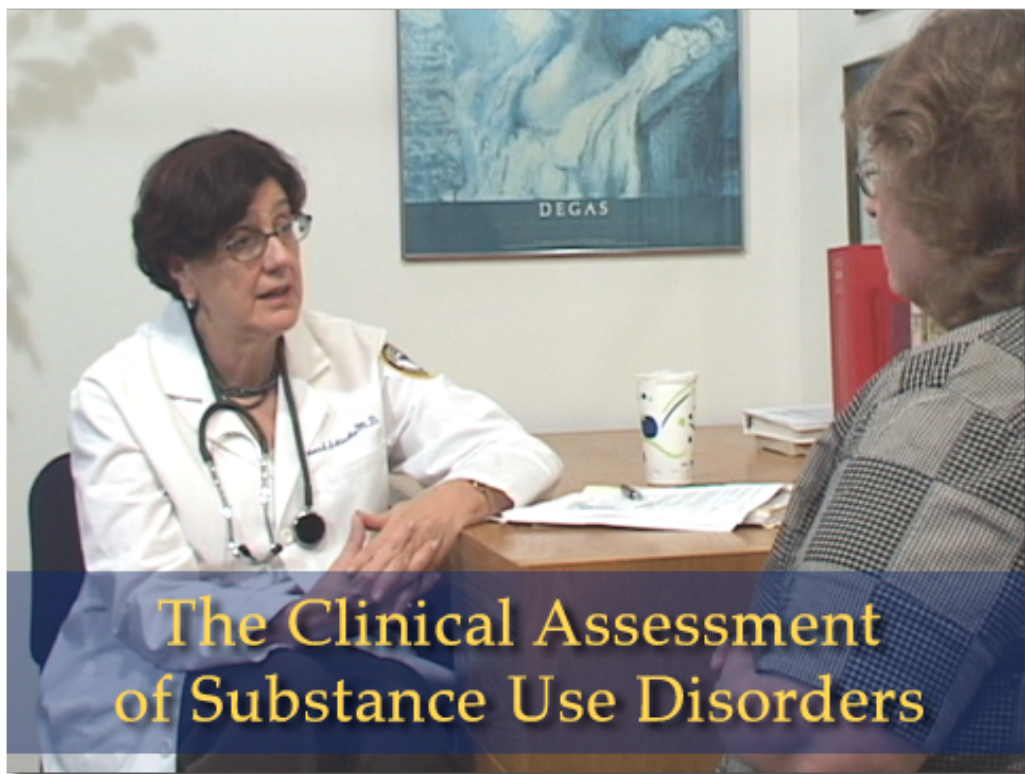


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AACH American Academy on
Communication in Healthcare



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Instructions on the Quick Read (QR) Barcodes:



Wherever you find a QR Barcode embedded in the text, you may scan it with your Smartphone – and the video it encodes will play, if you have a sufficient Internet connection and bandwidth. There are several free QR-Barcode Reader Apps available for iOS and Android Smartphones.

See <http://techcraver.com/2011/06/13/how-to-use-qr-codes/> for more information.

PREPARATION

See Page 2 for instructions how to use QR Barcodes!

Rationale



The Patient's View



The Doctor's View



Questions for Reflection:

1. How have your experiences with patients, family members, friends, and colleagues with substance use disorders affected your attitudes towards substance-using patients?
2. What reservations do you have about accepting the disease model for substance use disorders?
3. Why do physicians often fail to ask substance use screening questions?
4. Describe how you feel when your patients fail to curb their substance use, or even acknowledge interest in doing so?
5. Physicians often tell patients, "You will die if you do not stop using drugs!" or "Your wife says she is leaving unless you change your ways!" What are the implications of this type of communication?
6. How do you respond to some patients' disrespectful, dismissive, irritated, or

- angry responses when asked about substance use? What behaviors are most likely to “push your buttons,” so that your responses are not therapeutic?
7. Can you say “no” when patients you respect and care for over long periods of time request prescriptions for controlled drugs that are not of proven or clear medical value for them—e.g., diazepam, or oxycodone for chronic back pain or headache, or additional sedatives for insomnia?

Key Principles:

1. In 2008, an estimated 20.1 million Americans aged 12 or older were current (past-month) illicit drug users. (8.0% of the population). (2008 SAMSHA National Survey on Drug Use and Health report <http://www.drugabusestatistics.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#Ch2>, figure 2.2)
2. Substance use disorders affect 45% of patients who present for medical care but are routinely unrecognized by healthcare providers. (1)
3. Physicians and other healthcare providers can play a key role in facilitating the diagnosis and treatment of patients with substance use disorders
4. Conducting an unbiased clinical interview is critical in making an accurate diagnosis and facilitating treatment of patients with substance use disorders
5. The use of structured screening and assessment strategies (e.g. CAGE Questionnaire) is essential in the assessment of substance use disorders
6. Staging the severity of addiction, calibrating patients’ readiness to change behaviors, and willingness to access professional help are crucial to good medical care
7. Patients are more likely to follow plans that are negotiated in partnership with physicians and renegotiated at follow-up visits.
8. Sustained recovery requires many resources. To achieve treatment goals, physicians should become comfortable referring patients to resources such as self-help groups, professional treatment programs, and psychiatrists to treat co-morbid psychiatric disorders.

