

Working together to improve health care quality, outcomes, and affordability in Washington State.

Addiction and Dependence Treatment Report and Recommendations

January 2015

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Executive Summary

The Robert Bree Collaborative (the Collaborative) was established in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State. The number of people in Washington with substance use disorders, variation in screening protocols, lack of access to treatment, and lack of coordination and communication between primary care, emergency rooms, and treatment centers were identified by the Bree Collaborative as a priority area for improvement and the Collaborative elected to form a workgroup to address these issues.

This report and recommendations focuses on the integration of screening, brief intervention, brief treatment, and referral to treatment into primary, prenatal, and emergency room settings rather than specific treatment modalities or therapies through adoption of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically "identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."¹ The strength of the SBIRT model is providing early motivational conversations with people prior to alcohol and other drug misuse overly impacting their lives.

We use alcohol and other drug *misuse* throughout this document, unless a study or survey used another specific term, to capture those using alcohol and drugs at low to moderate levels but who still may be at risk and may benefit from early screening and intervention. We use the term *drug* throughout this document to refer to marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical and medical purposes.

The Addiction and Dependence Treatment workgroup met from April 2014 to January 2015 to research available evidence, meet with relevant stakeholders, and examine methods of improving the ways that those with substance use disorders interact with the health care system. The workgroup developed the following five focus areas and corresponding specific strategies to meet the goal focus areas for Washingtonians 13 years of age and older:

- Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
 - Educate health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on other health conditions, and the importance of screening for alcohol and other drug misuse
 - Train health care staff how to have non-judgmental, empathetic, culturally competent, and accepting conversations about alcohol and other drug misuse
 - Increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse as a chronic, relapsing-remitting disease on a continuum
- Increase appropriate alcohol and other drug use screening
 - Increase the number of appropriately trained staff who utilize an evidence-based screening tool
 - Increase annual alcohol and other drug misuse screening, starting with an initial primary care visit, using a validated, scaled screening tool
 - Implement universal alcohol and other drug misuse screening in primary, prenatal, and emergency rooms (ER)

- Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
 - Increase the number of appropriately trained staff who provide brief intervention and/or brief treatment in the primary, prenatal, and ER settings
 - Increase the number of patients who screen positive for alcohol and other drug misuse who receive appropriate brief intervention and/or brief treatment
 - Follow-up with patients as appropriate who have received brief intervention and/or brief treatment
 - Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible
 - Provide pregnant women misusing alcohol or other drugs with coordinated, wrap-around care with involvement of appropriate primary, addiction, obstetric, and pediatric providers
 - Enhance ability to triage patients to appropriate level of care if not improving
 - Increase the accessibility of consulting with qualified behavioral health providers
- Decrease barriers for facilitating referrals to appropriate treatment facilities
 - Increase the number of patients who screen positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria
 - Track patients as they receive appropriate recovery care
 - o Contact patients after they receive appropriate treatment to facilitate rapid return to function
 - \circ $\;$ Increase cross-site communication and data sharing
 - Increase chemical dependency resources sufficient to facilitate successful patient recovery for publicly and privately-insured individuals
 - Address the workforce shortage for certified chemical dependency professionals including training, continuing education, and wages
- Address the opioid addiction epidemic
 - Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
 - Increase capacity for primary care providers to prescribe medication-assisted treatment (e.g., increase Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability)
 - Train appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment.
 - Extend state and private capacity and support for opioid medication-assisted treatment Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
 - Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings (including prenatal) for patients using opiates to evaluate change over time
 - Provide opioid overdose education and offer a prescription for Naloxone to all persons at risk for having or witnessing an opioid overdose, including those prescribed opioids, using heroin, and those in their social networks as allowed for by law
 - Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks

Dr. Robert Bree Collaborative Background

The Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 "...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice evidence-based approaches that build upon existing efforts and quality improvement activities aimed at decreasing variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

The number of people in Washington with addiction and substance use disorders, variation in screening protocols, and lack of access to treatment were identified by the Bree Collaborative as a priority area for improvement and the Collaborative elected to form a workgroup to address these issues. The workgroup met from April 2014 to January 2015 to develop the following recommendations.

See **Appendix B** for the Addiction and Dependence Treatment workgroup charter and a list of members.

Problem Statement

Misuse of alcohol and other drugs leads to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. Identified as substance use disorder, this is a chronic, relapsing-remitting disease affecting millions. Almost 90% of individuals with identified substance use disorders do not receive appropriate care or treatment partially due to substance use being highly stigmatized and patients not being likely to receive or seek treatment themselves.² Current national and state-level data do not adequately capture the total number of individuals who misuse alcohol and other drugs due to inconsistent or non-existent screening practices.

We use alcohol and other drug *misuse* throughout this document to capture those using alcohol and drugs at low to moderate levels but who still may be at risk and may benefit from early screening and intervention. We also align our definitions with the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)*. The DSM-V recently has revised the substance-related and addictive disorders diagnoses to combine substance abuse and substance dependence into **substance use disorder**, measured on a continuum from mild to severe. Other terms such as "alcohol abuse" are used if they are used by studies or surveys conducted prior to the DSM-5 (e.g., results from the 2013 National Survey on Drug Use and Health).

Without accurately identifying alcohol and other drug misuse, linking individuals to appropriate care and treatment is not possible. Primary care, prenatal care, and emergency room settings are the first line of defense for recognizing these problems and best serve their patients by using formalized screening methods.³ This report and recommendations focuses on implementing the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model and integrating screening, brief intervention, brief treatment, and referral to treatment into primary, prenatal, and emergency room settings. This report does not recommend specific treatment modalities or therapies. Additionally, while a system-wide public health approach to reducing substance use disorder is most effective, these recommendations are limited to the health care system. While impactful, issues such as housing and the criminal justice system are out of the scope of these recommendations.

National alcohol and other drug misuse

More than half of Americans aged 12 or older reported current alcohol use in the 2013 National Survey on Drug Use and Health (NSDUH) (52.2% or 136.9 million people), approximately a quarter of those surveyed reported binge alcohol use (22.9% or 60.1 million people). Approximately 6.3% of the population reported heavy drinking (16.5 million people).² See **Figure 1** for national variation in alcohol use or abuse based on annual averages from 2010-2012 NSDUH.⁴ Approximately 10.9% reported driving under the influence of alcohol, highest among those 26-29 years of age.²





*Excessive use of alcohol is the fourth leading cause of preventable death in the United States, resulting in 9.8% of deaths and one in ten years of potential years lost in working-age adults.*⁵

Excessive alcohol use is strongly associated with: oral cavity, esophagus, larynx, colon, rectum, liver, and breast cancers; hypertension; liver cirrhosis; chronic pancreatitis; as well as a higher probably of injuries and violence.^{6,7} Drinking during pregnancy can adversely affect the health of the developing fetus, cause major organ birth defects, growth disorders, brain damage, and lead to lifelong disability.⁶ There is no known safe level of alcohol during pregnancy. In 2013, 60.1 million individuals aged 12 or older reported binge drinking in the past month, including 1.6 million adolescents.² The economic cost of excessive drinking is estimated at \$223.5 billion, or approximately \$1.90 per drink, mainly due to the effects of binge drinking.⁸

See **Figure 2** for national variation in drug dependence or abuse based on annual averages from 2010-2012 NSDUH.⁴ We use the term *drug* throughout this document to refer to marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical and medical purposes. An estimated 9.4% percent of the population aged 12 or older in 2013 used drugs (24.6 million people).²

Deaths from heroin have doubled from 2010 to 2012. Deaths from opioid pain relievers are twice that of heroin.⁹ Figure 2: Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older⁴



Medicaid beneficiaries with a substance use disorder have significantly higher physical health expenditures and hospital admissions when compared to beneficiaries with a behavioral health diagnosis but no substance use disorder diagnosis.¹⁰ Nationally, the economic cost of drug use is more than \$193 billion including the impact on crime (e.g., criminal justice system, crime victims), health (e.g., hospital and emergency room costs), and productivity (e.g., labor participation, premature mortality).¹¹ Deaths

from opioid pain relievers have increased substantially every year, rising to 100 deaths daily in 2008.¹² This is three times the rate 10 years prior and has led to the Centers for Disease Control and Prevention to call the situation an epidemic. Injection drug use is also associated with increased risk of HIV infection and Hepatitis B and C infection.

