The SBIRT Residency Training Program in Pediatrics

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SBIRT:

Screening,

Brief

Intervention,

Referral to

Treatment

For Alcohol and Illicit Substance Use

Scope of Substance Abuse

- Major preventable and treatable public health problem
  - Total annual economic costs to U.S estimated at >$414 billion.
  - Consequences to individual, workplace, society, healthcare system
- Situation in CT
  - Top 20% for past year alcohol and illicit drug dependence in 12yrs + (8.5%), and 18-25 yrs (23.1%)
  - Top 20% for binge drinking among 12-17 yrs (11.9%)
  - Top 20% for marijuana, cocaine, and Rx pain drugs among 18-25 yrs (15.2%)

CDC data, Behavioral Risk Factor Surveillance System, 2006

Substance Use Trends Among Adolescents

- After increase in early 1990s, adolescent SA has decreased steadily
  - "Record lows" for 12 graders - alcohol (45% past month use) and cigarettes (22%)
- One in four 12th graders report binge drinking in past month, 40% college age
- Marijuana most commonly used illicit substance among teens and young adults
- Rates of alcohol and cigarette use more than triple in 18-25 yrs versus 12-17 yrs

National Prevalence Data – High school seniors, 2005

Alcohol	76.8%
Cigarettes	52.8%
Any illicit substance	51.1%
Marijuana	45.7%
Amphetamines	7.5%
Methamphetamines	6.2%
Inhalants	10.9%
Tranquilizers	10.6%
Hallucinogens	9.7%
Cocaine	8.1%
MDMA	7.5%
Steroids	3.4%
Heroin	1.5%
Narcotics (other than heroin)	13.5%

Monitoring the Future Study, U, Michigan, 2005 data

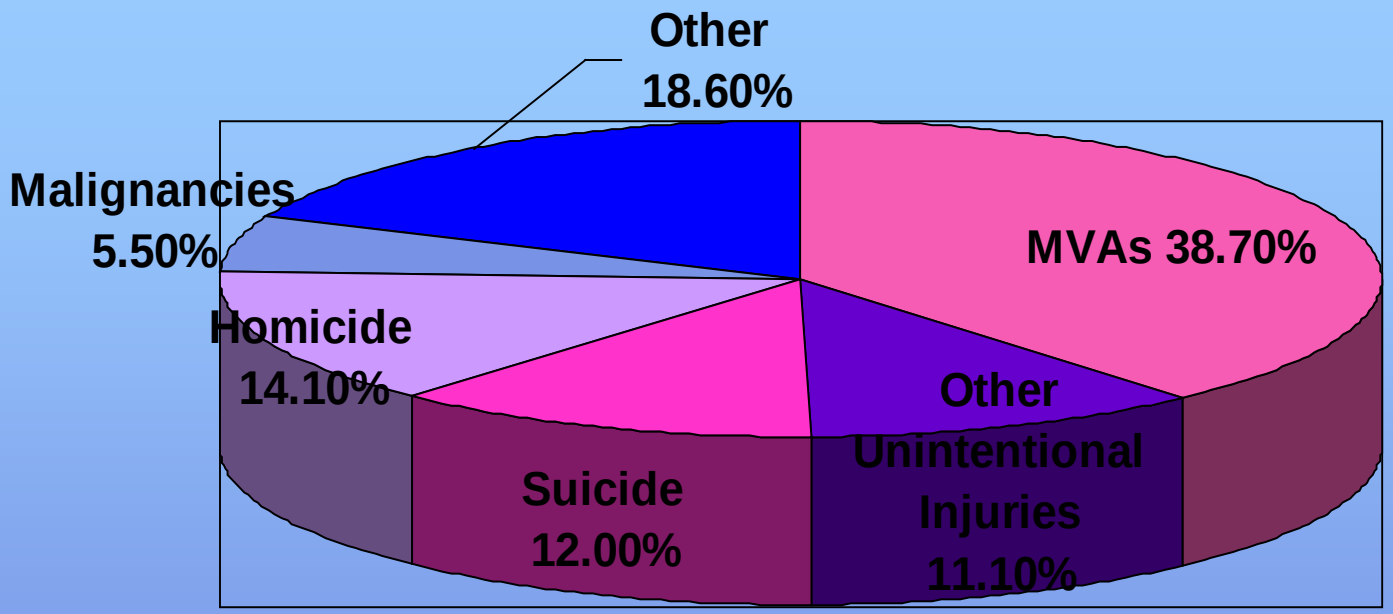
Young Adults

- Highest prevalence of alcohol consumption
- Major concern for college campuses
- Drivers between the ages of 16-25 account for 30% of alcohol-related fatalities

