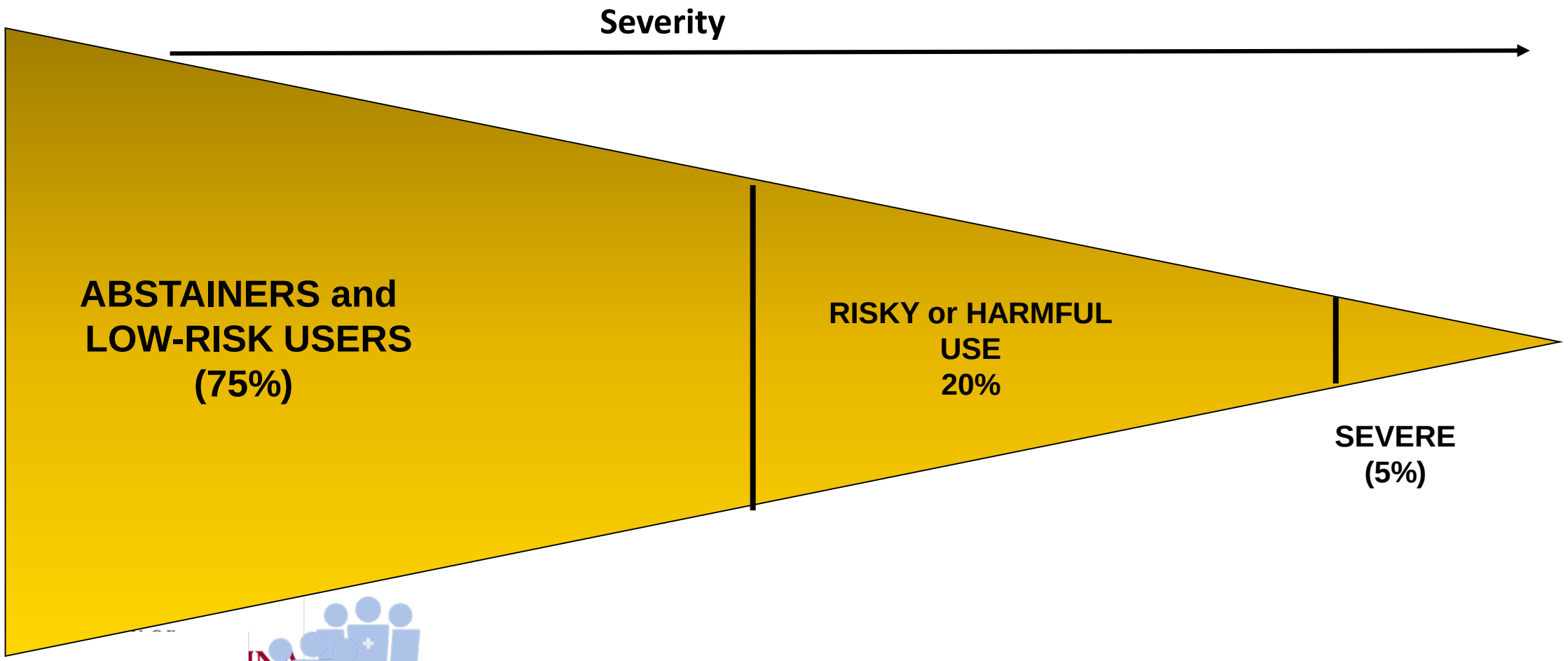
The Current Model
A Continuum of Substance Use



The SBIRT Model
A Continuum of Substance Use



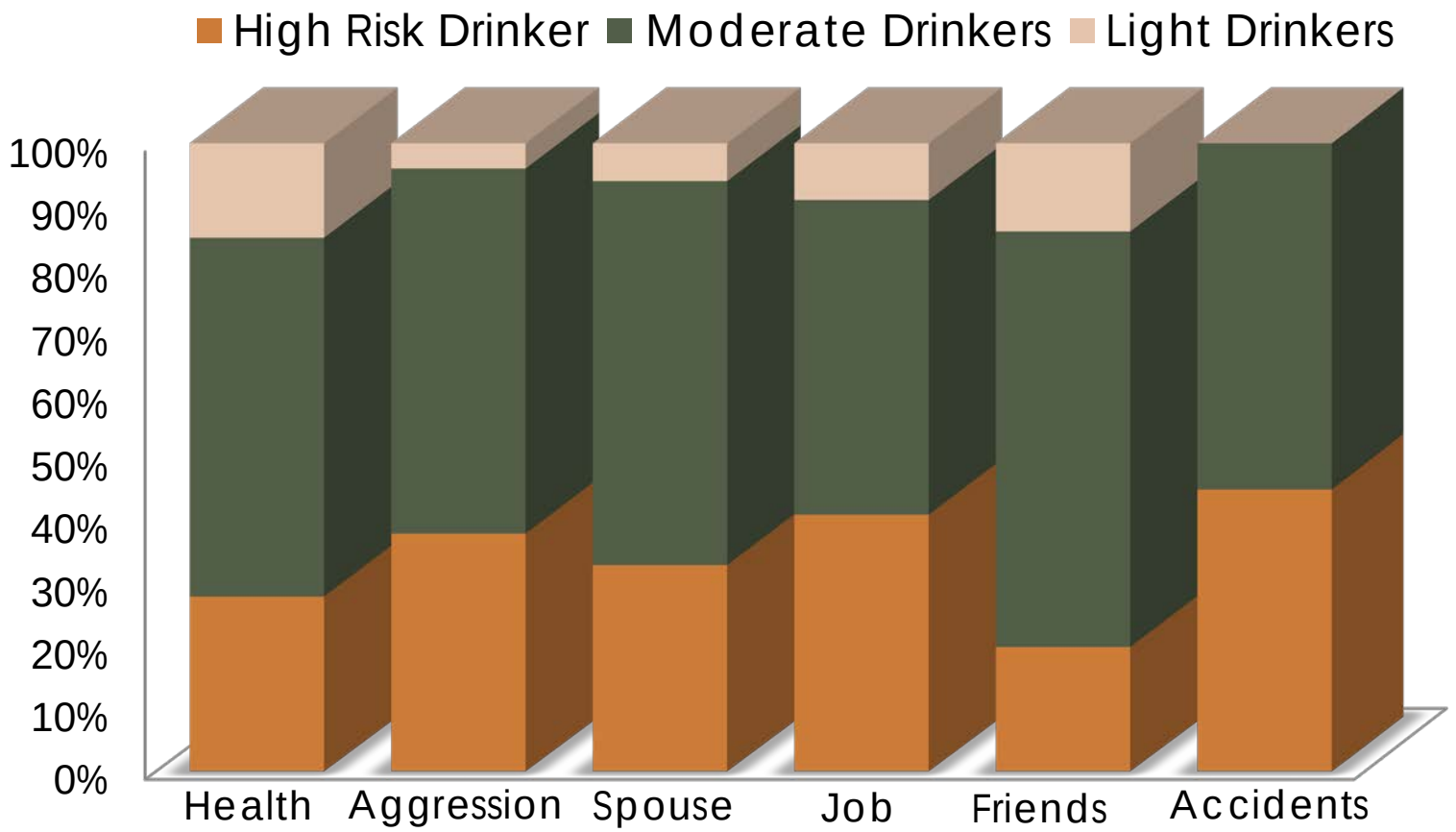
Continuum of Substance Use



Shifting the Paradigm

- From detection of alcohol use disorders to identification of health risk.

The Evidence Indicates That Moderate-Risk Drinkers Account for the MOST Problems



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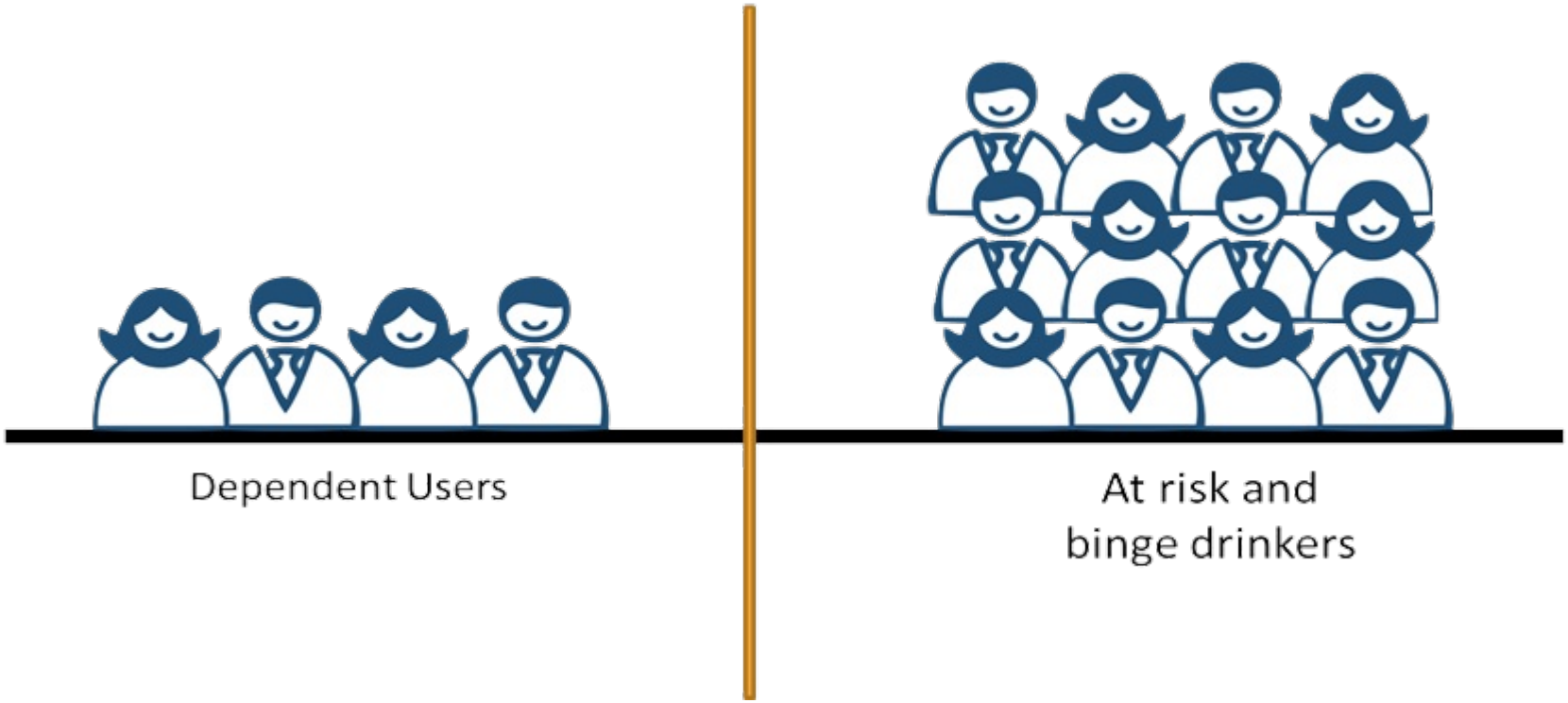
Rethinking Substance Use Problems From a Public Health Perspective



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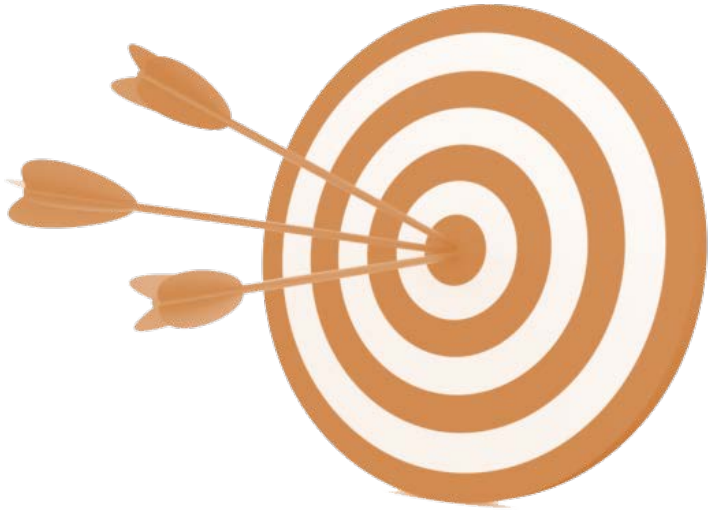
Goal

The primary goal of SBIRT is to identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.



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SBIRT Is a Highly Flexible Intervention

SBIRT Settings	
Aging/Senior Services	Inpatient
Behavioral Health Clinic	Primary Care Clinic
Community Health Center	Psychiatric Clinic
Community Mental Health Center	School-Based/Student Health
Drug Abuse/Addiction Services	Trauma Centers/Trauma Units
Emergency Room	Urgent Care
Federally Qualified Health Center	Veterans Hospital
Homeless Facility	Other Agency Sites
Hospital	

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Research Demonstrates Effectiveness

- A growing body of evidence about SBIRT's effectiveness—including cost-effectiveness—has demonstrated its positive outcomes.
- The research shows that SBIRT is an effective way to reduce drinking and substance abuse problems.

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Research Shows

Brief interventions—

- Are low cost and effective
- Are most effective among persons with less severe problems
- *"Brief interventions are feasible and highly effective components of an overall public health approach to reducing alcohol misuse."*

(Whitlock et al., 2004, for U.S. Preventive Services Task Force)

Strong Research and Substantial Experiential Evidence Supports the Model

- There is substantial evidence for the effectiveness of brief interventions for harmful drinking. There is a growing body of literature showing the effectiveness of SBIRT for risky drug use.

SAMHSA Whitepaper, 2011 (http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf)

SBIRT Decreases the Frequency and Severity of Alcohol and Drug Use

Macon GA SBIRT study, 2009. Results: Drinking Days

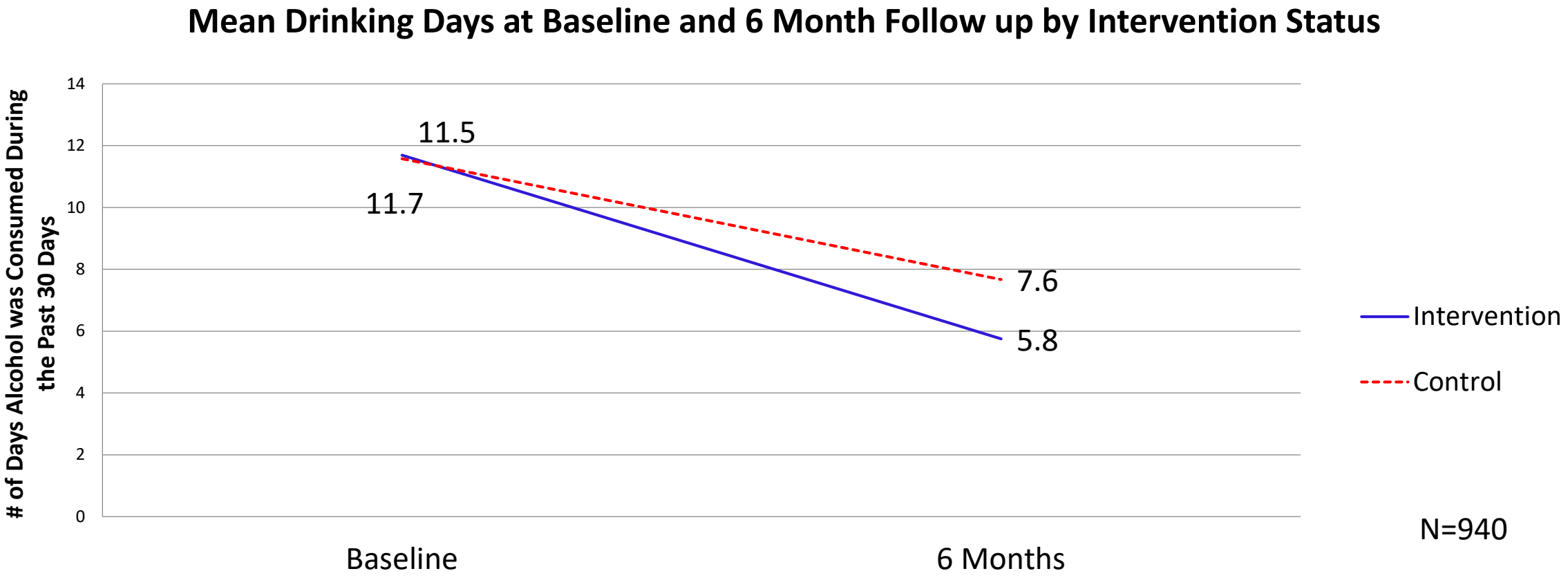


Table 4. Association of Intervention Status and Drinking Days at 6 Months

Variable	β	Confidence Interval	Significance	R^2
Drinking days at baseline	0.382	0.301 to 0.463	<0.001	0.176
Gender	-1.49	-3.34 to 0.364	0.115	0.178
Intervention Status	-1.96	-3.95 to 0.034	0.054	0.184

*Change in R^2 for intervention status = 0.006

Results: Binge Drinking Days

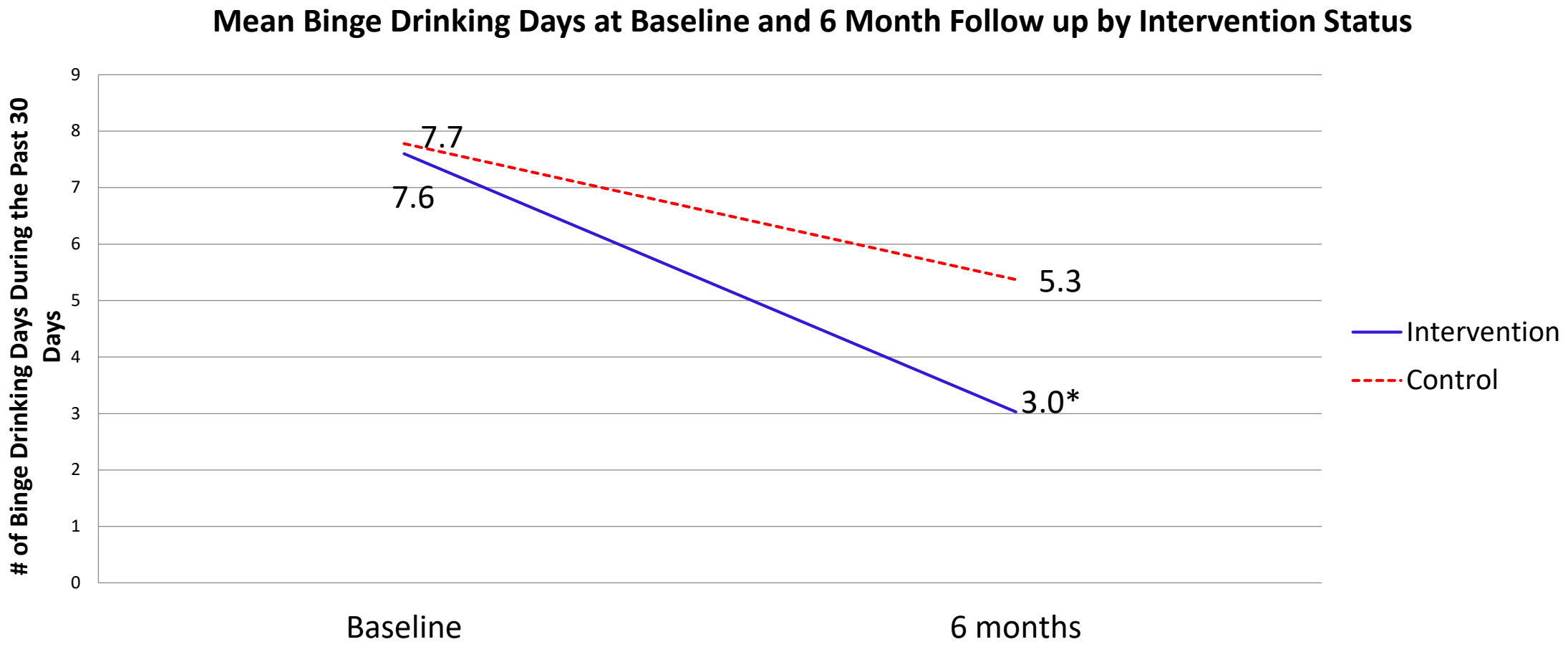
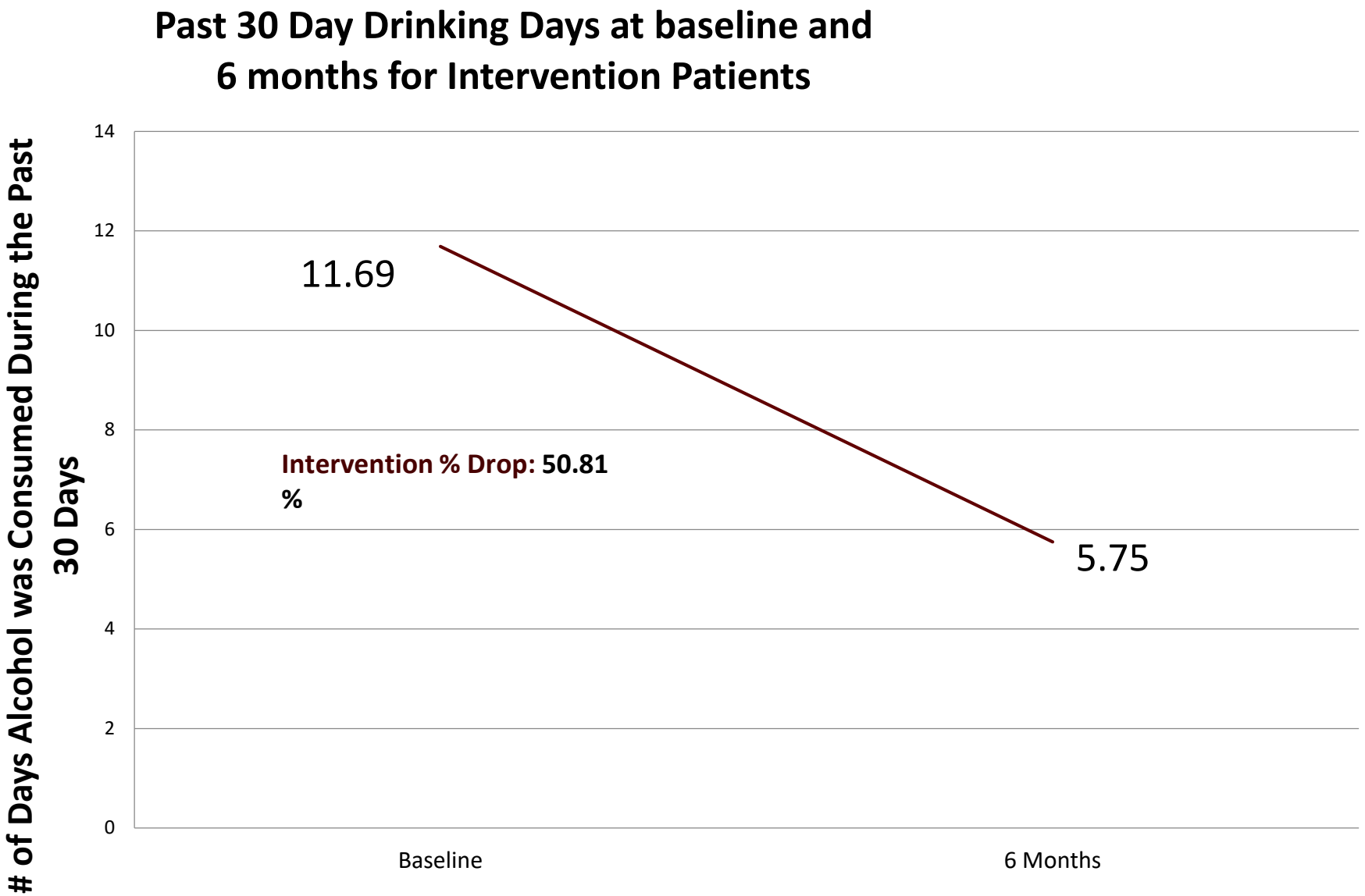
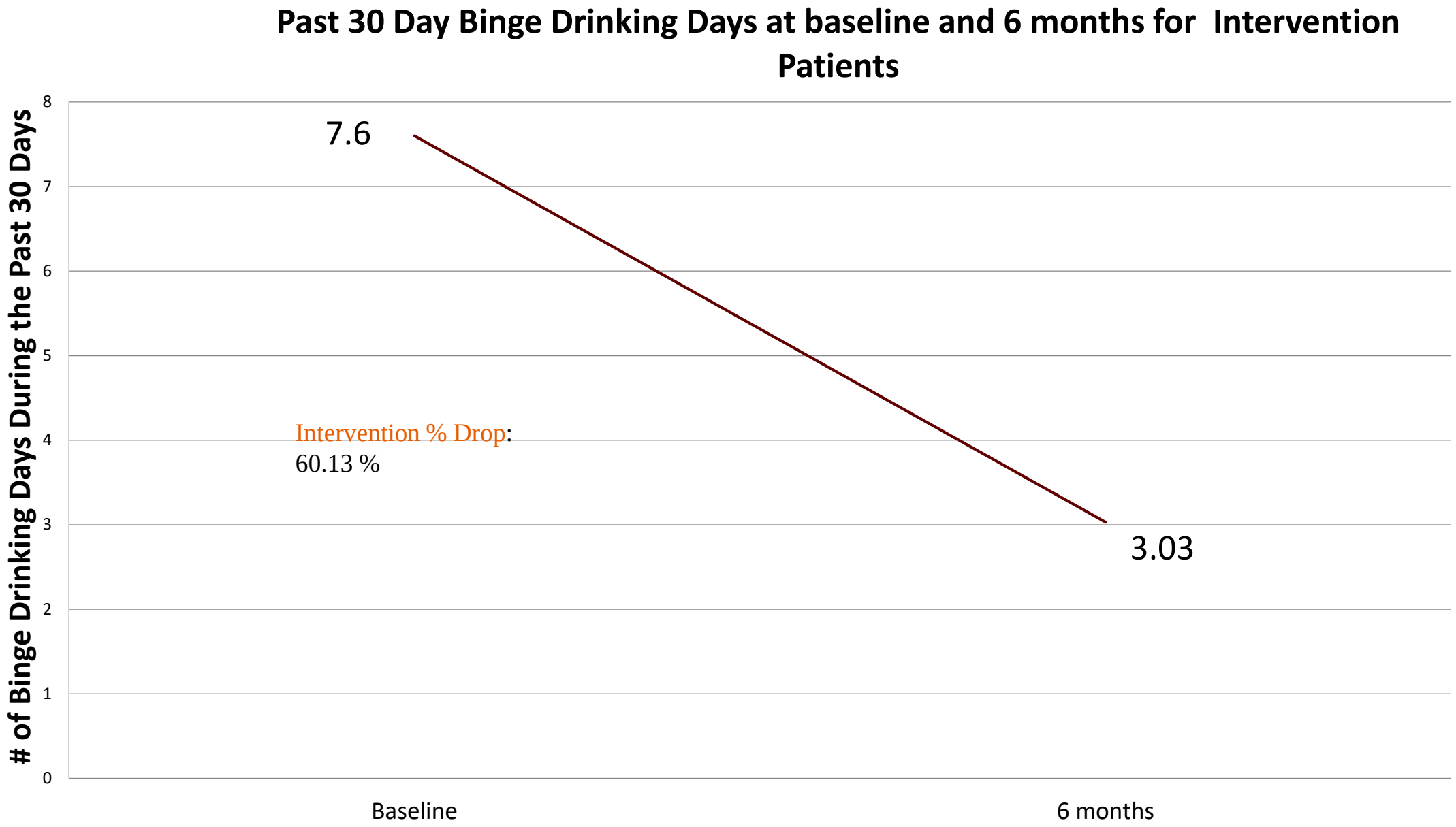


