Clinical Practice Guidelines (CPG): Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

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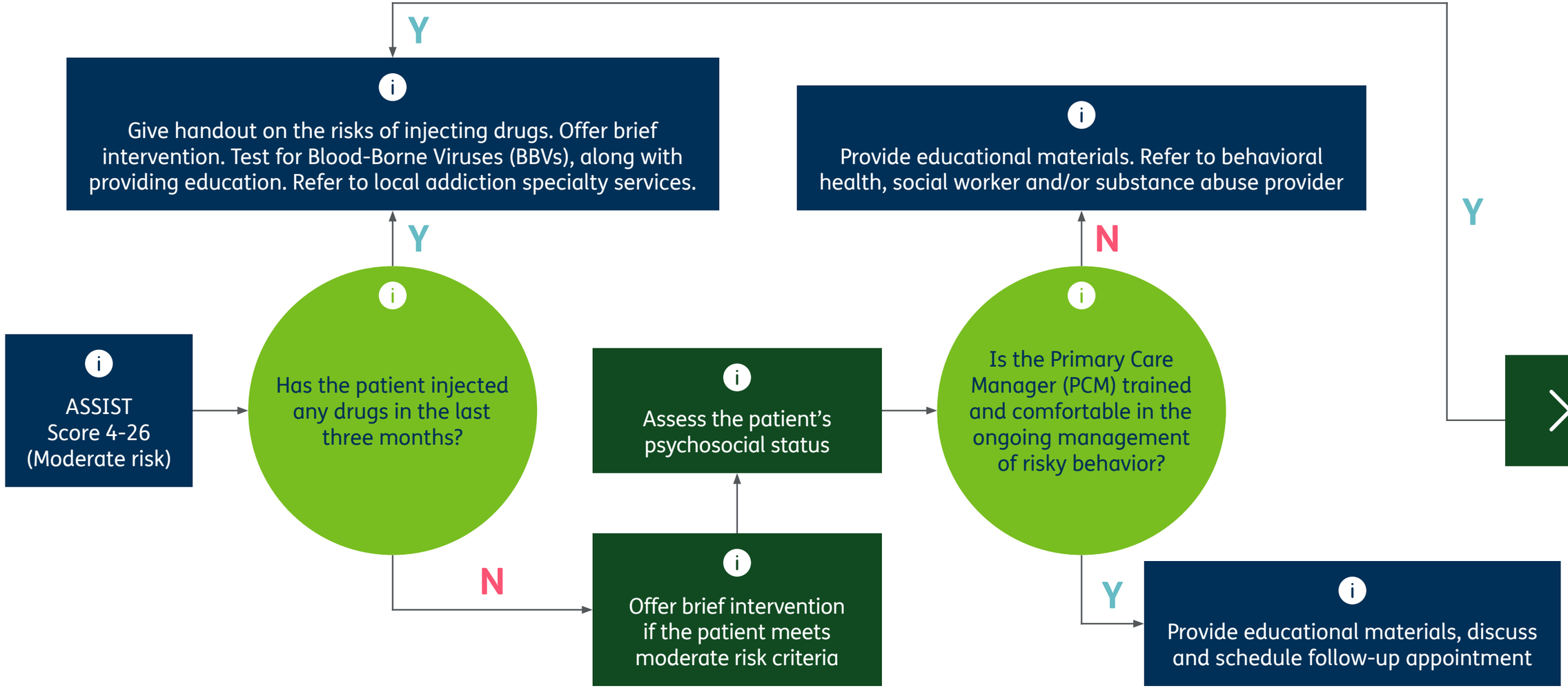
Clinical Practice Guidelines (CPG): Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)



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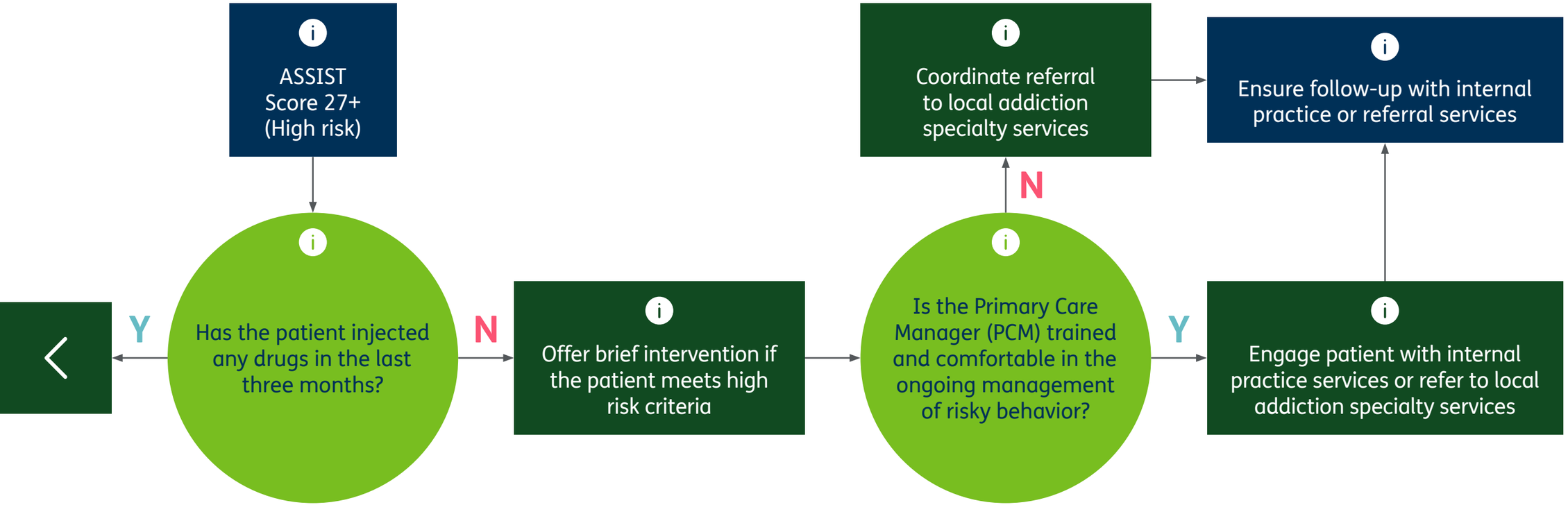
Clinical Practice Guidelines (CPG): Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)