Consequences of Drug and Alcohol Use

- Morbidity
  - Impairment of judgment
    - Effect on brain development; hippocampus?
  - Direct medical effects
  - Association with other high risk behaviors
    - STIs, HIV, pregnancy
    - Violence and aggression
    - Risky recreational vehicle use; injuries
- Mortality - injuries

Leading Causes of Mortality, Ages 15-19 years, National 2005 data



Drug and Alcohol Dependence

- Pediatric rates lower than subclinical use/problem use
- National Rates of Abuse/Dependence on Alcohol or Illicit Drugs*
  - 12-17 year olds - 8% M=F
  - 18-25 year olds - 17% F, 26% M
- Knight - clinical sample in Boston, MA
  - 16.3% of 14-18 yo had substance-related diagnosis of abuse or dependence, defined by DSM-IV.**

*SAMSHA, 2006 National Survey on Drug Use; ** Knight J. Arch Ped Adol Med 2002; 156:607-614.

Definitions - based on DSM IV, NIAAA

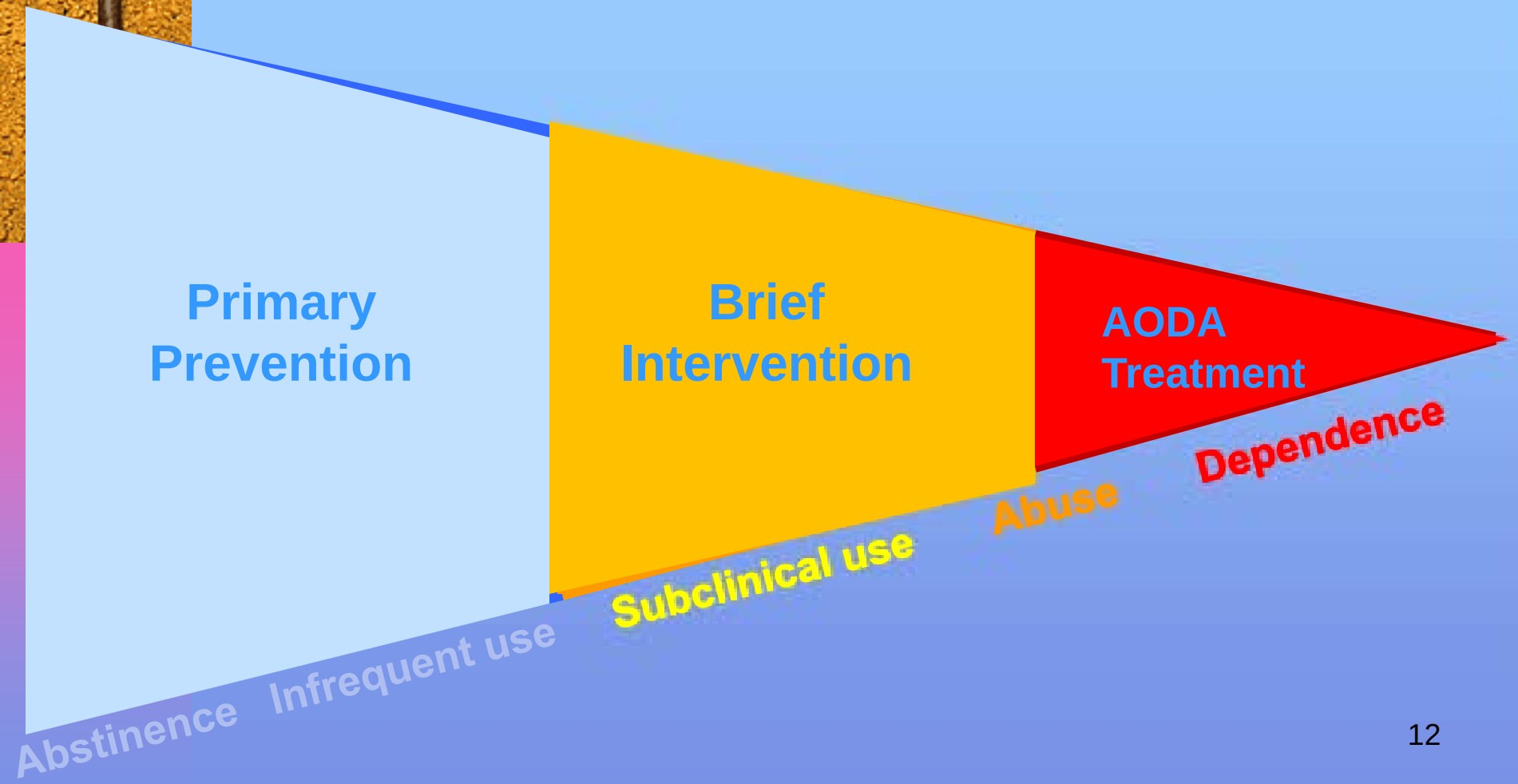
- Low risk use/experimental use
  - Not affecting health
  - Use <NIAAA guidelines for ETOH
- Hazardous use/Regular use
  - At risk for injury/medical or social problems
  - Use > NIAAA guidelines
- Harmful Use
  - Problem use - Currently experiencing problems
  - Abuse - using despite harm
  - Use >>NIAAA guidelines
- Dependence/Addiction
  - Out-of-control use, experiencing withdrawal symptoms

