SBIRT in the Perinatal Period: Counseling patients on tobacco, alcohol and drug use

Tricia E. Wright, MD MS FACOG FASAM
Associate Professor Department of Obstetrics, Gynecology and Women’s Health
Clinical Associate Professor Psychiatry
University of Hawaii JABSOM, Honolulu, HI

Objectives

• Realize the importance of screening all women of childbearing age for substance use
• Incorporate validated screening tools into clinical visits
• Identify motivational interviewing techniques so that a positive screen doesn’t throw the entire office schedule into disarray
• List some risks of alcohol, tobacco and drug use during pregnancy
Why Bother?

- Reasons not to talk about substance use:
  - “No time” - Too many other things to do in short clinic visit
  - Don’t know how to ask
  - “Not my job” - Not trained as a therapist/counselor
  - No one to refer to
  - Lack of reimbursement
  - My patients don’t have drug problems
  - Patients won’t change anyway

- 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
Postpartum Depression

The World Health Report 2002

Percent of disability-adjusted life years

Substance problems and public health

The 10 leading risk factors for disease in developed countries

- Tobacco
- Blood pressure
- Alcohol
- Cholesterol
- Overweight
- Low fruit & veg intake
- Inactivity
- Illicit drugs
- Unsafe sex
- Iron deficiency

Percent of disability-adjusted life years

The World Health Report 2002
Social Costs USA

- National estimates of costs of illness:
  - Alcohol ranks 2nd, tobacco 6th, drugs 7th

- The annual cost of substance abuse = $510.8 billion:
  - Alcohol abuse cost the Nation $191.6 billion;
  - Tobacco use cost the Nation $167.8 billion;
  - Drug abuse cost the Nation $151.4 billion.

- Diabetes ($128 billion/year) and Cancer ($210 billion/year)

- Programs designed to prevent substance abuse can reduce costs


Smoking is common among women and in pregnancy

Figure 4.5 Past Month Cigarette Use among Women Aged 15 to 44, by Pregnancy Status: Combined Years 2002-2003 to 2010-2011
Smoking behavior changes during pregnancy

Past Month Cigarette Use among Pregnant Women* Aged 15 to 44, by Trimester**: 2002-2005

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>3.3%</td>
<td>4.6%</td>
<td>4.0%</td>
<td>5.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Not pregnant</td>
<td>10.3%</td>
<td>10.2%</td>
<td>10.0%</td>
<td>9.8%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Illicit drug use is common
Drinking among women is common

NSDUH 2010/11

<table>
<thead>
<tr>
<th></th>
<th>Pregnant %</th>
<th>Not Pregnant %</th>
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</thead>
<tbody>
<tr>
<td>Current ETOH</td>
<td>9.4</td>
<td>55.1</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>2.6</td>
<td>24.5</td>
</tr>
<tr>
<td>Heavy drinking</td>
<td>0.4</td>
<td>5.3</td>
</tr>
</tbody>
</table>

First Trimester Binge Drinking

<table>
<thead>
<tr>
<th></th>
<th>2005-2006</th>
<th>2007-2008</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>4.6%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

FAS and FASD

- FAS: Prevalence 0.5–2/1000 live births (May AlResHel 2001)
- FASD: Prevalence 1/100 (Sampson Terat 1999)
- Alcohol use during pregnancy: The leading preventable cause of mental retardation
- Alcohol: leading preventable cause of birth defects
  - Affects estimated 40,000 infants each year
  - More than Spina Bifida, Down Syndrome and Muscular Dystrophy combined
FAS and the Brain

Consequences of FASD-Lifelong

- Birth defects
- Growth problems
- Cognitive delay
- Speech and language difficulties
- Mental Health Problems
- School, Work, Legal Problems
- Cost to society-$4 billion/year
### Substance problems are common

<table>
<thead>
<tr>
<th>Substance</th>
<th>Pregnant (%)</th>
<th>Not Pregnant (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>17.6</td>
<td>25.4</td>
</tr>
<tr>
<td>Drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>9.4</td>
<td>55.1</td>
</tr>
<tr>
<td>Binge</td>
<td>2.6</td>
<td>24.5</td>
</tr>
<tr>
<td>Heavy</td>
<td>0.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>5.0</td>
<td>10.8</td>
</tr>
</tbody>
</table>

NSDUH 2010/11

### Prevalence of screened for conditions in pregnancy

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic Fibrosis (Caucasians)</td>
<td>1/2500</td>
</tr>
<tr>
<td>Anemia</td>
<td>2-4%</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>2-10%</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>2-8%</td>
</tr>
<tr>
<td>Post partum depression</td>
<td>10-15%</td>
</tr>
</tbody>
</table>
Why Bother?

- Drug problems are associated with many diseases
- Drug problems are costly
- Drug problems are common among women
- In pregnancy drug problems are more common than many things we screen for

- Although universal screening recommended by ACOG (also AAP, IOM, ASAM, NIAAA, etc), rarely performed
  - Only 70% of PNC pts report being asked about smoking and alcohol (PRAMS 2009)

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

- For those with identified problems
  - Follow-up at subsequent visits

Screening: Identify patients who need further assessment or treatment

Brief Intervention

Referral to Treatment
SBIRT Process

- Not all use is problematic use
- Most people don’t have drug/alcohol problems
- Risk depends on patient population and substance
- Goal of Screening is to identify who is at risk

Screening stratifies patients into zones of misuse

Zones act as diagnostic aid and inform intervention

Risk Pyramid-Alcohol

- Alcohol dependent: 4%
- Referral to Treatment: 25%
- Risky drinkers: 25%
- Brief Intervention: 25%
- Abstainers or low-risk drinkers: 70%
- Positive reinforcement: 70%

