

SBIRT

JAMIE VANDERLINDEN, LCSW, LAC

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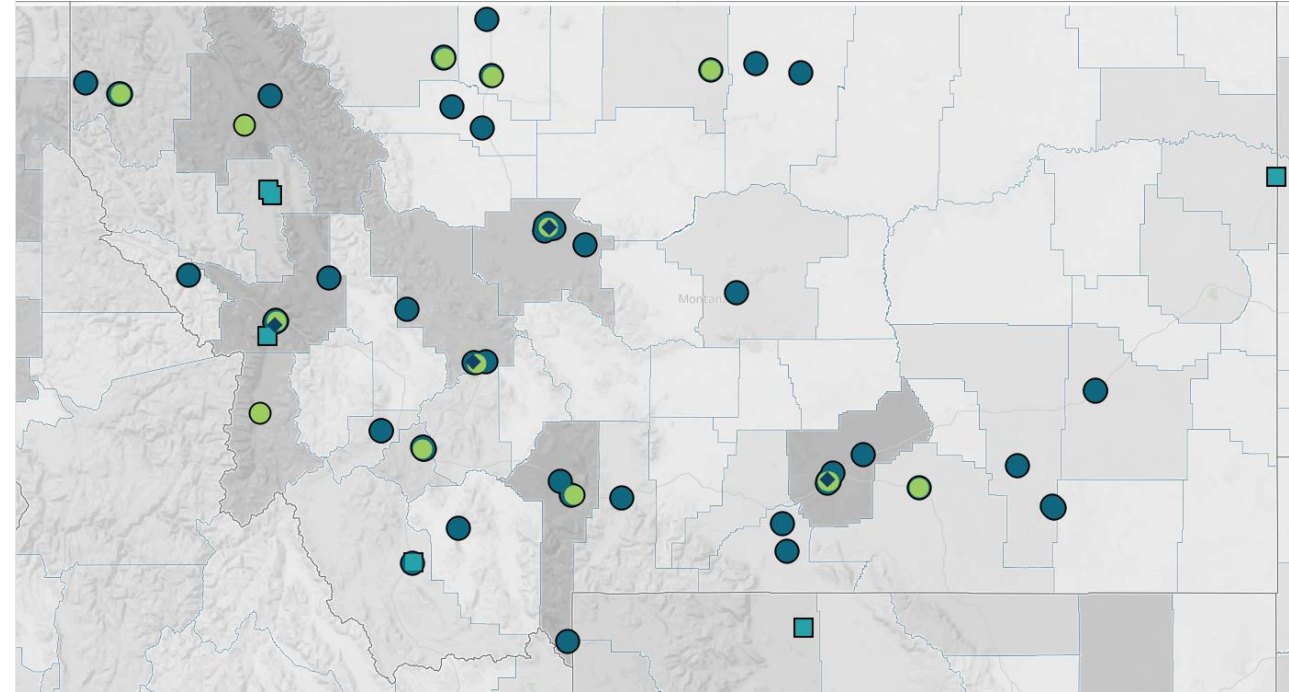
MPCA

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

MPCA values integrity, collaborations, and innovation.

The Montana Primary Care Association is the support organization for Montana's 13 Community Health Centers and 4 of our Urban Indian Centers. MPCA centers serve over 117,500 patients across Montana.



Agenda:

1. Four One Hour Webinars Reviewing:

1. Barriers to Using SBIRT
2. The Data in Montana
3. Screening – What to use and how to ask.
4. Brief Interventions – Using Motivational Interviewing Skills
5. Referrals to Treatment – Both Internal and External
6. Wrap Up and Practice...

2. Today –

1. Introduction to SBIRT
2. Barriers and Research



Group Agreement

- ❖ ZOOM can be unengaging...
 - ❖ Please participate so I don't get bored
- ❖ If you can, please use your camera...
 - ❖ It makes me feel less like I'm talking to myself.
- ❖ Be open to new ideas.
- ❖ Be kind to each other and yourselves!

Zoom meeting,
audio only



Zoom meeting
with video



Introductions

1. Name, Role, Where you Work
2. What do you hope to gain from this training?
3. What made you decide to register for this training?



What the heck is SBIRT?



- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- An evidence-based approach to identifying patients who use alcohol and other substances at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries.
- Risky substance use is a health issue and often goes undetected.





Not Really...

- ❖ This sounds so simple.
- ❖ So what makes it so difficult?
- ❖ Any ideas?



Alcohol Screening, Brief Intervention,
and Referral to Treatment



What do you picture...

Case Example:

A 52-year-old patient who does not have housing. He has been in and out of jail and prison most of his life. He is complaining of pain in his stomach. He smells like alcohol and is carrying a small brown bag with him today as he tells you his symptoms and struggles. His eyes are blood shot, and he has visible tremors as you speaking to him. You go consult with the PCP.

What might you hear from the PCP?

What might your front desk staff say to the patient?

What might the people in the waiting room be thinking?





