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Clinical Case Conference: Cultural Adaptation of Screening, Brief Intervention and Referral to Treatment (SBIRT) using Motivational Interviewing

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INTRODUCTION

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a public health approach that has been widely promoted for use in primary care and other medical settings to reduce hazardous drinking and drug use. While the empirical literature is limited, adaptations based on ethnicity and culture have the potential to improve SBIRT delivery for a range of U.S. populations, including non-Whites and members of varying cultural groups. This clinical case conference describes a fictional composite patient, Ronaldo, a Latino patient presenting in primary care with a history of hazardous drinking, symptoms of depression, chronic pain, and use of prescription opioids. This case study approach was developed as a tool to reinforce and expand on content previously explained (McMahon and Christopher, 2011), (e.g., the accompanying SBIRT review,) and to place this content in the context of a typical clinical setting (Lunney, 2008). We begin by describing Ronaldo's case and the screening and intervention by the provider, which incorporated motivational interviewing (MI) techniques. Following the case description, two expert clinicians (Sandra Larios, PhD, a psychologist working in outpatient drug and alcohol treatment with diverse populations in an urban public hospital; and Scott Steiger, MD, a primary care physician at an outpatient clinic with experience in addiction and pain management), respond with elaboration and suggestions regarding SBIRT in order to illustrate procedures for effective care using culturally appropriate adaptations.

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We place this case in the context of a primary care visit because primary care is a key setting for substance use intervention using SBIRT (U.S. Preventive Services Task Force, 2004). Potentially important clinical settings also include emergency departments (Cherpitel et al., 2010), psychiatry (Satre et al., 2013), and adolescent medicine (Barnett et al., 2001; Mitchell et al., 2013) among others (Madras et al., 2009). Alcohol is the main focus because it is the most frequently misused substance that providers encounter. Evidence supports the efficacy of primary-care based SBIRT in reducing hazardous drinking (Babor et al., 2007), but efficacy in reducing drug use has not yet been established (Saitz et al., 2014). Although we describe a primary care visit in this example, the approach used below could also be employed in other health care environments.

Motivational interviewing (MI) is an important aspect of the described intervention. MI is a directive, patient-centered style of interaction for exploring ambivalence about behavior change (Miller and Rollnick, 2012). In contrast to confrontational substance use interventions, which can increase resistance, MI seeks to evoke and reinforce patient "change talk" (e.g., statements of desire, need, ability, and reasons for change), in which the patient rather than the provider makes the case for substance use reduction.

MI has been incorporated into the SBIRT approach for primary care settings because it can be brief, is adaptable to a range of problem severity, and can enhance patients' motivation to engage with specialized substance use services if needed. Based on limited outcome data, MI can be effective with minority as well as non-minority groups (Hettema et al., 2005). Key MI principles include: expressing empathy with the patient's ambivalence about change, developing discrepancy between current behavior patterns and the patient's goals or values, avoiding argumentation, rolling with resistance, and supporting self-efficacy in making behavior changes.

MI also includes strategies to help elicit and reinforce change talk and enhance motivation: open-ended questions, reflective listening, affirmations and summaries (Miller and Rollnick, 2012). Open-ended rather than closed questions facilitate a dialogue between the clinician and patient that elicits the patient's views on behavior change. Reflective listening highlights key patient statements (such as a particular reason to make a behavior change) and conveys the clinician's understanding of the patient's perspective. Affirmations provide positive feedback in response to patients' willingness to make difficult behavioral changes and may highlight previous successes in making a behavior change. Summary statements are used to link together and reinforce session content and to transition from one topic to the next.

In working with patients from other cultures, it has been proposed that these MI tools be adapted using a social contextual framework (Lee et al., 2011). Key aspects of the model include an enhanced focus on family dynamics, social support, the social context of immigration, employment challenges and experiences of discrimination and health literacy. For example, open-ended questions can explore the impact of substance use on patients' family and knowledge about how substance use impacts medical conditions and medications. Empathic reflections and summaries also can incorporate these aspects of the patient's experience, e.g., that substance use may be occurring within contexts relevant to the patient's immigration history, or may be an understandable coping response to employment

or acculturation challenges. Affirmations can encourage the patient's intent to make changes or highlight important family or cultural components. Examples of these adaptations are integrated into the case description and responses below. See also Table 1 for guidelines on culturally competent SBIRT and MI.

CASE DESCRIPTION

Ronaldo is a 47 year-old married man who presented for services in primary care with symptoms including ongoing back pain and intermittent low mood. Ronaldo spoke both English and Spanish, and reported that he was born in Honduras and immigrated to the United States in his early teens along with his parents. Ronaldo completed high school and two years of technical training, and had worked repairing machinery for the San Francisco municipal railway for 25 years. He was married with two daughters in their early twenties who lived nearby.

