

A Guide to Substance Abuse Services for Primary Care Clinicians: Concise Desk Reference

Based on Treatment Improvement Protocol (TIP) 24

Desk Reference



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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A Guide to Substance Abuse Services for Primary Care Clinicians: Concise Desk Reference

Treatment Improvement Protocol (TIP) Series

24

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The guidelines in this document should not be considered substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse, provided as a service of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on experience and knowledge of clinical, research, and administrative experts to produce the TIPs. A distinguished group of substance abuse experts as well as other professionals in such related fields as primary care, mental health, and social services were used to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country.

The TIP series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payers.

The objective of TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians*, is to help physicians, nurses, physician assistants, and advanced practice nurses (nurse practitioners and clinical nurse specialists) screen their patients for substance use disorders, conduct brief interventions for patients in the early stages of problem development, and appropriately refer more severely affected patients for in-depth assessment and treatment. The TIP also gives an overview of the types of treatment available and outlines a primary care clinician's role in aftercare.

This document gives primary care clinicians specific guidance on how to identify indications of substance abuse, how to broach the subject with a patient, and how to choose the appropriate screening and assessment instruments.

It explains how to perform an office-based intervention in which patient and clinician set mutually agreed upon goals and "contract" to stop or cut back alcohol or other drug use.

While each TIP strives to include an evidence base for the practice it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly.

This TIP equips primary care clinicians who may not have any knowledge of the substance abuse field to address this pervasive disease.

The TIPs may be accessed via the Internet on the National Library of Medicine's home page at the URL <http://text.nlm.nih.gov>.

Editor's Note:

This publication, *Concise Desk Reference*, is a companion piece to Treatment Improvement Protocol (TIP) 24: *A Guide to Substance Abuse Services for Primary Care Clinicians*. Contained in the Desk Reference are highlights of the original guide, providing primary care clinicians with quick, easy access to vital, field-related information.

We hope that you will find the guide to be useful for substance abuse treatment initiatives.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses particular areas of expertise until they reach a consensus on the best practices. This panel's work is then reviewed and critiqued by field reviewers. The talent, dedication, and hard work that TIPs' panelists and reviewers bring to this highly participatory process have bridged

the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary and Recommendations

General Recommendations

The algorithm provided follows a patient with substance use problems who is treated in a primary care setting. The patient flow chart (page 3) will serve as a guide or road map through screening, brief assessment, brief intervention, assessment, referral, specialized treatment, and follow-up care as they are detailed in the TIP.

Since substance use disorders are often chronic conditions that progress slowly over time, primary care clinicians, through their regular, long-term contact with patients, are in an ideal position to screen for alcohol and drug problems and monitor each patient's status.

Studies have found that primary care clinicians can actually help many patients decrease alcohol consumption and its harmful consequences through office-based interventions that take only 10-15 minutes.^{1,2}

Saitz and colleagues found that in a sample of patients seeking substance abuse treatment, 45 percent reported that their primary care physician was aware of their substance abuse.³

Each guideline is followed by either "(1)" or "(2)." The summary guidelines supported by the research literature are followed by "(1)." Clinically-based recommendations are marked with "(2)."

This TIP recommends that primary care clinicians—a term that includes physicians, nurses, physician assistants, and advanced practice nurses—follow the following guidelines.

Screening

- Periodically and routinely screen all patients for substance use disorders. (2)
- Ask questions about substance abuse in the context of other lifestyle questions. (2)

- Use the Alcohol Use Disorders Identification Test (AUDIT)⁴ to screen for alcohol problems among English-speaking, literate patients, or use the first three quantity/frequency questions from AUDIT, supplemented by the CAGE⁵ questionnaire. (CAGE is a phonetic acronym for four questions which stand for: "cut down," "annoyed," "guilty," and "eye opener." See page 8.) (1)
- Use the CAGE-AID (CAGE Adapted to Include Drugs)⁶ to screen for drug use among patients. (1)
- Ask, "Have you used street drugs more than five times in your life?" A positive answer suggests further screening and possibly assessment. (2)
- Ask high-risk patients about alcohol and other drugs used in combination. (2)
- Use TWEAK⁷ to screen pregnant women for alcohol use. (1)
- Ask pregnant women, "Do you use street drugs?" If the answer is yes, advise abstinence. (2)
- Use CAGE, the AUDIT, or the Michigan Alcohol Screening Test—Geriatric Version (MAST- G)⁸ to screen patients over 60. (1)
- Screen adolescents for substance abuse every time they seek medical services. (2)
- When recording screening results, indicate that a positive screen is not a diagnosis. (2)
- Present results of a positive screen (and conduct all discussions about substance use) in a nonjudgmental manner. (1)

Assessment and Treatment

- Refer high-risk patients to a specialist, if possible, for in-depth assessment. (2)

- Ensure that a specialized assessor has familiarity with psychiatric disorders. (2)
- Ascertain that assessment is sequential and multidimensional. (1)
- Check gamma-glutamyl transferase (GGT) as part of the assessment process. (2)
- Use the criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition,⁹ in combination with the American Society of Addiction Medicine's *Patient Placement Criteria*, Second Edition,¹⁰ to make a diagnosis and devise an assessment-based treatment plan. (1)
- Become familiar with available assessment and treatment resources. (2)

Confidentiality

- Keep encouraging reluctant patients with substance use disorders to accept treatment of some kind. (2)

