SBIRT for Unhealthy Drug Use in Primary Care

Evidence versus Recommendations

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Disclosure

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Drug SBIRT: Outline

- Rationale
- The Basics
- Professional Recommendations
- Evidence
- Clinical Approach
- Conclusions
- Discussion
Rationale…

• Among Americans ≥ 12 years old:
  • 22.5 million people reported past month illicit drug use
  • 6.5 million have a drug (± alcohol) addiction

NSDUH/SAMHSA 2011
Rationale...

7.2 million Americans need treatment for illicit drug use:

- 91.4% DID NOT feel a need for Treatment
- 5.2% felt a need, but DID NOT make an effort
- 3.2% felt a need, and DID make an effort

5.8 million need but do not receive services

NSDUH/SAMHSA 2011
Why Primary Care?

- Extensive number & variety of patients\(^1\)
- Adults with drug use disorders are overrepresented\(^2\)
- Focus on prevention\(^1\)
- Longitudinal, trusting patient-clinician relationships\(^1\)

Rationale...

- Societal costs
  - $193 billion yearly (2010)

- Associated with negative consequences
  - Medical
  - Social
  - Legal
SBIRT

a comprehensive, integrated, public-health approach to the identification and delivery of early intervention services for individuals with unhealthy substance use
SBIRT Basics

Screening
- Single Question
  Screen, Conjoint Screen etc.

Assessment
- ASSIST, DAST,
  DUDIT, CRAFFT etc.

Brief Intervention
- MI principles,
  readiness to change

Referral to Treatment
Alcohol & Tobacco SBIRT

- SBIRT: documented efficacy for
  - Alcohol Misuse ★★★★★
    (USPSTF Grade B, 2013)
    high/moderate certainty of
    moderate/substantial net benefit
  - Tobacco Cessation ★★★★★★
    (USPSTF Grade A, 2009)
    high certainty of substantial net benefit
“Prescription drug abuse is the Nation’s fastest growing drug problem”
- Office of National Drug Control Policy (2011)
Professional Recommendations

- **AMA (2010):** “screening for… drug use in a variety of settings”
- **AAFP (2009):** “diagnose substance abuse and addiction in the earliest stage possible, and treat or refer for treatment”
- **AAP (2011):** “screening all adolescent patients… at every contact, and initiating BI and RT when appropriate”
- **ACOG & ASAM (2012):** opioid screening part of “complete obstetric care”
- **APA (2012):** “a routine part of medical assessment”
- **NIH-NIDA (2012), SAMHSA (2012)**
Existing Evidence

- 3 randomized controlled trials that included *universal* screening as a part of the SBI approach.
- Heterogeneity of study methods, including the drugs of focus and assessment tools, precluded data pooling and meta-analysis.
23,699 adult cocaine and/or heroin users from urgent care, women’s health & homeless clinics

DAST

1,175 eligible & enrolled

BI + follow up call  Handout only

Follow up at 6 months

Abstinence 1.5 times more likely in BI group than controls

6042 general hospital adult inpatients using addictive prescription drugs screened

126 eligible, consented & enrolled

2 BI sessions Handout only

Follow up at 3 months Reduction in daily PD dosages more in BI than controls

Follow up at 12 months Effect not maintained

Illicit Drugs: Humeniuk et al, 2012*

Primary care patients in Australia, Brazil, India, U.S.

ASSIST

731 eligible & enrolled

BI  Handout only

Follow up at 3 months

Reduction in Substance Involvement scores more in BI than controls

Humeniuk et al, 2012: Illicit Drugs in Primary Care Settings

<table>
<thead>
<tr>
<th></th>
<th>Australia (N = 171)</th>
<th>Brazil (N = 165)</th>
<th>India (N = 177)</th>
<th>U.S. (N = 218)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td>↓</td>
<td>↓</td>
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<td>↔</td>
</tr>
<tr>
<td><strong>Cannabis</strong></td>
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<tr>
<td><strong>Stimulants</strong></td>
<td>↓</td>
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<td>N/A</td>
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<tr>
<td><strong>Opioids</strong></td>
<td>N/A</td>
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<td>N/A</td>
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</tbody>
</table>
USPSTF Summary of Evidence

“the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use” in primary care settings (2008)
Clinical Approach: Drug SBIRT

- National Institute on Drug Abuse (NIDA)
- Revised: March 2012
- Addresses all forms of substance use
Clinical Approach: Setting the Stage

- Who does what?
- Incorporate SBI into current workflow
- Obtain reimbursement information
- Establish referral linkages
- Anticipate challenges
- Identify appropriate screening and assessment tools
### Clinical Approach: Ask

**Step 1 (ASK): In the past year, how often have you used the following? (positive screen)**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (heavy drinking)</td>
<td>“Yes”: Proceed with the NIAAA Clinician’s Guide recommended assessment</td>
</tr>
<tr>
<td>Tobacco Products (any use)</td>
<td>“Yes”: Proceed with the “Helping Smokers Quit” recommendations</td>
</tr>
<tr>
<td>Prescription Drugs for Non-Medical Reasons (any use)</td>
<td>“Yes”: Proceed with the NIDA recommended assessment (NIDA-Modified ASSIST survey)</td>
</tr>
<tr>
<td>Illegal Drugs (any use)</td>
<td></td>
</tr>
</tbody>
</table>

**“Never” response to all Step 1 questions: negative screen.**

Praise and reinforce. SBI is completed.