Accurate Empathy

How might this patient feel?

How difficult was it for them to walk into your clinic in the first place?

How can you improve the chances that they get what they need today and build a relationship with you or your providers?



What do you picture...

Case Example:

A 20-year-old college student who has come to see the PCP with a black eye and bruising after falling at a party. They were drinking and having fun.

How might this person be received by the PCP?

By the front desk?

Patients in the waiting room?





One More...

Case Example:

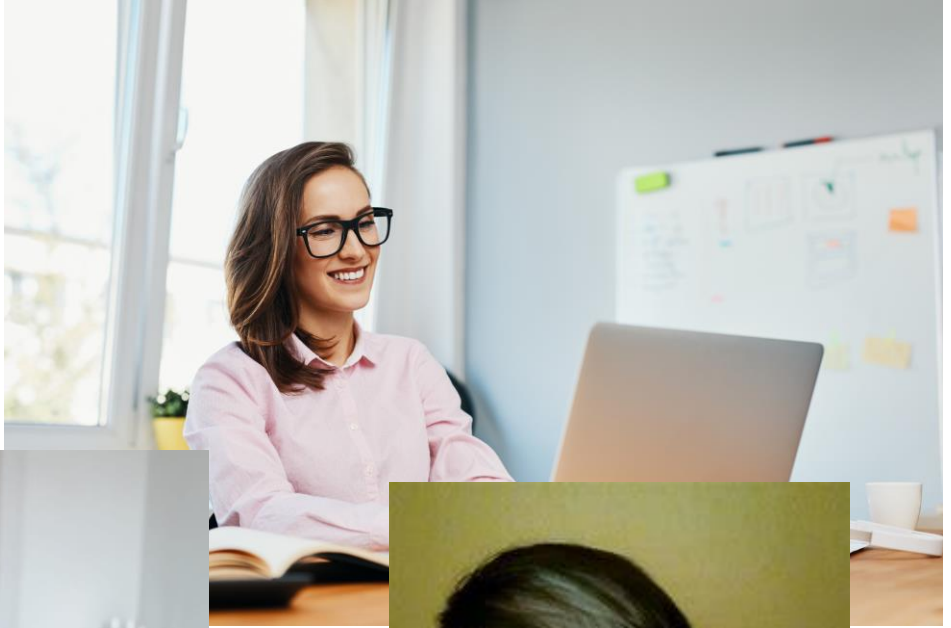
A 48-year-old woman with a professional career. She has high blood pressure and difficulties managing her A1C.

How might this person be received by the PCP?

By the front desk?

Patients in the waiting room?





Montana Primary Care Association



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Image ID: EHK777
www.alamy.com

Barrier: Bias

A human trait resulting from our brain's need to classify individuals into categories so that we can quickly process information and make sense of the world.

This largely happens below consciousness.

This “unconscious” classification of people occurs through schemas, or “mental maps,” developed from life experiences to aid in “automatic processing.”



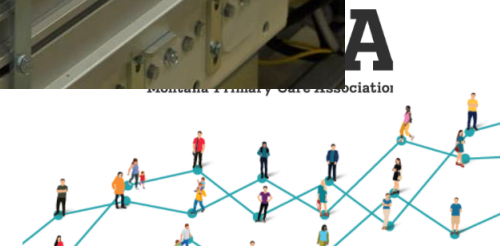
Stereotypes...

These schemas become templates that we use to process new information...

We then respond according to how we have been trained to react to that category/template.

When these schemas are used to categorize people by age, gender, race, or other criteria, they are called **stereotypes**.

This isn't necessarily bad...it's how the brain sorts information so that it can process quickly.



Attitude

- ❖ The positive or negative feelings or thoughts towards a person or thing.
- ❖ Attitudes are shaped by personal experiences and cultural exposure that leave a recorded imprint on our memory.