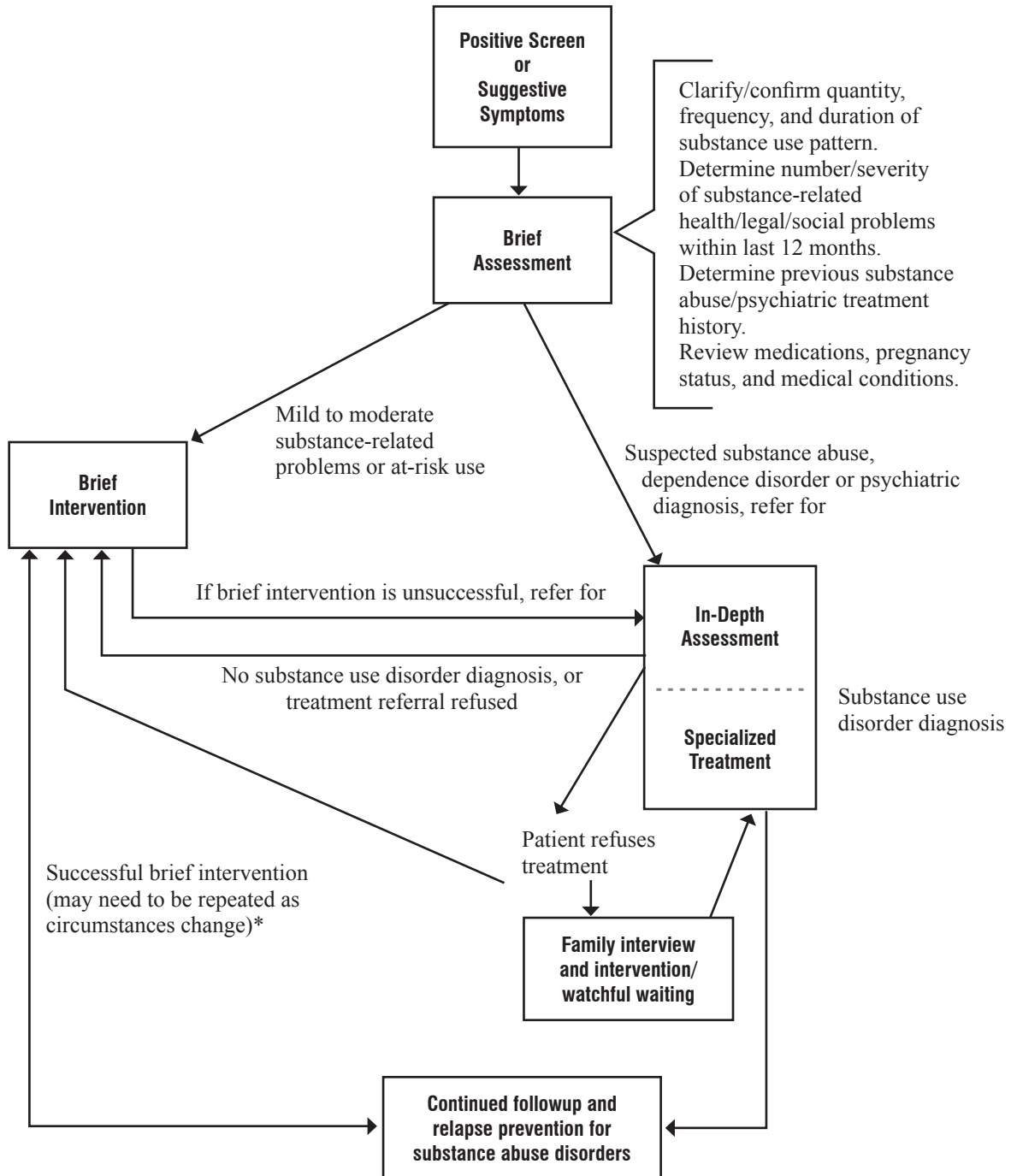
- Establish recordkeeping systems and reminder programs to provide cues about the need to screen and reassess patients for alcohol and drug abuse. (2)
- Do not perform screening or laboratory tests (such as blood or urine tests) without the patient's consent. (2)
- Consult patients before discussing their substance use with anyone else—family, employers, treatment programs, or the legal system. (2)

The Primary Care Clinician's Opportunity

Visits to primary care clinicians provide unparalleled opportunities to intervene with substance abuse problems at a relatively early stage in disease progression.

** See Patient Flow Chart on page 3.

Patient Flow Through Primary Care and Referral



*If situation deteriorates over time, a referral for specialized treatment remains an option.

Source: Derived from National Institute on Alcohol Abuse and Alcoholism, 1993; Brown, 1992.

Chapter 1

Substance Abuse and Primary Care

Using estimates from the Institute of Medicine,¹¹ a Robert Wood Johnson Foundation report calculated that about 5 million users of illicit drugs and 18 million people with alcohol use problems need treatment, but only one fourth of them receive it.¹²

Nearly one quarter of Americans say that “drinking has been a cause of trouble in their family” (Institute for Health Policy, 1993, p. 40). A forthcoming study based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition (DSM-IV),¹³ estimates that 52.9 percent of Americans 18 or older have a family history of alcoholism among first- or second-degree relatives.¹⁴

While not focused specifically on substance abuse, the report credits the “trust and partnership” that exists between primary care clinicians and patients as a key argument for expanding the role of primary care clinicians in screening for early disease detection, managing chronic diseases, and coordinating care among all those in providing patient services.¹⁵

Alcohol Use Among Primary Care Patients

The nature and intensity of alcohol-related problems vary according to consumption: Above two to three drinks a day, there is a clear dose-related curve.

