

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

A Guide to Substance Abuse Services for Primary Care Clinicians

Treatment Improvement Protocol (TIP) Series

24



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of CSAT, SAMHSA, or DHHS. No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized client 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 Service Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis, and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. Then recommendations are communicated to a Consensus Panel, non-Federal experts on the topic who have been nominated by their peers. This Panel participates in discussions over 5

days; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: <http://text.nlm.nih.gov>. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices 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. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

What Is a TIP?

The objective of this TIP, *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 identifying indications of substance abuse, how to broach the subject with a patient, and what screening and assessment instruments to use. It explains how to perform an office-based brief intervention in which patient and clinician set mutually agreed upon goals and "contract" to stop or cut back the alcohol or other drug use. The elements of in-depth assessments, appropriate referrals, and

specialized treatment are discussed. The appendixes to the document include discussions by experts on leading pharmacotherapies for alcohol and other drugs and legal issues of patient confidentiality.

This TIP equips primary care clinicians who may not have any knowledge of the substance abuse field to address this pervasive disease. The physicians, nurses, social workers, researchers, certified alcohol counselors, program directors, and pharmacologists on the Consensus Panel pooled years of research and practice to devise recommendations that can be readily implemented in a busy primary care setting. This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve substance abuse treatment.

Other TIPs may be ordered by contacting The National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA’s mission of building resilience and facilitating recovery by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel’s work is then reviewed and critiqued by field reviewers.

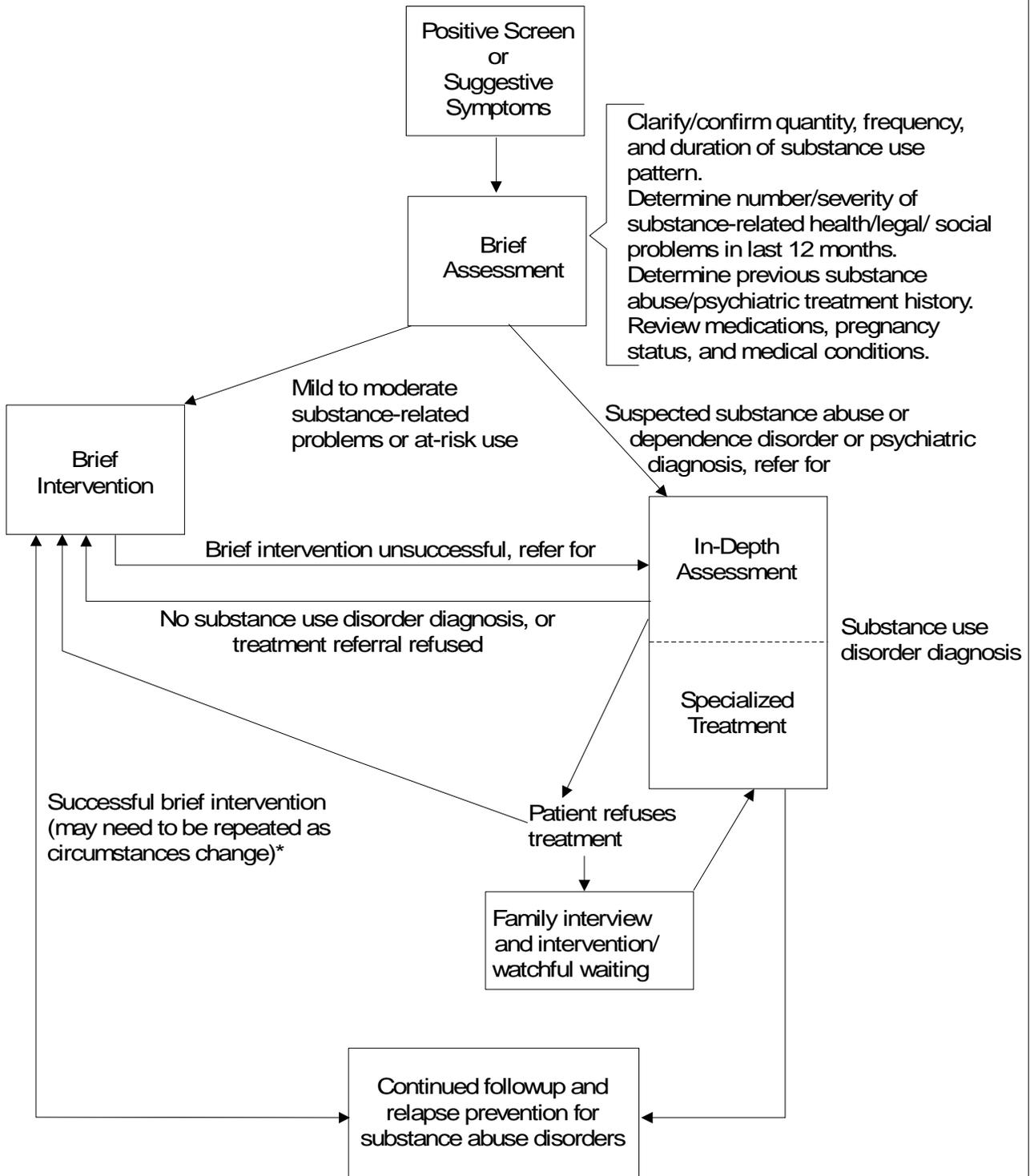
The talent, dedication, and hard work that TIPs Panelists and reviewers bring to this highly participatory process have bridged the gap

between the promise of research and the needs of practicing clinicians and administrators to serve people who abuse substances in the most current and effective ways. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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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.

Executive Summary and Recommendations

The goal of this TIP is to recommend guidelines for primary care clinicians to follow in caring for patients with alcohol and other drug use disorders. These guidelines were developed by a Consensus Panel of clinicians, researchers, and educators who work on the prevention and treatment of substance use disorders. Protocols are based partly on research evidence, partly on Panel members' clinical experience.

The algorithm to the left follows a patient with substance use problems who presents in a primary care setting. The chart will serve as a guide or road map through screening, brief assessment, brief intervention, assessment, referral, specialized treatment, and followup 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. Furthermore, 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 or 15 minutes (Kahan et al., 1995; Wallace et al., 1988). This potential, however, is largely untapped: Saitz and colleagues found that of a sample of patients seeking substance abuse treatment, 45 percent

reported that their primary care physician was unaware of their substance abuse (Saitz et al., in press).

Yet even though screening and limited treatment of substance use disorders do not require a large time investment, the Consensus Panel that developed this TIP recognized that many primary care clinicians are already overwhelmed by the demands imposed by expanded gatekeeper functions. The Panel realized that a practical approach to addressing patients' substance abuse problems was needed: one that recognized the time and resource limitations inherent in primary care practice and offered a series of graduated approaches that could be incorporated into a normal clinic or office routine.

Biological, medical, and genetic factors as well as psychological, social, familial, cultural, and other environmental features all bear on substance abuse. Addressing the condition effectively requires a team effort, especially when it has progressed beyond the early stage. For this reason, in addition to screening and intervention treatment options, these guidelines include information about viable referral for assessment and treatment, as well as followup.

Readers will notice that the TIP contains more information on alcohol use and abuse than on use of illicit drugs. This reflects both the scope of the problems and the research literature available about them. It is estimated that about

18 million people with alcohol use problems and 5 million users of illicit drugs need treatment.

Although the Panel recognizes that tobacco is an addictive substance with a major public health impact, it is not included in this TIP because the topic falls outside CSAT's purview. Readers are referred to *Smoking Cessation: A Guide for Primary Care Clinicians*, published by the Agency for Health Care Policy and Research (Agency for Health Care Policy and Research, 1996).

The Consensus Panel's recommendations are based on a combination of clinical experience and research-based evidence. In the list below, the summary guidelines supported by the research literature are followed by (1); clinically based recommendations are marked (2). Citations supporting the former are referenced in the body of the document. Screening and assessment instruments mentioned below are reproduced and discussed in Chapters 2 and 4 and Appendix C.

The guidelines are presented in more detail in Chapter 6.

General Recommendations

The Consensus Panel that developed this TIP recommends that *primary care clinicians*—a term that includes physicians, physician assistants, and advanced practice nurses—follow the guidelines below.

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) to screen for alcohol problems among English-speaking, literate patients, or use the first three quantity/frequency questions from the AUDIT, supplemented by the CAGE questionnaire. (1)
- Use the CAGE-AID (Cage Adapted to Include Drugs) 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 drug use in combination. (2)
- Use the TWEAK 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 the CAGE, the AUDIT, or the Michigan Alcoholism Screening Test—Geriatric Version (MAST-G) 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)

Brief Intervention

- Perform a brief intervention with patients whose substance abuse problems are less severe. (1)
- Include in the brief intervention feedback about screening results and risks of use, information about safe consumption limits and advice about change, assessment of patient's readiness to change, negotiated goals and strategies for change, and arrangements for followup visits. (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 the 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, in combination with the American Society of Addiction Medicine's *Patient Placement Criteria*, Second Edition, to make a diagnosis and devise an assessment-based treatment plan. (1)
- Become familiar with available assessment and treatment resources. (2)
- Keep encouraging reluctant patients with substance use disorders to accept treatment of some kind. (2)

Confidentiality

- 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 the patient before discussing his or her 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. Office or clinic visits also give clinicians an opening to discuss substance abuse prevention with patients and in many cases, forestall problems from ever developing. As one primary care physician observed, "With respect to substance abuse, our charge is straightforward: first we must *ask* something, then we must *do* something." This TIP is intended to assist primary care clinicians with both tasks.

