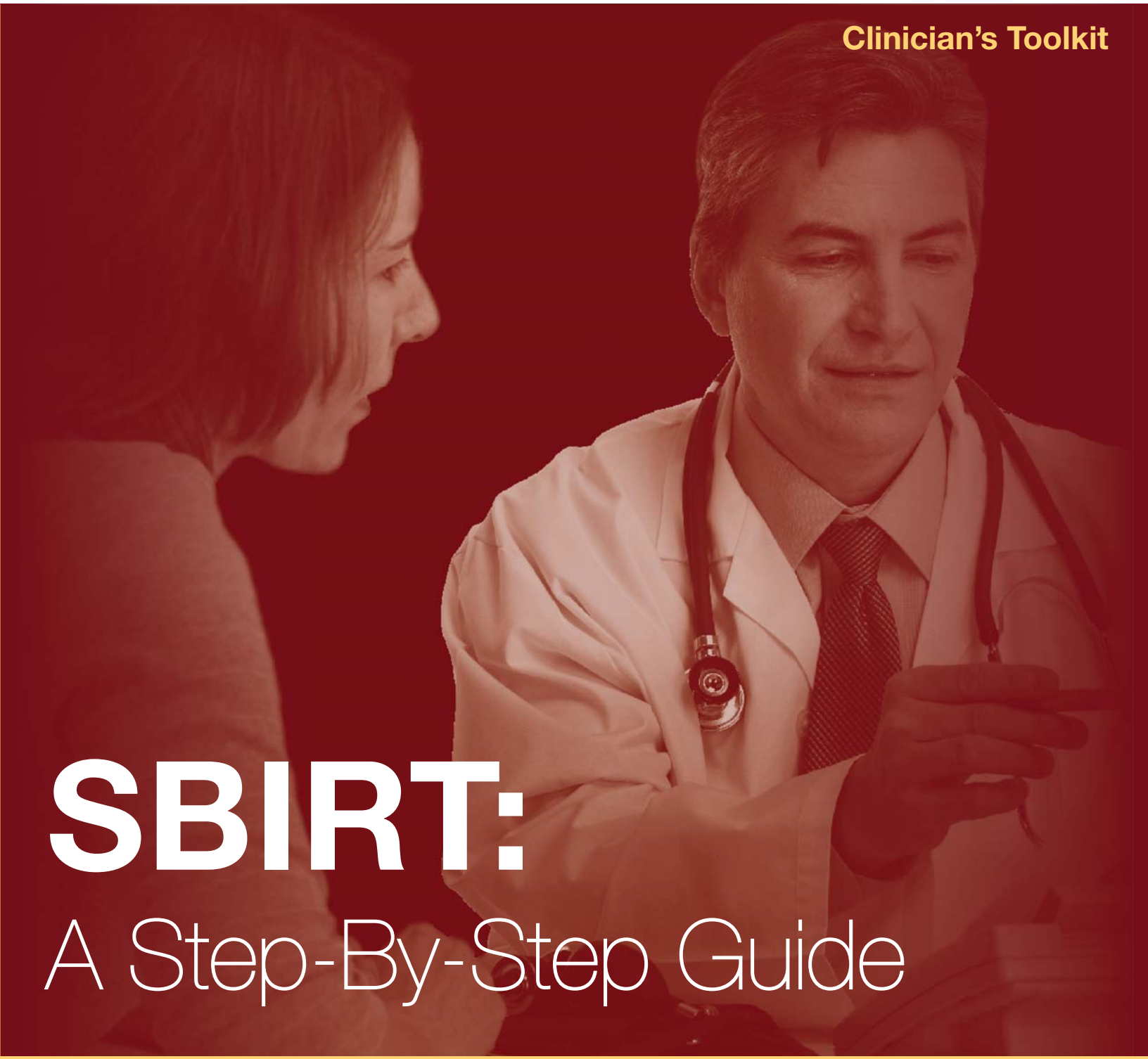
Clinician's Toolkit



SBIRT:
A Step-By-Step Guide

A Step-By-Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH

BSAS
Bureau of Substance Abuse Services

MA SBIRT
Asking questions.
Improving health.

About this Toolkit

This toolkit was developed to assist Massachusetts healthcare providers and organizations in implementing regular Screening, Brief Intervention and Referral to Treatment (SBIRT) for unhealthy alcohol and drug use in clinics and practices. SBIRT is a quick, easy way to identify and intervene with patients whose patterns of use put them at risk for, or who already have, substance-related health problems.

How much time is needed?

Most patients (75-85%) will screen negative. Completing 3-4 simple questions will take 1-2 minutes. For the remaining 15-25% of patients, the full screen and brief intervention will take between 5 - 20 minutes to complete.

This toolkit provides:

- Rationale for routine screening for unhealthy alcohol and drug use as an important component of good healthcare
- Two recommended **screening approaches** for alcohol and other drug use
- A suggested **brief intervention** script
- Steps for **referring patients** to substance use specialty care, when needed
- Questions to consider for **implementing SBIRT**
- ***Helping Patients Who Drink Too Much: A Clinician's Guide***, produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Of particular note, is the section on **"Prescribing Medications For Treating Alcohol Dependence"**, as well as suggested strategies to diagnose and help patients with alcohol use disorders.

For further information or to arrange SBIRT training and implementation assistance, please contact the Massachusetts Department of Public Health Bureau of Substance Abuse Services SBIRT Coordinator at Questions.BSAS@state.ma.us.

SBIRT focuses on the large numbers of people who may use alcohol or drugs in unhealthy ways but who do not have a substance use disorder (i.e., abuse, dependence). Research shows that they can and do successfully change their use with feedback and early intervention. SBIRT also gives positive feedback to those who make healthy decisions. [1,2,3,4]

