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Brief Emergency Medicine Interventions to Prevent Opioid Overdoses

Screening, Brief Intervention and Referral to Treatment (SBIRT) Getting to the point: a brief review of the brief negotiated interview

INTRO

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated approach to the delivery of early intervention and treatment for individuals at risk for the adverse consequences of alcohol and other drug use, and in this case focusing on those with probable substance use disorders. For the purpose of using SBIRT in the emergency settings of ED and ambulance, the concept of brief will be emphasized. The purpose of this introduction to SBIRT will be walking you through the individual steps recommended for use in emergency settings which include an initial screen, the brief negotiated interview, followed by referral to treatment.

SBIRT is typically initiated with tools, an initial short questionnaire that if positive leads to the use of a longer 10-28 question tool which more closely identifies the problem unique to the patient. The setting of an emergency room or the back of an ambulance may not afford the luxury of utilizing these validated tools and instead will be in the format of a brief face-to-face conversation between the medical provider and the patient. In this setting the main purpose of the conversation would be to determine who, for instance, would benefit from immediate initiation of suboxone followed by referral to longer term treatment.

Successful interviewing with SBIRT includes a constellation of techniques to create a meaningful understanding between you and the patient. It is known that change can only occur when the person is ready to own or acknowledge their problem, believe that they have the capacity and/or support needed to initiate that change, and have assistance with what and where to access help. The OARS model, a series of microskills used with SBIRT is based on using specific techniques to achieve this goal with the patient. **O**pen questions, **A**ffirmations, **R**eflective listening, and **S**ummarizing – the classic tools used in Motivational Interviewing, a major component of SBIRT.

Another skill needed to deliver SBIRT is embodied in the spirit of Motivational Interviewing. Specifically, this includes an understanding of letting go of the outcome and replace this with a goal of really learning what the patient is ready to do about their problem (if they even see this as a problem yet).

Many emergency departments have expanded services to initiate treatment to bridge navigation into community treatment programs or facilities, sometimes referred to as SBIN - The Screening, Brief Intervention, Brief Treatment and Navigation to Services. When emergency personnel have the resources to provide a "warm handoff" for a patient that at that moment is ready for change, the effort to use a tool such as SBIRT becomes much more satisfying

HOW TO DO A BRIEF NEGOTIATED INTERVIEW

Motivational interviewing is an evidence-based communication style that enhances patient's motivation to make health changes in their life. One of the advantages of motivational interviewing in the context of addressing substance use disorders is that has been developed and tested in this field and shown to be better than other strategies to helping patients accept treatment and reducing the negative functional consequences of substance use.

To make motivational interviewing easier to learn and more feasible to deliver brief motivational interview methods have been developed. An intro to motivational interviewing training workshop is typical 2-3 days in duration and to master motivational interviewing takes at least 4-5 days of forma training and months to years of practice. Using motivational interviewing can take 20-30 minute per patient; however brief motivational interviewing methods, such as the BNI can be learned quickly and delivered in only 5 minutes. As a result, the brief negotiated interview is ideally suited to busy primary care and emergency settings, where health care professionals must not only address substance use disorder, but also a multitude of other concerns.

There are a number of methods for brief motivational interviewing. The method we teach is one of several developed for the SBIRT process called the brief negotiated interview. The interview is composed of 3 elements – the spirit of MI, microskills, and the steps. The spirit of MI is based on a compassionate and empathetic approach to assisting patients with behavioral change. The microskills are specific communication techniques such as using open ended questions which tend to enhance motivation. The steps are a specific sequence of tactics designed to incrementally enhance a patient's self-reflection and motivation to change.

In the emergency setting there are any number of health care professionals who may do the brief negotiated interview. For each patient EMTs, nursing staff, emergency medicine clinicians, and social workers are personnel who may come in contact with a patient and could take advantage of a "teachable moment," and some emergency rooms may have a designated role for who provides the BNI. There are many approaches to how this can be done, however each person that patient comes in contact is an opportunity, and the more who have a familiarity with this approach, the more likely the patients is to get consistent supportive messages that at the very least embodies the spirit of motivational interviewing, regardless of whether specific sequence of topics are covered.

The spirit of motivational interviewing

The spirit of motivational interviewing is a term used to describe a belief system or attitude embodied by the interviewer which helps create an authentic, compassionate, and empathetic approach to supporting patients as they consider changes in their life. If one simply uses the techniques of motivational interviewing without the spirit, the resulting interview runs the risk of being manipulative and/or disingenuous. There are several key ingredients to the spirit of MI which each interviewer can cultivate and manage:

Empathy – trying to understand the patient and meet them where they are at, rather than placing unrealistic expectations. Trying to understand the challenges of change from both the patient perspective but also the understanding that human experience around lifestyle change. We can increase our empathy by being curious and learning more about each patient's unique experience with substance use, without judgement.