Physician Behaviors

- Despite AMA and AAP recommendations:
  - Less than 50% pediatricians report screening all teens for substance use/abuse
  - Less than 25% report screening for drinking and driving in teens*
  - Barriers reported:
    - "not a problem in my practice population
    - Inadequate training
    - Lack of effective treatment programs or referral sites
- Physicians often fail to detect/refer
  - Nationally, 11% of 23.6 million estimated to need SA treatment actually received care**

*Halpern-Felser B et. al. Arch Ped Adol Med 200:154:173-179; ** SAMHSA data, National Survey of Drug Use and Health, 2005-2006..

BI as a Response Option



Nation's Public Health Agenda: Healthy People 2010

- Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these problems in the emergency department

Alcohol Screening and the **B**rief **N**egotiated **I**ntervention (BNI).
What is it & Does it Work?

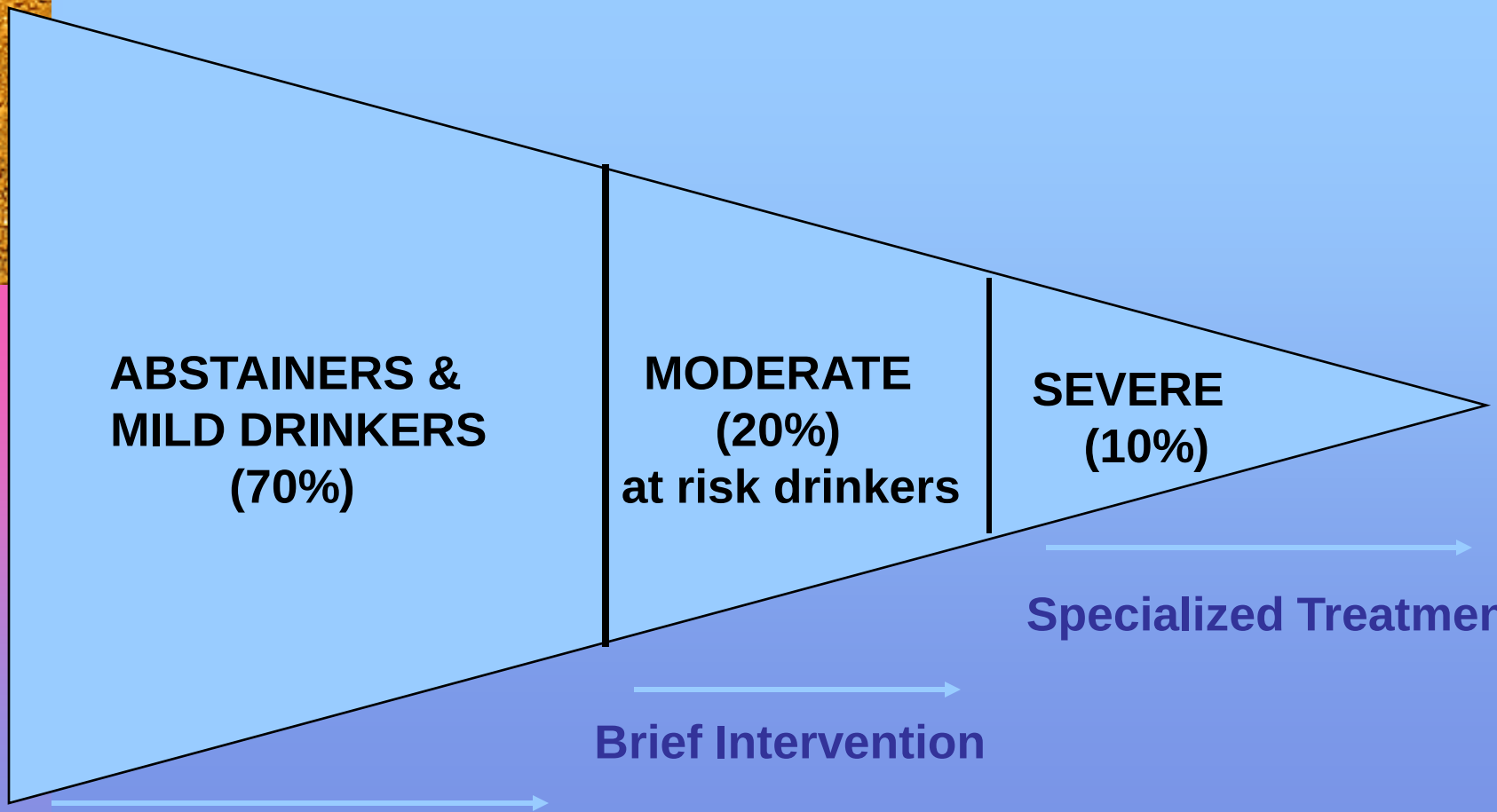
Several Truths

- Treatment does work
- The ED/Primary care visit is an opportunity for intervention
- Timely referral is effective
- Practitioners are reluctant to screen and intervene
- There are multiple barriers to the SBI

Why **Early** intervention?

- Screening and referral increases treatment contact
- $ saved
- Improved prognosis
- Medical opportunity is ‘Teachable Moment’

UNIVERSAL SCREENING WIDENS THE NET



Detection and Referral

