**SBIRT**
Briefly Intervening Saves Lives

Mnemonic for...
- Screening
- Brief Intervention
- Referral to Treatment

**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

4% of 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**


**Addiction is a Developmental Disease that starts in Childhood and Adolescence**

**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

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

  http://www.aap.org/cnnpediatrics/docs/mentalhealth/docs/MH-ScreeningChart.pdf
- Massachusetts General Hospital School Psychiatry Program & Madi Resource Center
  http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp
- Massachusetts Primary Care Behavioral Health Screening Toolkit

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

**Core Assumptions of MI**

1. Motivation is a state, NOT a trait

---

2. Ambivalence to change is normal
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

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.
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/peds.2011-1754; 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.

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

SUBSTANCE ABUSE AND SBIRT RESOURCES

• www.SBIRToregon.org
• WAIT21.org
• www.samhsa.gov/sbirt
THE NITTY G GRTTY
Nuts and Bolts of doing this in the office with CRAFFT

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.**
OPENING QUESTIONS

Adolescent SBIRT Opening Questions
During the past 12 months, did you:
1. Drink any alcohol more than a few times?
2. Use any marijuana or hashish?
3. Use anything else to get high?
   (Anything made to include drugs, over the counter and prescription drugs or things that you snort or "huff")

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.asked.org/contactforlife

YES TO ANY

Yes to Any

Administer CRAFT
C. Have you ever ridden in a CAR driven by someone who has had too much to drink or had been using 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 ALONE?
F. Do you ever FORGET things you did while using alcohol or drugs?
T. Have your family or FRIENDS ever told you that you should slow down or stop drinking or drug use?
H. Have your worst problems happened when you were using alcohol or drugs?

BRIEF ADVICE

(For the clinician or health care worker)

Interpreting the CRAFT (Substance use)
Each “Yes” response on questions 1-6 receives a point. Points are added for a total score:

<table>
<thead>
<tr>
<th>Score*</th>
<th>Risk</th>
<th>Recommended action</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No” to 3 opening questions</td>
<td>Low risk</td>
<td>Positive reinforcement</td>
</tr>
<tr>
<td>“Yes” to car question</td>
<td>Driving/Riding risk</td>
<td>Discuss plans to avoid driving after alcohol or drug use or riding with a driver who has used alcohol or drugs (Consider using Contract for Life)</td>
</tr>
<tr>
<td>CRAFT score = 0</td>
<td>Moderate risk</td>
<td>Brief advice</td>
</tr>
<tr>
<td>CRAFT score = 1</td>
<td></td>
<td>Brief intervention</td>
</tr>
<tr>
<td>CRAFT score ≥ 2</td>
<td>High risk</td>
<td>Consider referral for further assessment</td>
</tr>
</tbody>
</table>

CRAFTT ≥ 0 ≥ 1

Brief advice
I recommend that you stop (or reducing) drinking and never, for the next little while. Alcohol/drugs kill more kids 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 2-2

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 Informed Consent is required or not clear.

Your child needs help if they have a problem with alcohol and/or drugs and if they are feeling the negative effects of these substances. If you think your child may have a problem with alcohol and/or drugs, it is important to discuss this with their doctor or a mental health professional.

SIGNS OF ADDICTION

Signs of Addiction

- Your child may have trouble with alcohol and/or drugs and may be feeling the negative effects of these substances.

SIGNS OF ACUTE DANGER

Signs of Acute Danger

- Your child may have a problem with alcohol and/or drugs and may be feeling the negative effects of these substances.

Make an Immediate Intervention

- Consider having a conversation with your child about their substance use.

Contract for safety:

- If your child agrees to stop using alcohol and/or drugs for a certain period of time, they can be referred to a substance abuse counselor for further evaluation.
REIMBURSEMENT FOR SCREENING

- **CPT Codes: Overview**
  - 96110 (developmental screening, with scoring and documentation, per standardized instrument, covers practice overhead, i.e., the practice and malpractice expenses in the use of a screening instrument. The activity may take the form of the patient, score, and record by the nonphysician. A 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 rules require documentation of 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

GETTING PAID FOR SBIRT:

- Billing and Coding
- Full screen only:
  - CPT 99420
diagnosis: alcohol V79.1
drugs V82.9
- Full Screen plus Brief Intervention
  - \( \geq 15 \text{ min} \) 99408 Medicare G0396
  - \( \geq 30 \text{ min} \) 99409 Medicare G0397

IN SUMMARY REMEMBER TO COMPLETE THE STEPS USING: TSA

- **Tool(s) used**
- **Score(s) Achieved**
- **Action(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 for tobacco and patterns for tobacco as well as alcohol, and other drug use with a formal, validated screening tool such as the CBIRT screen.
- Screen all patients at every health supervision visit and appropriate acute care visits, and respond to screening results with the appropriate brief intervention.
- Develop and maintain 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.
- Familiarize themselves 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.
- Familiarize themselves with the levels of treatment available in the area.
- Advocate for health care institutions and payment organizations to 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.

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 pharmacists and prescribers
- Daily opioid doses > 100 mg (morphine equivalent)
- 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
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
• Opioid Overdose Education and Naloxone Distribution
  • Maxwell et al. J Addict Dis 2006:25; 89-96
  • 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
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
  - Morphine for Morpheus, Greek God of Dreams
  - Activation produces analgesia, but also euphoria
**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

---

**PARTIAL / FULL AGONIST ACTIVITY LEVELS**

- Partial Agonist (e.g., buprenorphine)
- Full Agonist (e.g., heroin)

But due to its "ceiling" maximum opioid agonist effect, it is never achieved.

Like Full Agonists, Partial Agonist drugs produce increasing Mu opioid receptor specific activity at lower drug doses.

---

**EFFECTS OF BUPRENORPHINE ON μ-OPIOID RECEPTOR AVAILABILITY**

- No drug
- Low dose
- High dose

MRI

- Binding potential (Bmax/Kd)
- Bup 0 mg
- Bup 2 mg
- Bup 16 mg
- Bup 32 mg

---

**STAYING IN TREATMENT**

- Pharmacologic treatment in combination with psychosocial interventions significantly enhances treatment effectiveness:
  - Retention after 1-year treatment: 75% in buprenorphine and 0% in placebo groups (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)
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

PROTRACTED WITHDRAWAL STATE

- An altered mental state that follows acute Opioid Withdrawal Syndromes
- May last 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 ADDICTION AND RECOVERY ACT:

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

- **Comprehensive Addiction 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.
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 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® 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 (i.e., sedatives, tranquilizers, or alcohol). It is extremely dangerous to take nonprescribed SUBOXONE® Film 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.

- 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.

- 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 controlled substance under the Controlled Substances Act.


  - In consultation with the Secretary of Health and Human Services (HHS) these requirements, and who have notified the Secretary 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.
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 CFR Part 2.31 Consent Form

1. (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/hold/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)

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=96686f7-9016-4c44-b2c1-939e43f68a43&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