Learning Goals:

1. Describe the essential components of the medical model of substance use disorders.
2. Delineate the interviewing skills necessary to screen effectively for substance use and abuse.
3. Recognize the high rate of psychiatric and medical co-morbidity and how to screen patients for both.
4. Demonstrate skills for evaluating patients’ stage of change, readiness to accept the diagnosis, and readiness to undertake behavior change.
5. Clearly and supportively recommend treatment to patients with substance use disorders.
6. Describe the skills required for addiction prevention counseling.
7. Define the skills that help set respectful limits on patient requests for prescription medication.
8. Demonstrate awareness of how physician/clinician attitudes toward patients with substance use disorders impact recognition, diagnosis, and treatment of patients.
9. Demonstrate knowledge of substance use disorder treatment standards and the ability to recommend appropriate referrals.

INTRODUCTION

Substance abuse and substance dependence are commonly seen in patients in medical practices, and are frequently co-morbid with other medical and psychiatric disorders. Considerable societal stigma exists toward patients with substance use disorders; healthcare providers frequently have negative attitudes toward these patients as well. Fortunately, there are established communication skills you can master that will facilitate the establishment of therapeutic relationships and motivate patients for treatment.

Substance abuse and substance dependence have a 10.3% lifetime prevalence; yet, they are routinely under diagnosed by healthcare providers. (2, 3) Approximately 20.1 million Americans age 12 and older used illicit drugs in the past month (8.0% of the population). (4) The prevalence of illicit drug use is 7 to 20% in ambulatory practices and up to 50% in trauma patients. (1) Psychiatric and physical co-morbidities are very common, and 60% or more of patients with substance use or dependence suffer from an additional psychiatric disorder.(4,5) In 2008, an estimated 23.1 million persons age 12 or older needed treatment for an illicit drug or alcohol use problem (9.2% of the population over 12). Of these, 2.3 million (0.9% of the population and 9.9% of those who needed treatment and received it) received treatment at a specialty facility.(4) In addition to the health and social consequences, these high rates of use and of undertreated patients contribute to the staggering financial costs of substance use (illicit drugs and alcohol), which are estimated at \$416 billion per year. These costs, do not, however, translate into treatment costs. For example, in 2003, only 1.3% (\$21 billion) of total health care expenditures were for the treatment of alcohol and drug disorders.(6,7)

People with substance use disorders are heavily stigmatized. Physicians are not immune from negative attitudes about substance use disorders. The identification, assessment and referral for treatment of patients are strongly influenced by physician attitudes and life experiences with personal, family, or prior patients' substance use. Effective tools and strategies can help you recognize the physiologic and behavioral red flags of addiction and elicit a substance use history in a nonjudgmental manner, so you can make the appropriate diagnosis and develop a patient-specific plan for treatment and referral. (8)

This educational module on the clinical assessment of substance abuse disorders presents written text and instructional videos that provide the knowledge, skills, and attitudes needed in the screening, evaluation, and referral of patients with substance use disorders. The video examples in this module focus on prescription drug abuse, a common and increasing problem in clinical practice. However, the strategies for screening and referral that we present are the same for all substance use disorders.

For additional information on drug abuse and addictive disorders, please go to the National Institute on Drug Abuse's NIDAMED Web site:
<http://www.drugabuse.gov/nidamed/>

MEDICAL MODEL OF SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE

Substance use disorders are complex chronic, relapsing and remitting diseases in both presentation and pathogenesis, resulting in significant morbidity and mortality. Despite the neurochemical changes and the chronic and relapsing nature of these diseases, treatment is effective and recovery possible. <http://www.drugabuse.gov/scienceofaddiction>

- Substance use disorders are characterized by compulsive drug seeking and use despite harmful physical, psychiatric, and interpersonal consequences. (9,10)
- Substances of abuse alter brain function, impact many health conditions, and can lead to major public health problems, including the transmission of HIV, hepatitis, and tuberculosis.
- Steady use of psychoactive substances causes biochemical and structural changes in the brain that limit self control and result in substance abuse and dependence as defined in the DSM IV-TR (see text under the heading "Diagnostic Criteria," below). Substances of abuse acutely activate and chronically dysregulate brain reward functions, largely via mesolimbic dopamine pathways. Brain-imaging studies show changes in both anatomy and physiology in areas known to be critical for judgment, decision making, learning, memory, and behavior control. (11) See also <http://www.drugabuse.gov/pubs/teaching/Teaching6/Teaching.html>.
- "Addiction" is a commonly used but frequently nonspecific term. In this text, "addiction" is defined as a chronic, relapsing brain disease, characterized by compulsive drug seeking and use despite known harmful consequences. It may include physical dependence, which refers to brain changes associated with daily substance use that produce noxious symptoms (e.g., gooseflesh, runny nose, hyper-alertness, sweating, tremor, confusion) when the person stops using (i.e., withdraws). Withdrawal is a powerful stimulus to use again, and the symptoms abate when use is restarted. However, physical dependence is not the same as addiction.



Please scan the qr barcode on the left to watch Cliff talking about his substance use and how he became addicted.

- Substance use disorders have a multi-factorial etiology, including genetics (can account for 40–60%), biologic changes in brain function, and pre-

existing co-morbid Axis I psychiatric disorders. Family history, societal, and life events can also be important etiologic factors. However, most people who "experiment" with drugs or alcohol do not develop a substance use disorder.



Please scan the qr barcodes on the left to watch Michelle discuss how mental health issues led to addiction and Rhonda discuss the complex life circumstances that led to her addiction.