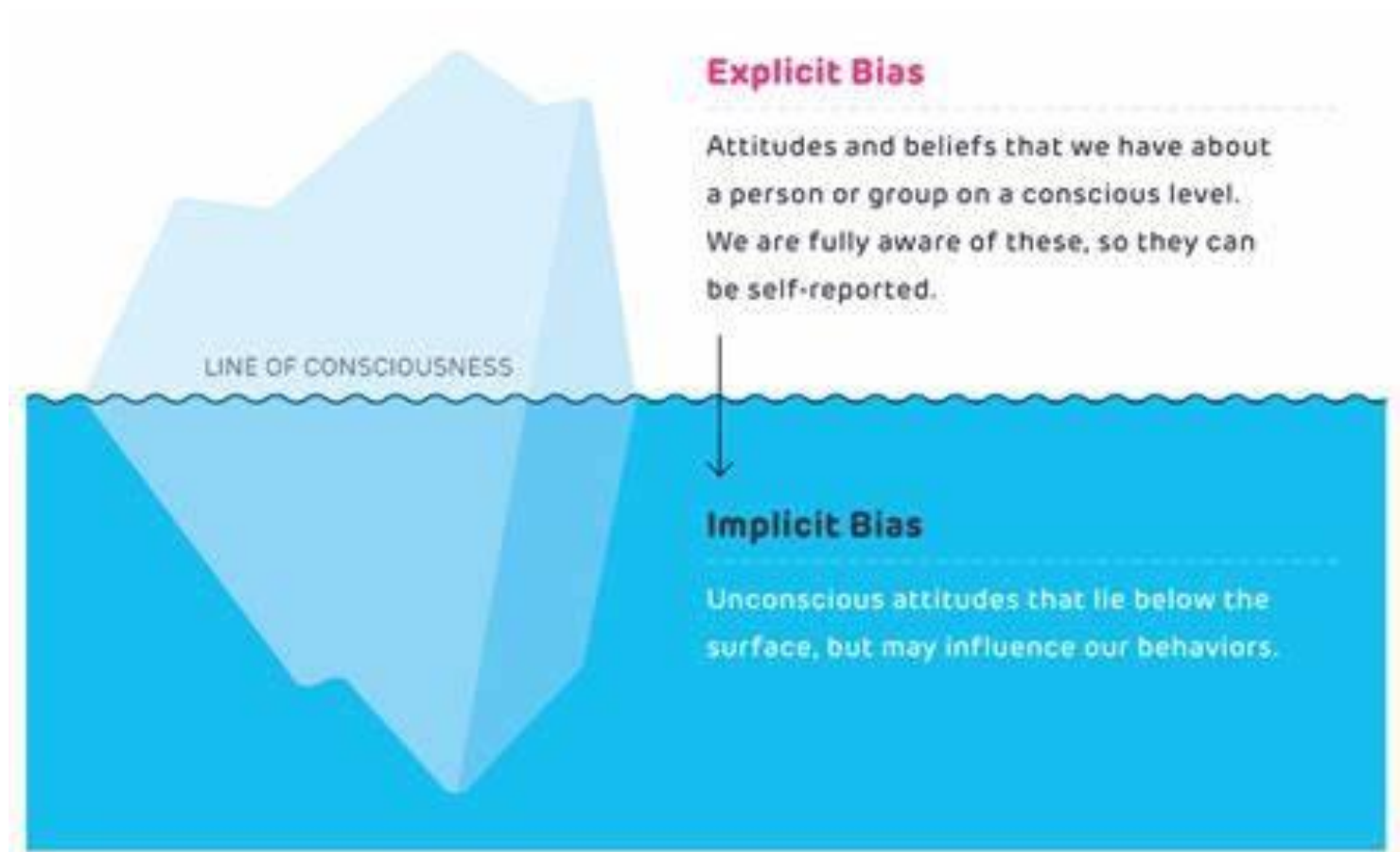
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Alzheimer's Family Care Association