Table 5. Association of Intervention Status and Binge Drinking Days at 6 Months

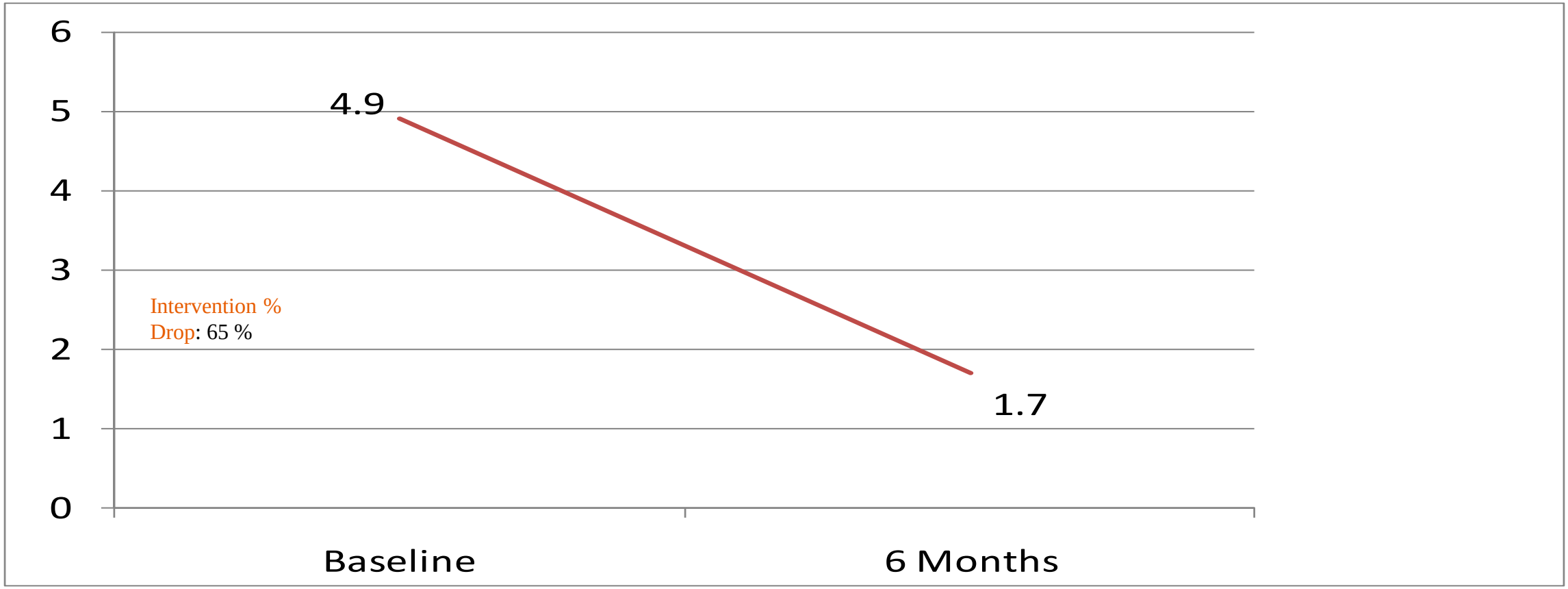
Variable	β	Confidence interval	Significance	R^2
Binge drinking days at baseline	0.265	0.187 to 0.344	<0.001	0.100
Intervention Status	-2.25	-4.08 to -0.419	0.015	0.113

*change in R^2 for intervention status = 0.013


Past 30 Day Drinking Days at baseline and 6 months for Intervention Patients
# of Days Alcohol was Consumed During the Past 30 Days
14
12
10
8
6
4
2
0
11.69
5.75
Intervention % Drop: 50.81 %
Baseline
6 Months


Past 30 Day Binge Drinking Days at baseline and 6 months for Intervention Patients
# of Binge Drinking Days During the Past 30 Days
8
7
6
5
4
3
2
1
0
7.6
3.03
Intervention % Drop:
60.13 %
Baseline
6 months

Past 30 Day Drug Use Days at baseline and 6 months



USPSTF on SBIRT
(US Preventive Services Task Force)

- For both alcohol screening and brief intervention
- Same level of recommendation as flu shots and cholesterol screening

USPSTF, 2004

SBIRT and prevention

- SBIRT ranks in the top 5 highest-ranking preventive services, based on effectiveness and clinic burden.

- Current levels of SBIRT delivery, meanwhile, are the lowest of comparably ranked services.

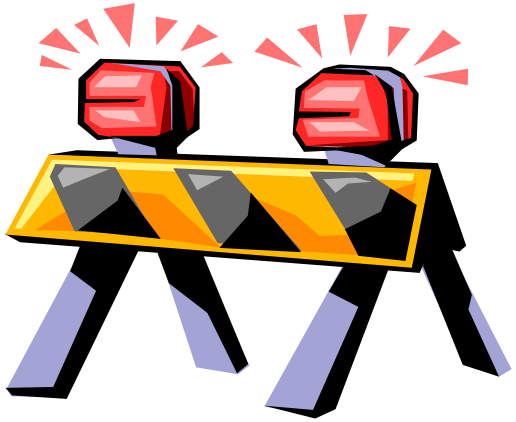
Leif, et al. 2008

Although highest rank tool, evidence also shows it is not used:

- In a study of 241 trauma surgeons, only 29% reported screening most patients for alcohol problems
- In a study of 7, 371 primary care patients, only 29% of patients reported being asked about their use of alcohol or drugs during the past year

- WE ARE NOT ASKING….

Clinician Barriers to Discussing Alcohol with Patients



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CASA: Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse, April 2000

Making a Measurable Difference

- Since 2003, SAMHSA has supported SBIRT programs, with more than 3 million persons screened.
- Outcome data confirm a 40 percent reduction in harmful use of alcohol by those drinking at risky levels and a 55 percent reduction in negative social consequences.
- Outcome data also demonstrate positive benefits for reduced illicit substance use.

Based on review of SBIRT GPRA data (2003–2013)

SBIRT Improves the Health and Welfare of the Whole Community

- Improves public safety
- Reduces social and workplace problems with at-risk users
- Reduces family conflict
- Supports health and wellness of the whole community

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Lessons Learned

- SBIRT is a brief and highly adaptive evidence-based practice with demonstrated results.
- SBIRT has been successfully implemented in diverse sites across the life span.
- Patients are open to talking with trusted helpers about substance use.
- SBIRT makes good clinical and financial sense.

Congratulations!

You have completed Module 1, *What is SBIRT?*

You are now ready to move onto Module 2: Motivational Interviewing

Motivational Interviewing

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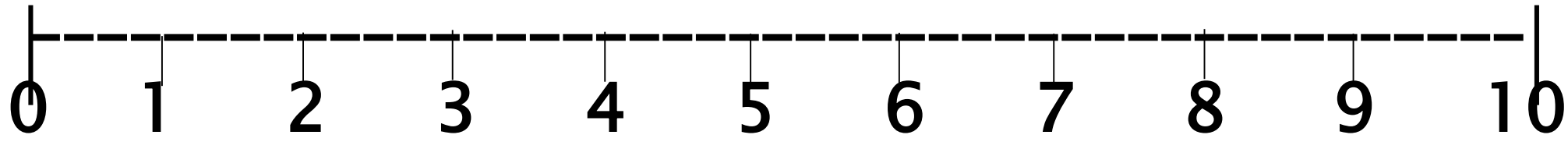
Session Overview

- Review the basic principles of Motivational Interviewing
- Learn simple MI techniques to assist individuals with behavior changes
- Have some fun!

How confident are you in your ability to catalyze change through conversation?

Not very **Very**

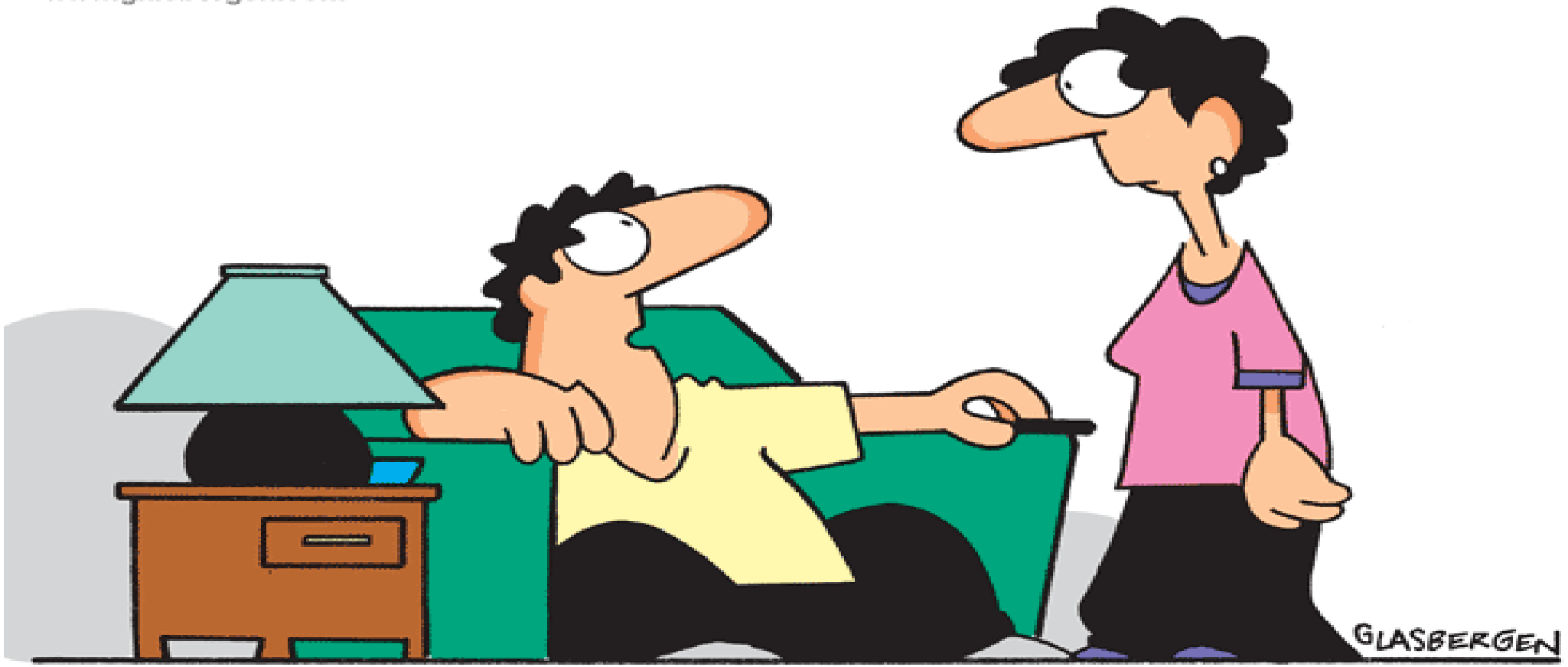


So much to change, so little time

What things do your consumers bring to you that they want to change?

What things do YOU want them to change?

WHY IS CHANGE SO HARD?



"My doctor told me to increase my exercise program, so I switched from not exercising three times a week to not exercising six times a week."

Problem Behaviors: Lifestyle Habits

- Diet
- Exercise
- Tobacco
- Procrastinatic
- Sleep Habits
- TV
- Computer

Think of something you have tried to change in the last 6-12 months.

Rate your success from 0 – 10.

Why Should We Be Interested in Patients' Motivation for Behavior Change?

Motivation Pretest

Let’s find out what you think about motivation.

Beliefs About Motivation

1. Until a person is motivated to change, there is not much we can do.
   a. True
   b. False

Beliefs About Motivation (continued)

2. It usually takes a significant crisis (“hitting bottom”) to motivate a person to change.
   a. True
   b. False

Beliefs About Motivation (continued)

3. Motivation is influenced by human connections.
   a. True
   b. False

Beliefs About Motivation (continued)

4. Resistance to change arises from deep-seated defense mechanisms.
   a. True
   b. False

Beliefs About Motivation (continued)

5. People choose whether or not they will change.
   a. True
   b. False

Beliefs About Motivation (continued)

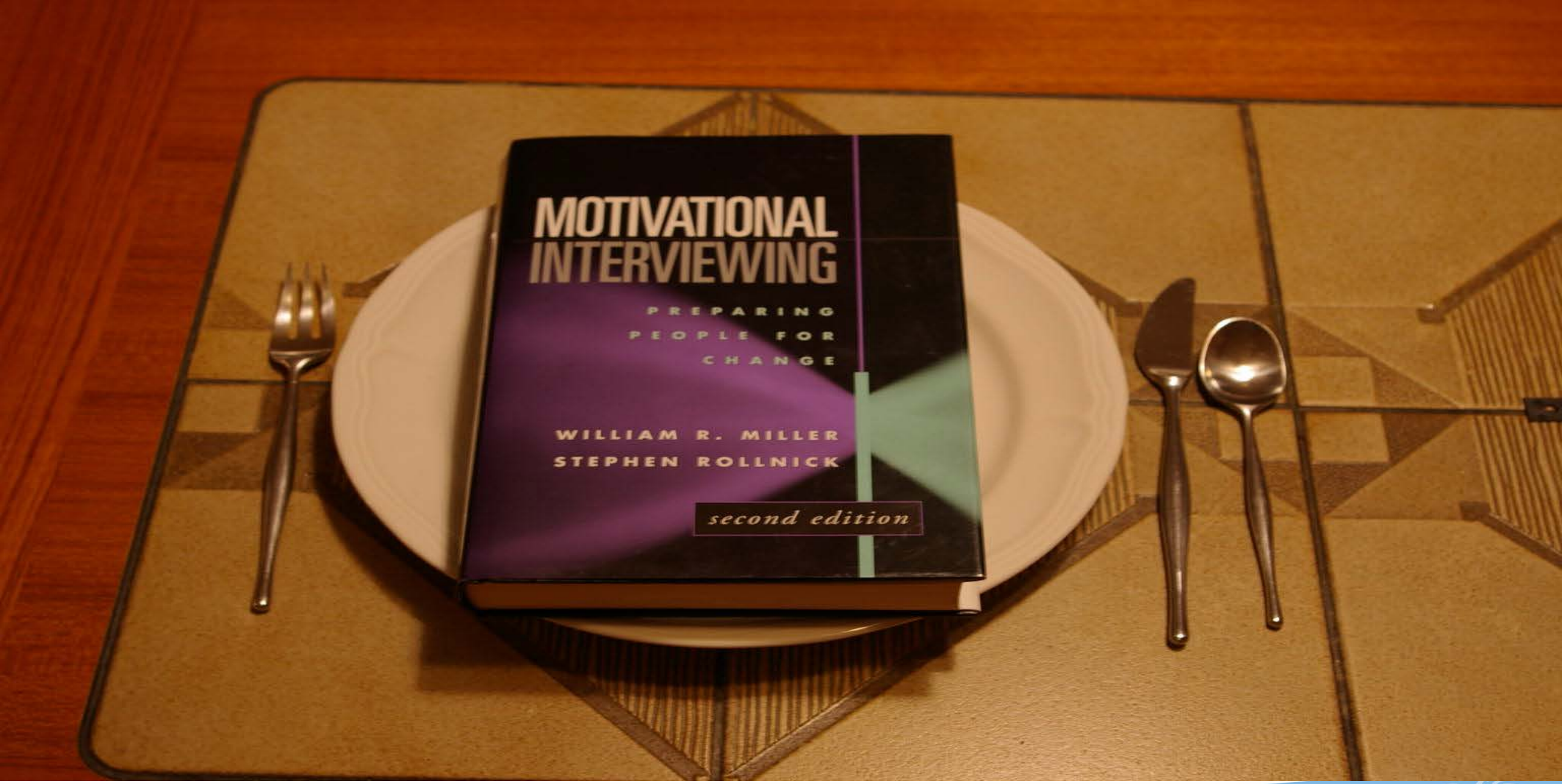
6. Readiness for change may involve a balancing of “pros” and “cons.”
   a. True
   b. False

Beliefs About Motivation (continued)

7. Creating motivation for change usually requires confrontation.
   a. True
   b. False

Beliefs About Motivation (continued)

8. Denial is not a patient problem; it is a clinician's skill problem.
   a. True
   b. False


MOTIVATIONAL
INTERVIEWING
PREPARING
PEOPLE FOR
CHANGE
WILLIAM R. MILLER
STEPHEN ROLLNICK
second edition

A taste of MI

A taste of MI – Round 1

The patient: Role play a person presenting for an appointment, where there is a clearly defined behavior change goal (diet, exercise, taking medication, not using drugs or alcohol, etc.) You are ambivalent and somewhat doubting your ability to change.

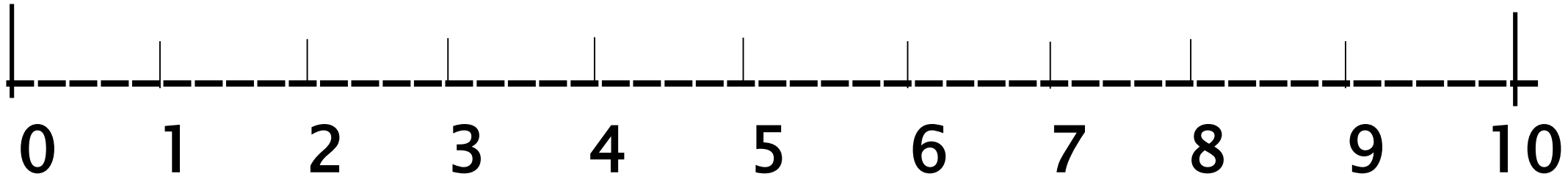
A taste of MI – Round 1

The Worker:

- Explain why the patient ***should*** make this change.
- Give at least three specific ***benefits*** that would result rom making the change.
- Tell the patient ***how*** to change.
- Emphasize how ***important*** it is for the patient to change, the consequences of not changing, and
- Tell the patient to ***do*** it.

Patients, how likely are you to change your behavior a result of this conversation?

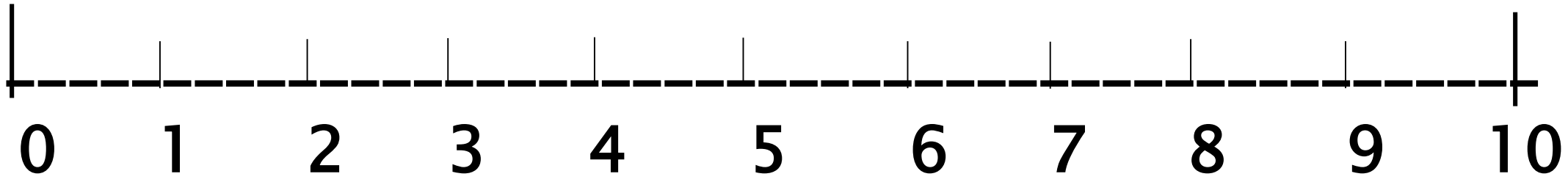
Not likely **Very likely**



An emergency department far, far away….

