HRSA
Health Resources & Services Administration

Intervening Successfully with Patients Experiencing Substance Use Disorder

Behavioral Health Technical Assistance

March 17, 2022, 1:00 – 2:00 PM ET

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Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Submitting Questions and Comments

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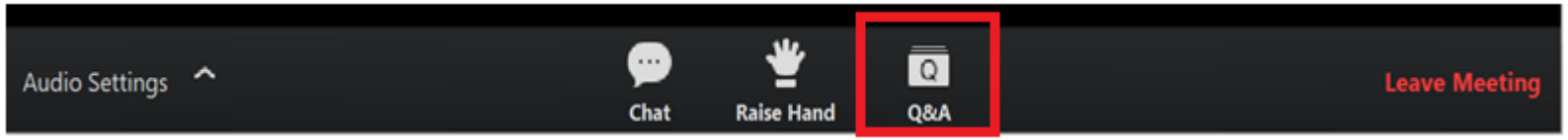

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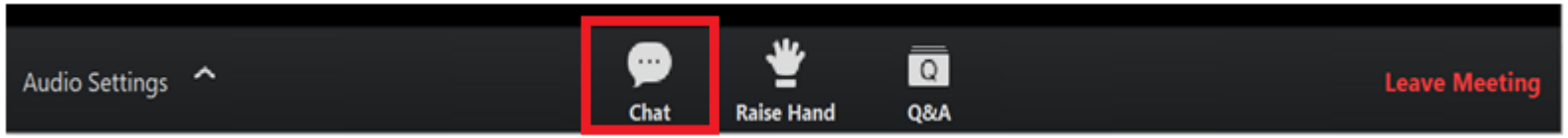

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- We will be offering 1 CE credit for attending today's E-Learning Webinar session.
- You must complete the Health Center Satisfaction Assessment at the end of the session.
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HRSA Health Center Program

Agenda

- Introductions
- Main topic: Why is it important to better understand substance use and substance use disorder (SUD), and why is it important for my health center?
- Populations of interest (e.g., transition-aged youth and persons with comorbid conditions such as chronic pain)
- Drugs of abuse
- Screening, Brief Intervention and Referral to Treatment (SBIRT): a workflow, not a program
- Evidence-based psychosocial treatments provided within health centers

Health Resources and Services Administration
Opening Remarks

Shamier Yates
Public Health Analyst, Quality Division
Office of Quality Improvement
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Health Resources and Services Administration

Presenter

- Joseph Hyde, MA, LMHC, CAS
- Behavioral Health Technical Assistance (BHTA) Project Director
- Senior Technical Expert Lead, JBS International, Inc. (JBS)

Webinar Objectives

- Participants of this webinar will be able to:
  - Help build staff member (e.g., medical, behavioral health, and support staff) understanding and buy-in for addressing risky polysubstance use and SUD within the patient population
  - Simplify a workflow for screening, brief consultation, and service engagement
  - Recognize and briefly discuss high-risk populations
  - Identify evidence-based practices that fit within health centers

Polling Question 1

- What are the most common substances of misuse?
  - Cannabis/marijuana
  - Alcohol
  - Opioids of any type
  - Methamphetamine
  - Novel synthetics (K2/Spice, etc.)

