SBIRT: SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT ON L&D

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DISCLOSURES

- I RECEIVE CONSULTING INCOME FROM MCKESSON-NOT RELATING TO THE CONTENT OF THIS TALK

- I RECEIVE ROYALTIES FROM OUR BOOK OPIOID USE DISORDERS IN PREGNANCY

OBJECTIVES

- REALIZE THE IMPORTANCE OF SCREENING ALL WOMEN OF CHILDBEARING AGE FOR SUBSTANCE USE
- INCORPORATE VALIDATED SCREENING TOOLS INTO CLINICAL CARE
- IDENTIFY MOTIVATIONAL INTERVIEWING TECHNIQUES SO THAT A POSITIVE SCREEN DOESN'T GET IGNORED, BUT TRIGGERS THE APPROPRIATE TEAM-BASED APPROACH

WHY BOTHER?

- REASONS NOT TO TALK ABOUT SUBSTANCE USE:
  - "NO TIME" - TOO MANY OTHER THINGS TO DO
  - DON'T KNOW HOW TO ASK
  - "NOT MY JOB" - NOT TRAINED AS A THERAPIST/COUNSELOR
  - NO ONE TO REFER TO
  - WE DON'T HAVE DRUG PROBLEMS AT OUR HOSPITAL
  - PATIENTS WON'T CHANGE ANYWAY

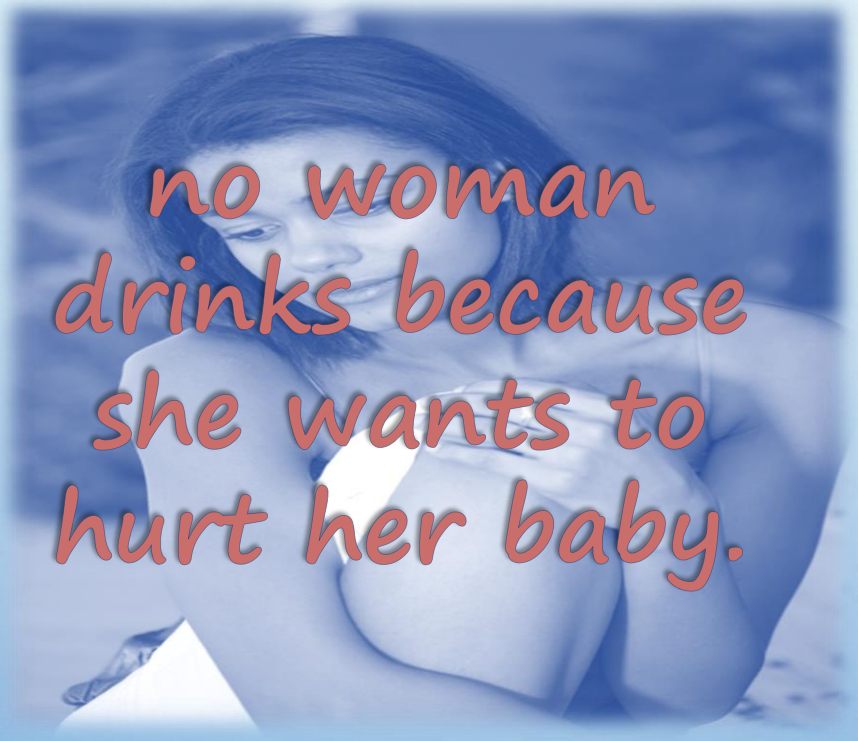
"BUT THEY ALL LIE TO ME."

- REASONS PATIENTS DON'T SHARE WITH US
  - FEAR OF STIGMA OR JUDGMENT
  - PREVIOUS BAD EXPERIENCE WITH HEALTH CARE PROVIDER
  - FEAR OF CHILD PROTECTIVE SERVICES
  - THEY DON'T CONSIDER THEIR USE PROBLEMATIC

MINIMIZING STIGMA

- SUBSTANCE USE DISORDERS ARE THE MOST STIGMATIZED MEDICAL CONDITION
- PREGNANT WOMEN WITH SUD ARE EVEN MORE STIGMATIZED
  - TERMS SUCH AS “CRACK BABY” AND “OPIOIDS TINIEST VICTIMS” SERVE TO PROMOTE THIS STIGMA
  - BABIES AREN’T “BORN ADDICTED” THEY ARE PHYSICALLY DEPENDENT
- TOWARDS AN “ADDICTIONARY”
- FOCUS ON PERSON-FIRST LANGUAGE
- USE DSM5 TERMINOLOGY

STIGMA



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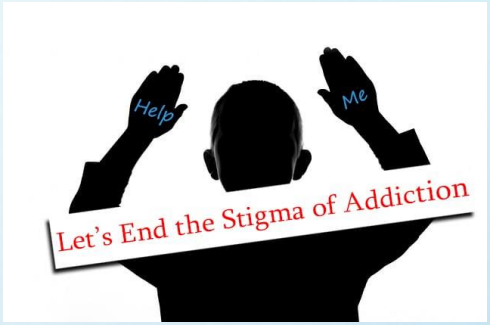


Changing the Language of Addiction

ASAM
American Society of Addiction Medicine

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

Terms Not to Use

- addict, abuser, user, junkie, druggie
- alcoholic, drunk
- oxy-addict, meth-head
- ex-addict, former alcoholic
- clean, dirty (drug test)
- addictions, addictive disorder