- Substance use disorders are a major co-factor in societal violence.
- Substance use often begins in childhood or adolescence, when the brain continues to undergo dramatic changes. One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control—putting adolescents at increased risk for poor decisions (such as trying drugs or continued abuse). Moreover, the immature brain may be particularly vulnerable to chemical changes caused by psychoactive drugs, and therefore drug use may increase the risk of abuse or dependence in adolescents and young adults. Adolescents who use alcohol or other psychoactive drugs also frequently have academic and social problems, as well as encounters with the criminal justice system.
- Symptoms of substance abuse, dependence, and withdrawal can mimic symptoms of major psychiatric disorders.
- Treatment works! Treatment enables people to regain control of their lives and counteract the powerful disruptive effects on the brain and behavior of substance abuse or dependence.
- Relapse rates for treatment of substance use disorders are similar to those of other chronic illnesses, like asthma or diabetes. Thus, substance use disorders should be treated like any chronic illness, with relapse serving as a trigger for renewed intervention.

Diagnostic Criteria

To serve your patients well, you must know features that distinguish the substance use disorders from one another and from non-problem-use. More important, you must take action when you are concerned, even if you cannot make a definitive diagnosis.

The DSM IV criteria for distinguishing substance use disorders, including substance abuse, dependence, and substance-induced disorders, are delineated in the next sections. The symptoms that practicing clinicians witness are frequently only the tip of the iceberg. Any concern on your part may indicate a more serious problem. Therefore, take action as soon as your screening protocols or the presence of any "red flag" suggests substance use problems. Refer all patients with evidence of a substance use disorder for further evaluation and possible treatment by a substance abuse professional.

Substance abuse specialists have the time and tools to make an exhaustive diagnostic inquiry; to distinguish between substance use, abuse, and dependence; and to adjust their interventions accordingly.

Substance Use Disorders and Substance Related Disorders

The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR (12), categorizes Substance Use Disorders and Substance-Induced Disorders, and specifies criteria for diagnosis: Abuse and dependence are maladaptive patterns of substance use leading to clinically significant impairment or distress, as manifested by persistent or recurrent social or interpersonal problems caused by substance use.

The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, categorizes Substance Use Disorders and Substance-Related Disorders as follows:

1) Substance Use Disorders include:

Substance Abuse: Maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following social or interpersonal problems caused by use of substance, within a 12 month period:

- Recurrent substance use resulting in failure to fulfill major role obligations at work, school or home.
- Recurrent substance use in situations in which it is physically hazardous
- Recurrent substance related legal problems.
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Substance Dependence: Maladaptive pattern of substance use leading to impairment as manifested by three or more of the following in any 12 month period of time:

- Tolerance- either 1) marked need to increase amounts of substance to achieve intoxication or desired effect or 2) markedly diminished effect with

- continued use of the same amount of substance
- Withdrawal- either 1) characteristic withdrawal symptoms of a specific substance or 2) use of the same or similar substance to avoid withdrawal symptoms
- Substance taken in a larger amounts or over a longer period of time than was intended
- Persistent desire or unsuccessful effort to cut down or control use
- Excessive time is spent in activities necessary to obtain the substance or recover from its effects
- Important social, occupational or recreational activities are given up or reduced
- Substance use continues despite knowledge of having persistent physical and/or psychological problems caused by the substance

2) Substance-Related Disorders include, but are not limited to:

- Intoxication
- Withdrawal
- Delirium and dementia
- Amnestic disorder
- Psychotic disorder
- Mood disorder
- Anxiety disorder
- Sexual dysfunction
- Sleep disorder

SCREENING FOR SUBSTANCE USE DISORDERS

A good clinical interview includes questions about substance use and sequelae of use across medical, psychiatric, personal, legal and social domains. Pay close attention to high risk or under recognized patients including pregnant women, young and older adolescents, older adults, Native Americans, health care providers, noncompliant patients, those with major psychiatric disorders and individuals in the criminal justice system.

- Screen all new patients and reevaluate established patients periodically. Data show that physicians very often overlook substance use disorders. In one primary care study, physicians reported a prevalence of substance abuse disorders of less than 1% of their patients despite an estimated substance abuse prevalence of 2%-9%.(3)
- Place particular attention on high risk patients with co-morbid medical or psychiatric disorders, including those with chronic pain, gastrointestinal complaints (abdominal pain), systemic infections including Hepatitis B and C, HIV/AIDS, other STD's, bacterial endocarditis, pulmonary disease, obesity, cardiovascular and cerebral vascular disease, trauma including motor vehicle accidents, gunshot wounds, and psychiatric symptoms including depression, anxiety, and insomnia.(13) (see <http://www.drugabuse.gov/consequences>)
- The assessment and management of chronic pain presents complex challenges to the clinician. Some patients will come to physicians having been treated with narcotics, and feel they cannot function without them. It is important to remember that pain is a subjective sensation that is very real for the patient. Many factors influence the processing of pain signals and the sensation of pain, including past life experiences, personality traits, fear and anxiety, the meaning of the pain, depression, "secondary gains," etc., in addition to any pathology that may be present. The factors that contribute to a patient's perception of pain may need to be evaluated over several visits, sometimes with the help of a pain professional or psychiatrist. All patients with chronic narcotic use for painful conditions should be evaluated for substance use and abuse disorders.
- **If any of the known medical, psychiatric, familial, social, school or employment, and legal "red flags" are present** (See next section on "Red Flags."), a more detailed evaluation is needed to ascertain the presence of a substance use disorder and the patient's readiness to accept treatment.
- When screening for substance use disorders, include questions about both alcohol and drug use, which are frequently linked. Many patients use more than one substance of abuse. Each should be explored. Ask specifically about tobacco (cigarettes, cigars, smokeless tobacco), alcohol (beer, wine, liquor), marijuana, cocaine/crack, methamphetamines, other stimulants, opioids (heroin and prescription pain medications), PCP, inhalants, and other prescription "pills." (8,14,15,16)

<http://www.nida.nih.gov/DrugPages/DrugsofAbuse.html> For example, the NIDA Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST) provides screening questions covering all drugs of abuse (specifically separating out prescription drugs from similar street drugs).
<http://www.drugabuse.gov/nidamed/screening>



Please click the video-button on the left to play [Ted Parran's Comment](#) on screening.