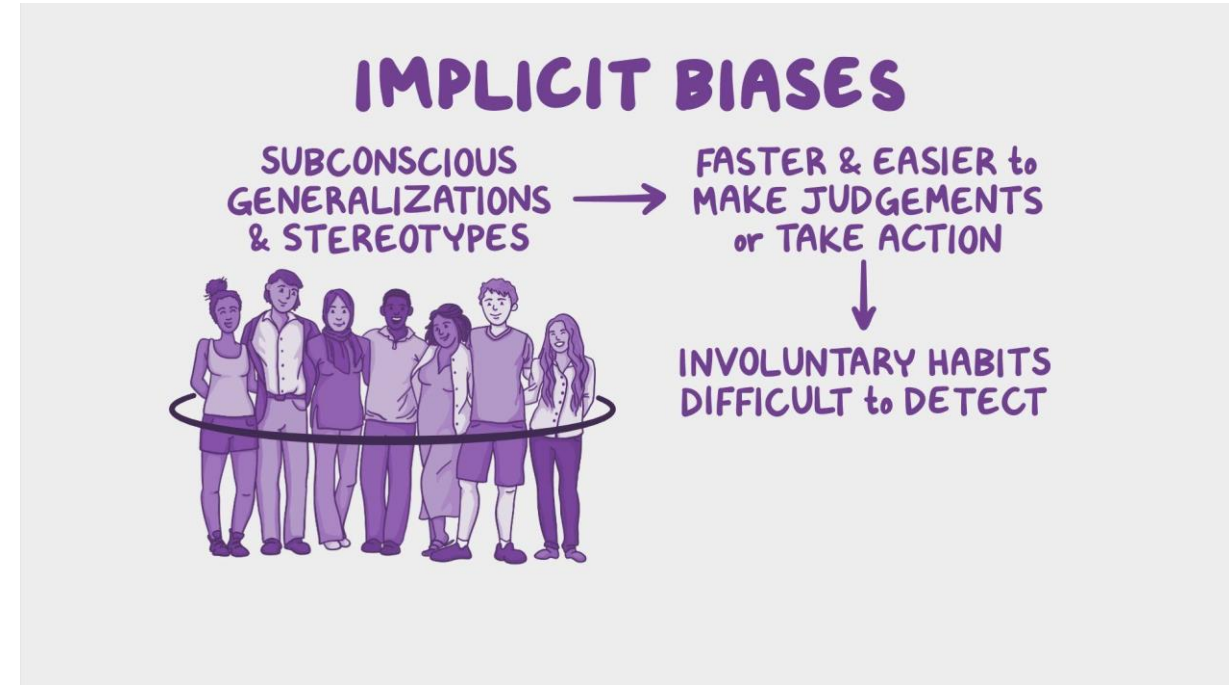
Explicit Bias

- ❖ The traditional concept of bias.
- ❖ The individual is aware of their prejudices or attitudes toward certain groups.
- ❖ Ex) Overt racism and racist comments



Implicit Bias

- ❖ Involves subconscious feelings, perceptions, attitudes, and stereotypes that have developed from prior influences and imprints.
- ❖ The automatic positive or negative preference for a group, based on one's subconscious thoughts.
- ❖ Can be just as problematic as explicit bias and may produce discriminatory behavior.
- ❖ Individual may be unaware that biases, not facts, are driving decision-making.
- ❖ Ex) Officers becoming suspicious of two young Hispanic males driving in a neighborhood where few Hispanics live.



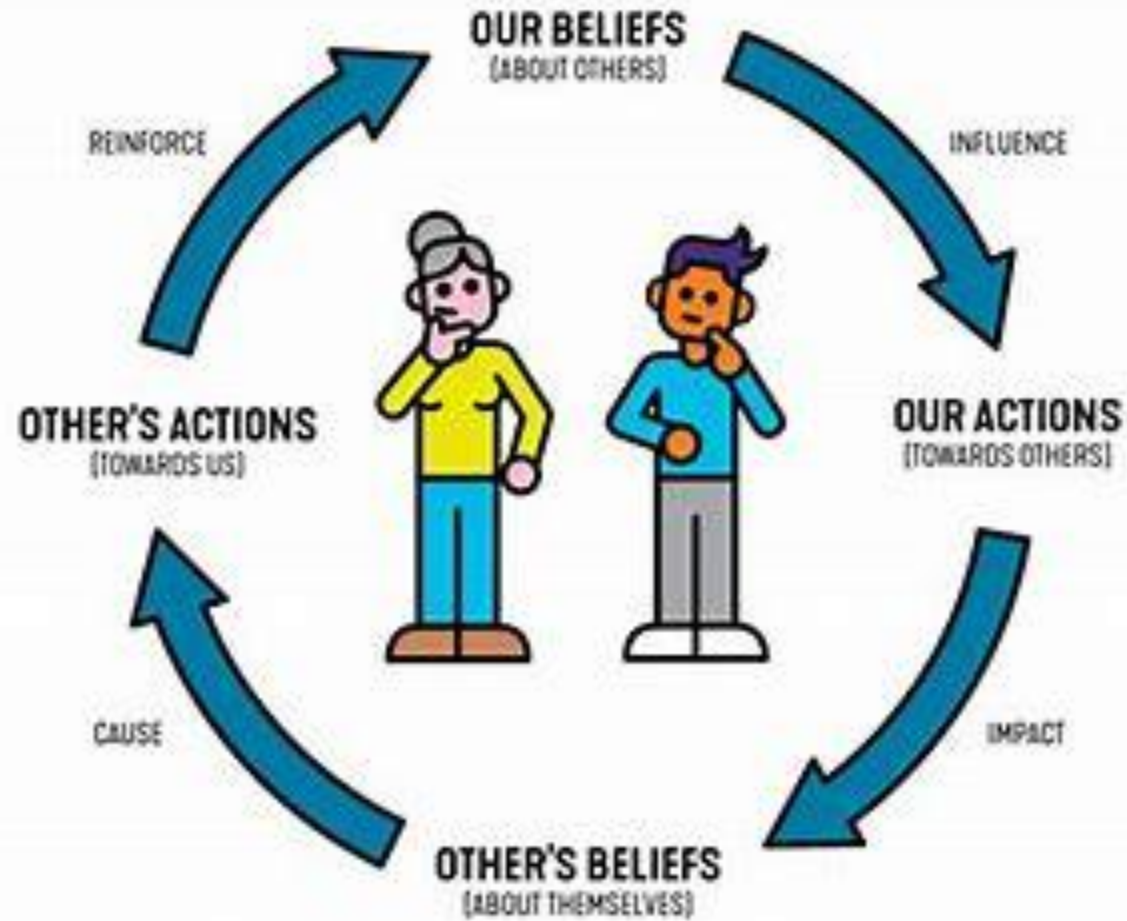
So, What Can We Do?



- ❖ Discuss biases and recognize them for what they are.
- ❖ Once recognized, they can be reduced or “managed,” and individuals can control the likelihood that these biases will affect their behavior.
- ❖ Engage in positive contacts with members of that group of people.
- ❖ “Counter-stereotyping,”
 - Individuals are exposed to information that is the opposite of the stereotypes they believe.