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ASSIST Score 0-3 (Low risk)

An ASSIST score of 0-3 means the individual is at low risk of health and other problems from his/her current opioid use.

When discriminating between opioid use and abuse, the ASSIST tool has a sensitivity (true positive) of 94% and a specificity (true negative) of 96%. [6,10,13,17]

Refer to the following screening sections for background information and secondary screening tools.

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Confirm that score of 0-3 is consistent with the clinical impression and review of PDMP.

The provider should confirm that his/her clinical impression is consistent with the patient's low risk score.

If the score is inconsistent with the provider's clinical impression, it may be best to consider addressing this issue at a follow-up visit, as some patients may have a difficult time accepting that they may have a problem with opioids or other substances. Resistance to change is normal, and it is important to avoid arguing with a patient around these issues.

Reviewing state Prescription Drug Monitoring Programs (PDMP) may further assist with confirming screening score results. State PDMPs allow practitioners to review information about patient-specific use of controlled substance prescriptions, such as opioid analgesics, benzodiazepines, and stimulants. These electronic databases aid in reducing misuse, abuse, diversion, and overdose by tracking prescription and dispensary behaviors. PDMPs can also be used to confirm the accuracy of screening results and to determine any inconsistencies between screening responses and PDMP data.

Each state has its own specific prescriber use mandates delineating database use frequency, prescribing restrictions, and which drugs prompt PDMP review. Since PDMP policies vary from state to state, it is recommended to review a specific state PDMP at pdmpassist.org or go directly to the specific state PDMP website. [22,23]

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Reinforce positive behavior. Briefly educate the patient regarding risks of OUD, discuss any needed follow-up.

Screening not only identifies those at risk for opioid misuse or OUD, but also identifies those engaging in healthy behaviors. Providers should reinforce healthy behaviors that are contributing to an individual's healthy status.

Providing low-risk individuals with verbal and/or written educational material may be beneficial as it may enhance general knowledge about the risks of opioid misuse and aid in identifying risky behavior in others. Additionally, such materials may act as a reminder of the dangers associated with OUD in individuals with a past medical history of OUD. [9,10]

The National Institute on Drug Abuse website can be accessed to obtain patient handout materials.

- Effects of Drugs
- FAQs About Opioids
- Pain Medicine (Oxy, Vike) Facts
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ASSIST Score 4-26 (Moderate Risk)

An ASSIST score of 4-26 means the individual is at risk of health and other problems from his/her current opioid use.

When discriminating between opioid use and abuse, the ASSIST tool has a sensitivity (true positive) of 94% and a specificity (true negative) of 96%. [6,10,13,17]

Refer to the following screening sections for background information and secondary screening tools.

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Has the patient injected any drugs in the last three months?

According to the ASSIST screening tool, individuals with drug injection use within the last three months should be asked about their injection patterns to help to determine their level of risk and best course of action.

- Injection pattern within the last three months: Once weekly or less or fewer than three days in a row should prompt a brief intervention. Education materials should be provided to the patient.
- Injection pattern within the last three months: More than once per week or three or more days in a row should prompt further assessment and more intensive treatment. The assessment and treatment may be provided by healthcare professionals in the primary care setting or referred to a specialist treatment facility.

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Offer brief intervention if the patient meets moderate risk criteria.

During brief intervention sessions, the healthcare professional provides information to increase the individual's awareness and understanding about his/her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. [9,10]

The clinician can initiate the conversation by asking:

"Are you interested in seeing how you scored on the questionnaire you just completed?" [9]

If the patient replies *"yes,"* proceed with:

"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see your score for opioids was..." [9]

"Moderate risk means that you are at risk of health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way." [26]

"Because you're in the moderate risk range for your use of opioid, the kinds of things associated with your current pattern are drowsiness, constipation, tooth decay, difficulty concentrating and remembering things, emotional problems and social problems, reduced sexual desire and sexual performance, relationship difficulties, financial and work problems, violations of law, tolerance and dependence, withdrawal symptoms, and overdose and death from respiratory failure " [26]

The number and duration of brief intervention sessions vary, typically involving 1 to 5 sessions lasting 5 to 60 minutes. The success of a brief intervention relies on a personalized and non-judgmental approach. [9,10]

The healthcare professional can choose from a variety of brief intervention approaches including motivational interviewing, FRAMES approach, OARS model, and model of behavior change. [9,16,20]

Refer to brief intervention section and Appendix D for further details.

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Assess the patient's psychosocial status.

Opioid Use Disorder (OUD) is a biopsychosocial condition and warrants obtaining a psychosocial history for all individuals.

The Primary Care Manager (PCM) should interview the patient about current alcohol, drug and tobacco use, as well as the presence or history of behavioral health and psychiatric disorders.

