SBIRT Tools
For Guiding People into Recovery

MaryAnne Murray, DNP, EdD, ARNP
Balance Beams Wellness, PLLC
Ocean Park, Washington
MaryAnneMur@msn.com
(253) 297-5570

Addiction Defined by ASAM*

Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

*ASAM (American Society of Addiction Medicine)

Addiction Defined by ASAM

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (ASAM, 2013, p. 10).

Substance Abuse: Scope of the Problem

- Perinatal Substance Abuse
  - Social stigma
  - Lack of prenatal care
  - Risk of pre-term labor
  - Neonatal Abstinence Syndrome
  - UTOX positive: CPS involvement
  - Impaired maternal/infant bonding
  - Feeding disorders

Substance Abuse: Scope of the Problem

- Impaired Learning in Childhood
  - Parental neglect
  - Poor nutrition
  - Witness to violence, PTSD
  - Early experimentation (substance use normalized)
  - Failure to complete basic education
  - Lack of motivation to complete GED

Substance Abuse: Scope of the Problem

- Career Impact
  - Lack of high school education diminishes capacity to earn
  - Falling into jobs rather than planning career
  - Briefer career/worklife duration due to increased risk of disability

Substance Abuse: Scope of the Problem

- Health Impact
  - Liver disease
  - Cirrhosis
  - Clotting disorders, esophageal and GI bleeds
  - Pancreatitis
  - Bacterial endocarditis, mitral insufficiency
  - Nicotine ingestion→ COPD
  - Increased risk of cancers

Substance Abuse: Scope of the Problem

- Iatrogenic Substance Abuse Problems
  - Kids with sports injuries
  - Post-op analgesia not managed adequately
  - Inappropriate diagnosis/treatment of ADHD

Substance Abuse: Scope of the Problem

- Meth Tax
- Dollar Costs
- Human Misery

The Health Care Team Members

- Case finding
- Harm reduction
- Treatment
- Maintaining recovery

The Health Care Team Members

- **Support Staff**
  - Providing and scoring screening instruments
  - Ears to the ground (local gossip, etc.)
  - Alerting providers
  - Making referral materials available

The NCQA Guidelines

"The practice assesses whether the patient or the patient's family has any mental health conditions or substance abuse issues (e.g., stress, alcohol, prescription drug abuse, illegal drug use, maternal depression)"

[NCQA, 2011, p. 44]

- PCP brief interventions are **powerful**
- Substance abuse screening is a quality indicator for primary care

In Primary Care…

… Physicians seldom identify or adequately address patients' drinking. A study of care quality in primary care practices found that patients with alcohol dependence received only 11 percent of the recommended care."

(Willenbring, Massey, and Gardner, 2009, p. 44)

Screening Instruments

- University of Washington's Alcohol and Drug Abuse Institute (ADAI) Library lists **159** Screening and Assessment Instruments for Adults (http://lib.adai.uw.edu/dbtw-wpd/exec/dbtwpub.dll)

Screening Instruments

Instrument	Pros	Cons
NIDA QuickScreen	Online, offers big resources	Many items; takes too long
DAST	Well known	28 items
MAST	Well known	25 items
AUDIT	10 items, versatile	Not well known
CAGE	Familiar	Cut not clear
SIST	Simple, easy	Not well known

The Health Care Team Members

- **Primary Care Providers**
  - Perceived as authorities
  - Note screening scores and severity of issues
  - Express concern and ask for more information
  - Order and interpret labs (increased LFTs, MCV > 100, dyslipidemia, etc.)
  - "I'm glad you came in! I can help you"
  - Know resources and make referrals to them

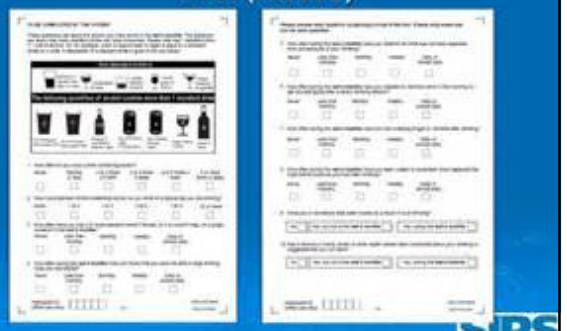
Primary Care Interventions

- CAGE
- GAINS
- Ask directly: *Are you using/abusing drugs or alcohol?*
- Ask about history of addiction or legal issues related to drugs (for patients wanting opioids/benzos)

CAGE

- Have you ever felt you ought to **Cut Down** on your drinking?
- Have people **Annoyed** you by criticizing your drinking?
- Have you ever felt bad or **Guilty** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**Eye opener**)?