THE PYGMALION EFFECT



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Barrier: Stigma Towards Self...

Patients who experience or expect stigma...

- ❖ Less likely to seek or access services
- ❖ Drop out of treatment early

Stigma is the primary persistent barrier to high quality integrated SUD services.

Patients often feel guilt and shame towards themselves for pain or disappointment they've caused others...



Bias in Health Care:

- We may view patients with SUDs differently
 - We have lower expectations for their health outcomes
 - Perceived Control
 - Perceived Fault



American Primary Care Association



Barrier: We Don't Ask!



- ❖ Believing that patients do not want us to ask
- ❖ Or that they will not tell us anyway
- ❖ Or us not wanting to know...
- ❖ Or believing that they aren't using or drinking excessively
- ❖ Or worries that we have no options to help them anyway...



How Do Patients React to Alcohol Screening?

The University of Connecticut School of Medicine's *"Cutting Back Study"*

Some medical personnel believe that when patients are asked about their drinking, many are uncomfortable and resistant. One reason personnel typically give for not asking about alcohol use is that "drinking behavior is private." This view is not, however, supported by research.

Screened primary care patients in five states for smoking, diet/exercise, and alcohol use.



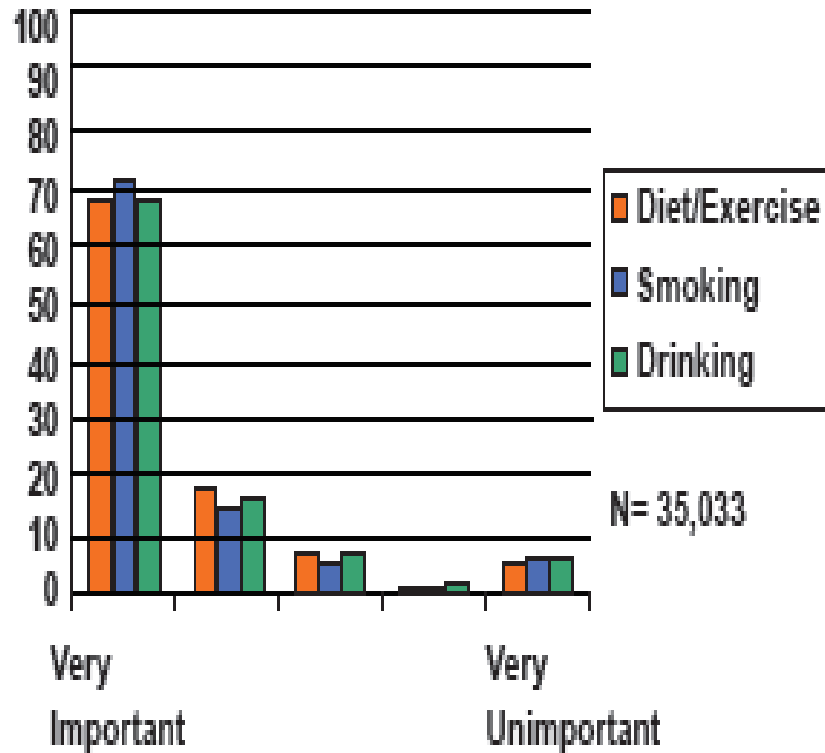
Patients were asked...

1. How comfortable do you feel answering these questions?
 2. How important do you think it is that your health care provider knows about these health behaviors?
- ❖ They were asked to express their views on a five-point scale from “very comfortable” and “very important” to “very uncomfortable” and “very unimportant”
 - ❖ ***FEWER THAN 9% OF PATIENTS INDICATED ANY DISCOMFORT OR ANY THOUGHT THAT SUCH INFORMATION WAS UNIMPORTANT TO THEIR HEALTHCARE PROVIDERS.***