Ronaldo rarely went to a physician, although he had medical coverage at a local health maintenance organization through his city employment. On this occasion he was encouraged to make a primary care appointment by his wife. While waiting to see his physician, Ronaldo met with a medical assistant and filled out an intake form that included standard alcohol screening questions on quantity and frequency of alcohol and drug use (National Institute on Alcohol Abuse and Alcoholism, 2004), as well as the Alcohol Use Disorders Identification Test (Babor et al., 2001). On this measure, he reported that: he drank 4 or more times per week (item 1), his usual quantity of alcohol consumption was 3 drinks (item 2), he consumed 6 or more drinks on one occasion monthly (item 3), he felt guilt or remorse about drinking on a monthly basis (item 8), he had been injured in the past year as a result of drinking (item 9), and a relative had expressed concern about his drinking in the past year (item 10). His total AUDIT score was 17, putting him in the at-risk drinking category (>8).

The physician, a 40 year-old African American woman, conducted an initial clinical interview to learn about Ronaldo's presenting problem and to obtain a brief social history. Building on the results of the AUDIT, she also conducted a brief, 15-minute, discussion with him about factors contributing to his alcohol consumption. She approached this discussion using the framework of motivational interviewing (MI) (Miller and Rollnick, 2012).The discussion of alcohol was introduced in a respectful and collaborative way. Since alcohol use was not Ronaldo's presenting problem, he seemed surprised at being asked so many questions about drinking. The physician started this process by saying, “I wonder if we might talk about your drinking today? I do this with all of my patients as part of my general appointments.” After being queried about his alcohol use, Ronaldo reported that for approximately 3 months he had been suffering from substantial lower back pain after falling down some stairs one evening while walking home after heavy drinking. Since then he had been going to work on most days, hoping that his back pain would resolve on its own. While there had been some improvement, he still felt moderate pain and he had eliminated many of his non-work activities. He still enjoyed occasional visits with his extended family in the San Francisco Bay Area, but typically spent several hours per day resting on the couch or lying in bed watching television.

The physician asked Ronaldo to describe his alcohol use in greater detail, saying “Please tell me a bit more about what your drinking has been like over the last few years.” Ronaldo reported that he had been a regular drinker since his teens. He reduced his alcohol consumption early in his marriage while his children were young at the request of his wife, but after his two daughters left the house his drinking increased “to more than when I was younger.” During the past 10 years, Ronaldo reported that he usually had 2-3 beers at home after work, and sometimes as much as 5-6 beers on the weekends or at family events such as birthdays. He occasionally tried to cut back, but usually reverted to his typical pattern within a few weeks. The physician reflected Ronaldo's statements by saying, “You've had some concerns about your drinking and can see the benefits of cutting back on how much you drink.”

Shifting focus back to Ronaldo's presenting problem, the physician said “Tell me more about what your pain has been like and how you have been dealing with it. How has it affected you and your family?” Ronaldo indicated that he was feeling more and more discouraged by his back problems, and wondered if he would ever feel like his old self again. In addition to general feelings of hopelessness, Ronaldo reported problems with sleep, poor concentration, irritability with his wife, and loss of appetite. He was also worried about money. He said, “Unless my back starts to get better soon, I don't see how I'm going to be able to support my family.” Thus far, he had attempted to relieve his pain by increasing his nightly alcohol consumption to 5-6 beers per night, and occasionally using Vicodin that he had obtained from a friend. Ronaldo had mixed feelings about asking for help from a doctor and was skeptical about whether it was possible to feel better. He also was sensitive to the issue of his drinking, given the renewed requests by his wife that he drink less.

Consistent with the MI model, Ronaldo's physician expressed empathy with his frustration around his ongoing pain, saying “I really understand how tired you are of dealing with this back problem.” Ronaldo indicated that he enjoyed drinking and felt it helped him manage his pain at night. However, he also said that he had been falling asleep in front of the TV and was waking up feeling stiff and unrested. The physician reflected and summarized Ronaldo's recent experience: “Initially, it seemed like alcohol was helping manage your pain and helping you fall asleep, but now your sleep isn't so good. You want to feel more rested in the morning.” Ronaldo agreed and reiterated that his lack of sleep was affecting his life. The physician then asked Ronaldo, “Is it ok if I give you some information about the ways that alcohol can affect sleep?” Ronaldo consented and the physician used this opportunity to gently explain how alcohol can have a negative impact on sleep quality. The physician continued to build rapport by asking about Ronaldo's values and goals while remaining mindful of his social context, saying “I wonder if you could tell me a little more about your family and what you hope to do over the next few years.” Ronaldo indicated it was important for him to be a positive role model for his adult children and that he wanted to provide financially for his family by continuing to work.

