SBIRT

Briefly Intervening Saves Lives

SBIRT

Mnemonic for…

- **S**creening
- **B**rief **I**ntervention
- **R**eferral to **T**reatment

ADOLESCENCE PROVIDES A WINDOW OF OPPORTUNITY

- Brain is undergoing significant changes
- Vulnerable to risk-taking behavior and addiction
- A child who resists substance use completely until the age of 21, unlikely to suffer SUD during lifetime.

Mental health and substance use are interrelated

- Co-occurring disorders
  - Among youth (12-17yo) with a past year of SUD, over 23% had a major depressive episode in the past year.
  - Substance use may be used as coping mechanism
  - Suicide - 33.3% tested positive for alcohol
  - History of trauma

Adolescent Substance Use: America's #1 Public Health Problem

A Problem of Epidemic Proportion

90% Of Americans started smoking, drinking, or using other drugs before age 18

75% Of high school Students have Used addictive substances

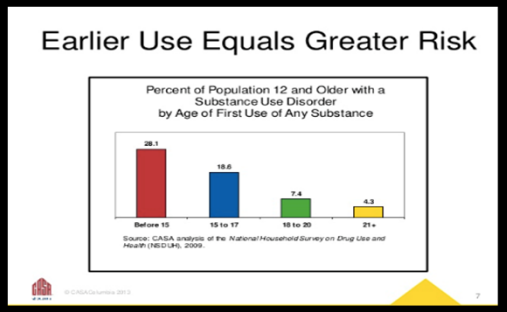
46% Of high school Students are current users

12% Of high school Students are addicted

Why is Adolescence the Critical Period?

- Brain not fully developed= Increased chance that teens will Take risks
- Addictive substance have a Greater negative impact on the developing brain

INTERVENING EARLY MATTERS!!



EFFECT OF DRUG USE ON THE ADOLESCENT BRAIN

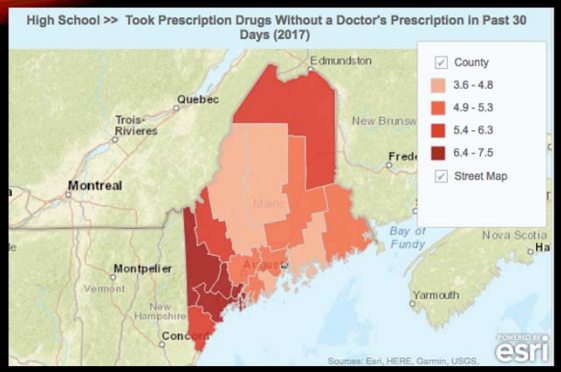
Short term effects include:

- Impaired short-term memory, impaired motor coordination, altered judgment, decreased impulse control

Long term effects include:

- Altered brain development, cognitive impairment, increased vulnerability to psychiatric disorders, and increased vulnerability to all substance use disorders

FOR THE REST OF THEIR LIVES



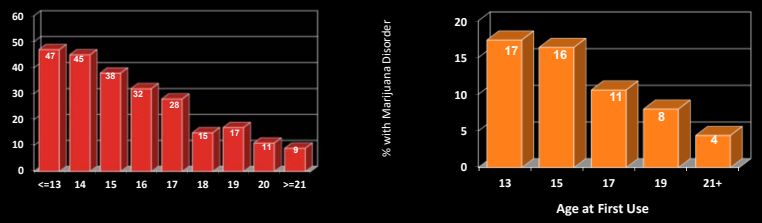
Maine Numbers

4% Middle Schoolers and 23% of High Schoolers used alcohol in last 30 days.

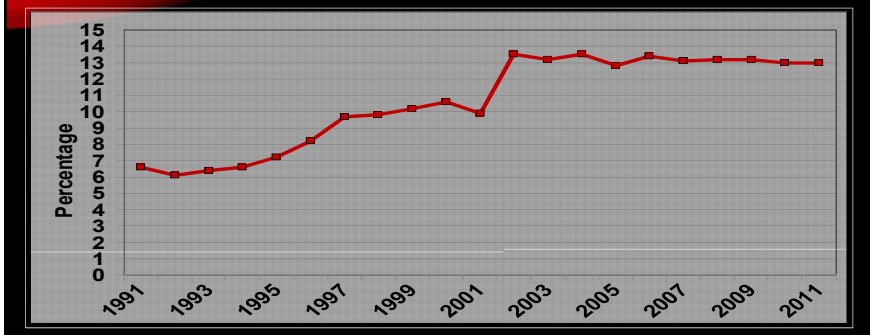
4% of Middle Schoolers and 19% of High Schoolers used Marijuana in last 30 days

MIYHS 2017

Age at First Use and Later Risk

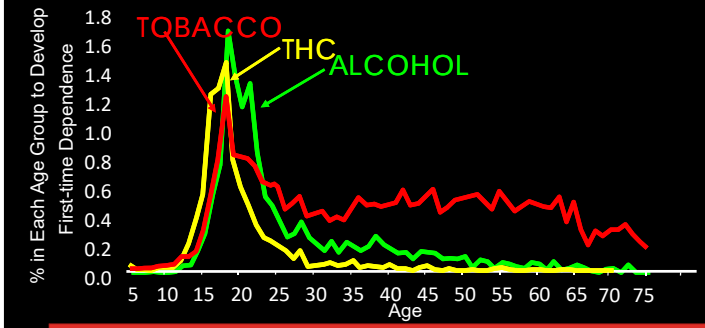


Rates of opioid misuse by 12th graders



Source: Johnston LD, et al., Monitoring the Future – National Results on Adolescent Drug Use: Overview of Key Findings, 2011

Addiction is a Developmental Disease that starts in Childhood and Adolescence



Age for tobacco, alcohol and cannabis dependence, as per DSM IV

PRIMARY CARE ADVANTAGE

- ✓Longitudinal, trusting relationship
- ✓Family centeredness
- ✓Opportunities for prevention and anticipatory guidance
- ✓Opportunities to intervene early
- ✓Experience in coordinating with specialists
- ✓Familiarity with chronic care principles and practice improvement
- ✓Comfort with diagnostic uncertainty

SBIRT EFFECTIVENESS

- Research has shown:
- Large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through screening in health care and other social service settings.
- SBIRT has been found to:
- Decrease the frequency and severity of drug and alcohol use
- Reduce the risk of trauma (car crashes, violence, suicide attempts)
- Reduce risky behavior (unprotected sexual encounters, DUI)
- Increase the percentage of individuals who enter specialized substance abuse treatment
- Improve quality-of-life measures (employment, housing stability, education status)
- SBIRT has also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit and cost-effectiveness analyses demonstrate net-cost savings from these interventions.