1 Substance Abuse and Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

(Institute of Medicine, 1996)

By any measure, effectively treating a primary care patient's substance abuse problem is addressing a significant "personal health care need." Alcohol-related disorders, for example, occur in up to 26 percent of general medical clinic patients, a prevalence rate similar to those for such other chronic diseases as hypertension and diabetes (Fleming and Barry, 1992). While not specific to the primary care setting, the most recent National Household Survey on Drug Abuse estimates that 12.8 million Americans, or 6.1 percent of the population age 12 and older, currently use illicit drugs, while about 32 million Americans (15.8 percent of the population) had engaged in binge or heavy drinking (five or more drinks on the same occasion at least once in the previous month) (Substance Abuse and Mental Health Services Administration, 1996b). Using estimates from the Institute of Medicine (Institute of Medicine, 1990), 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 (Institute for Health Policy, 1993).

Accurately gauging the costs of substance use problems, like estimating costs for heart disease or cancer, is difficult. This figure grows or shrinks by billions of dollars depending on the economic assumptions used. The costs to abusers, their families, and society at large, however, are indisputably enormous and encompass health care costs, premature mortality, workers' compensation claims, reduced productivity, crime, suicide, domestic violence, and child abuse.

Some 100,000 people die each year in the United States as a result of alcohol; illicit drug abuse and related acquired immunodeficiency syndrome (AIDS) deaths account for at least another 12,000 deaths (Rice et al., 1990; Stinson et al., 1993; Rosenberg et al., 1996). Every man, woman, and child in America pays nearly \$1,000 annually to cover the costs of unnecessary health care, extra law enforcement, motor vehicle crashes, crime, and lost productivity due to substance abuse (Institute for Health Policy, 1993). Furthermore, an "analysis of the epidemiological evidence reveals that 72 conditions requiring hospitalizations are wholly or partially attributable to substance abuse"

(Center on Addiction and Substance Abuse, 1993, p. 21).

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)* (American Psychiatric Association, 1994a) estimates that 52.9 percent of Americans age 18 and older have a family history of alcoholism among first- or second-degree relatives (Dawson and Grant, in press). In short, substance use disorders are simply too pervasive and too costly to be ignored.

Fortunately, not only is effective specialty treatment available for problem drinkers, alcoholics, and illicit drug users, but brief interventions, which can be done in a primary care setting, can substantially reduce hazardous drinking, a behavior that has enormous negative effects on public health (Kahan et al., 1995).

In a report on the financially driven changes in health care, the Institute of Medicine highlighted the growing need for primary care clinicians to diagnose and treat a range of problems previously addressed by specialists (Institute of Medicine, 1996). 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 involved in providing patient services. The American Medical Association’s *Guidelines for Adolescent Preventive Services* (GAPS) recommends patient education, anticipatory guidance, and early

intervention strategies to reduce adolescent patients’ use of alcohol and other drugs (Elster and Kuznets, 1994). Likewise, the American Academy of Pediatrics advises pediatricians to include anticipatory guidance on substance abuse to all children and adolescents.

In support of these recommendations, universities are implementing medical and nursing school curriculum modules while specialty organizations, including the National Nurses’ Society on Addictions, the American Society of Addiction Medicine, the Association for Medical Education and Research on Substance Abuse, the American Association of Obstetricians and Gynecologists, and the Drug and Alcohol Nurses Association, are promoting faculty development and the development of core competencies and practice standards for intervening with and treating substance abuse problems.

In this era of managed care, the primary care clinician’s responsibility is expanding. As the gatekeeper charged with ensuring the provision of comprehensive care, the primary care clinician will almost certainly provide some type of alcohol- or other drug-related service. Basic skills in identifying and diagnosing patients who are chemically dependent will become essential. Clinicians in areas with limited substance abuse resources may be responsible for assessments, while those trained in addiction medicine may be providing a range of treatment services. Regardless of how extensively involved clinicians become, those who are familiar with the medical complications of substance abuse and are able to relate them to other comorbid illnesses will be better equipped to deliver adequate care.

Alcohol Use Among Primary Care Patients

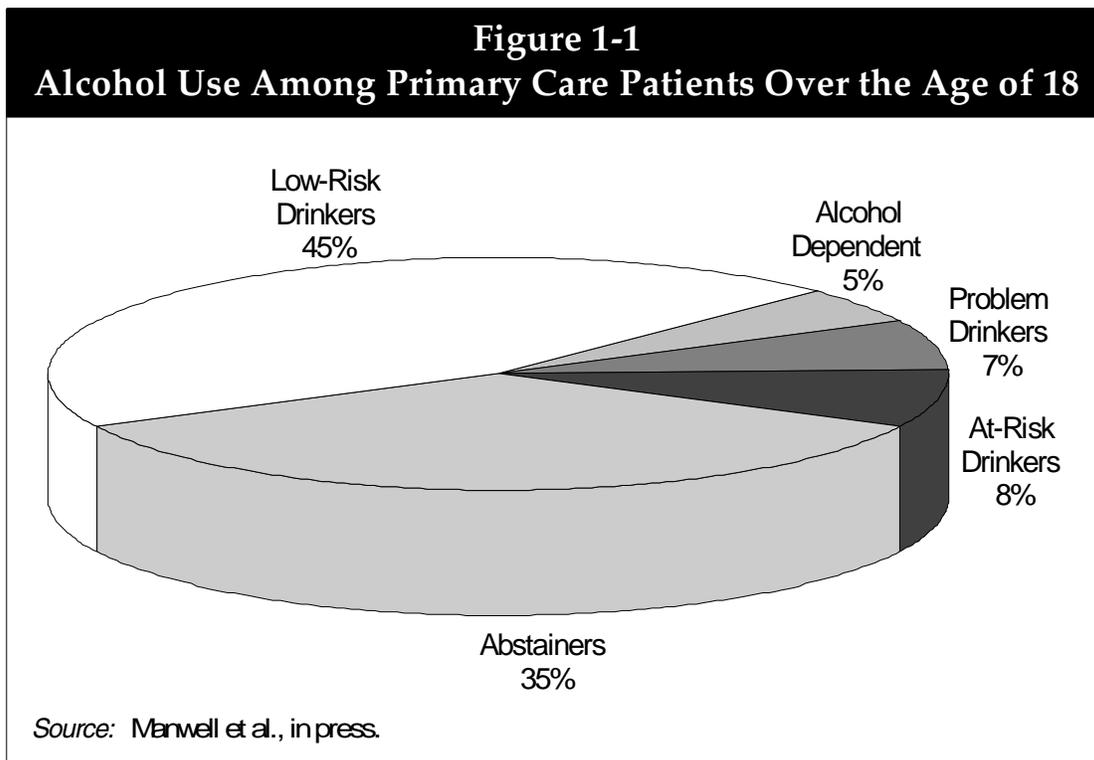
Since more Americans abuse alcohol than illicit drugs, primary care clinicians will encounter substantially more patients with alcohol problems than with drug problems (although many patients who abuse alcohol also abuse illicit drugs or prescription drugs and vice versa). Though most people who consume alcoholic beverages do not experience problems related to their use, primary care clinicians can expect that 15 to 20 percent of their male patients and 5 to 10 percent of their female patients will be at risk for or already are experiencing related medical, legal, or psychosocial problems. These problems include unresponsive diabetes, arrests for “driving under the influence,” problems with job or school, or family or marital difficulties. Figure 1-1 presents the current prevalence of alcohol

use and problems in primary care settings for patients over the age of 18 (Manwell et al., in press).

Levels of Use

The nature and intensity of alcohol-related problems vary according to consumption: Above two to three drinks a day, there is a clear dose-response curve. The higher the levels of consumption, the greater the risk of negative health effects including cirrhosis, cancer, heart disease, stroke, traumatic injury, and depression. For this reason, 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 age 65—No more than one drink per day (National Institute on Alcohol Abuse and Alcoholism, 1995b)



It is important for primary care clinicians to know patients' 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 where they provide a nonstigmatizing opportunity to share valuable risk reduction information

For example, just as a clinician may point out to patients with blood pressure higher than 140/90 that they are at risk for cardiovascular problems secondary to hypertension, people who consume more than two drinks per day should be told that they are at risk for heart and liver disease. When presented this way, information about levels may help motivate nonproblem drinkers and abstainers to maintain healthy habits, while offering those at risk for problems an incentive to reduce the amount of alcohol they consume.

Frequency of Problems Related to Use

To determine a patient's risk level, however, the clinician must consider more than consumption levels. Definitions of *low-risk* and *at-risk* use are based on the relationship between a given quantity of alcohol used and a number of health effects. Recognizing at-risk drinkers in particular can be difficult. Researchers have investigated indicators other than consumption levels in an effort to determine other risk factors.

Low-risk drinkers consume less than an average of one to two drinks per day, do not drink more than three to four drinks per occasion, and do not drink in high-risk situations (e.g., while pregnant, driving a car, or taking medication that interacts with alcohol). *At-risk drinkers* occasionally exceed recommended guidelines for use. While they are at risk for such alcohol-related problems as

burns, motor vehicle crashes, or falls because of their drinking habits, at-risk drinkers may never experience negative consequences as a result of their alcohol use and represent a prime target for preventive, educational efforts by primary care clinicians. A number of environmental, interpersonal, psychobehavioral, and biogenetic risk factors (e.g., social norms conducive to use, family and marital conflict, early onset of use, and inherited susceptibility) have been identified and are summarized in Figure 1-2 (Hawkins et al., 1985; Kandel et al., 1986; Newcomb and Bentler, 1988; Heath et al., 1989; Brook and Brook, 1990; Landry et al., 1991a; Landry, 1994).