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Supplemental Information

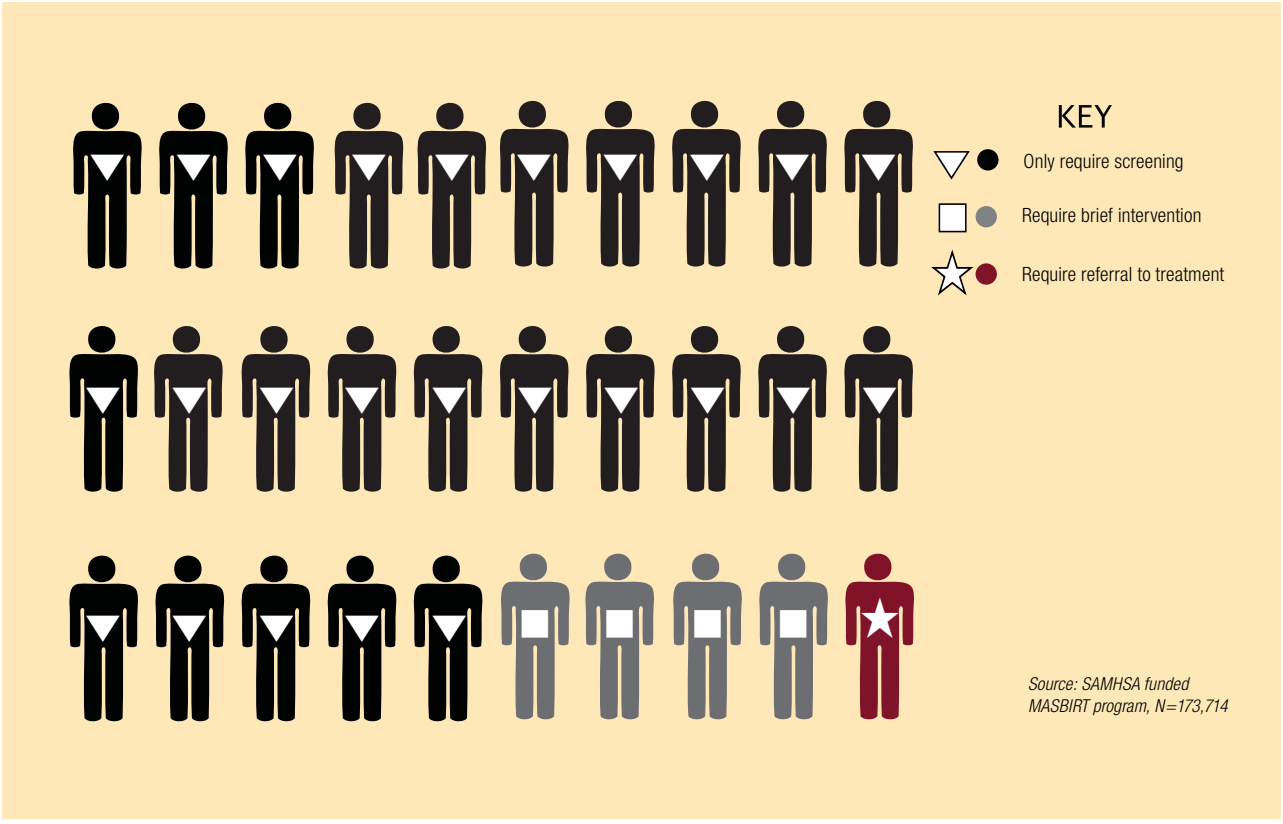
What is SBIRT?

Screening, **B**rief **I**ntervention and **R**eferral to **T**reatment (SBIRT) is a comprehensive, integrated, public health approach for early identification and intervention with patients whose patterns of alcohol and/or drug use put their health at risk.

SBIRT components are:

- Universal, annual **Screening (S)** identifies unhealthy use. 75-85% of patients will screen negative. For those who screen positive, further assessment is needed to determine level of risk.
- **Brief Intervention (BI)** provides feedback about unhealthy substance use. It also focuses on education, increasing patient insight and awareness about risks related to unhealthy substance use, and enhances motivation toward healthy behavioral change.
- **Referral** to **Treatment (RT)** helps facilitate access to addiction assessment and treatment. A referral is usually indicated for only about 5% of people screened.

Research shows SBIRT to be most effective with patients with unhealthy alcohol or drug use who do not have a substance use disorder.[5]



What is Unhealthy Alcohol or Drug Use?

Substance use (alcohol and drug) occurs on a continuum from no or low risk use to substance use disorders. Effective interventions are available for people at all points on that continuum. In most cases, unhealthy substance use issues can, and should, be addressed in general healthcare settings.

Unhealthy substance use is an all-encompassing term that includes the full spectrum of unhealthy use from:

- Risky use (i.e., consumption of amounts that increase the likelihood of health consequences)
- Substance use disorders (i.e., abuse and dependence)

Some people should not drink at all.
For more information about unhealthy alcohol use see p. 24 and 25 of the NIAAA Clinician's Guide included at the back of this toolkit.

All use of illegal drugs or misuse of prescription drugs is considered unhealthy use.

Risky Drinking

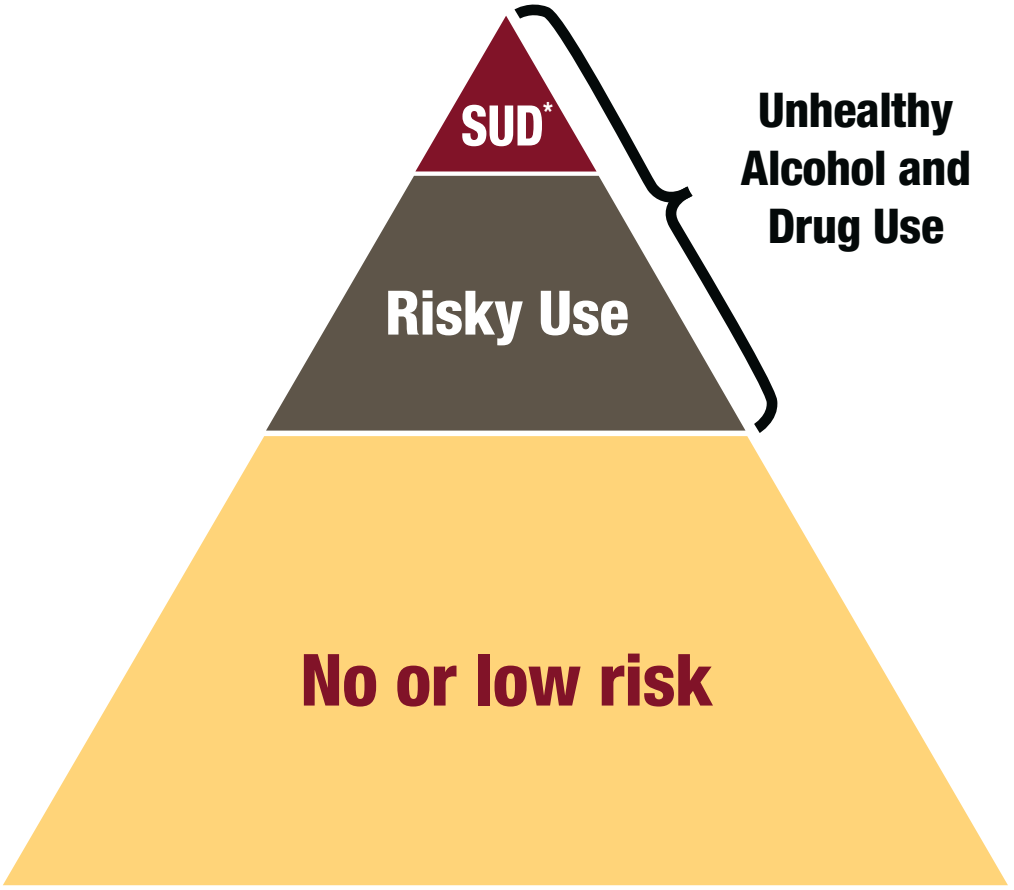
For healthy **men up to age 65 –**

- More than **4** drinks in a **day** AND
- More than **14** drinks in a **week**

For **all** healthy **women** and healthy **men over age 65**

- More than **3** drinks in a **day** AND
- More than **7** drinks in a **week**

As recommended by NIAAA



*Substance Use Disorders

Why Universally Screen and Intervene?