Relevant social and environmental factors should also be queried as well as screening for general well-being and life events. [2]

A few pertinent screening tools are listed below:

- Healthy Living Questionnaire
- Life Events Checklist
- Patient Health Questionnaire 2 (PHQ-2)
- My Mood Monitor (M-3)

This assessment may occur over numerous visits. Refer to psychosocial history section for further details.

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Give handout on the risks of injecting drugs. Offer brief intervention.Test for Blood-Borne Viruses (BBVs), along with providing education. Refer to local addiction specialty services.

If screening indicates the presence of injection drug use:

- Perform a brief intervention and provide the individual with educational materials on the risks of injecting drugs
- Inform the individual that injecting drugs is associated with an increased risk of BBVs (HIV/AIDS and hepatitis B and C) and recommend testing for these infections [6]
- Refer to specialty treatment and conduct further biopsychosocial assessment

During brief intervention sessions, the healthcare professional provides information to increase the individual's awareness and understanding about his/her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. [9,10]

The clinician can initiate the conversation by asking:

"Are you interested in seeing how you scored on the questionnaire you just completed?" [9]

If the patient replies *"yes,"* proceed with:

"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see your score for opioids was..." [9]

The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting 5 to 60 minutes. The success of a brief intervention relies on a personalized and non-judgmental approach. [9,10]

The healthcare professional can choose from a variety of brief intervention approaches including motivational interviewing, FRAMES approach, OARS model, and model of behavior change. [9,16,20]

Refer to brief intervention section and Appendix D for further details.

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Is the Primary Care Manager (PCM) trained and comfortable in the ongoing management of risky behavior?

Developing an SBIRT implementation plan involves considering the office's resources, patient population, and community resources and may enable the provider's adoption of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. [9,20]

Refer to SBIRT in the primary care setting and Appendix E for further details.

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Provide educational materials, discuss and schedule follow-up appointment.

The National Institute on Drug Abuse website can be accessed to obtain patient handout materials.

- Effects of Drugs
- FAQs About Opioids
- Pain Medicine (Oxy, Vike) Facts
- Prescription Drug Abuse

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Provide educational materials. Refer to behavioral health, social worker, and/or substance abuse provider.

The National Institute on Drug Abuse website can be accessed to obtain patient handout materials.

- Effects of Drugs
- FAQs About Opioids
- Pain Medicine (Oxy, Vike) Facts
- Prescription Drug Abuse

A referral aims to ensure the individual receives specialized assessment and appropriate treatment as well as promotes patient engagement in treatment. Referral would be particularly important for patients who document any history of injecting drugs.

The complexity of referral to treatment varies and may involve additional services, such as behavioral health services, case management and transportation needs.

It is vital to establish a communication feedback loop between the Primary Care Manger (PCM) and specialists to ensure proper patient engagement and overall medical care.

The PCM should schedule a follow-up appointment after the initial specialty appointment to confirm participation in treatment. [10]

Information on publicly funded substance use disorder treatment facilities may be found on SAMHSA's Behavioral Health Treatment Services Locater website.

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ASSIST Score 27+ (High Risk)

An ASSIST score of 27 or greater means the individual is at high risk of experiencing severe health, social, financial, and/or legal problems from his/her current opioid use.

When discriminating between opioid use and abuse, the ASSIST tool has a sensitivity (true positive) of 94% and a specificity (true negative) of 96%. [6,10,13,17]

Refer to the following screening sections for background information and secondary screening tools.

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Has the patient injected any drugs in the last three months?

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- Injection pattern within the last three months: Once weekly or less or fewer than three days in a row should prompt a brief intervention. Education materials should be provided to the patient
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Offer brief intervention if the patient meets high risk criteria.

During brief intervention sessions, the healthcare professional provides information to increase the individual's awareness and understanding about his/her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. [9,10]

The clinician can initiate the conversation by asking:

> *"Are you interested in seeing how you scored on the questionnaire you just completed?"* [9]

If the patient replies *"yes,"* proceed with:

> *"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see your score for opioids was..."* [9]

The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting five to 60 minutes. The success of a brief intervention relies on a personalized and non-judgmental approach. [9,10]

The healthcare professional can choose from a variety of brief intervention approaches including motivational interviewing, FRAMES approach, OARS model, and model of behavior change. [9,16,20]

Refer to brief intervention section and Appendix D for further details.

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Is the Primary Care Manager (PCM) trained and comfortable in the ongoing management of risky behavior?

Developing an SBIRT implementation plan considering the office's resources, patient population, and community resources and may enhance the PCM's usage of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. [9,20]

Refer to SBIRT in the primary care setting and Appendix E for further details.

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Coordinate referral to local addiction specialty services.

A referral aims to ensure the individual receives specialized assessment and appropriate treatment as well as promotes patient engagement in treatment. [10]

Opioid treatment programs may occur in inpatient hospitals, residential addiction facilities, licensed intensive outpatient clinics, and outpatient care settings. [2,22]

Quality treatment programs have the following features:

- State licensed or certified
- Prescribes FDA-approved medications to aid in recovery and prevent relapse
- Offers evidence-based therapies such as motivational intervention, cognitive behavioral therapy, counseling, and peer support
- Allows family members to participate in the treatment process
- Provides long-term treatments such as ongoing counseling, coaching and support, sober housing, employment supports

The complexity of referral to treatment varies and may involve additional services, such as behavioral health services, case management, and transportation needs.

It is vital to establish a communication feedback loop between the PCM and specialists to ensure proper patient engagement and overall medical care.

The PCM should schedule a follow-up appointment after the initial specialty appointment to confirm participation in treatment. [10]

Information on publicly funded substance use disorder treatment facilities may be found on SAMHSA's Behavioral Health Treatment Services Locater website.