AAP RECOMMENDATIONS

Periodicity schedule

- **Psychosocial/behavioral assessment** at every well-child visit
- **Depression screening** at every well-child visit (11 y – 21 y)
- **Alcohol and drug use assessment** at every well-child visit (11 y – 21 y)
  - And appropriate acute care visits

QUESTIONNAIRES

- Screening can be helpful (remember general considerations about screening)
- For initial recognition
- To confirm concerns already raised
- To have something to follow to gauge need for treatment or change of treatment
- Helps you remember the questions to ask

BUT RECALL SCREENING LIMITATIONS

- Predictive value can be low
- Quality of responses probably depends on how screen is presented
- Difficulties with literacy and culture/language

ADOLESCENT SUBSTANCE USE SCREENING & ASSESSMENT TOOLS

Brief Screens

- Screening to Brief Intervention *(S2BI)*
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- Alcohol Screening & Brief Intervention for Youth (NIAAA/AAP)

Assessment Guides

- Car, Relax, Alone, Friends/Family, Forget, Trouble *(CRAFFT)*
- Drug Abuse Screening Test - Adolescent Version (DAST-A)
- Alcohol Use Disorders Identification Test (AUDIT)

TOOL SELECTION

Useful Resources for Selecting Measures Include:

- American Academy of Pediatrics' Mental Health Toolkit (2010) http://www.aap.org/commpeds/dochs/mentalhealth/docs/MH-ScreeningChart.pdf
- Appendix chart in: Weitzman, C., & Wegner, L. (2015). Promoting optimal development: Screening for Behavioral and Emotional Problems. *Pediatrics, 135(2)*, 384-395.
- Massachusetts General Hospital School Psychiatry Program & Madi Resource Center http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp
- Massachusetts Primary Care Behavioral Health Screening Toolkit http://www.mcpap.com/pdf/PCCScreeningToolkitUpdate04292010.pdf

SCREENING

- Casts a wide net
- Is applied to everyone in a target group – in this case, adolescents
- Not simply a yes or no answer; each level of use requires a response
- Kids do stupid things; substance use helps them do stupid things more stupidly-

Even one-time use can lead to injury, violence, or risky sexual behavior!

SCREENING-THE CATCH

- Data From SAMHSA SBIRT Initiative in Adults-

459,599 screened- 22.7 screened positive for problematic use or abuse/addiction

Of that 22.7 % -15.9% Recommended for BI
3.2% Recommended for BT
3.7% Recommended for RT

Madras, 2009

BRIEF INTERVENTION

- Focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Brief intervention can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more intensive levels of care.
- BI lasts, on average, **6-8 minutes** but generally takes **no longer than 15 minutes.**
- A motivational interviewing approach is used which focuses on raising the individuals' awareness of substance use and its consequences and motivating them toward positive behavioral change.

Motivational Interviewing:
The Basis of a Brief Motivational Intervention

Motivational Interviewing (MI) is a collaborative, patient-centered form of guiding to elicit and strengthen motivation for change.

The Spirit of MI:
- Respects patient's autonomy
- Fosters patient-centered collaboration
- Evokes/elicits patient's own reasons for change

Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping People Change* (3rd ed.). New York, New York: The Guildford Press.

Core Assumptions of MI

1. Motivation is a state, NOT a trait

2. Ambivalence to change is normal

25

A GOOD MOTIVATIONAL GUIDE WILL:

- **Ask** the person where he/she wants "to go"
- **Listen** to and respect what the person wants
- **Inform** the person about options to achieve their goal and see what makes sense to them

THE FOUR PRINCIPLES OF MOTIVATIONAL INTERVIEWING (EDRS)

Express empathy: The provider makes a genuine effort to understand the client's perspective and an equally genuine effort to convey that understanding to the client. This is an inherent element of reflective listening.

Develop discrepancy: Listen for strategies that facilitate the client's identification of discrepant elements of a particular behavior or situation.

Example, values versus behaviors: client values being a responsible parent; however, the client is having difficulty tackling a heroin addiction. Areas of discrepancy may include: past versus present; behaviors versus goals.

Roll with resistance –avoid argumentation: This is the provider's ability to diminish resistance, connect with the client and move in the same direction. Avoid arguments. Expressing empathy, understanding why a client has a particular belief might be the intervention. Adjust to client resistance rather than opposing it directly.

Support self-efficacy: This is the provider's ability to support the client's hopefulness that change or improvement is possible. Focus on the client's strengths, previous successes, efforts and concerns. Key words: hope and optimism. Be optimistic.

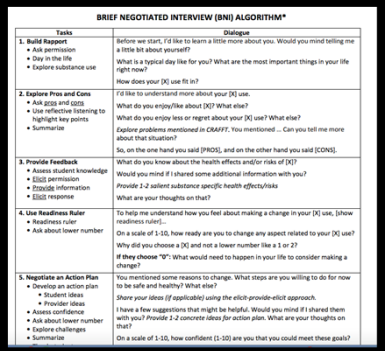
BRIEF INTERVENTION

Figure 2-4
FRAMES

- Feedback is given to the individual about personal risk or impairment.
- Responsibility for change is placed on the participant.
- Advice to change is given by the provider.
- Menu of alternative self-help or treatment options is offered to the participant.
- Empathic style is used in counseling.
- Self-efficacy or optimistic empowerment is engendered in the participant.

Source: Miller and Sanchez, 1993.

BRIEF INTERVENTION



BRIEF NEGOTIATED INTERVIEW (BNI) ALGORITHM*

Tasks	Dialogue
1. Build Rapport • Ask permission • Day in the life • Explore substance use	Before we start, I'd like to learn a little more about you. Would you mind telling me a little bit about yourself? What is a typical day like for you? What are the most important things in your life right now? How does your [X] use fit in?
2. Explore Pros and Cons • Ask pros and cons • Use reflective listening to highlight key points • Summarize	I'd like to understand more about your [X] use. What do you enjoy/like about [X]? What else? What do you enjoy less or regret about your [X] use? What else? *Explore problems mentioned in CRAFFT.* You mentioned … Can you tell me more about that situation? So, on the one hand you said [PROS], and on the other hand you said [CONS].
3. Provide Feedback • Assess student knowledge • Elicit permission • Provide information • Elicit response	What do you know about the health effects and/or risks of [X]? Would you mind if I shared some additional information with you? *Provide 1-2 salient substance specific health effects/risks* What are your thoughts on that?
4. Use Readiness Ruler • Readiness ruler • Ask about lower number	To help me understand how you feel about making a change in your [X] use, [show readiness ruler]… On a scale of 1-10, how ready are you to change any aspect related to your [X] use? Why did you choose a [X] and not a lower number like a 1 or 2? **If they choose "0"**: What would need to happen in your life to consider making a change?
5. Negotiate an Action Plan • Develop an action plan • Student ideas • Provider ideas • Assess confidence • Ask about lower number • Explore challenges • Summarize	You mentioned some reasons to change. What steps are you willing to do for now to be safe and healthy? What else? *Share your ideas (if applicable) using the elicit-provide-elicit approach.* I have a few suggestions that might be helpful. Would you mind if I shared them with you? *Provide 1-2 concrete ideas for action plan.* What are your thoughts on that? On a scale of 1-10, how confident (1-10) are you that you could meet these goals?