Unhealthy alcohol and other drug use are among the most common causes of preventable morbidity and mortality.[6] Despite their frequent presentation in primary care, unhealthy alcohol and other drug use often go unrecognized. While there is substantial research on SBIRT and alcohol, there is less research on SBIRT and drugs.[7,8]

Unhealthy substance use can complicate existing chronic conditions like diabetes,[9] hypertension,[10,11] cardiovascular diseases or mental health disorders[11] and interact with prescribed medications.[13,14]

Research has shown that large numbers of people whose patterns of use put them at-risk of developing alcohol or drug problems can be identified through screening.[15]

SBIRT has also been found to:

- decrease the frequency and severity of drug and alcohol use[16-18]
- decrease emergency department visits and hospital days[19]
- demonstrate net-cost savings[19-22]

BEFORE YOU BEGIN

1. Decide who will do SBIRT (i.e. clinician, support staff) and, if more than one person is involved, determine the process.
2. Communicate with your clinic management about how your practice will handle billing potential, documentation requirements and confidentiality regulations.
3. This toolkit was designed to help providers identify unhealthy use, rather than diagnose substance use disorders. For patients who may need further assessment and diagnosis, see NIAAA Clinician's Guide page 7, step 3, or refer to the current version of the DSM.
4. Identify referral resources in your area through your behavioral health staff or by calling the Massachusetts Substance Abuse Information and Education Helpline at 800-327-5050. See the Referral section on p. 11 for more information. Most insurance coverage includes counseling for substance use disorders.

See supplemental p. 14 for additional considerations for implementation.

SBIRT in Action

Alcohol only: Go to NIAAA Clinician's Guide located at the back of this toolkit.

Alcohol and Drug: (Proceed ahead)

We recommend two substance use screening strategies:

- The Standard Approach on p. 5-7 is longer and requires scoring but has been more rigorously tested for validity. We recommend this strategy when incorporating questions into your EMR.
- The Quick Approach on p. 8 may be preferable to some as it is easy to memorize, is validated, and can be completed within a few minutes.

These questions are like other tests in medical practice and have been validated as such. They may not work as well if altered. Recommended screening and assesment instruments have high sensitivity and specificity.[8, 23, 24, 25, 26,27]

All practices should routinely incorporate tobacco screening. Ask all patients about tobacco use and readiness to quit. QuitWorks (www.quitworks.org) is a resource for providers to help patients quit. Providers can also go to http://makesmokinghistory.org/quitting/for-health-care-providers.html for information on prescribing medications for tobacco addiction and other resources.

PATIENTS IN RECOVERY

By universally screening, some people who don't use alcohol or drugs may disclose that they are in recovery and working to maintain their health in spite of an addiction. This provides an opportunity to:

- congratulate the patient
- ask how long s/he has been in recovery
- ask whether s/he attends peer support groups or needs counseling or other support
- ask what – if any – concerns this may raise in relation to prescription medications, or other medical issues
- ask about tobacco use as this is a major cause of death for people in recovery[28]

Screen (S): Ask and Assess

STANDARD APPROACH
(Ideal for screening when questions can be integrated into the EMR)

STEP 1: *Ask about **alcohol & drug** use*

Alcohol Use

A drink is defined as: 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits. See NIAAA Clinician's Guide, p. 24.

AUDIT-C	0	1	2	3	4	Score
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?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	____
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____

SCORING 0

≥ 3 WOMEN	≥ 4 MEN	POSITIVE

[23]

If positive, go to STEP 2A to assess with the full AUDIT on p. 6.
Your patient has at least RISKY alcohol use.

If negative, reinforce their healthy decisions and continue with drug screening.

Drug Use

Single-item drug screen

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? (If asked what non-medical reasons means you can say because of the experience or feeling the drug caused.)

SCORING

≥1 WOMEN & MEN	POSITIVE

[8]

If positive, go to STEP 2B to assess with the DAST-10 on p. 7.
Your patient has at least RISKY drug use.

If negative, reinforce their healthy decisions.

STEP 2A: *If AUDIT-C positive, assess for **alcohol** use severity*

Bring the score of the AUDIT-C questions over with you to score the full AUDIT.

AUDIT	0	1	2	3	4	Score
AUDIT-C Score						
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, 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, not in the last year		Yes, during the last year	

0

SCORING

<13 WOMEN <15 MEN	**RISKY USE**
≥ 13 WOMEN ≥ 15 MEN	**FURTHER DIAGNOSTIC EVALUATION & REFERRAL**

[29]

Responses to AUDIT may be used in your brief intervention.

Go to Step 3 to perform a brief intervention, p. 9.

All patients receiving full AUDIT should receive a brief intervention.

Full printable AUDIT form is in NIAAA Clinician's Guide.

STEP 2B: *If single-item drug screen positive, assess for **drug** use severity*

DAST-10

"The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. In the following statements "drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include: cannabis (marijuana, hash), cocaine, heroin, narcotic pain medications, sedatives (benzodiazepines) or stimulants (amphetamines). Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right." [30,31]

DAST-10	0	1
In the past 12 months		
1. Have you used drugs other than those required for medical reasons? *If patient is positive in step 1, the answer to #1 is an automatic yes.*	☐ No	Yes ☐
2. Do you abuse more than one drug at a time?	☐ No	Yes ☐
3. Are you always able to stop using drugs when you want to?	☐ Yes	No ☐
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 ☐

Used with permission from Harvey A. Skinner PhD, CPsych, FCAHS; Dean, Faculty of Health, York University

SCORING

< 3 WOMEN & MEN	**RISKY USE**
≥ 3 WOMEN & MEN	**FURTHER DIAGNOSTIC EVALUATION & REFERRAL** [32]

Responses to DAST-10 questions may be used in your brief intervention.