Does it matter?????

Brief Negotiation Interventions

- Extensive experience by Yale Adult ED faculty - nationally and at Yale
  - BNI taught in context of comprehensive program can improve ED resident knowledge and practice*
  - Feasibility studies of BNI (7.5') in ED settings for harmful ETOH use - D'Onofrio**
  - Developed Project ASSERT - using BNI to facilitate linkages to community referrals for substance abuse

- * D'Onofrio G et.al., Annals Emerg Medi 2002; 40:50-62; **D.Onofrio et.al. Acad Emerg Med 2005;12:249-256.

Brief Negotiation Interventions

- Data on efficacy of BNI in various settings
  - Bernstein - Project ASSERT in Walk-in clinics - found reduced rates of cocaine, heroin use at 6 months*
  - Data in ED settings mixed-
    - D'Onofrio - no difference between BNI and Discharge instructions on ETOH use at 12 months**

*Bernstein J et al. Drug Alc Dep 2004; 77;49-59; **D'Onofrio G et.al. Annals Emerg Med 2008; 51:742-750;

COST-BENEFIT ANALYSIS OF BRIEF MOTIVATION

- RCT (n=774)
- primary care practice, managed care setting
- problem drinkers
- economic cost of intervention = $80,210 ($205 each)
- economic benefit of intervention = $423,519
  - $193,448 in ED and hospital use
  - $228,071 avoided costs in motor vehicle crashes and crime
  - 5.6 to 1 benefit to cost ratio
  - $6 savings for every $ invested

Fleming MF, et al. *Medical Care* 2000; 38:7-18.

