

Facilitator's Guide

The following is a suggested format that will need to be adjusted depending on the experience and level of training of your learners. The following format could be used for a 1–2 hour session. These guidelines assume that the learners have reviewed the module ahead of time.

First, go over the learning goals that learners will achieve by the end of the module:

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, and readiness to accept the diagnosis and 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 impacts on recognition, diagnosis and treatment of patients.
9. Demonstrate knowledge of substance use disorder treatment standards and the ability to recommend appropriate referral.

Discussion

Ask your learners about their experiences with patients who have had problems with substance use or abuse.

- What was the nature of the interaction?
- How did the patient make you feel?
- How did your feelings about the patient affect your care?
- What was the outcome of the interaction?
- In retrospect, what would you change about the interaction?

If you are working with a small group, ask each member of the group about his or her experiences. If you are working with a large group, ask trainees to turn to each other in groups of two or three at describe their experiences for 5 to 10 minutes. Afterwards ask each group to contribute the essential points about experiences in working with substance using patients. Next, read the following questions for reflection, one by one, from the module, and ask individual trainees to respond to each one, and allow time for others to provide their input.

- How have your experiences with patients, family members, friends, and colleagues with substance use disorders affected your attitudes towards substance-using patients?

- What reservations do you have about accepting the disease model for substance use disorders?
- Why do physicians often fail to ask substance use screening questions?
- Describe how you feel when your patients fail to curb their substance use or even acknowledge interest in doing so?
- 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?
- 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?
- 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?

You can then go over all the points in the learning goals of the module, asking individual learners to respond to each of the questions, and soliciting perspectives from other members of the group. Finally, ask your learners what are the major points of learning that they took away from the module?

Role-play

If there is time, do a brief role-play or two. We have provided two role plays, one on screening and one on an intervention. There are two ways to approach these role plays: ask the trainees to divide up in pairs, one playing the physician and the other playing the patient. You can use the role-plays provided, or ask trainees to role-play patients with whom they are very familiar. They can role-play the interaction for 5 minutes followed by 5 minutes of giving feedback to each other. Afterwards ask them to come back together as a group and discuss what they learned. As the facilitator you should keep strict time. An alternative way to do role plays is to ask for two volunteers to play the patient and physician roles, allowing either of the pair to ask for a timeout—a pause in the action to ask for any input from the group—and then resume the interaction.

Role-play: Screening

The person playing the physician role will assume that all parts of the history up until the substance use screening and psychiatric history are benign. The physician will start with substance use.

Patient role:

You are a 26-year-old architect recently hired by a medium sized architectural firm in the city (15 other architects and 8 staff members). As part of the new hire process, you were asked to see a doctor for a physical exam. You're in good health and have had no medical problems. You live in an apartment that you have shared with your significant other for the last year. You plan on

getting engaged soon. Your parents live in town and are supportive. Your major issue is that you snort cocaine almost every night. This started out about a year ago in college at a friend's party. The experience was just so amazing that you had to try it again which you did about a week later at another party. Soon, you began to use more regularly. You feel that you have it under control since you only use it only at night. You graduated from college and your masters program with high honors and managed to land a very good job. You have money left to you by your grandfather and so the costs have not been an issue. Your girlfriend/boyfriend has really been on your case about it, which has been annoying because you feel he/she doesn't understand and is making a big thing over nothing. You manage to get up and go to work each day and feel productive at work. In fact, being high at night gives you some great ideas. You also have smoked about a pack of cigarettes a day since you were 18. You drink alcohol "socially" (a beer or two with dinner and perhaps a little more at parties). You've never tried IV drugs, but smoke marijuana occasionally (at parties). You were sexually abused on several occasions when you are 13 years old by your mother's uncle. You never told anybody about this and still feel a fair amount of guilt and shame over this. You often feel in a down mood. The cocaine helps you feel a lot better. You occasionally feel guilty about the cocaine use but because you feel that you have it under control you don't think it is really a problem. The positives of using cocaine outweigh the negatives. You are not inclined to tell your new physician about your cocaine use because you worry about confidentiality, but if the doctor has a kind manner, assures you of confidentiality, and asks questions in a nonjudgmental way, you would acknowledge it.

Physician role:

You are seeing this patient for a routine H&P because he/she is a new hire at an architectural firm in town. You have completed the HPI, PMH, FH and these are all benign. He/she acknowledges no medical or past medical or surgical problems. You begin your questioning with screening for substance use and psychiatric disorders.

Role-play: Intervention

Patient role:

You are a 28-year-old man/woman with a long history of sickle cell anemia and painful sickle cell crises. You are admitted to the hospital approximately five times a year in pain. You get severe pain in your bones, joints, abdomen, and back. When you are admitted, you know that Dilaudid, 4 mg every 4 hours for the first 2 days, helps quite a bit and then can be scaled back to 2 mg every 4 hours on the third day. You are usually sent home on Percocet, one to two pills every 6 hours as needed. You have a lot of anxiety about these painful episodes. The sickle cell disease has affected your whole life. You are on total disability. You dropped out of high school in the 10th grade. You mostly sit around watching television or getting together with friends to play video games. You still live with your mother who works as a nurse's aide. You don't really know your father. You have dim memories of him, but he left the family when you were four and never got in touch again. You have no real plans for the future, and your mood is low a good deal of the time. You see a doctor in the neighborhood who has been willing to renew your Percocet prescription. You're not sure what triggers your crises but you know that when you start developing pain that you have to go to the hospital very quickly and get Dilaudid, or else your pain gets a lot worse. You know you're taking a lot of narcotics but don't think it's a problem since you have "real" pain. When you were a child the doctors at the Children's Hospital

encouraged you to ask for pain meds. The narcotics were so helpful that you now want them all the time. You were admitted two nights ago for a painful crisis and the admitting doctor was willing to give you the needed Dilaudid. You're about to meet your new intern. You know you told the doctor that by today you would be able to go down to 2 mg every 4 hours, but you still feel a lot of pain and want to continue on 4 mg today. You've had experience with doctors not wanting to give you the narcotics you need in the past and tend to get very upset when this happens. You feel that they are very unfair and don't understand what you're going through.

Physician role:

You are the intern just rotating on to a new service and are about to see this patient who was admitted with a painful sickle cell crisis. Your patient is a 28-yearold man/woman with a long history of sickle cell anemia and painful crises. He/she is admitted at least five times a year in pain, with severe pain in the bones, joints, abdomen, and back. When he/she was admitted to the hospital, he/she negotiated with the intern to get the usual dose of Dilaudid, 4 mg every 4 hours for the first day or two and agreed that on the third day the dose could be scaled back to 2 mg every 4 hours. The patient said that he/she is usually sent home on one to two pills of Percocet every 6 hours as needed. This is the third day of the hospitalization, and as agreed you are going to cut back the patient's Dilaudid dose. You suspect that this patient has a problem with substance dependence. Because of the history of painful crises, the admitting team started the patient on narcotics. However, by the morning after admission, the previous intern saw that the blood smear showed no sickling although the patient complained bitterly about pains in the joints when examined. You have been thinking about getting a psychiatric consult to evaluate the possibility of substance dependence.

After the Role-plays

If you are teaching a small group, go around the room and ask each person what he or she learned and what he or she is going to do differently in the future. If you are working with a large group, ask learners to turn to their neighbors to tell them what they have learned. Then ask people to volunteer some of the best lessons learned.