Crucial Conversations

Surrounding controlled medications and substance use disorders

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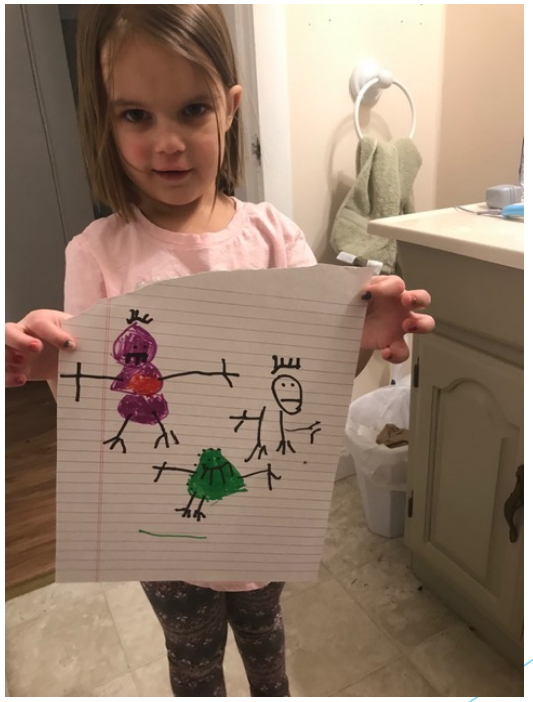
Disclosures

- Glenn V. Dregansky, DO FAAFP
- I raise service dogs for Paws With a Cause

- Eva Quirion NP, PhD

I am crazy about my granddaughter!



The art of the difficult conversation

ALWAYS

- Center around the patient
- Take responsibility
- Be kind and patient
- Be direct and hones

NEVER

- Center around anyone else
- Blame anyone else
- Get emotional
- Dance around the topic

Oh, those pills!

Opioids

- Most recent recommendations are to avoid except for the most extreme circumstances
- Less is best, shorter duration is best
- Not indicated for chronic non-cancer pain

Benzodiazepines

- Not intended for more than 1-2 weeks of therapy
- Effectiveness goes away
- Alters brain chemistry
- Lends itself to refractory anxiety

Some fundamental concepts

- Your patient did not prescribe opioids and benzodiazepines to themselves
- Someone told them that they NEED these medications
- Maybe YOU told them that they need this medication
- Pain and anxiety = Fear
- The threat of MORE pain and anxiety = MORE fear

How to break the news…

- The decision to taper has been made, what next?
- Before you speak with the patient, know your rationale and be confident
- Meet your patient face to face to discuss their medications
- Have a plan figured out to the best of your ability, but be flexible
- The more you do this, the better you will get!

The conversation

- Frame the ENTIRE conversation around the patient and their SAFETY
- Do not frame the conversation around other things like, “I am not comfortable…” or “the law says…” or “there is an epidemic…”
- Be reassuring, “I will walk beside you.” “I will work with you to treat your pain/anxiety in other ways.”
- Acknowledge that tapering can be difficult work

The conversation

- Reframe the purpose of their opioid medication during the taper
  - “You no longer take Percocet for pain, you are taking it to avoid being sick while we get you off this medication.”
- Normalize and anticipate sensations and difficulties that the patient may have
  - “Many people feel anxious, have trouble sleeping, feel achy. These things are normal and will regulate in time.”

Developing a taper plan

- There are tapering calculators, meh…
- Develop a plan that you think your patient can handle, but something that will not stagnate
- Think of it in percentages
- A 10% cut of the original dose is reasonable
- Weekly decreases are reasonable
- My style is usually no faster than every TWO weeks and less than 10%

Developing a taper plan

- Look back to why you are tapering
- If it's related to contract issues or a safety emergency, choose a more rapid taper
- If it's related to the long term health of a patient who is not having difficulty, you may wish to take more time
- It can be like ripping off a bandage and the patient may want to just get things over with

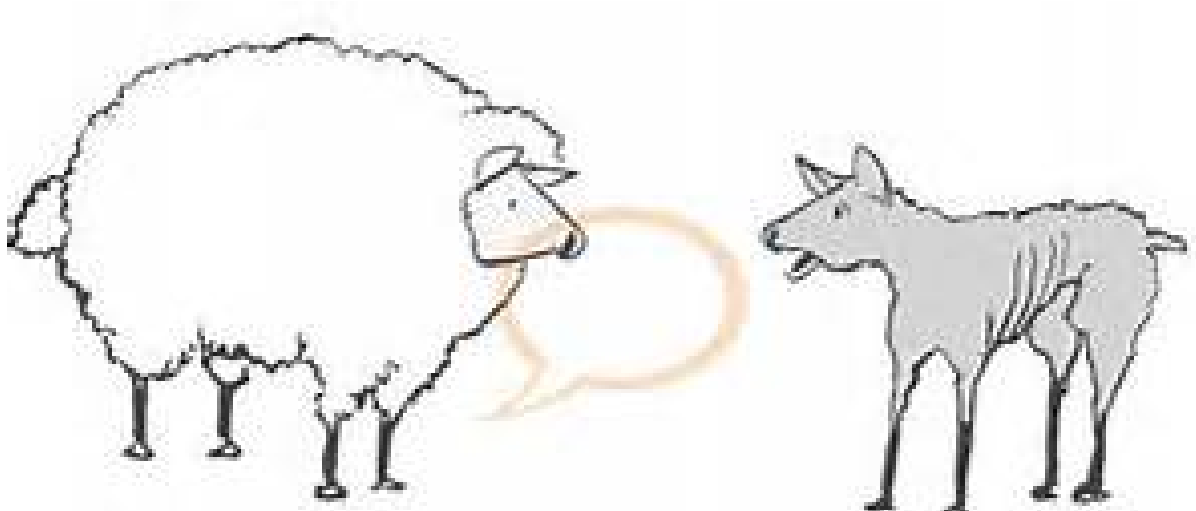
Developing a taper plan

- It’s great if you have a taper plan all written out with dates and doses at the time of the visit
- However, it’s OK to tell a patient that you need to write it down “I want to get it right and need time to concentrate” and mail it to them
- Before the patient leaves you, be sure that they know what the dose will be for their NEXT prescription, no surprises
  - Surprises frequently become a tug-of-war with support staff

The cast of characters

- The Negotiator
- The Sad Face
- The Angry Bird
- The Eager Beavers
- The Inheritance

The Negotiator



"The negotiations did not go well."

The Negotiator

- There are patients who will think of every reason they need to stay on the medication being tapered
- Some will tell you they don't care if they die
- Some will tell you that they will start buying opioids on the street
- Some will tell you that they will start drinking again
- Some will offer veiled or overt threat of suicide
  - This is called non-reassuring behavior
- "I care about you and do not want to see you harmed." "We do not treat suicidal thoughts with opioids."

The Sad Face


Crabby Road
8-1-12
If you're happy and you know it, thank your meds!
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Maxine.com

The Sad Face

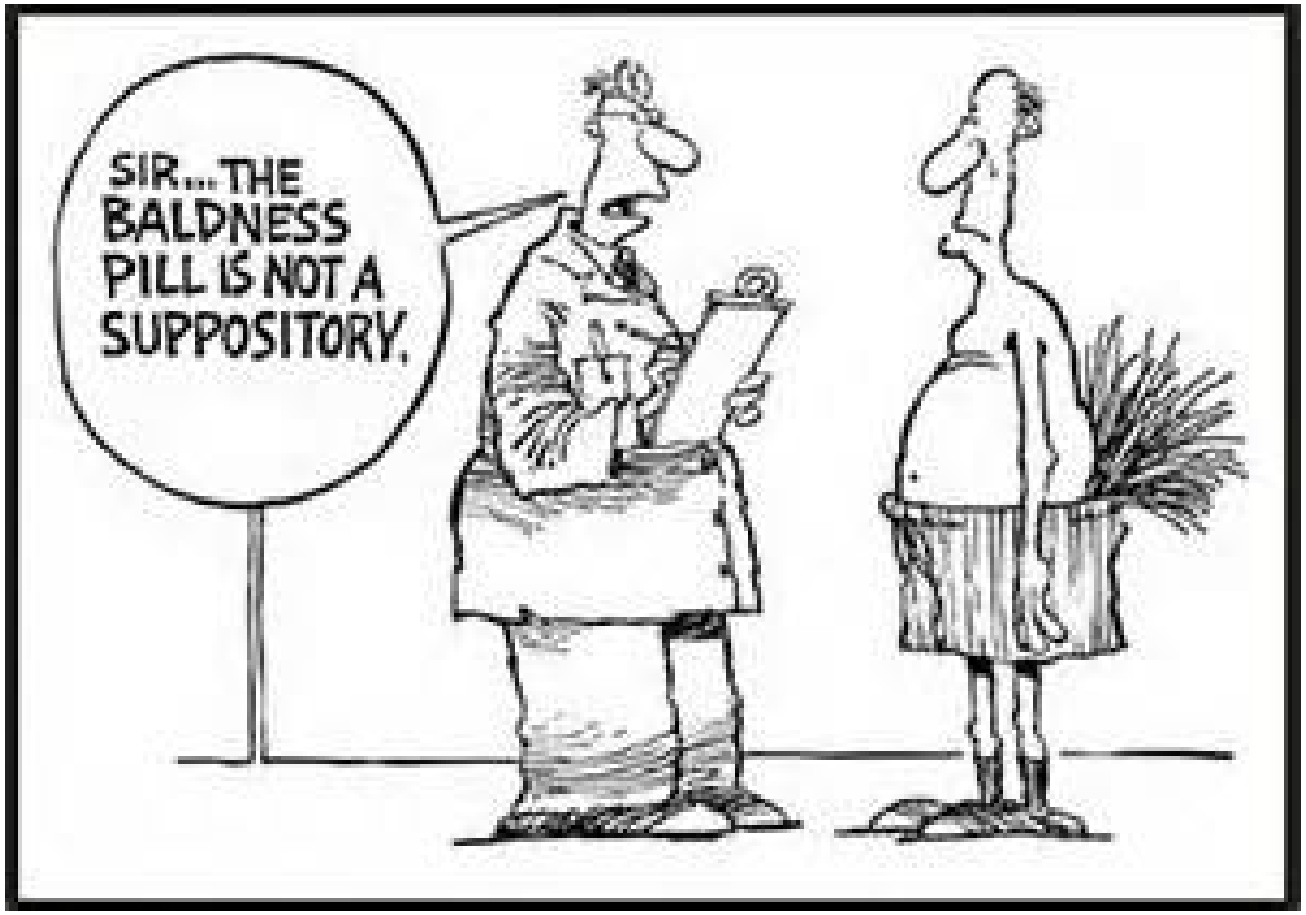
- This can feel like a breech of trust to the patient
- Some patients feel that they are being punished, “I have done everything you told me to do.”
- It’s a betrayal of sorts, “I thought you were different. I thought I could trust you.”
- There could be tears
- Disbelief
- They think that you might not understand just how much they hurt. “But I have BULGING disks!”
- “I care about you and I will help you find sustainable ways to help you manage your pain(anxiety).” “I don’t want to put you on any medications that I might have to take away from you as you get older.”