World Health Organization
(*Am J Pub Health* 1996)

"A cross-national trial of brief interventions with heavy drinkers"

- Multinational study in 10 countries (n=1,260)
- Interventions included simple advice, brief & extended counseling compared to control group
- Results: Consumption decreased:
  - 21% with 5 minutes advice, 27% with 15 minutes compared to 7% controls
  - **Significant effect for all interventions**

Why SBIRT/BNI with adolescents?

- A large population of “subclinical” AOD users exists
- Only 1 in 20 with clinical AOD involvement get services
- Primary care offers an “opportunistic” setting
- Expands service options, typically limited
- MI techniques congruent with aspects of adolescent development
  - Respect for autonomy, emerging independence
- It seems to work

Effectiveness of BNI in Teens

- Small, but growing literature
- Many “brief” programs extensive, not brief
- Outcomes: decreased AOD use, consequences, increased self-efficacy
  - D’Amico - RCT, 15’ intervention with 12-18 year olds in primary care clinic
  - Decreased MJ use at 3 month f/u*
- High satisfaction overall

***D’Amico EJ et.al. J Sub Abuse Treat 2008; 35:53-61.

Ok, What is the Brief Negotiated Interview & How do I perform this technique?

BNI: Brief Negotiated Intervention

- Short (5-7 min) counseling sessions
- Based on motivational interviewing techniques - patient-centered, assist in changing specific drinking/drug-using habits, use of reflective listening
- 4 Major Steps
  - Raise the subject
  - Provide feedback
  - Enhance motivation/develop discrepancy
  - Negotiate and advise
- Scripted
  - Manual developed for explanation of each step

Components of the BNI

1. Raise the Subject
2. Provide Feedback
3. Enhance Motivation
4. Negotiate and Advise

Step 1: Raise The Subject

- Establish Rapport
- Raise the subject of alcohol use

"Hello, I am……. Would you mind taking a few minutes to talk with me about your alcohol use?"

Establish Rapport

- To understand the patient's concerns and circumstances
- To explain the providers concern/role
- To avoid a judgmental stance

Raise the subject

- Get the patient's agreement to talk about the alcohol or drug use
- Talk about the pros and cons of their use/abuse
- Re-state what they have said regarding the pros and cons

What if the patient does not want to talk about their use/abuse ?

“ Okay, I see you aren’t ready to talk about this today. Remember that we are here 24 / 7 if you change your mind”

ASK Current Drinkers

- On average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What's the maximum number of drinks you had on a given occasion in the last month?

Screen Positive

	Drinks per week	Drinks per occasion
Men	> 14	> 4
Women	> 7	> 3
All Age >65	> 7	> 3

Drinking Patterns

	% of US adults aged 18+	Abuse without dependence	Dependence with or without abuse
Exceeds *daily* limit < once a week	16%	1 in 8 (12%)	1 in 20 (5%)
Exceeds *daily* limit once a week or more	3%	1 in 5 (19%)	1 in 8 (12%)
Exceeds both weekly & daily limits	9%	1 in 5 (19)	1 in 4 (28)

Source: NIAAA National Epidemiologic Survey on Alcohol and Related Conditions, 2003

Screening Questions - CRAFFT

- ***CRAFFT Screening***

  Have you ever ridden in a *CAR* by someone (including yourself) who was high or was using alcohol or drugs?

  Do you ever use alcohol or drugs to *RELAX*, feel better about yourself or fit in?

  Do you ever use alcohol or drugs while you are by yourself? *(ALONE)*

  Do your family or *FRIENDS* ever tell you that you should cut down on your drinking or drug use?