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Engage patient with internal practice services or refer to local addiction specialty services.

The patient will require ongoing care, either within the internal practice or a local addition specialty facility.

The patient may also need referrals to additional services, such as behavioral health services and case management.

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Ensure follow-up with internal practice or referral services.

Reference Humana Military referral network and criteria prior to referring a patient for specialty care.

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Screening

The Screening, Brief Intervention and Referral to Treatment (SBIRT) model utilizes screening as a preliminary and vital step in identifying individuals with opioid misuse or potential OUD. It is important to note that the screening process is not intended to be a diagnostic measure. Screening allows the healthcare professional to quickly assess for risky patterns associated with opioid misuse or OUD.[10] Furthermore, screening alone is unlikely to evoke change in an individual's risky opioid behaviors and, therefore, should be used in conjunction with intervention and referral.[9]

Successful implementation of an SBIRT program requires the office to assess their patients' needs and facility resources. Such assessment will allow the SBIRT program to be specifically tailored to the office's needs, thus maximizing its benefit. Given each facility's resources, the facility must determine which population to screen, how frequently to screen, which screening instruments to use, and method of instrument administration.[10]

Choosing a screening population

The population undergoing screening is to be determined by each facility. This determination can be revised based on evolving needs. Universal screening is entirely consistent with the SBIRT paradigm. Office constraints (i.e., time, staff availability, cost, etc.) may preclude a broad approach and require a more narrow focus towards at-risk individuals. Research has identified individual risk factors associated with opioid misuse or OUD. These risk factors include a personal history of SUD, mental illness, and/or overdose. Other distinctive risk factors include younger age, psychotropic medication use, long-term or high-dose opioid use, and a family history of SUD.[11] Additional aberrant behaviors that should prompt screening include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that non-opioid medications are ineffective, and the need for opioid-only therapy.[12]

Choosing a screening tool

Each facility should select a screening tool that best meets their practice's needs. An overall pragmatic screening strategy involves the use of a pre-screening tool followed by a secondary instrument to stratify risk, when indicated. Pre-screening tools provide the means to quickly evaluate risky opioid behaviors. A positive response obtained during the pre-screen requires advancing to a comprehensive secondary screening instrument. Numerous multi-question secondary screening tools have been designed for use in the primary care setting to identify the individual's level of risk.[9,10]

Screening tools may be administered by face-to-face interview, written self-report on a form, or use of a computerized program. Some screening questionnaires for opioid use are embedded in other health and lifestyle behaviors questions (such as cocaine, alcohol consumption, depression, and tobacco use).[10]

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Screening

The Screening, Brief Intervention and Referral to Treatment (SBIRT) model utilizes screening as a preliminary and vital step in identifying individuals with opioid misuse or potential OUD. It is important to note that the screening process is not intended to be a diagnostic measure. Screening allows the healthcare professional to quickly assess for risky patterns associated with opioid misuse or OUD.[10] Furthermore, screening alone is unlikely to evoke change in an individual's risky opioid behaviors and, therefore, should be used in conjunction with intervention and referral.[9]

Successful implementation of an SBIRT program requires the office to assess their patients' needs and facility resources. Such assessment will allow the SBIRT program to be specifically tailored to the office's needs, thus maximizing its benefit. Given each facility's resources, the facility must determine which population to screen, how frequently to screen, which screening instruments to use, and method of instrument administration.[10]

Choosing a screening population

The population undergoing screening is to be determined by each facility. This determination can be revised based on evolving needs. Universal screening is entirely consistent with the SBIRT paradigm. Office constraints (i.e., time, staff availability, cost, etc.) may preclude a broad approach and require a more narrow focus towards at-risk individuals. Research has identified individual risk factors associated with opioid misuse or OUD. These risk factors include a personal history of SUD, mental illness, and/or overdose. Other distinctive risk factors include younger age, psychotropic medication use, long-term or high-dose opioid use, and a family history of SUD.[11] Additional aberrant behaviors that should prompt screening include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that non-opioid medications are ineffective, and the need for opioid-only therapy.[12]

Choosing a screening tool

Each facility should select a screening tool that best meets their practice's needs. An overall pragmatic screening strategy involves the use of a pre-screening tool followed by a secondary instrument to stratify risk, when indicated. Pre-screening tools provide the means to quickly evaluate risky opioid behaviors. A positive response obtained during the pre-screen requires advancing to a comprehensive secondary screening instrument. Numerous multi-question secondary screening tools have been designed for use in the primary care setting to identify the individual's level of risk.[9,10]

Screening tools may be administered by face-to-face interview, written self-report on a form, or use of a computerized program. Some screening questionnaires for opioid use are embedded in other health and lifestyle behaviors questions (such as cocaine, alcohol consumption, depression, and tobacco use).[10]

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Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The ASSIST (version 3.0) is an eight-item screening tool developed by the World Health Organization. Items cover use of alcohol, tobacco, and various prescription drugs as well as illicit substances, including opioids. It has been internationally tested and validated for use in adults in the primary care setting. It takes less than 10 minutes for the healthcare professional to administer the questionnaire to the individual. A risk score for each substance is assigned to one of three categories: low risk (0-3), moderate risk (4-26), and high risk (>27). Individuals categorized as moderate risk should receive brief intervention, whereas individuals categorized as high risk should undergo further assessment and be referred for more intensive treatment. When discriminating between opioid use and abuse, this instrument is sensitive (94%) and specific (96%). This tool is available in multiple languages.[6,10,13,17]

Drug Abuse Screening Test (DAST-10)