The Angry Bird

The Angry Bird

- Again, some feel betrayed and may get angry at your for this clinical decision
- Agree that it's OK for a provider and patient to disagree on a clinical decision, but both the patient should agree to be respectful
- Remind the patient that the decision is made to improve medication safety
- Do NOT take the anger personally
- If you encounter abusive behavior, redirection and defusing is best. "It's OK for you to be angry, but you do not have permission to yell at staff."
- Offer reassurance again and again! Be very direct and speak plainly. This personal probably has a history of being traumatized.

The Eager Beavers



The Eager Beavers

- Surprisingly, some patients are happy to think about being free from controlled medications
- I have a patient who refers to controlled substances as “chemical cuffs”
- They are excited
- Caution them to not get too far ahead of the taper or they may unintentionally sabotage their own efforts
- Opioid withdrawal is uncomfortable, but not life threatening
- Benzo withdrawal can be life threatening

The Inheritance

The Inheritance

- These patients may have abandonment issues
- These patients may have hero worship for their previous provider
- DO NOT just continue with someone else's plan as a matter of routine
- Explain to patients that you will be different than their previous provider and that you plan to help them through changes
- "I think your doctor/NP/PA was an awesome provider, we just do things differently." "I don't think that this medication is helping you as much as we would like for something so high risk." "I am sure that all your providers have treated you with the desire to help."

Rules of the Road

- NO early refills
- If a patient is going to go without opioids for a few days and will withdraw…
- DO NOT REFILL in order to just continue the taper
- Provide comfort medications
- If the patient will withdraw from benzodiazepines, they may need inpatient detox
- You can also shorten the # of pills that they get and they would have to fill every couple of days

Withdrawal Symptoms-Abrupt Stopping

Opioids

- Abdominal cramping, nausea, vomiting, diarrhea
- Body Aches, muscle spasms
- Lack of appetite
- Yawning
- Runny eyes, runny nose
- Irritability
- Dysphoria
- Goose bumps
- Sweating
- Tachycardia

Benzodiazepines

- Rebound anxiety
- Rebound insomnia
- Headache
- Nausea
- Joint and muscle pain
- Seizure
- Psychosis
- Hallucinations
- Jitters

Benzodiazepine Withdrawal, 2 cases

- Here are two actual cases of benzo withdrawal
- One person was an eager beaver and refused to back on benzos
- The other patient over used and would not have been able to follow instructions to taper
- I have NO inpatient detox facility in someone who has not actually had a seizure
- Neither patient had seized when I saw them
- Treated with 0.1 mg clonidine TID PRN + 300 mg gabapentin TID PRN
- Both did very well and are still off benzodiazepines

Comfort Medications of Opioid W/D

- Clonidine 0.1 mg TID (opioids and benzos). Be sure that BP is robust enough for this.
- Promethazine 25 mg 3-4 times a day OR hydroxyzine 50-100 mg 3-4 times a day OR diphenhydramine 25-50 mg 3-4 times a day for N/V (opioids and benzos only if GI issues are present)
- Loperamide 4 mg first dose, then 2 mg after every loose stool (NTE 16mg/24 hours) (opioids only)
- Cyclobenzaprine 5 mg TID for aching (opioids only)
- Trazodone 50 mg QHS for sleeping (opioids usually, but may use for benzos if the person cannot sleep)
- Ibuprofen 200 mg + acetaminophen 500 mg 3-4 times a day for aching (opioids only)
- Sometimes I use gabapentin to restless legs and almost always to benzo withdrawal

The Unexpected

- Sometimes patients wish to pause their taper for a month
- “I have had a hard time.”
- Sometimes it is humane to pause for a month, but be very careful about repeated requests – make sure that you communicate the intention to restart the taper
- Also, remember that we don’t use opioids to treat stress, grief, and bad weather
- Anxiety is not an indication for long term benzodiazepines
- There are times when the provider must gather some tough love

Reversal Requests

- **NEVER** reverse a taper
- This is like letting your grounded teenager go to a movie
- Pause if appropriate
- If there is an acute injury, treat that independently while pausing the taper
- Once healing has happened, stop the acute medications and resume the taper
- “I know that this is difficult for you, how about you come in and we can have a conversation about other ways to help you?”

Tidbits

- The majority of your patients will do just as well
- Their pain and anxiety generally regulates to exactly what it was when the patient was on controlled medications
- Much of the time … they do BETTER
- “I thought I had Alzheimer’s, turns out I was just medicated.”
- “I thought you were crazy when you said that we should stop my pain medications. Now I am so much better!”
- “I didn’t realize how benzos made me irritable.”
- Function generally improves. Sometimes you have to draw this out of people.

Tidbits

- Work to gather a team around the patient
- Be sure that treatments are exhausted
- Work with your patient in the spirit of “lifestyle medicine.”
- Anti-inflammatory diet, yoga, exercise, weight loss, STOP SMOKING
- Cognitive behavioral therapy, biofeedback, acupuncture, counseling, massage, chiro, OMT, PT
- Pills **DO NOT** = compassion

Goals of Care

- Maintain or gain function
- Improve health and prognosis
- Restore the spirit, the personality, the relationships if possible
- Teach your patient to find things that bring them joy

OK, but my patient is a MESS!

- What happens when a patient is having issues with non-reassuring behavior as you taper them?
  - Calls for early refills, running out of medications, agreement issues, etc.
- Perhaps they have a substance use disorder
- Experts disagree in the literature, but about 35% of people on chronic opioids do develop a substance use disorder
- In my work, I have found that it seems about a 50/50 (purely anecdotal and observational)
- Why do you think that is? What types of patients are on chronic opioids and chronic benzodiazepines?
  - There tends to be ADVERSE selection for patients on controlled substances
  - Think about lifetime trauma

DSM-5 Criteria for Opioid use Disorder (OUD)

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by **at least two** of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

DSM-5 Criteria for OUD

6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of an opioid

    (Note: this criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.)

DSM-5 Criteria for OUD

11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome.
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

    (Note: this criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.)

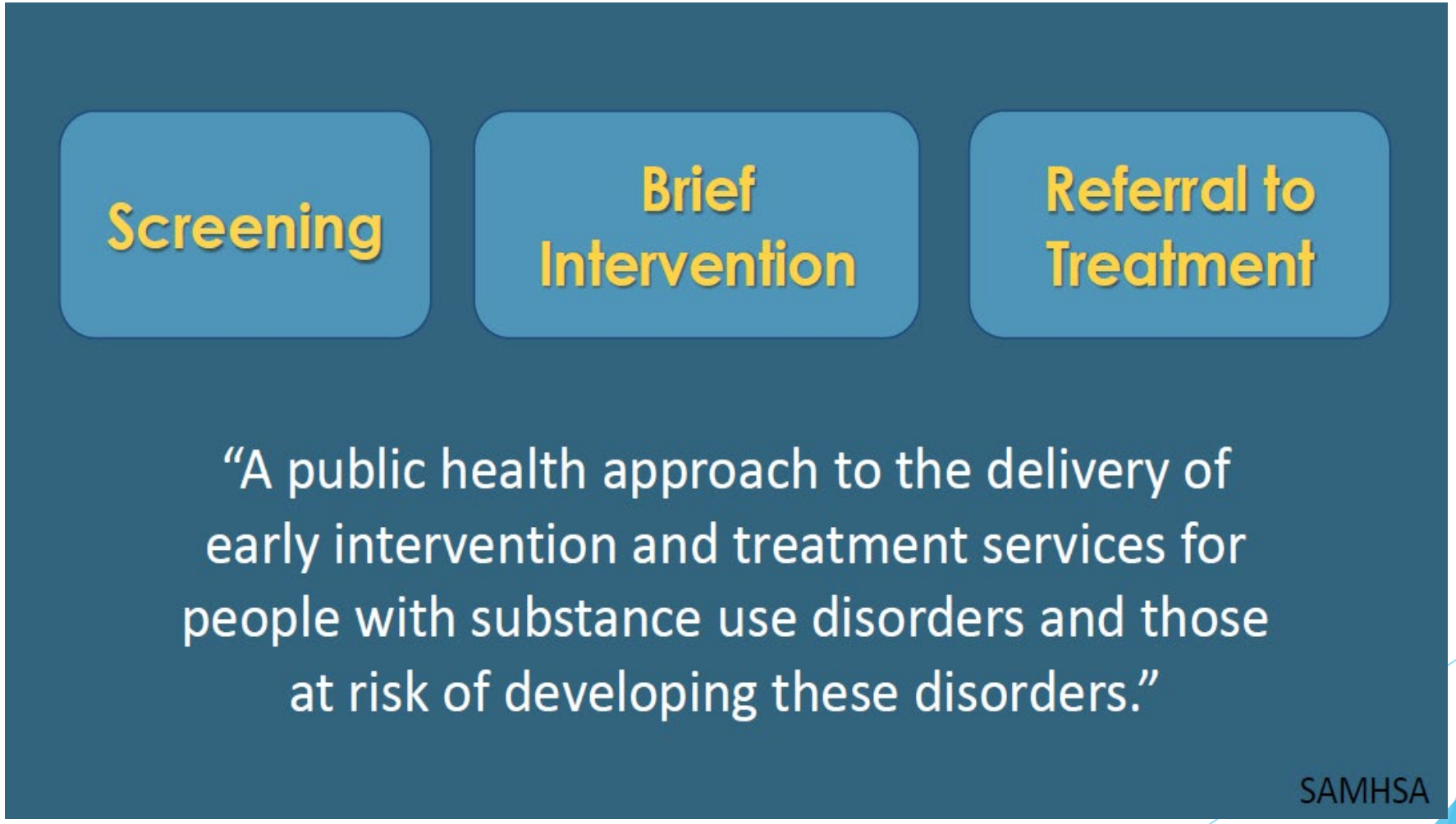
Specifiers

- In early remission
- In sustained remission
- On maintenance therapy
- In a controlled environment
- Mild: Presence of 2-3 symptoms
- Moderate: Presence of 4-5 symptoms
- Severe: Greater than 6 symptoms