CONTACT FOR LIFE WWW.SADD.ORG/CONTRACT.HTM

Contract for Life
A Foundation for Trust and Caring

This Contract is designed to facilitate communication between young people and their parents about potentially destructive decisions related to alcohol, drugs, peer pressure, and behavior. The issues facing young people today are often too difficult for them to address alone. SADD believes that effective parent-child communication is critically important in helping young adults to make healthy decisions.

Young Person

I recognize that there are many potentially destructive decisions I face every day and commit to you that I will do everything in my power to avoid making decisions that will jeopardize my health, my safety and overall well-being, or your trust in me. I understand the dangers associated with the use of alcohol and drugs and the destructive behaviors often associated with impairment.

By signing below, I pledge my best effort to remain free from alcohol and drugs. I agree that I will never drive under the influence; I agree that I will never ride with an impaired driver; and I agree that I will always wear a seat belt.

Finally, I agree to call you if I am ever in a situation that threatens my safety and to communicate with you regularly about issues of importance to both of us.

Young Person

Parent (or Caring Adult)

I am committed to you and to your health and safety. By signing below, I pledge to do everything in my power to understand and communicate with you about the many difficult and potentially destructive decisions you face.

Further, I agree to provide for you safe, sober transportation home if you are ever in a situation that threatens your safety and to defer discussions about that situation until a time when we can both have a discussion in a calm and caring manner.

I also pledge to you that I will not drive under the influence of alcohol or drugs; I will always seek safe, sober transportation home, and I will always wear a seat belt.

Parent/Caring Adult

SUBSTANCE ABUSE AND SBIRT RESOURCES

- www.SBIRToregon.org
- WAIT21.org
- www.**samhsa**.gov/**sbirt**

AAP POLICY STATEMENT: SUBSTANCE USE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT FOR PEDIATRICIANS

Committee on Substance Abuse

Pediatrics **2011**;128;e1330;originally published online October 31,2011;DOI:10.1542/peds2011-1754:Volume 128, Number 5, November 2011ppe1330-

- Levy SJ, Williams JF, AAP COMMITTEE ON SUBSTANCE USE AND PREVENTION. Substance Use Screening, Brief Intervention, and Referral to Treatment. ***Pediatrics.*** **2016**;138(1) e20161211.

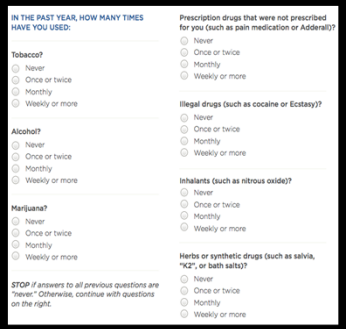
REFERRAL TO TREATMENT

- Provides those identified as needing more intensive treatment with access to specialty care.
- The effectiveness of the referral process to specialty treatment is a strong measure of SBIRT success.
- Individuals will be referred to either Brief Treatment (BT) or more intensive treatment based on the primary care provider's assessment after screening and discussion with patient.
- High risk individuals who are not willing to participate in more intensive treatment should be offered BT as an alternative.

THE NITTY GRITTY

Nuts and Bolts of doing this in the office with CRAFFT

S2BI



IN THE PAST YEAR, HOW MANY TIMES HAVE YOU USED:

Tobacco?
- Never
- Once or twice
- Monthly
- Weekly or more

Alcohol?
- Never
- Once or twice
- Monthly
- Weekly or more

Marijuana?
- Never
- Once or twice
- Monthly
- Weekly or more

STOP if answers to all previous questions are "never." Otherwise, continue with questions on the right.

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
- Never
- Once or twice
- Monthly
- Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?
- Never
- Once or twice
- Monthly
- Weekly or more

Inhalants (such as nitrous oxide)?
- Never
- Once or twice
- Monthly
- Weekly or more

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?
- Never
- Once or twice
- Monthly
- Weekly or more

GETTING STARTED: SCREENING

- S2BI developed at Boston Children's Hospital uses a combination of S2BI + CRAFFT
- However, if screen negative, you lose the **CAR** question
- Also unclear with new screens if they will be reimbursable **SO**

CRAFFT –SCREENING TOOL FOR SUBSTANCE USE: 3 SCREENING QUESTIONS + "CAR" FROM CRAFFT

1.Drink any alcohol (more than a few sips)?

2.Smoke any marijuana or hashish?

3.Use anything else to get high? ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.")

No to all (1+2+3) still =C

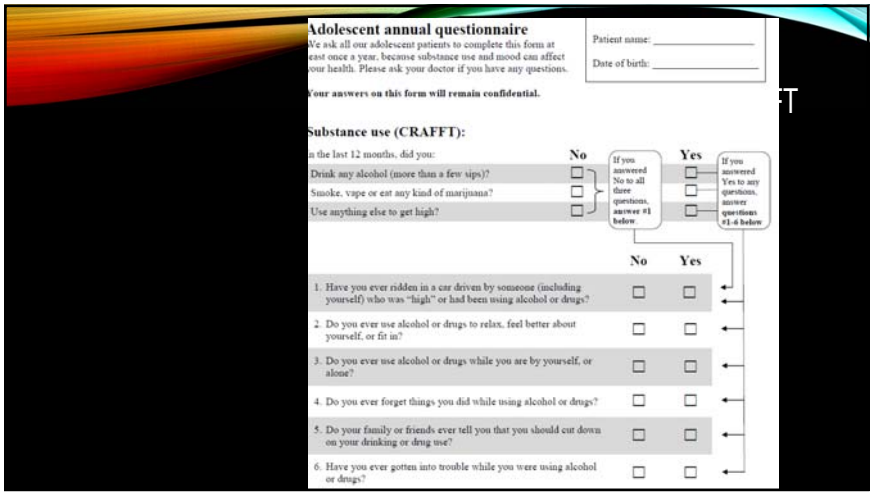
All patients are asked the **"C" (or "car")** question to determine if they have placed themselves at risk by riding with an alcohol- or drug-"influenced" or intoxicated driver.

*Those who answer "yes" to any of the opening questions are asked all **6 CRAFFT** questions*

FOR THE PURPOSE OF THIS DISCUSSION, WE WILL BE USING THE **CRAFFT** AS AN EXAMPLE.

WHO CAN ADMINISTER THE CRAFFT?

- 1) the physician
- 2) member of your office staff
- 3) the patient-via a self-administered written or electronic survey.
- Screening for substance use is most useful when conducted confidentially without a parent or guardian present.
- **Before screening, both patients and parents should be well informed about the confidentiality policy followed in your practice setting, including the safety-related limits that justify whether to continue or break confidentiality.**



Adolescent annual questionnaire

We ask all our adolescent patients to complete this form at least once a year, because substance use and mood can affect your health. Please ask your doctor if you have any questions.

Patient name: _____

Date of birth: _____

Your answers on this form will remain confidential.