Polling Question 2

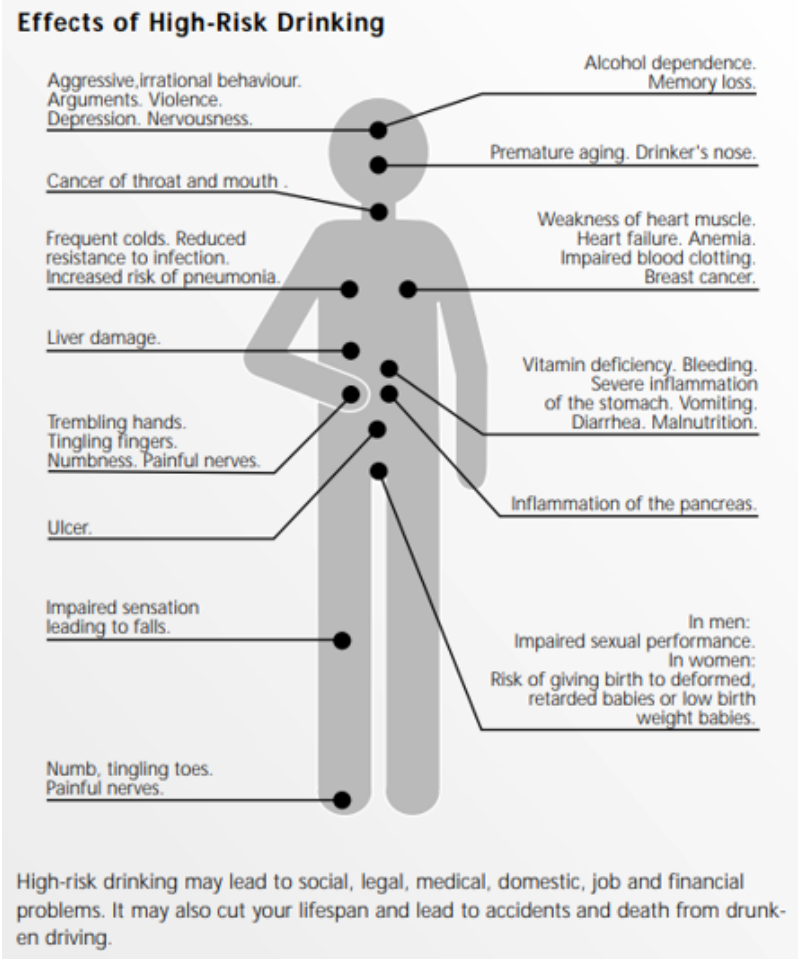
- On what specific substances would you like more information?
  - Cannabis/marijuana
  - Alcohol
  - Opioids of any type
  - Methamphetamine
  - Novel synthetics (K2/Spice, etc.)

HRSA Health Center Program

Remember – Polysubstance Misuse is Not New

- Why is it such a big concern now? The answer is simple: **Lethality!**
  - In the 70s and 80s, polysubstance use primarily included cannabis, alcohol, hallucinogens, cocaine, and, to a lesser degree, opioids
  - Polysubstance use today more frequently includes alcohol, heroin, prescription opioids, fentanyl, cannabis, methamphetamines, and synthetics
    - ✓ For those in red, the risks of overdose, neurotoxicity, organ damage, and death are significant

Medical and Psychiatric Harm from Substance Misuse



(Centre for Clinical Psychology, 2020)