The American Psychiatric Association's DSM-IV classifies mental disorders (including substance-related disorders) to help clinicians make useful diagnoses and to guide scientists' research. Although this approach works best when there are clear boundaries between types of disorders, categories within disorders cited in the DSM-IV are not necessarily discrete or static. Moreover, all individuals suffering from the same disorder are not necessarily alike (American Psychiatric Association, 1995). 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). These nondependent but problematic drinkers account for the "majority of alcohol-related morbidity and mortality in the general population" (U.S. Preventive Services Task Force, 1996, p. 567; Institute of Medicine, 1990).

Figure 1-2 Risk Factors for Alcohol and Other Drug Abuse

These factors are not definitive; rather their presence suggests that an individual may develop a problem. Absence of risk factors provides no assurance that an individual will not develop a problem with drugs or alcohol.

Psychiatric

Depression
Anxiety
Low self-esteem
Low tolerance for stress
Other mental health disorders (e.g., learning disabilities)
Feelings of desperation
Feelings of loss of control over one's life
Feelings of resentment

Behavioral

Use of other substances
Aggressive behavior in childhood
Conduct disorder; antisocial personality disorder
Avoidance of responsibilities
Impulsivity and risk-taking
Alienation and rebelliousness; reckless behavior
School-based academic or behavioral problems; school drop-out
Involvement with criminal justice system or illegal activities
Poor interpersonal relationships

Demographic

Male gender
Inner city or rural residence combined with low socioeconomic status; lack of employment opportunities

Family

Use of drugs and alcohol by parents, siblings, spouse
Family dysfunction (e.g., inconsistent discipline, poor parenting skills, lack of positive family rituals and routine)
Family trauma (e.g., death, divorce)

Social

Alcohol- and drug-using peers
Social or cultural norms approving use
Expectations about positive effects of drugs and alcohol
Availability of or accessibility to alcohol and drugs

Genetic

Inherited predisposition to alcohol or drug dependence
Deficits in neurotransmitters (e.g., serotonin)
Absence of aldehyde dehydrogenase (flushing or palpitations occur when alcohol ingested)

Source: Adapted from Hawkins et al., 1985; Kandel et al., 1986; Newcomb and Bentler, 1988; Heath et al., 1989; Brook and Brook, 1990; Landry et al., 1991a; Landry, 1994.

As a group, problem drinkers experience a range of alcohol-related problems from a "driving under the influence" citation to loss of job or family disruption. It is important for clinicians to understand, however, that problem drinkers, unlike alcoholics, often respond to clinician counseling and brief intervention efforts (see Chapter 3) and do not always require a referral to specialized treatment.

Alcoholic or dependent drinkers meet at least three of the seven DSM-IV criteria for substance

dependence: drinking more than intended; wanting to stop drinking; spending a great deal of time procuring alcohol; giving up social or occupational activities because of alcohol; drinking despite the physical or psychological problems it causes; and, in some cases, experiencing physical dependence as manifested by tolerance to alcohol's effects and withdrawal symptoms. Figure 1-3 illustrates the relationship between level and frequency of use

and the development of alcohol problems (Skinner, 1992).

Other Drug Use Among Primary Care Patients

Since unauthorized drug use is illegal, patients who use illicit drugs are considered drug abusers. While primary care clinicians can discuss approaches for reducing the amount of alcohol consumed as an acceptable goal with patients who are problem drinkers, such approaches will collide with the law if the

substance being abused is illegal. For illicit drug abusers, abstinence is the ultimate goal. However, the primary care clinician should recognize that quitting “cold turkey” may initially be untenable for some drug abusers and should encourage any steps the patient makes in that direction.

In 1995, 6.1 percent of Americans age 12 and older had used an illicit drug in the previous month (Substance Abuse and Mental Health Services Administration, 1996b). Figure 1-4 shows the percentages for specific drugs.

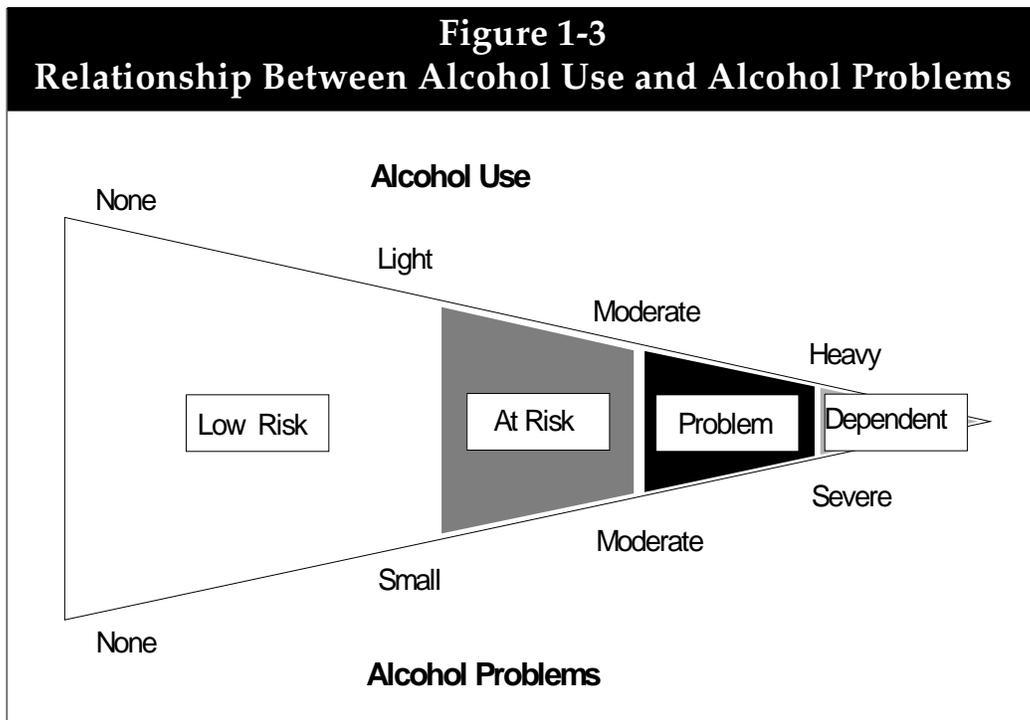
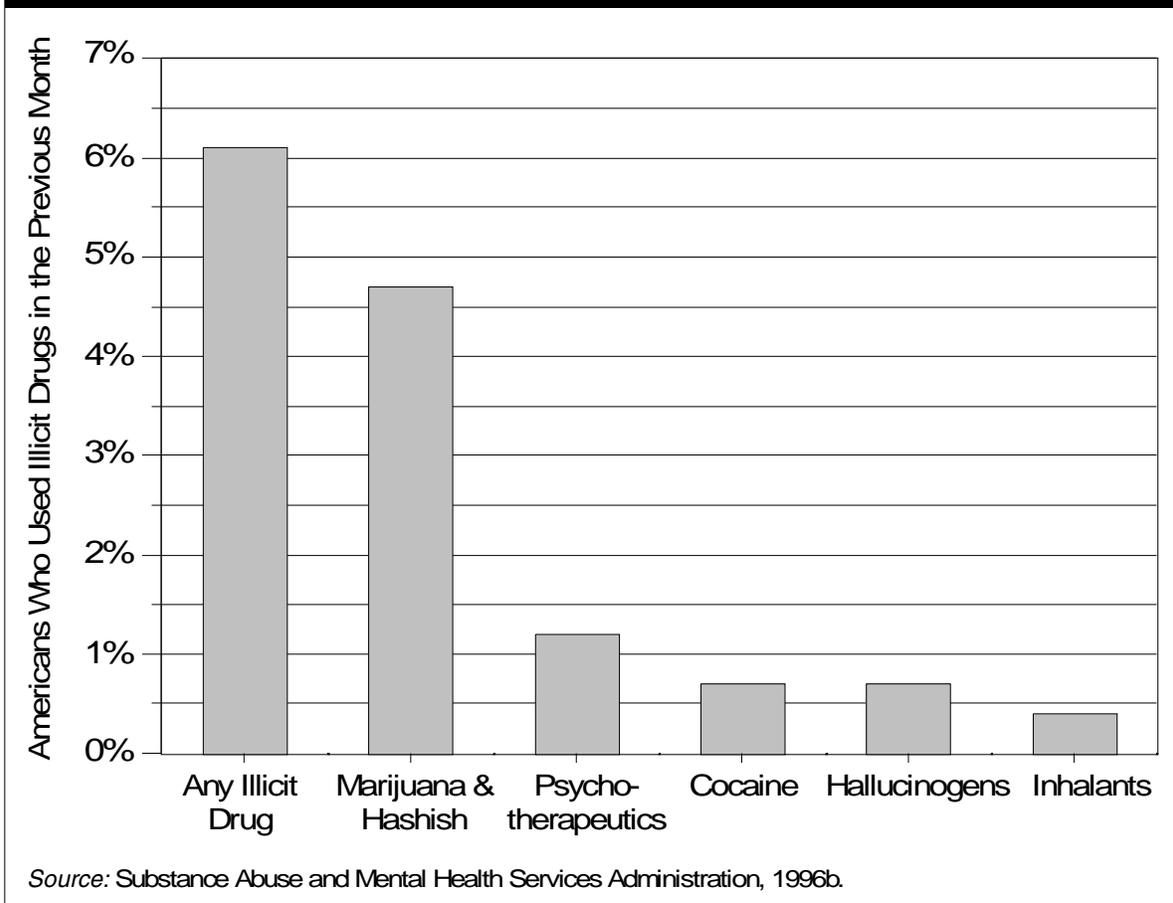


Figure 1-4
Past Month Illicit Drug Use, 1995



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 (Johnston et al., 1996). 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). Reports from medical examiners, hospital emergency departments, treatment programs, and others who participate in the National Institute of Drug Abuse Community Epidemiology Work Group indicate that a small but growing number of

young people are using heroin. Crack users increasingly are combining crack with heroin, and older intravenous drug users are shifting to intranasal use (Community Epidemiology Work Group, 1996).