Marijuana was by far the most highly used drug, see **Figure 3** for specific detail on the type of drug used.² While a higher rate of those who are unemployed report substance abuse, of those working full time, almost 10.8 million have a diagnosable substance use disorder.¹³ Of the estimated 23.1 million individuals aged 12 or older in 2013 needing treatment for alcohol or drug misuse, **only** 2.5 million received treatment at a specialty facility.²





Despite strong recommendations to screen patients for alcohol use by the National Institute on Alcohol Abuse and Alcoholism and the United States Preventative Services Task Force (USPSTF), many primary care providers are not equipped with the knowledge, training, and resources to treat or refer patients with substance use disorder and there has been little uptake in primary care and emergency room of screening for alcohol and other drug misuse.^{14,15}

Surveys indicate that 94% of primary care physicians missed or misdiagnosed patients who were misusing alcohol when presented with early symptoms of alcohol use disorder in adult patients.¹⁶ Approximately 55% of patients reported not believing that their physician knew how to detect addiction, 54% reported that their primary care physician did nothing about their substance use when detected, 43% said their physician never diagnosed their existing substance use, and 11% believed their physician knew about their addiction but did nothing about it. In the same survey, of patients who choose to seek treatment for substance use, 74.1% said their primary care physician was not involved in that decision and 16.7% reported that their physician was involved only a little. Other studies have found the majority of physicians surveyed, 88%, reporting asking their patients whether they drank alcohol, but only 13% reported used a formal screening tool.¹⁷ Of those physicians, the majority reported usually or always recommending a 12-step group to patients with problem drinking.

Approximately 4.1 million persons, 1.5% of the population 12 or older, received treatment at any location related to alcohol or drugs, the majority receiving treatment through a self-help group.² While, this report does not recommend specific treatment modalities or therapies, the Addiction and Dependence Treatment workgroup found it helpful to discuss barriers to treatment and to diagram treatment pathways, seen in Figure 9: Substance Use Disorder Framework, on page 13. Detail on locations where people received treatment is shown in Figure 4. The most common reasons for not





receiving treatment among those reporting a need for treatment were not having health coverage and not being able to afford the cost of treatment, 37.3%; not being ready to stop using, 24.5%; not knowing where to go for treatment, 9.0%; having health coverage that did not cover treatment, 8.2%; not having transportation or traveling to the location being inconvenient, 8.0%; the possibility of treatment having a negative effect on their job, 6.6%; being able to handle the problem without treatment, 6.6%; and not having time for treatment, 5.0%.²

Alcohol and other drug misuse in Washington State

Washington State has a higher than average percentage of deaths attributable to alcohol use among working age adults, 11.1% compared to 9.8% nationally.⁵ The average number of years of life lost among working age adults attributable to alcohol use is also higher than the national average, 12.7 compared to 11.5. Based on estimates using Centers for Disease Control and Prevention's (CDC) Alcohol Related Disease Impact System, 2,457 alcohol related deaths occurred in Washington in 2010.¹⁸





In Washington State in 2010, 16% of adults reported binge drinking, on at least one occasion in the past month, not a significant change from previous annual estimates and similar to the national rate.¹⁹ Reported binge drinking ranged from 21% in Ferry County to 8% in Wahkiakum County, see **Figure 5**. Age adjusted cirrhosis rates were 9-10 per 100,000, higher than the Healthy People goal of 8.2 per 100,000. The economic cost of substance use disorder in Washington State is estimated at \$5.21 billion in 2005, approximated to \$6.21 billion in 2012 dollars.²⁰ This includes costs from mortality, crime, morbidity, and health care (e.g., treatment, medical care, impact on other diseases) and is approximately \$832 for every non-institutionalized Washington state resident.

Substance use disorder is a leading cause of unnecessary hospitalizations and in 2007 an estimated 329,000 hospitalizations in Washington State were associated with alcohol and other drug

comprising use, of over half of all hospitalizations that year.²¹ From 2000 to 2011, rates of druginduced deaths were higher in Washington than the national average, both have increased over time.22

In 2011, Washington State had 1,033 drug-induced deaths due to opioids, heroin, cocaine, tranquilizers, methamphetamine, and other drugs, a rate of 15 per 100,000, higher than the Healthy People 2020 goal for age-adjusted drug-induced deaths of 11.3 per 100,000.²² Age-adjusted death rates vary by county, see **Figure 6** for more detail.

Deaths from opiates (heroin and prescription) have almost doubled in the past ten years, rising to 607 from 2009-2011. Heroin is the most common drug in treatment centers among 18-29 year olds and is driven by young adults and those primarily outside of the Seattle metro area.²³

Figure 6: Drug-induced death rates by Washington County, 2009-2011²²



Significantly improved health outcomes and cost savings have been found in Washington State for infants born to pregnant women provided with prenatal substance use disorder treatment. Receipt of prenatal substance use disorder treatment was associated with a decrease in very low birth weight among singleton infants by less than half, a reduction in fetal death rate, and a decrease in Medicaid expenditure for infant care during the first two years of life compared to women identified as substance abusers during the prenatal period who did not receive prenatal care.²⁴

While prevalence of HIV is low among injection drug users due to widespread syringe exchange programs, Hepatitis C prevalence is high, almost 75% in this population.²³ It is unclear whether prevalence of marijuana misuse has increased after legalization through the passage of Initiative 502, an initiative legalizing small amounts of marijuana for adults over 21 in 2012, but Washington State Patrol reports marijuana-positive driving under the influence to have increased approximately 30% in 2013 in King County.²⁵

The Washington State Healthy Youth Survey of 2012, found current (in the last 30 days) alcohol

use to be reported by: 2.5% of 6th graders, 11.9% of 8th graders, 23.3% of 10th graders, and 36.1% of 12th graders. ²⁶ Binge drinking was reported by 2.4%, 7.1%, 14.3%, and 21.8% of 6th, 8th, 10th, and 12th graders respectively. Marijuana use was reported by 1.2%, 9.4%, 19.3%, and 26.7% with other drugs (excluding alcohol, tobacco, or marijuana) being reported by 0.8%, 2.8%, 5.1%, and 7.3% of 6th, 8th, 10th, and 12th graders respectively. By 12th grade, lifetime alcohol use is reported by 68% and lifetime marijuana use by 45.6% of responders.