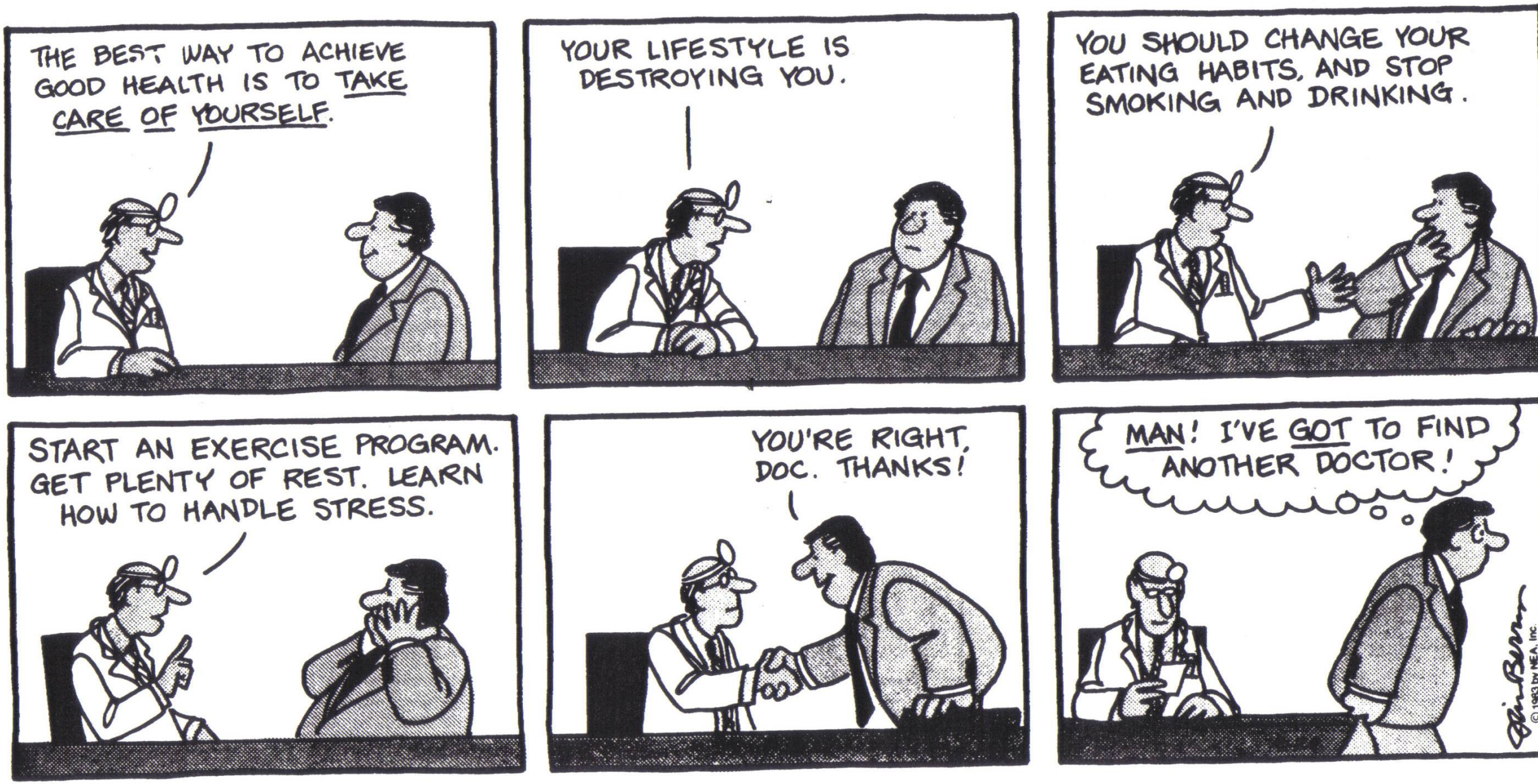
How likely is this patient to change his drinking or reduce his risk as a result of this conversation?

Not likely **Very likely**

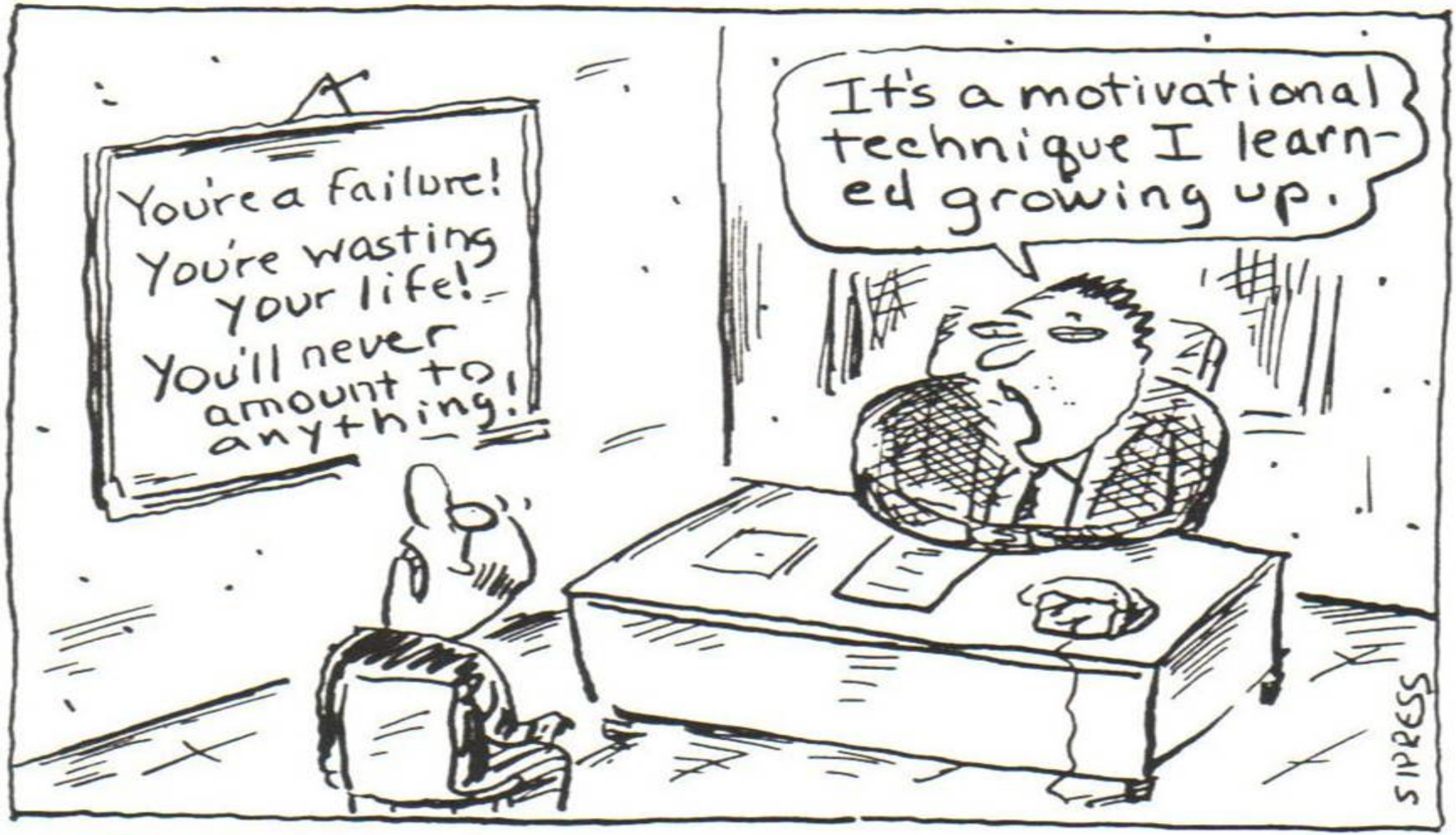


"I was able to get in one last lecture about diet and exercise."

Motivational Interviewing is making KNOWN what You KNOW

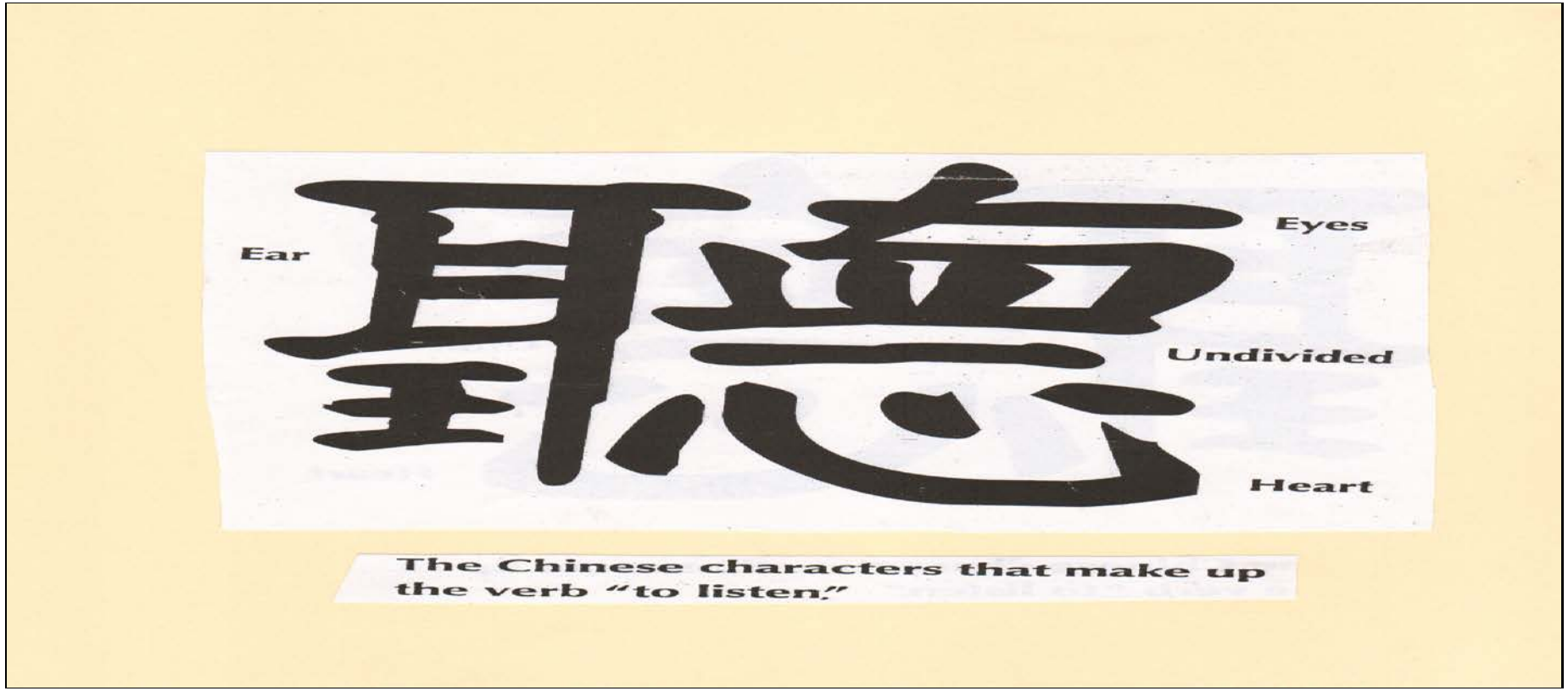

THE BEST WAY TO ACHIEVE GOOD HEALTH IS TO TAKE CARE OF YOURSELF.
YOUR LIFESTYLE IS DESTROYING YOU.
YOU SHOULD CHANGE YOUR EATING HABITS, AND STOP SMOKING AND DRINKING.
START AN EXERCISE PROGRAM. GET PLENTY OF REST. LEARN HOW TO HANDLE STRESS.
YOU'RE RIGHT, DOC. THANKS!
MAN! I'VE GOT TO FIND ANOTHER DOCTOR!

Compassionate Conversation


You're a failure!
You're wasting your life!
You'll never amount to anything!
It's a motivational technique I learned growing up.
SIPRESS

What most people really need is a good listening to.

~Mary Lou Casey



The Chinese characters that make up the verb "to listen."

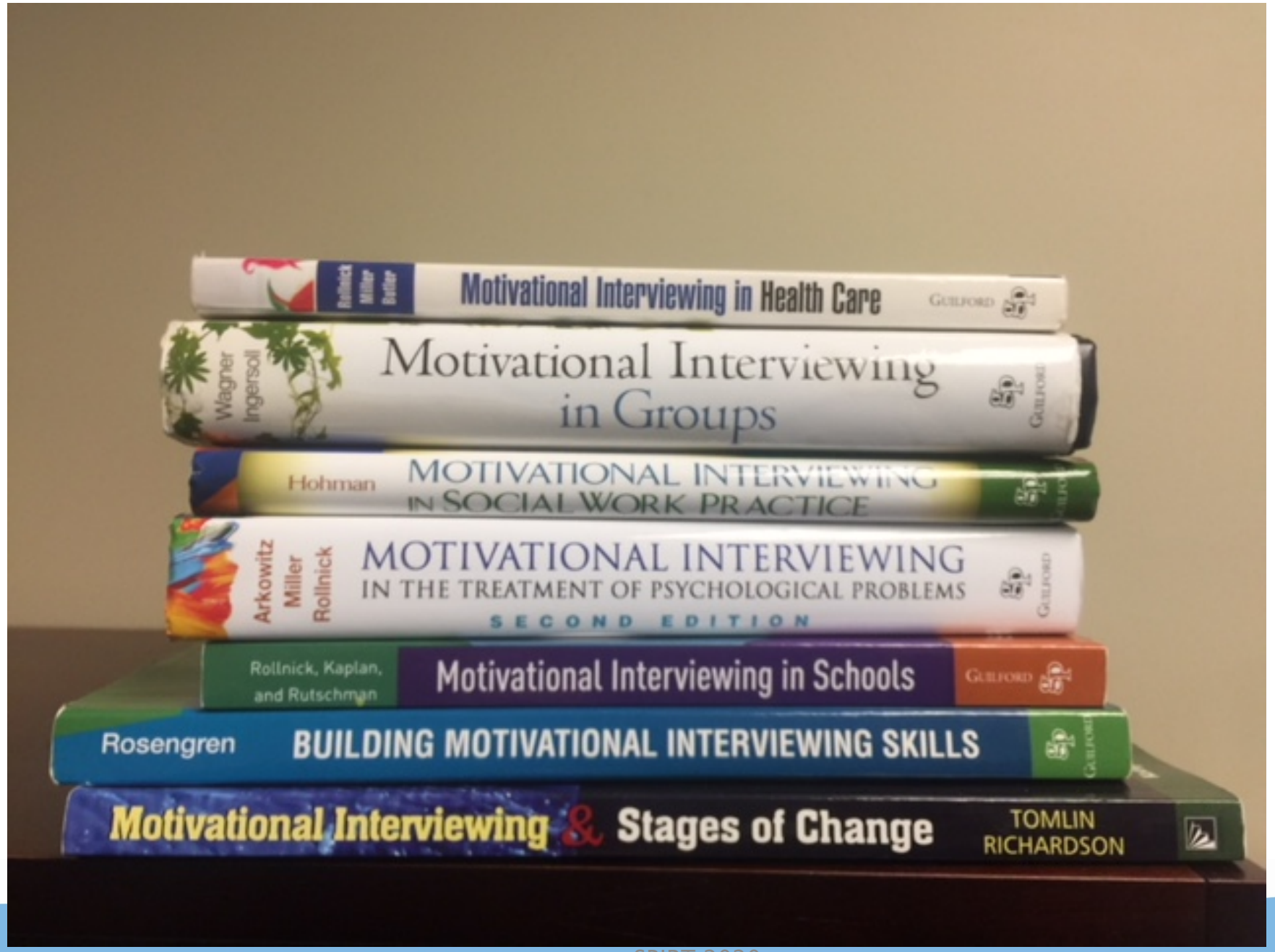

聽意

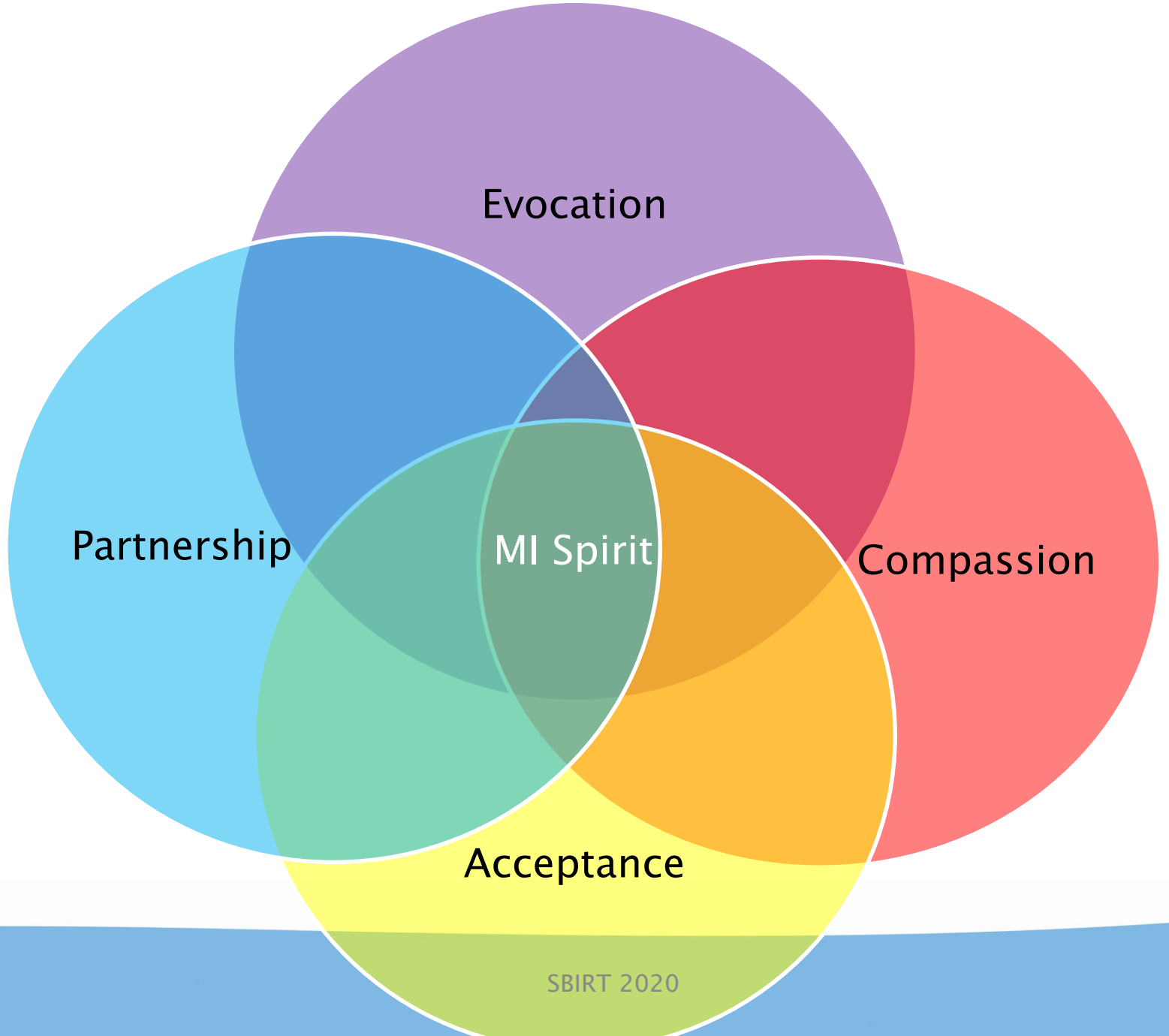
Motivational Interviewing

- Motivational Interviewing is an evidence based, person-centered method for addressing the common problem of ambivalence about change

Miller and Rollnick (2013)

Motivational Interviewing 3rd Ed.


Rollnick
Miller
Butler
Motivational Interviewing in Health Care
GUILFORD
Wagner
Ingersoll
Motivational Interviewing
in Groups
GUILFORD
Hohman
MOTIVATIONAL INTERVIEWING
IN SOCIAL WORK PRACTICE
Arkowitz
Miller
Rollnick
MOTIVATIONAL INTERVIEWING
IN THE TREATMENT OF PSYCHOLOGICAL PROBLEMS
SECOND EDITION
GUILFORD
Rollnick, Kaplan,
and Rutschman
Motivational Interviewing in Schools
GUILFORD
Rosengren
BUILDING MOTIVATIONAL INTERVIEWING SKILLS
GUILFORD
Motivational Interviewing & Stages of Change
TOMLIN
RICHARDSON


Evocation
Partnership
MI Spirit
Compassion
Acceptance

"…. is loving, selfless concern for the person's welfare" (Miller & Rollnick, 2013)

Acceptance

"I accept you for who you are and am here to help whatever you decide to do."

Partnership

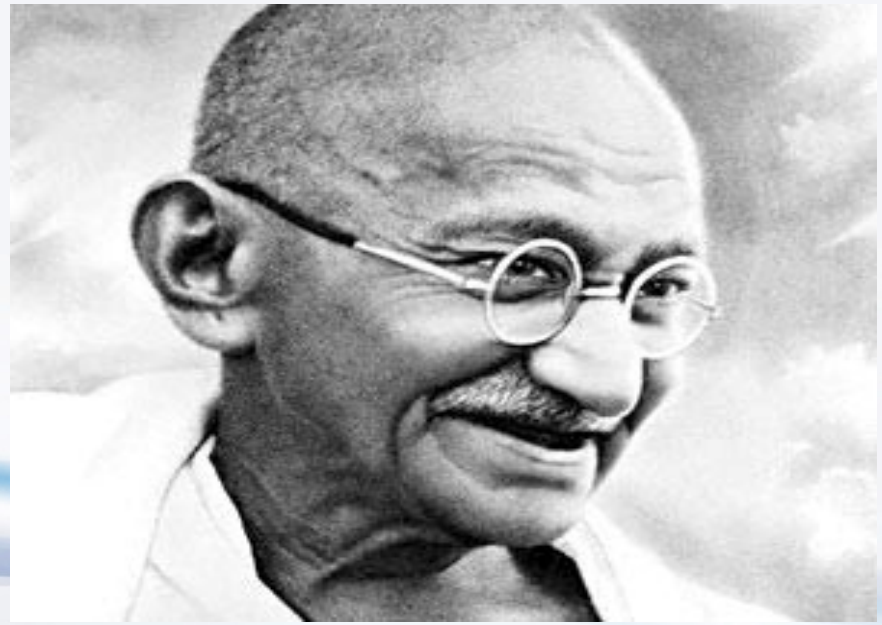
"You are the best judge of what is going to work for you."

Evocation


Compassion
Acceptance
Partnership
Evocation

But what if the client refuses to change?

What if the patient refuses to change?



- “A ‘No’ uttered from the deepest conviction is better than a 'Yes' merely uttered to please, or worse, to avoid trouble.”
  - Mahatma Gandhi

Avoiding the "Righting Reflex"

People in the helping professions have a natural tendency to want to fix what's wrong with patients

Yes but….