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 (Hanley-Hazelden Center, 1991; Chastain, 1992). Health care professionals are especially at risk for prescription drug abuse (Sullivan et al., 1990).

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

where patients are along this continuum is as important for effective intervention with drug abusers as it is for alcoholics.

Understanding Substance Use Disorders in a 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 (Fleming and Barry, 1992).

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 the 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. Therefore, it is important to monitor each patient's status regularly, just as clinicians do for hypertension.

Complex Etiologies

The interplay between genetic familial predisposition and lifestyle influences the development of substance abuse disorders just as it influences hypertension (Gordis and Allen,

1994; McGue, 1994; Landry, 1994). Many now believe that individuals may inherit a genetic susceptibility to substance abuse that may be fueled or quelled by a combination of family and social norms (parental use of drugs, community or peer acceptance or rejection of drug use, or equation of heavy drinking with masculinity), traumatic events (death of a loved one, divorce, childhood physical or sexual abuse, or war), pharmacodynamic effects (affinity for developing tolerance or withdrawal or positive reinforcing qualities of the drug used), or environmental factors (poverty or easy availability of drugs) (Collins, 1986; Yokel, 1987; Koob and Bloom, 1988; Gardner, 1992; Johnson and Muffler, 1992). 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 (Landry et al., 1991a; Meyer, 1986).

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, a patient will first have to accept that he or she has a problem. Compliance with treatment is ongoing and may be difficult.

Behaviorally oriented treatment includes a number of cognitive and behavioral approaches that help patients recognize and change maladaptive behaviors, develop new or enhanced social skills that will promote and sustain recovery, and learn techniques for responding to cravings without relapsing. Motivational enhancement therapy, cognitive behavioral therapy, contingency contracting

(e.g., use of positive rewards and negative consequences such as the threat of job loss to promote recovery), and cue exposure treatment are designed to promote resistance to those triggers or cues that prompt use and are among the most common behavioral therapies (American Psychiatric Association, 1995).

Favorable Prognosis for Recovery

Despite these problems, however, many substance abuse patients—like patients with diabetes, elevated cholesterol, and 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. For example, the National Treatment Improvement Evaluation Study (NTIES) completed in 1996 reports that clients served by federally funded substance abuse treatment programs were able to cut their drug use in half for up to 1 year after leaving treatment (Center for Substance Abuse Treatment, 1996). A study commissioned by the Oregon Office of Alcohol and Drug Abuse Programs concluded that for every dollar spent on substance abuse treatment, taxpayers saved \$5.60 (Finigan, 1996).

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 (Institute of Medicine, 1990; National Institute on Alcohol Abuse and Alcoholism, 1993).

Approach to Substance Abuse for Primary Care Clinicians

When the Center for Substance Abuse Treatment convened its Consensus Panel of experts on primary care, its goal was to devise a practical approach to addressing patient substance abuse problems, one that recognized the time and resource limitations inherent in primary care practice and offered approaches that could be implemented in a stepwise fashion without disrupting normal clinic or office routine. This Treatment Improvement Protocol *A Guide to Substance Abuse Services for Primary Care Clinicians* describes a series of graduated approaches for responding to the substance abuse problems typically encountered by primary care clinicians.

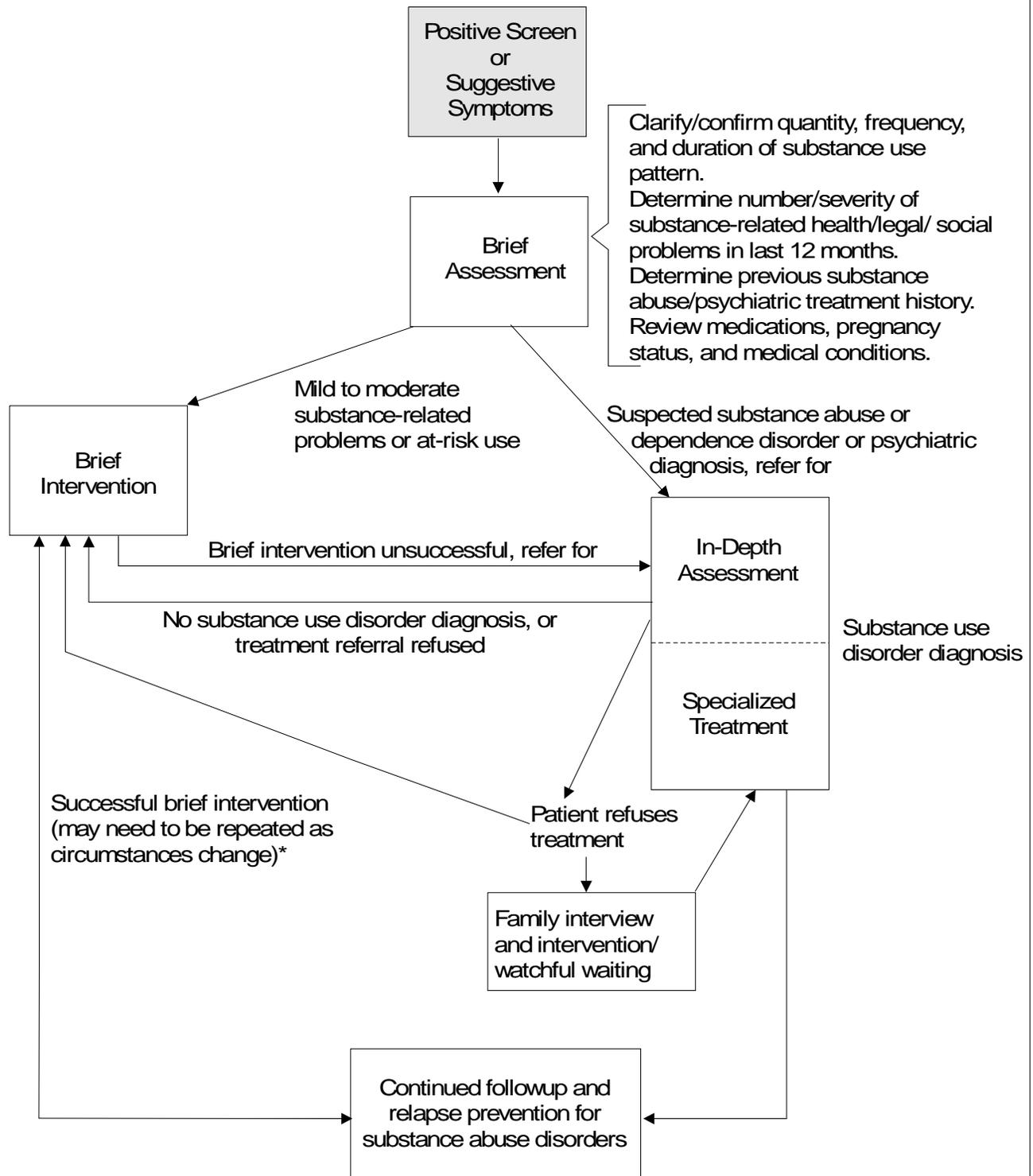
Chapter 2, Screening for Substance Use Disorders, provides specific dialogue and recommends particular instruments for uncovering substance use disorders. The chapter also explains how to tailor screening to special populations, how to document screening, and how to discuss a positive screen with a patient. Chapter 3, Brief Intervention, details how to perform this office-based pretreatment or prevention technique and which patients are most likely to benefit. Chapter 4, Assessment, presents the elements of an in-depth assessment, ideally performed by an addiction specialist. Chapter 5, Specialized Substance Abuse Treatment Programs, summarizes the referral process and the various forms of specialized treatment available. Chapter 6 suggests methods for implementing change and summarizes the Consensus Panel's recommendations. Appendix A,

Chapter 1

Pharmacotherapy, written by a leading detoxification expert, explains how to administer pharmacotherapy to aid withdrawal and to prevent relapse. Appendix B, Legal and Ethical Issues, outlines those issues and the laws governing them concerning privacy and

confidentiality for substance-abusing patients. Appendix C reproduces selected screening and assessment instruments, and Appendix D provides ordering information on pamphlets and brochures about substance abuse that clinicians can give to patients.

Patient Flow Through Primary Care and Referral SCREENING



*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.

2 Screening for Substance Use Disorders

Screening is the application of a simple test to determine if a patient has a certain condition. For screening to be meaningful in the primary care setting, the particular problem

- Must be prevalent within the general population
- Must diminish the duration or the quality of life
- Must have an effective treatment available that reduces morbidity and mortality when given during the asymptomatic stage of the disease
- Must be detectable via cost-effective screening earlier than without screening and must avoid large numbers of false positives or false negatives
- Must be detectable and treatable early enough to halt or delay disease progression and thereby improve outcome (U.S. Preventive Services Task Force, 1996; National Institute on Alcohol Abuse and Alcoholism, 1993)

Screening for substance abuse, which meets all the conditions above, need not take long and can be conducted effectively in a variety of settings (National Institute on Alcohol Abuse and Alcoholism, 1993). The Institute of Medicine has recommended that questions about alcohol use be included among routine behavioral and lifestyle questions asked of all

persons who seek care in a medical setting (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, identify patients who need further assessment to diagnose their substance use disorders and develop plans to treat them (see Chapter 4).

The Consensus Panel that developed this TIP recommends that primary care clinicians periodically and routinely screen all patients for substance use disorders. Deciding to screen some patients and not others opens the door for cultural, racial, gender, and age biases that result in missed opportunities to intervene with or prevent the development of alcohol- or drug-related problems. Visual examination alone cannot detect intoxication, much less more subtle signs of alcohol- and drug-affected behavior.