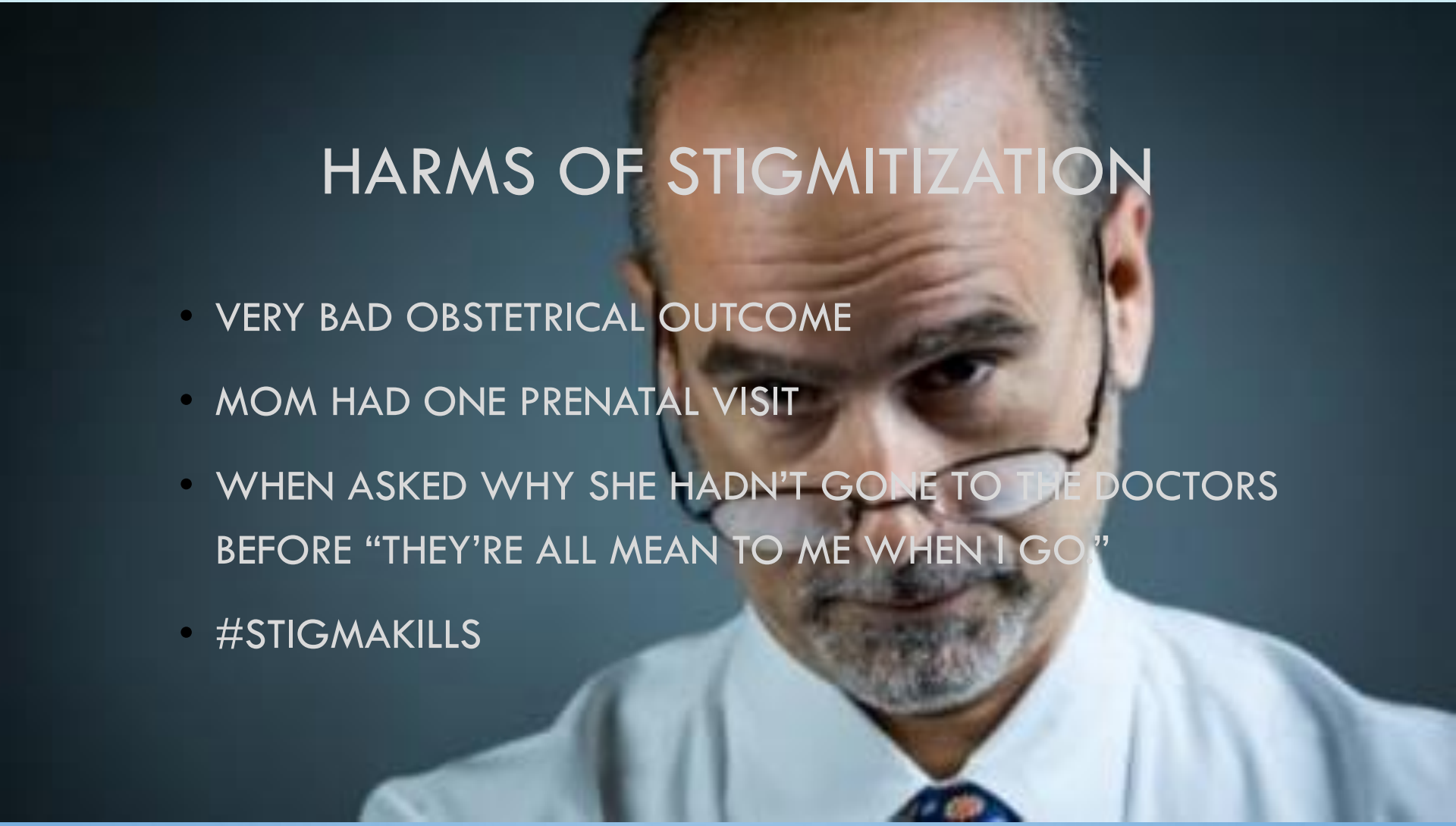
Terms to Use

- person with addiction
- person with an alcohol use disorder
- person with an opioid use disorder
- person in recovery
- negative positive result(s)
- addiction, substance use disorder

MINIMIZING STIGMA

- KELLY AND WESTERHOFF STUDY 2010 DOCTORATE-LEVEL ADDICTION AND MENTAL HEALTH PROVIDERS
- PROVIDED WITH CASE SCENARIOS OF PATIENTS WITH LEGAL DIFFICULTIES FROM SUBSTANCE USE.
- HALF THE SCENARIOS USED "SUBSTANCE ABUSERS"
- HALF USED "WITH A SUBSTANCE USE DISORDER."
- THE SCENARIOS WITH SUBSTANCE ABUSERS WERE SIGNIFICANTLY MORE LIKELY TO BE JUDGED AS DESERVING PUNISHMENT THAN THE EXACT SAME SCENARIOS AS THOSE HAVING A SUBSTANCE USE DISORDER.

The International journal on drug policy. 2010;21(3):202-7



HARMS OF STIGMITIZATION

- VERY BAD OBSTETRICAL OUTCOME
- MOM HAD ONE PRENATAL VISIT
- WHEN ASKED WHY SHE HADN'T GONE TO THE DOCTORS BEFORE "THEY'RE ALL MEAN TO ME WHEN I GO."
- #STIGMAKILLS

Drug-related Criminal Justice

- **Women are a fast growing proportion of the USA prison population**
  - **>61% of women in federal prison are incarcerated for nonviolent drug related crimes**
  - **Plea bargaining –punishes those not willing to inform on others**
  - **Conspiracy charges- mandatory minimum sentencing**
  - **Inability to obtain: public assistance, a job or housing**

https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ThematicChapter-WomenAndDrugs.pdf; http://www.drugpolicy.org/issues/women-lgbtqia-drug-war http://i.dailymail.co.uk/i/pix/2012/06/29/article-2166260-13D3BC4C000005DC-231_964x578.jpg

Race/Ethnicity

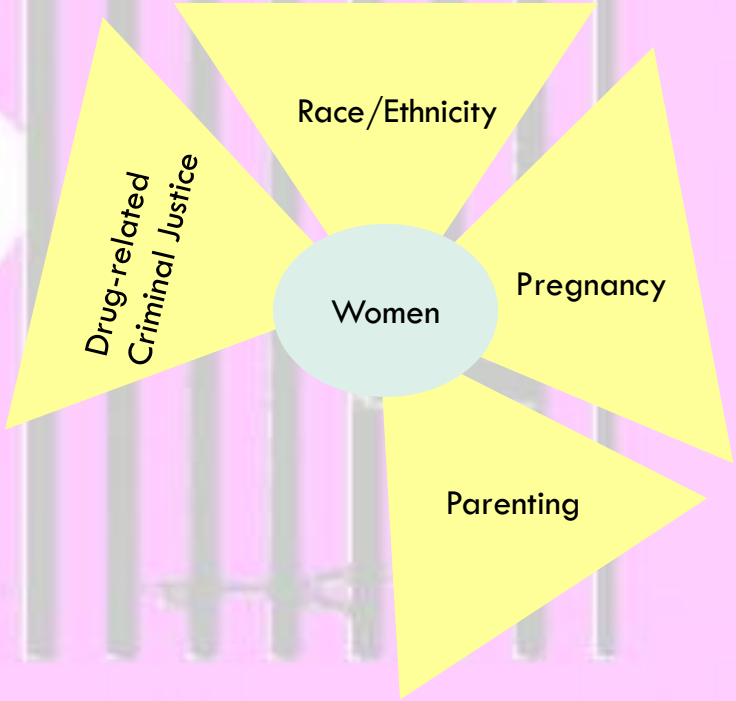
- **Drug use occurs at similar rates across groups**
- **Compared to White women:**
  - **Black women are almost twice as**
  - **Latinas are 20% more**
  - **Native American are 6 times more**
  - **….likely to be incarcerated**

https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ThematicChapter-WomenAndDrugs.pdf; http://www.drugpolicy.org/issues/women-lgbtqia-drug-war

- **Black women are no more likely to use illicit drugs during pregnancy but more likely to be reported to child welfare**
- **60% of women in prison are mothers of minor children**
- **The health and social situation of mothers involved with child protection services deteriorates after their child is taken into care**
- **Women with a child or children in foster care were less likely to complete treatment**

Wall-Wieler E et. al., J Epidemiol Community Health. 2017 Dec;71(12):1145-1151.
Lewandowski CA, Hill TJ. Child Youth Serv Rev. 2008;30(8):942-954.

- Women who use drugs are uniquely vulnerable to criminal justice and child welfare involvement – admit drug use or test positive at birth
- Criminalization of drug use puts mother and fetus at great risk to create barriers to treatment and prenatal care
- Prisons and jails use restraints during labor and delivery
- Deny breast feeding



National Drug Control Strategy. Office of National Drug Control Policy website https://www.whitehouse.gov/sites/default/files/ondcp/ndcs2011.pdf

Why Screen?

SUBSTANCE PROBLEMS ARE COMMON

	Pregnant (%)	Not Pregnant (%)
Smoking	11.6	25.4
Drinking		
Current	9.9	51.0
Binge	2.6	22.2
Heavy	0.4	4.5
Illicit drugs	5.4	10.8

NSDUH 2018

PREVALENCE OF SCREENED FOR CONDITIONS IN PREGNANCY

Cystic Fibrosis (Caucasians)	1/2500
Anemia	2-4%
Gestational diabetes	2-10%
Pre-eclampsia	2-8%
Post partum depression	10-15%

SUBSTANCE USE DISORDERS ARE EXPENSIVE

- NATIONAL ESTIMATES OF COSTS OF ILLNESS:
  - ALCOHOL RANKS 2ND, TOBACCO 6TH, DRUGS 7TH
- THE ANNUAL COST OF SUBSTANCE MISUSE = $510.8 BILLION: (HARWOOD, 2000)
  - ALCOHOL MISUSE COST THE NATION $191.6 BILLION;
  - TOBACCO USE COST THE NATION $167.8 BILLION;
  - DRUG MISUSE COST THE NATION $151.4 BILLION.
- DIABETES ($128 BILLION/YEAR) AND CANCER ($210 BILLION/YEAR)
- PROGRAMS DESIGNED TO PREVENT SUBSTANCE MISUSE CAN REDUCE COSTS

Source: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

SUBSTANCE USE DISORDERS ARE TREATABLE

- SUBSTANCE USE DISORDERS ARE CHRONIC RELAPSING CONDITIONS SUCH AS HYPERTENSION, ASTHMA, OR DIABETES
- THE TREATMENT SUCCESS RATES OF SUD ARE COMPARABLE TO HYPERTENSION, ASTHMA, OR DIABETES (NIDA, 2017)
- MEDICATIONS TO TREAT OPIOID USE DISORDERS DECREASE DEATH BY ALL CAUSES BY 50% (SORDO ET AL, 2017)
- SBIRT CAN HELP DECREASE RISKY USE, THUS PREVENT THE DEVELOPMENT OF SUD

WHAT IS SBIRT?