The DAST-10 consists of 10 yes/no questions assessing use of various classes of drugs in adults over the past 12 months. This brief tool is both reliable and valid for use in different healthcare settings. The tool can be administered as a self-report instrument (available in paper format and electronically) or in interview format and takes approximately five minutes to complete. The risk score categories are healthy (0), risky (1-2), harmful (3-5), and severe (6+). The severe category is suggestive of substance use problems and these individuals should undergo further assessment and be referred to specialized treatment. The DAST-10 correlated very high with the DAST-20. This screening instrument has a sensitivity of 80-85% and a specificity of 78-88%. This tool is available in several languages and may require a fee associated with its electronic use.[6,10,13,18]

Tobacco, Alcohol, Prescription medications, and other Substance (TAPS-2)

The TAPS-2 tool is the secondary screening tool to the pre-screen TAPS-1 tool and assesses more detailed use-related behaviors. Risk categories include no use in past three months (0), problem use (1), and higher risk (2+).[15] With respect to substances other than tobacco, alcohol, and marijuana, individuals scoring 1+ should receive further assessment. Despite TAPS having acceptable sensitivity and specificity for tobacco, alcohol, and marijuana, it is not yet suitable for detecting opioid misuse or OUD. Therefore, no further discussion of TAPS will occur within this guideline.[19]

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The healthcare professional initiates the screening process by using either a valid pre-screening or secondary screening tool to assess the presence of opioid misuse or OUD. Based on screening results, the healthcare professional can then identify an individual's risk level and determine the appropriate next step based on this information (see Appendix C). If screening determines that an individual's opioid use patterns fall in the moderate, risky, or harmful risk categories, a brief intervention follows.[9,10]

Provider response to healthy or low-risk categories

Screening not only identifies those at risk for opioid misuse or OUD, but also identifies those engaging in healthy behaviors. Providers should reinforce healthy behaviors that are contributing to an individual's healthy, low-risk, or risky status. Providing low-risk individuals with verbal and/or written educational material may be beneficial as it may enhance general knowledge about the risks of opioid misuse and aid in identifying risky behavior in others. Additionally, such materials may act as a reminder of the dangers associated with OUD in individuals with a past medical history of OUD.[9,10] The National Institute on Drug Abuse website can be accessed to obtain patient handout materials.

Provider response to risky, moderate-risk or harmful categories

If a secondary screen indicates the presence of risky behaviors, moderate risk, or harmful use, the PCM or designated interventionist may proceed to the brief intervention phase. During this portion of the protocol, the healthcare professional provides information to increase the individual's awareness and understanding about his or her inappropriate opioid use. The healthcare professional also assesses the individual's motivation toward behavioral change and provides advice on how to influence positive change. The healthcare professional and the individual engage in a collaborative effort to establish realistic goals and next steps. The number and duration of brief intervention sessions vary, typically involving one to five sessions lasting 5 to 60 minutes. The success of a brief intervention relies on a personalized and non-judgmental approach.[9,10]

The healthcare professional can choose from a variety of brief intervention approaches aimed at patient education and motivation towards reducing risky opioid use.[10]

Motivational interviewing

One such approach is motivational interviewing, which is a method that uses client-centered counseling to prompt behavior change. This method promotes an empathetic approach to reduce resistance thus encouraging the individual to discuss his or her ambivalence towards behavior change. Such admissions may foster a greater chance of success in later therapies, if indicated.[9,16,20]

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FRAMES approach

FRAMES may be used in collaboration with motivational interviewing. The elements of FRAMES are:[9,20]

- Feedback: The healthcare provider offers feedback on the dangers of misusing opioids.
- Responsibility: The individual is encouraged to accept responsibility for his or her behavior and decisions to address the opioid misuse.
- Advice: The healthcare provider clearly describes the harms and risk associated with opioid misuse.
- Menu of options: The healthcare provider communicates various strategies aimed at reducing opioid misuse.
- Empathy: The healthcare provider employs an empathetic, non-judgmental approach through reflective listening.
- Self-efficacy: The healthcare provider instills confidence in the individual that he or she is capable of change.

Open-ended questions, Affirming, Reflective listening, Summarizing (OARS) model

The techniques of the OARS model employ an interactive approach centered on the individual with motivational interviewing. The healthcare provider uses both verbal responses and non-verbal behaviors to develop rapport and assess the individual's needs to help create a trusting environment. The OARS acronym stands for:[20]

- Open-ended questions: These questions encourage a more robust dialogue since it fosters engagement with the individual. These questions typically begin with "how," "what," or "tell me about."
- Affirmations: The healthcare provider uses encouragement and positive assertion that the individual is being heard and understood.
- Reflective listening: Active listening ensures that the individual's message is being understood by the healthcare provider through reciprocation.
- Summarizing: The healthcare provider revisits the main concerns of the discussion, which may then lead into confirmation of mutual next steps.

Model of behavior change

A widely accepted model utilized within brief intervention is the stage of change model. This framework provides an understanding and assessment of an individual's process to change. The stages consist of pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Participation in each stage is not determined by any set period of time and the individual may cycle between stages. The healthcare professional may provide motivation specific to the individual's stage of change. Appropriate stage interventions may then be tailored specific to the individual's readiness to institute change pertaining to his or her risky opioid behaviors.[20]

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Time constraints are ever present within the primary care setting. At a minimum, the selected brief intervention approach employed by the healthcare team should address certain distinct communication points. The process begins by providing tailored feedback based on the individual's responses to the screen. Comparing the responses to expected norms may provide perspective on the individual's aberrant behavior. Promoting open communication will allow the healthcare provider to gauge the individual's view regarding his or her opioid misuse. This will also allow opportunity to ascertain the individual's goals or empathetically provide suggestive goals according to the individual's specific circumstances. Educational materials should be provided to the individual and a follow-up appointment should be scheduled.[9]

Refer to Appendix D for a sample of a step-by-step brief intervention for moderate-risk individuals. For a shorter three-minute intervention, use only the first five steps.