- A very common reactive response
- Assumes ‘I know better than you’
- Forces patient defensiveness
- When patient defends, it reinforces why not to change
- Not changing is now justified in mind of patient

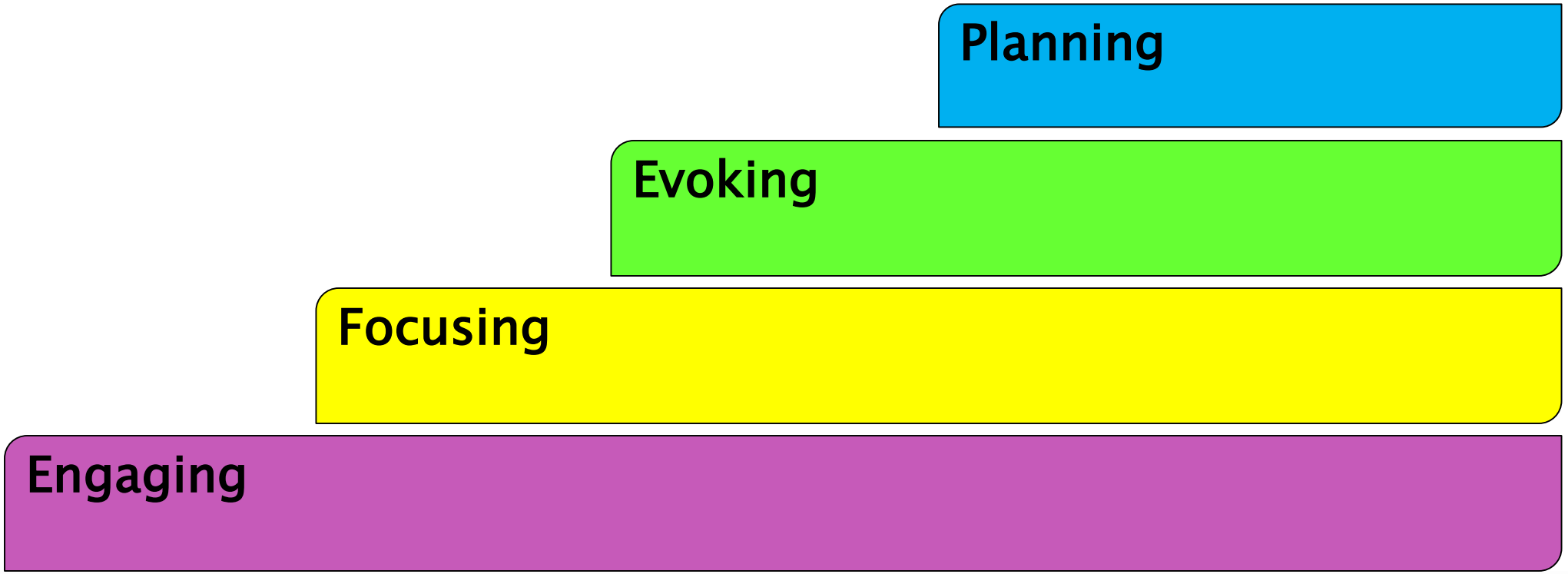
Common Reactions to Righting Reflex

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

Common Human Reactions to Being Listened to

- Understood
- Want to talk more
- Liking the clinician
- Open
- Accepted
- Respected
- Engaged
- Able to change
- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to come back
- Cooperative

Four Fundamental Processes of MI



Engaging

The Relational Foundation

Focusing

Guiding patient to a target behavior (that is important to them)

Evoking

Drawing out patient's intrinsic motivation and their own ideas for change

Planning

The Bridge to Change

Motivational Interviewing

- Assumes motivation is fluid and can be influenced
- Motivation is influenced in the context of a relationship – developed in the context of a patient encounter
- Principle tasks – to work with ambivalence and discord
- Goal – to influence change *in the direction of* health

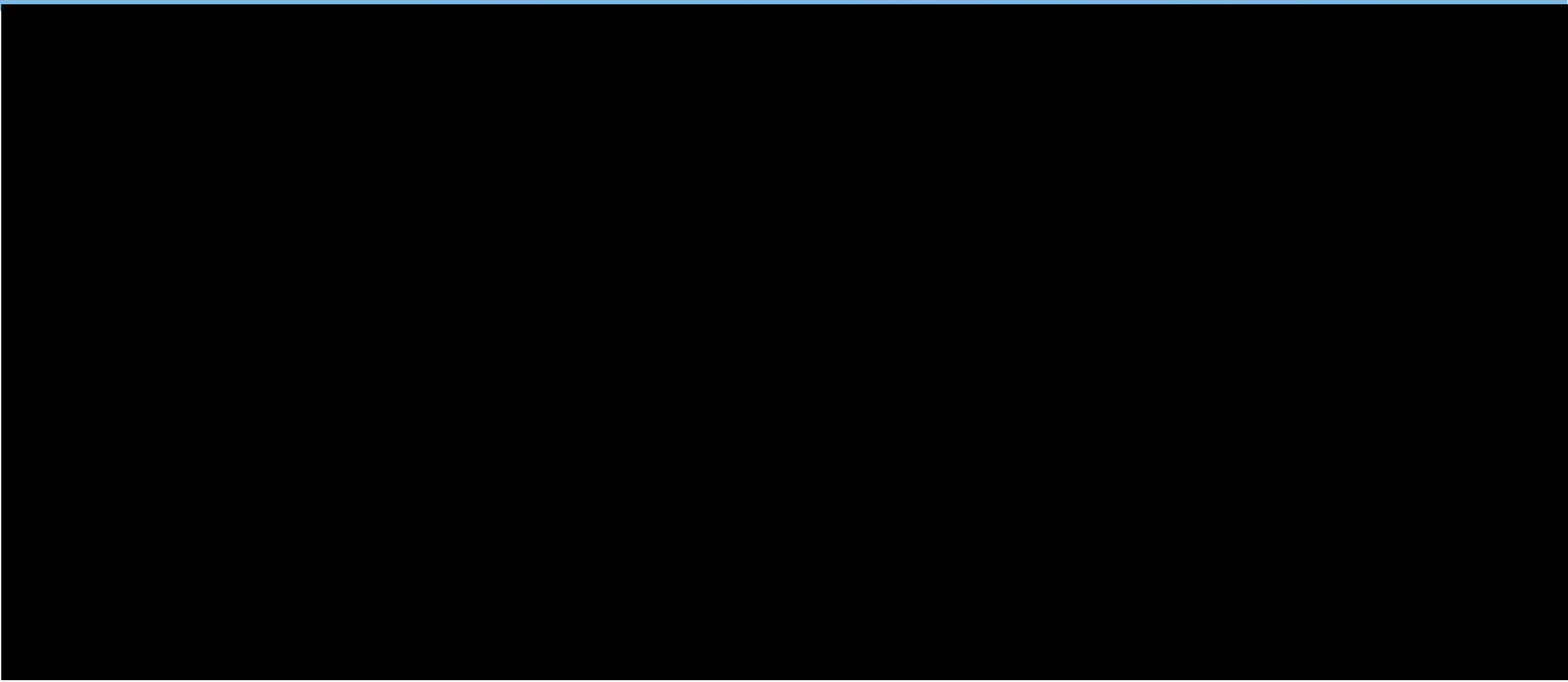
AMBIVALENCE

IS....


THE BEST THING YOU CAN DO IS GIVE UP SMOKING, DRINKING AND FRIED FOOD
WHAT'S THE SECOND BEST?

Fundamental Belief

- *The capacity and potential for change and adherence is within every person!*



How Does Motivational Interviewing Work?

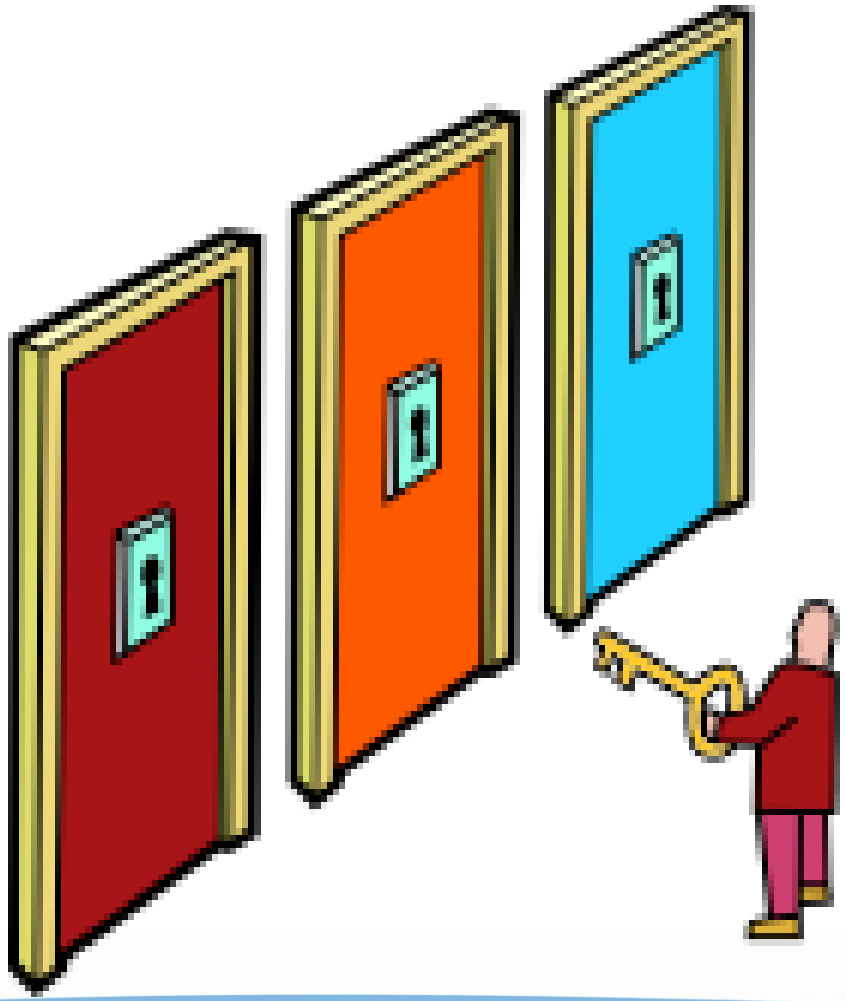
"Motivational interviewing is a style of communication that involves strategic use of questions and statement to help patients find their own reasons for change."

William Miller

OARS + I - MI Skills

- O – Open questions
- A – Affirmations
- R – Reflections
- S – Summaries
- +I - Information

Closed Questions sound like…



"Do you…Are you… Did you… Could you…Have you…?"

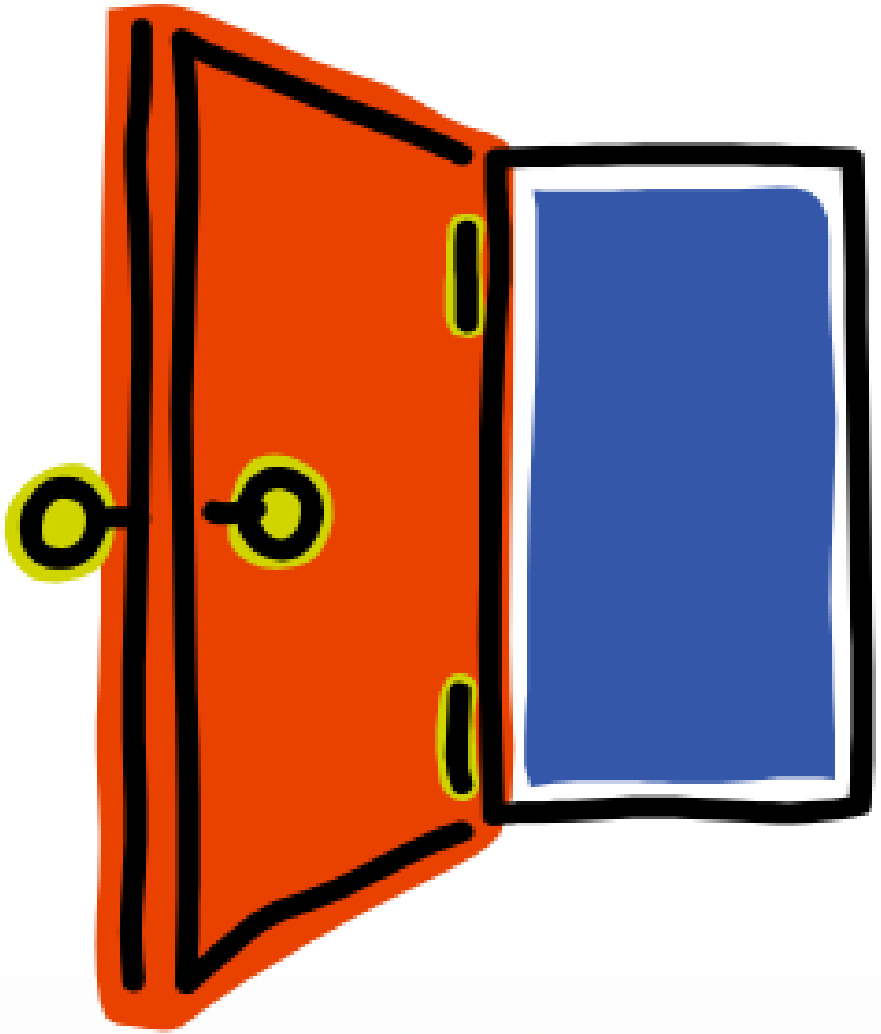
"Did you quit eating fast food?"

"Do you care about your family?"

"Did you think before you did that?"

"Do you have a drinking problem?"

Open-Ended Questions sound like…



"What…. Which…. Where… How… Tell me…"

- ✓ "How does it feel to be eating healthier?"
- ✓ "Where do you think your biggest challenge lies?"
- ✓ "What do you think you'll take care of first?"
- ✓ "Tell me about your family?"

Affirmations…

- Affirmations are sincere, specific and immediate.
- Affirmations are not cheerleading.

Affirmations

- Emphasize a strength
- Notice and appreciate a positive action
- Should be genuine
- Build feelings of empowerment
- Instill hope and “can-do” attitude
- Express positive regard and caring
- Strengthen the relationship

Reflections

Reflective Listening

Reflective listening is one of the hardest skills to learn.

"Reflective listening is a way of checking rather than assuming that you know what is meant."

(Miller and Rollnick, 2002)

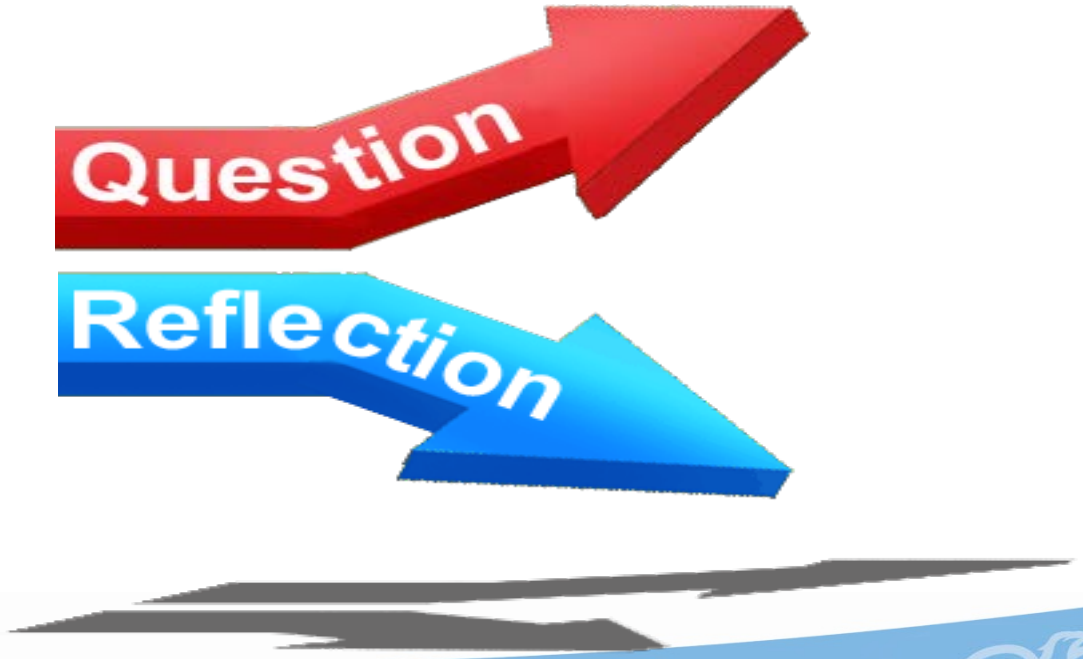
OARS

Phoenix Center

Prevent • Treat • Recover

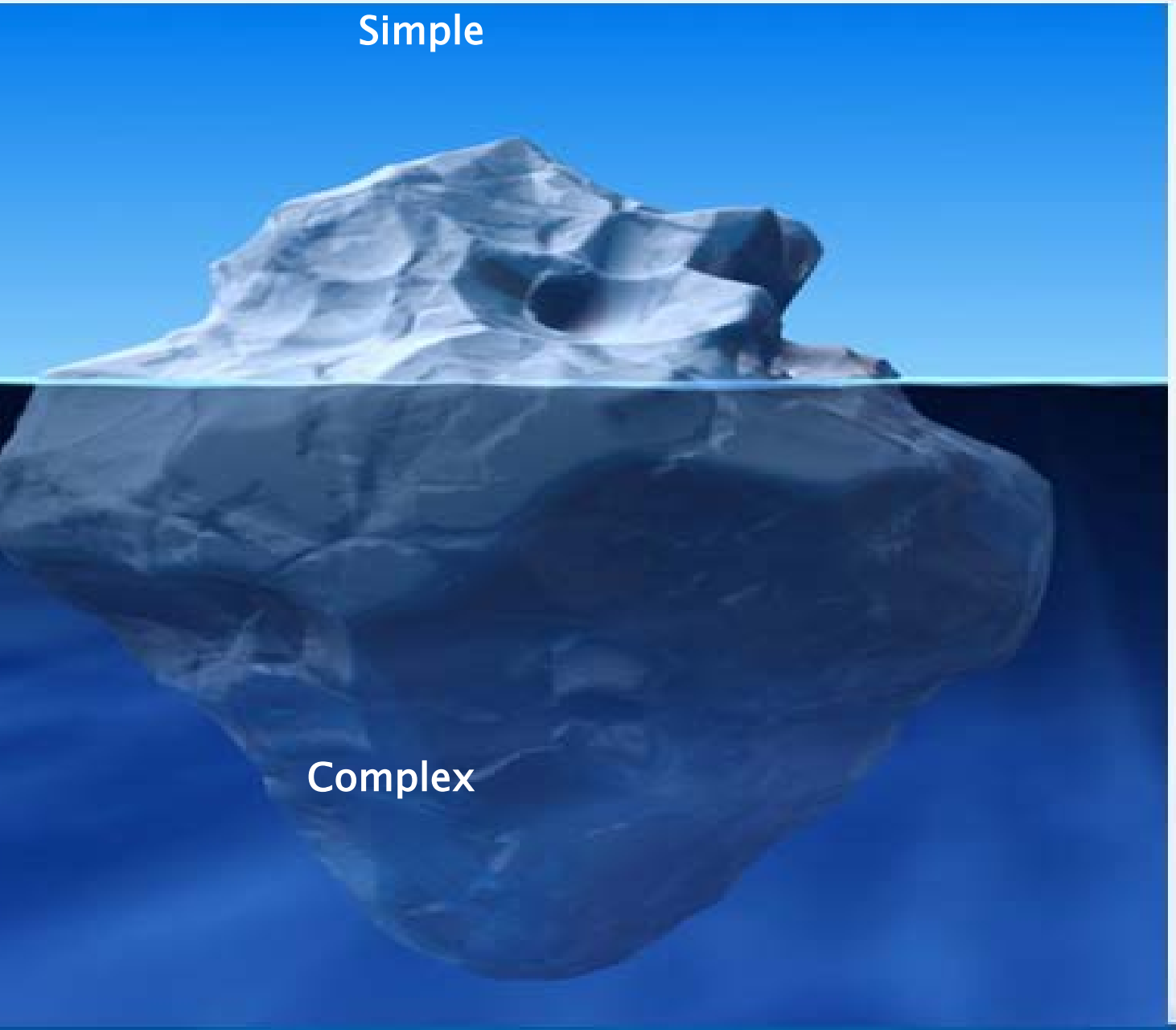
Reflective Listening

- A hypothesis (guess) about patient's meaning
- A statement to convey understanding and empathy
- Intonation down
- Short stems
  - "So…"
  - "Sounds like…"
  - "So you…"
  - "Seems like …"
  - "Its like…"
  - "You feel…"



Reflective Listening

- Involves listening and understanding the meaning of what the patient says
- Strengthens the empathic relationship
- Accurate empathy is a predictor of behavior change



Patient: “I’ve tried to quit and failed so many times.”

“You have not been successful.”

“You are persistent, even in the face of discouragement. This change must be really important to you.”

Levels of Reflection: Complex

- Complex Reflection—makes a guess
  - Paraphrasing—major restatement, infers meaning, "continuing the paragraph"

Patient: *"Who are you to be giving me advice? What do you know about drugs? You've probably never even smoked a joint!*

Clinician: *"It's hard to imagine how I could possibly understand."*

***

Patient: *"I just don't want to take pills. I ought to be able to handle this on my own."*

Clinician: *"You don't want to rely on a drug. It seems to you like a crutch."*

Levels of Reflection: Simple

- Simple Reflection—stays close
  - Repeating
  - Rephrasing (substitutes synonyms)
- Example

Patient: I hear what you are saying about my drinking, but I don't think it's such a big deal.

Clinician: So, at this moment you are not too concerned about your drinking and don't think it's a big deal.

Levels of Reflection: Complex

- Complex Reflection
  - Reflection of feeling—deepest

Patient: *My wife decided not to come today. She says this is my problem, and I need to solve it or find a new wife. After all these years of my using around her, now she wants immediate change and doesn't want to help me!*

Clinician: *Her choosing not to attend today's meeting was a big disappointment for you.*

Double-Sided Reflections

A double-sided reflection attempts to reflect back both sides of the ambivalence the patient experiences.

Patient: But I can't quit smoking. I mean, all my friends smoke!

Clinician: You can't imagine how you could not smoke with your friends, and at the same time you're worried about how it's affecting you.

Reflective listening…..

Summary

- **Set up Bookend**:
  - “Let me see if I have this right…”
  - “Let me summarize what you’ve said…”
- **Reflection, Reflection, Reflection**
- **Follow up Bookend**:
  - “So where does that leave you?
  - “What else would you like to add?”
  - “Now, tell me about ….”
  - “Tell me more about…”

Summary Statements:

Check your understanding of the person's situation as a whole

Reflect back key components of what the person has discussed

Signal a transition to another topic or the end of the session/consultation

Highlight change talk


Change
Talk


Changes
NEXT EXIT

Types of Change Talk:

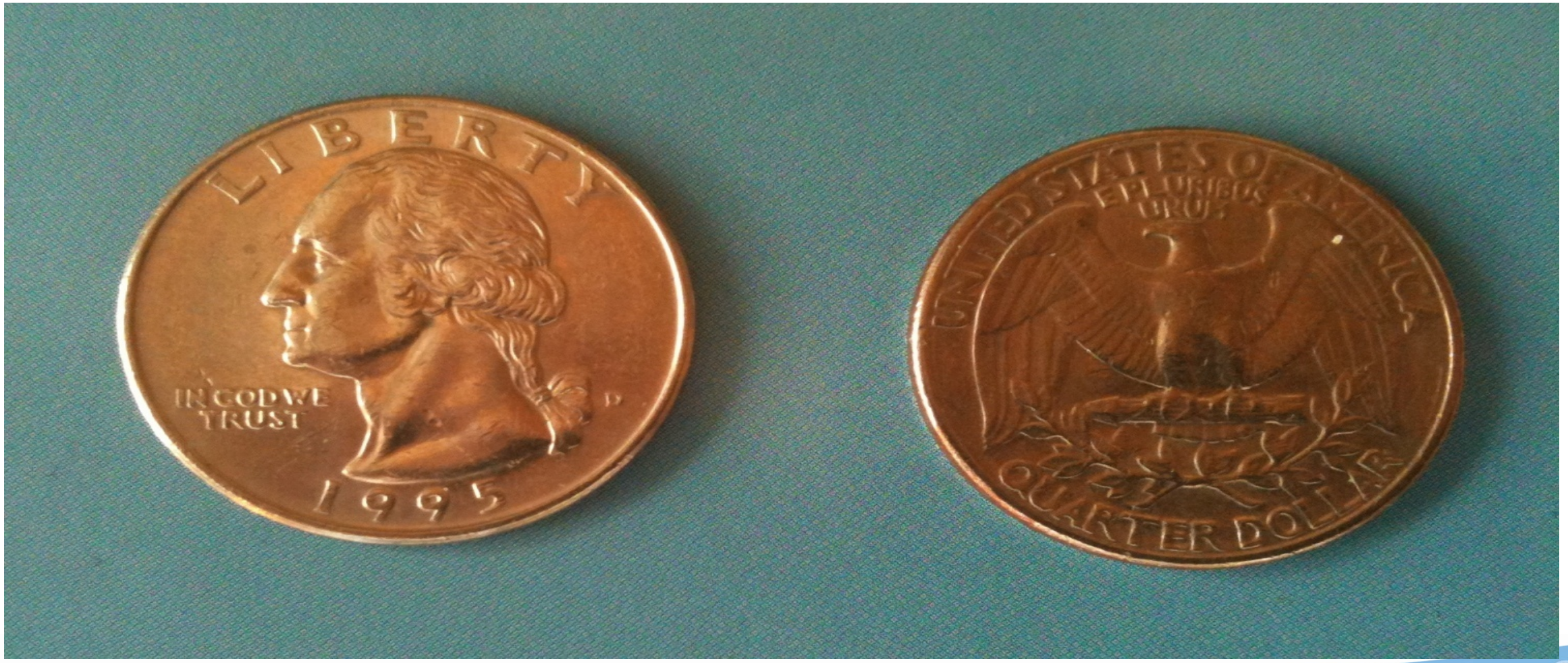
- **D**esire — I want to…. I'd really like to… I wish…
- **A**bility — I would… I can…. I am able to… I could…
- **R**eason — There are good reasons to…
  This is important….
- **N**eed — *I really need to…*
- **C**ommitment — *I intend to… I will… I plan to…*
- **A**ctivation — I'm ready… I'm able
- **T**aking Steps — I haven't had a drink in two weeks.