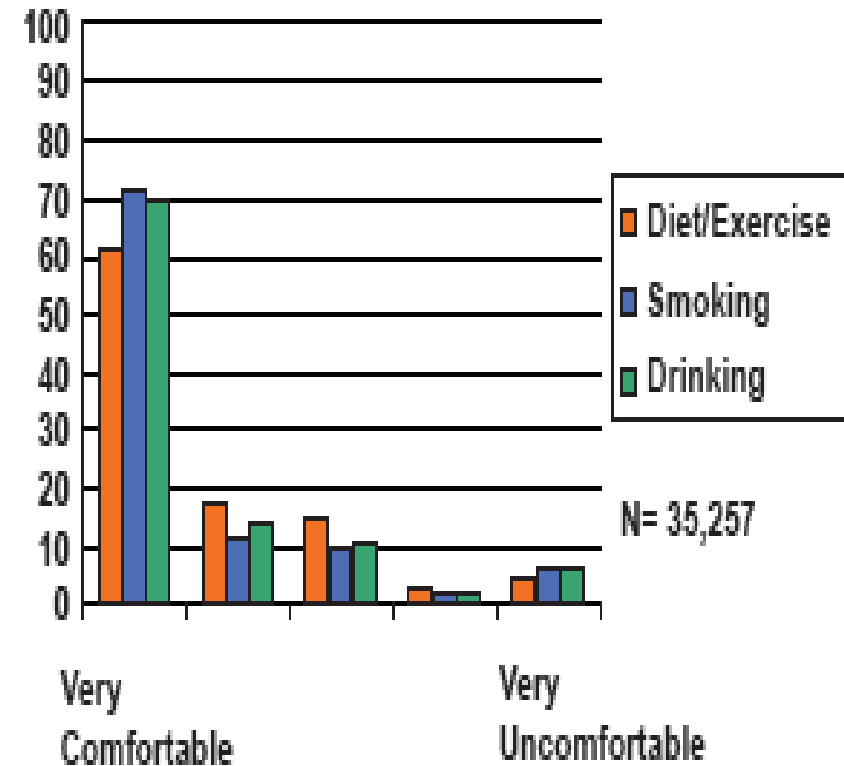


The University of Connecticut School of Medicine's "Cutting Back Study"

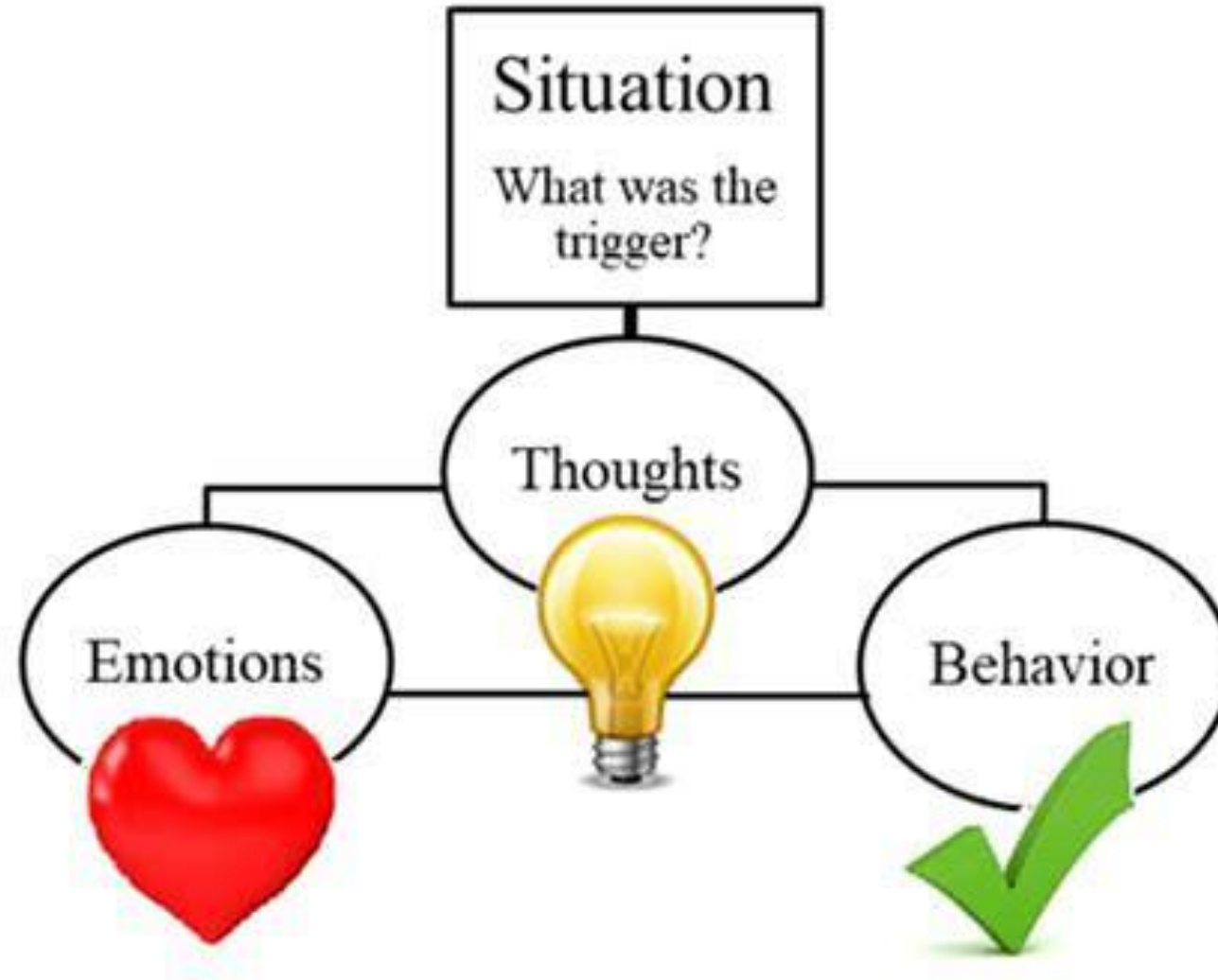
Patient Sense of Importance



Patient Comfort —Cutting Back



Reactions to One Another...