Provider response to high-risk or severe categories

Screening scores classifying the individual as high or severe risk warrant brief intervention and a referral to specialized treatment.[6,10,13,18] While not intended to treat individuals identified with serious opioid use issues, brief intervention may be beneficial in encouraging this population to pursue intensive treatment.

Refer to the Substance Abuse and Mental Health Services Administration and US Department of Health and Human Services (SAMHSA-HHS) website for additional resources on brief intervention.

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- Advice: The healthcare provider clearly describes the harms and risk associated with opioid misuse.
- Menu of options: The healthcare provider communicates various strategies aimed at reducing opioid misuse.
- Empathy: The healthcare provider employs an empathetic, non-judgmental approach through reflective listening.
- Self-efficacy: The healthcare provider instills confidence in the individual that he or she is capable of change.

Open-ended questions, Affirming, Reflective listening, Summarizing (OARS) model

The techniques of the OARS model employ an interactive approach centered on the individual with motivational interviewing. The healthcare provider uses both verbal responses and non-verbal behaviors to develop rapport and assess the individual's needs to help create a trusting environment. The OARS acronym stands for:[20]

- Open-ended questions: These questions encourage a more robust dialogue since it fosters engagement with the individual. These questions typically begin with "how," "what," or "tell me about."
- Affirmations: The healthcare provider uses encouragement and positive assertion that the individual is being heard and understood.
- Reflective listening: Active listening ensures that the individual's message is being understood by the healthcare provider through reciprocation.
- Summarizing: The healthcare provider revisits the main concerns of the discussion, which may then lead into confirmation of mutual next steps.

Model of behavior change

A widely accepted model utilized within brief intervention is the stage of change model. This framework provides an understanding and assessment of an individual's process to change. The stages consist of pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Participation in each stage is not determined by any set period of time and the individual may cycle between stages. The healthcare professional may provide motivation specific to the individual's stage of change. Appropriate stage interventions may then be tailored specific to the individual's readiness to institute change pertaining to his or her risky opioid behaviors.[20]

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Time constraints are ever present within the primary care setting. At a minimum, the selected brief intervention approach employed by the healthcare team should address certain distinct communication points. The process begins by providing tailored feedback based on the individual's responses to the screen. Comparing the responses to expected norms may provide perspective on the individual's aberrant behavior. Promoting open communication will allow the healthcare provider to gauge the individual's view regarding his or her opioid misuse. This will also allow opportunity to ascertain the individual's goals or empathetically provide suggestive goals according to the individual's specific circumstances. Educational materials should be provided to the individual and a follow-up appointment should be scheduled.[9]

Refer to Appendix D for a sample of a step-by-step brief intervention for moderate-risk individuals. For a shorter three-minute intervention, use only the first five steps.

Provider response to high-risk or severe categories

Screening scores classifying the individual as high or severe risk warrant brief intervention and a referral to specialized treatment.[6,10,13,18] While not intended to treat individuals identified with serious opioid use issues, brief intervention may be beneficial in encouraging this population to pursue intensive treatment.

Refer to the Substance Abuse and Mental Health Services Administration and US Department of Health and Human Services (SAMHSA-HHS) website for additional resources on brief intervention.

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3. **Advise on how to reduce risk associated with opioid misuse. It is important to avoid judging, embarrassing, or criticizing the patient, as this may lead to resistance.**

   "The best way you can reduce your risk of these things (harms) happening to you is to either cut down or stop using (drug)."

4. **Encourage patients to accept responsibility for their behavior and decisions to address the opioid misuse.**

   "What you do with this information about your drug use is up to you… …I'm just letting you know the kinds of harms associated with your current pattern of use."

5. **Ask patients if they are concerned about their scores.**

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8. **Summarize the patient's comments about his or her opioid use while emphasizing the negative aspects of using opioids.**

   "So you like drinking because it relaxes you and the first couple of drinks make you feel happy and talkative and confident when you're out… but you don't like that you find it difficult to stop drinking once you've started and that you usually get into arguments when you're drinking that often result in you saying or doing things that you regret the next day, including ending up in hospital last week because you were injured in a fight…"

9. **Ask patients if they are concerned about the negative aspects of using opioids.**

10. **"Do the less good things concern you? How?"**

11. **Provide patient with education materials.**

    "People find this booklet useful if they're thinking about whether or not they want to cut down on their substance use, and if they do want to cut down, then it provides them with some useful strategies for helping them to cut down or stop."

Reference: Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

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1. Creating a team. This team should consist of a “champion” to rally support, an office manager who is tasked with plan execution, and appropriate interdisciplinary providers.
2. Organization leadership buy-in. This buy-in effort will help establish or modify resource allocations.
3. Overcoming stigma. Educating leaders and office staff about SBIRT successes may help counteract stigmas associated with OUD.
4. Choosing a screening strategy. Given each facility’s resources, the facility must determine which population to screen, how frequently to screen, which screening instruments to use, and how to administer the instrument.
5. Electronic Medical Record (EMR) facilitation. EMR allows for more efficient documentation and usage of SBIRT tools as well as communication among providers.
6. Choosing a brief intervention strategy. Identify staff members responsible for conducting brief interventions and ensuring adequate training is provided.
7. Establishing referral resources. Identifying opioid use disorder resources within the community and creating a referral strategy system.
8. Employee training. Ensure adequate training and role definition for all staff involved in the SBIRT program.
9. Reimbursement. Research reimbursement mechanisms and criteria to ensure financial sustainability.
10. Ongoing quality improvement monitoring. Quality improvement initiatives provide process feedback, thus allowing for SBIRT improvements.