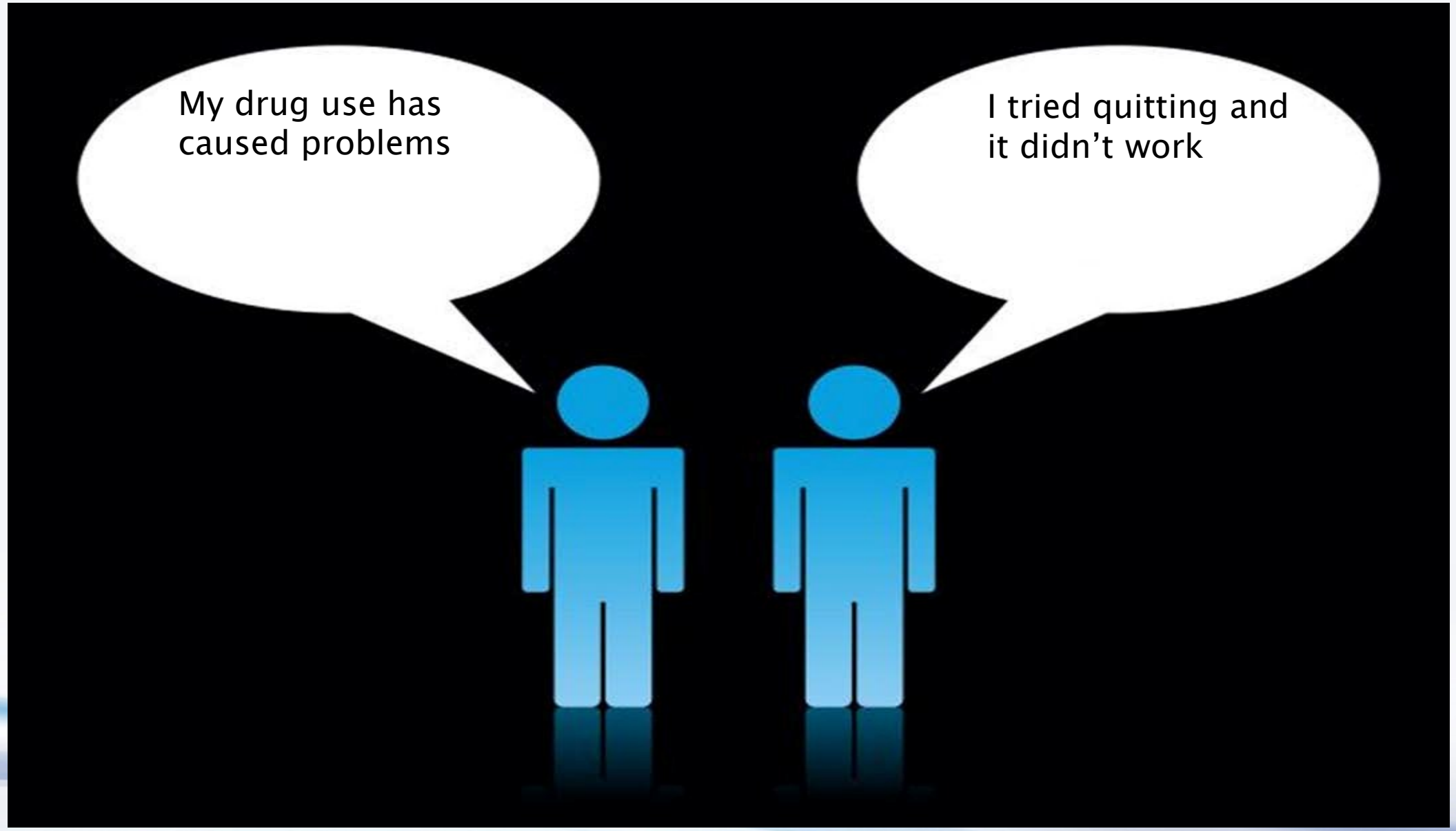
DARN CATs

Yet another metaphor:
MI Hill

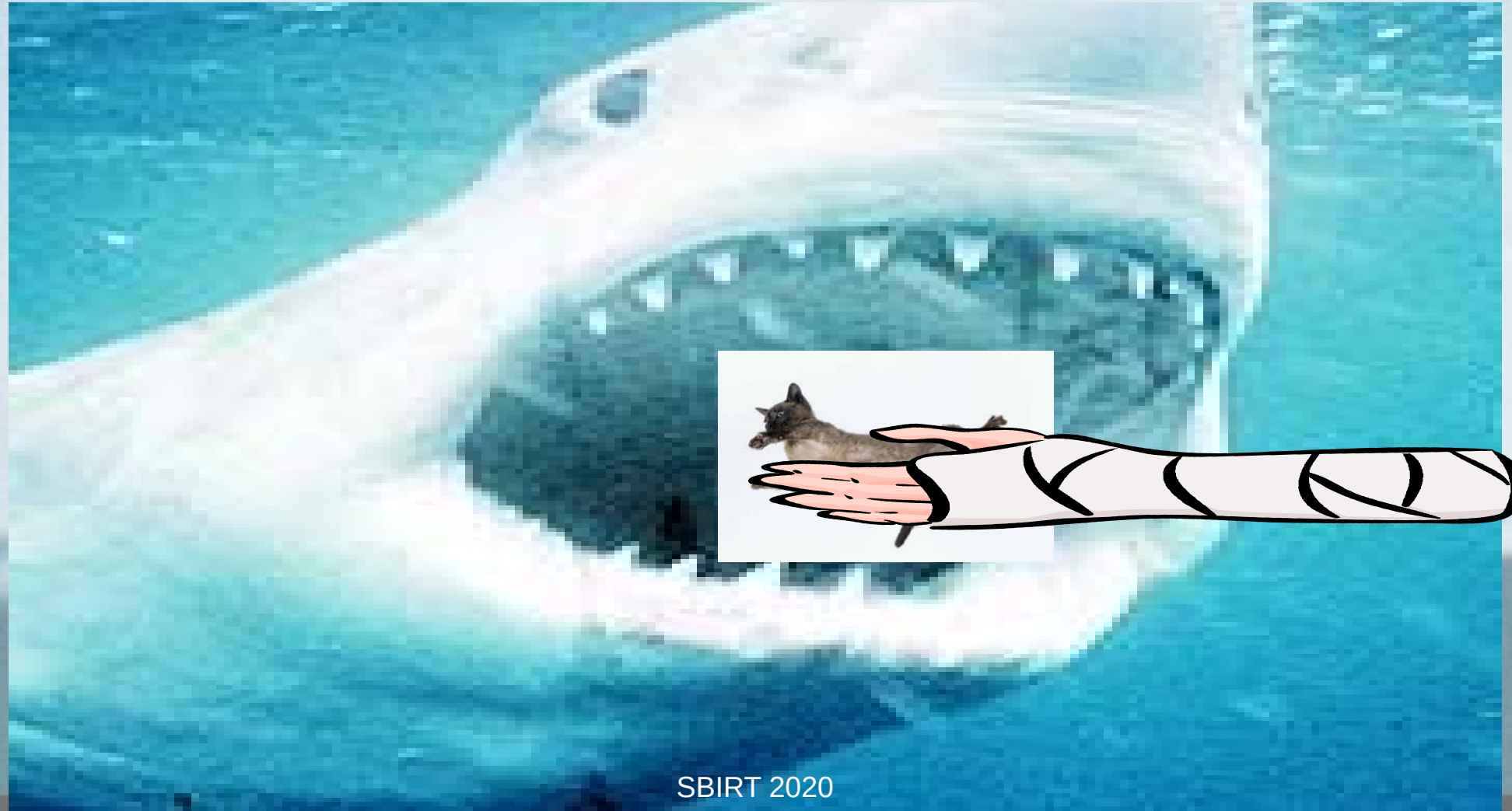
Thanks to Bill Miller

Change and Sustain Talk




My drug use has caused problems
I tried quitting and it didn't work

Snatching Change Talk from the Jaws of Ambivalence




Fistral Beach, Newquay

Snatching Change Talk from the Jaws of Ambivalence

- Change talk often comes intertwined with sustain talk
- That’s the nature of ambivalence

Snatching Change Talk from the Jaws of Ambivalence

- I really don’t want to stop smoking, but I know that I should. I’ve tried before and it’s really hard.
  - 1. You really don’t want to change
  - 2. It’s pretty clear to you that you ought to quit.
  - 3. You don’t think you can quit.

- See, the thing is, all my friends drink. Some of them probably drink way too much too, but if I quit drinking, I don’t have any friends. I just stay home.
  - 1. That would be pretty lonely
  - 2. Quitting would cause a new problem for you.
  - 3. And at the same time you recognize that you and probably some of your friends are drinking way too much.

- I know you’re worried that I’m getting addicted, and I guess I can see what you mean, but I really need more pain medicine. I don’t know how I would get through the day without it. If you won’t prescribe it, then I’ll find someone else who will.
  - 1. You understand my worry about dependence.
  - 2. It’s hard to imagine how you would get along without more medicine.
  - 3.One way or another, you’re going to get more medicine.

Change Talk is everywhere!

Intentions
Macklemore

- I wanna be sober, but I love getting high
  Wanna give it a hundred percent, but I'm too afraid to try
  I wanna be faithful, but love hooking up with randos
  I wanna live by the law, but still think like a vandal
  I wanna get exercise, but I'm too lazy to workout
  I want all the finer things, but don't wanna go to work now
  I wanna go outside, take my family to the beach
  I wake up in the morning, first thing I do is look at a screen, at a screen
- Wanna live freely, why isn't it so easy?
  I should read a book, but I keep watching this TV
  And I know this lifestyle doesn't really feed me
  I just tune out to the voice inside that's speaking

- All my little problems keep on building up and building up
  All my good intentions just ain't good enough to find the love
  So I smoke until my lungs are full
  Drink until I lose my cool
  Apology's my middle name and one day, I will change
  But I'm okay with who I am today
  I'm okay with who I, who I am today
- I want world peace, but I wanna watch Worldstar
  I know that I should stay home, and still wanna kick it where the girls are
  I wanna be a feminist, but I'm still watching porno
  I wanna eat healthy, but I'ma eat this DiGiornos
  We live on social media, read other people's thoughts
  Tweet about justice, but don't show up to the march
  I think about the earth and I think about the eco
  What am I willing to sacrifice at the expense of my ego?

- Wanna live freely, why isn't it so easy?
  I should read a book, but I keep watching this TV
  And I know this lifestyle doesn't really feed me
  I just tune out to the voice inside that's speaking
- All my little problems keep on building up and building up
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  But I'm okay with who I am today
  I'm okay with who I, who I am today
  I'm okay with who I am today
  I'm okay with who I, who I am today

Change-Talk Eliciting Strategies

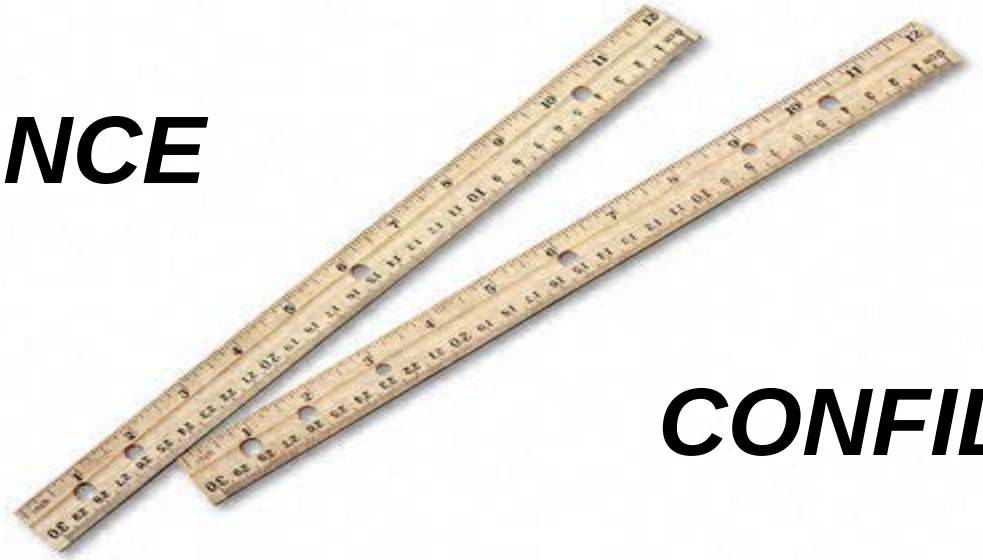
- Decisional Balance
  - Ambivalence is a normal part of the change process
  - Use ambivalence to promote positive change
  - Weigh pros and cons of behavior
  - Increase discrepancy

DECISIONAL BALANCE SHEET

Good things:	Not so good things:

Using Rulers to Assess Motivation

IMPORTANCE



CONFIDENCE

READINESS

Negotiate a plan of action

- Invite active participation by the patient
- Patient determines goals & priorities
- Patient weighs options
- Together, work out details of the plan

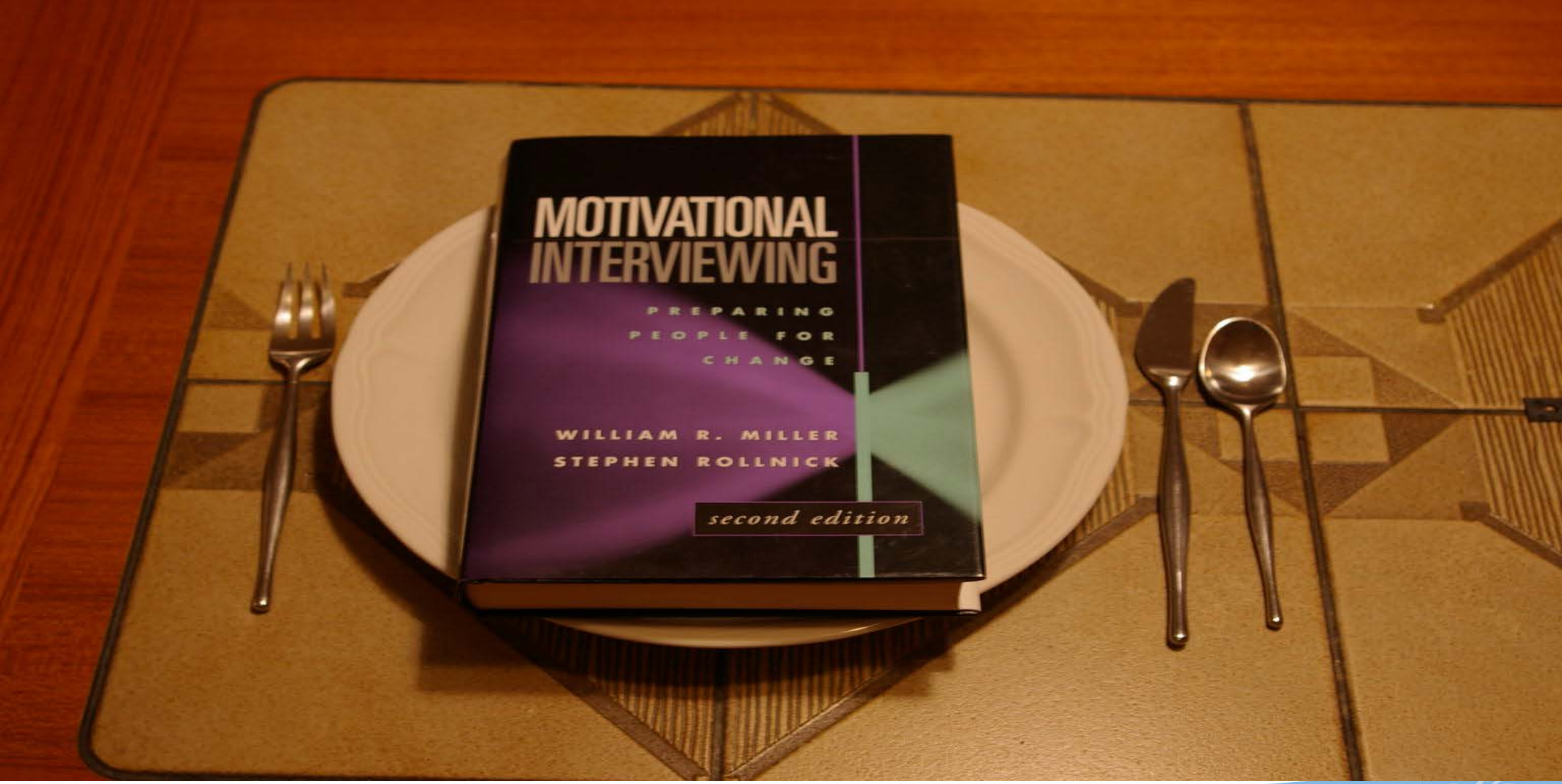
Finalizing the motivational interview

Summarize

- Review the commitment
- Review the plan
- Express encouragement

Giving Information and Advice: *3 Kinds of Permission*

1. The person asks for advice
2. You ask permission to give advice
3. You qualify your advice to emphasize autonomy


MOTIVATIONAL
INTERVIEWING
PREPARING
PEOPLE FOR
CHANGE
WILLIAM R. MILLER
STEPHEN ROLLNICK
second edition

A taste of MI

A taste of MI – Round 2

The patient: Talk about something about yourself that you want to change / need to change / should change / have been thinking about changing etc., but haven't changed yet (i.e., something you're ambivalent about.)

A taste of MI – Round 2 cont'd

Worker:

Listen carefully with a goal of understanding the dilemma. Give no advice. Ask these four questions:

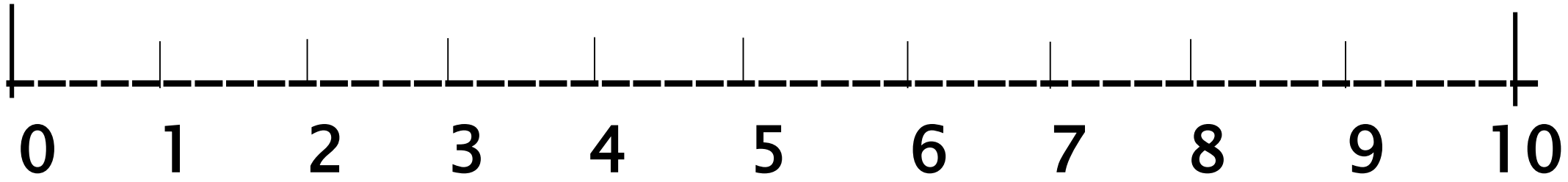
1. Why would you want to make this change?
2. How might you go about it, in order to succeed?
3. What are the three best reasons to do it?
4. On a scale from 0 to 10, how important would you say it is for you to make this change?

Summarize what they said about ***Desire*** for change, ***Ability*** to change, ***Reason***s for change, ***Need*** for change.

Then ask, "So what do you think you'll do?" and just listen with interest.

Patients, how likely are you to change your behavior a result of this conversation?

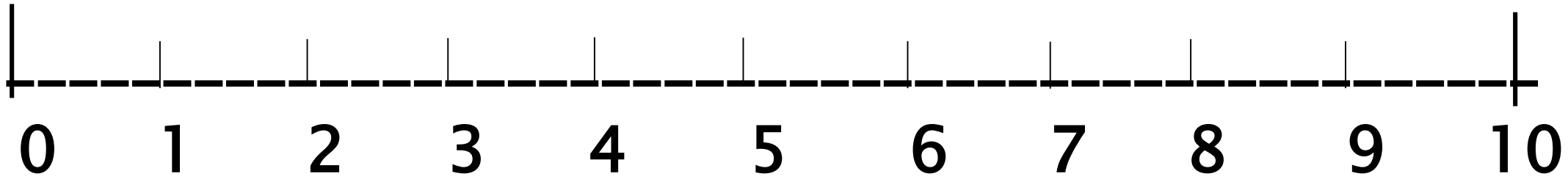
Not likely **Very likely**



Return to an emergency department far, far away….

How likely is this patient to change his drinking or reduce his risk as a result of this conversation?

Not likely **Very likely**



The MI Shift

From feeling responsible for changing patients' behavior to *supporting them in thinking & talking about their own reasons and means for behavior change.*

Congratulations!

You have completed Module 2, *Motivational Interviewing*

You are now ready to move onto Module 3: Screening

Module 3:
Screening
Patients for Substance Use in Your Practice Setting

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HOPES
Funded by SAMHSA Grant 1H79TI026428 (TI026428)

Before We Begin……

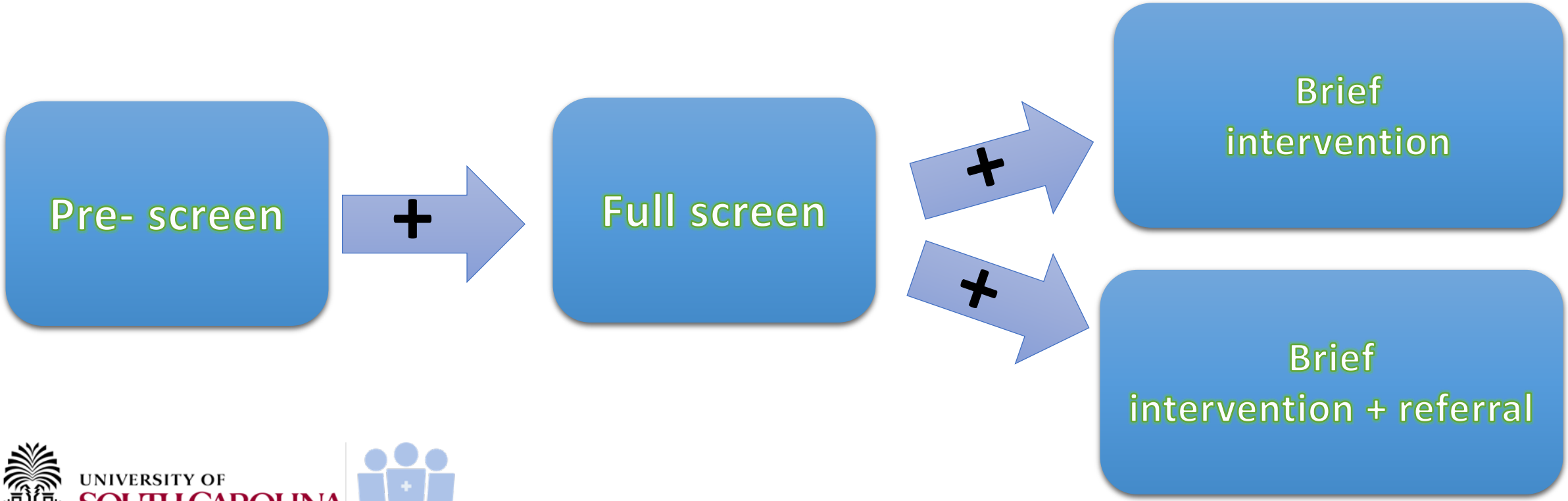
- I have handed out copies of the **BNI Steps**, the **AUDIT**, the **DAST** and the **Pocket Card** so that you may refer to these as we move through the material.