Having a broader discussion of Ronaldo and his family's concerns about his drinking helped elicit additional reasons to cut back. It emerged that Ronaldo was especially worried about his relationship with his wife and the amount of money he was spending on alcohol. Once he had described the negative impact of drinking on these areas of his family life, he seemed to

become more willing to reduce his consumption. Building on this opening, the physician said, “What do you know about the guidelines for moderate drinking?” Ronaldo indicated he hadn't heard of any drinking guidelines, so the physician offered the following information, “The NIAAA guidelines indicate that men should drink no more than 4 drinks on any one occasion and no more than 14 drinks per week on average. Drinking above this level could put you at risk for health problems. It can also be risky to drink alcohol while taking pain medication. What do you think about this information?” Ronaldo indicated he was surprised to hear that his current drinking level could be problematic. At the conclusion of the appointment, he agreed to have no more than 2 drinks per night and not to drink at all if his pain level was especially bad and he needed to take pain medication. The physician also referred Ronaldo to a specialized pain clinic and physical therapist within the health plan. Ronaldo agreed to return to primary care in four weeks to meet with his physician again to follow up on the plan for both pain management and alcohol use reduction, and to check in regarding his mood status. At the conclusion of the visit, the physician checked to confirm that Ronaldo's presenting problem and other concerns had been adequately addressed.

Ronaldo kept the appointment in four weeks and reported moderate success in reducing drinking and some improvement in depression symptoms. On most days he had only two drinks. He was no longer combining alcohol with pain medication, although pain remained a significant problem. However, the issue of community norms for drinking again came up, because of the expectation that heavy alcohol consumption would be part of family celebrations, (e.g., at a birthday party two weeks previously). The physician engaged in exploration and problem solving around how this could be addressed. After some further discussion it emerged that as one of the older members of his family, he had a degree of influence over how parties were conducted, especially ones in his home, and that he would try to play a leadership role in reducing drinking in his family. He was also concerned that his two daughters not develop negative consequences from alcohol use, and this proved to be an additional source of motivation. Ronaldo and his physician agreed to an additional follow up appointment in four weeks to continue to monitor his progress.

Response 1: Sandra Larios, PhD

Latinos are a diverse and varied group, encompassing many countries of origin as well as languages and cultures (Comas-Diaz, 2001). When working with such a diverse group it is always important to consider where each individual falls along the cultural dimensions known to influence substance use and treatment. One of the first to consider is acculturation. Other important cultural factors include values, especially “familismo,” “espiritismo,” “machismo,” and “respeto.” As described below, each of these is potentially relevant to the screening and intervention that Ronaldo received from his primary care physician. In considering the impact of cultural values, it is important not to make assumptions based on an individual patient's surname, language or appearance. Rather, values often ascribed to a specific ethnic group can be used as a starting point to stimulate discussion. The motivational interviewing approach is very effective in this regard, in that it directs the provider towards an individualized conversation about what each patient considers important.

Acculturation can be defined as the process by which change occurs when individuals from different cultures interact and share a common geographical space (Ryder et al., 2000; Vega et al., 1998). Acculturation also plays an important role when working with Latino patients because it can guide a provider's emphasis on more traditional cultural values. Older generations of Latinos (first- or second-generation) may identify more strongly with traditional Latino values than younger generations. Language and generation status can be used as proxy measures of a person's acculturation (Ryder et al., 2000), but further assessment of engagement with the Latino community and an individual's traditional cultural values is always warranted. In the case presented, Ronaldo was bilingual yet was a first generation immigrant. He ascribed to a hierarchical view of family structure (i.e., “respeto”) and was not very engaged in western medical treatment. Given this information, I would describe this patient as more acculturated to the Latino culture and proceed accordingly.

Another important component to consider when working with Latino patients is “familismo.” As was shown in the case, paying attention to the patient's “familismo” or reliance on and importance of the family (Lee et al., 2011; Marín and Marín, 1991) can be used as a tool for motivating an individual to stop drinking within the SBIRT/MI approach. Ronaldo identified his daughters’ well-being as an important reason for cutting back on his drinking and his wife was the impetus for him making the appointment in the first place. It appears that Ronaldo values “familismo” and this can be leveraged into making changes in his life so as to benefit the greater family unit. In future sessions it might be helpful to bring in members of his family to rally support and include them in his treatment plan.