The National Institute on Alcohol Abuse and Alcoholism recommends that patients who currently drink adhere to the following:

- Men—No more than two drinks per day
- Women—No more than one drink per day
- Men and Women over the age of 65—No more than one drink per day¹⁶

It is important for primary care clinicians to know patient’s drinking levels in order to gauge their potential risk for developing problems. Levels also can be discussed with patients in the context of general health problems in which clinicians can provide a nonstigmatizing opportunity to share valuable risk reduction information.

Frequency of Problems Related to Use

When the DSM-IV refers to such diagnostic levels as *substance abuse* and *dependence*, it views them as points on a continuum on which patients’ use may vary. The DSM-IV’s *dependence* is roughly equal to the term *alcoholic*, and *abuse* is synonymous with *problem drinkers*. The latter is seen more than the former in primary care (Kahan et al., 1995).

Other Drug Use Among Primary Care Patients

In 1995, 6.1 percent of Americans age 12 and older had used an illicit drug in the previous month.¹⁷

Since 1991, there has been a continuing rise in marijuana use among adolescents. Nearly 1 in 20 (4.9 percent) of high school seniors uses marijuana daily, while young people’s disapproval of marijuana continues to decline.¹⁸ Although the crack cocaine epidemic appears to be stabilizing, an estimated 1.4 million Americans are current cocaine users, with rates of use highest among 18- to 25-year-olds (Substance Abuse and Mental Health Services Administration, 1996b).

Over-the-counter and prescription drugs also are abused. An estimated 2 million adults age

65 and older, for example, are addicted to or are at risk of addiction to sleeping medications or tranquilizers.^{19, 20} Health care professionals are especially at risk for prescription drug abuse.²¹

Like alcohol-related problems, drug abuse problems also occur along a continuum from nondependent use to addiction.

Understanding Substance Use Disorders in Primary Care Context

Substance use disorders share many characteristics with other chronic medical conditions like hypertension. Among the similarities between the two are late onset of symptoms, unpredictable course, complex etiologies, behaviorally oriented treatment, and favorable prognosis for recovery.²²

Late Onset of Symptoms

Clinical problems related to substance abuse develop slowly and may remain undetected for a long time unless a traumatic injury, problem in the workplace, confrontation with police, or other serious event calls attention to it before physical symptoms become apparent. As with hypertension, routine screening for substance abuse is necessary to identify problems in the early stages of development.

Unpredictable Course

At this time, it is difficult to predict with any certainty which subset of heavy drinkers and drug users will develop serious substance abuse problems. Further, it is not possible to predict whose problems are situational and transient and whose will remain chronic and progressive.

Complex Etiologies

The interplay between genetic familial predisposition and lifestyle influences the development of substance abuse disorders just

as it influences hypertension.^{23, 24} At the same time, people without inherited susceptibility may develop problems as a response to external stresses or internal discomfort if they continue using alcohol or other drugs over time. Individual patients, for example, may use alcohol and other drugs to ameliorate or “self-medicate” psychiatric symptoms or to titrate medications.^{25, 26}

Behaviorally Oriented Treatment

Like treatment for hypertension, behaviorally-oriented substance abuse treatment requires the patient to assume primary responsibility for making difficult behavioral changes. As with any chronic condition that depends on behavioral change to improve outcome, patients will have to accept that they have a problem. Compliance with treatment is ongoing and may be difficult.

Favorable Prognosis for Recovery

Many substance abuse patients—such as patients with diabetes, elevated cholesterol, or hypertension—do respond to clinician recommendations and modify their behavior. The rate of 20 percent of problem drinkers (those meeting the DSM-IV criteria for alcohol abuse) who successfully reduce their drinking compares favorably with the prognosis rates of many chronic health conditions primary care providers routinely address (Kahan et al., 1995).

Data contradict the widespread belief that substance abuse treatment does not work.

When treatment is available, there have been documented reductions in use, hospitalizations, medical costs and sick time, family problems, and criminal activity as well as increases in employment, job retention, income, and improvements in an array of other health indicators.

As with other chronic conditions, the efficacy of substance abuse treatment is helped tremendously when family and friends support patients’ efforts to change their behavior, patients themselves are ready to make significant lifestyle changes, and the effects of co-occurring disorders are minimized.²⁷

Chapter 2

Screening for Substance Use Disorders

The Institute of Medicine has recommended that queries about alcohol use be included among routine behavioral and lifestyle questions asked of all persons who seek care in medical settings (just like questions about diet, exercise, and smoking) (Institute of Medicine, 1990).

The Goal of Substance Abuse Screening

The goal of substance abuse screening is to identify individuals who have or are at risk for developing alcohol- or drug-related problems and, within that group, to identify patients who need further assessment to diagnose their substance use disorders and develop plans to treat them.

Visual examination alone cannot detect intoxication, much less more subtle signs of alcohol- and drug-affected behavior.

In many practices, clinicians' long-standing relationships with patients give them the opportunity to conduct preliminary assessments, also known as brief assessments. Depending on a clinician's experience and training and the resources available within a community, the clinician may either develop a treatment plan or refer a patient for assessment by a skilled substance abuse specialist. In larger practices or clinics where provider-patient relationships are not as close, clear documentation of screening results will help ensure appropriate follow-up.