Reference: Pace CA and Uebelacker LA. Addressing unhealthy substance use in primary care. Med Clin N Am (2018). 102:567-586.

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Psychosocial history

Pain assessments should include a psychosocial history. The healthcare provider should interview the patient about alcohol, drug, and tobacco use, as well as the presence or history of mental health and psychiatric comorbidities. The healthcare provider should also inquire if the pain interferes with fulfilling work, school, or home obligations.[9]

Numerous instruments assessing psychosocial history are discussed in the Clinical Practice Guideline for Opioid Use Disorder in the Primary Care Setting. Refer to this guideline for detailed information describing these instruments.

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Evidence

SBIRT has a successful track record treating risky alcohol use. It is now being called into action to combat risky substance use. The clinical outcomes of using SBIRT for drug use varies among the research. Some research suggests that SBIRT purported beneficial outcomes in reducing drug use, whereas other research showed no benefit of using SBIRT to achieve abstinence or reduce medical services utilization. It is difficult to discern the effects of SBIRT specifically on opioid use since some of the studies collectively assessed various drugs. Regardless of the substance assessed, SBIRT demonstrated greater success when the PCM was directly involved in the intervention. [9]

Although the evidence surrounding SBIRT is contradictory, there are other achievable benefits from its implementation. For instance, the individual's opioid use history obtained through screening may alert the PCM to possible opioid-related complications, such as infections associated with injection drug use, sexually transmitted infections, and viral hepatitis. Such knowledge may help guide medical decisions, such as avoiding concomitant use of opioids and sedatives. [9]

Potential issues impeding implementation

Consistent screening, intervention, and treatment of individuals with risky opioid behaviors is paramount to the successful implementation of an SBIRT program in the primary care setting. Such factors contributing to a lack of engagement include time constraints, inadequate interdisciplinary staffing within the clinic, insufficient provider education regarding OUD and its subsequent management, minimal referral sources, confidentiality and compliance concerns, reimbursement and financial sustainability, stigma perceived by both providers and patients alike, and concern of disrupting provider-patient rapport when exploring unhealthy drug use. [9,20]

Implementation into clinical practice

Developing an SBIRT implementation plan considering the office's resources, patient population, and community resources may enhance the provider's adoption of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. SBIRT is a process that evolves according to the trials and errors experienced within each practice's workflow. [9,20] Points to consider when implementing SBIRT may be found in Appendix E.

Reimbursement

A critical component of a successful SBIRT program is sufficient funding and reimbursement. The office setting, staffing, and services rendered all factor into the costs incurred with implementing an SBIRT program. The individual's insurance coverage may dictate the use of SBIRT. Reimbursement may also guide the level of care provided. Terms of reimbursement and their corresponding codes vary among payers in both the public and private realm. SBIRT reimbursement codes for the insurance market include Current Procedural Terminology (CPT), Medicare G, and Medicaid Healthcare Common Procedure Coding System (HCPCS). Federal, state, and private sources provide potential funding to initiate SBIRT execution. Similarly, SAMHSA offers financial support for SBIRT initiatives at the state level as well as for private non-profit healthcare or behavioral healthcare systems. Facilities must be proactive in securing future monies to ensure sustainability. [10] The SAMHSA-HRSA website provides further detailed information on financing an SBIRT program.

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Evidence

SBIRT has a successful track record treating risky alcohol use. It is now being called into action to combat risky substance use. The clinical outcomes of using SBIRT for drug use varies among the research. Some research suggests that SBIRT purported beneficial outcomes in reducing drug use, whereas other research showed no benefit of using SBIRT to achieve abstinence or reduce medical services utilization. It is difficult to discern the effects of SBIRT specifically on opioid use since some of the studies collectively assessed various drugs. Regardless of the substance assessed, SBIRT demonstrated greater success when the PCM was directly involved in the intervention. [9]

Although the evidence surrounding SBIRT is contradictory, there are other achievable benefits from its implementation. For instance, the individual's opioid use history obtained through screening may alert the PCM to possible opioid-related complications, such as infections associated with injection drug use, sexually transmitted infections, and viral hepatitis. Such knowledge may help guide medical decisions, such as avoiding concomitant use of opioids and sedatives. [9]

Potential issues impeding implementation

Consistent screening, intervention, and treatment of individuals with risky opioid behaviors is paramount to the successful implementation of an SBIRT program in the primary care setting. Such factors contributing to a lack of engagement include time constraints, inadequate interdisciplinary staffing within the clinic, insufficient provider education regarding OUD and its subsequent management, minimal referral sources, confidentiality and compliance concerns, reimbursement and financial sustainability, stigma perceived by both providers and patients alike, and concern of disrupting provider-patient rapport when exploring unhealthy drug use. [9,20]

Implementation into clinical practice

Developing an SBIRT implementation plan considering the office's resources, patient population, and community resources may enhance the provider's adoption of the program. Such strategizing identifies facilitators and potential obstacles which will help guide the implementation process and tailor the program to the office's specific needs. SBIRT is a process that evolves according to the trials and errors experienced within each practice's workflow. [9,20] Points to consider when implementing SBIRT may be found in Appendix E.