- Studies show that “subtle” screening is not better than direct questioning. (16) Specific screening strategies include simple structured questionnaires, such as the CAGE-AID, adapted from the widely used CAGE questions for alcohol dependence. (17,18)

With adult patients, start with a question about use: *“Do you use, or have you ever experimented with alcohol or other substances?”*

If “yes”, or if the answer is equivocal, follow with:

- *Have you ever felt a need to **Cut Down** on or Control your use of alcohol or other drugs?*
- *Have friends/family made comments to you about your use of alcohol or other drugs ... have those comments ever **Annoyed** you?*
- *Have you ever felt bashful, embarrassed or **Guilty** about things you have said/done when using alcohol or other drugs that you would not have said/done otherwise?*
- *Do you ever use **Eye-openers** (drinking or using in the morning to “get going” or settle your nerves)?*



Please click the video-button on the left to play [Ted Parran's Comment](#) on patients' positive responses to these questions.

- If any answer is positive, initiate a “Brief Intervention” (below), but before doing so, ask follow up questions, because the patient’s responses to them will help you structure the particulars of your brief intervention conversation.
- Define patterns of use for each substance including the quantity, duration of use, frequency of use during that time, route of administration, effect of use, and cost. Explore periods of abstinence and triggers to use substances along with associated physical symptoms.(18)

One helpful strategy is to ask the patient about his/her perspectives and observations about their use and consequences. Helpful questions include the following:

- *Do you ever think you use too much?*
- *Have you ever tried to cut down on your use?*
- *Have you needed to use more to get the same effect?*
- *Has use created any problems, e.g. medical, educational, job?*

Red Flags for Substance Use Disorders

Despite good interview skills and use of effective screening tools, many patients with serious substance use disorders escape identification in physicians' offices. Attending to behavioral and physical red flags will help you identify a significant subset of patients who would otherwise remain "under the radar," and thus not benefit from intervention.

Patients with substance use disorders are often reluctant to reveal them. They may fear negative judgments, be embarrassed about their inability to control their lives, or be in denial about the extent of their problems. In a variety of subtle or not-so-subtle ways, patients effectively avoid disclosure. Their methods include not listening to questions; minimizing use or consequences of use; changing the topic; showing irritation, anxiety, or other symptoms that discourage further inquiry; blocking many facts from their own consciousness; and outright lying



Please scan the qr barcodes on the left to see what Michelle, Reno, and Rhonda have to say about interactions with their doctors.

However, there may be signals that appear in an interview, during the physical exam, in prior records or in statements from significant others, office staff, or hospital staff, that raise concern about a patient's substance use. These "red flags," whether mentioned by the patient, family, or another information source, should be an indication to follow up with the same diligence and persistence as you would after a positive drug screen or disclosure of heavy substance use, in order to ascertain the

presence of a substance use disorder and the patient's readiness to accept treatment.

Some common "red flags" are in the bulleted list below.

- **Physical findings:** Alcohol on the breath, ascites, an enlarged liver, nasal ulcers or a perforated septum, excoriated skin (from scratching), track marks, skin abscesses, obesity or anorexia, abnormal gait, tremor, slurred speech, change in pupil size, injuries, chronic pain, blackouts, accidental overdoses, withdrawal symptoms, other liver or gastrointestinal problems, premature labor, and vague somatic complaints.
- **Mental symptoms:** Depression, anxiety, flashbacks, insomnia, suicidal behavior, paranoia, irritability, vagueness, hallucinations, memory and concentration problems, and defensiveness about questions relating to substance use.
- **Social Problems:** Isolation/withdrawal, loss of previous friendships, marital difficulty including domestic violence, and loss of interest in prior activities (e.g., sports, hobbies).
- **Education and employment history:** School failure or poor grades, job losses, and frequent job changes.
- **Legal problems:** DUI, assaultive or violent behaviors, stealing, drug possession, and prostitution.
- **Family history:** May be positive for substance use or mental disorders; developmental problems in children.

Physician Attitudes

All patients have the same human needs for feeling well, attachment to others, and sense of self-control. Clinicians who have had difficult experiences with patients or others with addictive disorders may expect patients who have a substance use disorder to betray their trust and to manipulate them with drug-seeking behavior. These early experiences can lead to persistent negative attitudes, including cynicism and hopelessness resulting in lack of empathy and poor or inadequate screening for substance use disorders. These negative physician-patient interactions can also adversely impact patients' willingness to discuss use and accept referrals for treatment. (17)

- You can enhance your care of patients with substance use disorders by reflecting on your own attitudes and discussing them with colleagues, by increasing your knowledge about the medical nature of the disease and the effects of substance use disorders on patients' lives, and by practicing discussions about diagnosis and treatment with patients who are fearful and discouraged.
- Significant societal stigma still exists toward patients with substance use disorders despite significant advances in scientific knowledge, diagnosis, and treatment. (9,18)

- Remember that addiction is a disease of the brain and comparable to other chronic medical conditions such as diabetes, asthma, or hypertension, which also need ongoing monitoring and treatment.
- Lack of knowledge about clinical screening techniques and referral resources, however, increases clinician reluctance to evaluate patients for substance use disorders.



Please scan the qr barcode on the left to hear [Ted Parran's comments](#) about the benefits of honing skills in these challenging relationships.