Go to Step 3 to perform a brief intervention, p. 9.

All patients receiving DAST-10 should receive a brief intervention.

QUICK APPROACH

STEP 1: *Ask about alcohol & drug use*

Alcohol use [33]

A drink is defined as: 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits. See NIAAA Clinician's Guide, p. 24.

- Do you sometimes drink beer, wine, or other alcoholic beverages? ☐
- How many times in the past year have you had 5 or more drinks (4 or more for women and men over age 65) in a day? *One or more is considered positive. If positive, patient is at risk for acute consequences (e.g. trauma, accidents). If score is greater than zero, ask:* ☐
  - On average, how many days a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many drinks do you have? ☐

  If average exceeds 14 drinks per week for healthy men up to age 65 or 7 drinks per week for all healthy women and healthy men over age 65, patient is at-risk for chronic health problems.

Drug use [8]

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? (If asked what non-medical reasons means you can say because of the experience or feeling the drug caused.) *One or more is considered positive.* ☐

If positive, go to STEP 2. Your patient has at least RISKY alcohol and/or drug use.
If negative, reinforce their healthy decisions.

STEP 2: *Assess for alcohol and/or drug severity*

CAGE-AID[27]

1) Have you ever felt that you ought to **Cut** down on your drinking or drug use? ☐
2) Have people **Annoyed** you by criticizing your drinking or drug use? ☐
3) Have you ever felt bad or **Guilty** about your drinking or drug use? ☐
4) Have you ever had a drink or used drugs first thing in the morning **(Eye-opener)** to steady your nerves or get rid of a hangover? ☐

*Each **Yes** response equals 1.*

☐

SCORING

≤ 1 WOMEN & MEN	**RISKY USE**	> 1 WOMEN & MEN	**FURTHER DIAGNOSTIC EVALUATION & REFERRAL**

[28]

Responses to CAGE-AID questions may be used in your brief intervention.

Go to Step 3 to perform a brief intervention, p. 9.

All patients receiving CAGE-AID should receive a brief intervention.

Brief Intervention (BI)

A brief intervention (BI) is a collaborative conversation that enhances a patient's motivation to change their use of alcohol and/or other drugs in order to lower risk for alcohol and drug-related problems. A brief intervention may consist of offering advice and education about substance use and/or focus on eliciting the patient's own reasons to change. The practitioner guides the patient to develop his/her own plan for change. A BI focuses on whatever small steps the patient is willing to make.

BIs in primary care can range from 5 minutes to several follow-up conversations. Many of the tools used in BI are based on Motivational Interviewing (MI) concepts. For further information about MI, see Supplement p. 22.

See Brief Intervention Q&A (p. 20) for more information.

STEP 3: *Brief Intervention (BI)*

*This BI is based upon the Brief Negotiated Interview developed by the BNI-ART Institute.[34]

Sample BI for Unhealthy Alcohol and/or Drug Use (use for all positives on Standard or Quick Approach screen)

In instances when the patient is positive for multiple substances, ask the patient if there is a particular substance that he or she is most concerned about and focus on that substance during the BI.

BI STEPS	DIALOGUE/PROCEDURES
1. Understand the patient's views of use • Develop discrepancy between patient's goals and values and actual behavior	**Ask Pros and Cons** *"I'd like to know more about your use of [X]. Help me to understand what you enjoy about using [X]? What else?"* *"What do you enjoy less about using [X] or regret about your use".* **Summarize Pros and Cons** *"So, on the one hand you say you enjoy X because…"* *"And on the other hand you said…."* reiterate negative consequences, as stated by patient.
2. Give information/ feedback • Ask permission to give feedback • Use reflective listening, as outlined in MI section in Supplement on p. 24	**Review Health Risks** *"Is it OK if we review some of the health risks of using X?"* *"Are you aware of health risks related to your use of X?"* **If YES:** *Which ones are you aware of?* **If NO:** *Indicate problems. Refer to NIDA Commonly Abused Drugs chart for drug consequences, as needed on p. 18.* **If focus is on risky alcohol use and abstinence is not indicated:** *"Is it OK if I review with you what is considered safe drinking limits for your age and gender?" (No more than 4/3 drinks in one day and no more than 14/7 drinks in one week.) "Drinking more than this puts you at risk for experiencing illness or injury from your alcohol use."*

3. Enhance motivation to change • Ask readiness and confidence scales	**Readiness Scale** *"Given what we have been discussing, help me better understand how you feel about making a change in your use of X. On a scale from 0 -10, how ready are you to change any aspect of your use of [X]? A 10 would mean you are fully ready to change and a 0 means you are not at all ready."* Then, Ask: *"Why did you choose that number and not a lower one like a 1 or a 2?"* Patient will indicate reasons to change. You also ask the patient for other reasons for change. *"How does this fit with where you see yourself in the future? If you make these changes what would be different in your life?"* If the patient, answers "0" ask, *"What would need to happen to be at a higher number?"* **Confidence Scale** *"On a scale from 0-10, how confident do you feel to make these changes?"* *"A 10 would mean total confidence and a 0 means no confidence at all."* *"What needs to happen for you to feel more confident? What have you successfully changed in the past? How? Could you use these methods to help you with the challenges of this change?"*
4. Give advice and negotiate goal	**Give Advice** Review concerns, as discussed with patient. Advise abstinence or decrease in use, according to screening and assessment. Give referrals for further assessment, if appropriate. **Negotiate Goal** *"What can you do to stay healthy & safe? Where do you go from here?"* SUMMARIZE: "*Let me summarize what we've been discussing…* *Is that accurate? Is there anything I missed or you want to add?"* Suggest discussing progress of plan at next appointment.
Close: Thank Patient	*"Thank you for taking the time to discuss this with me and being so open."*

See Supplemental p. 20 for more information on Brief intervention.

If time does not permit a structured BI during the current visit, an offer of brief advice that includes feedback, advice, and goal setting is a good way to acknowledge your concerns and start a conversation that can be followed up at the next appointment. Some important concepts of brief advice are to: **ask permission**, **use non-judgmental language**, **state concerns as the provider**, and **set goals** (e.g., cut down, abstain for a short period of time) to discuss at the next visit.

Referral to Treatment (RT)

MA Substance Abuse Information and Education Helpline
800-327-5050 *(Interpreter services available)* TTY 888-448-8321
Website: www.helpline-online.com

Adolescent Central Intake Care and Coordination
617-661-3991 *Toll free:* 866-705-2807 TTY: 617-661-9051
Website: www.mass.gov/dph/youthtreatment

Most insurance cards provide a number to call about mental health and substance abuse services to help your office (or your patient) determine an appropriate level of care.