- "SBIRT IS A COMPREHENSIVE, INTEGRATED, PUBLIC HEALTH APPROACH TO THE DELIVERY OF EARLY INTERVENTION AND TREATMENT SERVICES FOR PERSONS WITH SUBSTANCE USE DISORDERS, AS WELL AS THOSE WHO ARE AT RISK OF DEVELOPING THESE DISORDERS." (CSAT, 2009)
- THIS IS THE DEFINITION USED BY SAMHSA
- HOWEVER SBIRT CAN BE USED FOR ANY BEHAVIORAL INTERVENTION OR AS THE TREATMENT PROCESS FOR ANY HEALTH BEHAVIOR CHANGE

SBIRT

- ***SCREENING*** – QUICKLY ASSESS SEVERITY OF SUBSTANCE USE AND IDENTIFY THE APPROPRIATE LEVEL OF TREATMENT
  - PATIENT ADMINISTERED INSTRUMENT
  - PROVIDER QUESTIONS
- ***BRIEF INTERVENTION*** – INCREASE INSIGHT AND AWARENESS OF SUBSTANCE USE; MOTIVATION TOWARDS BEHAVIORAL CHANGE
  - BRIEF – 3 MINUTES
  - BASED ON MOTIVATIONAL INTERVIEWING
- ***REFERRAL AND TREATMENT*** – PROVIDE THOSE IDENTIFIED AS NEEDING MORE TREATMENT WITH ACCESS TO SPECIALTY CARE
  - SYSTEMS OF CARE

Screening → Brief Intervention → Referral and Treatment

SBIRT PROCESS

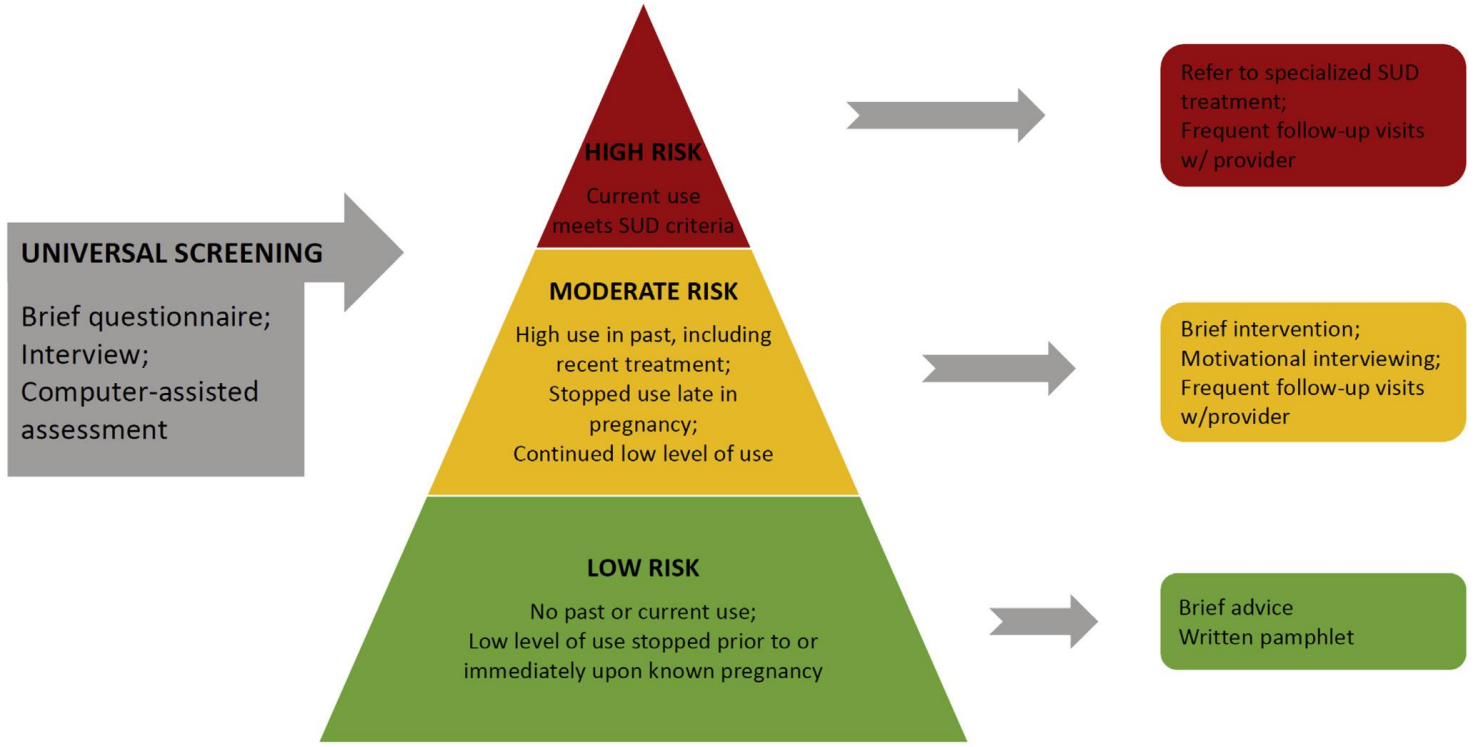
- SBIRT AT
  - ANNUAL EXAMS
  - NEW OB VISITS
  - RESCREEN WITH MENTAL HEALTH SCREENING DURING EVERY TRIMESTER
  - UPON ADMISSION TO L&D
- FOR THOSE WITH IDENTIFIED PROBLEMS
  - FOLLOW-UP AT SUBSEQUENT VISITS

SBIRT PROCESS

print & web 4C/FPO

FIGURE 1

Risk pyramid for assessment of substance use during pregnancy



SUD, substance use disorder.

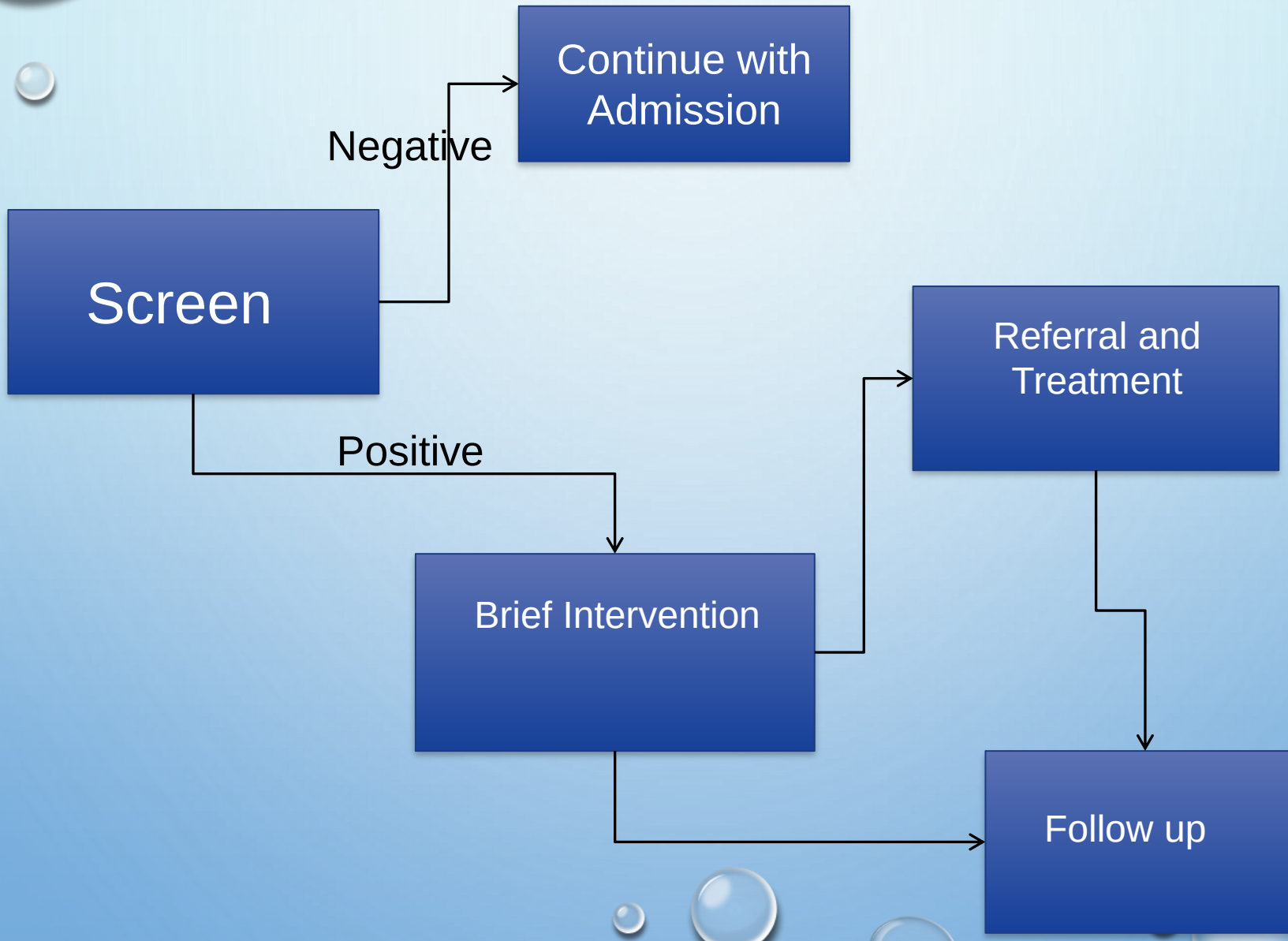
Wright. SBIRT in pregnancy. Am J Obstet Gynecol 2016.