- Anger toward patients, especially when they are noncompliant or relapsing, will only drive a wedge between the patient and physician and exacerbate noncompliance.
- Negative clinician attitudes can be manifested in the way physicians ask and respond to questions about substance use, e.g., "You don't use drugs, do you?" or in responding "Good" when a patient initially denies use.
- If negative attitudes persist and interfere with good patient care, remind yourself that addictive disorders are comparable to other chronic medical conditions with exacerbations and remissions, e.g., diabetes and asthma. Addressing patients' drug-seeking behaviors respectfully and directly, in an empathic manner, while setting appropriate limits on requests for prescription drugs, will increase the possibility of engaging patients in treatment.
- Patients' behaviors may continue to be frustrating, but a positive attitude and belief in the possibility of recovery can energize patients. After all, many patients do recover, though it may be a long process and take several interventions. You can visualize frustrations as challenges to overcome, and feel compassion for patients' struggles. Learning and using effective communication strategies and setting relationship limits in a respectful and straightforward manner create a healing relationship. Your hope and respect give your patients both hope and a new measure of dignity. If patients feel that you won't give up on them, they may be less likely to give up on themselves.

Respond to irritability and suspicion with interventions that reflect what you hear

- *"Many people are concerned about these questions."* or
- *"I hear some concern or irritation in your voice."* or
- *"I'm feeling a bit confused by your responses. Help me better understand what you are saying."*

When patients express irritation with your reflections or your limit-setting, or at their own shortcomings, here are some helpful responses for you to consider.

- *"I hear your frustration that I will not prescribe more oxycodone for you" or*
- *"I understand your frustration. Patients in recovery tell me that my firm limits were helpful in getting them into treatment; I hope that will be the case for you."* or
- *"I hear your sense of hopelessness now, and I've heard so many people turn that around when they get into treatment."* or
- *"I know you feel bad about failing to carry out the plan. But let's look at some of the details together and see if we can learn something that will help you succeed the next time."*

Physical Examination

Prognosis for recovery is better if diagnosis and intervention are made early in the course of the disease. Some physical findings may be present in early stages of substance use disorders. Others, particularly the "classic" physical findings occur only in later stages.

Injuries from accidents, or from altercations in the home or on the streets, may appear early in the course of substance use disorders, and they are always cause for active intervention.

Other early clues include alcohol on the breath; signs of intoxication such as abnormal gait, slurred speech, sedation, dilated or constricted pupils, excoriated skin (from scratching), track marks, and skin abscesses; and behavioral symptoms such as irritability, vagueness, paranoia, and poor concentration.

The earlier a diagnosis is made, the better the prognosis. However, use over periods of years produces physical findings that make diagnosis much easier. Some examples of physical symptoms and findings that ensue after persistent use include the following:

- Malnutrition, including cachexia, but also obesity
- Systemic infections including cellulitis, sexually-transmitted diseases, HIV, hepatitis B and C, tuberculosis, and bacterial endocarditis
- Elevated blood pressure, tachycardia, chest pain, transient ischemic attacks, restlessness, sweating, and tremor—from withdrawal
- Physical damage from administering a drug that involve chronic sinus/nasal problems, worsening bronchitis from marijuana or cocaine smoking, or "track marks" from injection drug use
- The myriad systemic effects of alcoholism, including delirium, liver enlargement or failure, ascites, anemia, thrombocytopenia and bleeding, seizures, trauma, myopathy, and cardiomyopathy
- In pregnant women, abruptio placenta, premature birth, low gestational size, and neonatal withdrawal syndrome

Intervention may seem more difficult in later stages of the disease process, but many patients have suffered enough by that time and are more ready to accept the diagnosis and referral for treatment with experienced professionals. Be clear about availability and efficacy of treatment, even after many years of destructive use; be respectful and compassionate; and be persistent with later-stage patients.



For more information about specific medical consequences of substance use, please see <http://www.nida.nih.gov/consequences/>

Laboratory Evaluation

Lab testing has limited usefulness in the diagnosis of substance use disorders and in the discovery of associated physical harm. Drug testing does not measure severity of the disease. However, testing to monitor drug use is an important component of every treatment regimen.

- No specific laboratory test establishes an unequivocal diagnosis of substance use disorder; however, blood alcohol levels may confirm tolerance, or detection of another drug may confirm the origin of coma or confusion.
- Routine laboratory screening including liver function tests, complete blood count (anemia from chronic gastritis or a slightly high Mean Corpuscular Volume [MCV] with excessive alcohol consumption), and vitamin B12 and folate levels occasionally are the "red flags" that stimulate further diagnostic inquiry.
- Blood alcohol levels, breathalyzer test results, urine drug screens, and, less commonly, hair and saliva analysis can be used to assess patients for possible alcohol and other drug use. A drug screen may be useful in evaluating an adolescent with school problems, or in accidents, domestic violence, or other trauma situations.
- Performing urine and blood screens in some situations (e.g., school, employment) may be controversial, so it is advisable to obtain the patient's (and/or parents') permission before initiating such screens. Failure to do so can damage the physician-patient relationship and cause legal consequences for the physician.
- Blood, urine, and saliva studies add a crucially important dimension to the effectiveness of treatment programs. Testing adds structure and limits that are critical aspects of helping patients regain self-control and self-respect.

Annotated Video: Initial Visit

 <p>Annotated Video</p> <ul style="list-style-type: none"> DOC: red flag when patient uses narcotics.. PAT: questions are worrying me.. PAT: why is my sleep of concern? DOC: what's going on in her life? PAT: I'm worried that my son smokes marijuana.. DOC: the patient might be depressed.. PAT: of course I'm down.. PAT: why does Doc use word 'addiction'? PAT: I'm not an addict! PAT: I'm worried that I said too much! 		<p><i>Please scan the qr barcode at the left to play the video that shows an initial visit.</i></p> <p><i>Remark: only the web-version features our unique "annotated video"</i></p>
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THE BRIEF INTERVENTION

When clinical screening indicates a potential substance use disorder, assess the patient's readiness to change and conduct a brief intervention to facilitate treatment engagement.