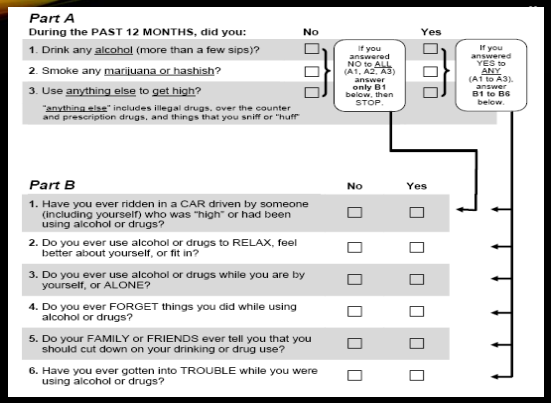
Substance use (CRAFFT):

In the last 12 months, did you:	No	Yes
Drink any alcohol (more than a few sips)?	☐	☐
Smoke, vape or eat any kind of marijuana?	☐	☐
Use anything else to get high?	☐	☐

If you answered No to all three questions, answer #1 below.

If you answered Yes to any questions, answer questions #1-6 below.

	No	Yes
1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	☐	☐
4. Do you ever forget things you did while using alcohol or drugs?	☐	☐
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into trouble while you were using alcohol or drugs?	☐	☐



Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

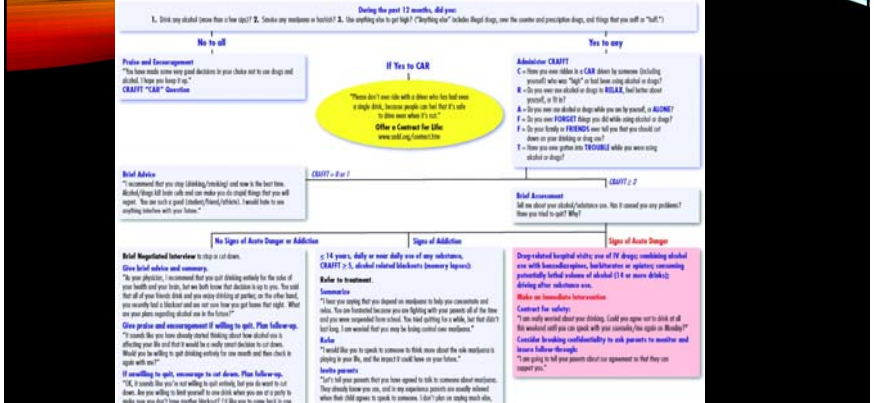
"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer only B1 below, then STOP

If you answered YES to ANY (A1 to A3), answer B1 to B6 below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐



Adolescent SBIRT Opening Questions

During the past 12 months, did you:

1. Drink any alcohol (more than a few sips)? 2. Smoke any marijuana or hashish? 3. Use anything else to get high? ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.")

No to all

Praise and Encouragement
"You have made some very good decisions in your choice not to use drugs and alcohol. I hope you keep it up."
CRAFFT "CAR" Question

Brief Advice
"I recommend that you stop (drinking/smoking) and now is the best time. Alcohol/drugs kill brain cells and can make you do stupid things that you will regret. You are such a good (mother/friend/athlete). I would hate to see anything interfere with your future."

Brief Negotiated Interview to stop or cut down.
Give brief advice and summary.
"As your physician, I recommend that you quit drinking entirely for the sake of your health and your brain, but we both know that decision is up to you. You said that all of your friends drink and you enjoy drinking at parties; on the other hand, you recently had a blackout and are not sure how you got home that night. What are your plans regarding alcohol use in the future?"
Give praise and encouragement if willing to quit. Plan follow-up.
"It sounds like you have already started thinking about how alcohol use is affecting your life and that it would be a really smart decision to cut down. Would you be willing to quit drinking entirely for one month and then check in again with me?"
If unwilling to quit, encourage to cut down. Plan follow-up.
"OK, it sounds like you're not willing to quit entirely, but you do want to cut down. Are you willing to limit yourself to one drink when you are at a party to make sure you don't have another blackout? I'd like you to come back in one month to see how that goes.

Yes to any

If Yes to CAR
"Parents don't ever ride with a driver who has had even a single drink, because people can feel that it's safe to drive even when it's not."
Offer a Contract for Life:
www.said.org/contract.htm

Administer CRAFFT
C = Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R = Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
A = Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
F = Do you ever **FORGET** things you did while using alcohol or drugs?
F = Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
T = Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

CRAFFT = 0 or 1

Brief Assessment
Tell me about your alcohol/substance use. Has it caused you any problems? Have you tried to quit? Why?

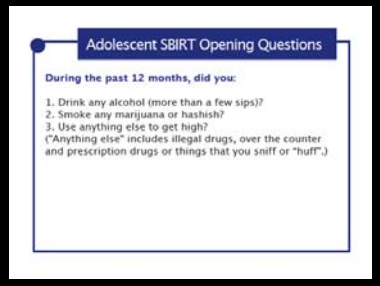
CRAFFT ≥ 2

No Signs of Acute Danger or Addiction

Signs of Addiction
≤ 14 years, daily or near daily use of any substance.
CRAFFT ≥ 5, alcohol related blackouts (memory lapses).
Refer to treatment.
Summarize
"I hear you saying that you depend on marijuana to help you concentrate and relax. You are frustrated because you are fighting with your parents all of the time and you were suspended from school. You tried quitting for a while, but that didn't last long. I am worried that you may be losing control over marijuana."
Refer
"I would like you to speak to someone to think more about the role marijuana is playing in your life, and the impact it could have on your future."
Involve parents
"Let's tell your parents that you have agreed to talk to someone about marijuana. They already know you are, and in my experience parents are usually relieved when their child agrees to speak to someone. I don't plan on saying much else, but is there anything you would like to be sure I keep confidential?"

Signs of Acute Danger
Drug-related hospital visits; use of IV drugs; combining alcohol use with benzodiazepines, barbiturates or opiates; consuming potentially lethal volume of alcohol (14 or more drinks); driving after substance use.
Make an immediate intervention
Contract for safety:
"I am really worried about your drinking. Could you agree not to drink at all this weekend until you can speak with your counselor/me again on Monday?"
Consider breaking confidentiality to ask parents to monitor and insure follow-through:
"I am going to tell your parents about our agreement so that they can support you."

OPENING QUESTIONS



NO TO ALL (1+2+3) STILL =C

NO TO ALL (1+2+3) AND A NO TO C
POSITIVE REINFORCEMENT

THE **CAR** QUESTION

- Have you ever ridden in a CAR driven by someone (including yourself)who was "high" or had been using alcohol or drugs?

YES TO CAR QUESTION

If Yes to CAR

"Please don't ever ride with a driver who has had even a single drink, because people can feel that it's safe to drive even when it's not."

Offer a Contract for Life:
www.sadd.org/contract.htm

YES TO ANY

Yes to Any

Administer CRAFFT
C = Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R = Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
A = Do you ever use alcohol or drugs while your **ALONE**?
F = Do you ever **FORGET** things you did while using alcohol or drugs?
F = Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
T = Have your ever gotten in **TROUBLE** while you were using alcohol or drugs?