The percentage of admissions for prescription opiates and heroin in

Washington State have increased from 1999 to 2013, see **Figure 7**.²² This trend for increased heroin use is also seen when looking at substance use treatment admissions in the age 18-29 cohort, see **Figure 8**.²³



Figure 8: Substance abuse treatment admissions, age 18-29, 1999-2012²³

Initiative 502 (I-502) was passed by a majority of Washington State voters in 2012 and authorized the liquor control board to regulate and tax marijuana for persons twenty-one years of age and older and license, regulate, and tax the production and processing of marijuana. The Initiative created a dedicated marijuana fund to be used for a variety of health, education, and research purposes and the state general fund. The Washington State Department of Health is the lead agency for implementing marijuana education campaigns.

For more information: www.LearnAboutMarijuanaWA.org

The Washington State Division of Behavioral Health and Recovery (DBHR) is required under I-502 to design and administer the Washington State Healthy Youth Survey, analyze collected data, and produce reports. Information from the survey can be used to identify trends in substance use disorder over time, identifying youth attitudes, risk behaviors, and their consequences, and risk and protective factors for school, community, family, and individuals.

The 2014 passage of Washington State Senate Bill 6312, integrating state purchasing of mental health and chemical dependency services for those with severe mental illness through managed care, and Washington State House Bill 2572, mandating that primary care services be available in mental health and chemical dependency treatment facilities, that mental health and chemical dependency be available in primary care, and giving an option for local governments to fully integrate behavioral and physical health, is expected to significantly alter treatment for alcohol and other drug misuse in Washington State.

For more information: www.governor.wa.gov/documents/2014_behavorial_health_paper.pdf

These recommendations are meant to acknowledge the limitations of the current system; recommend steps to improve health care quality, outcomes, and affordability; and support mental health, chemical dependency, and primary care integration in Washington State.

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a community-based paradigm seeking to encourage health care providers to systematically "identify, reduce, and prevent problematic use, abuse and dependence on alcohol and illicit drugs."¹ The strength of the SBIRT model is to provide early motivational conversation with people prior to alcohol and other drug misuse overly impacting their lives.

After analyzing the SBIRT model, the USPSTF recommended that "clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse" giving the recommendation a B rating meaning that, "there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial."¹⁴ The Patient Protection and Affordable Care Act requires that Medicare and most private insurance plans cover preventive services that have been given an A or B rating by the USPSTF at no cost to the patient.²⁷

SBIRT has been endorsed nationally and has been successfully used within Washington State as well. The Substance Abuse and Mental Health Services Administration (SAMHSA) supports an SBIRT model that:²⁸

- Is brief
- Universally screens all patients for a specific issue (e.g., alcohol and other drug misuse)
- Occurs in a non-chemical dependency treatment setting (e.g., primary care, hospital)
- Includes a seamless transition between screening, brief intervention, brief treatment, and referral to specialty chemical dependency treatment
- Demonstrates success

Implementing evidence-based recommendations for increasing appropriate screening, brief intervention, brief treatment, and facilitated referral to treatment in primary, prenatal, and emergency room settings is the first step to addressing the large and growing problem of alcohol and other drug misuse in Washington State.

Recommendations

The Addiction and Dependence Treatment workgroup developed the following five focus areas and corresponding specific strategies to meet the goal focus areas for Washingtonians **13 years of age and older**.

	Focus Area	Specific strategies
1.	Reduce stigma	Primary and prenatal care settings and emergency rooms:
	associated with	• Educate health care staff on the prevalence of alcohol and other drug misuse,
	alcohol and other	the impact of alcohol and other drug misuse on other health conditions, and the
	drug screening,	importance of screening for alcohol and other drug misuse
	treatment	• Train health care staff how to have non-judgmental, empathetic, culturally
		competent, and accepting conversations about alcohol and other drug misuse
		• Increase the number of people who see alcohol and other drug misuse screening
		as a usual part of care and are comfortable discussing alcohol and other drug
		misuse as a chronic, relapsing-remitting disease on a continuum
2.	Increase appropriate	Primary and prenatal care settings and emergency rooms:
	alcohol and other	• Increase the number of appropriately trained staff who utilize an evidence-
	drug use screening in	based screening tool
	emergency room	• Increase annual alcohol and other drug misuse screening, starting with an initial
	settings	primary care visit, using a validated, scaled screening tool
		Implement universal alcohol and other drug misuse screening
3. Increase ca provide bri interventio	Increase capacity to	Primary and prenatal care settings and emergency rooms:
	provide brief	Increase the number of appropriately trained staff who provide brief
	hrief treatment for	intervention and/or brief treatment
	alcohol and other	Increase the number of patients who screen positive for alcohol and other drug
	drug misuse	misuse who receive appropriate brief intervention and/or brief treatment
	•	• Follow-up with patients as appropriate who have received brief intervention
		and/or brief treatment
		 Manage adolescents with addictions collaboratively with child and adolescent
		addiction specialists, if possible
		• Provide pregnant women misusing alcohol or other drugs with coordinated,
		wrap-around care with involvement of appropriate primary, addiction,
		obstetric, and pediatric providers
		Enhance ability to triage patients to appropriate level of care if not improving
		Increase the accessibility of consulting with qualified behavioral health providers
4.	Decrease barriers for	Primary and prenatal care settings and emergency rooms:
	achitating referrais to	Increase the number of patients who screen positive who are referred to and
	treatment facilities	receive care at an appropriate chemical dependency treatment facility
		consistent with the American Society of Addiction Medicine criteria
		Irack patients as they receive appropriate recovery care
		• Contact patients after they receive appropriate treatment to facilitate rapid
		return to function
		Primary and prenatal care settings, emergency rooms, and chemical dependency
		ireaiment jacinities:
		Increase cross-site communication and data sharing

	The State of Washington and Health Plans:
	• Increase chemical dependency resources sufficient to facilitate successful
	patient recovery for publicly and privately-insured individuals
	The State of Washington:
	• Address the workforce shortage for certified chemical dependency professionals
	including training, continuing education, and wages
5. Address the opioid	Primary and prenatal care settings and emergency rooms:
addiction epidemic	• Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
	• Increase capacity for prescribing medication-assisted treatment (e.g., increase
	Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability)
	• Train appropriate staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment
	• Provide opioid overdose education and offer a prescription for Naloxone to all persons at risk for having or witnessing an opioid overdose, including those prescribed opioids, using heroin, and those in their social networks as allowed for by law
	• Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
	Primary and prenatal care settings, emergency rooms, and chemical dependency
	treatment facilities:
	• Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks
	The State of Washington and Health Plans:
	• Extend state and private capacity and support for opioid medication-assisted treatment
	 Track changes to the number of admissions cost morbidity and mortality in
	emergency room, hospital, and outpatient settings (including prenatal) for patients using opiates to evaluate change over time

This report acknowledges that substance use disorder is a chronic, relapsing-remitting disease on a continuum and seeks to increase the number of people screened for alcohol and other drug misuse. The recommendations are primarily focused on the integration of screening, brief intervention, brief treatment, and referral to treatment into primary, prenatal, and emergency room settings rather than focused on recommending specific treatment modalities or therapies. However, the Addiction and Dependence Treatment workgroup found it helpful to diagram treatment pathways through, **Figure 9: Substance Use Disorder Framework,** below. This diagram is not an exhaustive list of all treatment modalities and does not represent endorsement by the Bree Collaborative for a specific treatment modality. Additionally, this report makes no recommendation as to the validity of harm reduction vs abstinence as the goal of substance use disorder treatment. This report uses categorizations the low risk, risky, harmful, dependent categories used by the WA-SBIRT demonstration project.



Adopted by the Bree Collaborative, January 21, 2015.