Reimbursement

A critical component of a successful SBIRT program is sufficient funding and reimbursement. The office setting, staffing, and services rendered all factor into the costs incurred with implementing an SBIRT program. The individual's insurance coverage may dictate the use of SBIRT. Reimbursement may also guide the level of care provided. Terms of reimbursement and their corresponding codes vary among payers in both the public and private realm. SBIRT reimbursement codes for the insurance market include Current Procedural Terminology (CPT), Medicare G, and Medicaid Healthcare Common Procedure Coding System (HCPCS). Federal, state, and private sources provide potential funding to initiate SBIRT execution. Similarly, SAMHSA offers financial support for SBIRT initiatives at the state level as well as for private non-profit healthcare or behavioral healthcare systems. Facilities must be proactive in securing future monies to ensure sustainability. [10] The SAMHSA-HRSA website provides further detailed information on financing an SBIRT program.

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ASSIST: ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST	
Risk level Score	**SBIRT action**
Low risk 0-3	No intervention Reinforce positive behavior
Moderate risk 4-26	Brief intervention Provide educational materials
High risk ≥27	Brief intervention and referral to treatment Provide educational materials

Key: SBIRT: Screening, Brief Intervention and Referral to Treatment

References: Drug screening questionnaire (DAST). **sbirtoregon.org**
World Health Organization. ASSIST v3.0.

Alcohol, Smoking and Substance Involvement Screening Test

DAST-10: DRUG ABUSE SCREENING TEST	
Risk level Score	**SBIRT action**
Healthy 0	No intervention Reinforce positive behavior
Risky 1-2 Plus the following criteria: No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment	Offer advice on the benefits of abstaining from drug use Monitor and reassess at next visit Provide educational materials
Risky 1-2 Patient does not meet above risky criteria	Brief intervention
Harmful 3-5	Brief intervention or referral to specialized treatment
Severe 6+	Referral to specialized treatment

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CPG: ASSIST

Clinical Practice Guidelines (CPG): Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

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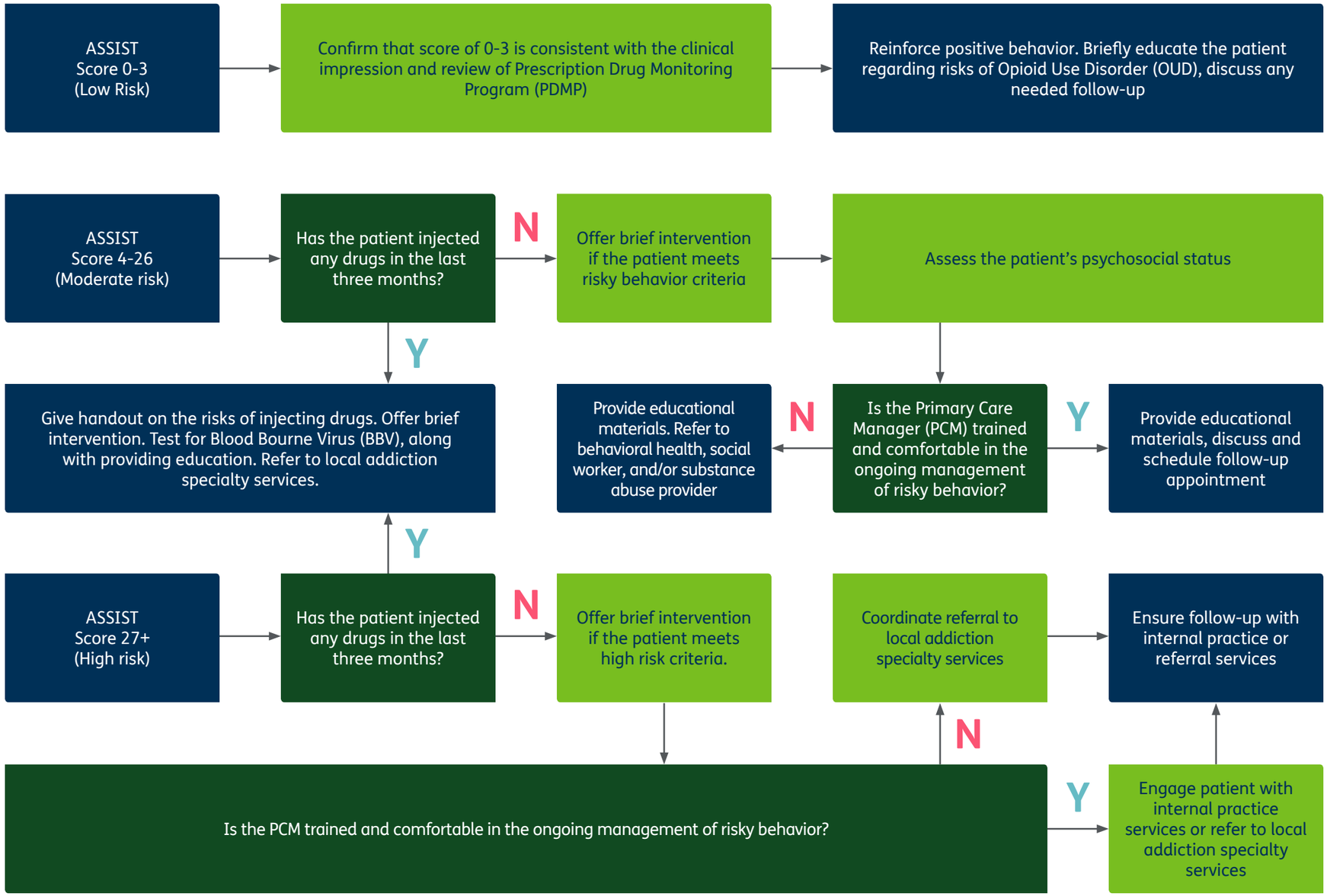

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