WHAT YOU CAN EXPECT

- AFTER THE SCREENING RESULTS ARE AVAILABLE, YOU CAN EXPECT THAT ONLY A SMALL PROPORTION WILL BE IN NEED OF A BRIEF INTERVENTION.
- THE GOAL OF BRIEF INTERVENTION (BI):
  - NOT TO "CURE" THE PATIENT OF THE PROBLEM, SIMPLY INSTILL SOME LEVEL AWARENESS AND POSSIBLE REFERRAL TO SPECIALIZED TREATMENT IF NECESSARY.

Babor & Higgins-Biddle, 2009

SBIRT Flow


Continue with Admission
Negative
Screen
Positive
Brief Intervention
Referral and Treatment
Follow up

HOW DO WE SCREEN?

POLL:
YOUR HOSPITAL PROTOCOLS

1) UNIVERSAL URINE TOXICOLOGY ON ALL BIRTHING PEOPLE

2) URINE TOXICOLOGY WITH CERTAIN CRITERIA (E.G. NO PRENATAL CARE, PREGNANCY COMPLICATION)

3) UNIVERSAL VERBAL SCREENING

4) I'M NOT SURE/WE HAVE NO PROTOCOL

NEED FOR UNIVERSAL SCREENING

- ASK EVERY WOMAN ABOUT USE
- USE NON-JUDGMENTAL LANGUAGE
  - "I ASK ALL MY PATIENTS ABOUT THINGS THEY DO THAT CAN AFFECT THEIR HEALTH.
    - HOW MUCH DO YOU EXERCISE?
    - HOW MANY CIGARETTES HAVE YOU SMOKED IN YOUR LIFETIME?
    - HOW MUCH ALCOHOL DID YOU DRINK BEFORE YOU GOT PREGNANT?
    - HAVE YOU EVER USED DRUGS FOR REASONS OTHER THAN MEDICAL?"
  - NOT: "YOU DON'T DO DRUGS, DO YOU?"
  - AND DON'T ASK JUST TO "CHECK THE BOX"

NIDA-4

If the answer is yes to any of the above, then the screen is positive, and an assessment should be done

IN THE LAST 1 YEAR HAVE YOU…

- ❑ SMOKED TOBACCO OR VAPED?
- ❑ HAD MORE THAN 3 DRINKS OF ALCOHOL IN ONE DAY OR MORE THAN 7 IN ONE WEEK
- ❑ USED A PRESCRIPTION FOR SOMETHING OTHER THAN PRESCRIBED
- ❑ USED AN ILLEGAL OR ILLICIT DRUG
- ❑ USED MARIJUANA*

* For states that have legalized recreational or medical cannabis

AUDIT 1-3

AUDIT 1-3 (US)	Scoring							Score
	0	1	2	3	4	5	6	
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	
How many units of alcohol do you drink on a typical day when you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
How often do you have X (5 for men; 4 for women and 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:	

Scoring AUDIT 1-3 (US):

The following scores are considered positive and optimal for identifying alcohol use disorders or risky drinking. If patient is pregnant, provide advice about the risks to her health and the developing fetus:

For pregnant women	Any use
For women and men aged 65+	≥ 7 points
For men under 65	≥ 8 points

4P'S

- ***PARENTS***
  - ***DID EITHER OF YOUR PARENTS EVER HAVE A PROBLEM WITH ALCOHOL OR DRUGS?***
- ***PARTNER***
  - ***DOES YOUR PARTNER HAVE A PROBLEM WITH ALCOHOL OR DRUGS?***
- ***PAST***
  - ***HAVE YOU EVER DRUNK BEER, WINE, OR LIQUOR? HAVE YOU EVER USED ILLICIT DRUGS***
- ***PREGNANCY***
  - ***IN THE MONTH BEFORE YOU KNEW YOU WERE PREGNANT, HOW MANY CIGARETTES DID YOU SMOKE?***
  - ***IN THE MONTH BEFORE YOU KNEW YOU WERE PREGNANT, HOW MANY BEERS/HOW MUCH WINE/HOW MUCH LIQUOR DID YOU DRINK?***

Chasnoff, 2007

SCREENING PROTOCOLS- THOUGHTS FROM L&D NURSES

"WE NEED TRAINING ON ASSESSMENT AND CARE MANAGEMENT! WE CAN HAVE ALL THE EMPATHY WE WANT BUT IF WE DON'T HAVE TOOLS AND SYSTEMS, PATIENT WILL CONTINUE TO BE HARMED."

"THERE IS A CHECK BOX STYLE ADMISSION QUESTION ABOUT SUBSTANCE USE... CURIOUS IF THERE'S A BETTER WAY TO ASSESS AND ADDRESS THIS THAT DOESN'T FEEL SO CLINICAL AND RUSHED."

"WE AS NURSES DON'T KNOW WHAT PHYSICIANS CAN DO AND HOW TO GET REFERRALS GOING. NURSES DON'T KNOW WHAT RESOURCES ARE AVAILABLE"

SCREENING VS. TESTING: WHAT'S THE DIFFERENCE?

SCREENING

- UNIVERSAL, VERBAL
- NON-JUDGMENTAL
- OPPORTUNITY TO DESTIGMATIZE USE
- OPPORTUNITY TO OFFER SERVICES
- SUPPORTED AS GOLD STANDARD BY ACOG, ASAM
- CAN ALSO CAUSE HARM IF NOT DONE IN TRAUMA-INFORMED WAY

TESTING

- VARIOUS BIOLOGIC OPTIONS & FREQUENCIES (URINE, MEC, HAIR, ETC.)
- FALSE POSITIVES ARE NOT INFREQUENT
- QUALITATIVE DATA: TRAUMA & TRIGGERS RELATED TO TESTING DUE TO USE AS FORM OF POLICING FAMILIES
- URINE TESTING DIAGNOSES ONLY RECENT USE; IS NOT DIAGNOSTIC FOR A SUBSTANCE USE DISORDER OR ABILITY TO PARENT

FALSE POSITIVES ON URINE DRUG TESTING

	Amphet-amines	Benzos	Barbit-urate	Phencycli-dine (PCP)	Metha-done
Bupropion	X				
Dextromethorphan				X	
Diphenhydramine					X*
Doxylamine					X*
Fioricet/Fiorinal			X		
Labetalol	X				
Metformin	X				
Promethazine	X				
Quetiapine (≥ 125 mg)					X*
Sertraline (150 mg or >)		X			
Trazadone	X				
Venlafaxine				X	