If clinicians do not have the time (or the expertise) for a face-to-face discussion of a problem, they can give a patient lists of resources for additional help and a handout or brochure on the effects of alcohol or other relevant drugs.

Factors to Consider in Selecting a Screening Instrument

Sensitivity and Specificity

Most screening instruments have been designed for substance abuse treatment populations, not primary care populations. The four-question CAGE questionnaire (Ewing, 1984) and the Alcohol Use Disorders Identification Test (AUDIT),²⁸ however, have been extensively tested in primary care settings. A number of other studies of outpatient, substance abuse treatment populations support the practice of applying substance abuse screening instruments to primary care populations.^{29, 30, 31}

Costs

Costs of administering a screening depend on who does the screening (e.g., physician, nurse, nurse practitioner, or physician assistant), how long it takes, and what special training (if any) is required; whether the instrument can be self-administered by the patient via pencil and paper or computer; and how long it takes to score the instrument.

Patient Acceptance

Simply broaching the subject of substance abuse with patients can be useful. Evidence indicates that asking questions about alcohol or other drugs "primes" the patient to disclose information, and results in a two- to three-fold increase in their stated intention to discuss substance abuse problems with their health care provider in the future.³²

Screening Instruments

Alcohol Screening Instruments

The normal cutoff for the CAGE is two positive results. However, the consensus panel recommends that primary care clinicians lower the threshold to one positive result to identify more patients who may have substance abuse disorders.

A number of other screening tools are also available. In addition to the AUDIT and CAGE tools, the Michigan Alcohol Screening Test (MAST) (Selzer, 1971) and the Short MAST (SMAST) (Selzer et al., 1975) can be used.

Drug Screening Instruments

Of the drug abuse screening instruments, CAGE-AID (CAGE Adapted to Include Drugs) is the only tool that has been tested with primary care patients.³³ Like the CAGE, CAGE-AID focuses on lifetime use. While those patients who are drug dependant may screen positive, adolescents and those who have not yet experienced negative consequences as a result of their drug use may not. For this reason, the consensus panel recommends asking patients, "Have you used street drugs more than five times in your life?" In panelists' experience, a positive answer indicates that drugs may be a problem and suggests the need for in-depth screening and possibly assessment.

Because the questions were originally developed for alcohol, the CAGE-AID will not apply to every illicit drug or drug user. It is, however, a useful starting point.

Supplementary Laboratory Tests

At this time, there is no test like the blood glucose test for diabetes or the blood pressure test for hypertension to identify substance use disorders. For this reason, the consensus panel does not recommend the routine use of laboratory tests as screening tools in the primary care setting.^{34, 35, 36}

The CAGE Questions Adapted to Include Drugs (CAGE-AID)

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Source: Reprinted with permission from the *Wisconsin Medical Journal*. Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.

Matching Screens With Patients

Certain screening instruments may work better for different age, gender, racial, and ethnic groups. There is concern that cultural, gender, and age issues are not addressed adequately by instruments currently available. No instrument has been shown to be consistently culturally sensitive with all ethnic populations.³⁷

The CAGE has been found to have a higher sensitivity for identifying alcohol dependence in African Americans compared to Whites, while the AUDIT identifies alcohol dependencies at roughly the same rate in both races (Cherpitel and Clark, 1995). AUDIT has been validated in six countries with disparate cultures, although not across the various cultures in the United States.³⁸

Pregnant Women

It is generally accepted that quantity/frequency criteria should be lower for females than males and that pregnant women should abstain from drinking alcohol and other drug use.

Short Michigan Alcohol Screening Test

1.	Do you feel you are a normal drinker? (By normal we mean you drink less than, or as much as, most other people.)	YES	NO
2.	Does your wife, husband, a parent, or other close relative ever worry or complain about your drinking?	YES	NO
3.	Do you ever feel guilty about your drinking?	YES	NO
4.	Do friends or relatives think you are a normal drinker?	YES	NO
5.	Are you able to stop drinking when you want to?	YES	NO
6.	Have you ever attended a meeting of Alcoholics Anonymous?	YES	NO
7.	Has drinking ever created problems between you and your wife, husband, a parent, or other close relative?	YES	NO
8.	Have you ever gotten into trouble at work or school because of your drinking?	YES	NO
9.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	YES	NO
10.	Have you ever gone to anyone for help for your drinking? If YES: was this other than Alcoholics Anonymous or a hospital? (If YES, code as YES; if NO, code as NO.)	YES	NO
11.	Have you ever been in a hospital because of drinking? If YES: Was this for (a) detox; (b) alcoholism treatment; (c) alcohol-related injuries or medical problems, e.g., cirrhosis or physical injury incurred while under the influence of alcohol (car accident, fight, etc.)?	YES	NO
12.	Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	YES	NO
13.	Have you ever been arrested, even for a few hours, because of drunken behavior?	YES	NO

Source: Selzer, M.L.; Vinokur, A.; and Van Rooijen, L. A self-administered Short Michigan Alcoholism Screening Test (SMAST). *Journal of Studies on Alcohol* 36(1):117-126, 1975.

The Audit Questionnaire

Circle the number that comes closest to the patient's answer.