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

- Screen
  - Positive: Brief Intervention
  - Negative: Continue with Appointment

- Brief Intervention
  - Referral and Treatment

- Follow up
SBIRT: A national initiative

- SAMHSA’s Screening, Brief Intervention, Referral and Treatment (SBIRT) cooperative agreements
- Boards and federal agencies major interest in SBIRT (JACHO; ACOG)
- American College of Surgeons’ Committee on Trauma
- Federation of State Medical Boards
- Accreditation Council for Continuing Medical Education
- Possible JCACO mandate

Evidence behind SBIRT

- More than 34 RCTs and at least 6 meta-analyses
  - Most concern alcohol in at risk or problem drinkers
  - Many in hospitalized/ED settings
- Overall outcomes
  - 10-30% reduction in ETOH consumption at 12 months
- USPSTF - Class B rating for both ETOH screening and brief interventions
  - Same rating as Flu vaccination or cholesterol screening
SBIRT effectiveness

• SBIRT leads to
• Fewer hospitalizations and ED visits
• Cost savings:
  • Screening and intervention cost per pt = $177
  • Cost savings per pt = $1170
  • Benefit/cost ratio = 6.6/1

Fleming, et al, 2002

How do we screen?
Screening

- CAGE

- T-ACE
  - Tolerance (>=2 drinks) = 1 pt.
  - Annoyed = 1 pt.
  - Cut Down = 1 pt.
  - Eye Opener = 1 pt.
  Positive test is >= 2 pts.

- T-WEAK
  - Tolerance (>= 2 drinks) = 2 pts.
  - Worry = 2 pts.
  - Eye Opener = 1 pt.
  - Amnesia = 1 pt.
  - Kut down = 1 pt.
  Positive test is >=3 highly suggestive of problem drinking

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?
  - Have you ever smoked?
  - How much alcohol did you drink before you got pregnant?
  - Have you ever used drugs?”
- Not: “You don’t do drugs, do you?”
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
Reasons for Lack of Screening

- Lack of training
- Skepticism about treatment
- Discomfort discussing alcohol or drug use/abuse
- Patient resistance
- Time/financial constraints

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 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

Using

- What’s good about using
- What’s not so good about using

Stopping

- What’s good about stopping
- What’s not so good about stopping

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-Risks of Tobacco

• Preterm labor (delivery before 37 weeks)
• Small for gestational age
• Abruption (placental separation)
• Developmental difficulties (ADHD/LD)
• SIDS
• Childhood asthma
• ?Childhood obesity
Rolling with Resistance

- Are you ready to quit smoking?
  - (note closed ended question)
- No. Clearly meeting some resistance.
- So it sounds like you really like smoking and are not ready to quit at all.
- I wouldn’t say I’m not ready to quit at all, but not right now.
- When do you think you’ll be ready.

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
Feedback-Drugs

- Methamphetamines
  - Preterm Labor
  - Abruption
  - Small for gestational age
  - Developmental Difficulties (ADHD/LD)
  - Preeclampsia
  - Maternal cardiac problems
- Opioids
  - Preterm labor
  - Neonatal abstinence syndrome
  - Maternal risk of overdose death

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)

Brief Intervention in Action

If all else fails...

Rule of Thumb
- 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.
- 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)
At this point...

- Perhaps you completed Brief Intervention (BI) with a patient and can schedule follow up appointment. However, more might be needed for some patients.

- When is this the case?
  - Detox or needs more intensive treatment setting
  - Problem too severe for BI
  - You want further assessment
  - Patient wants more assistance

Referral and Treatment

- For patients needing more extensive treatment than SBIRT, referral to specialized treatment provider may be necessary.

- Referral to treatment is integral component of SBIRT and necessitates strong collaboration between SBIRT provider or team and substance abuse treatment providers in your agency or in community.

- Know your community resources!
Decision Tree Example

Screen

Negative

Continue with Appointment

Positive

Referral and Treatment

Brief Intervention

Follow up

Referral Process

Steps involved in a Referral
1. Assess client referral needs
2. Plan the referral
3. Help client access referral services
4. Document Referral
5. Feedback and Follow-up

Although this may be done by someone else in your setting, it is important that you remain involved and updated
In conclusion

- “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 2005

- SBIRT has been shown to:
  - Decrease frequency and severity of drug and alcohol use,
  - Reduce risk of trauma, and
  - Increase percentage of patients who enter specialized substance abuse treatment.

- This process can be adapted to use in any health setting for a variety of health behaviors and diverse populations.

Resources

- Alcohol, drug, and/or mental health problems treatment referral and information: SAMHSA’s National Helpline:
  - 1-800-662-HELP 24 hours, free and confidential
    http://www.samhsa.gov/treatment

- American Society of Addiction Medicine www.asam.org

- American Academy of Addiction Psychiatry www.aaap.org

- http://www.motivationalinterview.net/training/miorderform.pdf

Web-based Trainings

- [www.smokingcessationandpregnancy.org](http://www.smokingcessationandpregnancy.org)
  - Excellent web-based virtual clinic with actual and simulated patients.
  - $25 access for 1 year. Free for residents.
  - CDC, Dartmouth, ACOG

  - Developed by ACOG
  - Free, includes 3 hours CME

  - Free CME

- [http://www.sbirtraining.com](http://www.sbirtraining.com)
  - Developed by ASAM (American Society for Addiction Medicine)
  - $50 includes 4 hours CME

Questions?