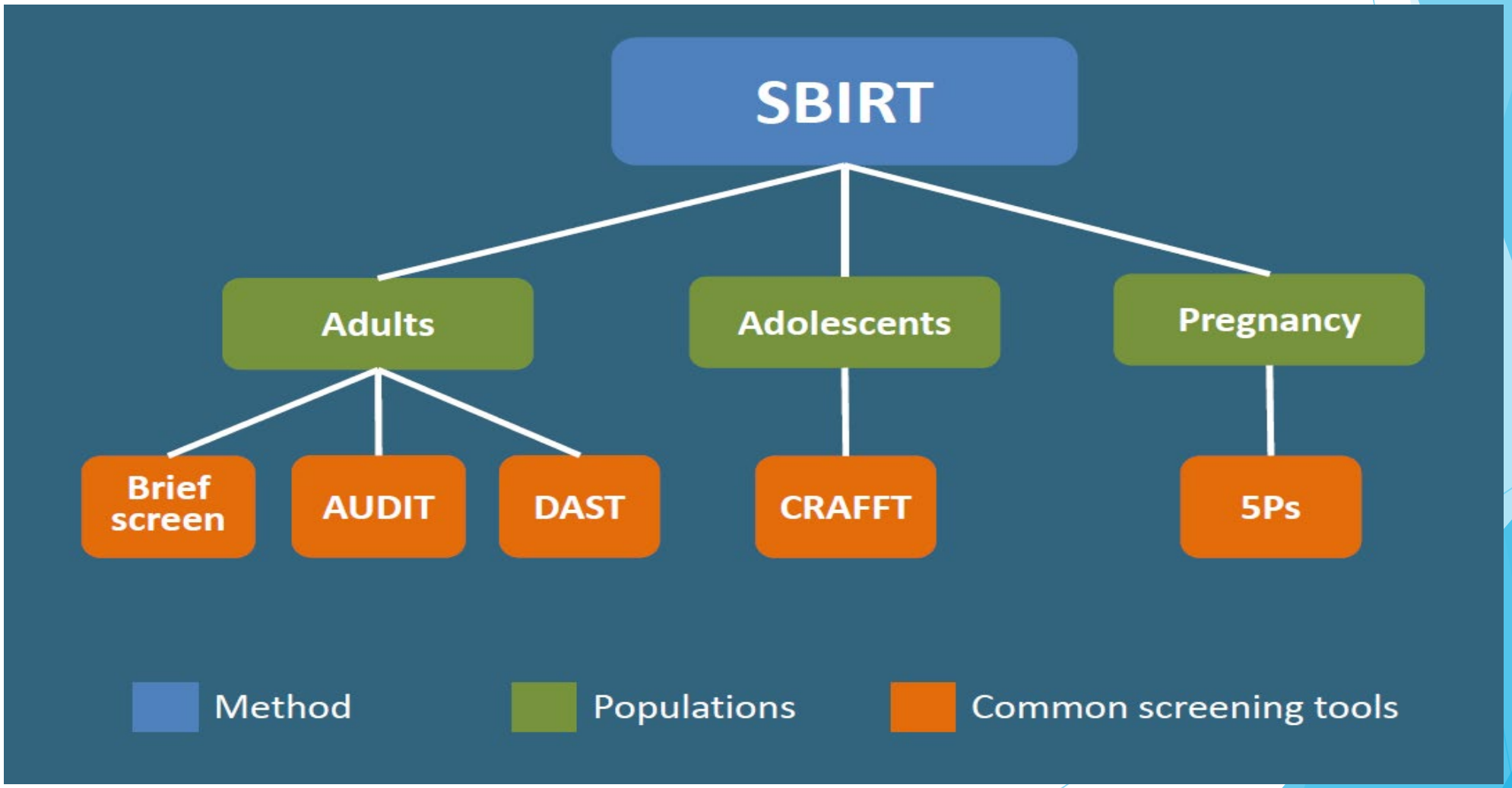
SBIRT

- How are you going to know if you are dealing with early SUD or high risk behavior?
- If you never look for it, you will only find the most egregious cases of SUD, or rather, they will find you.
- There are validated tools that practitioners can use to screen for high risk use and SUD. The purpose of this portion of the workshop is to familiarize you with those tools and give you a framework to include screening in your everyday practice.

What is SBIRT?



SBIRT Common Terms

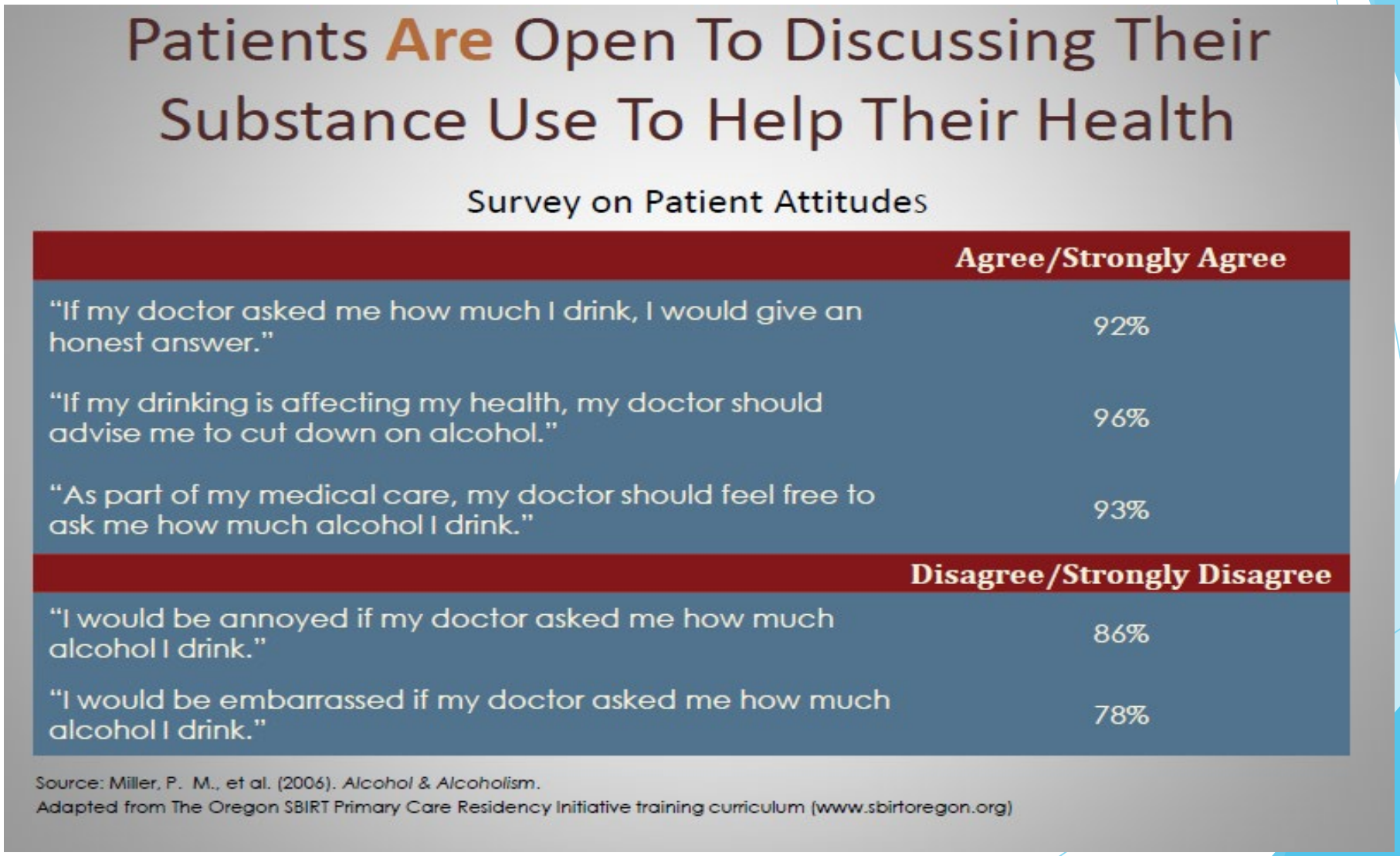


SBIRT

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

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

SBIRT


Patients Are Open To Discussing Their Substance Use To Help Their Health
Survey on Patient Attitudes
Agree/Strongly Agree
"If my doctor asked me how much I drink, I would give an honest answer."
92%
"If my drinking is affecting my health, my doctor should advise me to cut down on alcohol."
96%
"As part of my medical care, my doctor should feel free to ask me how much alcohol I drink."
93%
Disagree/Strongly Disagree
"I would be annoyed if my doctor asked me how much alcohol I drink."
86%
"I would be embarrassed if my doctor asked me how much alcohol I drink."
78%
Source: Miller, P. M., et al. (2006). Alcohol & Alcoholism.
Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