Smokers' Helpline
800-QUIT-NOW (800-784-8669)

The Substance Abuse Helpline provides free, confidential information and referrals for alcohol and other drug use problems to healthcare providers, patients and their families. Information on over 600 statewide programs can be accessed through the Helpline website or by calling to talk to a referral specialist.

Many people recover on their own and do not access substance abuse treatment services. Encouraging your patient to seek services, but being open to alternative methods to achieve recovery, can be a good way to engage your patient in changing behaviors.

COMMON TREATMENT MODALITIES THAT MAY BE OFFERED TO PATIENTS

Outpatient counseling	Individual or group treatment provided weekly or at other intervals; may include motivational and cognitive behavioral methods.	
Acute Treatment Services (Detox)	For patients requiring medical intervention to manage withdrawal from alcohol/drugs. Lengths of stay are usually 4-7 days, followed by transition to ongoing treatment. Detoxification deals with the *physical dependency* to alcohol/drugs. To address the psychological, social factors, and the often complex behavioral issues that coexist with addiction, all patients are encouraged and assisted in enrolling in ongoing treatment programs.	
Clinical Stabilization Services (CSS)	For patients who have completed detoxification or do not require medically supervised care but require a period of intense residential counseling and time to plan next steps. Lengths of stay are typically 7-10 days.	
Alcoholics Anonymous (AA) **Narcotics Anonymous (NA)** **Al-Anon Family groups**	Peer-based mutual support rooted in the 12-steps. Meetings are held at various places and times everyday. Patients may want to attend several different meetings to find a good fit.	www.aa.org 617-426-9444 www.na.org 866-624-3578 www.al-anon.alateen.org 866-624-3578

Find full descriptions of all levels of service at www.helpline-online.com

SENDING A PATIENT FROM PRIMARY CARE TO DETOX

Very few patients need detox, though some patients with alcohol or opiate addictions may need this level of care. See NIAAA Clinician's Guide page 7, step 3, to determine whether this type of referral may be appropriate.

Patients can be sent directly to detox from primary care with medical clearance. Public and private detox facilities may have various admission requirements. These facilities are not equipped or staffed to treat unstable medical conditions (i.e. severe liver disease, conditions requiring IV administration, heart problems, etc.) or unstable psychiatric problems (i.e. active psychosis, suicidality, etc.).

A Medical Clearance letter for a detox placement should verify that the patient:

1) Is medically and psychiatrically stabilized enough to be safely treated in a free-standing detox which may have minimal or no on-site medical support
2) Has no outstanding medical problems that need to be currently addressed
3) Does not need help with activities of daily living (ADLs).

In addition, it is helpful if patients bring their own medications (not just prescriptions) preferably with refills available.

Patients can "self-refer" to detox without primary care involvement. If the patient is not ready to engage in detox, the provider can suggest that the patient engage in treatment when ready.

SPECIAL PRIVACY REGULATIONS AND PATIENT CONSENT

Substance use treatment programs may not disclose any information about any patient without that patient's specific written consent except in a few narrowly defined circumstances (e.g. medical emergency).

Because of the stigma attached to substance abuse treatment, *Confidentiality of Alcohol and Drug Abuse Patient Records - 42 CFR part 2*, was developed as part of the Code of Federal Regulations. This regulation goes beyond HIPAA and protects all information about any person who has applied for or been given diagnosis or treated for alcohol or drug use problems.

Consideration of these regulations should be incorporated into healthcare practice and appropriate safeguards of patient information should be put into place. More information is available at: **www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf**

As behavioral health care becomes more integrated into health care settings, organizational agreements known as Qualified Service Organization Agreements (QSOAs) may smooth this process for patients and providers. Some practices already have already developed these more formal collaborative relationships.

If you want to communicate with a treatment program, or receive reports back on your patient's progress, and your patient agrees, the patient must sign a specific consent. A sample consent form 'Consent for Release of Confidential Information' is included in the Supplemental pages and can be copied for use with your patients.

If your patient does not sign the specific consent for release form, the addiction treatment provider cannot disclose any information about the patient including whether your patient is under their care.

Supplemental Information

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize
(Name of patient)

_____,
(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____,
(Name of person or organization to which disclosure is to be made)

the following information:

_____
(Nature and amount of information to be disclosed, as limited as possible)

_____

The purpose of the disclosure authorized in this consent is to:

_____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: _____

_____ _____
Signature of patient Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

Prepared by the Legal Action Center

SAMPLE NOTICE PROHIBITING REDISCLOSURE

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Commonly Abused Drugs

Visit NIDA at www.drugabuse.gov

National Institutes of Health
U.S. Department of Health and Human Services

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Tobacco			*Increased blood pressure and heart rate/*chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed	
Alcohol			*In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/*increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed	
Cannabinoids			*Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis/*cough; frequent respiratory infections; possible mental health decline; addiction
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	I/smoked, swallowed	
Hashish	Boom, gangster, hash, hash oil, hemp	I/smoked, swallowed	
Opioids			*Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing/*constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	I/injected, smoked, snorted	
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
Stimulants			*Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis/*weight loss; insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction **Also, for cocaine**—nasal damage from snorting **Also, for methamphetamine**—severe dental problems
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/snorted, smoked, injected	
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/swallowed, snorted, smoked, injected	
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	II/swallowed, snorted, smoked, injected	
Club Drugs			***MDMA****—mild hallucinogenic effects; increased tactile sensitivity, empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/* sleep disturbances; depression; impaired memory; hyperthermia; addiction ***Flunitrazepam****—sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/*addiction ***GHB****—drowsiness; nausea; headache; disorientation; loss of coordination; memory loss/* unconsciousness; seizures; coma
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	I/swallowed, snorted, injected	
Flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	I/swallowed	
Dissociative Drugs			*Feelings of being separate from one's body and environment; impaired motor function/*anxiety; tremors; numbness; memory loss; nausea ***Also, for ketamine****— analgesia; impaired memory; delirium; respiratory depression and arrest; death* ***Also, for PCP and analogs****—analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations* ***Also, for DXM****—euphoria; slurred speech; confusion; dizziness; distorted visual perceptions*
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	III/injected, snorted, smoked	
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/swallowed, smoked, injected	
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked	
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Not scheduled/swallowed	
Hallucinogens			*Altered states of perception and feeling; hallucinations; nausea* ***Also, for LSD and mescaline****—increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion* ***Also, for LSD***—Flashbacks, Hallucinogen Persisting Perception Disorder ***Also, for psilocybin****—nervousness; paranoia; panic*
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot, yellow sunshine, blue heaven	I/swallowed, absorbed through mouth tissues	
Mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked	
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	I/swallowed	
Other Compounds			***Steroids****—no intoxication effects/*hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics ***Inhalants*** *(varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/*cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice, gym candy, pumpers	III/injected, swallowed, applied to skin	
Inhalants	*Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Prescription Medications			
CNS Depressants Stimulants Opioid Pain Relievers	For more information on prescription medications, please visit http://www.nida.nih.gov/DrugPages/PrescripDrugsChart.html.		

** Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.*

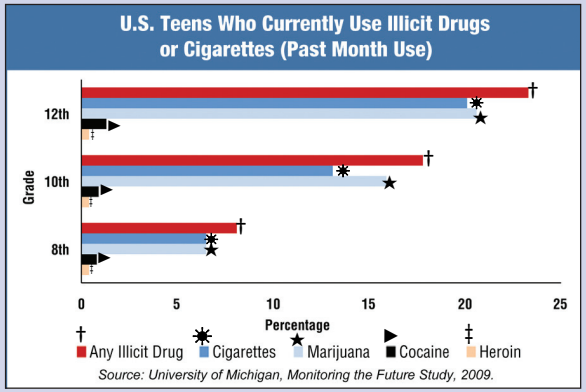
*** Some of the health risks are directly related to the route of drug administration. For example, injection drug use can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

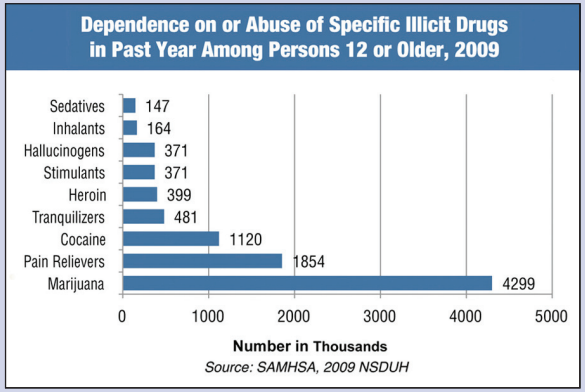
**** Associated with sexual assaults.*

Principles of Drug Addiction Treatment

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in *NIDA's Principles of Drug Addiction Treatment: A Research-Based Guide.* The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs alter the brain's structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.
2. **No single treatment is appropriate for everyone.** Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.
5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problemsolving skills, and facilitating better interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or an oral medication (buproprion or varenicline), can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person's changing needs.
9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.
11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.





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Revised October 2010

BRIEF INTERVENTION Q&A

1. What is a Brief Intervention (BI)?

A brief intervention is a conversation with a patient with the overall aim of enhancing a patient's motivation to lower his or her risk for alcohol and/or drug-related problems. This conversation based upon Motivational Interviewing principles and skills, elicits from the patient his/her own reasons to change. The conversation should be conducted in a collaborative manner with non-judgmental interest and curiosity about the patient's perspective.

2. Is the focus of a BI different for people using different substances?

The basic format and structure of a BI is the same; whether the focus is on alcohol use only, drug use only, or both. Patients with risky alcohol use may be encouraged to decrease their drinking to within the NIAAA drinking guidelines (see NIAAA Clinician's Guide, p. 4). Patients using drugs may be willing to stop for a period of time or start by decreasing use with the ultimate goal of stopping. Patients with a substance use disorder (abuse and dependence) should be encouraged to achieve abstinence and seek further evaluation by a substance abuse specialist.

Abstinence should be considered in the following circumstances:[35]

- Patient is under age 21, for legal reasons related to alcohol use and because of possible detrimental effects on brain development
- Pregnancy, planning to conceive, or at risk of becomming pregnant
- Prior consequences (eg, substance-related injury)
- Failed prior attempts to cut down
- Physical or mental health condition secondary to use
- Taking a medication that contraindicates any alcohol use (e.g. warfarin)
- Personal or family history of an alcohol use disorder

"While the risks of drug use vary by drug, amount, and frequency of use, many consider any drug use, either illegal drugs or misuse of prescription drugs, as risky, thus suggesting a goal of abstinence. Some consider the risk of legal consequences alone to warrant an abstinence goal."[35]

3. What are the components of a Brief Intervention?

A BI can be highly structured (see Step 3: Brief Intervention on p. 9), with the practitioner undertaking successive actions or less structured with the practitioner providing information and education, while using principles of Motivational Interviewing (MI).[35] See Supplement pages for a review of Motivational Interviewing (MI) principles and skills.

Generally, a BI includes three components:[36]

A. **Understanding patients' views of drinking or drug use and enhancing motivation.** This might include asking about:
   - how the patient perceives drinking and the role it plays in his/her life
   - the patient's view of the good and less good things about drinking or drug use (pro's and con's)
   - using a 0 -10 scale to identify the patient's readiness to change
   - using a 0 -10 scale to identify the patient's degree of confidence to be able to make a change

B. **Giving information/feedback.**

Begin this section of the BI by asking for the patient's permission to give him/her feedback, regarding answers to the screening questions and potential consequences of their use.
After giving the feedback, ask open-ended questions about what the patient's reaction to the feedback. Giving feedback includes:

- telling patients the results of the screening and assessment
- giving information related to the (potential) impact of alcohol or drug use on a patient's health
- providing education about drinking limits
- informing that abstaining or cutting back can reduce the risk of injuries or health problems

C. Giving advice and negotiating change plan.

After asking and receiving the patient's permission, it is important to provide clear advice to the patient to change. Providing a menu of options and goals is often helpful. Discussion can be directed toward options in which the patient shows interest. Negotiating a goal with a patient often involves a compromise between what the clinician thinks is the safest and what the patient is willing to do. Emphasis on the patient having sole responsibility for changing his/her own use is crucial.
This might include:

- goal setting (i.e. quitting drinking versus cutting back). Goals should optimally be generated at least in part by the patient.
- developing a plan (telling a friend about one's goals, avoiding certain people or locations).
  See NIAAA Clinician's Guide included in the back of the toolkit for Strategies to Cut Down (p.26).