* If GC-MS is used initially, a false positive should NOT be produced

VERBAL SCREENING

Table 3. Validity Indices for the 4P's Plus, NIDA Quick Screen, and SURP-P

	4 P's Plus	NIDA Quick Screen ASSIST	SURP-P
Sensitivity*	91.2 (85.7–95.1)	83.5 (76.8–89.0)	93.1 (88.0–96.5)
Specificity*	28.6 (23.7–33.9)	80.8 (76.0–85.0)	21.0 (16.7–25.9)
Positive predictive value*	39.0 (34.0–44.1)	68.4 (61.3–74.9)	37.0 (32.3–41.9)
Negative predictive value*	86.7 (78.6–92.5)	90.8 (86.8–93.9)	85.9 (76.2–92.7)
Sensitivity†	94.7 (88.5–97.4)	85.4 (76.4–89.5)	95.4 (90.7–98.4)
Specificity†	28.7 (23.8–33.6)	76.1 (71.4–80.6)	21.1 (17.3–26.1)
Positive predictive value†	32.6 (28.9–38.8)	56.4 (50.1–64.4)	30.6 (27.3–36.5)
Negative predictive value†	93.6 (85.7–96.7)	93.5 (88.8–95.2)	92.7 (84.8–97.3)
Sensitivity‡	90.2 (84.5–93.8)	79.7 (71.2–84.2)	92.4 (87.6–95.8)
Specificity‡	29.6 (24.4–35.2)	82.8 (78.1–87.1)	21.8 (17.4–27.2)
Positive predictive value‡	44.1 (39.7–50.0)	74.0 (67.8–80.4)	42.0 (38.0–47.9)
Negative predictive value‡	83.0 (73.4–88.9)	86.9 (81.3–89.7)	82.3 (72.1–90.0)

Data are % (95% CI).
* Reference standard: hair test results.
† Reference standard: urine test results.
‡ Reference standard: hair and urine test results combined; positive on either urine or hair sample testing.

Coleman-Cowger et al Green Journal, May 2019.

RACISM IN TESTING → RACISM IN CPS REFERRALS

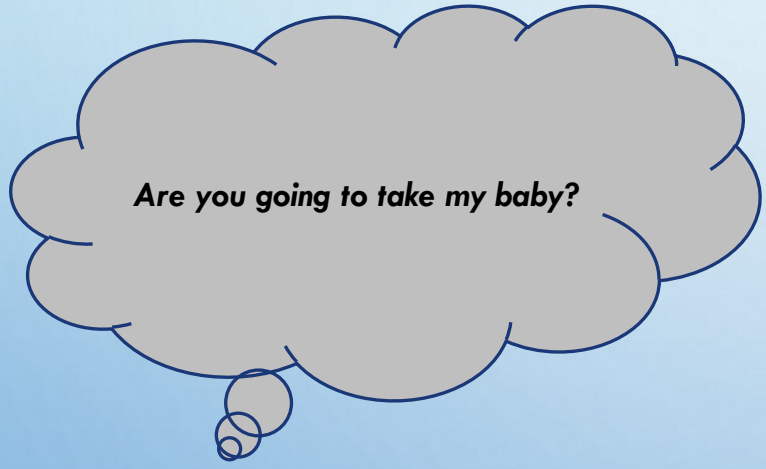
- SUBSTANCE USE IS SIMILAR BY RACE/ETHNICITY IN THE US AMONG "WOMEN" (MOST NIH DATA DON'T HAVE GENDER-INCLUSIVE DATA; DATA FROM 2010S)

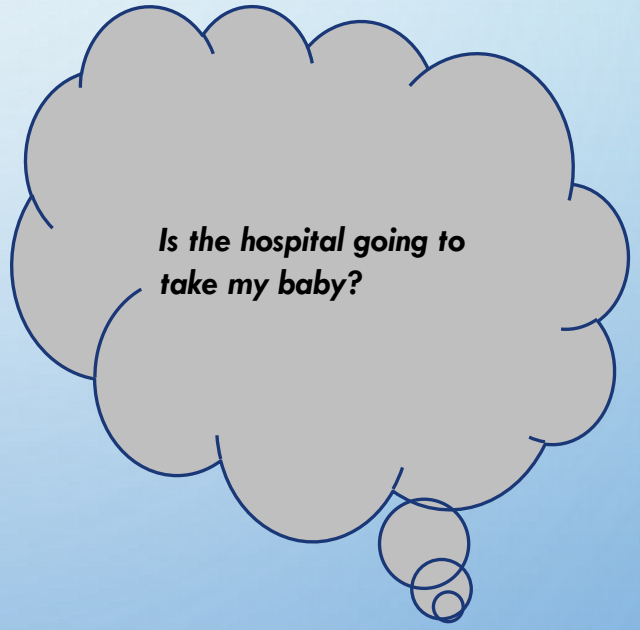
- NUMEROUS STUDIES SHOW BLACK PREGNANT PEOPLE AND THEIR INFANTS ARE MORE LIKELY TO HAVE DRUG TESTING AT BIRTH (DATA FROM 1990S-2000S)

- AFTER A POSITIVE TEST, BLACK BIRTHING PARENTS WERE 10X MORE LIKELY TO BE REPORTED TO CPS (DATA FROM 1990S)

https://orwh.od.nih.gov/sites/orwh/files/docs/WoC-Databook-FINAL.pdf
https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf
https://mk0nationaladvoq87fj.kinstacdn.com/wp-content/uploads/2019/10/NAPW202522Clinical20Drug20Testing20of20Pregnant20Women20and20Newborns252220March202019.pdf

LONG-LASTING RAMIFICATIONS OF DRUG TESTING





MacAfee Obstet & Gynecol 2020; Roberts Maternal Child Health J 2011

REVISION OF THE URINE TOXICOLOGY TESTING GUIDELINES AT SFGH – *IN PROCESS*

PURPOSE

- AID IN IDENTIFICATION OF PREGNANT/BIRTHING PEOPLE WHO NEED SUPPORT RELATED TO SUBSTANCE USE
- IDENTIFY BIRTHING PARENTS AND INFANTS EXPOSED TO SUBSTANCES WHO MAY NEED SPECIFIC CLINICAL TREATMENTS (I.E. TREATMENT OF WITHDRAWAL)
- MINIMIZE BIAS AND DISCRIMINATION IN CARING FOR PATIENTS AND FAMILIES
- *NOT* USED TO ASSESS PARENTING ABILITY OR SAFETY

GUIDELINES IN PROCESS (CONT)

NOTEWORTHY POINTS

- MULTIDISCIPLINARY GROUP IS LEADING REVIEW PROCESS; EVEN WHEN "FINALIZED," WILL BE INTERIM TO ALLOW FOR COMMUNITY REVIEW
- GOAL IS TO BE NARROW WITH INDICATIONS / DECREASE USE OF URINE TESTING
- VERBAL DISCLOSURE ALMOST ALWAYS ELIMINATES THE NEED FOR BIOLOGIC TESTING
- A BIRTH PARENT WITH CAPACITY MUST CONSENT TO URINE TESTING; INFANT TESTING REQUIRES DISCLOSURE TO BIRTH PARENT
- BIRTH PARENT TOXICOLOGY TEST IS ALWAYS PREFERABLE TO NEWBORN TEST. NEWBORN TESTING SHOULD ONLY BE PERFORMED IF THERE IS CLINICAL INDICATION FOR NEWBORN MANAGEMENT AND BIRTH PARENT DECLINES TESTING
- **URINE TOXICOLOGY TESTING, LIKE CPS CALLS, SHOULD ALWAYS BE A GROUP DECISION, ALLOWING OPPORTUNITY FOR REFLECTION ON POTENTIAL BIASES, DISCRIMINATION, AND HARM REDUCTION STRATEGIES**
- GOAL IS TO BE CONSISTENT ACROSS SFGH & UCSF

GUIDELINES IN PROCESS (CONT)