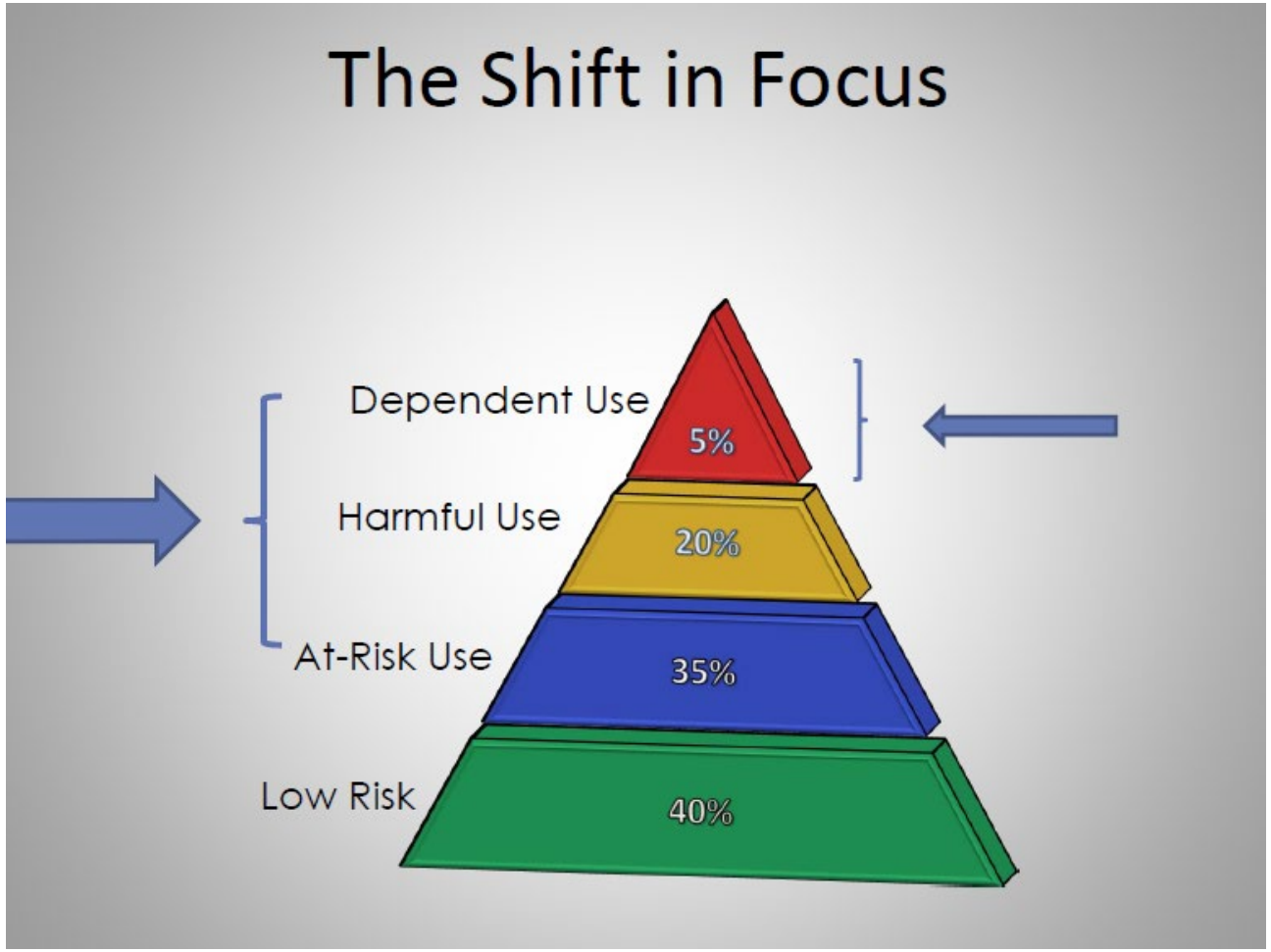
SBIRT

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

SBIRT

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

SBIRT


The Shift in Focus
Dependent Use
5%
Harmful Use
20%
At-Risk Use
35%
Low Risk
40%

SBIRT


Levels of Alcohol/Drug Conditions
Dependence—a cluster of behavioral, cognitive, and physiological symptoms that develop after repeated use (Addicts, alcoholics)
Harmful Use —use causes some harm (physical/ mental/social)
Hazardous Use —use causes elevated risk (no harm [yet])

SBIRT Goal

Goal

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

SBIRT is Proven to Work in Alcohol and Data Suggests it Also Works in Drug Use

Research Demonstrates Effectiveness

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

Evidence Based for Alcohol Misuse

Research Shows

Brief interventions—

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

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

Likely Will be Considered Evidence Based for Drug Misuse in the Near Future

Strong Research and Substantial Experiential Evidence Supports the Model

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

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

It Works

Making a Measurable Difference

- Since 2003, SAMHSA has supported SBIRT programs, with more than 1.5 million persons screened.
- Outcome data confirm a 40 percent reduction in harmful use of alcohol by those drinking at risky levels and a 55 percent reduction in negative social consequences.
- Outcome data also demonstrate positive benefits for reduced illicit substance use.

Based on review of SBIRT GPRA data (2003–2011)

Screening Tools: Why Use Them?

- Asking/answering questions is normal and expected.
- Adding questions on alcohol drug use normalizes the conversation.
- Self-report screening is quick, accurate, and inexpensive.
- May be combined with screening for tobacco, other health risk factors.

Screening Tools

- Many written and electronic screening tools exist
  - Check your EHR or create (steal) an electronic screening form
- Prescreen with one question tools either before the appointment or after rooming
  - Support staff can give the screening
  - This is analogous to the way we use PHQ-2 and PHQ-9 in primary care
- Screening should be part of an annual wellness visit, new patient visit or sports physical for adolescents
  - Never pass up an opportunity to screen
  - You will be amazed how much alcohol and drug risky behavior or use disorder you will uncover
  - Or you can live in the delusion that SUD and risky use don't exist in your practice

Brief Health Screen

Brief health screen
We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

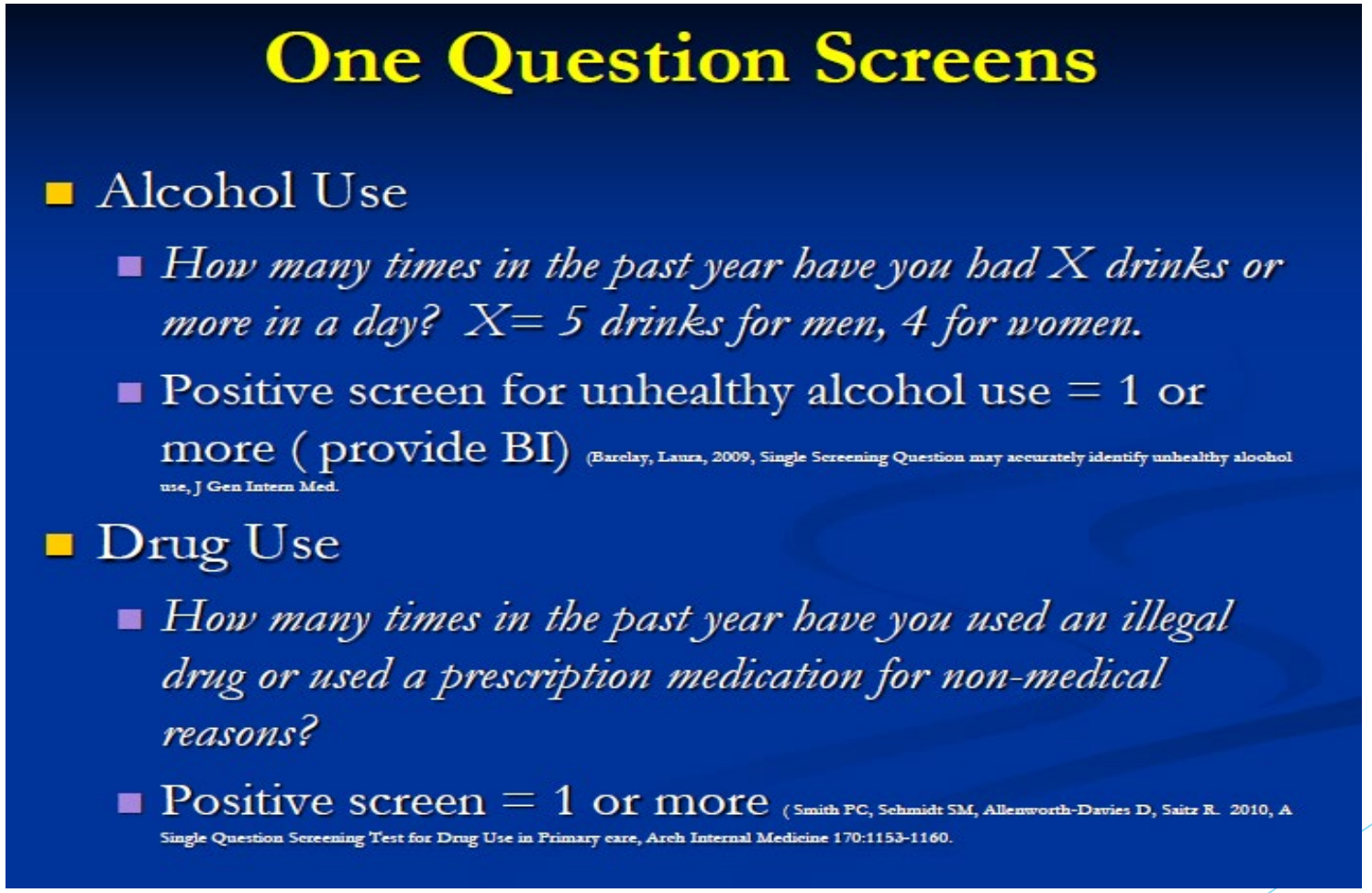
	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

One Question Screens



AUDIT 1-3 or AUDIT -C

QUESTIONS	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than Monthly	Monthly	Weekly	2–3 times a week	4–6 times a week	Daily	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5–6 drinks	7–9 drinks	10 or more drinks	
3. How often do you have X (5 for men; 4 for women & men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2–3 times a week	4–6 times a week	Daily	
							Total	

The AUDIT 1–3 (US) can be used for clinical purposes without permission or cost.

Source

Babor TF, Higgins-Biddle J, Dauser D, Burleson JA, Zarkin GA, Bray J. Brief Interventions for at-risk drinking: patient outcomes and cost-effectiveness in managed care organizations. *Alcohol Alcohol* 2006 Nov–Dec; 41(6): 624–31.

AUDIT

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

AUDIT Scoring

(For the health professional)

Scoring and interpreting the AUDIT:

Each answer receives a point ranging from 0 to 4. Points are added for a total score that correlates with a zone of use that can be circled on the bottom left corner of the page.

Score*	Suggested zone	Indicated action
0-3: Women 0-4: Men	**I – Low risk** (low risk of health problems related to alcohol use)	Brief education
4-12: Women 5-14: Men	**II - Risky** (increased risk of health problems related to alcohol use)	Brief intervention
13-19: Women 15-19: Men	**III - Harmful** (increased risk of health problems related to alcohol use and a possible mild or moderate alcohol use disorder)	Brief intervention or referral to specialized treatment
20+: Men 20+: Women	**IV - Severe** (increased risk of health problems related to alcohol use and a possible moderate or severe alcohol use disorder)	Referral to specialized treatment

Brief education: An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Patients with numerous or serious negative consequences from their drinking, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up. The recommended behavior change in this case is to either cut back to low-risk drinking levels or abstain from use.