A major advantage of conducting substance abuse screening as part of the ongoing process of primary care is that positive screens can be followed up at subsequent visits. In many practices, clinicians' long-standing relationships with patients give them the opportunity to

conduct preliminary assessments also known as *brief assessments*. Depending on the clinician's experience and training and the resources available within a community, he may either develop a treatment plan or refer the 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 followup.

Negative screens for substance abuse also warrant discussion. They allow clinicians to play a health promotion and prevention role by reinforcing the wisdom of abstinence from illicit drugs and maintenance of safe levels of alcohol use. If a clinician does not have the time (or the expertise) for a face-to-face discussion of the problem, she can give the patient lists of resources for additional help and a handout or brochure on the effects of alcohol or the other relevant drug. See Appendix D for selected resources.

Factors To Consider in Selecting a Screening Instrument

In the primary care setting, substance abuse screening is done using brief written, oral, or computerized questionnaires, referred to throughout this TIP as *screening instruments*. A number of factors must be considered in determining the suitability of a screening instrument for this setting. These include sensitivity and specificity, cost, ease of administration, and patient acceptance.

Sensitivity and Specificity

Sensitivity is a screening instrument's capacity to identify true cases of the target condition in a given population. The closer to 100 percent of those with alcohol and other drug problems that a screen identifies as positive for that condition, the more sensitive the test.

Specificity refers to an instrument's ability to identify people who do *not* have the disorder. *False positives* (identifying people who do not have the disorder as having it) tend to increase as sensitivity increases, and *false negatives* (missed cases) tend to increase as specificity increases. Because screening instruments are imperfect, balancing sensitivity against specificity is a situation-specific issue. Generally, for screening in primary care, sensitivity should be emphasized over specificity—that is, it is more important *not to miss true cases* than it is to assess further some patients who ultimately turn out not to have a substance use disorder. A positive screen can usually be confirmed or refuted with further history taken on the spot or, if necessary, evaluation by a substance abuse specialist. The screening instruments recommended by the Consensus Panel achieve a reasonable balance between sensitivity and specificity (see Appendix C).

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) (Babor et al., 1992), however, have been extensively tested in primary care settings, and a number of other studies of outpatient, substance abuse treatment populations support the practice of applying substance abuse screening instruments to primary care populations (Buchsbaum et al., 1991, 1995; Bohn et al., 1995; Barry and Fleming, 1993; Saunders et al., 1993). The CAGE questionnaire is reproduced below, and the AUDIT appears in Appendix C.

Cost

Costs of administering a screen 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.

Ease of Administration

The written questionnaire format is self-explanatory; the interview format consists of a clinician's asking the patient a set of predetermined questions. Computerized versions of validated paper questionnaires such as the CAGE are growing in popularity, and preliminary studies on the effectiveness of this approach are promising (Barry and Fleming, 1990). A study of adolescents found that when 15-year-olds were asked about past-week alcohol use, 10 percent responded positively to a computerized questionnaire, but only 5 percent to a paper questionnaire (Paperny et al., 1990). Across populations, however, studies have shown that similar results were obtained regardless of the form of the test (National Institute on Alcohol Abuse and Alcoholism, 1993).

Computers also can reduce the time needed for manual scoring and keep track of who has been screened and when. In addition, some computerized screens like the Diagnostic Interview Schedule format (Blouin et al., 1988) will automatically ask selected assessment questions if the score on screening is positive.

Patient Acceptance

Simply raising the subject of substance abuse with patients can be useful. Evidence indicates that asking questions about alcohol or other drugs "primes" patients to disclose information and results in a two- to threefold increase in their stated intention to discuss substance abuse problems with their health care provider in the future (Skinner et al., 1985).

While opinions vary about whether to integrate substance abuse screening into a standard history, asking potentially sensitive

questions about substance abuse in the context of other behavioral and lifestyle questions appears to be less threatening to patients. Studies have found that screening for alcohol-related disorders is more acceptable to patients if it is part of a comprehensive health-risk evaluation that covers topics like exercise, diet, weight control, and medication use (Allen et al., 1995). Placing the questions within the larger context of preventive health care can help both patient and clinician feel more comfortable, reduce any perceived stigma or bias about the questions, and decrease anxiety in the patient.

Members of the Consensus Panel have learned that this finding holds true when screening for use of illicit drugs as well (Fleming and Barry, 1991). Primary care clinicians with experience in substance use screening also report that discussing problematic use can help foster the ongoing relationship between patient and clinician.

Screening Instruments

To expedite screening and increase the likelihood of honest answers, clinicians should ask questions sequentially, beginning with the legal drug alcohol (Institute of Medicine, 1990). Typically people with substance use disorders drink, so asking, "Please tell me about your drinking" serves as an effective filter. If the patient replies that he does not drink, the clinician should ask, "What made you decide not to drink?" If the answer is that the patient is a life-long abstainer or has been in recovery for 5 years or more, the clinician can conclude the screening process (Steinweg and Worth, 1993).

There are a few exceptions. Even if they don't admit to drinking, adolescents should be asked about drug use, particularly marijuana. Pregnant women and women older than 60, as well as women who have experienced a major life transition (e.g., death of a spouse or retirement), should be queried about their

psychoactive prescription drug use and use of over-the-counter sleep aids. See TIPs 3 (*Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*) and 4 (*Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*) for a full discussion of assessing and treating adolescents (CSAT, 1993b, 1993c) and TIP 2 (*Pregnant, Substance-Using Women*) for information about that population (CSAT, 1993a). Substance abuse among people over 60 is covered in a forthcoming TIP, *Substance Abuse Among Older Adults* (see back cover for TIPs ordering information).

Alcohol Screening Instruments

Alcohol screening instruments question patients about how much and how often they drink and/or the consequences of their drinking. Answers to quantity/frequency questions indicate whether a patient was, is, or may be at risk for becoming a problem drinker, a binge drinker, and/or an alcoholic, distinctions important in determining the clinician's response. A hallmark of alcoholism (and drug addiction) is continued use of a substance despite adverse consequences. Questionnaires focusing on consequences generally are quite successful in detecting dependent users; without quantity/frequency questions, however, these instruments tend to miss early stage problem drinkers and at-risk drinkers.

Since no single screening instrument can be used with all primary care patients, clinicians will want to select those options that best meet the needs of their patient population. For patients with low literacy skills, face-to-face interviews where the clinician asks the questions and documents answers will best elicit information. Regardless of the information-gathering technique, however, clinicians are

relying on self-reports with no assurance that answers are truthful. At this time, there is no viable alternative to self-reports in the primary care setting (Institute of Medicine, 1990), although urine tests (discussed further below) can often detect recent use of some common illicit drugs, and liver function tests may show liver damage, suggesting excessive alcohol consumption. Since denial is a major symptom of dependence, the validity of self-reports is frequently an issue for those patients with alcohol or drug problems. In this situation, when the clinician suspects that a patient is not responding honestly, she may, with the patient's permission, seek information from such collateral sources as the patient's spouse, parents, and siblings. To assist primary care clinicians with screening instrument decisions, the Consensus Panel recommends the following widely used instruments for the primary care setting.

To screen for alcohol problems using a self-administered written questionnaire, a brief instrument like the AUDIT is appropriate, particularly where the expected reading level and comprehension of written English are not likely to be problematic. The AUDIT takes about 2 minutes to answer (Hays et al., 1993) and about 15 seconds to score. If the screen will be administered by a clinician, the CAGE, supplemented by the first three quantity/frequency questions from the AUDIT, is recommended. This combination will increase sensitivity for detection of both problem drinking and alcohol dependence because it includes questions about both alcohol consumption and its consequences. Self-administering the CAGE alone takes about 30 seconds (Hays et al., 1993).

CAGE Questionnaire

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

Scoring: Item responses on the CAGE are scored 0 for “no” and 1 for “yes” answers, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

Source: Ewing, 1984.

As mentioned above, the normal cutoff for the CAGE is two positive answers. However, the Consensus Panel recommends that primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance use disorders.

A number of other screening tools also are available. Appendix C includes some of the most widely used options to the AUDIT and the CAGE, including the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971) and the Short MAST (SMAST) (Selzer et al., 1975).

Drug Screening Instruments

Although screening for drug use in the primary care setting can make patients and clinicians uncomfortable, asking about illicit drug use is as important as asking about other personal practices (such as sexual practices that put patients at higher risk for sexually transmitted diseases) that can affect a patient’s health.

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 (Brown and Rounds,

1995). Like the CAGE, CAGE-AID, reproduced below, focuses on lifetime use. While those patients who are drug dependent 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.

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.

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. As with the CAGE, the Panel recommends that one positive answer prompt further evaluation.

The Panel recommends that clinicians treating patient populations at high risk for drug abuse ask their screening questions regarding alcohol and drug use in combination. (This high-risk group includes those with psychiatric, behavioral, demographic, familial, social, or genetic risk factors that increase the likelihood

of drug abuse. Red flags include work-related, marital and family, or legal problems. See Chapter 1, Figure 1-2.) Patients may view questions about drug use paired with questions about alcohol as less onerous than questions about drug use alone.

Supplementary Laboratory Tests

Although several laboratory tests can detect alcohol and other drugs in urine and blood, these tests measure recent substance use rather than chronic use or dependence. At this time, there is no test like the blood sugar 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 (Babor et al., 1989; Beresford et al., 1990; Bernadt et al., 1982). Laboratory tests, however, may be useful during the assessment process to confirm a diagnosis, to establish a baseline, and later, to monitor progress (Schuckit and Irwin, 1988). Positive test results can be a powerful incentive for changing behavior or motivating patients to accept referrals for treatment.

For some adolescents, a drug test may be a useful supplement to the screening instrument, especially if changes have occurred in school performance, sleep patterns, weight, mood, or social group. Again, depending on the clinician's expertise and available resources, urine tests can be done in the primary care setting or can be referred out to a drug treatment specialist.