(For the clinician or behaviorist)

Interpreting the CRAFFT (Substance use)

Each "Yes" response on questions 1-6 receives a point. Points are added for a total score:

Score*	Risk	Recommended action
"No" to 3 opening questions	Low risk	Positive reinforcement
"Yes" to car question	Driving/Riding risk	Discuss plan to avoid driving after alcohol or drug use or riding with a driver who has been using alcohol or drugs (Consider using Contract for Life)
CRAFFT score = 0	Moderate risk	Brief advice
CRAFFT score = 1		Brief intervention
CRAFFT score ≥ 2	High risk	Consider referral for further assessment

BRIEF ADVICE

CRAFFT = 0 or 1

Brief Advice
"I recommend that you stop (drinking/smoking) and now is the best time. Alcohol/drugs kill brain cells and can make you do stupid things that you will regret. You are such a good (student/friend/athlete). I would hate to see anything interfere with your future."

BRIEF ASSESSMENT

CRAFFT ≥ 2

Brief Assessment
Tell me about your alcohol/substance use. Has it caused you any problems? Have you tried to quit?

NO SIGNS OF ACUTE DANGER

No Signs of Acute Danger or Addiction

Brief Negotiated Interview to stop or cut down.
Give brief advice and summary.
"As your physician, I recommend that you quit drinking entirely for the sake of your health and your brain, but we both know that decision is up to you. You said that all your friends, drink and you enjoy drinking at parties; on the other hand, you recently had a blackout and are not sure how you got home that night. What are your plans regarding alcohol use in the future?"
Give praise and encouragement if willing to quit.
Plan follow-up.
"It sounds like your have already started thinking about how alcohol is affecting your life and that it would be a really smart decision to cut down. Would your be willing to quit drinking entirely for one month and then check in again with me?"
If unwilling to quit, encourage to cut down. Plan follow-up
"OK, it sounds like you're not willing to quit entirely, but you do want to cut down. Are you willing to limit yourself to one drink when you are at a party to make sure you don't have another blackout? I'd like you to come back in one month to see how that goes."

SIGNS OF ADDICTION

Signs of Addiction

≤14 years, daily or near daily use of any substance
CRAFFT ≥ 5, alcohol related blackouts (memory lapses):
Refer to treatment.
Summarize
"I hear you saying that you depend on marijuana to help you concentrate and relax. You are frustrated because you are fighting with your parents all the time and you were suspended from school. You tried quitting for a while, but that didn't last long. I am worried that you may be losing control over marijuana."
Refer
"I would like you to speak to someone to think more about the role marijuana is playing in your life, and the impact it could have on your future."
Invite parents
"Let's tell your parents that you have agreed to talk to someone about marijuana. They already know you use, and in my experience, parents are usually relieved when their child agrees to speak to someone. I don't plan on saying much else, but is there anything your would like to be sure I keep confidential?"

SIGNS OF ACUTE DANGER

Signs of Acute Danger

Drug-related hospital visits; use of IV drugs; combining alcohol use with benzodiazeoines, barbiturates or opiates; consuming potentially lethal volume of alcohol (14 or more drinks); driving after substance use.

Make an Immediate Intervention

Contract for safety:
"I am really worried about your drinking. Could you agree not to drink at all this weekend until you can speak with your counselor/me again on Monday?"

Consider breaking confidentiality to ask parents to monitor and insure follow-through:
"I am going to tell your parents about our agreement so that they can support you."

REIMBURSEMENT FOR SCREENING

- CPT Codes: Overview
  - **96110** (**developmental screening**, with scoring and documentation, per standardized instrument), covers office overhead, i.e., the practice and malpractice expenses in the use of a screening instrument (nonphysician may give the instrument to the patient, score, and record but physician reviews)
    - CT Medicaid requires specification of results: Positive or Negative (effective August 1, 2014)
  - **96127** (**brief emotional or behavioral assessment**, with scoring and documentation, per standardized instrument)
    - Code became effective nationally: January 1, 2015
    - CT Medicaid requires specification of results: Positive or Negative
  - **99420** covers administration and interpretation of health risk assessment instruments, e.g., postpartum depression screening
- Coding Resource
  - AAP Coding Hotline: aapcodinghotline@aap.org
  - Download the CT Provider Bulletin: PB 2014-91 2015 HIPPA Update.pdf

GETTING PAID FOR SBIRT:

- Billing and Coding
- Full screen only : CPT 99420
  diagnosis : alcohol V79.1
  drugs V82.9
  Full Screen plus Brief Intervention
- >/= 15 min 99408 Medicare G0396
- >/= 30 min 99409 Medicare G0397

IN SUMMARY REMEMBER TO COMPLETE THE STEPS USING: TSA

- **T**ool(s) used
- **S**core(s) Achieved
- **A**ction(s) taken-guidance provided to parents/child, referral made, etc.

THE AAP RECOMMENDS THAT PEDIATRICIANS:

- Become knowledgeable about all aspects of SBIRT.
- Become knowledgeable about the spectrum of substance use and the patterns of nicotine, alcohol, and other drug use, particularly by the pediatric population in their practice area.
- Ensure appropriate confidentiality.
- Screen all adolescent patients for tobacco, alcohol, and other drug use with a formal, validated screening tool, such as the CRAFFT screen, at every health supervision visit and appropriate acute care visits, and respond to screening results with the appropriate brief intervention.
- Becoming familiar with motivational-interviewing techniques.
- Develop close working relationships with qualified and licensed professionals and programs that provide the range of substance use prevention and treatment services, including tobacco cessation, that are necessary for comprehensive patient care.
- Facilitate patient referrals through familiarity with the levels of treatment available in the area.
- Make referrals to adolescent-appropriate treatment for youth with problematic use or a substance use disorder.
- Remember that psychiatric disorders can co-occur in adolescents who use psychoactive substances.
- Remain familiar with coding regulations, strategies, and updates for billing.
- Advocate that heath care institutions and payment organizations provide mental health and substance use services across the pediatric/adolescent ages and developmental stages while ensuring parity, quality, and integration with primary care and other health services.

•Prevention and early intervention can make a huge difference in the life of the future adult in front of you

OPIATE ABUSE EPIDEMIC NATIONALLY AND LOCALLY

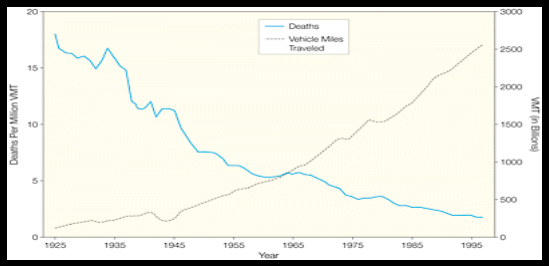
- The CDC has declared this an epidemic.
- Overdose deaths from legal opioid drugs surged by 16.3% to 18,893.
- Overdose deaths from heroin climbed by 28% to 10,574.