Referral to specialized treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral. Referrals to treatment are delivered to the patient using the brief intervention model.

More resources: www.sbirtoregon.org

* Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

DAST

Drug Screening Questionnaire (DAST)
Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

DAST Scoring

(For the health professional)

Scoring and interpreting the DAST:

"Yes" responses receive one point each and are added for a total score. The score correlates with a zone of use that can be circled on the bottom right corner of the page.

Score	Zone of use	Indicated action
0	**I – Healthy** (no risk of related health problems)	None
1 - 2, plus the following criteria: No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment.	**II – Risky** (risk of health problems related to drug use)	Offer advice on the benefits of abstaining from drug use. Monitor and reassess at next visit. Provide educational materials.
1 - 2 (without meeting criteria)		Brief intervention
3 - 5	**III – Harmful** (risk of health problems related to drug use and a possible mild or moderate substance use disorder)	Brief intervention or Referral to specialized treatment
6+	**IV – Severe** (risk of health problems related to drug use and a possible moderate or severe substance use disorder)	Referral to specialized treatment

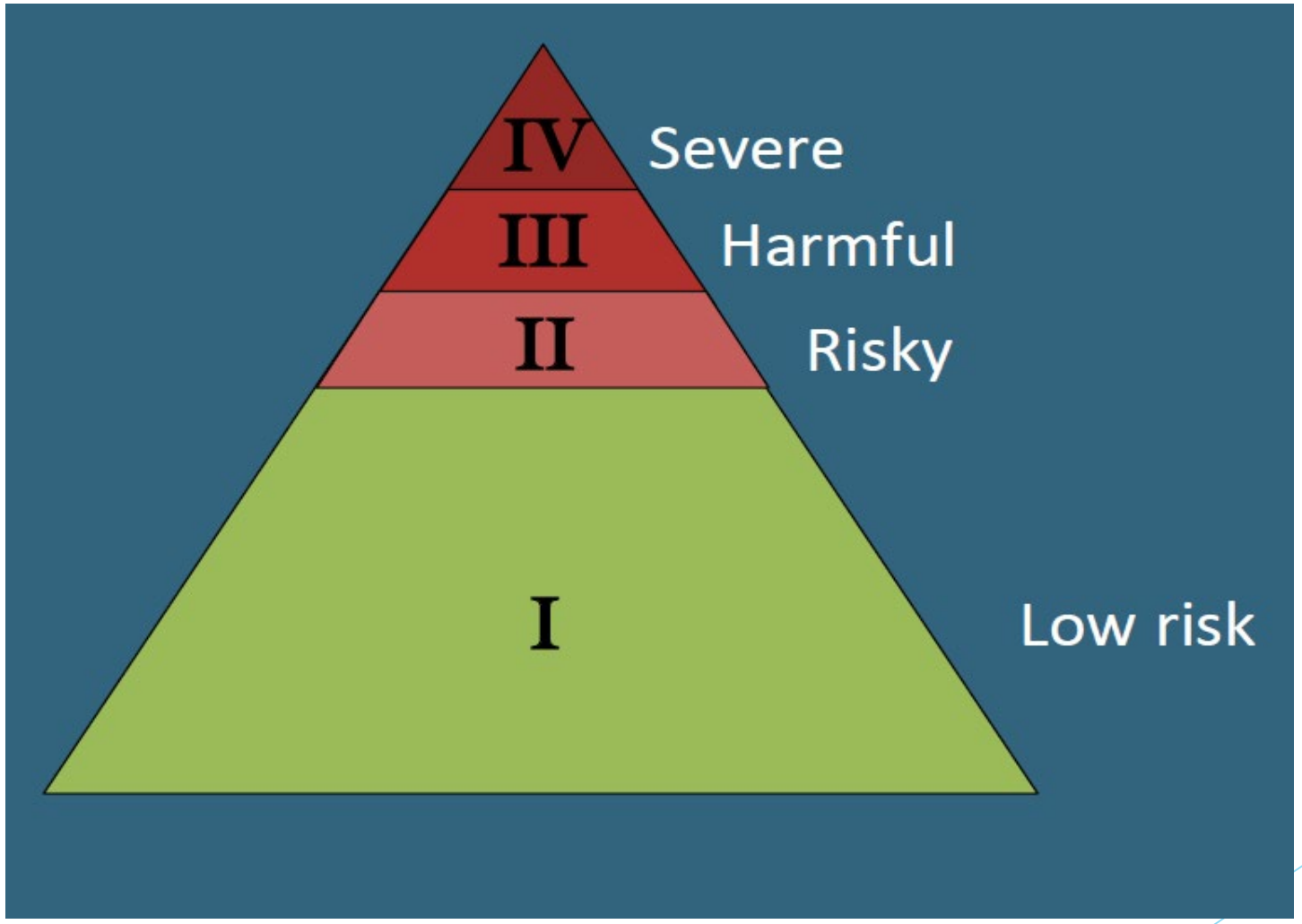
Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

Patients with numerous or serious negative consequences from their substance use, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

Referral to specialized treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

Zones of Drug and Alcohol Use

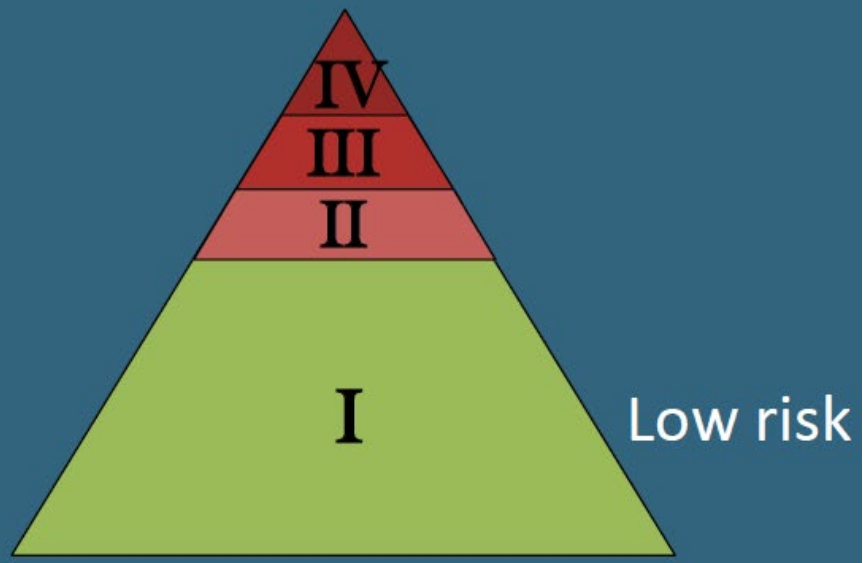


Zone I Low Risk

Defined by:

- No use, or
- Adult alcohol use under risky limits

Low-risk limits do not apply to drug use

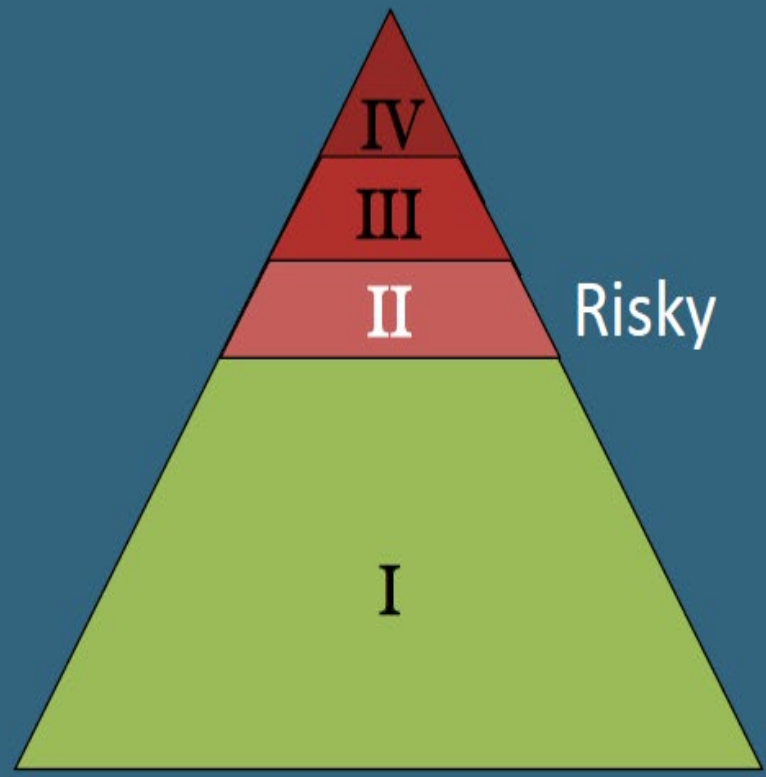


Zone II: Risky

Defined by:

- Alcohol use that exceeds risky limits
- Any adolescent use
- Any recreational drug use

Likely no consequences (yet)

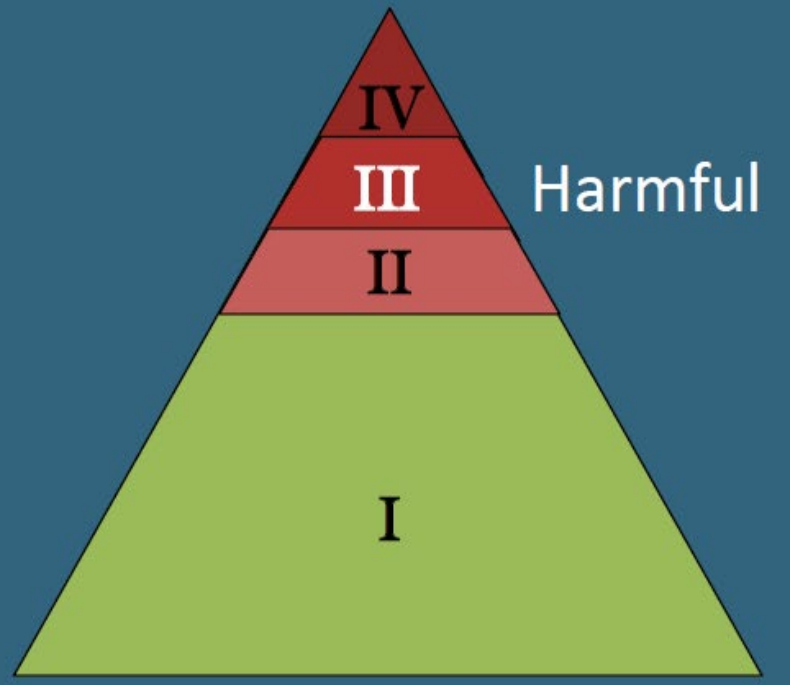


Zone III: Harmful

Defined by:

- Repeated negative consequences from use
- Failure to fulfill some major obligations
- Use continues despite persistent problems

Likely correlates with mild or moderate SUD

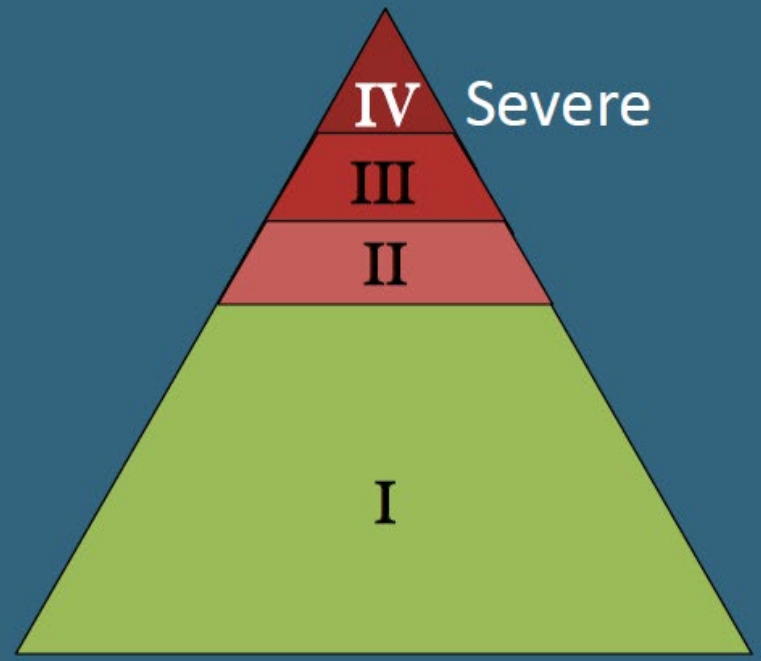


Zone IV: Severe

Defined by:

- Patient's life orbits around use
- Distress or disability
- Tolerance and withdrawal
- Use in larger amounts or longer period than intended

Likely correlates with moderate or severe SUD



Adolescents

- Don’t use adult tools on teens
- It’s best practice to concomitantly screen for mood when a brief screen for substance use is positive
- The PHQ-9 has a modified form for adolescents sometimes called PHQ-A
- Sports Physicals are a great time to screen all teens for substance use of any kind

Adolescents

Teen health screen

We ask all our teen patients about alcohol and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

S2BI:

In the **PAST YEAR**, how many times have you used:	Never	Once or twice	Monthly	Weekly
Tobacco:	☐	☐	☐	☐
Alcohol:	☐	☐	☐	☐
Marijuana:	☐	☐	☐	☐

If you answered "Never" to all questions above, you can skip to **CRAFFT question #1** and then turn the page. Otherwise, please continue answering all questions below.

Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)	☐	☐	☐	☐
Illegal drugs: (such as cocaine or ecstasy)	☐	☐	☐	☐
Inhalants: (such as nitrous oxide)	☐	☐	☐	☐
Herbs or synthetic drugs: (such as salvia, "K2", or bath salts)	☐	☐	☐	☐

If you answered "Never" or "Once or twice" to all questions above, you can answer only **CRAFFT question #1** below and then turn the page. Otherwise, please continue answering all questions below.

CRAFFT questions	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?	☐	☐

PHQ-9 Modified for Teens:

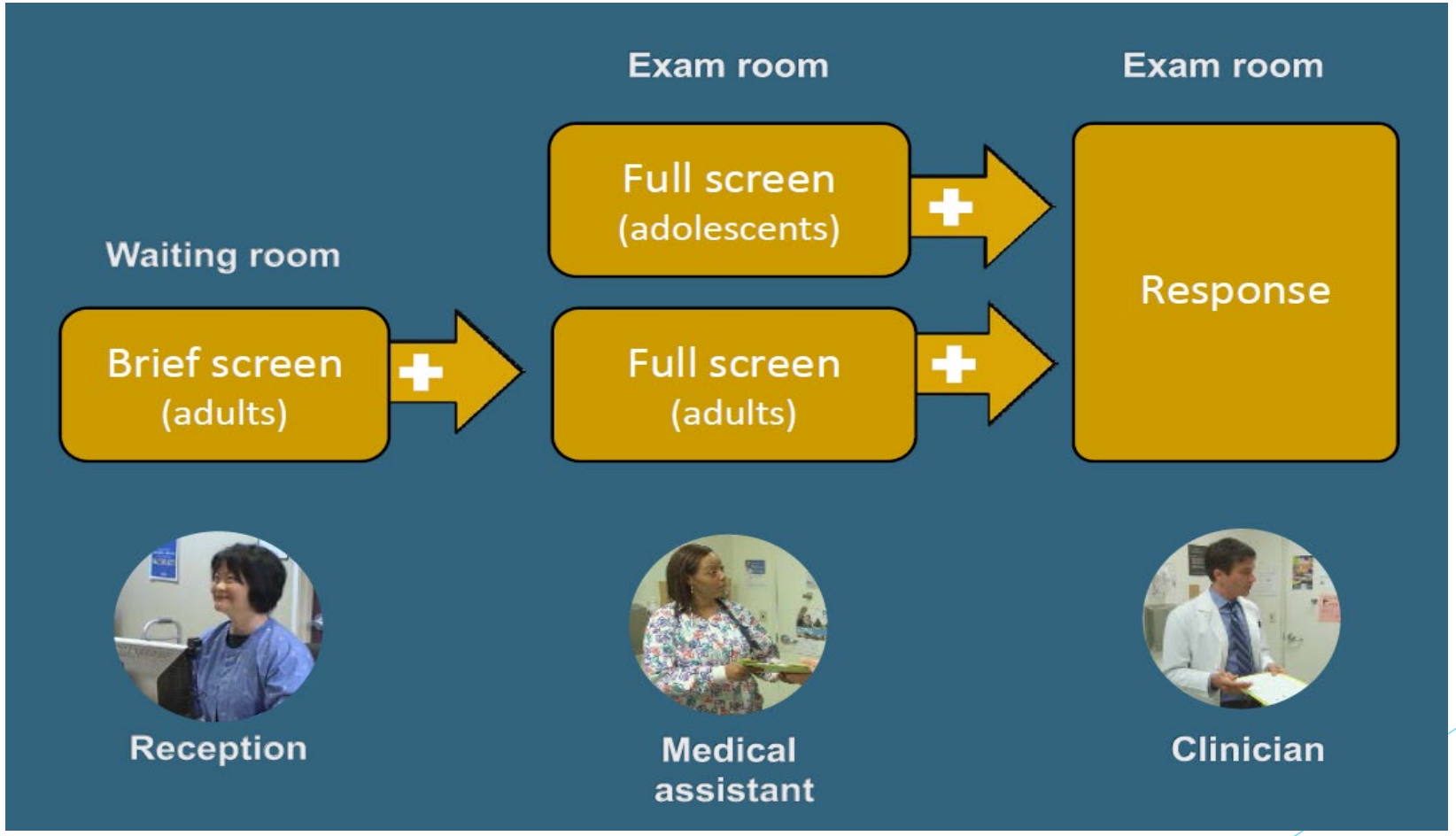
How often have you been bothered by each of the following symptoms during the past **TWO WEEKS**?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐

If you answered "Not at all" to both questions above, you are finished answering questions. Otherwise, please continue answering all the questions below.

3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired, or having little energy?	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
	0	1	2	3

In the **PAST YEAR**, have you felt depressed or sad most days, even if you felt okay sometimes?	☐ Yes	☐ No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult		
Has there been a time in the past month when you have had serious thoughts about ending your life?	☐ Yes	☐ No
Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?	☐ Yes	☐ No