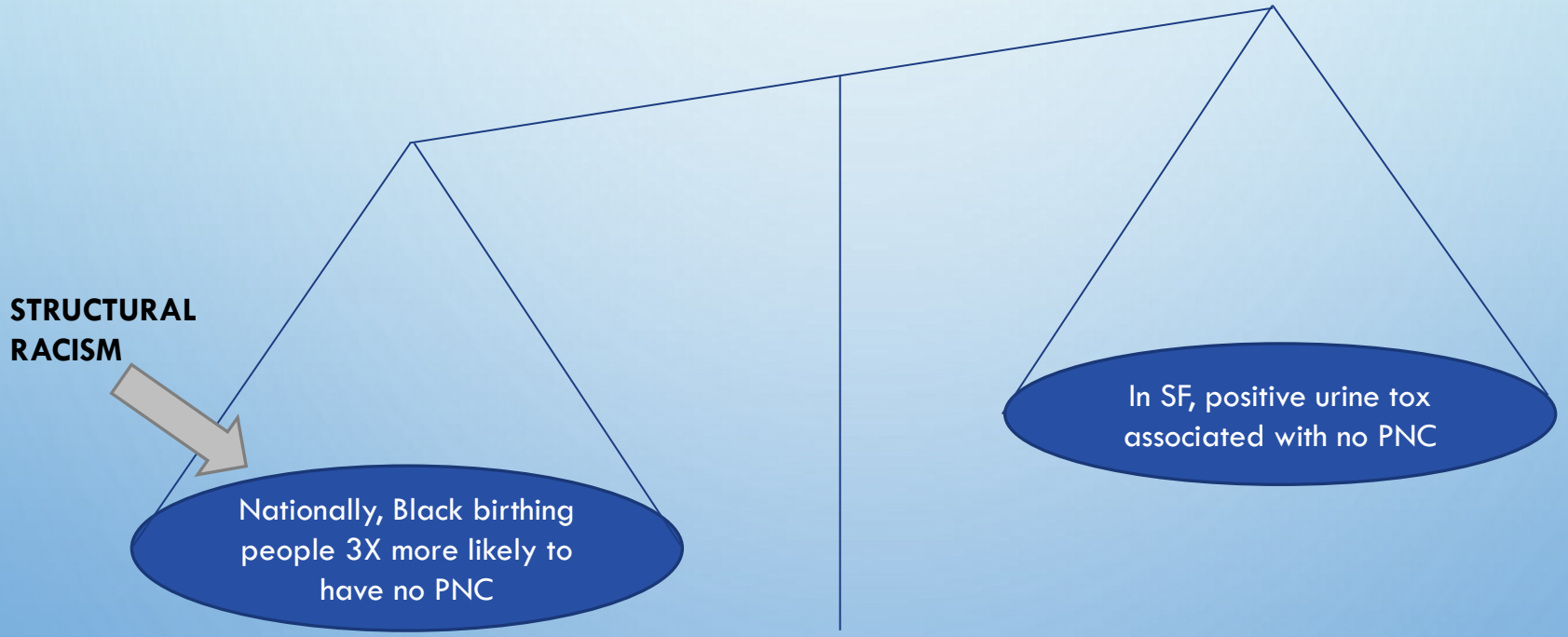
BIRTHING PARENT CONSIDERATIONS:

- ACUTE MENTAL STATUS CHANGES, PSYCHOSIS, MANIC SYMPTOMS, SOMNOLENCE (NOT OTHERWISE EXPLAINED)
- BEHAVIOR CONSISTENT WITH INTOXICATION OR WITHDRAWAL, SUCH AS SLURRED OR PRESSURED SPEECH, INCOORDINATION, OR EXTREME AGITATION
- IF DESIRED BY THE BIRTHING PARENT (I.E., TO DEMONSTRATE RECOVERY AND/OR SAFETY OF BREASTFEEDING)

NEWBORN CONSIDERATIONS:

- TO GUIDE TREATMENT OF THE NEWBORN CARE: NEWBORN BEHAVIOR CONSISTENT WITH INTOXICATION OR WITHDRAWAL. OTHER CAUSES OF NEWBORN CLINICAL PRESENTATION SHOULD BE EXPLORED (NICOTINE, SSRI'S, HYPOGLYCEMIA, ETC).

LATE TO CARE / NO PRENATAL CARE – TO OFFER TESTING OR NOT? WHAT CAUSES MORE HARM?



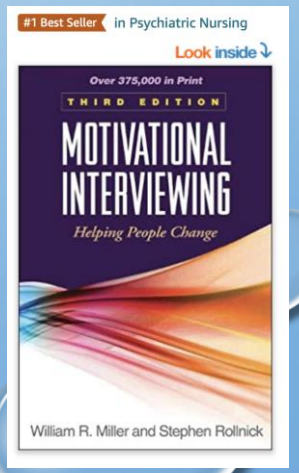
Vintzileos AJOG 2002; Mayor's Task force on Strengthening families (very small, unpublished data 2020)

YOU'VE CAUGHT HER IN A CAGE

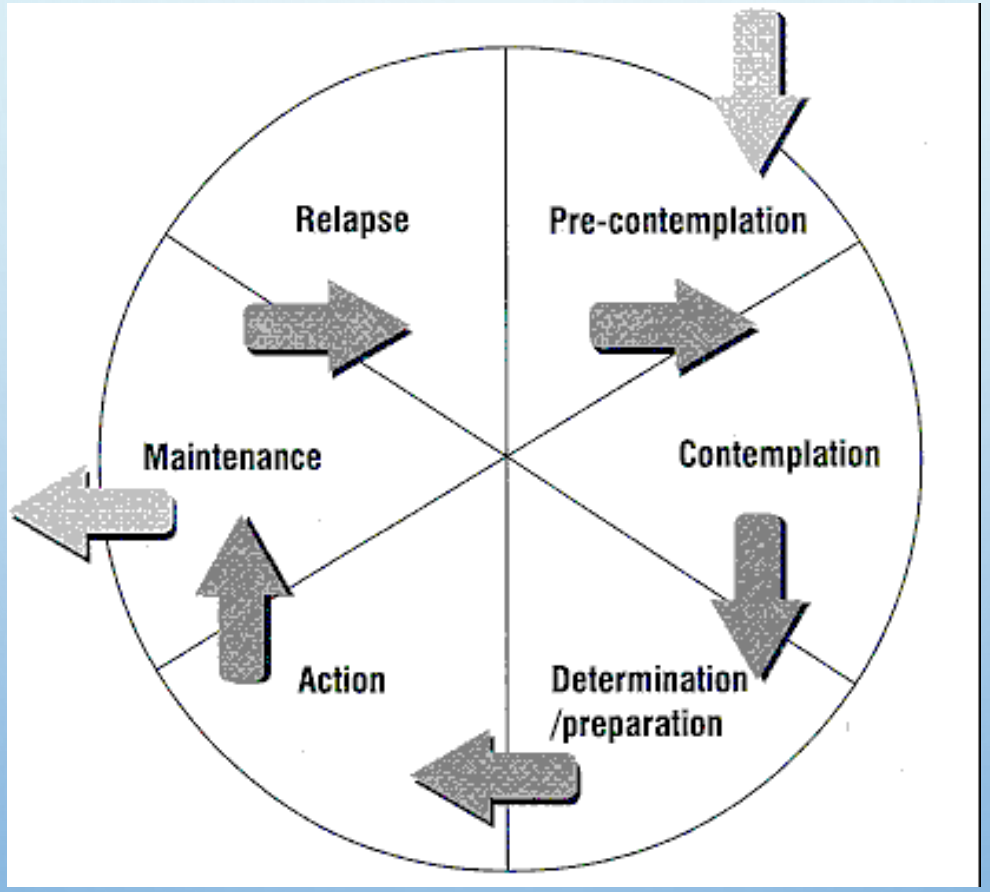
NOW WHAT?...