Language Study by Recovery Research Institute

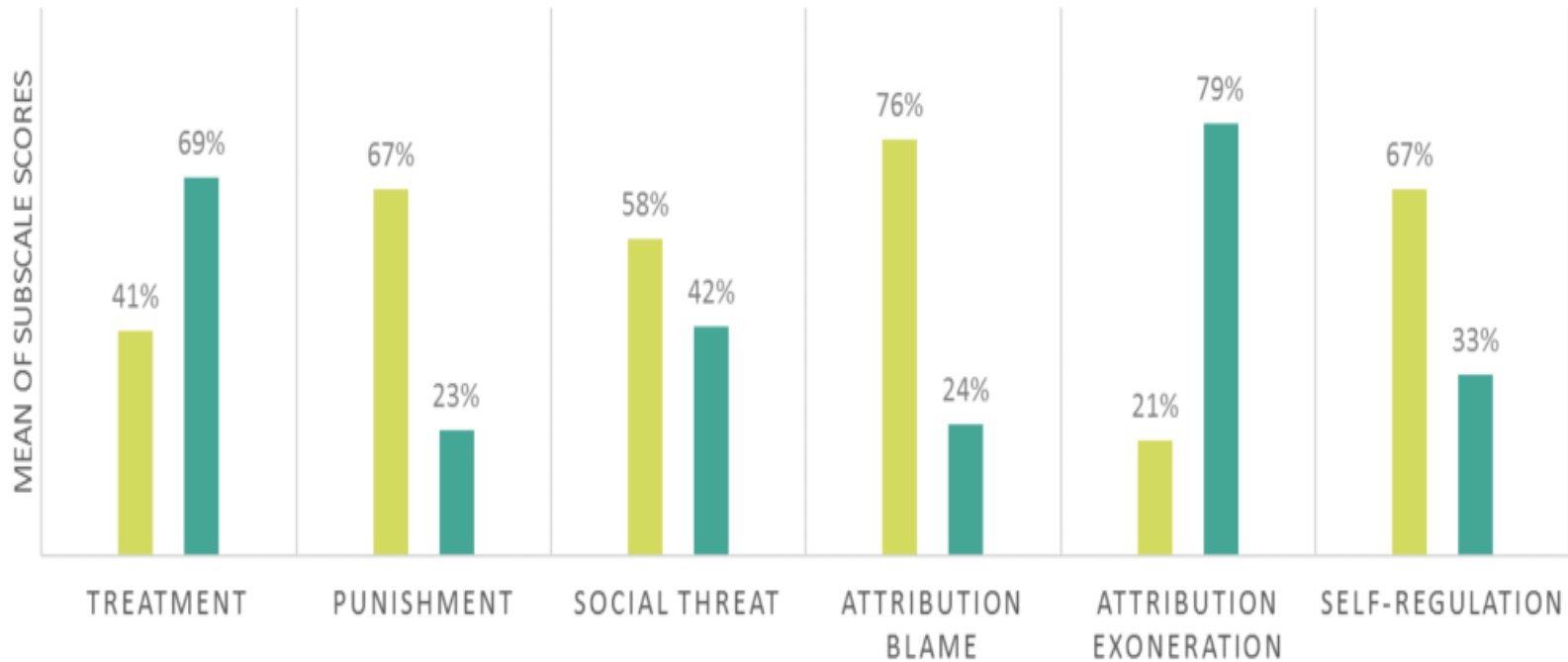
- Dr. John Kelly, Harvard-MGH Recovery Research Institute published a 2010 study & 2015 editorial in American Journal of Medicine which showed an impact on clinical care
- Trained clinicians were given identical scenarios about someone with a substance use disorder and the only thing changed was in one scenario the person was called a 'substance abuser,' and in the other scenario, a 'person with a substance use disorder.' Dr. John Kelly found that when you called someone a substance abuser, it elicited, even from trained clinicians, a **much more punitive response.**



Study by Recovery Research Institute

SUBSCALES COMPARING THE SUBSTANCE ABUSER & SUBSTANCE USE DISORDER DESCRIPTIVE LABELS

■ Substance Abuser ■ Substance Use Disorder



- 50% of participants were in health care
- 20% students
- 29% outside healthcare
- 01% nothing listed
- Average age 31 (range 17-68)
- 81% White
- 76% Female
- 50% Bachelors degree or higher



Person-Centered Language

LANGUAGE MATTERS

When words are used inappropriately to describe individuals with a substance use disorder, it not only negatively impacts the cultural perception of their disease, but creates stigma that can stop people from seeking help. Language matters. Let's replace terms like "addict" and "junkie" with smarter language that aligns with the science.