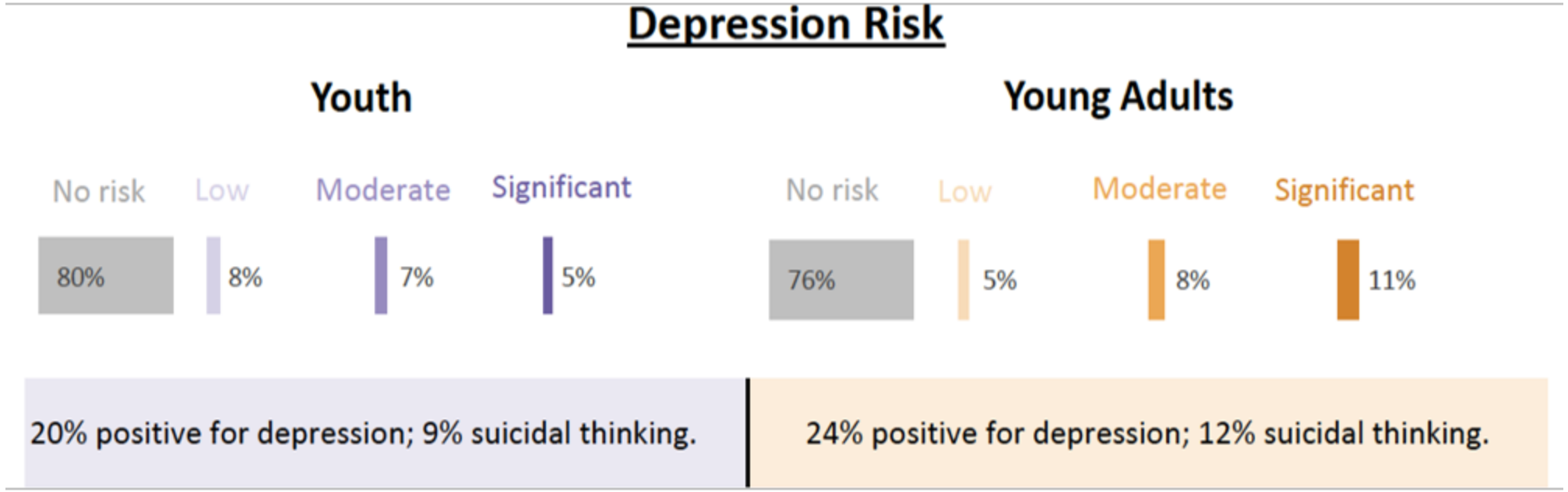
Polysubstance Misuse and Co-occurring BH Disorders

- The highest rates of polysubstance use and co-occurring mental conditions happen for transition-aged youth between ages 18 and 25. This age group has the highest rates of:
  - Polysubstance misuse
  - Accidental overdoes
  - Emerging symptoms of mental illness
  - Immaturity and poor decision-making skills
  - Certain sub-groups at highest risk

At Risk Youth (12-17 yrs.) and Young Adults (18-25 yrs.)

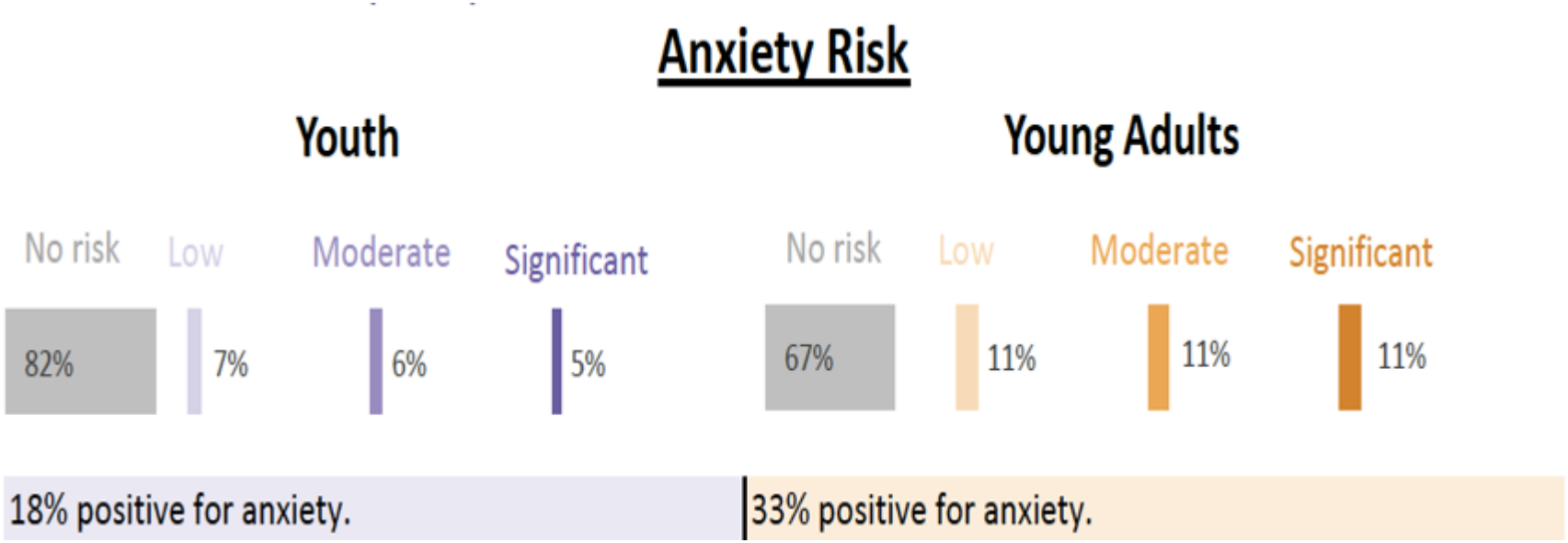
(YSBIRT Vermont, 2020)