MOTIVATIONAL INTERVIEWING

- BASED ON TECHNIQUES FIRST DESCRIBED BY MILLER IN 1990.
- EFFECTIVE IN ER PATIENTS AFTER AN ALCOHOL-RELATED MVA.(BAZARGAN-HEJAZI ET AL., 2005)
- FOUND TO BE EFFECTIVE IN DECREASING ALCOHOL USE IN THE PREGNANT POPULATION. (HANDMAKER AND WILBOURNE, 2001)
- FOUND TO INCREASE TOBACCO ABSTINENCE RATES IN PREGNANT WOMEN FROM 8% TO 33% (FERREIRA-BORGES, 2005)



STAGES OF CHANGE



Prochaska and DiClemente

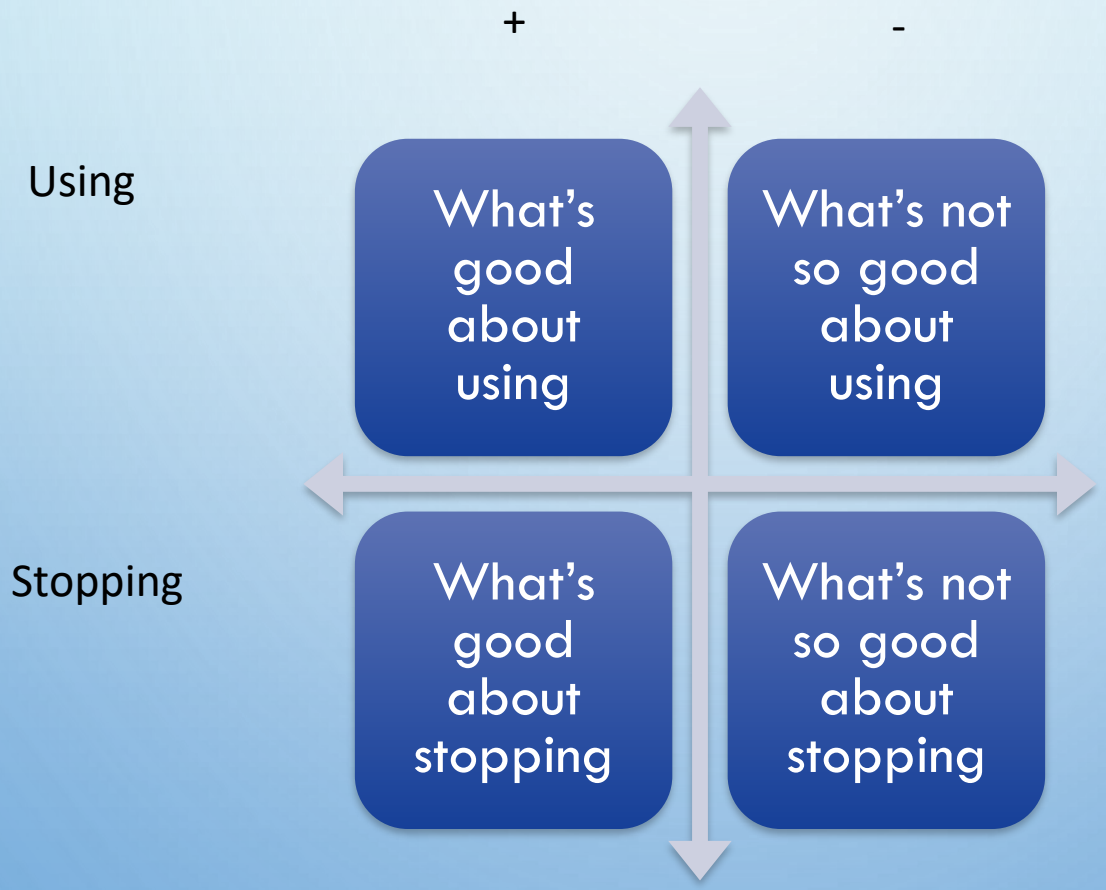
AMBIVALENCE

AMBIVALENCE

- AMBIVALENCE IS NORMAL
- PEOPLE WANT TO CHANGE, BUT THEY DON'T WANT TO CHANGE
- "WORKING WITH AMBIVALENCE IS WORKING WITH THE HEART OF THE PROBLEM"

THE DECISIONAL BALANCE:

EXPLORE THE PROS AND CONS OF CURRENT BEHAVIOR



MOTIVATIONAL INTERVIEWING PRINCIPLES

- EXPRESS EMPATHY
  - ASK OPEN-ENDED QUESTIONS
  - DEVELOP RAPPORT
- SUPPORT SELF-EFFICACY
  - BELIEF THAT CHANGE IS POSSIBLE
- ROLL WITH RESISTANCE
- DEVELOP DISCREPANCIES BETWEEN CURRENT BEHAVIOR AND FUTURE GOALS.

WWW.MOTIVATIONALINTERVIEW.ORG

THE THREE TASKS OF BRIEF INTERVENTION

Feedback

Listen and Understand

Options Explored

HOW NOT TO MOTIVATE

- Challenging
- Warning
- Finger-wagging
- Moralizing
- Giving Unwanted Advice

- Shaming
- Labeling
- Confronting
- Being Sarcastic
- Playing expert

FEEDBACK

- YOUR JOB IN F IS **ONLY TO DELIVER** THE FEEDBACK!
  - RISK TO MOM AND BABY FROM HER BEHAVIOR
  - ASK PERMISSION
  - WHAT HAVE YOU HEARD ABOUT THE RISKS OF DRINKING DURING PREGNANCY?
  - DRINKING DURING PREGNANCY CAN CAUSE BIRTH DEFECTS.
  - NO AMOUNT OF DRINKING IS CONSIDERED SAFE.
  - WHAT DO YOU MAKE OF THAT?
- **LET THE PATIENT DECIDE** WHERE TO GO WITH IT.

FEEDBACK: FINDING A HOOK

- ASK THE CLIENT ABOUT THEIR CONCERNS
- PROVIDE NON-JUDGMENTAL FEEDBACK/INFORMATION
- WATCH FOR SIGNS OF DISCOMFORT WITH STATUS QUO OR INTEREST OR ABILITY TO CHANGE
- ALWAYS ASK THIS QUESTION: “WHAT ROLE, IF ANY, DO YOU THINK ALCOHOL/SMOKING/DRUG USE PLAYED IN YOUR PROBLEMS?”
- LET THE PATIENT DECIDE
- JUST ASKING THE QUESTION IS HELPFUL

ROLL WITH RESISTANCE

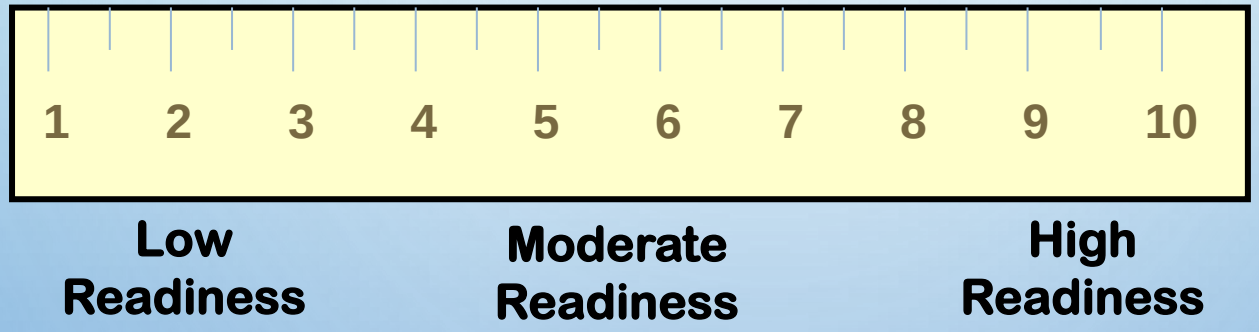
- "I'M NOT GOING TO PUSH YOU TO CHANGE ANYTHING YOU DON'T WANT TO CHANGE
- I'M NOT HERE TO CONVINCE YOU THAT YOU'RE AN ALCOHOLIC
- I'D JUST LIKE TO GIVE YOU SOME INFORMATION…
- I'D REALLY LIKE TO HEAR YOUR THOUGHTS ABOUT…
- WHAT YOU DO IS UP TO YOU.

LISTEN AND UNDERSTAND

IMPORTANCE/CONFIDENCE/READINESS

ON A SCALE OF 1-10…

- HOW IMPORTANT IS IT FOR YOU TO QUIT SMOKING?
- HOW CONFIDENT ARE YOU THAT YOU CAN CHANGE YOUR SMOKING?
- HOW READY ARE YOU TO QUIT SMOKING?