Say This	Not That
Person with a substance use disorder	Drug addict
In recovery	Clean
Currently using substances	Dirty
Substance use	Substance abuse
Not engaging with treatment	"Bombed out"
Recurrence of symptoms, return to use	Relapsed
Positive drug screen	Dirty drug test
Medication assisted treatment (MAT)	Medication replacement, substitution therapy



Sources:
 JAMA: "Changing the Language of Addiction", Michael P. Botticelli, MEd
 Howard K. Koh, MD, MPH
 Language, Substance Use Disorders, and Policy: The need to Reach Consensus
 on an "Addiction-ary", John F. Kelly PhD, Richard Saitz MD & Sarah Wakeman MD



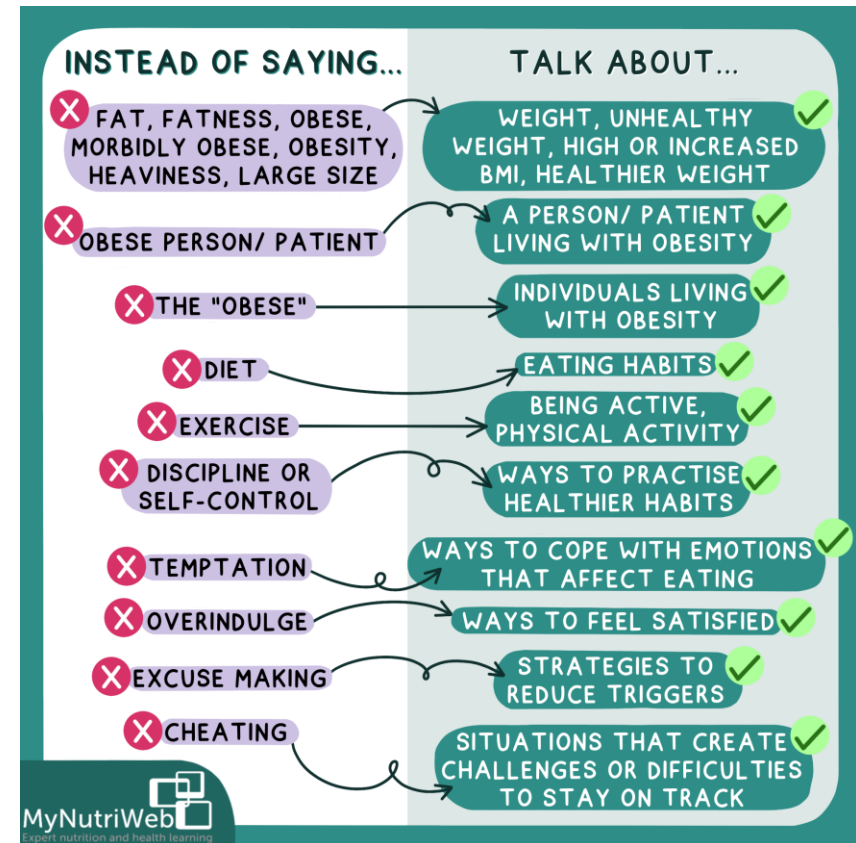
DON'T: use stigmatizing language that labels people.

"She's depressed."
 "He's bipolar."
 "She committed suicide."



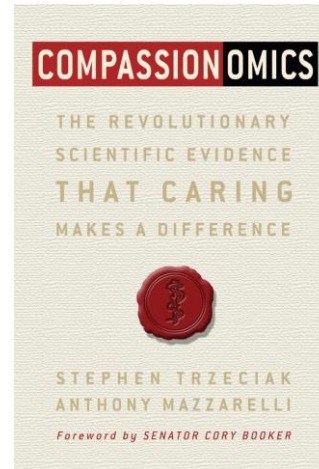
DO: use people-first language that shows acceptance.

"She has depression."
 "He has bipolar disorder."
 "She died by suicide."



Compassion

- 80% higher odds of better blood sugar control in patients with diabetes
- Pt with a common cold had improved symptoms
- Pts more likely to take medications
- Lower Healthcare Costs



- 56% of physicians believe they do not have time for compassion
- 40 seconds of compassion makes a meaningful difference for patients
 - Powerful to the workers delivering compassion also
 - Triggers reward pathways in the brain



We all have bias rooted in:

- ❖ *Our privilege*
- ❖ *Our worldview*
- ❖ *Our upbringing and socialization*



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Break Out!!

Project Implicit Health – Redirect

- ❖ Questions for yourself...what patients do you least enjoy working with?
- ❖ Who do you struggle to relate to or empathize with?
- ❖ Is this something you have considered in the past? How do you work through it?
- ❖ Do you staff this with YOUR supervisor?
- ❖ 15 Minutes then we will be back.



Other Barriers?



Contact Info:

Jamie VanderLinden

MPCA – IBH Team

jvanderlinden@mtpca.org

Barbara Schott

MPCA - IBH Team

bschott@mtpca.org

Next Training: Thursday, February 13th at 10:00.