Reduce stigma associated with alcohol and other drug misuse screening, intervention, and treatment

Stigma regarding alcohol and other drug misuse is prevalent among the general population and among health care providers.²⁹ People with substance use disorders are likely to be seen as having control over their alcohol or drug use, reducing the number of people screened and who receive treatment. Screening for drug use among pregnant women was associated with increased fear among patients of psychological, social, and legal consequences (e.g., contacting child protective services); fears about confidentiality and judgment from the health care provider; and possible avoidance of prenatal care.³⁰

A systematic review of interventions to reduce stigma around substance misuse found interventions to be generally targeted toward people with substance use disorders; the general public; or groups such as medical students, police officers, or substance use counselors.³¹ More than half of the studies found significant reductions in stigma. A structured drug and alcohol education and clinical experience program reduced stigma among medical students. Stigma appears to be most effectively reduced through positive depictions of people with substance use disorders and educational and skills training among professionals. Screenings for alcohol and other drug misuse themselves may help to reduce the stigma attached to seeking help.

The Bree Collaborative recommends training health care staff how to have empathetic, accepting, culturally-competent, and non-judgmental conversations about drug misuse and clear policies and communication about testing practices and confidentiality of testing.^{30,32} The Collaborative also recommends training health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on health conditions, the importance of screening for alcohol and other drug misuse, and that alcohol and other drug misuse is a chronic, relapsing-remitting disease on a continuum. The Collaborative seeks to increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse.

Increase appropriate alcohol and other drug screening

There are several widely used and validated screening tools for alcohol and other drug misuse, some of which are short, one-item screeners. Screening alone has also been shown to reduce alcohol misuse, potentially due to increased self-awareness and self-monitoring.^{33,34} The Bree Collaborative recommends using a scaled and validated question or series of questions for both alcohol and other drug misuse for all patients over age 13 and to be aware of cross-cultural challenges or appropriateness specific to any tool. The Collaborative recommends screening all patients 13 years of age and older as minors 13 years of age and older may receive substance use disorder treatment without parental consent.³⁵ Additionally, pregnant women should be screened for alcohol and other drug misuse during routine prenatal care. The Collaborative does not recommend a specific questionnaire or tool as many are being successfully used in our community. Co-morbidity of alcohol with other drug misuse, and vice-versa, can be common and can greatly impact health and social function and should be taken into consideration.³²

The Bree Collaborative acknowledges that other mental health diagnoses often co-occur with substance use disorder, especially anxiety and depression. As discussed in the case study of the Washington State SBIRT program on page 16, once patients screened positive for alcohol or other drug misuse, patients were then screened for depression with the patient health questionnaire nine item scale (PHQ-9) and anxiety with the generalized anxiety disorder seven-item scale (GAD-7). It is recommended that patients be screened as appropriate for anxiety and depression, but discussing screening, intervention, and treatment for these co-occurring disorders in more detail is out of the scope of this document.

Adopted by the Bree Collaborative, January 21, 2015.

The Alcohol Use Disorders Identification Test (AUDIT) is designed for low to moderate alcohol users, has ten questions, a sensitivity of 0.92 and a specificity of 0.94 for harmful use when a cutoff of eight or more is used, and has been validated across many diverse populations.³⁶ The AUDIT-C is a modified version of the 10 question AUDIT instrument containing only the first three questions and can identify persons who are hazardous drinkers or have active alcohol use disorders, including alcohol abuse or dependence. The full AUDIT, AUDIT-C, and a single-item AUDIT screener (sometimes called AUDIT-3 as it is the third question in the full ADUIT) have been validated in primary care settings among both men and women as well as having been extensively used by the Veterans Administration.^{37, 38} It is important to keep in mind that while faster, some studies have shown single-item screeners to be slightly less accurate in predicting alcohol use disorders.^{39,40}

Single Item AUDIT Screener: How many times in the past year have you had (4 for women, 5 for men) or more drinks in a day? Answers: Never, Less than monthly, Monthly, Weekly, Daily or almost daily

The AUDIT can be given as an interview by clinical staff or as a self-report questionnaire. The self-report questionnaire takes less time, is easy to administer, and may lead to more accurate answers due less stigma on the part of the clinical staff person, but may be unsuitable for patients with low health literacy or poor reading skills.⁴¹ Issues with interview-based screening stem from a lack of workforce development, having to do with biased and error-prone questioning on the part of the interviewer.⁴² This potentially results in high rates of false-negatives and indicates that use of a validated screening tool needs to be accompanied by staff training and education. Lessons learned from the Veterans Administration implementation of interview-based screening for alcohol use disorders include: educating staff about screening as prevention, addressing the assumption that a positive screen means the patient is a problem-drinker or an alcoholic, addressing the fact that alcohol misuse is a continuum rather than a dichotomous condition, and the problematic impact of administrative protocols that target high rates of screening not necessarily incentivizing high-quality screening (perverse incentives).^{42,43} A scaled questionnaire allows individual progress to be tracked over time and possible prediction of a patient's alcohol or drug misuse-related health conditions such as increased hospitalizations or increased likelihood of gastrointestinal illness.^{44,45}

A survey of trauma surgeons found that a majority believed a trauma center to be an appropriate setting to address alcohol misuse and frequently checked blood alcohol consumption.⁴⁶ Use of a validated screening test occurred in about a quarter of cases. About half of the physicians surveyed understood brief interventions but fewer than half of patients received any type of intervention or treatment at the center.

Education about the importance of screening and a corresponding brief intervention, if needed, could increase the number of people who are screened, receive appropriate intervention or treatment, and reduce injury related to alcohol and other drug misuse.

The **Drug Abuse Screening Test (DAST)** has 28 questions with a shorter 10 item version known as the DAST-10. The DAST has been successfully used in both primary care and emergency room settings.⁴⁷ A one-item screener, *How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons* with answers of *None or once or more* is used as a pre-screen by the Washington SBIRT program, profiled on the following page.

The Bree Collaborative recommends that adolescents be screened for alcohol and other drug use annually starting at age 13. Although minors aged 13 and older may receive substance use disorder treatment without parental consent, parents may be contacted if "the minor signs a written consent authorizing the disclosure; or the treatment program director determines that the minor lacks capacity to make a rational choice regarding consenting to disclosure."³⁵

Case Study: Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration⁴⁸

The Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration (WA-SBIRT) started as a five-year grant from SAMHSA from 2003 to 2008 to implement Screening, Brief Intervention, and Referral to Treatment in nine **emergency departments** across the state. After a successful five years, Washington State applied and received a grant to expand services for another five years from 2011 to 2016 in **clinics** across the state.

Medicaid patients visiting one of the nine emergency departments were approached by a chemical dependency professional and after agreeing to participate in the program, 48% classified as screening only, 49% were screened and received a brief intervention, and 3% were screened, received a brief intervention, and went on to receive brief therapy or chemical dependency treatment. However, of those referred to brief therapy or chemical dependency treatment to the facility to which they were referred.

For more key findings from the initial grant period, read:

www.wasbirt.com/sites/default/files/Final%20tracking%20report%20WASBIRT1.pdf



Next steps depend on the patient's risk levels determined by a score on the AUDIT or DAST-10:

- Low Risk: AUDIT score of 0-6 for women and 0-7 for men, DAST-10 score of 0

 No intervention.
- 2. **Risky**: AUDIT score of 7-15 for women and 8-15 for men, DAST-10 score of 1-2
 - a. Brief intervention.
- Harmful: AUDIT score of 16-19 for both women and men, DAST-10 score of 3-5

 Brief intervention and referral to brief treatment.
- 4. Dependent: AUDIT score of over 20 for both women and men, DAST-10 score of 6 or more
 - Brief intervention and referral to chemical dependency treatment.