Compassion – Compassion is the ability to recognize human suffering in all of its forms and have the desire and ability to act beneficially to validate, support, and when needed act in the patient's best interest. One can enhance their compassion by connecting with each patient and their own innate desire to help those in need. We can work on own our implicit bias about patients with substance use disorder and learn to develop plans for patients which are medically sound, uninfluenced by our own frustrations, fears, or external pressures

Support autonomy – patients will be most successful coming from a place of self-empowerment – by operating from their own values and strengths patients will be more successful. An effective clinician will explore and/or align the plan those values and strengths.

Microskills

The microskills used in motivational interviewing are called OARS; Open ended questions, affirmations, reflections, and summaries. These conversational techniques are used because they tend to foster a curious, non-judgmental, collaborative environment where the patient can engage in self-reflection.

Open ended questions: Open ended questions allow patients to more easily explore their own values and ideas. Close ended questions and advice giving don't encourage patients to more freely explore what is important to them. Asking, "what are some of the negative experiences you have had with heroin?" encourages a patient to think about their own experience, as opposed to telling them why using heroin is bad for them.

Affirmations: Affirmations are a recognition of positive steps, strengths, and values that are empowering to the patient. If a patient has quit smoking, for example, this was an important milestone in their life that will contribute to successful opioid treatment. When an interviewer uses affirmation the recognize and then positive reflect back to the patient the importance of what the patient has said.

Reflections: Reflective listening, is a method of verbally reflecting back to a person what was just said. This method allows patients to feel heard and validated. It allows us to confirm meaning and importance with the patient. When we reflectively listen, we stay centered on the patient's ideas, avoid advice giving and other traps.

Summaries: summaries are a special form of reflectively listening where we pull together a series of reflections into a paragraph for the patient. This is most often done when the interview if about to go through a transition.

Steps

Pros and cons of change
Feedback on risks of continued use
Ruler
Collaborative plan

1. The first step of SBIRT is to raise the subject. This traditionally is done by exploring the pros of the current behavior and the cons. Though it may seem awkward to discuss the pros of drug use, the spirit of motivational interviewing allows us to see with empathy, that patients had good reasons for using a drug, at least at the very beginning. Drugs offer excitement in people's life, social bonding, and relief from stress. These are all good things on the surface, and for one reason or another people often begin using drugs for these benefits without adequately weighing the pros and cons and thinking about the long term risks. Your conversation with the patient will create a safe place where the patient can now explore those pros and cons without judgement. Using open ended questions, you can explore what were the factors for starting drugs, what factors drive continuing them, followed by what are the down sides for them of using drugs. The practitioner would use open ended questions to initiate these conversations followed by reflective listening.
2. Feedback on risks of current use – using research or clinical experience is there a way to let the patient know what would have happened now as a consequence of drug use had someone not intervened? When appropriate, is there a standard that you might use to draw from to help a patient gauge the safety of their current drug use. For example, with alcohol you could say, "Guidelines recommend that men drink no more than 14 drinks a week or else they risk elevated blood pressure, accelerated cognitive decline, and organ damage."
3. Using a ruler. This technique helps you better understand how likely a patient is to invest in getting better at this time, and further understand what factors might further enhance that motivation.
   "On a scale of 0-10, how interested are you in reducing (or stopping) your use of ….." Patients who score themselves 8 or higher are very likely to engage in treatment for their condition. Those who score below 8 can be asked why not a higher number. This helps explore barriers to change. Subsequently, they can be asked why not a lower number. This ends the conversation on a positive note, with the patient thinking positive about making a change.

4. A collaborative plan could include referral to treatment or starting treatment at your work site for those patients who are willing. For those who are not willing, smaller commitments such as follow up visits with PCP, going to alcoholic anonymous, or some other positive step forward can be very helpful.

REFERRAL TO TREATMENT

'Referral to treatment (RT) is provided to individuals who, based on screening results (which could be a positive urine drug screen), have a probable substance use disorder diagnosis. This is often followed by brief intervention whether that be initiation of suboxone in the case of opioid use disorder or treatment for other identified substance use disorder.

Effective RT requires adequate resources within the emergency setting. Resources can be, and often are, in the form of partnerships with agencies external to the hospital. Resources will include case management to facilitate treatment initiation and to link the individual with appropriate service options, including addiction counselors and peer services, behavioral therapy, out-patient medication treatment programs and in-patient facilities. Borrowing from the substance mis-use literature, evidence-based RT includes:

- co-location of services: service providers from other organizations and programs can be co-located within the ED or close proximity within the hospital to facilitate warm hand offs and seamless access to navigating a complex system of care. This is a cost-effective way for the ED to provide extended services without shouldering the cost of personnel;
- 'warm hand-off' procedures, which include seamless transition along the continuum of care, preferably involving personal introductions from one provider to another. This can include safer housing options for homeless patients such as sober housing. Navigators such as recovery coaches can facilitate transfer of care and introductions to primary care providers who agree to transitions of care from the ED setting;
- scheduling appointments prior to medical discharge and provision of transportation or other services (e.g. child care) to remove barriers to care;
- navigating insurance barriers and the use of free or sliding-scale service providers and facilities for low-income patients.