Youth and Young Adults Risk of Depression



(YSBIRT Vermont, 2020)

Youth and Young Adults Anxiety Disorder Risk



(YSBIRT Vermont, 2020)

Aging Out of Child Welfare

- Transition-aged youth (17 – 25 yrs.) are at the highest risk when aging out of child welfare:
  - 42% reported having had a homeless experience by age 21
  - 27% are referred for SUD treatment
  - 33% experienced incarceration
  - 34% are uninsured
  - 25% had no primary care provider
  - Significant number receive primary care through either urgent care or hospital emergency departments

(National Youth in Transition Database, 2017)

High-Risk Adult Patients with Chronic Pain

- Most patients with opioid use disorder (OUD) (64.4%) had chronic pain conditions, and, among them, 61.8% had chronic pain **before** their first OUD diagnosis:
  - Pain patients are at elevated risk for major depression and suicidality 27% are referred for SUD treatment
  - In the aftermath of the issuance of Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing, many states adopted strict prescriber rules. Anecdotally, some providers report that large number of providers will no longer prescribe opioids 34% are uninsured
  - Some pain patients have resorted to purchasing opioids “off the street” or online Significant number receive primary care through either urgent care or hospital emergency departments

(Dowel, 2016; Fishbain, 1999)

Reducing Risk for Pain Patients

- Use “universal precautions” to detect concerning behaviors:
  - Treatment agreements (“contracts”)
  - Urine testing for drugs
  - Pill counts
  - Prescription monitoring
  - Care coordination
  - Screening

(Dowel, 2016; Fishbain, 1999)

Psychosocial Support for Pain Patients

- Pain patients are best served in an integrated care setting, due to multiple co-morbidities
  - Regular screening for depression
  - Mindfulness practices
  - Cognitive behavioral therapy
  - Enhanced peer support
  - Complementary medicine (e.g., yoga, tai chi)

(Dowel, 2016; Fishbain, 1999)

Polysubstance Drug Trends

- Opioids, methamphetamines, and synthetics are most often combined:
  - Alcohol
  - Cannabis
  - Nicotine
  - Benzodiazepines

(Dowel, 2016; Fishbain, 1999)

Monitor and Address Concerning (Aberrant) Medication-Taking Behaviors

- Illegal activities – forging scripts, selling opioid prescription, or buying drugs from illicit sources
- Multiple “lost” or “stolen” opioid prescriptions
- Non-adherence with monitoring requests (e.g., pill counts or urine drug tests)
- Deterioration in function at home and work
- Resistance to change therapy despite adverse effects (e.g., over-sedation)
- Running out early (i.e., unsanctioned dose escalation)
- Requests for specific opioid by name, “brand name only”
- Requests for increased opioid dose
- Non-adherence with other recommended therapies (e.g., physical or behavioral therapy.)

For most of these concerns, track pattern and severity over time, and provide patient feedback and guidance. Some patients may need MAT. Those engaged in illegal activity are often discharged and referred to an opioid treatment program.