ASAM the Voice of Addiction Medicine
American Society of Addiction Medicine

OPIOID ADDICTION DISEASE
2015 FACTS & FIGURES

- Opioids are any of various compounds that bind to specific receptors in the central nervous system and have analgesic (pain relieving) effects including prescription medications such as oxycodone and hydrocodone and illicit substances such as Heroin
- Opioid addiction is federally described as a progressive, treatable brain disease
- *ASAM Addiction definition:* Chronic, relapsing brain disease characterized by compulsive drug seeking behavior and drug use despite harmful consequence
- Any type of opioid can trigger latent chronic addiction brain disease
- 1.9 million Americans live with opioid pain reliever addiction and 517,000 are addicted to heroin.
  (NSDUH Report, 2015)

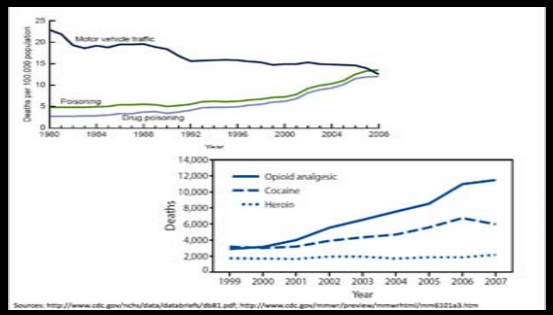
MOTOR VEHICLE SAFETY: A PUBLIC HEALTH ACHIEVEMENT



Motor-Vehicle–Related Deaths Per Million Vehicle Miles Traveled (VMT) and Annual VMT, by Year—United States, 1925-1997

Source: US Department of Health and Human Services

CDC HAS DECLARED THIS AN EPIDEMIC

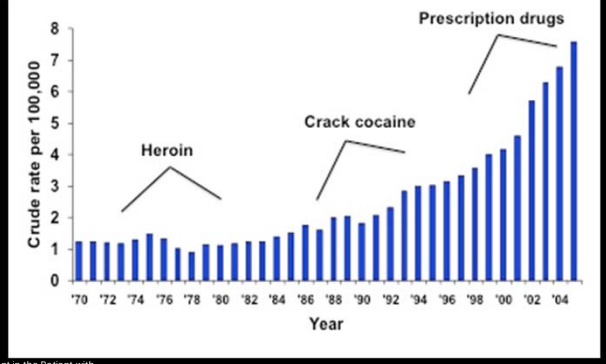


WHO IS ABUSING OPIOIDS?

- Young people (Partnership for Drug-Free America, 2005)
- College students (McCabe et al., 2005)
- Elderly (SAMHSA, 2005)
- Women (Manchikanti,2006; Green et al., 2008)
- Chronic pain patients (Butler et al., 2004, 2008; Passik et al.,2006)
- Street drug users (Davis & Johnson, 2008)
- Geographic patterns: greater in rural areas, but also seen among street-based users in large cities (Paulozzi et al., 2009; Brownstein et al., 2009)
  - **Three-quarters of new users of heroin, initially began using prescription painkillers for nonmedical reasons. **

JAMA Forum: Community Approaches to the Opioid Crisis

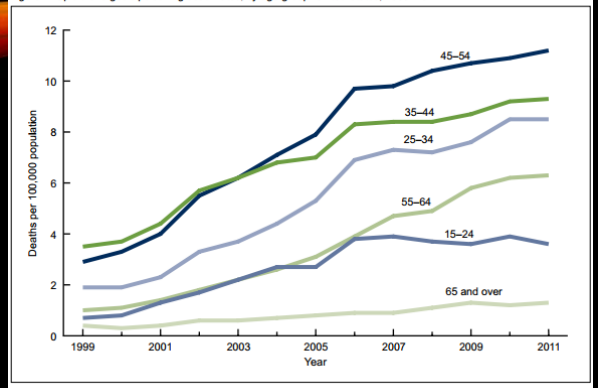
BY HOWARD KOH, MD, MPH *ON* SEPTEMBER 2, 2015



Risk Factors for Opioid Overdose

- ***Recent emergency medical care for opioid intoxication/overdose***
- Receiving prescriptions from multiple pharmacies and prescribers
- Daily opioid doses > 100 mg (morphine equivalents)
- ***Comorbid renal dysfunction, hepatic disease, or respiratory diagnoses (smoking/COPD/emphysema)***
- History of opioid addiction or other substance use disorder
- ***Concurrent use of benzodiazepines or alcohol***
- Comorbid mental illness
- ***Release from incarceration or discharge from a treatment facility***

Figure 4. Opioid-analgesic poisoning death rates, by age group: United States, 1999–2011



NOTE: Access data table for Figure 4 at: http://www.cdc.gov/nchs/data/databriefs/db166_table.pdf#4.
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality File.

STRATEGIES TO ADDRESS OVERDOSE

- Screening and Brief Intervention and Referral
- Prescription monitoring programs
  - Paulozzi et al. Pain Medicine 2011
- Prescription drug take back events
  - Safe disposal
- Safe opioid prescribing education
  - Albert et al. Pain Medicine 2011; 12: S77-S85
- Expansion of opioid agonist treatment
  - Clausen et al. Addiction 2009:104;1356-62
- Safe injection facilities
  - Marshall et al. Lancet 2011:377;1429-37
- Opioid Overdose Education and Naloxone Distribution
  - Maxwell et al. J Addict Dis 2006:25; 89-96
  - Evans et al. Am J Epidemiol 2012; 174: 302-8
  - Coffin PO, et al. *Ann Intern Med*. 2013;158(1):1-9.
  - Walley et al. *BMJ* 2013; 346: f174

RATIONALE FOR OPIOID OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION

- Most opioid users do not use alone
- **Known risk factors:**
  - Mixing substances, abstinence, using alone, unknown source
- **Opportunity window:**
  - opioid OD takes minutes to hours and is reversible with naloxone
- Bystanders can be trained to recognize signs and symptoms of OD
  Fear of police can delay or interfere with timely intervention


ABOUT NALOXONE

- Naloxone reverses opioid-related sedation and respiratory depression = pure opioid antagonist
  - Not psychoactive, no abuse potential
  - May cause withdrawal symptoms
- May be administered IM, IV, SC, IN
- Acts within 2 to 8 minutes
- Lasts 30 to 90 minutes, overdose may return
- May be repeated
- Narcan® = naloxone

Naloxone ≠ Suboxone ≠ Naltrexone

WHO BENEFITS MOST FROM NARCAN TRAINING & PRESCRIPTION?

Patients:

- ***treated for opioid poisoning or intoxication at ED***
- beginning Methadone or Buprenorphine therapy for addiction
- with higher-dose opioid prescriptions (>100 mg morphine equivalent/day)
- rotated from one prescription opioid to another
- with opioid prescriptions and:
  - Benzodiazepine prescription
  - Anti-depressant prescription
  - Smoking, COPD, asthma, or other respiratory illness
  - Renal dysfunction, hepatic illness, cardiac disease, HIV/AIDS
  - Concurrent alcohol use

NARCAN LOCATOR/ OPIOID PRESCRIBING / AND OTHER RESOURCES

- www.overdosepreventionalliance.org/p/od-prevention-program-locator.html
- www.harmreduction.org/
- www.Aids-ct.org
- https://www.indiegogo.com/projects/naloxone-saves-lives#/
- www.ct.gov/dcp/naloxone
- https://www.scopeofpain.com/
- http://pcss-o.org

NARCAN LOCATOR/ OPIOID PRESCRIBING / AND OTHER RESOURCES

- The CO*RE/ASAM ER/LA Opioid REMS Course
  January 11, 2016 | Live Webinar | FREE CME
- The CO*RE/ASAM ER/LA Opioid REMS Course
  January 16, 2016 | Westin La Paloma Resort & Spa | Tucson, AZ
- The ASAM National Practice Guideline on Medications to Treat Opioid Use
  January 25, 2016 | Live Webinar | FREE CME
- The CO*RE/ASAM ER/LA Opioid REMS Course
  January 27, 2016 | Live Webinar | FREE CME
- Rushford intake 877-577-3233

WHO SHOULD BE TREATING THIS PROBLEM?