Espiritismo (Spiritualism or spirituality) refers to the critical role that faith plays in the Latino culture. As it does for others, religion offers many Latinos a sense of direction in their lives and guidance when thinking about their health and the connection between mind and body. Depending on where they are from, they may also seek medical or mental health care from alternative healthcare providers, such as *curanderos*, *sobadores*, and *espiritistas* (Pajewski and Enriquez, 1996). In working with the Latino community it can be helpful to incorporate spiritual support in treatment and to discuss the role of their higher power in recovery. Because Latinos generally tend to rely on extended family members more than on friends for social support (Schweizer et al., 1998), this cultural value may not translate into Alcoholics Anonymous (AA) attendance, but it is possible that Latino patients may be more open to discussion of AA as an option if it is in accord with their individual spiritual beliefs.

Machismo refers to a man's responsibility to provide for, protect, and defend his family (Arciniega et al., 2008). Machismo has been linked to a societal expectation that Latino men are drinkers and are able to hold their liquor while also providing for their families. This increases the potential for men to self-medicate, as was seen in the presented case. Ronaldo felt pressure to take care of his family despite his chronic back pain and was using alcohol to manage his physical pain and possibly his anxiety about being unable to provide for his family. In this situation, highlighting the connection between his alcohol use and his inability to care for his family may be an important way to use his machismo to increase his motivation to reduce drinking. As was discussed in the case, Ronaldo was eager to set a good example for his daughters and protect them from potential problems in the future. Treatments that emphasize the ability to fulfill role requirements while at the same time

enlisting family support are effective and take into consideration multiple cultural values important to the Latino community.

Latino culture generally places a high value on demonstrating “respeto” in interactions with others, which literally translates into respect. “Respeto” means that each person is expected to defer to those who are in a position of authority because of age, gender, social position, title, economic status, etc. In the presented case, the provider was able to use this cultural value to help modify the patient's behaviors. By discussing his choice to drink in terms of protecting his family and highlighting his important role in the family hierarchy, the provider was able to use the cultural values of respeto and machismo to increase the patients desire to change his behavior in order to set a better example for the entire family.

Response 2: Scott Steiger, MD

Ronaldo's case illustrates how a primary care provider can integrate a culturally sensitive brief intervention into a short primary care visit to increase patient motivation to reduce hazardous drinking. His extra-medical opioid use could confuse the clinical picture, but his provider responded in an appropriate manner that reduced his risk of complication. Ronaldo screened positive for risky drinking, and the physician expertly tailored her intervention to his specific situation.

While SBIRT appeared well-integrated into the overall primary care visit, delivery may not always flow smoothly. Fortunately language was not a barrier in this case, and the physician tied the patient's presenting issue (management of back pain) into an exploration of substance use, a useful strategy for reducing resistance to a shift in what the patient expects to discuss. The typical primary care visit is short, and time constraints and competing clinical demands are significant challenges when conducting MI-based explorations of substance use consequences and other motivational factors (Rahm et al., 2014). In this case example, initial substance use screening conducted by a nurse helped to reduce pressure on the physician's time.

The assessment triggered by the physician's evaluation of the positive AUDIT screen reminds us that the classification of alcohol diagnoses has changed with the publication of the DSM-5. Whereas previous editions of the manual delineated a difference between alcohol abuse and dependence, the current edition includes a single diagnostic category of “alcohol use disorder,” modified by severity indexed to the number of adverse consequences experienced or compulsive behaviors exhibited. Risky drinking is not captured by this new system yet remains important to identify. In two other relevant changes, craving was added as a feature and “legal problems” eliminated. This latter change was made in part because ethnic minorities are much more likely to be profiled and have “legal problems,” hence inflating their substance use disorder rates versus whites. While legal problems were not part of Ronaldo's case presentation, this is a diagnostic system change especially relevant to non-whites.

Depending on how his clinician classifies his troubles with his wife, his increased use, and the persistence of his desire to cut down, he may meet criteria for mild alcohol use disorder. Clinically, the treatment for this case— brief intervention integrating MI techniques—

remains the same under either classification system. Regardless of whether or not the patient meets criteria for an alcohol use disorder, routine screening for risky drinking can help providers recognize that there is a problem earlier in its natural history, when they can still address it within the context of primary care.