- FOR EACH ASK…
  - WHY DIDN'T YOU GIVE IT A LOWER NUMBER?
  - WHAT WOULD IT TAKE TO RAISE THAT NUMBER?

THE THIRD TASK: OPTIONS FOR CHANGE

WHAT NOW?

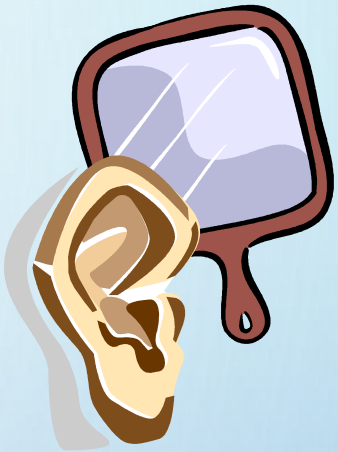
- WHAT DO YOU THINK YOU WILL DO?
- WHAT CHANGES ARE YOU THINKING ABOUT MAKING?
- WHAT DO YOU SEE AS YOUR OPTIONS?
- WHERE DO WE GO FROM HERE?
- WHAT HAPPENS NEXT?

OPTIONS FOR CHANGE

OFFER A MENU OF OPTIONS

- MANAGE YOUR SMOKING (CUT DOWN).
- ELIMINATE YOUR SMOKING (QUIT)
- WASH HANDS AND CHANGE CLOTHES AFTER SMOKING (REDUCE HARM)
- UTTERLY NOTHING (NO CHANGE)
- SEEK HELP (TRY MEDICATIONS, ACUPUNCTURE, HYPNOSIS)

REFLECTIVE LISTENING



- REPEATING – SIMPLEST
- REPHRASING – SUBSTITUTE SYNONYMS
- PARAPHRASING – MAJOR RESTATEMENT
- REFLECTION OF FEELING – DEEPEST
  - REFLECTIVE LISTENING BEGINS WITH A WAY OF THINKING
  - IT INCLUDES AN INTEREST IN WHAT THE PERSON HAS TO SAY AND A DESIRE TO TRULY UNDERSTAND HOW THE PERSON SEES THINGS
  - IT IS ESSENTIALLY HYPOTHESIS TESTING
  - WHAT YOU THINK A PERSON MEANS MAY NOT BE WHAT THEY MEAN

SIMPLE FLOW OF MI

- ASK THREE OPEN-ENDED QUESTIONS
  - WHAT DO YOU LIKE ABOUT X?
  - HOW DOES X GET YOU INTO TROUBLE?
  - WHAT IS YOUR GOAL RELATED TO X?
- FOLLOWED BY A SUMMARY
- "SO, YOU LIKE THAT SMOKING CALMS YOU DOWN, BUT YOU DON'T LIKE THAT IT COSTS SO MUCH AND YOU KNOW IT'S BAD FOR YOU. YOU'D LIKE TO CUT DOWN YOUR SMOKING AND EVENTUALLY BE ABLE TO QUIT."

SUPPORT SELF-EFFICACY

- BI BY ITSELF CAN EFFECT CHANGE, ESPECIALLY WITH RISKY USE THAT IS NOT YET A SUBSTANCE USE DISORDER.
- IT CAN MOTIVATE PATIENT TO GET INTO TREATMENT.
    - KNOW YOUR LOCAL COMMUNITY RESOURCES FOR TREATMENT.

REVIEW

- UP TO THIS POINT IN THE SBIRT PROCESS:
  - THE PROVIDER CONDUCTED NECESSARY SCREENING REQUIRED TO DETERMINE PATIENT'S LEVEL OF RISK WITH THEIR SUBSTANCE USE. (S)
  - THE PROVIDER HAS EITHER THEMSELVES CONDUCTED BI OR MADE NECESSARY ARRANGEMENTS SOMEONE ELSE TO CONDUCT BI. (BI)
  - THE THIRD STEP IS REFERRAL AND TREATMENT. (RT)

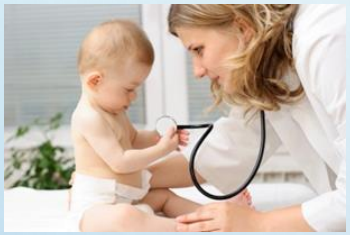
REFERRAL AND TREATMENT

- FOR PATIENTS NEEDING MORE, REFERRAL TO SPECIALIZED TREATMENT.
  - DETOX OR NEEDS MORE INTENSIVE TREATMENT SETTING
  - PROBLEM TOO SEVERE FOR BI
  - YOU WANT FURTHER ASSESSMENT
  - PATIENT WANTS MORE ASSISTANCE
- REFERRAL TO TREATMENT IS INTEGRAL COMPONENT OF SBIRT
- NECESSITATES STRONG COLLABORATION AMONG MEMBERS OF THE TEAM.
  - ANESTHESIA
  - PEDIATRICS
  - MENTAL HEALTH
  - SOCIAL WORK
  - ADDICTION MEDICINE
  - COMMUNITY HEALTH NURSES
- ASSEMBLE YOUR TEAM!

TEAM-BASED CARE

- COMMUNICATION THROUGH EMR
- PROBLEM LISTS
- CHECKLIST DOT PHRASES JUST LIKE EVERY OTHER HIGH-RISK PREGNANCY CONDITION
- DEPENDING ON YOUR SYSTEM, OBTAINING 42CFR(2)-COMPLIANT CONSENTS TO TALK WITH ADM, SUD COUNSELORS
- PEDIATRICS HAS SHARED WITH US THEY WOULD BE MUCH MORE COMFORTABLE NOT DOING TOX SCREENS ON BABY/NOT REFERRING TO CPS IF THEY HAVE RESULTS OF SCREENING ON CHART/UPDATED PROBLEM LISTS

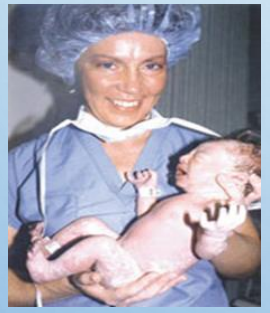
IT TAKES A VILLAGE…



Pediatrician

Substance abuse counselor

Opioid medication provider

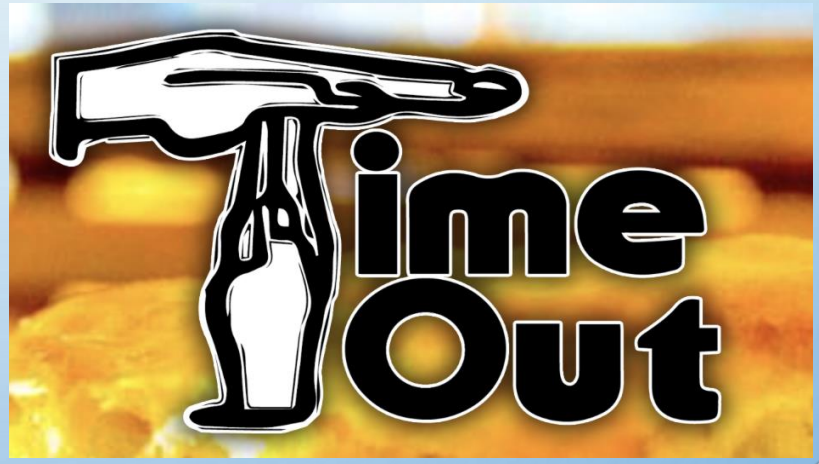


Obstetric provider

Community based nursing

CPS TIMEOUTS-ZSFGH

- TIME –OUT. A PAUSE BEFORE A HIGH-RISK PROCEDURE OR INTERVENTION
- GIVEN THE KNOWN HARMS OF SEPARATION OF MOTHER AND BABY, AND THE RACIAL BIASES THAT EXIST WITH DRUG TESTING AND THE INABILITY TO OBTAIN PRENATAL CARE, WE DECIDED THAT UNLESS IT IS AN EMERGENCY, CPS CAN ONLY BE CALLED AFTER A MULTI-DISCIPLINARY MEETING



QUESTIONS?

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