Take steps to determine the patient's willingness to accept the diagnosis and accept further exploration, intervention, and referral for treatment. Prior to discussing treatment options, check patients' readiness to change their behavior. Inquire directly about patients' interest in changing and about their confidence in accomplishing change.

In a brief intervention, you tell the patient your diagnosis and specific recommendations in a matter-of-fact and non-confrontational way. You offer educational materials and choices about next steps, emphasize that any change is up to the patient, and convey confidence in the patient's ability to change his or her behaviors. You help the patient work out appropriate and doable next steps toward accomplishing your recommendations. Encourage the patient to regularly report progress toward his or her established goals. (18)

You then make definite treatment recommendations, tailoring your conversation based on the patient's apparent readiness to take action. Acknowledge that the patient is the one who decides what to do and, in fact, does all the real work.

Most physicians find that telling patients of a diagnosis of addiction is a difficult task, an uncomfortable example of "giving bad news." The discomfort can arise from an incomplete understanding of the pathophysiology of substance use disorders, from previous negative experiences with substance abusing patients, from negative judgments about the patient's behaviors (impulsivity or criminal activity), and from a lack of practice with skills for this special type of doctor-patient interaction. The following guidelines present ideas about the content of recommendations, the process of giving them, and some "how to's" about skills for responding to patients' reactions, as well as information that may assist you in examining your own biases.

Determining Readiness to Change

When clinical screening indicates a potential substance use disorder, take steps to determine the patient's willingness to accept the diagnosis and accept further exploration, intervention and referral for treatment. Prior to discussing treatment options, check patients' readiness to change their behavior. Inquire directly about patients' interest in changing, and about their confidence in accomplishing change.

Researchers have found that patients go through a series of predictable stages in the process of changing unhealthy behaviors. Stages of change include:

precontemplation, contemplation, preparation, action, and maintenance.

(20) It is important to understand what stage your patient is in, since your counseling will need to address the patient's particular needs and expectations relevant to that stage. Briefly, in **Precontemplation**, the patient is content with the behavior and doesn't see the need to change. In **Contemplation**, the patient

understands that there are benefits of the behavior, but also risks and current negative consequences, and is thinking about changing the behavior. In **Preparation**, the patient has decided that it is best to change the behavior, begins to gather information on what it will take to change, and plans concrete actions necessary to change. In **Action**, the patient undertakes the necessary behavior, social, and environmental changes necessary. In **Maintenance**, the patient practices the many behaviors necessary to substitute for the previous unhealthy behaviors and to avoid restarting the previous behaviors.



Please scan the qr barcodes on the top to listen to Reno, George, and Cliff talk about how they remain in maintenance stage.

In **Relapse**, the patient restarts the previous unhealthy behaviors and usually returns to the contemplation stage.



Please scan the qr barcodes for "Contemplation", "Action", and "Relapse" in the graphic on top to play video examples showing medical encounters with a patient in these stages.

Asking two questions about patients' **conviction** and **confidence** helps you ascertain their motivational readiness. Conviction assesses what patients believe about the *importance* of taking action, and confidence assesses what patients believe about their present *ability* to adopt or change a behavior (despite obstacles or barriers.) The latter is often referred to as their degree of "self-efficacy."

Ask patients to help you understand where they stand by using a numerical rating scale.

*"On a scale of 0–10, how **convinced** are you that quitting cocaine is important?"*

Not only will patients' answers to readiness questions alert you to material not usually made explicit, but also many patients respond with more dialogue and useful information about the past and the present. This is true even when patients protest that they do not like to use number scales.

Usually, asking why the number the patient chose is not LOWER than the one the patient named proves a helpful continuation of the dialogue. You may wish to incorporate this tactic in your Brief Intervention (below), perhaps saying,

"So you are at a "6" about thinking you need to quit cocaine; I'm wondering why you did not name a lower score?"

Asking about lower scores encourages patients to speak (and to hear themselves speak) about change in positive terms. You can then move more smoothly to talking about next steps.

Frame your confidence question as follows:

*"Let's suppose for a moment that you were a 10, completely convinced that you should cut down or quit; on a 0–10 scale, how **confident** are you that you would be able to entirely abstain for the next 4 weeks?"*

If the patient chooses a low number, you might ask, "What would it take for you to get your confidence level higher, say to an 8?" The patient may then suggest strategies that develop a greater sense of self-efficacy and hope.

Content of a Brief Intervention

This section delineates the principles and rationale for a brief intervention, along with sample dialogue for handling patients' denial and their normal resistance to changing their behavior that has progressed to the point that it controls their lives. Depending on severity, you will support positive lifestyle choices, recommend abstinence from illicit drug use, recommend that psychoactive prescription drugs be taken only as prescribed, and suggest referral to professional treatment.

All intervention dialogue with patients should be

- direct
- empathic
- nonjudgmental

When talking about next steps, present information without alienating patients who may be ashamed, in denial, ambivalent, or resistant to change. The use of shame, guilt, threats, confrontation, arguments, and arbitrary treatment plans is counterproductive and should be avoided. Express optimism about recovery and willingness to continue to work collaboratively with your patients. (18) NIDA Info-Facts for "Understanding Drug Abuse and Addiction" are available at <http://www.nida.nih.gov/infofacts/understand.html>

Non-problem use:

For patients who are using substances but appear to be at low risk of a substance use disorder, give them information about safe limits for alcohol use, and acknowledge that the only reasonable advice about other drug use is not to use illicit substances and not to exceed amounts prescribed for any psychoactive prescription drugs. Continue to screen patients periodically to verify that they have not developed a substance use disorder.