  Do you ever *FORGET* things that you did while using alcohol or drugs?

  Have you gotten in *TROUBLE* while you were using alcohol or drugs?

  alpha - .68; sensitivity .80; specificity .86 - to predict any problem; PP+ .83; PP- .91

  Knight, J. et.al. 2002.

ASK Current Drinkers

CAGE

C → Cut Down

A → Annoyed

G → Guilty

E → Eye Opener

Step 2: Provide Feedback

- Review patient's drinking patterns
- Make connection to ED visit or other aspects of if possible
- Compare to National Norms and offer NIAAA guidelines

Step 2: Provide Feedback

"From what I understand you are drinking…"

"What connection (if any) do you see between your drinking and this ED visit?"

"These are what we consider to be the upper limits of low-risk drinking for your age and sex. By low-risk we mean that you would be less likely to experience illness or injury."

Express Empathy and Rapport

- Attitude : Acceptance by provider
- Technique: Skillful reflective listening
- Basis of change: Patient ambivalence

Assess Readiness To Change

"On a scale of 1-10 (1 being not ready and 10 being very ready) how ready are you to change any aspect your drinking patterns?"

1 2 3 4 5 6 7 8 9 10

Step 3: Enhance Motivation

On a scale from 1-10, how ready are you to change any aspect of your drinking?

If patient indicates:

≥ 2 : "Why did you choose that number and not a lower one? What are some reasons that you are thinking about changing."

≤ 1: "Have you ever done anything that you wish you hadn't while drinking: What would make this a problem for you." Discuss pros and cons

Not Ready for Change

- Don’t
  - Use shame or blame
  - Preach
  - Label
  - Stereotype
  - Confront

Avoid Argumentation

- Counter productive
- Defending breeds defensiveness
- Perceptions can be shifted
- Labeling is unnecessary
- Resistance is a signal to change strategies
  - Rolling with resistance

Not Ready for change

- Do
  - Offer information, support and further contact
  - Present feedback and concerns, if permitted
  - Negotiate: “What would it take you to consider a change ?”

Unsure Patients

- **Don't**
  - Jump ahead
  - Give advice
  - Expect argument about change
- **Do**
  - Explore pros & cons
  - "help me to understand what alcohol does for you"
  - "Are there things you don't like about your alcohol use?"

Step 4: Negotiate and Advise

- Elicit response

  "How does all this sound to you?"

- Negotiate a goal

  "What would you like to do?"

- Give advice

  "It is never safe to drink and drive, etc…"

- Summarize

  "This is what I heard you say.. Thank you…
  (Provide PCP f/u or treatment referral)

Develop Discrepancy
Explore Pros and Cons

- Patient awareness of situation
- Discrepancy between present behavior and important goals as change motivator
- Let the patient name the problem and the pros and cons

Dangerous Assumptions

- This person ought to change
- This person is ready to change
- This person's health is the prime motivating factor for them
- If they decide not to change the BNI has failed

Dangerous Assumptions

- Patients are either motivated or not
- Now is the right time to change
- A tough approach is best
- I am the expert and they should follow my advice

The Ready Patient

- Help the patient to:
  - Name a solution for themselves
  - Choose a course of action
  - Decide how to achieve it
  - Encourage patient choice

Referral

- Consult the
  - Social worker
  - Psychiatric services
- Discharge sheet of possible centers and / or programs and information

Summary

- Alcohol problems are common, identifiable and treatable disorders
- Knowledge and skills for screening and intervention can be learned

Short-term Components

- Expanded curriculum
  - Topics adapted for each specialty
    - - Substance-induced medical problems, intoxication, withdrawal, treatment of addiction, pain management, psychiatric complications
- Website
  - modules, didactic presentations, video clips, case studies, readings

Long-term Components

- "Virtual coach"
  - Automated clinical skills testing and training
  - Individualized practice and reinforcement
  - 3-4 Virtual SPs
    - Give personalized feedback, praise, constructive feedback, award points for correct steps
- Integration of curricular elements into residency program
- Sustainability through "train the trainer"
- Dissemination throughout CT

Remember:

Just start the conversation,

you may save a life!