Screening and brief intervention took approximately 15 minutes per patient.⁴⁹ Chemical dependency professionals also used their clinical judgment to assess level of risk independent of the AUDIT or DAST score. In order to receive reimbursement for SBIRT under Medicaid, the Health Care Authority requires those billing to have at least four hours of training. Advanced registered nurse practitioners, mental health counselors, marriage and family therapists, independent and advanced social workers, physicians, psychologists, dentists, and dental hygienists can bill for SBIRT services and chemical dependency professionals, licensed practical nurses, physician assistants, and registered nurses can provide the services but cannot themselves bill.

More information is available, here: www.wasbirt.com/content/training.

In phase two, services are provided to adults receiving primary care in selected community health clinics in King, Whitman, Cowlitz, and Clallam Counties. An anticipated 96,000 adults will be screened and served over the life of the grant, which is anticipated to reduce substance use and related injuries as well as health care use and costs for chronic conditions such as depression and anxiety.

For more information about WA-SBIRT, visit <u>www.wasbirt.com</u>.

The American Academy of Pediatrics recommends an SBIRT protocol adapted from Children's Hospital in Boston starting with a series of pre-screen questions asking "In the past 12 months, did you 1) Drink any alcohol (more than a few sips;) 2) Smoke any marijuana or hashish, 3) Use anything else to get high ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or huff.)"⁵⁰ If the patient answers yes to any, it is recommended that the provider administer the **CRAFFT**, a mnemonic acronym of the six questions (Car, Relax, Alone, Forget, Friends, Trouble). The CRAFFT is designed for alcohol and other drug use screening in adolescents and teenagers aged 12-21. This validated instrument recommends a score of 2 or higher as a positive screen, screens for both alcohol and other drug use, and has sensitivities ranging from 0.61-1 and specificities ranging from 0.33-0.97.^{51,52} If patients answer no to the pre-screen questions, providers should provide "brief positive feedback" and ask the Car question of the CRAFFT, "Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?"⁵⁰

Other validated screeners for those over age 18 include the **CAGE**, also a mnemonic acronym of key words within the four questions (Cut down, Annoyed, Guilty, and Eye-opener) to which patients answer yes or no. The CAGE has been adopted to assess drug use, called the CAGE-AID. Two positive responses are considered a positive test and indicate that further assessment is warranted.⁵³ A systematic review found an average sensitivity of 0.71 and specificity of 0.90.⁵⁴ However, the CAGE has been shown to be less accurate in screening low to moderate levels of alcohol misuse and may not be developmentally appropriate for adolescents.

Pregnant women should also be screened for alcohol and other drug misuse during routine prenatal care. Several screening tools have been validated for pregnant patients.⁵⁵ The T-ACE (tolerance, annoyance, cutdown, eye-opener) has four questions, can be administered in less than a minute, and is able to detect low levels of alcohol use.⁵⁶ The TWEAK has five questions and is better able to detect alcoholism or heavy drinking. The care and treatment needs of pregnant women are specialized and require adherence to best practice protocols. There is no known safe level of alcohol during pregnancy and pregnant women should be advised not to drink alcohol.

Additionally, older adults are another population requiring special screening consideration and potentially specialized care and treatment.

The Bree Collaborative recommends annual drug and alcohol misuse screening, starting with an initial primary care visit or prenatal care visit, using one of the validated, scaled, and culturally and developmentally appropriate screening tools as appropriate for patients aged 13 and older. The Collaborative also recommends implementing standardized drug and alcohol screening for all emergency room visits among those aged 13 and older. The Collaborative proposes supporting this recommendation through increasing the number of appropriately trained health care staff who provide appropriate screening and increasing health care providers' awareness of and comfort with alcohol and other drug misuse screening.

Increase capacity to provide brief intervention and brief treatment for alcohol and other drug misuse

Evidence suggests that those with moderate to risky alcohol use benefit from access to brief intervention and/or brief treatment, showing an opportunity to intervene before patients' lives are overly impacted.^{10,57} A systematic review of primary care interventions to reduce alcohol misuse across multiple payers found screening and behavioral counseling interventions to be cost effective and perhaps cost saving to delivery systems.⁵⁸

Evaluation of the WA-SBIRT program found significant cost savings in Medicaid per member per month cost and decreased utilization of inpatient services through SBIRT implementation in emergency departments compared to patients not receiving SBIRT.⁴⁹

SAMHSA defines brief interventions as consisting of 5 minutes of brief advice to 15 to 30 minutes of brief counseling intended "to treat problematic or risky substance use" and using "brief versions of cognitive behavioral therapy and[/or] motivational interviewing."⁵⁹ Many guidelines exist outlining brief interventions. The WA-SBIRT program limits reimbursement for brief interventions to four per client, per provider annually.⁴⁸

Examples of brief interventions can be found on the SAMHSA website, here: www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions.

WA-SBIRT suggests the following for brief interventions⁴⁸

- **Raising the subject**: establish rapport with the patient, ask permission to discuss alcohol or other drug misuse which may be a sensitive issue, explain who you are and set an agenda
- **Provide feedback**: review alcohol or drug use patterns, share the score from the screener, talk about the effect of alcohol and other drug use on health
- Enhance motivation: assess readiness to change, explore the patient's ability to change
- **Negotiate a plan**: summarize the conversation, recommend changes, ask the patient what they will do, agree on a strategy

For adolescents, brief interventions can include positive feedback for a negative screen and for a positive screen can range from brief advice to a brief negotiated motivational interview to encourage behavior change and, if relevant, acceptance of a referral for treatment.⁵⁰ The contract for life, available here: <u>www.sadd.org/contract.htm</u>, can facilitate discussion. The American Academy of Pediatrics recommends different pathways depending on whether an adolescent patient scores 0 to 1 or more than 2 on the CRAFFT.⁵⁰

If the adolescent patient scores 0 or 1 they should receive **clear** advice to stop alcohol and/or drug use, education on health effects of continued use, and recognition of individual strengths. If adolescent patients score 2 or greater on the CRAFFT, it is recommended that providers:⁵⁰

- Conduct a brief assessment (e.g., "Tell me about your alcohol use. Has this caused problems?") to assess acute danger or addiction.
 - o If there are no signs of acute danger or addiction, conduct a brief negotiated interview.
 - If signs of addiction are present, refer patient to treatment (e.g., summarize, refer, invite parental involvement).
 - If there are signs of acute danger, conduct an immediate intervention (e.g., contract for safety, consider breaking confidentiality to involve parents).