1. How often do you have a drink containing alcohol?

- (0) Never (1) Monthly or less (2) Two to Four times per month (3) Two to Three times per week (4) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 or 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

6. How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

7. How often in the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or Almost Daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, a friend, a doctor, or other health care worker been concerned about your drinking or suggested you cut down?

- (0) No (2) Yes, but not in the last year (4) Yes, during the last year

In determining the response categories it has been assumed that one drink contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25 percent from 10 g, the response category should be modified accordingly. Record sum of individual scores on the line below.

Fetal alcohol syndrome is the most common preventable cause of mental retardation.^{39, 40} Opiates and cocaine have been implicated in intrauterine growth retardation, premature births, neurobehavioral and neurophysical dysfunction, and birth defects.

Because of the potential risk to the fetus, primary care clinicians should ask all pregnant patients about their drug use.

Of the alcohol screening instruments that have been modified for pregnant women, the TWEAK⁴¹ (a phonetic acronym for its five questions: “Tolerance,” “Worried,” “Eye-openers,” “Amnesia,” “Cut down”) has been found to be the most effective for this population, for whom any use is relevant.⁴² Based on the best clinical judgement, the panel recommends the use of TWEAK (see “Tweak Test” at right) for pregnant patients in the primary care setting.

Older Adults

A recent study found that for patients age 65 and older, the prevalence of hospitalizations for alcohol-related medical conditions and for myocardial infarctions are similar.⁴³ To ensure that older adults receive needed intervention services, stepped-up identification efforts by primary care clinicians are essential.⁴⁴ The consensus panel recommends that all adults age 60 or older be screened for alcohol and prescription drug abuse as part of their regular physical examination.

To screen for prescription drug use, a clinician can ask questions such as:

- “Do you see more than one health care provider regularly? Why? Have you switched doctors recently? Why?”
- “What prescription drugs are you taking? Are you having any problems with them?”
- “Where do you get your prescriptions filled? Do you go to more than one pharmacy?”
- “Do you use any other nonprescription medications? If so, what, why, how much, how often, and how long have you been taking them?”

TWEAK Test

T	Tolerance: How many drinks can you hold?
W	Have close friends or relatives worried or complained about your drinking in the past year?
E	Eye-opener: Do you sometimes take a drink in the morning when you first wake?
A	Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
K (C)	Do you sometimes feel the need to cut down on your drinking?

Scoring: A seven-point scale is used to score this test. The “tolerance” question scores two points if a woman reports she can hold more than five drinks without falling asleep or passing out. A positive response to the “worry” question scores two points, and a positive response to the last three questions scores one point each. A total score of two or more indicates that the woman is likely to be a risk drinker.

Source: Russell, 1994.

Screening Techniques

Asking the Questions

The consensus panel believes that both physicians and nonphysicians can reliably screen for alcohol problems. Regardless of their professional positions, the clinicians should have proven screening skills.

Screening also can reveal that a member of the patient’s family has problems with alcohol or other drug use. Clinicians should be aware of this possibility.

Documenting Screening

A positive screen does not constitute a diagnosis, even if the screen suggests a high probability of risky alcohol- or drug-related behavior. If and when the positive screen is confirmed by further assessment and discussed with the patient, clinicians should then explain the implications of including positive screening results in the medical record. While medical records are confidential, patients routinely waive confidentiality in order to provide information to insurers. Patients should be apprised of their right to deny insurers access to their medical records but warned that such refusal could make it more difficult to obtain insurance coverage later.

The consensus panel recommends that clinicians flag charts with positive results, but because of confidentiality concerns, chart reminders should remain neutral and not identify the problem being flagged.

Responding to Screens

Negative Screens

Even if the screen is negative, the consensus panel recommends periodic rescreening for substance abuse because problematic alcohol use, illicit drug abuse, and their consequences can vary over an individual's lifetime.

Positive Screens

Clinicians should present results of positive screens in a nonthreatening manner. Clinicians must make some quick decisions at the time of screening to determine the appropriate clinical response. Three possible approaches are:

1. The clinician can follow-up immediately with a brief assessment during the initial visit.
2. The clinician can schedule a subsequent visit for assessment if the screening results are inconclusive.
3. The clinician can decide to refer to another source for assessment.

Chapter 3

Brief Intervention

Brief intervention is quite inexpensive for the yields, involving clinician–patient contacts of 10 to 15 minutes—the typical duration of an office visit—and a limited number of sessions. At least one follow-up visit is usually recommended, but the number and frequency of sessions depends on the severity of the problem and the individual patient’s response.

Critical Components of Brief Interventions

- 1. Give feedback about screening results, impairment, and risks while clarifying the findings.*
- 2. Inform the patient about safe consumption limits and offer advice about change.*
- 3. Assess the patient’s readiness to change.*
- 4. Negotiate goals and strategies for change.*
- 5. Arrange for follow-up treatment.*

Deciding to Refer for Further Assessment or Treatment

One of the most important concepts of substance use treatment is that one treatment failure is no reason to give up. Clinicians should be prepared for brief intervention to fail: The patient may not be able to achieve or maintain the mutually established goal of reducing or stopping use after one or even several tries.

Chapter 4

Assessment

Unlike brief intervention, in-depth substance abuse assessment requires specialized skills and consumes a substantial amount of time—anywhere from 90 minutes to 2 hours. As a result, many primary care clinicians will refer patients suspected of having a substance abuse problem to specialists for both assessment and treatment, although clinicians in underserved areas or with expertise in substance abuse may assume partial or total responsibility for this function. However, even clinicians who will not perform substance abuse assessments should have a basic understanding of the elements and objectives so they can:

- Initiate an appropriate referral.
- Participate effectively as a member of the treatment team, if required.