- All of us

- These Children Belong To Us

AAP MAT (MEDICATION-ASSISTED-TREATMENT) RESOURCES

- **Treating Youth With Opioid Use Disorder**
- With opioid use disorder being identified in younger patients, it is critical for pediatricians to become trained and approved to provide medication-assisted treatment to youth.
- There is an insufficient number of providers of this life-saving service, fewer still with the willingness and developmental expertise to provide it to adolescents and emerging adults.
- This 8-hour online course is free to AAP members and will allow them to apply for a waiver to prescribe buprenorphine as part of treatment of young people with opioid use disorder and learn about the use of naltrexone.
- The course can be accessed at www.aap.org/mat

TREATMENT OPTIONS

- Pharmacologic treatment options:
  - Methadone
  - Buprenorphine
  - Naltrexone
  - Alpha adrenergic agonists (clonidine)
- Psychosocial support:
  - 12 step programs
  - Cognitive Behavioral Therapy, Motivational Enhancement Therapy etc

Rushford
A Hartford HealthCare Partner

BUPRENORPHINE

SUBOXONE© SUBUTEX©

WHAT IS BUPRENORPHINE?

- Partial μ-opioid agonist
- High receptor affinity and receptor occupancy:
  - 95% occupancy at 16 mg

    (Greenwald et al, 2003)
  - Blockade or attenuated effect of the use of additional opioids
- Lower intrinsic activity than full agonists:
  - Favorable safety profile due to "ceiling" effect
  - Lower street value
  - Lower abuse potential

(Walsh and Eissenberg, 2003)

PHARMACOLOGIC BENEFITS

- Slow receptor dissociation:
  - Longer duration of action
  - Milder withdrawal
- Lower physical dependence liability than full agonists
- Limited development of tolerance
- Ceiling effect on respiratory depression
  - Increased safety against overdose

OPIOID RECEPTOR TYPES

Mu Receptor	Associated with opioid addiction
	Mu is for morphine
	Morphine for Morpheus Greek God of Dreams
	Activation produces analgesia, but also euphoria

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A Hartford HealthCare Partner

RECEPTOR DISSOCIATION

- **DISSOCIATION** is the speed (slow or fast) of disengagement or uncoupling of a drug from the receptor
  - With buprenorphine and methadone the dissociation is slower
  - Therefore receptor remains occupied and adding a substance results in lower or no euphoric response

Mu Receptor

Bup dissociation is slow

Therefore Full Agonists can't bind

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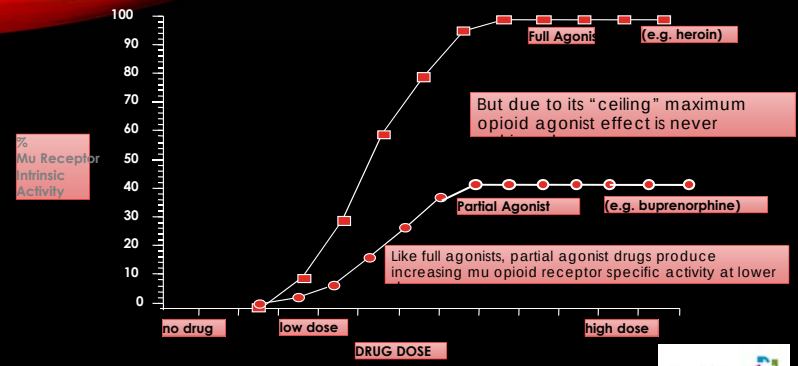
PARTIAL /FULL AGONIST ACTIVITY LEVELS



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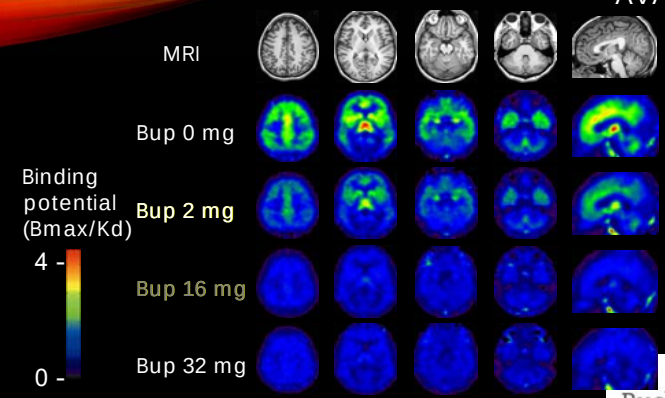
EFFECTS OF BUPRENORPHINE ON μ-OPIOID RECEPTOR AVAILABILITY



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STAYING IN TREATMENT

- Pharmacologic treatment in combination with psychosocial interventions significantly enhances treatment effectiveness:
  - Retention after 1-year treatment, 75% and 0% in buprenorphine and placebo groups respectively (Kakko *et al*, 2003)
- Pharmacotherapy helps patients stay in treatment:
  - Reduces illicit drug use due to decreased cravings and withdrawal symptoms
  - Reduces mortality by up to 4-fold (Kreek and Vocci, 2002)

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ONCE OPIATE ADDICTED, WHY ISN'T IT EASY TO STOP?

- Withdrawal from opioids is associated with an extremely unpleasant syndrome:
  - Physical pain (muscle aches, cramps)
  - Nausea and vomiting
  - Diarrhea
  - Dysphoria
  - Depression
  - Irritability and anxiety
  - Dysregulation of brain reward systems

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PROTRACTED WITHDRAWAL STATE

- An altered mental state that follows acute Opioid Withdrawal Syndromes
  - May lasts for weeks to months
  - May include insomnia, dysphoria, and opioid craving
- No clearly specific pharmacologic treatments for this state but it may explain…
  - …why opioid agonist maintenance treatment outcomes are so much better than abstinence based treatment outcomes
  - …why longer duration of tapering agonist drugs as a withdrawal treatment has better outcome than a short taper

FEDERAL OPIOID LEGISLATION (CARA) COMPREHENSIVE ADDITION AND RECOVERY ACT:

The bill is an attempt to address the growing rate of overdose deaths from heroin and other opioids

Comprehensive Addition and Recovery Act:
1. Expands access to medication-assisted treatment
2. Further expands access to naloxone
3. Expands access to prescription drug monitoring programs
4. Expands prevention and education efforts
5. The bill provides no new funding to address the issue

For more information on resources available in Connecticut for addiction to heroin and opioids, go to www.hartfordhealthcarebhn.org.