Learning Objectives

At the end of this training module you will be able to:

- Describe the SBIRT method
- Define levels of risk of alcohol and substance use
- Ascertain levels of risk using AUDIT & DAST screening instruments
- Determine next steps based on screening results

The SBIRT Method



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Rationale for Screening

- Drinking and drug use are common.
- Drinking and drug use can increase risk for health problems, safety risks, and a host of other issues.
- Drinking and drug use often go undetected.
- Clients are more open to discuss their use and change than you might expect.

Why Screen Universally?

- Detect current health problems related to at-risk alcohol and substance use at an early stage—before they result in more serious disease or other health or social problems.
- Detect alcohol and substance use patterns that can increase future injury or illness risks.
- Intervene and educate about at-risk alcohol and other substance use.
- Research has shown that approximately 90 percent of substance use disorders go untreated (NSDUH, 2017).

Prescreening Strategy

Use brief yet valid screening questions:

- The NIAAA Single Question Screener
- The Single Question Drug Screener

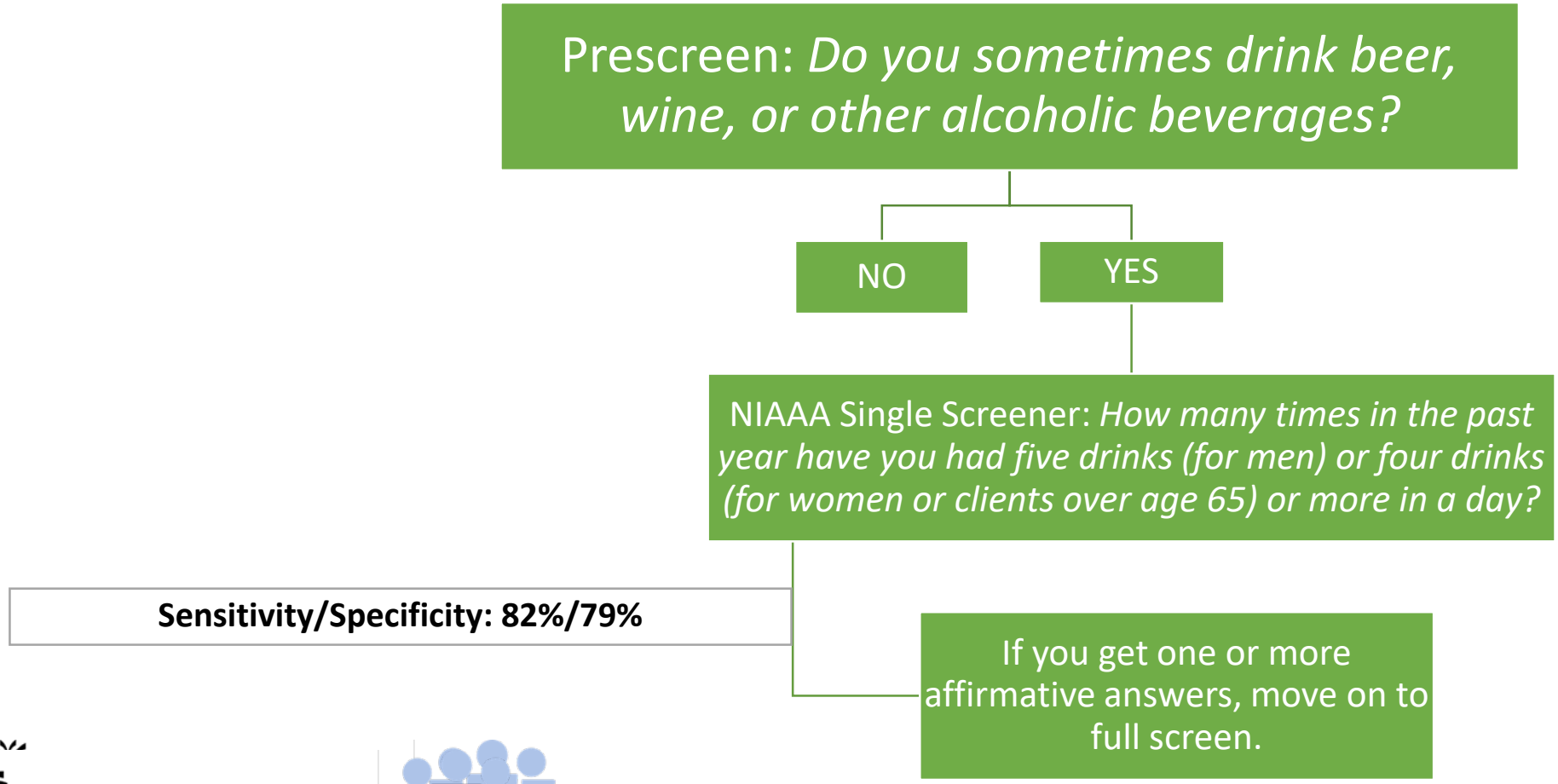
Negative

- Based on previous experiences with SBIRT, screening will yield 75–80 percent negative responses.

Positive

- If you get a positive screen, you may ask further assessment questions.

Prescreening for Alcohol



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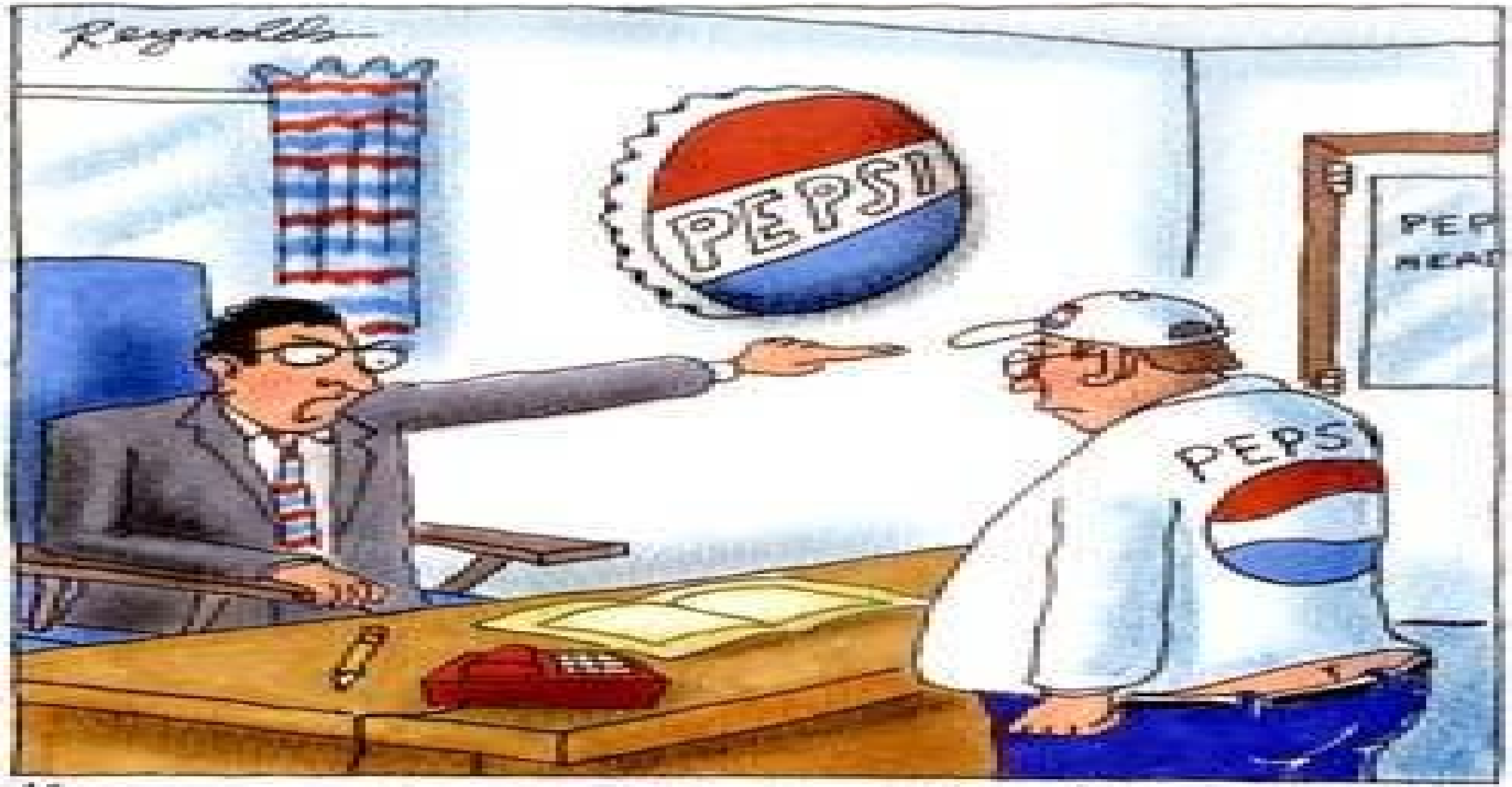
Source: Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2009). Primary care validation of a single-question alcohol screening test. *J Gen Intern Med, 24*(7), 783–788.

Detecting Risk Factors Early

Screening can be a significant step toward effective intervention:

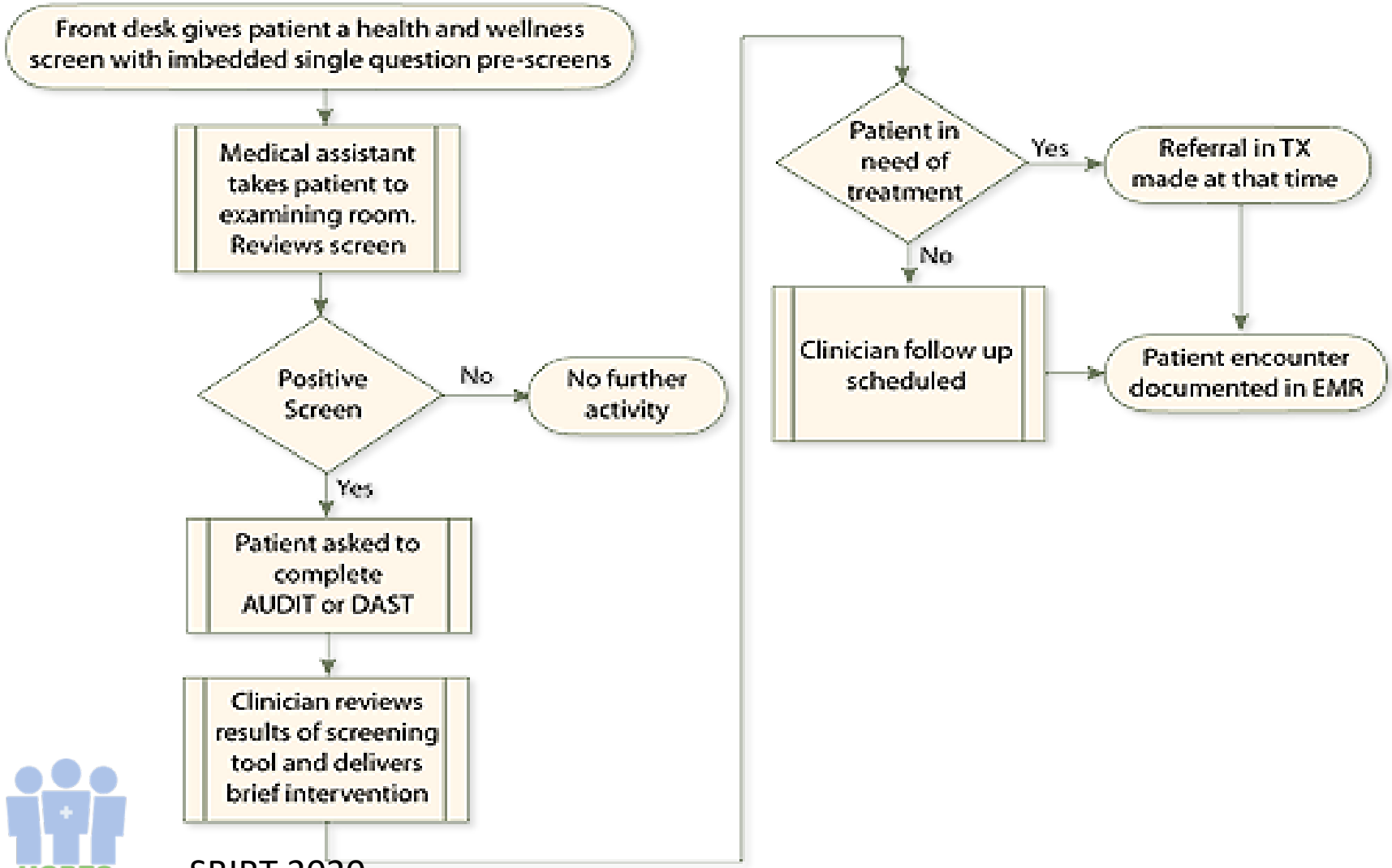
- The clinician is often the first point of contact.
- Early identification and intervention lead to better outcomes.
- Patients are often seen by a clinician because of a related physical problem.

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* Retrieved from http://www.unodc.org/ddt-training/treatment/a.html


Reynolds
PEPSI
PEPS
"You're fired, Jack. The lab results just came back, and you tested positive for Coke."

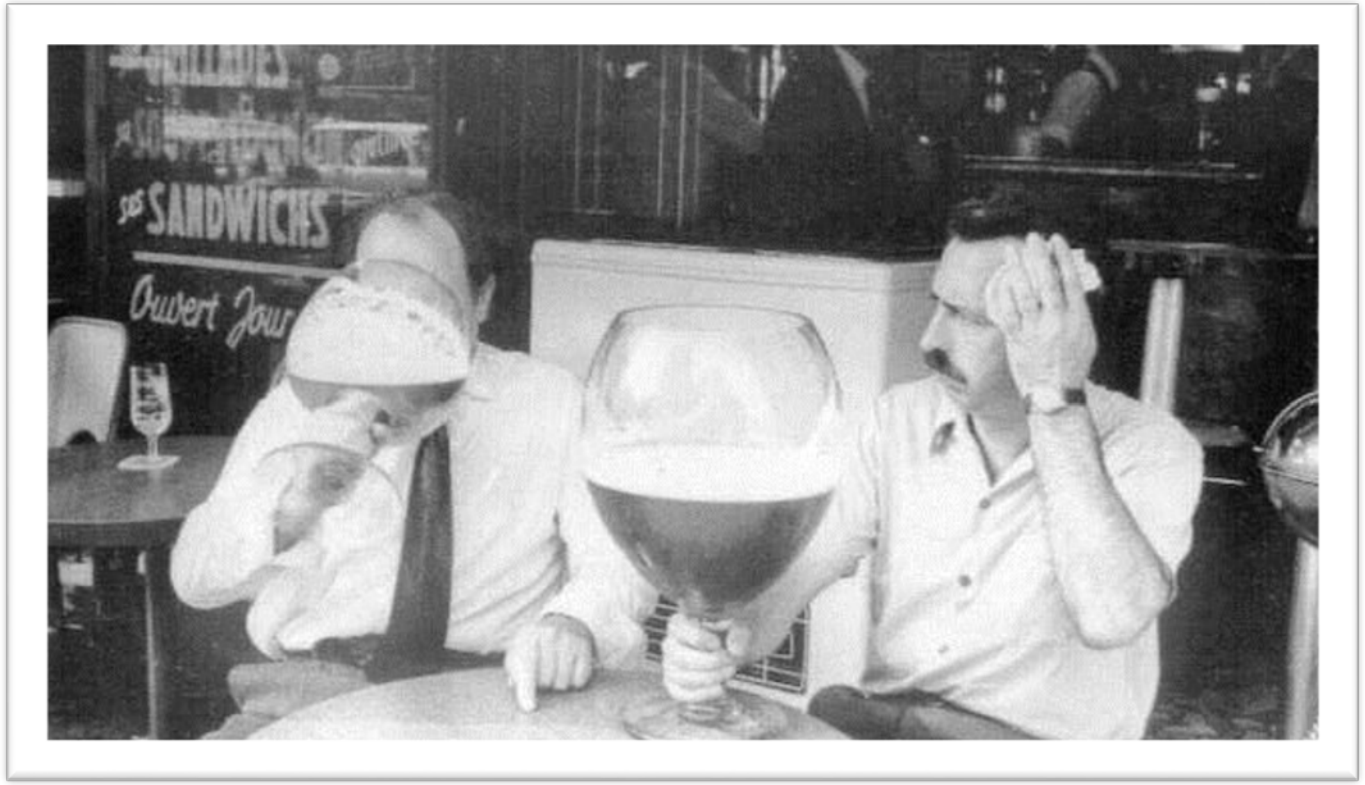
Screening in a Practice Setting

Most practices use a teaming approach



Alcohol Use Screening

When Screening, It's Useful To Clarify What One Drink Is!



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How Much Is “One Drink”?

5-oz glass of wine
(5 glasses in one bottle)

1.5-oz spirits
80-proof
1 jigger

12-oz glass of beer (one can)

Equivalent to 14 grams pure alcohol

How Much Is "One Drink"?

12 fl. oz **regular beer**	=	8 - 9 fl. oz **malt liquor** (shown in a 12 oz. glass)	=	5 fl. oz **table wine**	=	1.5 fl. oz shot of **90-proof spirits** (hard liquor - whiskey, gin, run, vodka, tequila, etc.)
						
about 5% alcohol		about 7% alcohol		about 12% alcohol		about 40% alcohol

The precent of "pure" alcohol expressed here as alcohol by volume (alc/vol) varies by beverage.

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SBIRT 2020

How Much Is "One Drink"?

Lines on a 16 oz cup exist to help with appropriate measurement!

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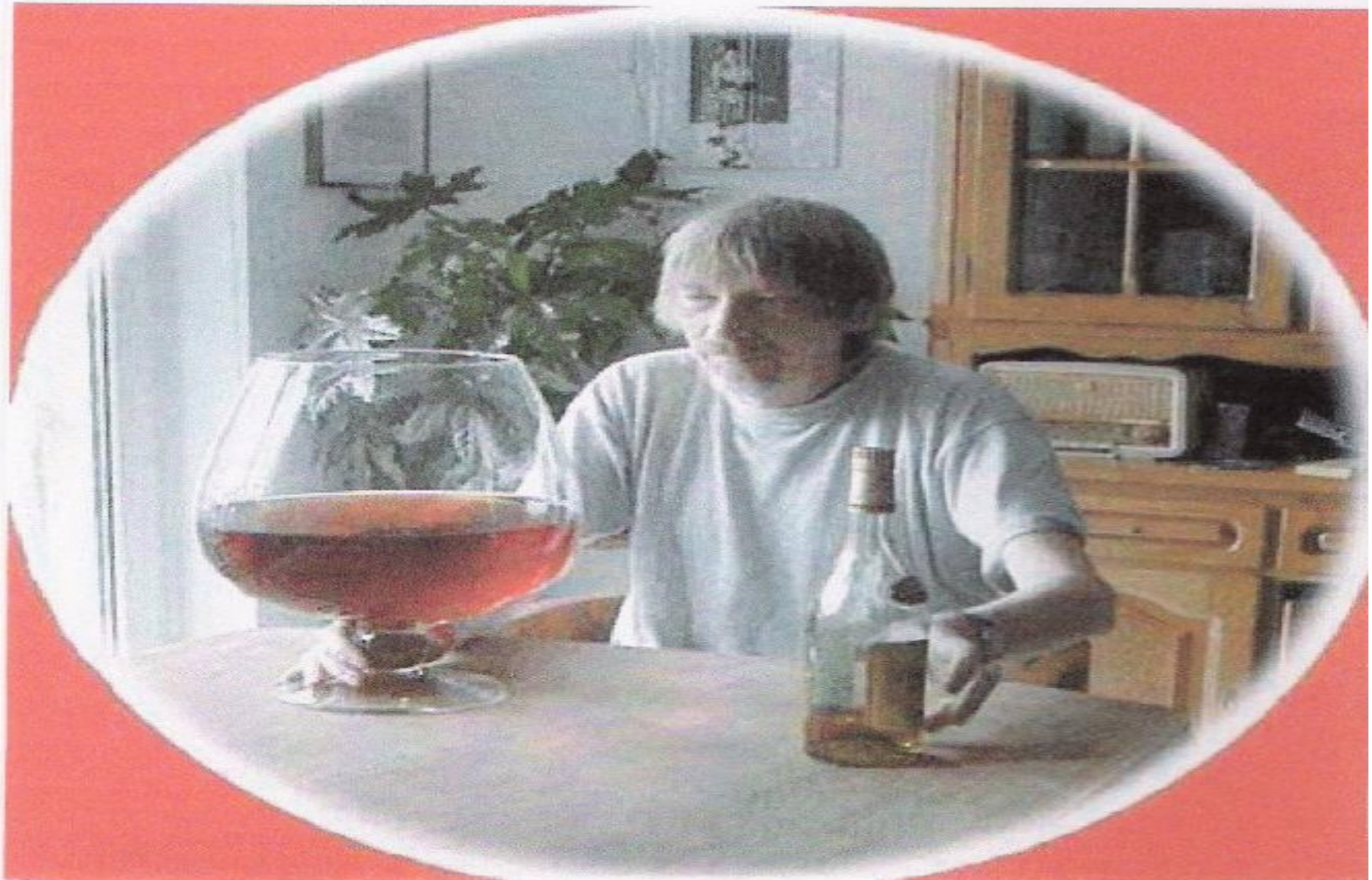
SBIRT 2020

What Is At-Risk Drinking?

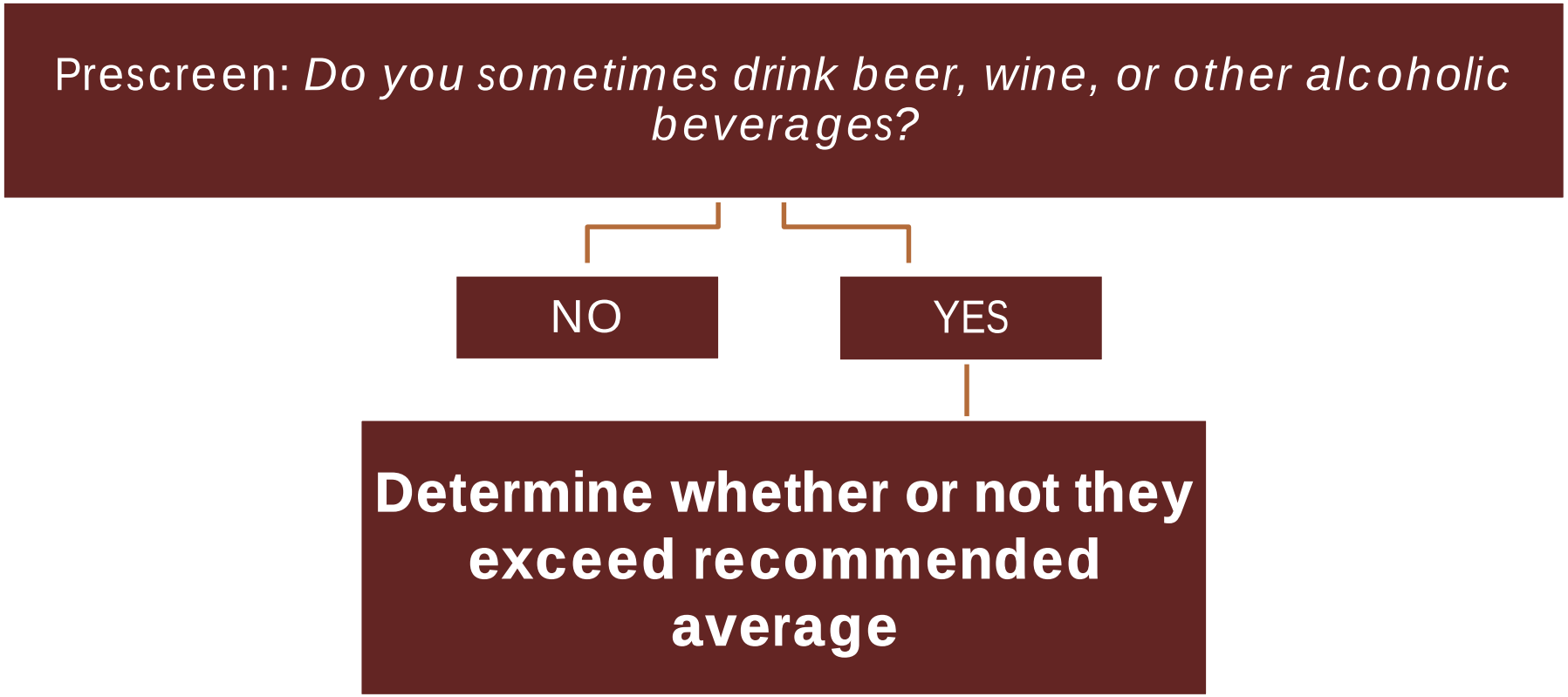
- **Men:** More than 14 drinks per week (*2 drinks* per day) **and** no more than 4 drinks on any one day

- **Women:** (and anyone age 65+): more than 7 drinks per week (*1 drink* per day) **and** no more than 3 drinks on any one day

My Doctor said "Only 1 glass of alcohol a day". I can live with that.