(Butler et al., 2007)

Pain Patients and Psychosocial Support

- Pain patients best served in an integrated care setting, due to multiple comorbidities
- Regular screening for depression
- Mindfulness
- Cognitive behavioral therapy (CBT)
- Enhanced peer support
- Complementary medicine (e.g., yoga and tai chi)

Trends in Polysubstance Misuse

Opioids, methamphetamines, and synthetics are most often combined with:

- Alcohol
- Cannabis
- Benzodiazepines
- Nicotine

Note: Opioids are potentiated by alcohol and/or benzos and can lead to respiratory arrest.

Emerging Drugs of Abuse – Fentanyl and Carfentanil

The Drug Enforcement Administration has issued a warning to the public and law enforcement nationwide about the health and safety risks of fentanyl and carfentanil.

- Carfentanil is a synthetic opioid that is 10,000 times more potent than morphine and 100 times more potent than fentanyl, which itself is 50 times more potent than heroin.
- Traces of fentanyl and carfentanil have been detected in other illicit substances (e.g., marijuana).
- Mortality risks are extremely high. (U.S. Drug Enforcement Agency, 2016)

Any patient with an active OUD or at risk for OUD should be offered a naloxone kit.

Re-Emerging Methamphetamine

- Crystallized methamphetamine, known as "ice," "crystal," or "glass," is a smokable and more powerful form of the drug.
- Methamphetamine use causes a euphoric experience that can alter brain functioning, memory, decision making, and mood and potentially damage the central nervous system.
- Chronic or long-term methamphetamine use can result in irreversible physiological (e.g., damage to teeth and liver, stroke, heart attack, and death) and psychological damage.
- Evidence-based psychosocial interventions are available, including CBT and contingency management. There are no Food and Drug Administration-approved medications for stimulant use disorder.

(National Institute on Drug Abuse (NIDA), 2013; Rusyniak, 2013; Otero et al., 2006)

- Methamphetamine is more prevalent in rural communities.

Synthetics: K2, Spice, Bath Salts, MDMA, and Synthetic THC

K2, Spice, bath salts, MDMA (Ecstasy), and synthetic cannabinoids:

- As these are all produced illegally, the exact content and potency is variable. Traces of fentanyl have been detected in some cases.
- More than 60% of users are under the age of 25.
- Even though synthetics are marketed to be “safer,” the strength and type of ingredients used to make synthetic drugs are often unknown, making them even more dangerous than the drugs they are designed to mimic. Psychosis, major depression, self-harm, and death have occurred.

(NIDA, 2020; CDC, n.d.)

The Increased Lethality of Current Substance Use

is a major public health concern.

Screening and early intervention is an important strategy.

Polling Question 3

What TA needs do your staff have in providing the following services?

- SUD Screening
- Brief evidence-based consultation (15-20 minutes)
- Motivational interviewing
- Cognitive behavioral therapy
- Pharmacotherapies for SUD (MAT)
- Psychosocial treatments for MAT patient
- Accessing harm reduction strategies (naloxone, syringe exchange)

Source: iStock

SBIRT Re-Imagined

Too often, providers with good intention wrongly imagine SBIRT as a program and not what it is....a workflow for screening and intervention.

Workflow sometimes is made unnecessarily complex.

The following provides a simplified workflow.

Why Are Screening and Intervention Important?

- Unhealthy and unsafe alcohol (1) and drug use (2) are major, preventable, public health problems, resulting in more than 200,000 deaths each year and untold suffering for persons with a use disorder and for their families.
- The costs to society are more than $600 billion annually.
- Effects of unhealthy and unsafe alcohol and drug use have far-reaching implications for individual health, family functioning, and the health care system.
- Behavioral health screening **should be** the 4th vital sign in your clinic.

(National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2021; CDC, 2021)

Rationale for Universal Screening

- Risky alcohol use and drug use are common.
- Depression and anxiety are common.
- These concerns often go undetected.
- When the screening process is conducted properly, people are more open to these conversations than you might expect.
- And most important to remember.....

IF YOU DON'T SCREEN, YOU DON'T KNOW!