- Better fulfill the gatekeeper’s monitoring responsibility with respect to patient progress.
- Carry out needed case management functions as appropriate.

Who Should Assess?

Where possible, the consensus panel recommends referring patients to an experienced substance abuse specialist for intensive assessment. If referral is not possible, the panel believes that physicians, physician assistants, and advanced practice nurses with experience in emphatic motivational interviewing may perform intensive assessments after receiving training.

Chapter 5

Specialized Substance Abuse Treatment Programs

Primary care clinicians need to be familiar with available treatment resources for their patients who have diagnosed substance abuse or dependence disorders.

Understanding the specialized substance abuse treatment system, however, can be a challenging task. No single definition of treatment exists, and no standard terminology describes different dimensions and elements of treatment.

Directories of Local Substance Abuse Treatment Systems

In most communities, a public or private agency regularly compiles a directory of substance abuse treatment facilities that provides useful information about program services (e.g., type, location, hours, and accessibility to public transportation), eligibility criteria, and cost and staff qualifications, including language proficiency. Also the Substance Abuse and Mental Health Services Administration distributes a *National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs* (for a copy of the directory call 1-877-SAMHSA-7 [1-877-726-4727]).

Goals and Effectiveness of Treatment

While each individual in treatment will have specific long- and short-term goals, all specialized substance abuse treatment programs

have three similar generalized goals⁴⁵ (American Psychiatric Association, 1995):

- Reducing substance abuse or achieving a substance-free life.
- Maximizing multiple aspects of life functioning.
- Preventing or reducing the frequency and severity of relapse.

For most patients, the primary goal of treatment is attainment and maintenance of abstinence (with the exception of methadone-maintained patients), but this may take numerous attempts and failures at “controlled” use before sufficient motivation is mobilized. Until the patient accepts that abstinence is necessary, the treatment program usually tries to minimize the effects of continuing use and abuse through education, counseling, and self-help groups that stress reducing risky behavior, building new relationships with drug-free friends, changing recreation activities and lifestyle patterns, substituting substances used with less risky ones, and reducing the amount and frequency of consumption, with a goal of convincing patients of their individual responsibility for becoming abstinent.⁴⁶ Total abstinence is strongly associated with a positive long-term prognosis.

Becoming alcohol- or drug-free, however, is only a beginning. Most patients in treatment for substance abuse have multiple and complex problems in many aspects of living, including medical and mental illnesses, disrupted relationships, underdeveloped or deteriorated social and vocational skills, impaired performance at work or in school, and legal or financial troubles.

Increasingly, treatment programs are also preparing patients for the possibility of relapse and helping them understand and avoid dangerous “triggers” of resumed drinking or drug use. Patients are taught how to recognize cues, how to handle craving, how to develop contingency plans for handling stressful situations, and what to do if there is a “slip.” Relapse prevention is particularly important as a treatment goal in an era of shortened formal, intensive intervention and more emphasis on aftercare following discharge.

Patients who remain in treatment for longer periods of time are also likely to achieve maximum benefits—duration of treatment episode for 3 months or longer is often a predictor of a successful outcome.⁴⁷ Almost 90 percent of those who remain abstinent for 2 years are also drug- and alcohol-free after 10 years (American Psychiatric Association, 1995).

Treatment Dimensions

A recent publication of the Substance Abuse and Mental Health Services Administration, *Overview of Addiction Treatment Effectiveness* (Landry, 1996), divides substance abuse treatment along three dimensions:

- (1) *Treatment approach*—the underlying philosophical principles that guide the type of care offered and that influence admission and discharge policies as well as expected outcomes, attitudes toward patient behavior, and the types of personnel who deliver services
- (2) *Treatment setting*—the physical environment in which care is delivered
- (3) *Treatment components*—the specific clinical interventions and services offered to meet individual needs.

Treatment Models and Approaches

1. *A medical model*
2. *A psychological model*
3. *A sociocultural model*

These three models have been woven into a biopsychosocial approach in most contemporary programs.

The four major treatment approaches now prevalent in public and private programs are:

1. *The Minnesota model of residential chemical dependency treatment* incorporates a biopsychosocial disease model of addiction that focuses on abstinence as the primary treatment goal and uses the Alcoholics Anonymous 12-Step program as a major tool for recovery and relapse prevention.
2. *Drug-free outpatient treatment* uses a variety of counseling and therapeutic techniques, skills training, and educational supports with little or no pharmacology to address the specific needs of individuals moving from active abuse to abstinence.
3. *Methadone maintenance (or opioid substitution) treatment* specifically targets chronic heroin or opioid addicts who have not benefited from other treatment approaches. Such treatment includes replacement of licit or illicit morphine derivatives with longer-acting, medically safe, stabilizing substitutes of known potency and purity that are ingested orally on a regular basis.
4. *Therapeutic community residential treatment* is best suited to patients with a substance dependence diagnosis who also have serious psychosocial adjustment problems and require resocialization in a highly structured setting.

Treatment Settings

Inpatient hospitalization includes around-the-clock treatment and supervision by a multidisciplinary staff that emphasizes medical management of detoxification or other medical and psychiatric crises, usually for a short period.