A study of Washington State Medicaid expenditures found significant cost savings associated with provision of substance use disorder treatment.⁶⁰ Additionally, a brief motivational intervention for patients through inner-city hospital outpatient clinics found a significant effect on cocaine and heroin abstinence six months post-intervention.⁶¹

The National Institute on Drug Use suggests five A's for brief intervention⁶⁷

- 1. **Ask** permission to discuss the screening results and review the results with the patient
- 2. Advise provide medical advice about drug use
- 3. Assess the patient's readiness to quit
- 4. **Assist** the patient in making a change
- 5. **Arrange** specialty assessment, drug treatment, follow-up visit as appropriate

It is important to acknowledge that after analyzing the impact of SBIRT on drug misuse, the USPSTF concluded that although treatments reduce drug use in the short term, evidence was insufficient to find an association between treatment and longer-term positive effects on morbidity or mortality.⁶² This conclusion is partially due to the majority of patients who were in treatment for drug use having already developed drug-use associated problems. Additionally, two recent randomized clinical trials have shown no effect of brief treatment in primary care on drug use.^{63,64} One of these studies compared a 10-15 minute negotiated interview conducted by a health educator, a 20-30 minute adaption of motivational interviewing with a 20-30 minute booster conducted by a masters level counselor, to no intervention while the other study compared a brief intervention with motivational interviewing and an attempted 10-minute telephone booster two weeks later to usual care.

These recommendations seek to increase the number of patients screened for drug use prior to patients encountering the treatment system for other reasons and prior to developing severe drug-use associated problems. Additionally, a growing body of evidence is showing positive effects from brief intervention for drug use in primary care and emergency rooms.^{65,66} The National Institute on Drug Abuse and many other organizations recommend brief intervention for non-medical prescription drug use.⁶⁷

However, the limitations of brief intervention on drug use and potentially severe alcohol use must be acknowledged. The University of Washington Advanced Integrated Mental Health Solutions (AIMS) Center recommends extending the role of primary care from only providing screening and brief intervention to also providing brief treatment, as seen in **Figure 10**, below.

Figure 10: Expanded Role of Primary Care to Provide Brief Treatment⁶⁸



While a brief intervention can be 1-5 sessions lasting 5-10 minutes, a brief treatment can consist of about 5-12 sessions that can last up to an hour.²⁸ The goal of brief treatment is to address alcohol and/or drug misuse and "also to address long-standing problems with harmful drinking and drug misuse and help patients with higher levels of disorder obtain more long term care" and it is often performed by "allied health professionals such as nurses, social workers, or health educators, with results and actions noted in the patient chart for physician notification and oversight."²⁸ SAMHSA estimates that approximately 3% of patients screen into brief treatment. Rather than being an extension of brief intervention, brief treatment "should be characterized as a self-contained modality" with specific goal-setting and change strategies.⁵⁹

While brief interventions have been shown to be effective for alcohol misuse and marijuana misuse, in many cases, brief treatment may be more appropriate for those misusing other drugs or who are severely dependent on alcohol.⁵⁹

The AIMS Center model has been used in Washington State's Mental Health Integration Program whose purpose extends beyond that of substance use screening and treatment into "integrat[ing] high quality mental health screening and treatment into primary care settings serving safety net populations."⁶⁹ The program was funded by the Washington State Legislature, Community Health Plan of Washington (CHPW), and Public Health Seattle and King County and involved over 200 community health centers across the state. Key additions of this program to usual care were a Care Management Tracking System allowing centers to share data across sites and a collaborative team approach in which the primary care provider and care manager were able to consult with a psychiatrist regarding the caseload. This allowed heightened focus on more challenging patients, ability to increase level of care if needed with a facilitated referral, multiple brief consultations, and better opportunity to make treatment recommendations if patients did not improve.⁵¹ Care managers used the registry to track patient progress, regularly review and assess the appropriate level of intervention, and connect to community resources as necessary.

Key Recommendations for Integrating Brief Treatment:⁶⁸

- Develop mechanisms (e.g., electronic health record system) to support patient screening, tracking, ability to triage to appropriate level of care if not improving, and capacity to facilitate referrals
- Increase provider and staff knowledge and comfort with SBIRT
- Train and supervise appropriate staff to enhance skills
- Access to psychiatric consult to help support this process

The amount of trained masters-level addiction counselors is not currently adequate to meet the growing population need. To address this, the Bree Collaborative wishes to acknowledge the importance of competencybased counselors who may not have masters-level counseling training but exhibit the skills necessary to engage with patients and who have received adequate training. Competencies can be gained through experience and focused training. While this role has been challenged by a greater emphasis on education as qualification, experience and focused training may also contribute to greater empathy and the necessary connection to patients needed for a brief intervention, brief treatment, or referral to treatment at a chemical dependency facility.⁷⁰ Additionally, the Bernstein et al. study found a positive effect of behavioral intervention on drug use abstinence at six months after intervention led by trained peer educators who themselves had been in recovery for three years.⁶⁶ Dr. Dorynne Czechowicz of the National Institute on Drug Abuse added that the findings, "...suggest that peer educators can play an important role in busy clinical environments and enhance outreach to abusers of cocaine, opiates, and perhaps other drugs."⁷¹ SAMHSA recommends four transdisciplinary foundations for addiction professionals:⁷²

- Understanding addiction,
- Knowledge of types of treatment,
- Application to practice, and
- Professional readiness.

The Washington State Department of Health licenses chemical dependency professionals based on meeting specific requirements including having postsecondary education.⁷³

The Bree Collaborative seeks to increase the availability of brief intervention and brief treatment within primary, prenatal, and emergency room settings and the number of people receiving these services appropriately. The Collaborative recommends increasing the number of appropriately trained staff who can provide brief intervention and/or brief treatment in the primary care and ER settings through increased staff and provider education and training about brief intervention and brief treatment. The Collaborative also recommends following up with patients as appropriate who have received brief intervention or brief treatment; enhancing the ability of primary care and emergency room staff to triage patients to more appropriate level of care if follow-up shows a lack of improvement; managing adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible, and providing pregnant women misusing alcohol or other drugs with coordinated, wrap-around care with involvement of appropriate primary, addiction, obstetric, and pediatric providers. The Collaborative recommends consulting with qualified behavioral health providers as necessary to supplement staff ability to intervene with patients.

Decrease barriers for facilitating referrals to appropriate treatment facilities

The Bree Collaborative's goal is to increase the number of patients needing treatment who receive the entire recommended course of treatment and to facilitate information sharing between the referring provider, the treatment facility, and the patient. The recommendations are primarily focused on the integration of screening, brief intervention, brief treatment, and referral to treatment into primary, prenatal, and emergency room settings rather than focused on recommending specific treatment modalities or therapies.

Being referred to a chemical dependency facility outside of the primary, prenatal, or emergency room setting without a supportive facilitating referral can lead to patients disengaging from care. Financial, managed care, administrative, informational, confidentiality, and access (e.g., travel or distance) are all significant barriers to successful care transitions. Approximately 79% of patients referred to an external treatment agency as part of phase I of the WA-SBIRT program did not engage in treatment.⁴⁹

One of the primary barriers to facilitated referrals across sites are funding streams. Adequate resources to ensure coverage of people receiving care from different sites must support the public chemical dependency system's move into a managed care environment.

As discussed earlier, the 2014 passage of Washington State Senate Bill 6312, integrating state purchasing of mental health and chemical dependency services for those with severe mental illness through managed care, and Washington State House Bill 2572, mandating that primary care services be available in mental health and chemical dependency treatment facilities, that mental health and chemical dependency be available in primary care, and giving an option for local governments to fully integrate behavioral and physical health, is expected to significantly alter treatment for alcohol and other drug misuse in Washington State.

For more information: www.governor.wa.gov/documents/2014_behavorial_health_paper.pdf

These recommendations are meant to acknowledge the limitations of the current system; recommend steps to improve health care quality, outcomes, and affordability; and support mental health, chemical dependency, and primary care integration in Washington State.

Substance use education, treatment, and prevention confidentiality are codified in Federal law through 42 CFR part 2.⁷⁴ Protected information can be shared through informed written consent.