How SBIRT Can Flow in a Primary Care Setting



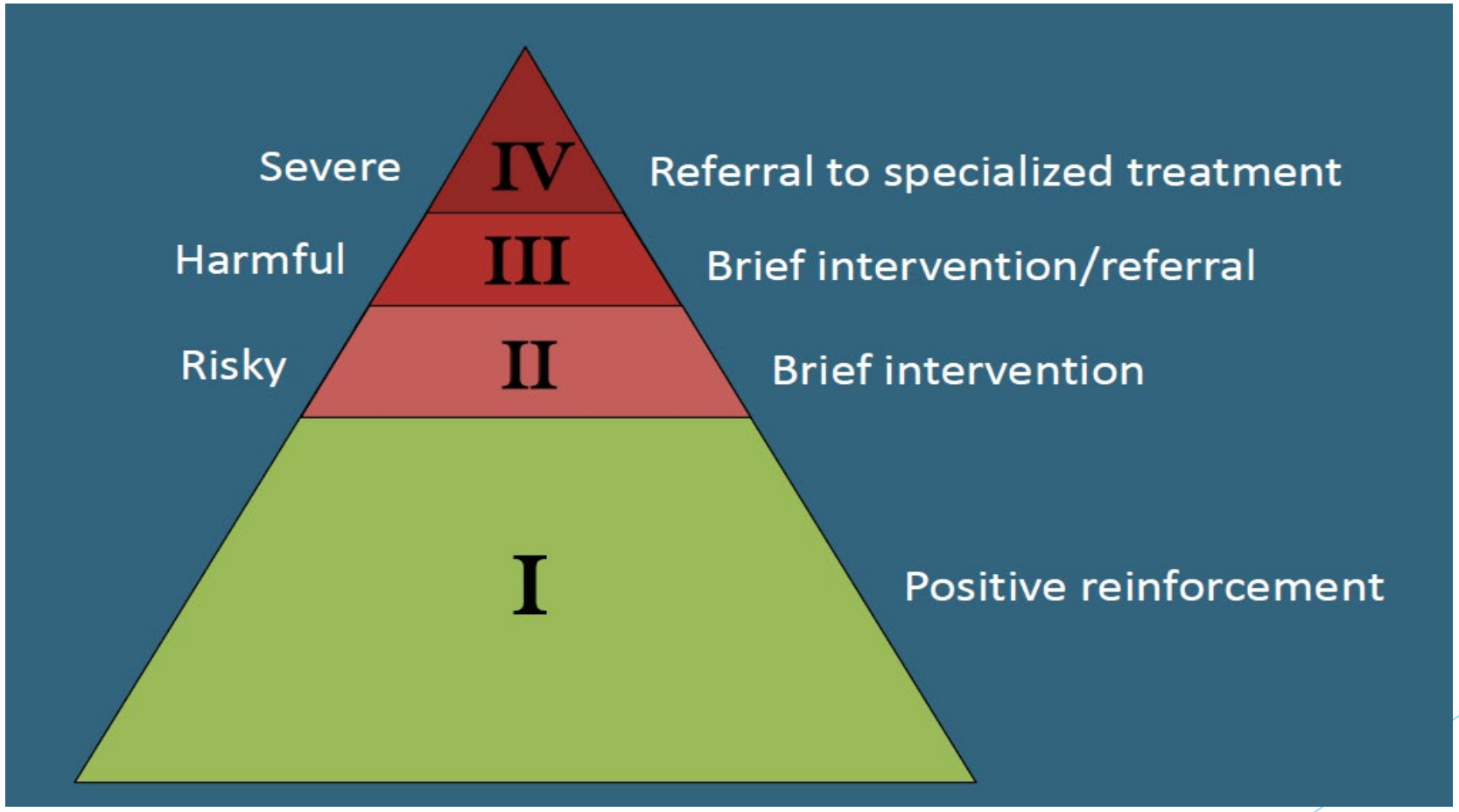
First Ask Then Always Respond

- We'll talk in more detail about dealing with positive screening results
- We need to normalize asking and normalize responses to screening
- You will do a great service to your patients by making routine screening for drugs and alcohol a standard part of your interactions with your patients

OMG the screening is positive!!

- There are several important steps that any primary care practitioner can take to evaluate for risky substance use or SUD
- You don't need special training to intervene but, like any interviewing skill, you must practice it
- I recommend everyone review the SBIRT Oregon materials, especially the videos
  - www.sbirtoregon.org

Interventions and Zones



Response to Zone I

- Positive reinforcement, review healthy use

Response to Zone II Score

- This is where you use your new found skills in conducting a brief intervention
- Brief intervention is just another term for motivational interviewing
- We've used the screening tool and our review of it to raise the subject
- Here's a short video that demonstrates this skill
  - https://www.youtube.com/watch?v=b-ilxvHZJDc

Brief Intervention

- Brief Intervention is a brief motivational and awareness-raising intervention given to risky or problematic substance users.

Steps in the Brief Intervention

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

Build Rapport – Raise the Subject

1. Begin with a general conversation.

2. Ask permission to talk about alcohol or drugs.

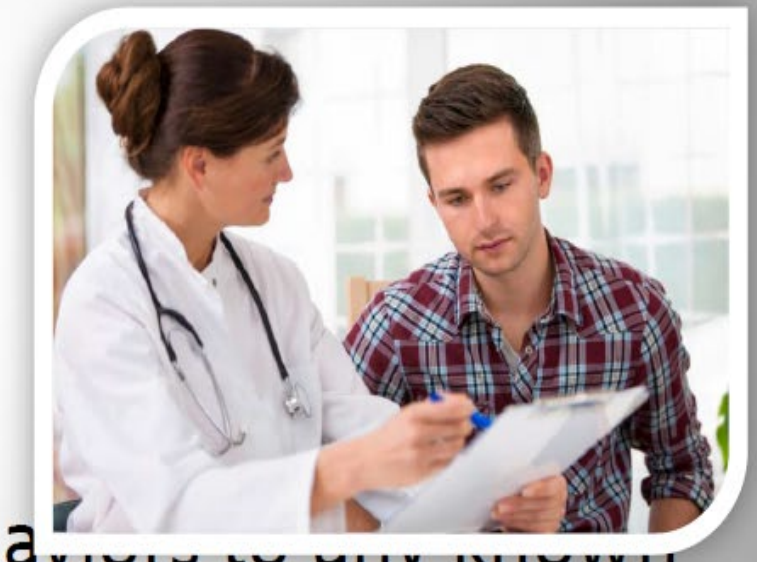
Discuss the Pros and Cons of Use

Help me understand through your eyes.

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

Provide Feedback

1. Ask permission to give information.
2. Discuss screening findings.
3. Link substance use behaviors to any known consequences.



Build Readiness to Change

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

On a scale from 1 to 10, 1 being not ready at all and 10 being completely ready, how ready are you to make any changes in your substance use?

Negotiate a Plan For Change

- A plan for reducing use to low-risk levels

OR

- An agreement to follow up with specialty treatment services

Response to Zone III or IV Score

- Depending on your practice setting and comfort level (which we hope will improve after this workshop) you either refer for treatment or start office based treatment

Let’s Talk About Treatment

- Opioid use disorder is something that can be APPROPIATELY treated by primary care providers
- Like any other disease, providers must learn and do (sometimes simultaneously)
- What is MAT?
  - Medication Assisted Therapy or Treatment

A Mini History Lesson on MAT

- Methadone invented in 1937 by Germans during a morphine shortage
- Heroin came into large American cities starting in the 1950's
- Methadone was used to detox heroin addicted patients over 7-10 days, but there was a 90% relapse rate
- In early 1960's researchers at the Rockefeller Foundation developed methadone dosing protocols and suggested that NYC establish treatment programs
- 1970's saw the first methadone clinics

Isn’t MAT just replacing one addiction with another?

- MAT reduces and/or eliminates the use of heroin and reduces death rates and crime associated with heroin use
- Patients improve their health and social productivity
- Decreased cravings and withdrawal
- Less HIV and hepatitis infections
- Better pregnancy outcomes
- Remember, there is a 90% relapse rate without medication at least in the earlier stages of recovery
- Some people will be on MAT forever
- Some people will eventually get off MAT
- Compare this to diabetes – some people get off insulin, some do not!

A little more history

- Sublingual buprenorphine/naloxone became approved in 2002 to treat SUD
- CARA act in 2016 allowing the ADDITION of NPs and PAs to provide SUD treatment to patients in the primary care setting
- Providers need a special DEA number (called an X-waiver) in order to prescribe buprenorphine to treat SUD
- Physicians require an 8 hour training course and NPs/Pas require a 24 hour training course.

The Ingredients of Treatment

- I dream of the day that primary care providers assess for, diagnose and treat substance use disorders as a matter of routine
- Trust me, you already have patients you care for who have substance use disorders, you just might not know that you do
- Treating patients who have opioid use disorder is some of the most difficult and most satisfying work I have ever done
- Most of the time, this is really fun to see people get BETTER

What do you Need

- X-Waiver training
  - Courses offered through ASAM web site
  - For NP's, the AANP has a free course
  - Apply to the DEA for your number (30 max to start, then 100, then 275)
- Trained support staff
  - Must do urine screens
  - Need staff who can set boundaries with patients
  - Need to coach patients to be ready for treatment
- Access to behavioral health
  - Integrated or community
- Recovery community with peer supports
  - Help with housing, food, employment, paper work, insurance

Perceived and Actual Barriers to Being a MAT provider

- I don’t want to bring a lot of “those people” into my office
- Time for training
- Properly trained staff
- This does not interest me

Additional Resources and References

- There are two case studies to demonstrate using, scoring and discussing results of both the AUDIT and DAST

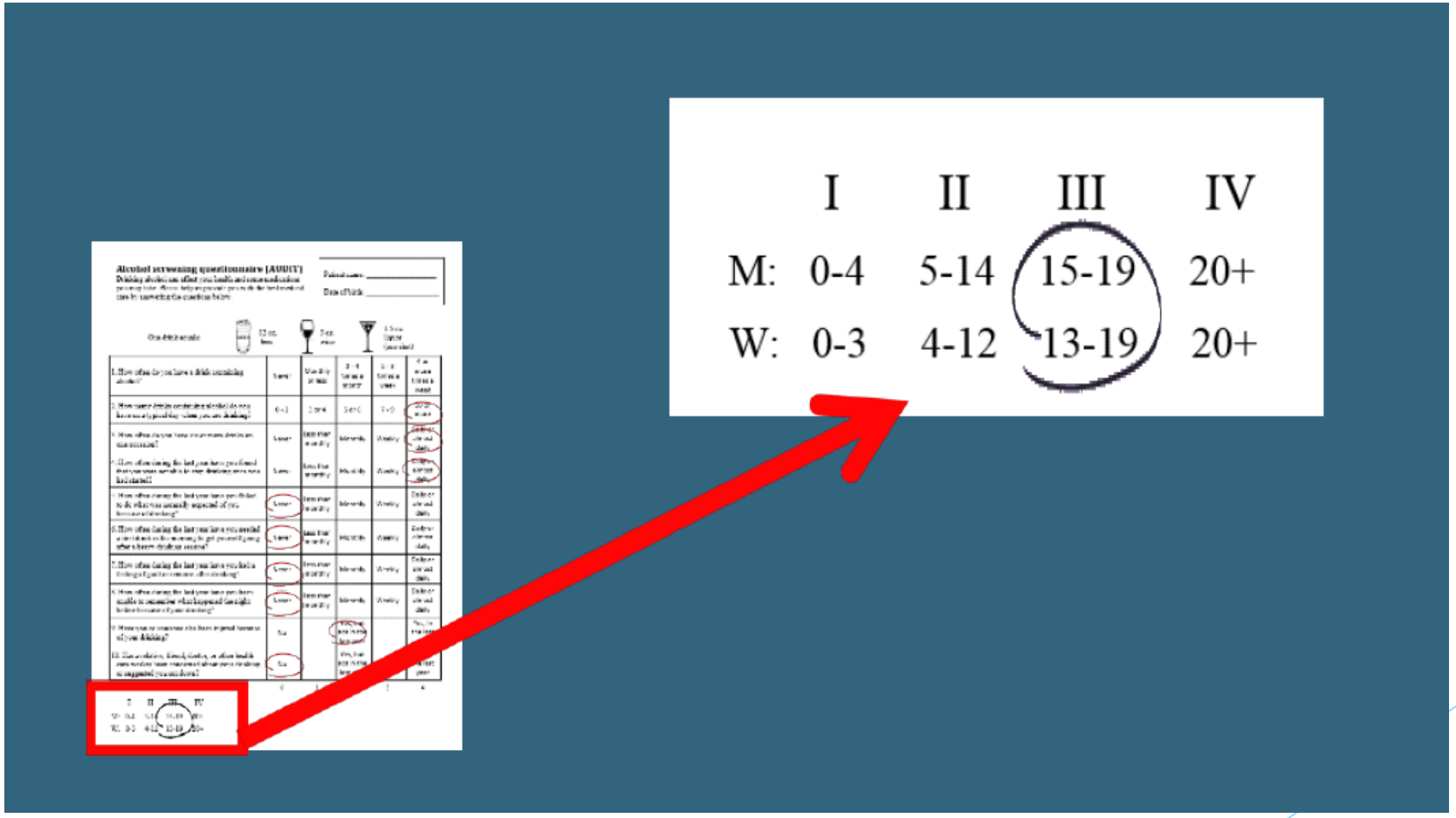
Case Study: “Clark”