Alcohol Use Disorders Identification Test (AUDIT)



The Health Care Team Members

- **Hospital Emergency Providers**
- RNs, ARNPs, PA-Cs, MDs, DOs, RPhs,
  - Be suspicious when mechanism of injury does not match physical findings
  - Be alert to “frequent flyers” with known hx
  - Check Prescription Monitoring Program report
  - Express concern, alert interventionists
  - Offer detox assistance
  - Refer to PCP for detox mgmt, and treatment,

The Health Care Team Members

- **Hospital RNs and Providers**
  - Recognize and treat symptoms of withdrawal
  - Suspect substance abuse when the symptoms do not match reported health history
  - Gather collateral data, e.g., from family
  - Express concern
  - Link symptoms to suspected substance abuse
  - Refer to PCP and treatment for follow-up

Pop the ETOH Question!

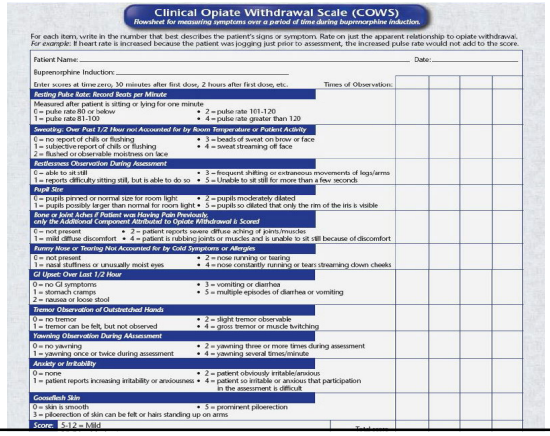
- How many times in the past year have you had more than *n* drinks in a day?
  - *n* = 4 (or 14 per week) for men
  - *n* = 3 (or 7 per week) for women

(Willenbring, Massey, and Gardner, 2009)

Pop the Drug Question!

- *How many times in the past year have you used an illegal drug or used a prescription drug for nonmedical reasons?*

Smith, Schmidt, Allensworth-Davies, and Saitz, (2010)



Clinical Opiate Withdrawal Scale (COWS)

Rowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. *For example:* If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation:			
Resting Pulse Rate: Record Heart Rate per Minute				
Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below • 2 = pulse rate 101-120 1 = pulse rate 81-100 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity				
0 = no report of chills or flushing • 3 = beads of sweat on brow or face 1 = subjective report of chills or flushing • 4 = sweat streaming off face 2 = flushed or observable moistness on face				
Restlessness Observation During Assessment				
0 = able to sit still • 3 = frequent shifting or extraneous movements of legs/arms 1 = reports difficulty sitting still, but is able to do so • 5 = Unable to sit still for more than a few seconds				
Pupil Size				
0 = pupils pinned or normal size for room light • 2 = pupils moderately dilated 1 = pupils possibly larger than normal for room light • 5 = pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored				
0 = not present • 2 = patient reports severe diffuse aching of joints/muscles 1 = mild diffuse discomfort • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies				
0 = not present • 2 = nose running or tearing 1 = nasal stuffiness or unusually moist eyes • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour				
0 = no GI symptoms • 3 = vomiting or diarrhea 1 = stomach cramps • 5 = multiple episodes of diarrhea or vomiting 2 = nausea or loose stool				
Tremor Observation of Outstretched Hands				
0 = no tremor • 2 = slight tremor observable 1 = tremor can be felt, but not observed • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment				
0 = no yawning • 2 = yawning three or more times during assessment 1 = yawning once or twice during assessment • 4 = yawning several times/minute				
Anxiety or Irritability				
0 = none • 2 = patient obviously irritable/anxious 1 = patient reports increasing irritability or anxiousness • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin				
0 = skin is smooth • 5 = prominent piloerection 3 = piloerection of skin can be felt or hairs standing up on arms				
Score: 5-12 = Mild	Total:			

Managing Withdrawal: Opioids

- Monitor with Clinical Opioid Withdrawal Scale (COWS)
- Kick Kit: Clonidine, Bentyl, and Robaxin
  - Catapres (Clonidine) 0.1 mg QID+ PRN general misery
  - Bentyl (Dicyclomine) 10 to 20 mg QID PRN diarrhea/cramping
  - Robaxin (Methocarbamol) 500 mg: 1 or 2 QID PRN muscle spasms
- Poor Man's Kick Kit: Tylenol/Motrin, Lomotil and Gatorade. Specify maximum doses of OTCs

Addiction Research Foundation Clinical Institute Withdrawal Assessment Alcohol (CIWA-Ar)

Addiction Research Foundation Clinical Institute Withdrawal Assessment Alcohol (CIWA-Ar) The scale is not copyrighted and may be used freely.