Substance use disorders:

Explicitly and clearly recommend that patients with substance abuse or dependence abstain from all illicit drugs. For patients with a co-morbid psychiatric disorder, help the patient find a qualified psychiatrist to prescribe and supervise the taking of any appropriate psychoactive drugs—it is particularly helpful if the psychiatrist is associated with a substance use disorder treatment program. Coordination of care is essential. Do not prescribe any psychoactive drugs for patients, unless they are active in a treatment program, and then only with specific guidance from that program; otherwise your prescriptions may not be effective, and they are likely to worsen patients' problems. Articulate your medical concerns and be specific about the patient's substance use and the related medical issues. Provide patients with written information from the National Institute on Drug Abuse (NIDA) about drug abuse disorders and steps they can take. It is important to convey that you believe they need the help of substance abuse professionals and that you would like to refer them to local treatment programs.



Substance dependence:

Recommendations for patients who have progressed to dependence are essentially the same as for substance abuse--abstinence and participation in local treatment programs. Office counseling is rarely useful for patients who are not participating in other treatment activities and it unwittingly contributes to prolonging or worsening the dependent state. You may wish to follow up and support such patients, but leave the treatment to professionals.



Under normal clinical situations, you should not prescribe medications that drug-dependent patients can abuse. Instead of prescribing, respectfully and calmly say "no" and continue recommending that the patient take advantage of specialist treatment. No matter how persuasive (or demanding) patients are, or how much you think a small dose of "x" might ease their suffering, we cannot emphasize enough this caveat.

Patients who are drug dependent and require narcotic medication for pain management following surgery or trauma should be managed collaboratively, by their surgeon/trauma physician, dentist, and addiction treatment professional. The patient always needs to be an integral part of the treatment team.

Annotated Video: Second Visit

<p>Annotated Video</p>  <ul style="list-style-type: none"> Empathic behavior Non-judgmental evaluation Assess details of drug use Assess consequences of use Inform about potential impact Follow up red flag Empathic behavior Inform about mental health Obtain patient's perspective Empathic behavior Continue Brief Intervention Obtain patient's perspective Communicate with family Empathic behavior Inform about substance use 		<p>Please scan the qr barcode at the left to play the video that shows the second visit.</p> <p>Remark: only the web-version features our unique "annotated video"</p>
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Annotated Video: Narcotic Contract

<p>Annotated Video</p>  <ul style="list-style-type: none"> Show willingness to continue care Inform about treatment Inform about impact Empathic statement Empathic behavior Inform about treatment Empathic behavior 		<p>Please scan the qr barcode at the left to play the video where a narcotic contract is made.</p> <p>Remark: only the web-version features our unique "annotated video"</p>
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Dealing with Resistant Patient Behaviors

Behavior change is difficult for everyone. Patients' resistance to accepting a substance use diagnosis or treatment is frustrating and often contributes to physicians' negative counter-transference behavior and defensiveness. Talking with patients who do not appear to want help enervates physicians.

In dialogue with a respectful physician, some patients are prepared to accept their diagnosis and a treatment referral. On the other hand, many do not initially. Physicians who seek to understand patients' resistance to change can develop an effective treatment alliance. During ongoing conversations they can use their understanding of the nature of resistance to augment patients' intrinsic motivation and helpfulness and shepherd patients towards recovery.

- Patients suffering from the disease of substance abuse or dependence are ensnared in diverse traps that lead to emotional isolation, irrational fears, discouragement, and hopelessness, accompanied by an overwhelming inner certainty that they are worthless and undeserving persons. Some of these traps include the following:
 - Estrangement from family
 - Loss of friends who are not part of a substance-using subculture
 - Daily life restricted to obtaining the substance, or to finding the means to obtain it

- Large amounts of time recovering from the effects of use
 - Criminal behaviors such as shoplifting, burglary or other types of stealing
 - Daily small and large lies about feelings and about actions
 - Negative interactions with healthcare personnel, particularly around episodes of intoxication or injury
 - Begging, pleading, or wheedling for their substance of choice, or any substitute that might stem the urge or craving—from doctors, pharmacists, dealers, and other users
 - Destructive episodes of uncontained anger or impulsivity, resulting in violence to friends, family, or strangers such as pedestrians, people in other vehicles, or healthcare personnel
 - Repetitively and abjectly poor performance of social roles such as parent, spouse or partner, worker, or citizen
- The psychological mechanism of denial, intrinsic to the disease process, may play a key role in the patient's inability to recognize the problem and seek treatment. Sporadic or binge users of psychoactive drugs can have even more difficulty saying, "I can stop anytime."
 - Shame and guilt based on reactions from friends and family contribute to resistance. When patients imagine their physicians' negative response to discovering their involvement with substance use, their shame and guilt and need to stay hidden increase further.
 - A co-morbid psychiatric disorder can limit patients' ability to accept a diagnosis or participate in treatment.
 - Substance use-induced cognitive impairment can impede patients' understanding of the need for treatment and ability to follow through with treatment.
 - In concert with the patient and his or her family, develop a differential diagnosis as to why a patient is resistant to treatment. Remain open to addressing the patient's concerns and resistances without confrontation, and develop skills and strategies that effectively communicate your expertise and your concern. (21) For students attending universities with doc.com memberships, see also "[doc.com](#)" modules 9 (Understands the patient's perspective), 13 (Responding to strong emotions), 14 (It goes without saying: Nonverbal communication in clinician-patient relationships), and 29 (Alcoholism diagnosis and counseling).