Following the goal setting, it is useful to elicit what the patient thinks of the clinician's advice and recommendations regarding goals. The clinician should state her or his belief that the patient can make a change and reinforce the patient's self-efficacy or belief in his or her ability to change behavior.[27]

4. Is a BI effective for people with all severity of substance use issues?

Research supports BIs for people with risky/harmful alcohol use.[37] Studies are being conducted to determine if BIs are effective for people with drug use.[38]

Studies have shown varying effectiveness of BIs for people with dependence, but some have found benefits for women with dependence, but not for men with dependence.[39] Variations of BIs have also been found to be effective for motivating people with alcohol dependence to attend long-term alcohol treatment, as well as decrease their use. **(See NIAAA Clinician's Guide included in the back of this toolkit for BI for people with Alcohol Use Disorders p. 6-7.)**

5. Are BIs only used for dealing with alcohol and other drug issues?

In fact, BI's are widely used by physicians and other medical staff to address an array of patient behaviors including dietary habits, weight loss, smoking and taking medications as prescribed. BI's for at-risk drinking result in health, social, and economic benefits for the individual and society. [36]

6. What skills and knowledge are needed to perform a BI?

BIs are based upon Motivational Interviewing principles and skills as developed by Miller and Rollnick. These principles and skills are reviewed on p. 22 of this manual. With practice, BI's can become effectively carried out by most practitioners. Even those with little experience report good success when following basic BI guidelines.

MOTIVATIONAL INTERVIEWING OVERVIEW

Taken from *Brief Intervention for Substance Abuse: A Manual for Use in Primary Care. World Health Organization* [40]

Motivational interviewing is a directive, client centered-style of interaction aimed at helping people to explore and resolve their ambivalence about their substance use and move through the stages of change. It is especially useful when working with patients in the pre-contemplation and contemplation stages but the principles and skills are important at all stages.[13]

Motivational interviewing is based on the understanding that:

- effective treatment assists a natural process of change,
- motivation for change occurs in the context of a relationship between the patient and the therapist, and
- the style and spirit of an intervention is important in how well it works, in particular, an empathic style is associated with improved treatment outcomes.[13]

The brief intervention approach adopted in this manual is based on the motivational interviewing principles developed by Miller[12] and further elaborated by Miller and Rollnick.[13]

Principles of Motivational Interviewing

Express empathy

In the clinical situation empathy involves an accepting, non-judgemental approach which tries to understand the patient's point of view and avoids the use of labels such as 'alcoholic' or 'drug addict'. It is especially important to avoid confrontation and blaming or criticism of the patient. Skillful reflective listening which clarifies and amplifies the person's own experience and meaning is a fundamental part of expressing empathy. The empathy of the health worker is an important contributor to how well the patient responds to the intervention.[13]

Develop discrepancy

People are more likely to be motivated to change their substance use behavior when they see a difference or discrepancy between their current substance use and related problems and the way they would like their life to be. The greater the difference between their important goals and values and their current behavior, the more important it is likely to be to patients to change. Motivational interviewing aims to create and amplify a discrepancy between current behavior and broader goals and values from the patient's point of view. It is important for the patient to identify their own goals and values and to express their own reasons for change.

Roll with resistance (avoid argument)

A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the patient to consider new information and perspectives on their substance use. When the patient expresses resistance, the health worker should reframe it or reflect it rather than opposing it. It is particularly important to avoid arguing in favor of change as this puts the patient in the position of arguing against it.

Support self efficacy (confidence)

As discussed above patients need to believe that reducing or stopping their substance use is important and be confident that they are able to do so. Using negotiation and confidence building to persuade patients that there is something that they can do is an important part of motivational interviewing. The therapist's belief in the patient's ability to change their behavior is also important and can become a self-fulfilling prophecy.

Specific Skills

Motivational interviewing makes use of five specific skills. These skills are used together to encourage patients to talk, to explore their ambivalence about their substance use, and to clarify their reasons for reducing or stopping their substance use[13]. The first four skills are often known by the acronym OARS – Open-ended questions, Affirmation, Reflective listening, and Summarizing. The fifth skill is 'eliciting change talk' and involves using the OARS to guide the patient to present the arguments for changing their substance use behavior.

OARS

Open ended questions

Open-ended questions are questions which require a longer answer and open the door for the person to talk. Examples of open-ended questions include:

- "What are the good things about your substance use?"
- "Tell me about the not so good things about using (drug)?"
- "You seem to have some concerns about your substance use; tell me more about them."
- "What concerns you about that?"
- "How do you feel about (drug)?"
- "What would you like to do about that?"
- "What do you know about (drug)?"

Affirmation

Including statements of appreciation and understanding helps to create a more supportive atmosphere, and helps build rapport with the patient. Affirming the patient's strengths and efforts to change helps build confidence, while affirming self-motivating statements (or change talk) encourages readiness to change. Examples of affirmation include:

- "Thanks for coming today."
- "I appreciate that you are willing to talk to me about your substance use."
- "You are obviously a resourceful person to have coped with those difficulties."
- "I can see that you are a really strong person."
- "That's a good idea."
- "It's hard to talk about... (drug) I really appreciate your keeping on with this."

Reflective listening

A reflective listening response is a statement guessing at what the patient means. It is important to reflect back the underlying meanings and feelings the patient has expressed as well as the words they have used. Using reflective listening is like being a mirror for the person so that they can hear the therapist say what they have communicated.

Reflective listening shows the patient that the therapist understands what is being said or can be used to clarify what the patient means. Effective reflective listening encourages the patient to keep talking and you should allow enough time for that to happen.

In motivational interviewing reflective listening is used actively to highlight the patient's ambivalence about their substance use, to steer the patient towards a greater recognition of their problems and concerns, and to reinforce statements indicating that the patient is thinking about change. Examples include:

- "You are surprised that your score shows you are at risk of problems."
- "It's really important to you to keep your relationship with your boyfriend."
- "You're feeling uncomfortable talking about this."
- "You're angry because your wife keeps nagging you about your substance use."
- "You would like to cut down your substance use at parties."
- "You really enjoy your substance use and would hate to give it up, and you can also see that it is causing some financial and legal problems."

Summarize

Summarizing is an important way of gathering together what has already been said and preparing the patient to move on. Summarizing adds to the power of reflective listening especially in relation to concerns and change talk. First patients hear themselves say it, then they hear the therapist reflect it, and then they hear it again in the summary. The therapist chooses what to include in the summary and can use it to change direction by emphasizing some things and not others. It is important to keep the summary succinct. An example of a summary appears below.

"So you really enjoy using speed and ecstasy at parties and you don't think you use any more than your friends do. On the other hand you have spent a lot more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills and your credit cards have been cancelled. Your partner is angry and you really hate upsetting him. As well, you have noticed that you are having trouble sleeping and you're finding it difficult to remember things."

Eliciting change talk

The fifth skill 'eliciting change talk' is a strategy for helping the patient to resolve ambivalence and is aimed at enabling the patient to present the arguments for change. There are four main categories of change talk:

- Recognizing the disadvantages of staying the same
- Recognizing the advantages of change

- Expressing optimism about change
- Expressing an intention to change.