Adapted from the NIDA Resource Guide (2012)
Clinical Approach: Ask

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Screen)</td>
<td>(Assessment)</td>
<td>(Brief Intervention)</td>
<td></td>
</tr>
<tr>
<td>Yes to nonmedical prescription drugs use or illegal drug use?</td>
<td>Determine risk level with Substance Involvement score</td>
<td>ADVISE</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>HIGH RISK Score ≥ 27</td>
<td>ASSESS</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>MODERATE RISK Score 4 - 26</td>
<td>ASSIST</td>
<td></td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>LOW RISK Score 0 - 3</td>
<td>ARRANGE</td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td>Begin NIDA-Modified ASSIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription amphetamines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription opioids</td>
<td></td>
<td></td>
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</tbody>
</table>

Adapted from the NIDA Resource Guide (2012)
Clinical Approach: Advise

- Direct, non-judgmental personal advice about substance use
- Give specific reasons for quitting or cutting down
Public Health: Harm Reduction Paradigm

Abstinence  "Low-risk" Use  "Risky" Use  Abuse  DEP

Problem severity

Amount of substance used

USE DISORDERS (DSM-V)

DSM-IV
Clinical Approach: Advise

- Offer HIV + STI screening to sexually active patients. Encourage safe sex.
- Offer HIV and Hepatitis B/C testing for positive history of injection drug use.
- Refer for evaluation of suspected co-occurring conditions.
Clinical Approach: Assess

**Not ready**
- Reaffirm the consequences of drug use
- Restate willingness to help when ready.
- Revisit the issue at subsequent visits.

**Ready**
- Reinforce current efforts. Assist in making changes.
Clinical Approach: Assist

- Jointly create a follow up plan
- Help set concrete and reasonable goals for making a change
- Prescribe addiction treatment medications as appropriate
Clinical Approach: Arrange

- Refer patients as appropriate
- If no nearby treatment, provide support group information and counseling resources
- Schedule follow up appointment
- Offer continuing support at follow up visits
Issues to Consider

- Sparse evidence yet widely endorsed
- Which screening tools to choose?
- Multiple drug use
Issues to Consider

- Accessibility: insurance, geographic
- Confidentiality/Stigma
- Provider: comfort level, time pressure

**Resources**
- SAMHSA’s Treatment Services Locator: [http://findtreatment.samhsa.gov](http://findtreatment.samhsa.gov)
- NIDA’s List of Community Treatment Programs: [www.drugabuse.gov/CTN/ctps.html](http://www.drugabuse.gov/CTN/ctps.html)
- Buprenorphine Web-Based Training: [http://buprenorphine.samhsa.gov/training_main.html](http://buprenorphine.samhsa.gov/training_main.html)
What about Marijuana?

• Legal in 21 U.S. states & D.C. Considered illicit by the Federal Government

• AAFP (2009): “opposes the recreational use of marijuana. With regards to the medical use of marijuana, the AAFP defers to all applicable federal and state laws…”

• ASAM (2012): “…opposes proposals to legalize marijuana… The analyses on the possible outcomes—both intended and unintended—of the state-based… proposals… suggest that risks are unacceptable.”
Conclusions

- Evidence for drug SBI is growing, but still inconclusive
- Recommended as an approach to halting drug use
- Need for brief, validated tools
- More research is needed
Thank You!

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Other Resources

- NM-ASSIST: [www.drugabuse.gov/nmassist](http://www.drugabuse.gov/nmassist)
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Why Do People Change?

Information
“feedback”

Motivation
vulnerability
confidence
intention

Improved skills

Improved health

Five Principles of MI

- **Roll with Resistance**
  - with reflection, reframing, redirection
- **Express Empathy**
  - through reflective listening
- **Avoid Argumentation**
  - or direct confrontations
- **Develop Discrepancy**
  - between goals and behavior
- **Support Self-efficacy**
  - optimism, ability to make changes
SBI in Youth: Statement

USPSTF (2008)

“the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use” in primary care settings
SBI in Youth: Recommendations

- **AAP (2011):** “screening all adolescent patients… at every contact, and initiating BI and RT when appropriate”
- **APA (2009):** “psychiatrists should support treatment for adolescents with substance use problems by appropriate screening, diagnosis, treatment, referral and coordination of care”
SBI in Youth: Issues

- What age to start screening?
- Confidentiality
- Parental involvement

Resource
  - Center for Adolescent Health and the Law (www.cahl.org)