Patient:	**Date:** ___/___/___ y m d	**Time:** _____ **(24 hour clock, midnight = 0:00)**
Pulse or heart rate, taken for one minute:		**Blood Pressure:** _____/_____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited? Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Managing Withdrawal: Alcohol

- Monitor with Clinical Indicators of Withdrawal-Alcohol (CIWA scale)
- Thiamine prior to carbohydrate ingestion
- Librium or Ativan QID PRN
- Neurontin (Gabapentin) 300 mg QID for seizure prevention
- Dispense daily (enlist pharmacist support!)

Opioid Replacement Therapy Options

- Offer Suboxone (Buprenorphine/Naloxone) for opioid replacement therapy (ORT) in clinic
  - Only MD or DO with special training (8 hours) can prescribe it; rules in process for NPs/PAs
  - Huge need for ORT in rural areas!
  - Income generator
  - Could fund chemical dependency counselor

Managing Withdrawal: Cannabis Crazies

- Anxiolytic, e.g., Vistaril
- Atypical antipsychotic for treatment of paranoia

Managing Withdrawal: Stimulant Psychosis

- Keep patient in a safe environment, especially if agitated
- Haldol or atypical antipsychotic

The Health Care Team Members

- Chemical Dependency and Mental Health Counselors
  - Inquire about current use, age at which use began, blackouts, DWI or other legal issues related to use, last use, also substance use-involved injuries to self and others
  - Motivational Interviewing
  - Community-based self-help support groups
  - Refer to higher level of care if indicated

The Health Care Team Members

- Psychiatric/Mental Health Providers
  - Always assess substance abuse when doing psychiatric/mental health evaluation
  - Prescribe ReVia, Vivitrol, Antabuse as appropriate
  - Refer to interventionist or assessment counselor
  - Communicate with treatment providers
  - Monitor sobriety maintenance
  - Encourage smoking cessation

The Health Care Team Members

- **Treatment Providers**
  - Refer for psychiatric evaluation as indicated
  - Encourage taking meds exactly as prescribed
  - Encourage lifestyle change
  - Urge smoking cessation
  - Teach recovery/refusal skills
  - Be alert for off-baseline behavior and inquire about faithfulness to medication regimen

American Society of Addiction Medicine (ASAM) Criteria

- Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions
- Different criteria for adults versus youths

Dimensions:

1. Intoxication or Withdrawal Potential
2. Biomedical
3. Emotional, Behavioral, Cognitive
4. Readiness to Change
5. Relapse/Use Potential
6. Recovery Environment

ASAM

ASAM Level 0.5: Early Intervention

1. No risk of withdrawal
2. No biomedical complications
3. No emotional, behavioral, or cognitive complications
4. Ready to explore how use/abuse affects goals
5. Has skills to change current use/abuse
6. Social support system increases risk of personal conflict regarding use/abuse

ASAM Level OMT: Opioid Maintenance Therapy

1. Physiologic dependence; needs OMT to prevent withdrawal
2. Biomedical manageable with outpt monitoring
3. Behaviors manageable in outpatient structured environment
4. Ready to change but not total abstinence
5. High relapse risk without OMT and structure of treatment
6. Supportive recovery environment and personal skills

ASAM Level I: Outpatient Treatment

1. Absent or minimal risk of severe withdrawal
2. Medically stable or concurrent medical monitoring
3. Behaviorally stable or receiving mental health monitoring
4. Ready for recovery; needs motivational help
5. Able to maintain abstinence or control use
6. Supportive recovery environment and personal skills

ASAM Level II.1: Intensive Outpatient Treatment

1. Minimal risk of severe withdrawal
2. Minimal medical complications
3. Behavioral symptoms mild but can distract from recovery
4. Variable engagement in treatment; knowledge deficit re: substance abuse or mental health
5. High risk for relapse without close monitoring
6. Recovery environment not supportive; with structure can cope

ASAM Level II.5: Partial Hospitalization

1. Moderate risk of severe withdrawal
2. Manageable medical complications
3. Behavioral symptoms mild to moderate but can distract from recovery; patient needs stabilization
4. Poor engagement in treatment; knowledge deficit re: CD & MH; needs structure
5. High risk for relapse; needs close monitoring & support
6. Recovery environment not supportive; with structure and respite can cope

ASAM Level III.1: Clinically Managed Low-Intensity Residential

1. Minimal withdrawal
2. Medically stable or monitored as needed
3. Minimal behavioral symptoms, or Dual Diagnosis Capable/ Enhanced program
4. Open to recovery; needs structure
5. Understands relapse; needs structure to maintain gains
6. Home environment dangerous but recovery doable with structure