Residential treatment in a live-in facility with 24-hour supervision is best suited for patients with overwhelming substance use problems who lack significant motivation or social supports to maintain abstinence on their own, but do not meet clinical criteria for hospitalization. Many

residential facilities offer medical monitoring of detoxification and are appropriate for individuals who need that level of care but do not need management of other medical or psychiatric problems.

Intensive outpatient treatment requires a minimum of 9 hours weekly attendance, usually in increments of 3 to 8 hours a day for 5 to 7 days a week.

Least intensive is *outpatient treatment* with scheduled attendance of less than 9 hours per week, usually including once- or twice-weekly individual, group, or family counseling as well as other services.

Treatment Techniques

Within each treatment approach, a variety of specialized techniques (also known as elements, modalities, components, or services) are offered to achieve specified goals. The principal elements are:

- *Pharmacotherapies*
- *Psychosocial or psychological interventions*
- *Behavioral therapies*
- *Self-help groups.*

Pharmacotherapy

Medications to manage withdrawal take advantage of cross-tolerance to replace the abused drug with another or safer drug in the same class. The latter can then be gradually tapered until physiological homeostasis is restored.

Medications to discourage substance use:

- Disulfiram (Antabuse). This agent inhibits the activity of the enzyme that metabolizes a major metabolite of alcohol resulting in the accumulation of toxic levels of acetaldehyde and numerous side effects such as flushing, nausea, vomiting, hypotension, and anxiety.
- Naltrexone. This keeps opioids from occupying receptor sites, thereby inhibiting their euphoric effects.

Agonist substitution therapy. The leading substitution therapies are methadone and the even longer acting levo-alpha-acetyl-methadol (LAAM). Buprenorphine, a mixed opioid agonist-antagonist, is also being used to suppress withdrawal, reduce craving, and block euphoric and reinforcing effects.⁴⁸

Medications to treat comorbid psychiatric conditions are an essential adjunct to substance abuse treatment for patients diagnosed with both a substance use disorder and a psychiatric disorder. Since there is a high prevalence of comorbid psychiatric disorders among people with substance dependence, pharmacotherapy directed at these conditions is often indicated.

Psychosocial Interventions

Individual therapy uses psychodynamic principles with such modifications as limit-setting and explicit advice or suggestions to help patients address difficulties in interpersonal functioning.

Group therapy is one of the most frequently used techniques during primary and extended care phases of substance abuse treatment programs. Group therapy offers the experience of providing closeness, sharing painful experiences, communication of feelings, and helping others who are struggling with control over substance abuse.

Marital therapy and family therapy focuses on the substance abuse behaviors of the identified patient and on maladaptive patterns of familial interaction and communication.

Behavioral Therapies

Cognitive behavioral therapy attempts to alter the cognitive processes that lead to maladaptive behavior, intervene in the chain of events that lead to substance abuse, and then promote and reinforce necessary skills and behaviors for achieving and maintaining abstinence.

Behavioral contracting or contingency management uses a set of predetermined rewards and punishments established by a therapist and patient (and significant others) to reinforce desired behaviors.

Relapse prevention helps patients first recognize potentially high-risk situations or emotional “triggers” that have led to substance abuse and helps them to learn a repertoire of substitute responses to cravings.

Self-Help Groups

Mutually supportive, 12-Step groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, or more recent alternatives (e.g., Rational Recovery and Women for Sobriety) are the backbone of many treatment efforts as well as a major source of continuing care.

Other Primary and Ancillary Services

Patients in treatment may need other primary and adjunctive services as well: social services, vocational training, education, legal assistance, financial counseling, health and dental care, and mental health treatment. Adjunctive services to encourage patients to enter and remain in treatment may include child care, transportation arrangements, financial assistance or welfare support, supported housing, and other supplemental help.

The Treatment Process

All the components, approaches, techniques, and settings discussed above must be monitored and adjusted as treatment progresses. Primary care clinicians should understand the following aspects of appropriate care:

Repeated assessments to evaluate a patient’s changing medical, psychological, social, vocational, educational, and recreational needs, especially as more basic and acute deficits or crises are resolved and new problems emerge or become amenable to treatment.

Developing a comprehensive treatment plan that clearly reflects all identified problems, that has explicit goals and strategies for their attainment, and that specifies techniques and

services to be provided by designated specialists at particular frequencies or intensities.

Monitoring progress and clinical status through written notes or reports that describe responses to treatment approaches and outcomes of services provided, including counseling sessions, group meetings, urine or other biological testing, physical examinations, medications administered, and referrals for care.

Establishing a therapeutic alliance with an empathetic primary therapist or counselor who can gain the confidence and trust of the patient and significant others or family members and take responsibility for continuity of care.

Providing education to help the patient and concerned parties to understand the diagnosis, the etiology and prognosis for the disorder, and the benefits and risks of anticipated treatment.

Treatment Programs for Special Populations

A variety of substance abuse treatment programs have been developed to meet the particular needs of special populations, including women, pregnant and postpartum mothers, adolescents, elderly persons, members of various minority groups, public inebriates or homeless persons, drinking drivers, and children of alcoholics. These special programs are found in the public and private sectors and include both residential and ambulatory care settings using the therapeutic community, the Minnesota model, and outpatient drug-free and methadone maintenance approaches.

Notable components of these separate programs for special populations are as follows (Institute of Medicine, 1990; American Psychiatric Association, 1995; Landry, 1996).