Matching Screens With Patients

Certain screening instruments may work better for different age, gender, racial, and ethnic groups. There is some concern that cultural, gender, and age issues are not addressed

adequately by the instruments currently available and that the instruments cannot detect the particular problems that may occur within different populations. No instrument has been shown to be consistently culturally sensitive with all ethnic populations (Cherpitel and Clark, 1995), although some instruments work better with some subpopulations of patients and are less culturally biased than others.

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 dependence at roughly the same rate of sensitivity 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 (Babor et al., 1992).

To assess the effectiveness of a given screening instrument with a given population, a clinician must evaluate, among other factors, patients' understanding of the questions, their emotional responses to them, and the instrument's psychometric properties in the given patient population. Further studies in multiple populations are necessary to build on the current research and validate experiential knowledge. There is insufficient evidence at this time to support a recommendation for specific alternative screening instruments for different cultural groups. Nor do existing data suggest that special tools are necessary to screen different populations.

Nevertheless, some points can be made about some specific populations.

Pregnant Women

It is generally accepted that quantity/frequency criteria should be lower for females than males and that pregnant women should abstain from all alcohol and other drug use. Fetal alcohol syndrome is the most common preventable cause of mental retardation (Abel and Sokol, 1991; Centers for Disease Control and

Prevention, 1993). Opiates and cocaine have been implicated in intrauterine growth retardation, premature births, neurobehavioral and neurophysical dysfunction, birth defects, cardiovascular problems in mother and fetus, spontaneous abortion and fetal compromise, vascular disruptions, and increased risk for infectious diseases including human immunodeficiency virus (HIV) (Bandstra and Burkett, 1991).

Because of the potential risk to the fetus, primary care clinicians should ask all pregnant patients about their drug use. The Panel recommends asking directly, “Do you use street drugs?” If the patient answers yes, advise her about possible negative effects on the fetus and recommend abstinence.

Of the alcohol screening instruments that have been modified for pregnant women, the TWEAK (Russell, 1994) (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 (Chan et al., 1993). Based on best clinical judgment, the Panel recommends the use of the TWEAK (reproduced below) 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 (Adams et al., 1993). As high as the numbers are now, projections of the future prevalence of alcohol-related problems indicate that the problems among older adults will increase appreciably, especially when the Baby Boom generation turns age 60. To ensure that older adults receive needed intervention services, stepped-up identification efforts by primary care clinicians are essential (DeHart and Hoffmann, 1995). Since warning signs of substance abuse (e.g.,

sleep problems, falls, and confusion) can be easily confused with or masked by other concurrent illnesses and chronic conditions associated with aging, the Consensus Panel recommends that all adults age 60 and older be screened for alcohol and prescription drug abuse as part of their regular physical examination. At the very least, those older adults undergoing key life transitions (e.g., death of a spouse, retirement, moving, or cessation of caretaker responsibilities) should be screened.

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 get up?
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?
<p><i>Scoring:</i> A 7-point scale is used to score the test. The “tolerance” question scores 2 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 2 points, and a positive response to the last three questions scores 1 point each. A total score of 2 or more indicates the woman is likely to be a risk drinker.</p> <p><i>Source:</i> Russell, 1994.</p>	

The CAGE and the Michigan Alcoholism Screening Test—Geriatric Version (MAST-G) (Blow et al., 1992) are alcohol screening instruments that have been validated for use

with older adults. The Consensus Panel recommends the use of the CAGE, again with a cutoff score of 1. The lower threshold is particularly important for this population because “age-related physical changes . . . can cause older people to develop more severe intoxication and subsequent problems at lower levels of consumption” (American Psychiatric Association, 1994a, pp. 201–202). There is also “some evidence of increased neural sensitivity to single doses of alcohol with age” (American Medical Association, 1995, p. 5).

Since the MAST-G was developed specifically for older adults, it provides a sound screening option for clinicians willing to spend the time required to administer this 24-item test, reproduced in Appendix C. Although the AUDIT has not been evaluated for use with older adults, it has been validated cross-culturally. Since there are few culturally sensitive screening instruments, the AUDIT may prove useful for identifying alcohol problems among older members of ethnic minority groups.

Individuals with chronic health problems also may be using a large number of prescription drugs, which can cause complications when combined with alcohol and other drugs. 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?”

If the clinician suspects that prescription drug abuse may be occurring and the older

patient is confused about her prescriptions, seeing more than one doctor, using more than one pharmacy, or seems reluctant to discuss her use, assessment is warranted.

Health Care Professionals

Health care professionals are not exempt from substance abuse problems and should be screened according to the same protocols applied to the larger primary care population. Limited histories should be obtained from all, and a thorough screening done if the provider is being prescribed a mood-altering drug—especially when anxiety, depression, and generalized physical complaints are presented. Interventions with this population may be challenging because health care professionals may be convinced that they know about substance use, which they think somehow makes them immune to this problem (Sullivan et al., 1988). While the incentive to complete treatment is compelling—a license and professional reputation are in jeopardy—the high stakes may also make it unlikely that they will admit to alcohol or drug abuse on a simple screening. Providers also should watch for physical or psychological signs of substance abuse or behaviors like excessive prescribing or personal use among their colleagues.

Adolescents and Young Adults

Because epidemiological evidence indicates high risk among adolescents and young adults and since early intervention among this group can greatly reduce future health and other social costs, primary care clinicians should routinely screen these patients. According to the American Medical Association’s *Guidelines for Adolescent Preventive Services* (GAPS), all adolescents should be asked annually about their use of alcohol, tobacco, and illicit drugs and about their use of over-the-counter and prescription drugs for nonmedical purposes, including anabolic steroids (Elster and Kuznets,

1994). However, since many teens do not receive annual physical examinations, the Panel recommends that screening occur every time they seek medical services, including visits necessitated by acute illness and accidents or other injuries.

Although the routine use of urine toxicology as part of the screening process of adolescents is not recommended, there are important exceptions. When there is a clinical reason to suspect a substance abuse problem (e.g., recent onset of an emotional or behavioral disorder, a change in school performance, or unexplained need for large sums of money), urine tests can be a prudent adjunct to the screening questions. Adolescents should not be tested without their knowledge and consent, except in a medical emergency. The knowledge that a test will be conducted sometimes prompts more honest replies, although this is not always the case.

If any of the following risk factors or “red flags” are revealed during questioning and examination, the adolescent should be referred to a substance abuse treatment specialist with expertise in adolescent issues for a comprehensive assessment.

Risk Factors

- Physical or sexual abuse
- Parental substance abuse
- Parental incarceration
- Dysfunctional family relationships
- Peer involvement with drugs or alcohol or with serious crime
- Smoking tobacco

Red Flags

- Marked change in physical health
- Deteriorating performance in school or job
- Dramatic change in personality, dress, or friends
- Involvement in serious delinquency or crimes

- HIV high-risk activities (e.g., injection drug use or sex with injection drug user)
- Serious psychological problems (e.g., suicidal ideation or severe depression)

Detailed information about screening, assessing, and treating alcohol- and other drug-abusing adolescents is provided in TIPs 3 (*Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*) and 4 (*Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*) (CSAT, 1993b, 1993c). The Consensus Panel that developed those documents recommends using the Problem Oriented Screening Instrument (POSIT) (Rahdert, 1991) because it covers 10 potentially problematic areas, takes only 20 minutes to self-administer, requires no training, is easy to score and interpret, is available in Spanish, and can be obtained free of charge from the National Clearinghouse for Alcohol and Drug Information. The POSIT does, however, require literacy. (See Appendix C for a copy of the POSIT and ordering information.)

Screening Techniques

Asking the Questions

The Consensus Panel believes that both physicians and nonphysicians can reliably screen for alcohol problems. Expanding the pool of people who screen to include nurse practitioners and physician assistants increases the likelihood that patients who should be screened are. Regardless of their professional positions, the clinicians should have proven screening skills: Early screening by unqualified people can lead to false reporting, which becomes part of the patient’s record. Those screening should be familiar with the questionnaire and its interpretation, demonstrate considerable interviewing skills, be able to establish rapport with the primary care patient population, and be sensitive to the

potentially stigmatizing nature of screening for alcohol and drug problems.

How the questions are asked tends to be more important than who is asking. One study demonstrated, for example, that the sensitivity of the CAGE questionnaire is dramatically enhanced by an open-ended introduction: “Please tell me about your drinking” (Steinweg and Worth, 1993). Some problem drinkers and illegal drug users may feel embarrassed and guilty about their use; others may respond with hostility to questions raising the possibility of an alcohol or drug problem. To overcome discomfort with alcohol and drug screening questions and increase the likelihood of honest answers, clinicians should pose screening questions and accept patient responses matter-of-factly without judgment. Some clinicians report that assumptive questioning yields more accurate responses: “When was the last time you were high?” for example, is a better question than “Do you drink?” Other helpful questions are, “At what age did you first use?”, “At what age did you use most frequently?”, and “How many times did you use last month?” Ensuring privacy during the screening also reassures patients that the information they provide will be kept confidential and enhances the rapport between patients and clinicians.

Since screening also can reveal that a member of the patient’s family has problems with alcohol or other drug use, clinicians should be sensitive to this possibility. The ongoing, long-standing contact with patients and their families that many primary care clinicians enjoy presents a unique opportunity to support non-using family members who are upset by a spouse’s, child’s, parent’s, or sibling’s substance abuse problem, confused about how to proceed, and exhausted from covering up or attending to the problem on their own. These relationships also smooth the way for clinicians to discuss

possible substance abuse among other family members and devise a plan for intervening with all those who may be involved. In discussions like these, it is important to assure the patient that confidentiality will be maintained (see Appendix B).