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SUBOXONE

- SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII) is a prescription medicine indicated for treatment of opioid dependence and should be used as part of a complete treatment plan to include counseling and psychosocial support. **Treatment should be initiated under the direction of physicians qualified under the Drug Addiction Treatment Act.**
- This requires the physician to complete training, apply for a a waiver and receive a special DEA number that starts with an X
- SUBOXONE Film can be abused in a manner similar to other opioids, legal or illicit.
- SUBOXONE Film contains buprenorphine, an opioid that can cause physical dependence with chronic use. Physical dependence is not the same as addiction.
- Do not stop taking SUBOXONE Film suddenly without talking to your doctor. You could become sick with uncomfortable withdrawal symptoms because your body has become used to this medicine.

SUBOXONE CONTINUED…

- SUBOXONE Film can cause serious life-threatening breathing problems, overdose and death, particularly when taken by the intravenous (IV) route in combination with benzodiazepines or other medications that act on the nervous system (ie, sedatives, tranquilizers, or alcohol). It is extremely dangerous to take nonprescribed benzodiazepines or other medications that act on the nervous system while taking SUBOXONE Film.
- You should not drink alcohol while taking SUBOXONE Film, as this can lead to loss of consciousness or even death.
- Death has been reported in those who are not opioid dependent.
- Your doctor may monitor liver function before and during treatment.
- SUBOXONE Film is not recommended in patients with severe hepatic impairment and may not be appropriate for patients with moderate hepatic impairment. However, SUBOXONE Film may be used with caution for maintenance treatment in patients with moderate hepatic impairment who have initiated treatment on a buprenorphine product without naloxone.

SUBOXONE CONTINUED…

- **Accidental or deliberate ingestion by a child may cause respiratory depression**
- **that can result in death. If a child is exposed to one of these products, medical**
- **attention should be sought immediately.**
- Instruct patients never to give these products to anyone else, even if he or she has the
- same signs and symptoms. They may cause harm or death.
- Advise patients that selling or giving away buprenorphine-containing products is against
- the law.

SUBOXONE CONTINUED…

- **Pediatric Use**
- The safety and effectiveness of SUBOXONE sublingual film have not been established in pediatric patients. This
- product is not appropriate for the treatment of neonatal abstinence syndrome in neonates, because it contains
- naloxone, an opioid antagonist.
- Buprenorphine is a Schedule III narcotic under the Controlled Substances Act.
- **Under the Drug Addiction Treatment Act (DATA) codified at 21 U.S.C. 823(g), prescription use of this product**
- **in the treatment of opioid dependence is limited to physicians who meet certain qualifying requirements,**
- **and who have notified the Secretary of Health and Human Services (HHS) of their intent to prescribe this**
- **product for the treatment of opioid dependence and have been assigned a unique identification number that**
- **must be included on every prescription**

SUBOXONE CONTINUED…

- Clinical guidelines for buprenorphine treatment and general information on the treatment of addiction is available through numerous sources such as the following: Substance Abuse and Mental Health Services (SAMHSA) Center for Substance Abuse Treatment (CSAT) Web site at www.dpt.samhsa.gov American Society of Addiction Medicine Web site at **www.asam.org/** and the American Academy of Addiction Psychiatry website at
- **www.aaap.org/**
- For more information, call our toll-free help line at 1-877-SUBOXONE (1-877-782-6966) or visit our Web site at www.suboxone.com.
- Please see enclosed full Prescribing Information
- Attachment to Pharmacist Brochure: SAMPLE 42

SUBOXONE CONTINUED…

- Attachment to Pharmacist Brochure: SAMPLE 42 CFR Part 2.31 Consent Form
- 1.I (name of patient) _____{time} Authorize:
- 2. Dr._____
- 3. To disclose: (kind and amount of information to be disclosed) Any information needed to confirm the validity of my prescription and for submission for payment for the prescription.
- 4. To: (name or title of the person or organization to which disclosure is to be made) The dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, as well as to third party payors.
- 5. For (purpose of the disclosure) Assuring the pharmacy of the validity of the prescription, so it can be legally dispensed, and for payment purposes.
- 6. Date (on which this consent is signed)_____
- 7. Signature of patient _____
- 8. Signature of parent or guardian (where required)

SUBOXONE CAUTIONS: AGE, PREGNANCY, BREASTFEEDING, LIVER FUNCTION

- Pregnancy: Based on animal data, buprenorphine (the active ingredient in SUBOXONE) may cause fetal harm
- Nursing mothers: Caution should be exercised when SUBOXONE is administered to a nursing woman
- Safety and effectiveness of SUBOXONE in patients below the age of 16 has not been established
- Administer SUBOXONE with caution to elderly or debilitated patients
- SUBOXONE sublingual film is not recommended for use in patients with severe hepatic impairment and may not be appropriate for patients with moderate hepatic impairment

SPECIAL URINE CUPS

- phone | 318.798.3306 ext 126/ toll free: 1.866.526.2873 / fax: 318.798.3386
  7607 Fern Ave #703 Shreveport, LA 71105
- email | lrearden@americanscreeningcorp.com
- website | americanscreeningcorp.com

WE pay $4.00/per cups for 13 panel.

- **J. Craig Allen, MD**
- Medical Director
- jonathancraig.allen@hhchealth.org

ANSWERS FROM AAP

- All 3 options provided will allow pediatricians to obtain their waiver. It's your preference as to which method works best for you.
- The course is strictly clinical management.
- It will not connect you with referral sources for therapy.
- The hope is that you will be able to provide treatment to any adolescent patients of yours that you find have an opioid use disorder.
- Also, there is a directory of buprenorphine providers at http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- It is possible for youth not currently being seen by you may contact you for treatment. I have heard that many buprenorphine prescribers are hesitant to treat youth, making it all that more important that pediatricians become treatment providers.
-

QUESTIONS ABOUT MAT FROM A PEDIATRICIAN

- There are several options for training: https://www.aap.org/en-us/my-aap/Pages/Pediatric-Online-Waiver-Training.aspx?nfstatus=200&nftoken=966886f7-9016-4caa-b25b-6b2c1ca92f8c&nfstatusdescription=Set+the+cookie+token
- • Online 8-Houre Course
- • Live 8-Hour Course
- • Half Online / Half Live Option
- Will it matter which option to choose from? (Learning style only)
- And will the training help identify who to partner with for counseling and other support.
- In other words is the intention to be a resource for our patients or for new patients in the community?
-

CONCLUSION:

SBIRT can be time-efficient,

SBIRT is effective,

Remember it is all about promoting child health and mitigating risk!

Substance use issues do not have to be solved in one visit,

whenever possible, it is always best to keep services within the medical home.

WAIT21.ORG WHY WAIT?

90% of those that struggle with addiction started before age 21

If you smoke drink or use before age 21 – you have a 1 in 4 chance of becoming addicted. After 21 , it is a 1 in 25 chance Annual recovery rate for addiction is about 5% / year– total number of people affected is about 40 million.

Addiction is third leading Cause of Death in USA

QUESTIONS/COMMENTS