In the following example, the physician addresses denial directly and uses "reflection" in a genuine attempt to understand and hear the patient's perspective.

MD: *Hmmmm. You are doubtful about my diagnosis of a substance use disorder.*

Patient: *I really don't think I have a problem. I know I can stop at any time!*



MD: *You are pretty certain that the relationship problems and health issues we have discussed do not come from your drug use.*

Patient: *Well, I'm always stressed out with my crazy family, and my horrible boss. I just need to chill out now and then.*

MD: *I hear that even if drug use caused some of the problems, you need drugs to*

help you chill out. Have I got that right?
Patient: *I'm thinking you are way off, doc.*
MD: *You know, as we speak, I get more worried about your health. I could be mistaken, but what you have told me about your situation and the way you are looking at it as we talk sounds like what I have heard from others affected by substance use before they got well. In medicine, we understand that this process is common, and we even have a name for it—"denial". Perhaps I am wrong, but I am deeply concerned, and worry that the disease of substance abuse has taken control of your life. What do you think?*
Patient: *Thanks for your concern. What about my rash? it is really killing me.*
MD: *I'll recommend an effective, simple treatment for your skin. How can you and I work together to look out for your overall health, now and into the future?*

Annotated Video: Dealing with Resistant Patient

<div><p>Annotated Video</p><ul style="list-style-type: none">Conduct Brief InterventionEmpathic behaviorInform about testingEmpathic behaviorInform about family impactEmpathic behaviorTell diagnosis (BI element)Willingness to continue careEmpathic behaviorStart planningRefuse Rx (BI element)Empathic behaviorTell diagnosisEmpathic behaviorInform about treatment optionsEmpathic behavior</div>		<p><i>Please scan the qr barcode at the left to play the video where a narcotic contract is made.</i></p> <p><i>Remark: only the web-version features our unique "annotated video"</i></p>
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TREATMENT OF SUBSTANCE USE DISORDERS

Treatment for substance abuse or dependence requires specialist care from certified counselors or comprehensive community programs or mutual help groups. You should understand the core principles of treatment, so you can best advise your patients.

- Primary care physicians play a key role in identifying high-risk patients and providing appropriate prevention counseling. When appropriate, family members should be engaged as well.
- Primary care physicians also play an essential role in referring patients for treatment. Convey to patients that substance use disorders are chronic, relapsing diseases that can be successfully treated and managed and that recovery is a long-term process.
- Effective treatment needs to be individualized, and it includes psychosocial and pharmacological interventions.
- Treatment recommendations need to be staged based on patients' immediate treatment needs, e.g. brief intervention identifying the diagnoses for the patient, detoxification to manage withdrawal symptoms, residential or outpatient treatment, and 12-step programs.
- Initial and brief interventions include discussions of the results of screening, advice about the need to change substance use behaviors, evaluation of patients' readiness to make change, negotiation of goals, scheduling of follow-up visits and referral for specialized substance use disorder treatment.
- Assessment and treatment for co-morbid psychiatric disorders are essential components of substance abuse treatment.



Please scan the qr barcode on the left to watch George discuss his treatment.

NIDA Treatment Guidelines

The **N**ational **I**nstitute on **D**rug **A**buse (NIDA) recommends a set of overarching principles that characterize effective substance use disorder treatments.

<http://www.drugabuse.gov/infofacts/Treatmeth.html>

No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Treatment needs to be readily available. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Buprenorphine and methadone are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine-replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective

component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important. (See also <http://www.drugabuse.gov/drugpages/buprenorphine.html>)

Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase both treatment entry and retention rates and the success of drug treatment interventions.

Possible drug use during treatment must be monitored continuously.

Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases; and counseling to help patients modify or change behaviors that place themselves or others at risk of infection. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

BEHAVIOR CHECKLIST

ASK:

1. Screen all patients for past and present substance use.
2. If any use, ask "CAGE" questions for alcohol/drugs, or use NIDA modified "ASSIST" questionnaire.
3. Ask about frequency of use.
4. Ask about method of administration.
5. Ask patients for their perspective on the current and potential consequences of drug use.
6. Ask patients how they acquire their substances, including how they can afford them.
7. Ask about past quit attempts, or attempts to cut down; including withdrawal symptoms, how long abstinent, etc.
8. Ask about current mood and any past mental health problems.
9. Ask patients if they are open to hearing that they might have a substance abuse problem and might need specific help for this.
10. Assess patients' conviction and confidence about their willingness to quit using.
11. Conduct interviews in a non-judgmental way. (ie: Do not say, "This is really a will-power problem and you need to just quit!" or make other statements that might induce judgment or shame.)

TELL (Brief Intervention):

1. Tell patients that you are concerned that they have a substance abuse problem, and need help to manage it. Talk about the potential negative impact of substance use on patients' health, family, employment, mental health and well-being.
2. Recommend assistance / treatment, and speak succinctly about options: stop on their own, join a 12 step program, go to an addiction specialist, be referred to a treatment center.
3. If patients are on prescription narcotics, negotiate a treatment contract with them.
4. Inform patients about the role of drug and alcohol testing in treatment monitoring.
5. Communicate that individual needs vary, and that treatment usually includes psychological, social, vocational, and biological interventions.
6. Make a supportive statement like, "Recovery is usually a long-term process and it may take years to return to full functioning."
7. Offer to communicate with patients' families.
8. State your willingness to provide continuing care to patients who abuse substances.

ASK:

1. Ask patients if they are ready to accept a referral to treatment.
2. Ask patients about their reactions to the discussion.
3. Ask patients about their questions and concerns.

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