One of the most important aspects of facilitating a referral to an appropriate chemical dependency treatment facility for primary, prenatal, and emergency rooms is verbal confirmation with the facility and with the patient. Refer to **Figure 9** for more information on treatment pathways and **Figure 11**, below, for the American Society of Addiction Medicine's (ASAM)'s continuum of care. SAMHSA emphasizes that one of the roles of primary care is to assist patients in accessing specialized treatment and "helping to navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a speciality setting."⁷⁵

Referrals to chemical dependency treatment facilities should be consistent with protocols as for any other specialty referral.

- WA-SBIRT suggests how to make good referrals through familiarization with treatment options and having a good relationship with local treatment centers. More information, here: <u>www.wasbirt.com/content/referrals-treatment</u>
- SAMHSA provides a behavioral health services treatment locator, here: <u>http://findtreatment.samhsa.gov/</u>

All referrals should comply with ASAM's placement criteria. ASAM recommends "six dimensions of multidimensional assessment:⁷⁶

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications (e.g., health history, current conditions)
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential (e.g., history with treatment and relapse)
- Recovery and living environment"

For adolescents, a supported referral to an appropriate substance use disorder specialist or chemical dependency treatment center is especially important. It can be appropriate to conduct motivational interviewing with the patient and family to encourage acceptance of the referral.⁵⁰ Primary care and emergency room settings are recommended to manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available.

Assessment and referral should be realistic and holistic. ASAM recommends that referrals follow a continuum of care as shown in **Figure 11**, on the following page.



Figure 11: American Society of Addiction Medicine Continuum of Care⁷⁶

American Society of Addiction Medicine. What is the ASAM criteria? Copyright 2014. Accessed: October 2014. Available: www.asam.org/publications/the-asam-criteria/about/.

Aspirational goals for the health care system are to better address access to the full continuum of substance use treatment including medically supervised detoxification in the context of treatment. Ideally, patients would be able to detoxify in one facility and then transfer to another chemical dependency treatment facility. Additional goals are to integrate medical care into chemical dependency treatment facilities to insure that client's medical needs as well as mental health and behavioral needs are addressed in a coordinated fashion including those with developmental disabilities.

The Bree Collaborative seeks to increase the number of patients screening positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria. The Collaborative recommends accurate and timely communication from the referring primary care or emergency room setting to the chemical dependency treatment facility and also from the facility to primary care or the emergency room. Primary care and emergency rooms are recommended to track patients as they receive recovery care and contact patients after treatment has been concluded when the chemical dependency facility has communicated this. Increased cross-site communication and data sharing consistent with CFR 42 should help increase the probability that patients contact and complete recovery care at the chemical dependency treatment facilities reach out to patients who have been referred to but have not reached out the facility and increasing chemical dependency resources sufficient to facilitate successful patient recovery. Additionally, the Bree Collaborative recommends training staff on how to be compliant with CRF 42 and addressing the workforce shortage for certified chemical dependency professionals including training, continuing education, and wages.

Address the opioid epidemic

The Bree Collaborative recognizes that drug misuse trends change over time and recommends that the chemical dependency system remain aware of and able to respond to these trends. Opioids are discussed here due to their current trend toward increased misuse and the example that this epidemic makes of the deficits of the capacity of the health care system to facilitate substance use disorder rehabilitation.

Currently, deaths from opioid overdose have propelled the annual increase in overall deaths from unintentional drug overdose; now the second-leading cause of accidental death nationally.⁷⁷ As discussed earlier, deaths from opiates (heroin and prescription) have almost doubled in the past ten years, rising to 607 from 2009-2011 in Washington State. Heroin is the most common drug in treatment centers among 18-29 year olds and is driven by young adults and primarily outside of the Seattle metro area.²³

The Bree Collaborative recommends that primary, prenatal, and emergency room staff be aware of current drug misuse trends in their community and of effective interventions and treatment modalities. Primary care, prenatal, and emergency rooms have the potential to be very effective in helping to stop high rates of opioid misuse in our community. Pregnant women using opioids should be treated according to the standard of care.

The Institute for Clinical and Economic Review published a well-done review of opioid management bestpractices, Management of Patients with Opioid Dependence: A Review of Clinical Delivery System, and Policy Options. The report is available, here: <u>http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf</u>.

Those at risk for or having witnessed an opioid overdose should be provided opioid overdose education and offered a prescription for naloxone (an opioid overdose antidote). This should include those prescribed opioids, using heroin, and those in social networks as allowed for by <u>RCW 69.50.315</u> "Medical assistance — Drug-related overdose — Naloxone — Prosecution for possession."

Information and training available, here: www.stopoverdose.org.

To address the high and increasing rates of opioid misuse in Washington State, the Bree Collaborative recommends:

- Decreasing inappropriate opioid prescribing for non-cancer, non-terminal pain
- Increasing capacity for primary care providers to prescribe medication-assisted treatment
- Training appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment
- Extending state and private capacity and support for opioid medication-assisted treatment (e.g., increase Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability)
- Facilitating referrals and decreasing barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
- Tracking changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings in patients using opiates to evaluate change over time
- Providing opioid overdose education and offering a prescription for Naloxone to all persons at risk for having or witnessing an opioid overdose, including those prescribed opioids, using heroin, and those in their social networks as allowed for by law
- Utilizing the <u>Prescription Monitoring Program</u> to evaluate a patient's controlled substance history for potential risks

Stakeholder-Specific Recommendations

The Bree Collaborative acknowledges primary care's underutilized role in impacting a patient's substance use disorder and recommends greater screening for alcohol and other drug misuse in this setting. Primary care in this case also includes prenatal care providers and pediatricians. The Collaborative also acknowledges that people may primarily engage with the health care system through the emergency room setting or through a mental health care provider and encourages appropriate substance use screening in these settings as well. The Collaborative recommends that prenatal, emergency, and mental health care providers communicate the results of screening, brief intervention, brief treatment, and/or referral to treatment to the person's primary care provider while in compliance with federal law through 42 CFR part 2.

Although these recommendations are directed at specific stakeholders, we encourage all those involved with chemical dependency screening and treatment to be aware of recommendations for other stakeholders. We encourage the chemical dependency system as a whole to work more collaboratively and adopt better, more consistent communication and information sharing practices in order to help patients navigate the health care system and fully recover.