Effective implementation of a screening system will require ongoing training, monitoring, training supervision, and attention to issues of reliability, empathy, appropriate responsiveness, and consistency over time. Use of a well-validated screening questionnaire reduces the risk of personal bias in interpretation.

Documenting Screening

It is important to remember that 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 a refusal could make it more difficult to obtain insurance coverage later. See Appendix B for more on confidentiality and patients’ right to deny access.

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. Appendix B details three recordkeeping systems that protect patients’ privacy.

Responding to Screens

Negative Screens

Even if the screen is negative, the Consensus Panel recommends periodic rescreening for substance abuse because problematic use of alcohol, illicit drug use, and their consequences can vary over an individual's lifetime. Since there is no clear scientific evidence to define appropriate intervals for screening in asymptomatic patients, the Panel recommends that clinical considerations govern the frequency of rescreening. Indications might include presentation of medical conditions that are often alcohol- or drug-related such as hypertension or insomnia; diabetes or ulcers that do not respond to treatment; persistent requests for prescription drugs; unexplained weight loss; staph infection on face, arms, or legs; frequent falls; repeated fractures, lacerations, or burns; repeated trauma that suggests domestic violence; depression; and sexually transmitted diseases.

Positive Screens

Clinicians should present results of positive screens in a nonthreatening manner. For example, a clinician might say, "After reviewing your answers on the screening questionnaire,

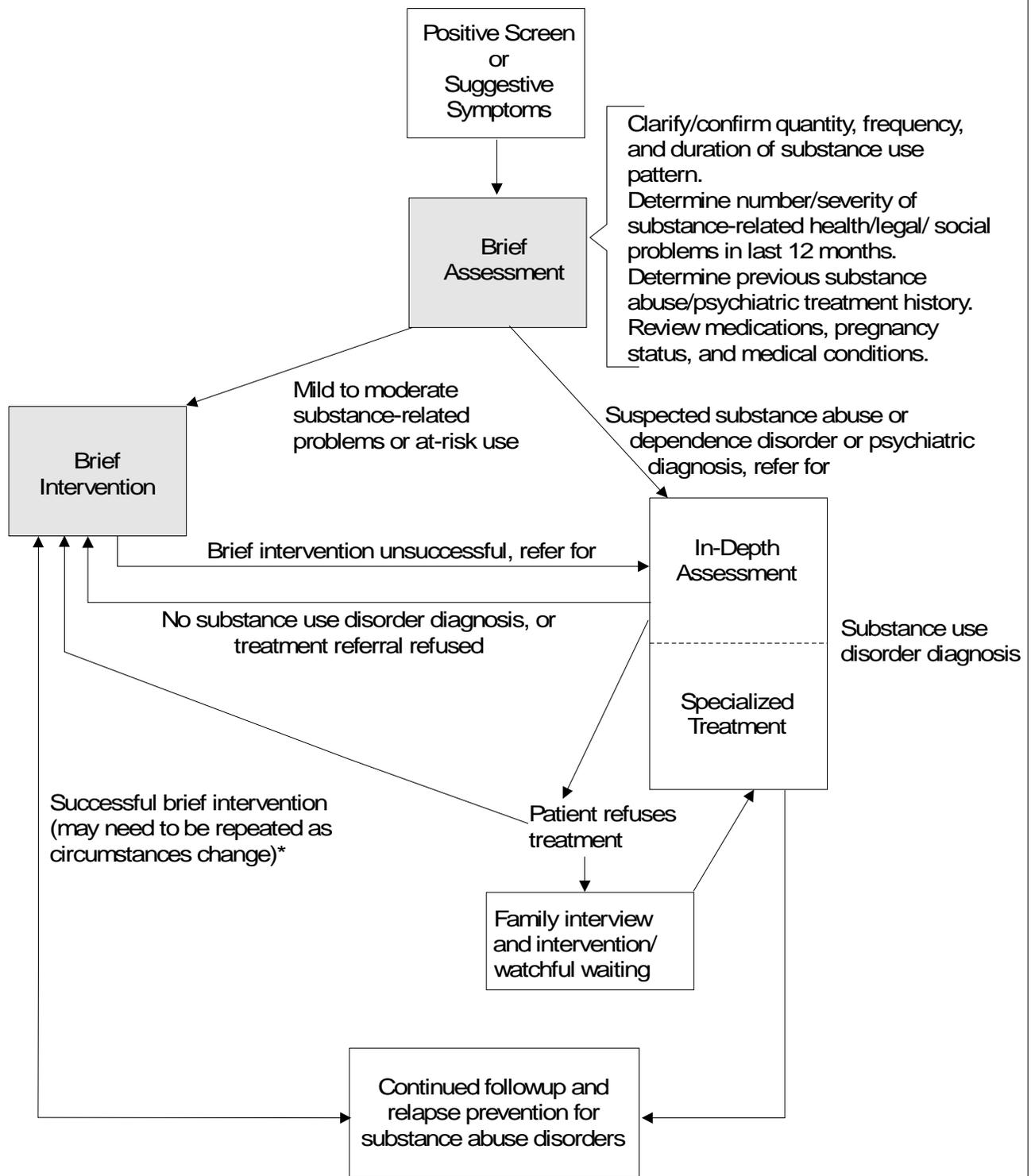
there are some things I'd like to follow up with you," or, "Your answers to this questionnaire are similar to the answers of people who may be having a problem with alcohol."

Clinicians must make some quick decisions at the time of screening to determine the appropriate clinical response. Three possible approaches are suggested based on severity of the problem and possible risk (none of the three is appropriate for an intoxicated patient, who may require an immediate response):

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.

In areas where specialized substance abuse resources are available, the Consensus Panel recommends that high-risk patients be referred for assessment. The following chapters of this TIP provide information on the next steps: conducting brief assessments and brief interventions and referring and following up on patients who need specialized assessments and treatment.

Patient Flow Through Primary Care and Referral BRIEF INTERVENTION



*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.

3 Brief Intervention

The type and sequence of activities undertaken in response to screening results will depend on several factors: the severity of any positive findings, the specialized assessment and treatment resources available, and the primary care clinician's expertise in the substance abuse field.

All patients who undergo screening for alcohol and drug use should be told the results. Those who screen negative because they are abstinent should be commended for their health-conscious lifestyle with reinforcing comments about the benefits of drug- and alcohol-free living. The clinician may wish to ascertain, however, whether current abstinence reflects a lifelong commitment, a recent decision, or recovery from some previous episode of substance abuse or dependence that may indicate a potential for relapse. This can be resolved by saying, "Not drinking is a healthy decision. What made you decide not to drink?"

Patients with positive findings from the screening will need some type of followup. The next step may not be immediately apparent from the initial screening and depends on how much time and effort the clinician is willing to commit and how much training and experience she has in addiction medicine. The Consensus Panel recommends that clinicians at this point conduct a brief assessment to obtain more information. The questions should cover the severity of the suspected alcohol or drug involvement, the types and frequency of problems connected with the patient's use, and

other special medical and psychiatric considerations. If the patient's responses suggest a diagnosis of a substance abuse or dependence disorder according to criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994a), the clinician should initiate a referral for an in-depth assessment.

However, if only mild to moderate substance abuse problems are apparent, if the patient appears to be at risk for experiencing negative consequences as a result of current consumption patterns, if coexisting illnesses or conditions may be exacerbated by continued drinking or other medications, or if the patient refuses referral for further assessment or treatment, the clinician can initiate a brief, office-based, therapeutic intervention.

Guidelines for Clinician Involvement in the Care Of Substance-Abusing Patients

In 1979, the American Medical Association issued guidelines recommending that all physicians with clinical responsibility become involved in the prevention and treatment of alcohol- and drug-related problems among their patients at one of the following three levels:

1. Minimally, by learning to recognize dysfunction caused by substance abuse as

early as possible by taking a history of alcohol and drug use in any health examination (screening), identifying medical complications or symptoms that suggest alcoholism or drug abuse, attempting to match patient needs for ongoing assessment and treatment with available resources, and making a referral for appropriate medical care

2. To a limited extent, by assisting patients to become alcohol- or drug-free through management of withdrawal syndromes in preparation for more extensive assessment and/or treatment; teaching selected patients about the disease and formulating a plan for recovery; involving significant others, as appropriate, in the recovery plan; and continuing posttreatment medical management
3. Comprehensively, after acquiring specialized knowledge, training, and experience, by being available to patients for an indefinite period of recovery; establishing a nonjudgmental and supportive relationship; helping to develop, evaluate, and update an appropriate recovery plan; providing medical care and any necessary pharmacotherapy; involving the patient in appropriate health, social, vocational, and spiritual support systems, including an abstinent peer group; and continually monitoring, treating, or referring any complicating illness or relapse (American Medical Association, 1979a; Landry et al., 1991b; CSAT, 1995b)

Although these AMA guidelines were promulgated before the development and widespread use of brief interventions in office-based practices, this type of early care seems to fit naturally between the minimal responsibility for early identification of alcohol or drug problems and the more involved, but still limited, responsibilities of primary care

clinicians for managing withdrawal and making treatment referrals.

Brief Intervention

Brief intervention is a pretreatment tool or secondary prevention technique that primary care clinicians can easily incorporate into their medical practice settings. Within one or several office visits, a clinician explains screening results, provides information about safe consumption limits and advice about changing, assesses the patient's readiness to change, negotiates goals and strategies for change, and arranges for compliance monitoring. These five steps are discussed in detail below.

Brief intervention is quite inexpensive for the yield, 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 followup visit is usually recommended, but the number and frequency of sessions depends on the severity of the problem and the individual patient's response.