ASAM Level III.3: Clinically Managed Medium-Intensity Residential

1. Moderate withdrawal is manageable
2. Medically stable or monitored concurrently
3. Mild to moderate behavioral symptoms; needs structure. Dual Diagnosis Capable (if stable) or Enhanced program required
4. Little awareness of recovery; severely needs structure
5. Ignorant re: relapse; needs structure to prevent relapse
6. Home environment dangerous; needs 24-hour structure to learn coping skills

ASAM Level III.5: Clinically Managed High-Intensity Residential

1. Minimal risk of severe withdrawal
2. Medically stable or monitored as needed
3. Poor impulse control, personality disorder, or other functional deficits requiring 24 hour structure
4. Unmotivated or oppositional to treatment
5. **Understands relapse; needs structure to maintain gains**
6. Home environment dangerous but recovery doable with structure

ASAM Level III.7:
Medically Monitored Intensive Inpt Tx

1. High risk of severe withdrawal
2. Requires 24 hour medical monitoring but not intensive tx
3. Poor impulse control, personality disorder, psychiatric or other functional deficits requiring 24 hour structure
4. High resistance to tx and poor impulse control, needs 24 hour structure
5. Dangerous, unable to control use despite tx at lower level
6. Dangerous home environment and lack of coping skills

ASAM Level IV: Medically Managed Intensive Inpatient Tx

1. High risk of severe withdrawal requiring full hospital resources
2. Requires 24 hour nursing and full hospital resources
3. Severe instability; 24 hour psychiatric and addiction care needs
4. Relapse potential does not qualify for level III
5. Relapse potential does not qualify for level III
6. Problems with recovery environment do not qualify for level III care

Abstinence Versus Opioid Replacement Therapies

ABSTINENCE

•Best, if achievable

•Fewer, briefer relapses over time

•Most people can eventually become sober long-term

•Community-based self-help support groups

- **OPIOID REPLACEMENT**
- Depends on duration and severity of use
- Some perceive it as cop out
- Like insulin for diabetic
- Inconvenient, costly
- Restore social, financial, vocational wellbeing

Mission Critical Professions: Special Programs for Substance Abuse Disorders

- Airline Pilots
- Attorneys
- Clergy
- Physicians
- Nurses
- 42 states offer alternative-to-discipline programs for impaired health professionals
- Washington Physicians Health Program (WPHP)
- Tracks for substance abuse, mental health, and disruptive behavior
- Washington Health Professional Services (WHPS) serves 70+ professions; RNs and CDPs most frequently

Resources/References

- International Nurses Society on Addictions: http://www.intnsa.org/
- American Society for Addiction Medicine: http://www.asam.org/
- Directory of Addiction Studies Programs: http://www.nattc.org/addiction-programs/search.aspx.
- Washington Health Professional Services (360) 236-2880; whps@doh.wa.gov

Resources/References

- SCREENING TOOLS: http://www.drugabuse.gov/nidamed-medical-health-professionals/ tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults
- THE "GREEN BOOK" of all Certified Chemical Dependence Programs in Washington State: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Cert%20%26%20LIcensing/Directory%20of%20Certified%20CD%20Svcs-March%202015%20150401.pdf

Resources/References

- http://nursece4less.com/ has online courses on addictions. You can take lots for annual fee.
- Clinical Institute for Withdrawal from Alcohol scale with detox protocol: *www.cbhallc.com/ Documents/4a-DETOX%20Guidelines.pdf.*

Resources/References

- Allensworth-Davies, D., Cheng, D. M., Smith, P. C., Samet, J. H., & Saitz, R. (2012). The short inventory of problems—modified for drug use (SIP-DU): Validity in a primary care sample. *The American Journal on Addictions, 21*, 257-262.
- National Committee for Quality Assurance (2011).Standards and guidelines for NCQA's Patient Centered Medical Home (PCMH) 2011.Author. Washington, D.C.
- Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2010). A single question screening test for drug use in primary care. *Archives of Internal Medicine, 170*(13), 1155-1160.
- NIDA QuickScreen (available : http://www.drugabuse.gov/nmassist/)
- Alcohol Use Disorders Identification Test (AUDIT) [available: http://www.ncbi.nlm.nih.gov/books/NBK64829/#A45987]
- Treatment Improvement Protocol (TIP) 24: A Guide to Substance Abuse Services for Primary Care Clinicians (available: http://www.ncbi.nlm.nih.gov/books/NBK64827/)