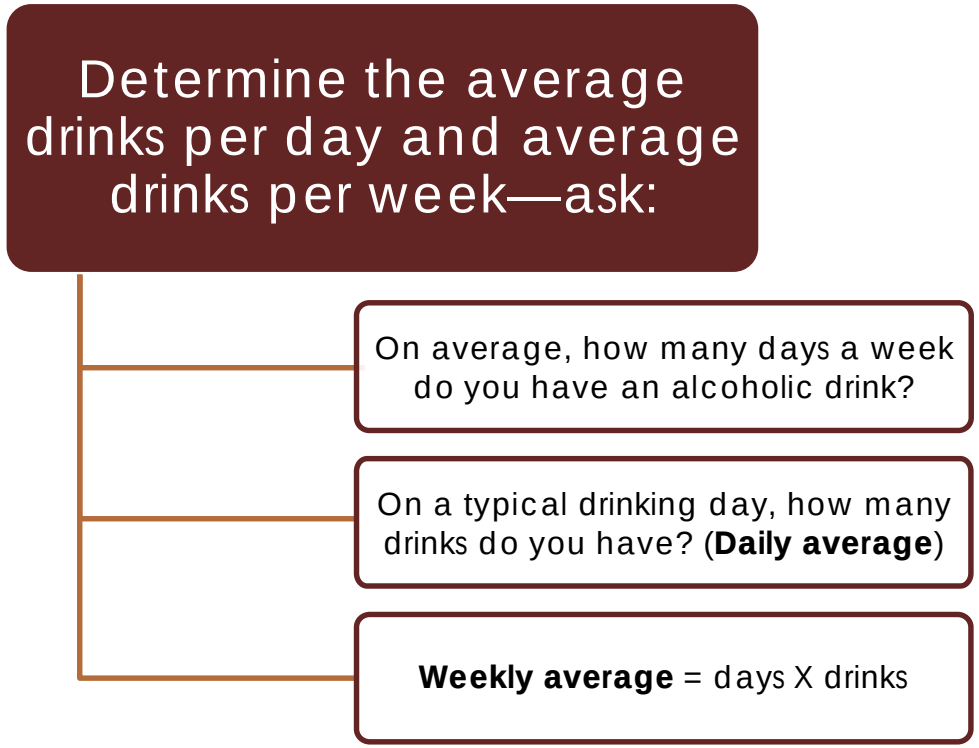


Alcohol Prescreening



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

Prescreening Drinking Limits



Recommended Limits

Men = 2 per day/14 per week
Women/anyone 65+ = 1 per day or 7 drinks per week

> Regular limits = at-risk drinker

Alcohol prescreen: positive

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?	○	✗

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Alcohol


Low-risk drinking limits
MEN
WOMEN
On any single DAY
No more than 4 drinks on any day
No more than 3 drinks on any day
** AND **
** AND **
Per WEEK
No more than 14 drinks per week
No more than 7 drinks per week
To stay low risk, keep within BOTH the single-day AND weekly limits.

A Positive Alcohol Screen = At-Risk Drinker

Binge drink
(≥5 for men or ≥4 for women/anyone 65+)
Or patient exceeds regular limits?
(Men: 2/day or 14/week
Women/anyone 65+: 1/day or 7/week)

NO

Patient is at low risk.
Move to single question drug prescreen

YES

Patient is at risk. Screen for maladaptive pattern of use and clinically significant alcohol impairment using AUDIT.
(30% of men, 16% of women, 2013)

* Zero alcohol is recommended during pregnancy and as indicated for specific medical and psychological conditions and/or medications.

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SBIRT 2020

Evidence Behind the Numbers

- Studies demonstrate that the 5+/4+ limits accurately reflect the amount of alcohol consumed at which psychomotor and cognitive impairment is notably increased in both men and women.

- Epidemiologic risk curve analyses reveal significant and rapid increases in the risks of—
  - Unintentional injuries
  - Deaths resulting from external causes
  - Being a target of aggression or taking part in an aggression-related event
  - Alcohol use disorders
  - Unfavorable medical, work-related, legal, and social consequences related to drinking

- As the frequency of exceeding NIAAA'S guidelines increases, the likelihood of developing these problems increases.

AUDIT
Alcohol Use Disorders Identification Test

- What is it?
  - Ten questions, self-administered or through an interview; addresses recent alcohol use, alcohol dependence symptoms, and alcohol-related problems
  - Developed by World Health Organization (WHO)

AUDIT

- What are the strengths?
  - Public domain—test and manual are free
  - Validated in multiple settings, including primary care
  - Brief, flexible
  - Focuses on recent alcohol use
  - Consistent with ICD-10 and DSM-5 definitions of alcohol dependence, abuse, and harmful alcohol use
- Limitations?
  - Does not screen for drug use or abuse, only alcohol

HOPES AUDIT Questionnaire

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Alcohol Screening Questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by circling your answer to each question below. Think about your drinking **in the past year.**

One drink equals:  12 oz. can of BEER  5 oz. glass of WINE  1.5 oz. shot of SPIRITS (whiskey, gin, rum, vodka)  2-4 oz. glass of LIQUEUR (sherry or champagne)

QUESTIONS	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
3. How often do you have a X (5 for men; 4 for women & men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	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 past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
6. How often during the past year have you needed a drink first thing 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 past 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 past year have you been unable to remember what happened the night before because you had been 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 past year		Yes, during the past year			
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year			
							Total	

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AUDIT Domain

Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

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WHO, 1992

AUDIT Scoring and Interpretation

AUDIT Screening Results Interpretation			
Risk Level		AUDIT Score	Intervention
Zone I	Low Risk	0-6 (women) 0-7 (men)	Screening and Feedback
Zone II	At-Risk	7-15 (women) 8-15 (men)	Brief Intervention to encourage reduction/abstinence
Zone III	Harmful Use	16-24	Extended Brief Intervention or Brief Therapy
Zone IV	Dependent Use	25+	Referral for Evaluation and Treatment

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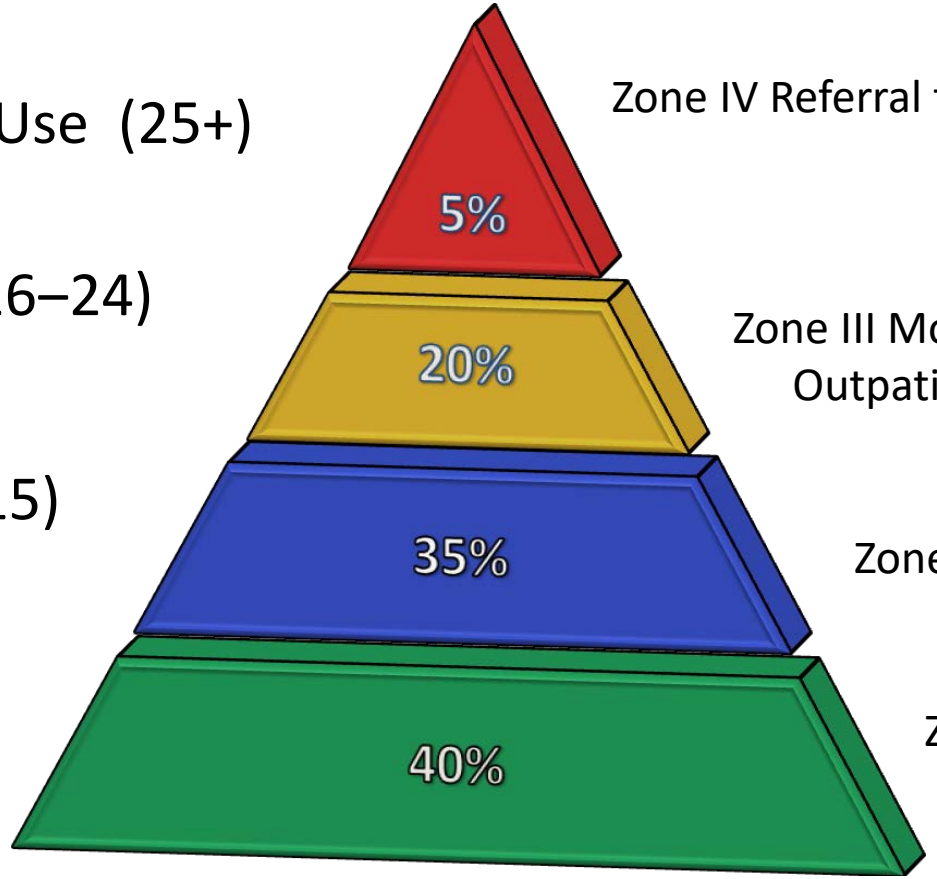
Risk Pyramid

Dependent Use (25+)

Harmful Use (16–24)

At-Risk Use (8–15)

Low Risk (0–7)



Zone IV Referral for Evaluation and Treatment

Zone III Monitoring and Possible Brief Outpatient Treatment

Zone II Brief Intervention

Zone I Screening and Feedback

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Drugs

Drug Use Screening

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Drug Use

- In 2013, an estimated 24.6 million Americans aged 12 or older—9.4 percent of the population—had used an illicit drug in the past month. This number is up from 8.3 percent in 2002.
- Methamphetamine use was higher in 2013, with 595,000 users, compared with 353,000 users in 2010.
- **More than half of new illicit drug users begin with marijuana.** Next most common are prescription pain relievers, followed by inhalants (which is most common among younger teens).
- **Drug use is increasing among people in their fifties and early sixties.**

Prescription Drug Misuse

Although many people take medications that are not prescribed to them, we are primarily concerned with—

- Opioids (oxycodone, hydrocodone, fentanyl, methadone)
- Benzodiazepines (clonazepam, alprazolam, diazepam)
- Stimulants (amphetamine, dextroamphetamine, methylphenidate
- Sleep aids (zolpidem, zaleplon, eszopicione)
- Other assorted (clonidine, carisoprodol)

What is Drug Misuse?

To misuse a drug is to use a drug for purposes for which it is not intended.

Prescreening for Drugs

"How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

(...for instance because of the experience or feeling it caused)

Positive screen: 1 or more times. (If response is, "None," screening is complete).

If response contains suspicious clues, inquire further.

Sensitivity/Specificity: 100%/74%

Source: Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2010). A single-question screening test for drug use in primary care. *Arch Intern Med ,170(13), 1155–1160.*

A Positive Drug Screen

ANY positive on the drug prescreen question puts the patient in an "at-risk" category. The followup questions are used to assess impact and whether substance use is serious enough to warrant a substance use disorder diagnosis.

- Ask which drugs the patient has been using, such as cocaine, meth, heroin, ecstasy, marijuana, opioids, etc.
- Determine frequency and quantity.
- Ask about negative impacts.

DAST-10

What is DAST-10?

- Shortened version of DAST-28, containing 10 items, completed as self-report or via interview. DAST-10 consists of screening questions for at-risk drug use that parallel the MAST (an alcohol screening instrument)
- Developed by Addiction Research Foundation, now the Center for Addiction and Mental Health
- Yields a quantitative index of problems related to drug misuse

What are the strengths?

- Sensitive screening tool for at-risk drug use

What are the weaknesses?

- Does not include alcohol use

DAST(10) Questionnaire

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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 possible by answering the questions below.

Which recreational drugs you have used in the past year?

- ☐ Stimulants (cocaine, speed, crystal, crank)
- ☐ Cannabis (marijuana, pot)
- ☐ Inhalants (paint thinner, aerosol, glue)
- ☐ Tranquilizers (valium)
- ☐ Prescription Drugs (i.e., Ritalin, Adderall)
- ☐ Opiates (heroin, oxycodone, morphine, codeine, methadone, etc.)
- ☐ Hallucinogens (LSD, mushrooms)
- ☐ Mixes/Synthetic, Psychoactive Drugs: i.e., Ecstasy, Molly
- ☐ Other : _____ _____

Question	Answer		Comments
1. Have you used drugs other than those required for medical reasons?	No	Yes	
2. Do you use more than one drug at a time?	No	Yes	
3. Are you able 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/partner (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	

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DAST(10) Interpretation

		DAST-10 Screening Results Interpretation	
Risk Level		DAST-10 Score	Intervention
Zone I	Low Risk	0	No intervention. Encourage low risk use
Zone II	At Risk	1-2	Brief Intervention to encourage reduction/abstinence
Zone III	Harmful	3-5	Extended Brief Intervention or Brief Therapy
Zone IV	Dependent	6-10	Referral to Higher Level Care

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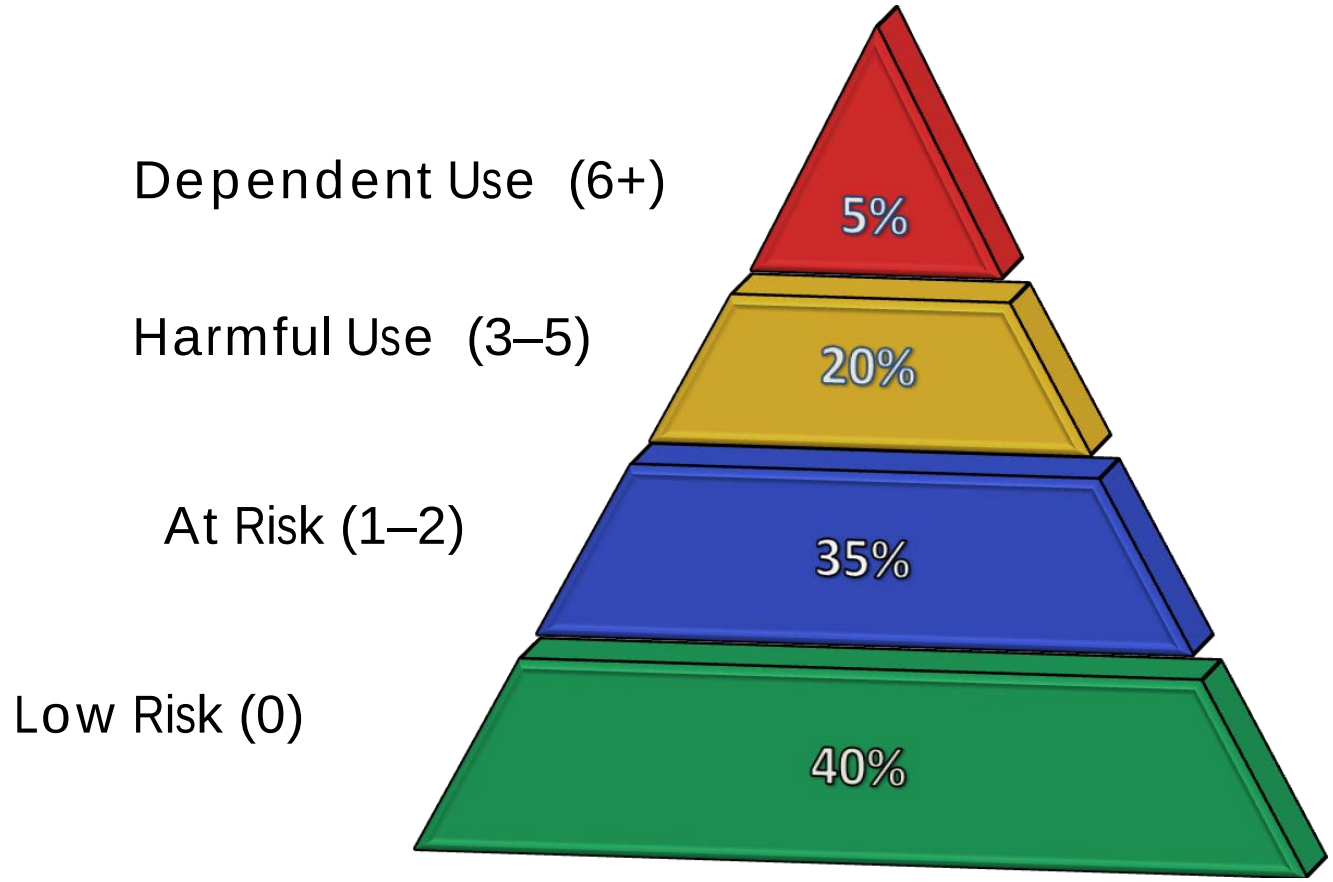
Scoring the DAST(10)



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Key Points for Screening

- Screen **everyone** for both alcohol and drugs
- Use a **validated** tool and ask questions **verbatim**.
- **Normalize screenin**g by emphasizing that all patients are asked about alcohol, tobacco and drugs because they are important medical issues
- Provide **non-judgmental, empathic feedback** regarding the screening results
- For positive screens: **proceed** with a brief intervention

Screening: Summary

- Screening is the first step of the SBIRT process and determines the severity and risk level of the patient's substance use.
- Often the process of screening sets in motion patient reflection on their substance use behavior.
- The result of a screen allows the provider to determine if a brief intervention or referral to treatment is a necessary next step for the patient.

Congratulations!

You have completed Module 3, *SCREENING*

You are now ready to move onto
Module 4: Brief Intervention

Module 4:

Brief Intervention:

The Brief Negotiated Interview

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Funded by SAMHSA Grant 1H79TI026428 (TI026428)

Learning Objectives

By the end of this session you will be able to—

- Describe an evidence-based practice model of brief intervention, the brief negotiated interview (BNI).
- Apply specific motivational interviewing (MI) skills to BNI.
- Implement next steps based on risk level.
- Practice SBIRT brief intervention skills using the BNI.

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Review of SBIRT

Do you recall the primary goal of SBIRT?

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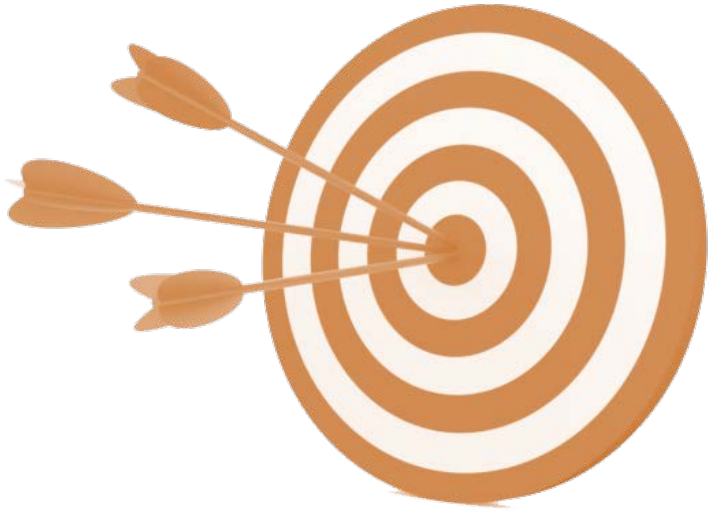
Goal

The primary goal of SBIRT is to identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.



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Review of SBIRT (continued)

Substance use continuum

- Abstinence
- Moderate use (lower risk use)
- At-risk use (higher risk use)
- Abuse
- Dependence

Substance Use Disorders (SUDs)

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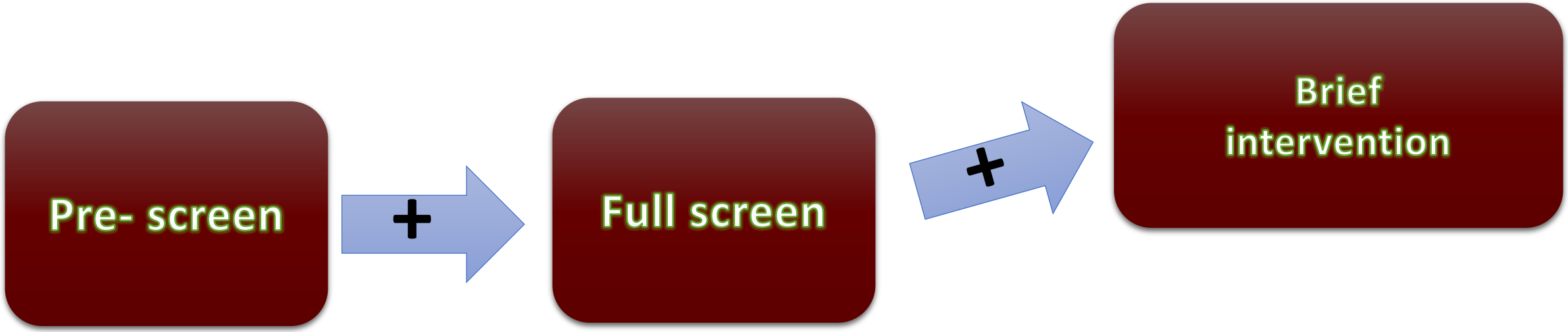
A Short Video….

The SBIRT Method



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What Is Brief Intervention?

- Beginning a Brief Intervention is a based on information gleaned from the AUDIT or the DAST screening
- Brief Intervention is a brief motivational and awareness-raising intervention given to users who engage in risky or problematic substance behaviors.
- Brief Intervention helps the patient think differently about their substance use and provides them with skills to reduce or discontinue use.

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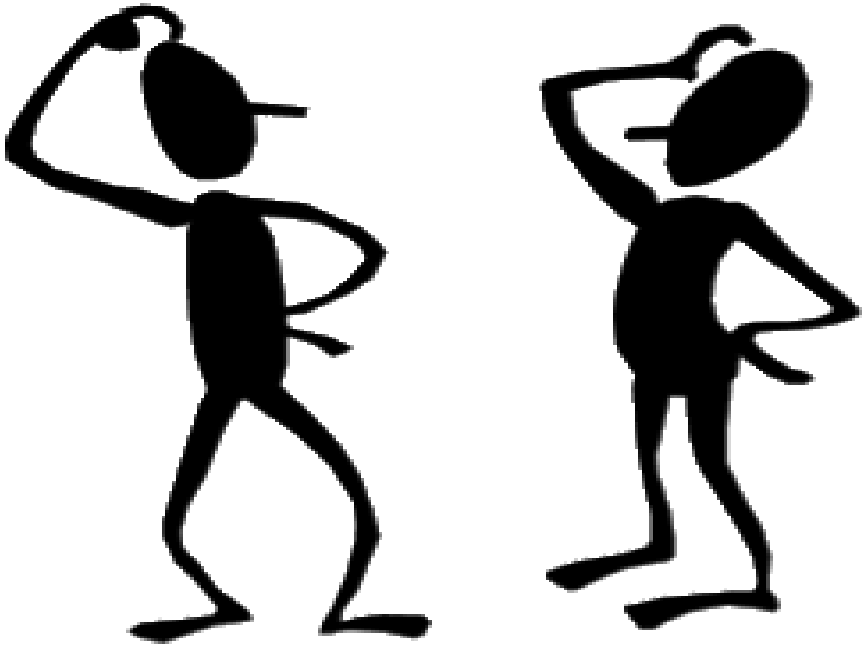
Brief Interventions



- Brief interventions can be performed in as little 5 minutes
- Aimed to motivate those at-risk to change their behavior
- Aimed to motivate individuals with more severe risk to seek assessment/treatment
- Designed to provide personal feedback, enhance motivation, and promote self-efficacy to promote behavior change

What Is the Brief Negotiated Interview?