- 68yo male, never married, retired, lives alone
- Mild hypertension and diabetes since 1999, not obese
- Presents twice a year for follow up, usually no medical complaints
- Latest visit: discloses drinking 10 beers a night at local bar

Clark's AUDIT Answers

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

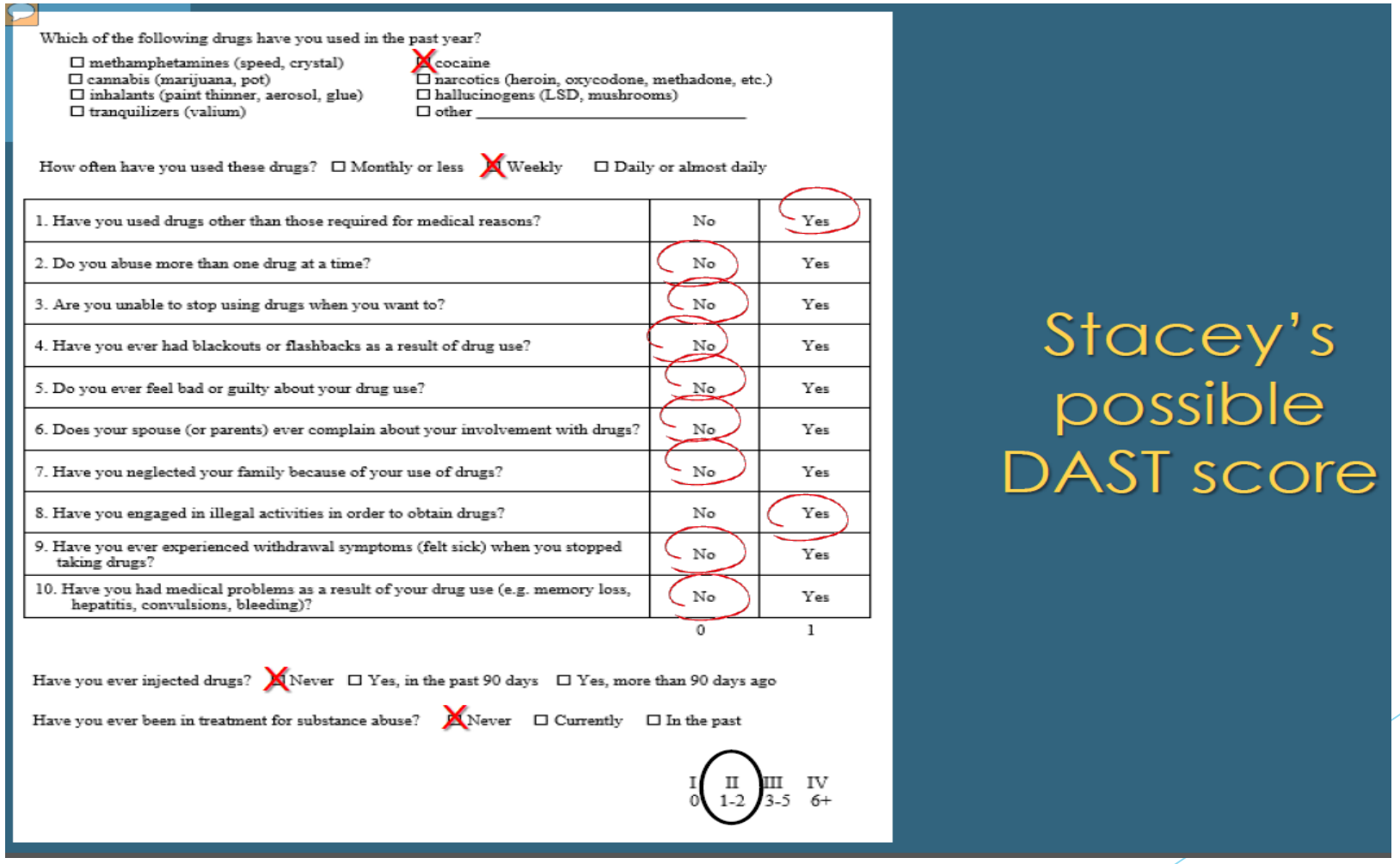
Clark's AUDIT Scoring



Case Study: “Stacey”

- 30yo female, single, works at restaurant, lives with housemate
- Takes Aderall for ADHD since 2013
- Presents every few months for in-person follow up, usually no medical complaints.
- Uses a “bump” of cocaine most weekends

DAST Score



Which of the following drugs have you used in the past year?

- ☐ methamphetamines (speed, crystal)
- ☒ cocaine
- ☐ cannabis (marijuana, pot)
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ tranquilizers (valium)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☒ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

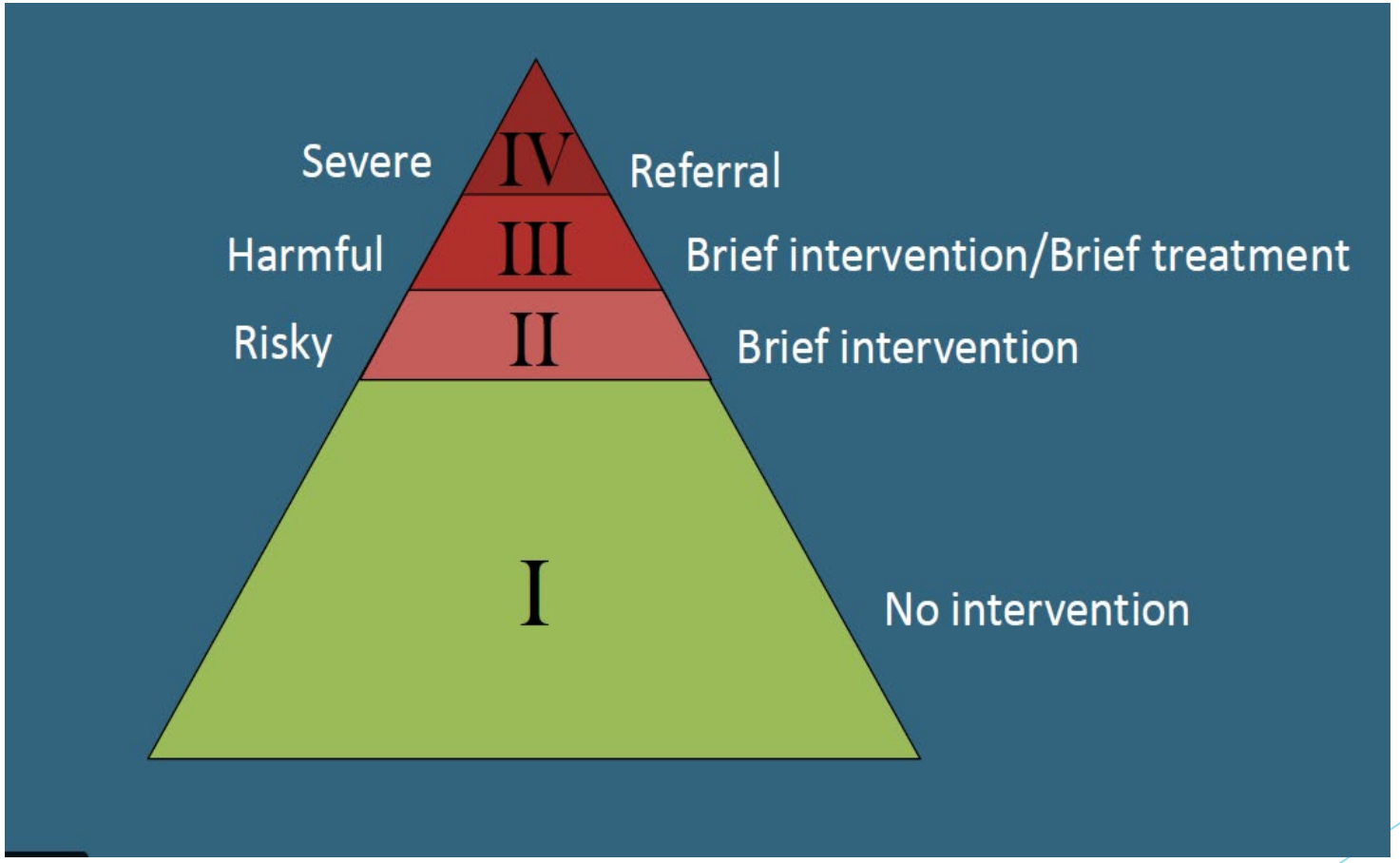
Have you ever injected drugs? ☒ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☒ Never ☐ Currently ☐ In the past

I 0 | II 1-2 | III 3-5 | IV 6+

Stacey's possible DAST score

DAST Zones and Interventions



SBIRT Additional Information

- Screening for Drug Use in General Medical Settings: Quick Reference Guide.

www.nida.nih.gov/nidamed/resguide/resource guide.pdf

- Screening for Alcohol Use: www.niaaa.nih.gov/Publications/EducationTraiiningTrainingMaterials/CME_CE.htm
- Screening tools: http://www.ihs.gov/nonmedicalprograms/nc4/documents/appendices_b-c-d-e.pdf

Additional Information

- SAMSA-HRSA Center for Integrated Health Solutions: Implementing SBIRT in Community health and Community Behavioral Health Centers: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
- Screening adolescents: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/YouthGuide

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Build it and they will come!

- Questions?