Women are more likely than men to have comorbid depressive and anxiety disorders, including post-traumatic stress disorders as a result of past or current physical or sexual abuse. Treatment components can address women’s special issues and needs for obtaining child care, developing parenting skills, building healthy

relationships, avoiding sexual exploitation or domestic violence, preventing HIV infection and other sexually transmitted diseases, and addressing self-esteem issues. A high ratio of female staff and same-sex groups are also thought to improve treatment retention.

Pregnant and postpartum women and their dependent children have numerous special needs including prenatal and obstetrical care; pediatric care; knowledge of child development; parenting skills; economic security; and safe, affordable housing.

Adolescents need treatment that is developmentally appropriate and peer-oriented. Educational needs are particularly important as well as involvement of family members in treatment planning and therapy for dysfunctional aspects. Substance abuse among adolescents frequently correlates with depression, eating disorders, and a history of sexual abuse (America Psychiatric Association, 1995).

Elderly persons may have unrecognized and undertreated substance dependence on alcohol or prescribed benzodiazepines and sedative hypnotics that can contribute to unexplained falls and injuries, confusion, and inadvertent overdose. Age decreases the body's ability to metabolize many medications. Other coexisting medical and psychiatric conditions can also complicate treatment and compromise elderly patients' ability to comply with recommended regimens.

For some *African-American* patients, involving church and treatment that incorporates spiritual elements may improve outcomes. Treatment programs for *Native American* tribes often incorporate their traditions and a family focus. Bilingual staff and translated written materials are important ingredients of many treatment programs for *Hispanics*.

Confidentiality

One important aspect of working with, or making a referral for, substance abuse treatments is the legal requirement to comply with Federal regulations governing the confidentiality of

information about a patient's substance use or abuse. Laws protecting the confidentiality of alcohol and drug abuse patient records were instituted to encourage patients to enter treatment without fear of stigmatization or discrimination as a result of information disclosure without the patient's express permission (42 C.F.R. Part 2). Clarifying amendments passed in 1987 make it clear that patient records generated in general medical settings and hospitals are not covered unless the treating clinician or unit has a primary interest in substance abuse treatment.⁴⁹ If a referral is made by the primary care clinician for a substance abuse assessment or to a specialized treatment program, written permission of the patient is required before any information or records can be disclosed in which the patient's identity is revealed, *except in cases of medical emergency or reporting suspected child abuse to the proper authorities*. Nonetheless, records containing information about substance use disorders should always be handled with discretion.

The Role of the Primary Care Clinician Throughout Treatment

As already noted, all primary care clinicians have important roles to play in identifying, screening, and referring patients with substance use disorders for in-depth assessment or treatment and in delivering brief interventions to patients with milder substance-related problems. In addition, the clinician has an array of options, depending on time and resources available, for offering ongoing support and encouragement to patients who do enter the formal treatment system. These options include:

- Learning about treatment resources in the community that offer appropriate services.
- Keeping in touch with specific treatment programs where the patient is enrolled to ascertain its quality and understand the approach and services offered.

- Requesting formal reports regarding the treatment plan and progress indicators from the program on a periodic basis (with the patient's explicit permission).
- Clarifying the clinician's role in the continued care of the patient (e.g., treating specified medical conditions, writing prescriptions, and monitoring compliance through urine or other biological testing).
- Reinforcing the importance of continuing treatment to the patient and relatives.

Appendix A

Pharmacotherapy

In the context of substance abuse, *pharmacotherapy* is the treatment of drug or alcohol dependence with medication to achieve one

of three ends: detoxification, relapse prevention, or opioid maintenance.

Ways in Which Psychopharmacology Is Used to Treat Alcohol or Other Drug Dependencies

Purpose	Treatment Goal	Examples
Detoxification	Enable patients to be safely withdrawn from their drug of dependency	Chlordiazepoxide for alcohol withdrawal
		Clonidine or methadone for opiate withdrawal
		Phenobarbital or valproate in benzodiazepine withdrawal
Relapse Prevention	Make drinking alcohol aversive	Disulfiram (Antabuse)
	Block reinforcing effects of opiates	Naltrexone (ReVia)
	Treat underlying or drug-induced psychopathology that may cause relapse to drug use	Antidepressants, mood stabilizers (e.g., lithium or valproate)
Opioid Maintenance	Reduce the medical and public health risks of heroin use	Methadone LAAM Buprenorphine*

* Investigational at the time this was written (1997)

Appendix B

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Appendix D

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Concise Desk Reference Guides have been prepared for five published TIPS. These TIPS and their related guides are listed below:

- TIP 24** *A Guide to Substance Abuse Services for Primary Care Clinicians* BKD234
Concise Desk Reference (SMA) 08-3740
Guia de Servicios para el Abuso de Sustancias Para Proveedores de Atencion Primaria de la Salud
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- TIP 25** *Substance Abuse Treatment and Domestic Violence* BKD239
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- TIP 26** *Substance Abuse Among Older Adults* (SMA) 07-3918
Substance Abuse Among Older Adults: A Guide for Treatment Providers MS669
Substance Abuse Among Older Adults: A Guide for Social Service Providers MS670
Substance Abuse Among Older Adults: Physicians Guide MS671
- TIP 27** *Comprehensive Case Management for Substance Abuse Treatment* BKD251
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- TIP 28** *Naltrexone and Alcoholism Treatment* BKD268
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