Primary Care

- Screen all patients over age 13 for alcohol and other drug misuse at the first visit and annually using a validated and scaled screening tool or pre-screen followed by a validated full screen
- Educate staff on:
 - The prevalence of alcohol and other drug misuse
 - Current trends in alcohol and other drug misuse
 - The impact of alcohol and other drug misuse on health conditions
 - That substance use disorder is a chronic, relapsing-remitting disease on a continuum
 - The importance of screening for alcohol and other drug misuse
- Train health care providers how to have non-judgmental, empathetic, culturally competent, and accepting conversations about alcohol and other drug misuse
- Train primary care providers and other appropriate staff to provide brief intervention and if possible brief treatment
- Track patient results from alcohol and other drug misuse screens over time
- Follow-up with patients who have received brief intervention or brief treatment, as appropriate
- Enhance ability to triage patients to appropriate level of care if not improving
- Increase provider and site accesses to qualified behavioral health providers
- Increase site knowledge of available chemical dependency treatment facilities
- Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available
- Wherever possible, provide coordinated, wrap-around care for pregnant women with appropriate primary, addiction, obstetric, and pediatric providers
- Train staff how to do a 42 CFR part 2 compliant release of information
- Establish and maintain working relationships with chemical dependency treatment facilities to facilitate referrals and ensure appropriate communication
- Facilitate patient referral to a chemical dependency treatment facility
- Contact patients after they have been referred to chemical dependency treatment to address any barriers to accessing treatment

- Communicate verbally with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed
- When provided with a patient's hospital discharge information, record the results of screening, brief intervention, brief treatment and/or referral to treatment and follow-up with the patient and the chemical dependency treatment facility to which the patient has been referred to assess whether treatment was initiated and/or completed
- Plan for inclusion of the patient's perspective as additional work is done to increase the capability of the chemical dependency system
- Educate staff about opioid use disorders
- Educate staff about medication-assisted treatment and appropriate counseling
- Increase capacity for primary care providers to prescribe medication-assisted treatment for alcohol and other drug misuse as for other chronic conditions (e.g., increase Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability)
- Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
- Train appropriate staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment
- Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks

Hospitals

In alignment with the Bree Collaborative's <u>Potentially Avoidable Hospital Readmissions Report and</u> <u>Recommendations</u>, this report also recommends that hospitals adopt the Washington State Hospital Association's <u>Care Transitions Toolkit</u> in its entirety. It is understood that some variation may be appropriate based on clinically compelling reasons. The Collaborative acknowledges that communication between hospitals and primary care providers is necessary to positively impact a patient's health, especially with a chronic, relapsing-remitting disease such as substance use disorder.

- Screen all emergency room patients over age 13 for alcohol and other drug misuse using a validated and scaled screening tool or pre-screen followed by a validated full screen
- Educate staff on:
 - The prevalence of alcohol and other drug misuse
 - Current trends in alcohol and other drug misuse
 - The impact of alcohol and other drug misuse on health conditions
 - That substance use disorder is a chronic, relapsing-remitting disease on a continuum
 - The importance of screening for alcohol and other drug misuse
- Train health care providers and other appropriate staff to provide non-judgmental, empathetic, culturally competent, and accepting conversations about and screen for alcohol and other drug misuse
- Increase the number of staff trained to provide brief intervention and, if possible, brief treatment
- Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available
- Wherever possible, provide coordinated, wrap-around care for pregnant women with appropriate primary, addiction, obstetric, and pediatric providers.
- Train staff how to do a 42 CFR part 2 compliant release of information

- Provide all patient's discharge information to the primary care provider or aftercare provider including the results of screening, brief intervention, brief treatment and/or referral to treatment in compliance with 42 CFR part 2 and follow-up as needed
- Enhance staff ability to triage patients to appropriate chemical dependency treatment facilities if needed
- Increase the accessibility of consulting with qualified behavioral health providers
- Dedicate staff time to:
 - Follow-up with patients or caregivers as appropriate who have received brief intervention or brief treatment
 - Establish and maintain working relationships with chemical dependency treatment facilities to facilitate referrals and ensure appropriate communication
 - Communicate verbally with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed
 - Track patients as they receive appropriate recovery care
- Increase capacity to prescribe medication-assisted treatment for alcohol and other drug misuse as for other chronic conditions (e.g., increase Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability)
- Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
- Train appropriate staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment
- Provide opioid overdose education and offer a prescription for Naloxone to all persons at risk for having or witnessing an opioid overdose, including those prescribed opioids, using heroin, and those in their social networks as allowed for by law
- Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks
- Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)

Chemical Dependency Treatment Facilities

- Train staff how to do a 42 CFR part 2 compliant release of information
- Establish and maintain working relationships with primary care providers, prenatal care providers, and hospitals to facilitate referrals and ensure appropriate communication
- Communicate with referring primary care, prenatal, and/or hospital staff when a patient is initially referred and again when the patient is discharged from treatment
- Reach out to patients who have been referred to chemical dependency treatment but have not reached out to your facility
- Preserve the role of competency-based counselors who may not have masters-level counseling training but exhibit the skills necessary to engage with patients and are state certified as Chemical Dependency Professionals
- Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks

Health Plans

- Reimburse for screening, brief intervention, brief treatment, and referral to treatment (SBIRT) services
- Track health care cost and utilization trends over time including hospital admissions as well as morbidity and mortality in patients with substance use disorders
- Comply with the American Society of Addiction Medicine patient placement criteria
- Decline to contract with medical providers (e.g., primary care, prenatal, hospitals) that do not provide screening, brief intervention, brief treatment, and referral to treatment
- Extend capacity and support for opioid medication-assisted treatment

Employers/Purchasers

- Work with the health plan or third party administrator to make benefit design changes to:
 - Reimburse for SBIRT services in primary care and emergency room settings
 - o Comply with the American Society of Addiction Medicine patient placement criteria
 - Provide mental health parity
 - Adopt performance-based contracting for identification, treatment, and follow-up of people with substance use disorders
 - Decline to contract with medical providers (e.g., primary care, prenatal, hospitals) that do not provide screening, brief intervention, brief treatment, and referral to treatment
- Work to reduce stigma associated with receiving alcohol and other drug misuse screening, brief intervention, brief treatment, and referral to treatment
- Provide educational material to employees about alcohol and other drug misuse screening, brief intervention, brief treatment, and referral to treatment
- Ensure that adequate staff exist to monitor compliance with recommendations

The State of Washington

- Increase chemical dependency resources sufficient to facilitate successful patient recovery for publicly and privately-insured individuals
- Address the workforce shortage for certified chemical dependency professionals including training, continuing education, and wages
- Extend capacity and support for opioid medication-assisted treatment
- Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings (including prenatal) for patients using opiates to evaluate change over time

Definitions

Substance Use Disorder: This definition is in alignment with the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition* that combines two previously distinct disorders, substance abuse and substance dependence. Specific substances are diagnosed separately (e.g., alcohol use disorder, opioid use disorder) and categorized as mild (presence of 2-3 of the 11 symptoms), moderate (presence of 4-5 of the 11 symptoms), or severe (presence of 6 or more of the 11 symptoms).⁷⁸ Alcohol use disorder is used as an example below, and for another substance, such as opioids, the first symptom would read, "Opioids are often taken in larger amounts or over a longer period than was intended" etc.

For alcohol use disorder, the 11 symptoms include:⁷⁹

- 1. "Alcohol is often taken in larger amounts or over a longer period than was intended.
- 2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- 3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- 4. Craving, or a strong desire or urge to use alcohol.
- 5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- 6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- 7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- 8. Recurrent alcohol use in situations in which it is physically hazardous.
- 9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
- 10. Tolerance, as defined by either of the following
 - a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
 - b. Markedly diminished effect with continued use of the same amount of alcohol
- 11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for alcohol
 - b. Alcohol (or closely related substance such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms."

Binge Drinking: Consistent with the National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism and the Centers for Disease Control and Prevention, consuming four or more drinks for women within two hours and five or more drinks for men within two hours.

Heavy Drinking: Consistent with the National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism and the Centers for Disease Control and Prevention, consuming eight or more drinks per week for women and 15 or more drinks per week for men.

Drugs: Marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical and medical purposes

SBIRT: Screening, Brief Intervention, and Referral to Treatment Primary Care Integration project is a universal, evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence of alcohol and other drugs.

Standard Drink: One 12-ounce bottle of beer, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits.

Use: Any use of alcohol or other drugs. Adopted by the Bree Collaborative, January 21, 2015.

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