Ronaldo's extra-medical access to Vicodin is unsurprising. More hydrocodoneacetaminophen prescriptions are filled annually in the United States than any other medication (IMS Institute for Healthcare Informatics, April 2012), and not all of these pills are taken by the people for whom they are prescribed. Numerous reports from recent medical literature and popular press have focused on the way widespread access to prescription opioids has increased opioid addiction and overdose death. These stories may imply that both parties in the extra-medical opioid exchange are morally inferior, with the people taking the diverted medication “misusing” or “abusing” pills and “dealers” or “pill pushers” providing them. Clinical experience and common sense suggest that stories like Ronaldo's are much more common: my friend or loved one has some acute pain, so I give them something that might help. Of course, this apparently humane gesture has potential pitfalls—it is not difficult to imagine that a man intoxicated enough to fall down stairs on the way home might forget how many Vicodin he already took. Ronaldo's clinician appropriately recognizes that mixing substances may be more immediately dangerous to her patient than the putative risk of opioid use disorder, and they agree that he should avoid using Vicodin when he drinks.

The MI techniques used by his clinician allow her to engage Ronaldo in changing his behavior within the context of family and culture. While no information from the case suggests an exaggerated machismo (nor any specific difficulty in interacting with a female physician), he does acknowledge a sense of financial and moral responsibility for his family that is consonant with a man from a socially conservative Latino background. He exhibits traditionally masculine traits of stoicism (going to work despite the pain), independence (self-treating rather than seeking help from a doctor), and he prizes his standing within a large family (visiting them being the only activity he continues after his injury). The clinician could have chosen to support his self-efficacy and remind him of his past success at reducing his drinking, but he may not need much cheerleading—cultural norms may have set him up to feel empowered to make changes without it. If clinical feedback can help further enhance his self-image as a strong male leader of his family, he may respond better to entreaties to role fulfillment than to independence.

SUMMARY

The case of Ronaldo illustrates a clinical situation in which cultural considerations impact SBIRT implementation, including screening and evaluation of substance use severity in a primary care context as well as delivery of a brief intervention using MI skills to reduce both hazardous drinking and drug use. This case discussion serves to illustrate the accompanying literature review, which indicates that SBIRT can be effectively delivered to patients from a wide range of backgrounds if an understanding of cultural values and differences informs adaptations to clinical care. In the case of Ronaldo, awareness of the patient's degree of acculturation provides a tool to understand the potential effects of cultural values relevant to

family, spirituality, gender roles and personal respect. Rather than stereotyping the experience of patients from diverse backgrounds, the case description and expert clinical commentary highlight how an MI approach may elicit cultural factors to effectively enlist Ronaldo in a discussion of his alcohol and drug use. This can lead to enhanced motivation to reduce use to a less hazardous level and also lays the foundation for an effective patient-provider relationship in managing the patient's overall medical care.

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Table 1

Guidelines for Culturally Competent SBIRT and MI

Guideline	Applications in Clinical Practice
Reflect empathy, curiosity and respect, which are fundamental to successful cross-cultural encounters.	Apply core SBIRT and MI skills such as active listening and empowering patients to make decisions.(Lee et al., 2011; Teal and Street, 2009)
Demonstrate knowledge about cultural groups but recognize that each group is heterogeneous.	Assess cultural issues for individual patients in order to avoid stereotyping.(Carrillo et al., 1999; Teal and Street, 2009)
Understand the meaning or explanatory model of illness for each patient.	Assess patient's agenda based on their explanatory model of illness.(Carrillo et al., 1999)
Increase focus on social context and social support.	Specifically ask about environment, finances, social stressors, immigration and social networks.(Teal and Street, 2009; Wu et al., 2009)
Accommodate patient's language preference.	Translate materials into other languages, use a multilingual staff, and use diagnostic instruments validated for minority groups.(Carroll et al., 2009; Forbat, 2003; Hinton et al., 2005; Lee et al., 2011; Yu et al., 2009)
Match patient's health literacy levels and provide appropriate education.	Assess patient's health literacy level. Deliver MI-adherent health information on substance use impacts.(Lee et al., 2011; Miller and Rollnick, 2012) Ask patient to repeat back action steps or plan to assess comprehension of instructions.
Cultivate diversity in clinic workforce.	Hire a diverse staff when possible. Diverse medical residents Howard University found cross-cultural SBIRT training clinically helpful.(Marshall et al., 2012)
Incorporate members of the community in the design and implementation of cross-cultural programs.	Studies with American Indian and Alaska Natives show that substance programs are accepted by participants when organized, in part, by community members.(Masis and May, 1991; Montag et al., 2012)
Adopt a family-centered approach.	Explore family context and family impact of substance use.(Lee et al., 2011)
Integrate traditional practices and traditional spirituality when appropriate.	Incorporating traditional activities and traditional spirituality can have positive effects on alcohol cessation with diverse populations.(Stone et al., 2006)
Negotiate mutually agreeable treatment options.	Treatment and management of disease should be based on the patient's individual information and preferences.(Carrillo et al., 1999)