- There are several models for brief intervention, including the BNI, originally developed by Gail D'Onofrio, M.D., Ed Bernstein, M.D., Judith Bernstein, M.S.N., Ph.D., and Steven Rollnick, Ph.D.

- The BNI is a semi-structured interview process based on MI that is a proven evidence-based practice and can be completed in 5–15 minutes.

Special acknowledgement is made to Drs. Stephen Rollnick, Gail D'Onofrio, and Ed Bernstein for granting permission to orient participants to the "brief negotiated interview."

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What Does Engaging a patient in a BNI Hope To Accomplish?

- Raise awareness about current behaviors.
- Builds readiness to change.
- Help patients identify personal and compelling reasons to change.
- May direct a commitment to change.
- Can be completed very quickly within 5-15 minutes.

Two Brief Intervention Pathways

(1) No substance use disorder: conduct brief intervention, provide follow-up and ongoing care

(2) Patients with possible substance use disorder: conduct brief intervention, offer menu of additional support options, & negotiate a plan that may include referral

Helping Patients Who Drink Too Much: A Clinician's Guide. NIAAA, 2005.

Goals of Brief Intervention

- For the moderate risk user: The goal is to negotiate a reduction in use to lower risk levels.
- For the person who appears to have a substance use disorder (high risk): The goal is to negotiate a treatment referral for full assessment and a level of intervention to be determined.

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Review of MI

- **O**pen questions
  - "Ten strategies for evoking change talk"
- **A**ffirmations
  - Emphasize autonomy and personal choice
  - Acknowledge strengths and supports
- **R**eflections
  - Paraphrase, repeat back which will help patient understand his/her own thoughts better
- **S**ummaries
  - Pull together everything stated, allowing for a transition to a new topic or to "move forward" in the BNI

Strategy Tips: OARS in Action

- **O**pen questions
  - Explore Decisional Balance-Pros and Cons
  - Readiness Ruler
- **A**ffirmations
  - Sprinkle them in!
- **R**eflections & **S**ummaries
  - Double sided reflection
- "So on one hand….and on the other hand…."

Cultivating Change Talk: The Importance of Listening

- "I want…"
- "I can…"
- "It's important…"
- "I need to…"
- "I will…"

Steps in the BNI

1. Build rapport—raise the subject. Explore the pros and cons of use.
2. Provide feedback.
3. Build readiness to change.
4. Negotiate a plan for change.

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1. Build Rapport—Raise the Subject

1. Begin with a general conversation.

2. Ask permission to talk about alcohol or drugs.

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1. Build Rapport—Raise the Subject continued

What if the patient does not want to talk about his or her use?

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Discuss the Pros and Cons of Use (a)

Help me understand through your eyes.

1. What are the good things about using alcohol?

2. What are some of the not-so-good things about using alcohol?

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Discuss the Pros and Cons of Use—Applying MI (a)

Using open-ended questions—

- Enables the patient to convey more information
- Encourages engagement
- Opens the door for exploration

Using reflections

- Reflective listening
- Thinking reflectively

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Discuss the Pros and Cons of Use—Applying MI (b)

Summarizing

- Reinforces what has been said
- Shows careful listening

Discuss the Pros and Cons of Use (b)

Summarize using a decisional balance…

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2. Provide Feedback (a)

1. Ask permission to give information.
2. Discuss screening findings.

3. Link substance use behaviors to any known consequences.

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2. Provide Feedback (b)

Evoke a response:

- Positive reaction—move forward
- Negative reaction—revisit the pros and cons

3. Build Readiness To Change

Could we talk for a few minutes about your interest in making a change?

On a scale from 0 to 10, 0 being not ready at all and 10 being completely ready, how ready are you to make any changes in your substance use?

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Step 3. Build Readiness to Change

- Use the 0-10 readiness ruler.
- Ask, “Why not a lower number?”
- For patients with low readiness, explore what might increase readiness even slightly or what holds them back.
- Look for and reflect “change talk.”

Utilize Motivational Interviewing (MI) Skills in This Step

- Use OARS (open questions, affirmations, reflections and summaries)
- Consider use of other scaling rulers (Importance, Confidence)

4. Negotiate a Plan for Change

- A plan for reducing use to low-risk levels

OR

- An agreement to follow up with specialty treatment services

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4. Negotiate Plan

- "If you were to make a change, what would be your first step?"
- Encourage a specific plan/goal to reduce use, abstain and/or seek further support or referral.
- Support patient autonomy.
- Make an affirming statement.
- Schedule follow-up.

SMART Goals

- Specific
- Measurable
- Achievable
- Relevant
- Timed

BIs for Patients at Higher Risk Levels

- Use the same intervention outline
- Encourage abstinence
- Assess Withdrawal Risk
- With patient's permission, offer a menu of support options

Situations in Which You Might Encourage Abstinence

- High AUDIT/DAST score
- Prior history or family history of alcohol or substance dependence
- Pregnant or could become pregnant
- Medication interactions
- Serious mental illness or medical condition
- Signs or symptoms of alcohol or substance use disorder

Withdrawal Assessment:

- "Some people have the following symptoms after a day or two without drinking/using. Has this ever happened to you?"
  - Felt sick or shaky
  - Tremors
  - Nausea
  - Heart racing
  - Seizures
  - Seen or heard things that were not there

Options for Addressing Potential Withdrawal

- Arrange withdrawal treatment immediately
  - Transfer to detox unit or treatment center
  - Outpatient detox where appropriate
- Tell patient what to do if these symptoms occur
  - Present to ED/Detox Center
  - Call on-call physician
- Document what you did in the patient's chart

Offering a Menu of Options for Support:

- Start by Asking Permission

"Many patients at your risk level find they do better with more support. Could I share with you some of the things that have helped some other patients?"

Brief Treatment

- SAMHSA recommends an intermediate level of treatment for
  - Individuals who score at the higher range of the moderate risk level, have more consequences, or need more support
  - Individuals who are ambivalent about seeking other types of treatment
- May be internal to organization

Prescription for Change

- “Those are great ideas! Is it okay for me to write down your plan, your own prescription for change?”
- “Please help me summarize the steps you will take to change your [x] use.”
- “I’ve written down your plan, a prescription for change, for you to keep with you as a reminder.”

Close the Encounter

- Extend gratitude
- Support autonomy
- Voice confidence
- Suggest follow-up

Congratulations!

You have completed Module 4, *Brief Intervention*

You are now ready to move onto the final module

Module 5: Referral to Treatment

Module 5:
Referral to Treatment

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Funded by SAMHSA Grant 1H79TI026428 (TI026428)

Learning Objectives

By the end of this session you will be able to—

- Identify the practical aspects of making a successful treatment referral.
- Identify types of treatment.

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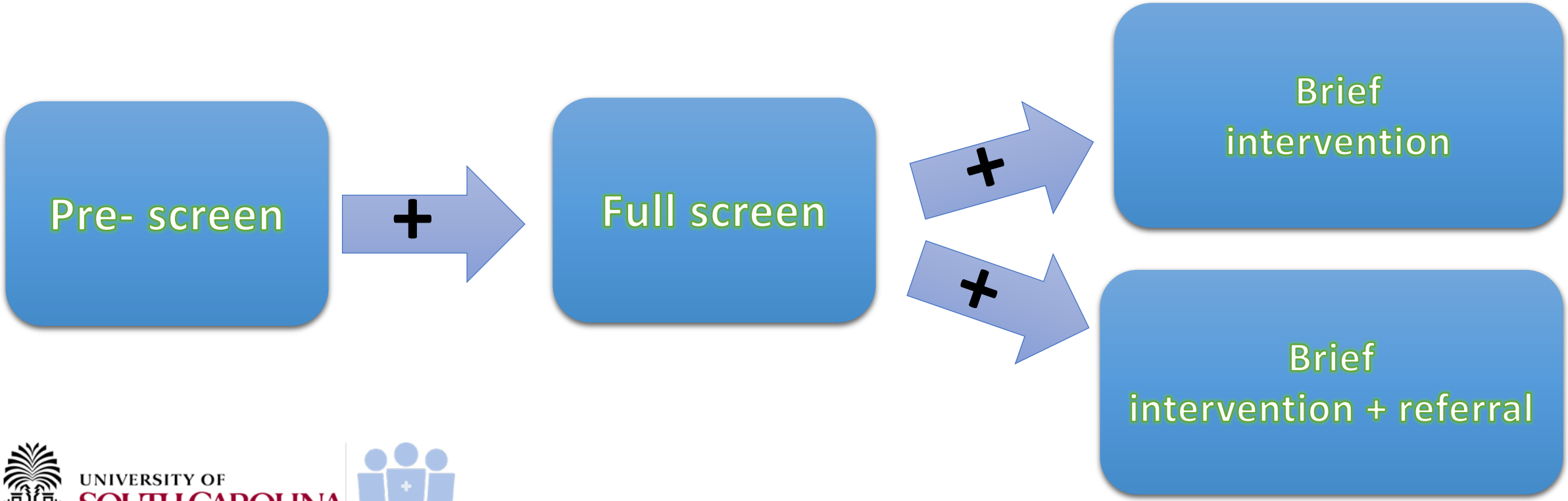
The SBIRT Method



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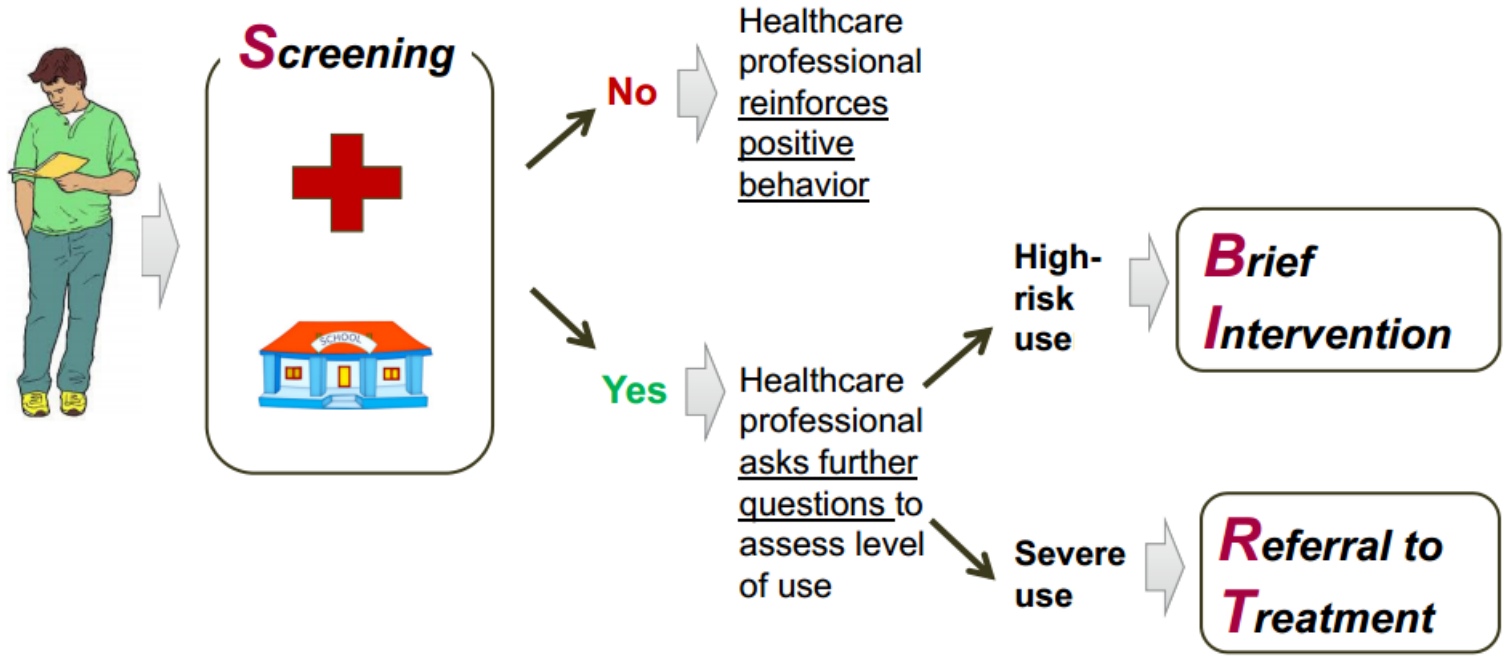
SBIRT: Referral to Treatment

1. Screening (Module 3)
2. Brief Intervention (Module 4)
3. Referral to Treatment (Module 5)



About Patients Screened in Primary Care

- Evidence indicates that approximately 5 percent of patients screened will require a referral to either brief treatment or specialty treatment.

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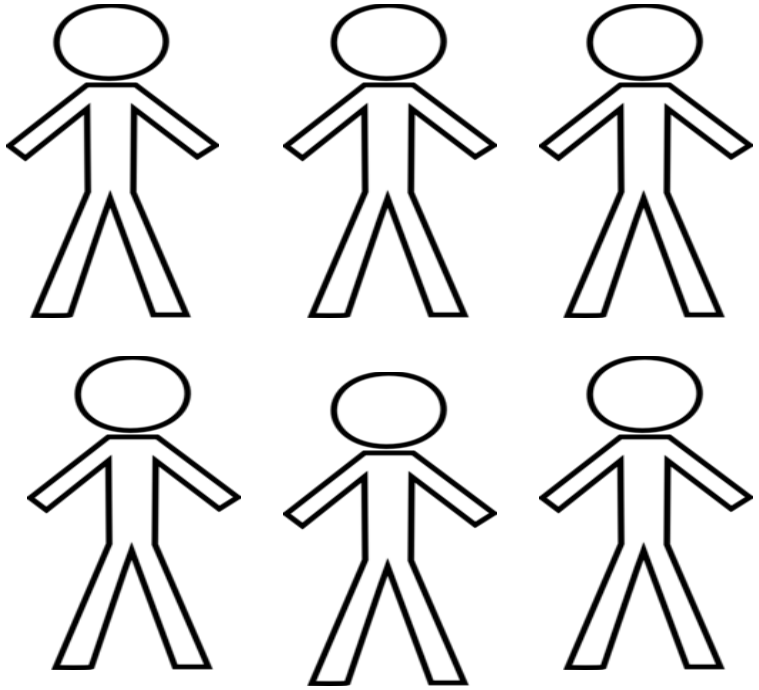
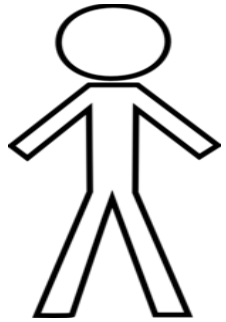
Of those who perceive a need for treatment, only 1 of 7 accessed it.





Mojtabai, R., & Crum, R. M. (2012). Perceived unmet need for alcohol and drug use treatments and future use of services: Results from a longitudinal study. *Drug and Alcohol Dependence ,127* (1-3), 59-64.

Barriers to Acceptance of Treatment

- Not ready to stop using substances
- Social stigma
- Pessimistic attitudes toward the effectiveness of treatment
- Sense of self-reliance
- Minimizing the problem
- Lack of insurance/financial support
- Warm handoff not provided

Source: Mojtabai, R., & Crum, R. M. (2012). Perceived unmet need for alcohol and drug use treatments and future use of services: Results from a longitudinal study. *Drug and Alcohol Dependence ,127* (1-3), 59-64.

What Is Treatment?

Treatment may include—

- Counseling and other psychosocial rehabilitation services
- Medications
- Involvement with self-help (AA, NA, Al-Anon)
- Complementary wellness (diet, exercise, meditation)
- Combinations of the above

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Medication for Addiction Treatment

- Used for patients with moderate or severe alcohol or opioid use disorder (dependence)
  - Alcohol—oral disulfiram or acamprosate; injectable naltrexone (Vivitrol).
  - Opioids—buprenorphine/naloxone (oral Suboxone et al., injectable Sublocade), naltrexone (Vivitrol).
- Advantages—decrease craving, improve recovery rates by ~10%, can be provided in primary care setting (except methadone)

What Is Treatment? (continued)

- Substance abuse treatment is provided within levels of care often available in multiple treatment settings.
- Level of care is determined by severity of illness:
  - Is the patient a person who is dependent or nondependent on substances?
  - Are there medical or psychiatric comorbidities?
- Inpatient treatment is reserved for those with more serious illness (dependence, comorbidity).

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A Strong Referral to Appropriate Treatment Provider Is Key

When your patient is ready—

- Make a plan with the patient.
- You or your staff should actively participate in the referral process. The warmer the referral handoff, the better the outcome.
- Decide how you will interact/communicate with the provider.
- Confirm your follow-up plan with the patient.
- Decide on the ongoing follow-up support strategies you will use.

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MI Principles for Making a Treatment Referral

- Respect patient's autonomy - "Any decision you make is entirely up to you."
- Make every effort to help patients make contact with treatment providers while they are still with you (sometimes referred to as a "warm hand-off").

What Is a Warm-Handoff Referral?

The “warm-handoff referral” is the action by which the clinician directly introduces the patient to the treatment provider at the time of the patient’s medical visit. The reasons behind the warm-handoff referral are to establish an initial direct contact between the patient and the treatment counselor and to confer the trust and rapport. Evidence strongly indicates that warm handoffs are dramatically more successful than passive referrals.

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Plan for the Nuts and Bolts

- Whom do you call?
- Do you have access to referral resource information?
- What form do you fill out?
- What support staff can help?

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How do I know where these services are?

- http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx
  - Local Support Groups
  - Veterans Assistance Programs
  - Community Service Boards
  - Clinic-Based Social Worker
  - Employee Assistance Programs
  - Student Services and Crisis Hotlines.

Referral to Treatment Resources

- SAMHSA Treatment Locator: https://www.samhsa.gov/treatment
- NIAA Treatment Resources: https://www.rethinkingdrinking.niaaa.nih.gov/help-links/

Considerations When Choosing a Treatment Provider

- Language ability/cultural competence
- Family support
- Services that meet the patient's needs
- Record of keeping primary care provider informed of patient's progress and ongoing needs
- Accessible location/transportation

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Payment for Services

- Does the provider accept your patient's insurance?
- Will the patient need to get prior insurance authorization?

- If the patient does not have insurance, does the provider offer services on a sliding-fee scale?

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What Should You Expect?

- Substance abuse treatment facilities should provide you ongoing updates with a valid release of information.
- If they do not, you may choose to refer elsewhere.

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What Should You Expect?

- Substance abuse treatment facilities should provide you with a structured discharge plan discussing the patient's ongoing treatment needs and recommend providers.

What Should You Expect?

- Programs change over time. Maintain an up-to-date roster of public and private treatment and self-help resources in your community.

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Common Mistakes To Avoid

- Rushing into “action” and making a treatment referral when the patient isn’t interested or ready
- Referring to a program that is full or does not take the patient’s insurance
- Not knowing your referral base

- Not considering pharmacotherapy in support of treatment and recovery
- Seeing the patient as “resistant” or “self-sabotaging” instead of having a chronic disease

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Summary

- Treatment works.
- With a minimal amount of preparation, you can know what is available in your community.
- Clarify your procedures for referral.
- Warm handoffs work best.
- Follow up.

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The Business of SBIRT

SBIRT Cost Effectiveness and Reimbursement

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Overview

- Multiple studies have shown the cost benefits of providing SBIRT services.
  - One study (Gentilleo, Eble, Wickizer, et al. 2005) showed:
    - A cost saving of $89 for each patient screening and $330 for each patient who received a brief intervention.
    - Health expenditures decreased $3.81 for each $1.00 spent providing SBIRT services.
  - A study of Medicaid patients in Washington State (Estee, et al. 2008) showed:
    - A cost savings of $271 per member, per month for those who received at least a brief intervention.

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Coding for SBIRT Reimbursement

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

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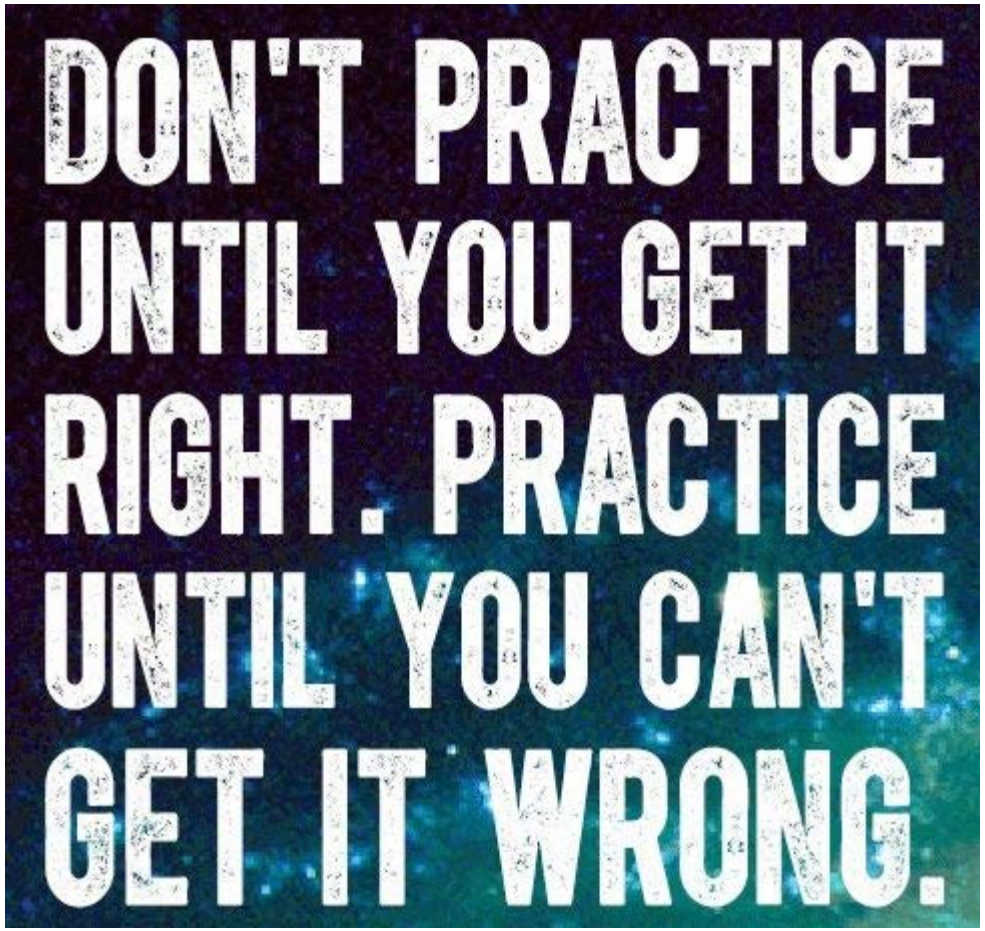
Substance Abuse and Mental Health Services Administration. Coding for SBIRT reimbursement. Retrieved from http://www.integration.samhsa.gov/sbirt/reimbursement_for_sbirt.pdf.

Role-Play Practice

- Work in triads
- patient – Worker- Observer
- Utilize screening tools (AUDIT or DAST)
- Perform BNI

20 minutes each round.



Questions?

Congratulations!

You have completed Module 5, *Referral to Treatment*

And the live SBIRT training.