Screening Universally Is the 4th Vital Sign

Why?

- Detect current social and functional issues related to at-risk substance use, depression, anxiety, or other behavioral health issues at an early stage—before they result in more serious disease or other health problems.
- Identify those who should receive intervention services and those who require further assessment.
- Research has shown that approximately 90% of SUDs and 75% of depression go untreated.

(SAMHSA, 2020)

The Unspoken Messages of Universal Screening for Your Patients

- My whole health is important: mind, body, and spirit.
- Staff are taking notice of me and how I am living.
- Staff are interested and truly care about my well-being.
- Healing can begin in unexpected ways and expected places.
- My perspective matters, and my views are taken seriously.
- There doesn't have to be stigma related to alcohol or substance use; it's like any other health issues, not a personality defect or flaw.

Detecting Risk Factors Early Matters.

Screening can be a significant step toward effective intervention.

- The primary care office is often the first point of contact.
- Early identification and intervention lead to better outcomes.
- Patients are often seen by a clinician because of a related physical problem.

Screening Summary

- Screening is the first step of workflow and determines the severity and risk level of the patient's substance use and other behavioral health risks.
- The result of a screen allows the provider (behavioral health or primary care) to determine if a brief consultation or referral to treatment is a necessary next step for the patient.

(CDC, 2014)

Expediting Behavioral Health Consultation

When a patient screens at risk for SUD or a behavioral health concern, many health centers now make direct referrals to behavioral health services.

- This simplifies the workflow, saving time and effort on the part of the medical provider.
- The behavioral health consultant reviews screening results and engages in a brief, motivational, and enhancing conversation exploring client service readiness, treatment engagement, or a plan for risk reduction.
- For this type of brief consultation, the evidence-based MI strategy (the Brief Negotiated Interview) has great utility.

When Treatment Is Provided Within the Health Center

What evidence-based practices fit most easily:

Psychosocial intervention:

- MI
- CBT, including mindfulness-based CBT
- Integrated MI/CBT
- Behavioral activation (Most contemporary CBT includes behavioral activation.)

Pharmacotherapies for OUD and alcohol use disorder (AUD) (e.g., MAT):

- Buprenorphine for medication for OUD
- Naltrexone and Acamprosate for AUD

Polling Question 4

What type of staff reluctance (if any) exist in relation to serving persons with SUD? *(check all that apply)*

- Provider and/or other staff bias
- Staff knowledge and skill for screening, intervening, and treating
- Treating adolescents
- Treating complex patients (e.g., pain and opioids and comorbid conditions)
- Providing culturally relevant care
- Skills in evidence-based treatment
- No staff reluctancy

Source: iStock

Addressing Staff Reluctance to Address SUD

What helps reduce staff hesitance:

- Leadership
- Medical, nursing, and behavioral health champions
- Training
- Role modeling by supervisors, opening space for honest conversations
- Introducing peer recovery specialists

Polling Question 5

Which areas would be of high interest for further training and technical assistance (T/TA)?

- Strategies for brief consultation
- Evidence-based treatment that fits in a health center
- Enhancing cultural relevance in clinical practice
- Working with patients with comorbid conditions

Source: iStock

Q&A

TA Opportunities for Health Centers

- One-on-One Coaching
- Communities of Practices (CoPs)
- Virtual Intensive T/TA
- SDoH Roundtables
- Office Hours
- Webinars

Accessing Additional T/TA Opportunities

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com/ta-request-form

EMAIL

healthcenter_BHTA@jbsinternational.com

BH TA WEEKLY UPDATE

healthcenter_BHTA@jbsinternational.com

CE Revisited

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- CE credits will be distributed to training participants who complete the Satisfaction Assessment within 2 weeks of training.

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- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature; click the link now to have the browser open.
- We will also email you a link to the Satisfaction Assessment.

Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.

Thank you!

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Thank You!

Joe Hyde, BHTA Project Director and JBS Senior Technical Expert Lead

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