There are a number of ways of drawing out change talk from the patient.

- Asking direct open questions; for example:

  "What worries you about your substance use?"
  "What do you think will happen if you don't make any changes?"
  "What would be the good things about cutting down your substance use?"
  "How would you like your life to be in five years time?"
  "What do you think would work for you if you decided to change?"
  "How confident are you that you can make this change?"
  "How important is it to you to cut down your substance use?"
  "What are you thinking about your substance use now?"

- Use the importance and confidence rulers (see figure 3 and figure 4, Miller and Rollnick[13]) suggest using the ruler to obtain the patient's rating and then asking the following two questions.

  "Why are you at a (eg. 3) and not a 0?" This gets the patient to verbally justify, or defend, their position which can act to motivate the patient to change.

  "What would it take for you to go from a (eg. 3) to a (eg. 6) (a higher number)?" This gets patients to verbalize possible strategies for change and gets them to start thinking more about change.

- Probe the decision balance (see figure 2) by encouraging the patient to talk about the benefits of change and the costs of staying the same.

- Ask the patient to clarify or elaborate their statements - for example, a person who reports that one of the less good things about using cocaine is having panic attacks could be asked:

  "Describe the last time this happened."
  "What else?"
  "Give me an example of that."
  "Tell me more about that?"

- Ask the patient to imagine the worst consequences of not changing or the best consequences of changing.

- Explore the patient's goals and values to identify discrepancies between the patient's values and their current substance use. For example, ask:

  "What are the most important things in your life?"

[12] Miller W. (1983) Motivational interviewing with problem drinkers. Behavioural Psychotherapy. 11:147-172
[13] Miller W, Rollnick S (2002) Motivational Interviewing. 2nd Edition. Guilford Press New York and London.

SBIRT CONSIDERATIONS FOR SPECIAL POPULATIONS

While it is important to recognize the unique characteristics and risks of each of the groups noted here, it is most important to ask about alcohol and other drug use universally. Tools designed for these unique groups can help approach patients in a nonjudgmental and respectful way that elicit honest responses that can help you develop an appropriate and effective brief intervention.

Women of Childbearing Age

Women are affected by alcohol more quickly than men,[41] so safe drinking limits are lower than those for men. Recent research is implicating even moderate alcohol use in development of breast cancer.[42] Substance use can be uniquely harmful during and after pregnancy. "One half of pregnancies are unplanned and this has led to a recent paradigm shift in primary care to treat all women of childbearing age as potentially pregnant (preconception care)."

There is no known safe amount of alcohol or drug use when pregnant.

Screening of pregnant or potentially pregnant women adds some level of complexity. Questions that may be appropriate for the general population may not elicit honest responses from this group of women – especially those who may be concerned about losing custody of their children. Yet, pregnancy presents an opportunity to take advantage of increased motivation to change and live a healthy lifestyle.

Questionnaires of a more relational nature – such as the 5 P's – are recommended for use with pregnant or potentially pregnant women. For more information about screening women of childbearing age, see the ***Protecting Women and Babies from Alcohol and Drug Affected Births: Tools and Resources*** toolkit available at **www.maclearinghouse.com** under Alcohol and Drugs.

Adolescents

All drugs – including tobacco and alcohol – are illegal for adolescents. Their bodies and brains are still developing and the substances they consume may impact this development. Recent research indicates that the earlier a youth starts using alcohol the greater the risk of lifetime substance dependence problems.[43]

The CRAFFT screening tool has been validated for use with this age group and is one of the tools approved for use by the Massachusetts Children's Behavioral Health Initiative. The CRAFFT Toolkit is available at **www.masspartnership.com/pcc/pdf/CRAFFTScreeningTool.pdf.**

Older Adults

With age comes increased sensitivity and decreased tolerance for alcohol, drugs, and medications. Over time, an older person whose drinking patterns haven't changed may find s/he has a problem. Aging bodies are less able to metabolize alcohol or drugs. In addition, older persons have a greater likelihood of using multiple prescription medications that can increase their risk for harm when alcohol or other drugs are combined. Interactions between alcohol and medications can also increase the risk of falls and accidents.

The guidelines recommend men and women over age 65 should have no more than 3 drinks in a day and no more than 7 drinks in a week.

Aging adults are a growing population. It's estimated people over 65 will be 20% of the population by 2030. Some older adults have used alcohol throughout their lives and some others may start in their older years as additional free time, losses and other changes impact them. The oldest of the baby boom generation have started turning 65 and many in this generation are more comfortable with a variety of drugs – legal and illegal – than previous generations of older adults.

There are age appropriate screening tools for this group, such as the G MAST. This tool is available as part of the ***Provider Update: Alcohol and Medication Issues for Older Adults*** available at **www.maclearinghouse.com** under Alcohol and Drugs.

Other Languages

While much SBIRT research and implementation has been international, it may be difficult to access appropriate translated screening tools. Another complication is that few nations use the same measurement standards as the US.

Page 12 of the NIAAA Clinicians' Guide available at the back of this toolkit contains a Spanish translation of the AUDIT screening tool. A Spanish version of the DAST-10 can be accessed in the following publication, Bedregal LE, Sobell LC, Sobell MB, Simco E. Psychometric characteristics of a Spanish version of the DAST-10 and the RAGS. *Addict Behav*. 2006; 31(2): 309-319.

NMHA Screening and Brief Intervention Toolkit for the Hispanic Patient

This toolkit was developed by the National Hispanic Medical Association (NHMA). It provides a summary of existing screening tools with a recommendation by Hispanic physicians; a quick reference card (English and Spanish) that can be used for brief interactions with patients; and a guide to communicating effectively with Hispanic patients developed with input from members of the National Hispanic Medical Association. **www.nhmamd.org/files/alcoholToolkit.pdf**

The ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) screening tool, was developed for the World Health Organization (WHO) and has been translated and validated into several languages. For more information visit: **www.who.int/substance_abuse**.

The CAGE has been validated in Spanish.[44]

CAGE Questions in Spanish

1. ¿Ha tenido usted alguna vez la impresión de que debería beber menos?

2. ¿Le ha molestado alguna vez la gente criticándole su forma de beber?

3. ¿Se ha sentido alguna vez mal o culpable por su costumbre de beber?

4. ¿Alguna vez lo primero que ha hecho por la mañana ha sido beber para calmar los nervios o para librarse de una goma (una resaca)?

Saitz R, Lepore MF, Sullivan LA, Amaro H, Samet J. Alcohol Abuse and Dependence in Latinos Living in the United States: Validation of the CAGE (4M) Questions. *Arch Intern Med.* 1999; 159:718-724.

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