The broad goal of brief intervention is to get patients to reduce or eliminate alcohol or other drug consumption and thereby avoid or minimize associated problems, whether through the technique itself or through subsequent referral. The specific goal varies depending on the patient's current status and previous treatment attempts. For a patient who does not realize there is a problem, the goal may be to get the individual to start thinking about the issue and come back for another visit. A brief intervention could also be an appropriate primary prevention tool for the alcohol or drug user who is at risk for problem development because of a hazardous consumption pattern but has not yet experienced harmful consequences (e.g., the college student who is drinking heavily in a fraternity setting). For patients who recognize that some of their health or other problems are alcohol- or drug-related, and who

are ready for and capable of change, the goal will be to reduce or eliminate substance use through specified steps. If the problem is more serious, and if initial attempts to change do not succeed, the goal of brief intervention is to convince a patient to accept a referral for more specialized assessment and treatment services.

Brief intervention is an appropriate response to the types of patients mentioned above for several reasons. A specialized alcohol and drug treatment network has been developed for persons with relatively severe and chronic substance abuse disorders, but the majority of patients seen in most general practice medical settings are likely to have only mild to moderate substance use problems and may not require treatment in this formal system. Since rapid progression to a full-scale substance abuse or dependence disorder is not inevitable, specialized treatment is not always advisable. Spontaneous remission occurs in substance disorders as in many other medical conditions, so brief intervention may be all that is needed (Sobell et al., 1993; Vaillant et al., 1983).

Furthermore, brief intervention in a primary care setting does not wield the stigma associated with longer-term specialized treatment. In fact, specialized substance abuse treatment could actually cause harm if, for example, a patient is coerced into participating in a treatment program that is antithetical to her values or if her coexisting psychiatric illness is ignored during formal substance abuse treatment. Nor are light to moderate consumers of alcohol and other drugs likely to seek help directly from the specialized substance abuse treatment system, particularly if problems related to substance use are transient or only mildly inconvenient. Many persons do not recognize—or they deny—that their difficulties are directly caused by or complicated by alcohol or drugs. The physical condition or health concern that brings the patient to a primary care clinician's office offers a "teachable moment"—through a traumatic

crisis or a welcomed event such as pregnancy—in which the risk factors associated with alcohol and other drug consumption can be pointed out and behavior potentially changed.

Since all treatment must be considered in the context of risk/benefit analysis, a conservative and palliative approach within a primary care setting may be preferable to specialized treatment absent a well-substantiated diagnosis of a substance use disorder (Institute of Medicine, 1990). Brief interventions as secondary prevention tools have the potential to help an estimated 15 to 20 million heavy drinkers in the U.S. alone by minimizing serious adverse consequences such as costly emergency room visits, domestic violence, or road accidents (National Institute on Alcohol Abuse and Alcoholism, 1993). The occasional alcohol- or other drug-related problems of a very substantial number of moderate users account for a large share of the public health burden (Samet et al., 1996).

Effectiveness in General Medical Practice Settings

Clinical trials and research studies in this country and abroad over the past 15 years have demonstrated the feasibility and effectiveness of brief intervention (Kristenson et al., 1983; Persson and Magnusson, 1989; Romelsjo et al., 1989). The technique is commended as practical and cost-effective by the Institute of Medicine, and several variations have been evaluated as successful on a number of dimensions (Institute of Medicine, 1990). Convincing evidence compiled over the past 20 years demonstrates that this approach, when used with carefully selected patients, can reduce or eliminate alcohol consumption and ameliorate or markedly limit associated problems (Orford et al., 1976; Edwards et al., 1977; Bien et al., 1993). Though few studies have included illicit drug users, the Panel believes that brief intervention

has the potential to stop or curb some patients' drug use also.

Most research on brief intervention has focused on patients who are moderate to heavy drinkers rather than alcohol dependent, with encouraging results. Brief interventions of even a single session can decrease alcohol consumption and its harmful consequences by 20 to 50 percent (Kahan et al., 1995). Even modest effects for 10 to 20 percent of participants are potentially important because of the prevalence of alcohol-related problems and the large public health implications (Bien et al., 1993). Researchers in one large-scale English study estimated that 15 percent of patients with alcohol-related problems in general practice settings would reduce consumption to moderate levels following a 10-minute brief intervention (Wallace et al., 1988).

In a large-scale preventive health effort in Malmo, Sweden (Kristenson et al., 1983), heavy drinkers identified by elevated liver enzyme levels of gamma-glutamyl transferase (GGT) were encouraged to lower their alcohol consumption and received monthly checkups with a nurse and quarterly followups by a physician. Compared to a control group receiving no treatment, these heavy drinkers more successfully reduced their absenteeism and hospitalization rates as well as mortality over a 6-year period. Another important study found no difference between the effectiveness of advice and counseling about drinking practices delivered by alcohol treatment specialists in a traditional outpatient setting and that provided by general practitioners with the support of specialist staff in a medical setting (Drummond et al., 1990). At 6-month followup, both groups exhibited similar improvements on a variety of drinking-specific and other related outcomes.

The research literature on brief interventions demonstrates that this approach works for women as well as men (Sanchez-Craig et al., 1989). Recent studies (WHO Brief Intervention

Study Group, 1996) supported by the World Health Organization in 10 countries confirm that brief interventions can work in a variety of cultural settings and with diverse populations and health care systems. However, no studies pertain to the specific applicability of this technique for older adults or adolescents.

Although research studies have established the important short-term effects of brief interventions, the relative effectiveness of different components is not yet clear. Specifically, the optimal number and duration of brief advice visits is not known. While studies of smoking cessation programs indicate that four or five interventions work better than one (Kahan et al., 1995), and some researchers have found correlates between additional followup contacts and alcohol consumption reduction (Wallace et al., 1988; Persson and Magnusson, 1989), other studies have found no advantage beyond single sessions (Chick et al., 1988; Babor and Grant, 1992) and no difference in outcomes between 5-minute sessions and 30- to 60-minute visits (Chick et al., 1988).

Other research focusing on the educational component of brief interventions have found that having patients read self-help booklets and manuals can be an effective intervention with heavy but nondependent drinkers (Heather et al., 1986, 1990). (See Appendix D.)

Selecting Appropriate Patients for Brief Intervention

In response to screening questionnaires or other suggestive symptoms or laboratory findings from an office visit, patients can be categorized into one of three groups:

1. Patients who do not appear to have any alcohol- or drug-related problems; either abstain from alcohol and illicit drug consumption altogether or drink at acceptable, nonrisky social levels; and do not have other complicating medical conditions or medication needs that require temporary

- or permanent abstinence. These patients require no further intervention at this time.
2. Patients with positive but low scores on any screening tests (e.g., one positive response to the CAGE [Ewing, 1984] or CAGE-AID [Brown and Rounds, 1995] or a score of less than 8 on the AUDIT [Babor et al., 1992], see Chapter 2) and light to moderate alcohol use (e.g., above established cutoff limits), occasional use of marijuana (e.g., five or more episodes in a lifetime), or questionable use of mood-altering prescription medications. These patients may be appropriate candidates for a brief intervention.
 3. Patients with several positive responses to screening questionnaires and suspiciously heavy drinking or drug use histories, symptoms of substance dependence, chronic or escalating use of addictive prescription medications, current use of illicit drugs, or complicating medical illnesses and psychiatric disorders. These patients need further in-depth assessment to confirm a substance use disorder.

This separation into groups requires some clinical judgment but can usually be accomplished quickly and easily with a brief assessment that follows up on positive responses to the screening instruments and clarifies the information provided. For example, further questions about why a patient acknowledges “feeling guilty” about drinking (on the CAGE questionnaire) may reveal alcohol-related difficulties with the family or at work (Brown, 1992). Additional questions to elucidate a patient’s current (within the last 12 months) drinking or drug-using pattern are also appropriate, especially if tolerance and a likelihood of withdrawal effects are suspected. A review of the patient’s chart may be indicated if medications are prescribed that will be affected by alcohol or other drug use, if the patient may be pregnant or planning to

conceive, or if other medical or psychiatric conditions are present that could be exacerbated by otherwise acceptable alcohol use patterns. A patient’s earlier substance abuse and psychiatric treatment history can also help the clinician decide whether to perform a brief intervention or refer for specialized assessment.

Samet and colleagues (Samet et al., 1996) recommend that clinicians

1. Ask explicitly about any adverse consequences of substance use—on family, work, social relationships, and health.
2. Inquire about loss of control when using the primary substance.
3. Determine whether the patient perceives the alcohol or drug use as problematic (“How much of a problem do you think you have with drinking?”).
4. Assess the patient’s readiness to change.

In general, patients with recurrent and significant alcohol- or other drug-related problems within the past 12 months that interfere with role performance; cause legal, social, or interpersonal problems; or pose dangers to the individual and others are less likely to respond to a brief intervention. Not all patients, however, who experience a serious alcohol- or other drug-related incident need referral for specialized substance abuse treatment: The college student injured in an auto accident may have been driving while intoxicated but not be a regular consumer of alcohol or other drugs. Patients with several additional diagnostic criteria for substance dependence (e.g., physical tolerance, withdrawal symptoms, uncontrollable use, unsuccessful attempts to reduce consumption, or an intensive and excessive focus on obtaining the substance with accompanying impact on other occupational, personal, or social activities) are even more likely to require specialized and intensive treatment beyond the capabilities and time limits of the primary care clinician who is

not an addiction specialist. Patients with a previous history of substance abuse treatment are not likely to achieve abstinence from an office-based intervention alone (Sanchez-Craig, 1990; Bien et al., 1993; Kahan et al., 1995).

Nonetheless, patients who are suspected to have diagnosable substance use disorders may initially resist referral for further assessment, even though they express a willingness to participate in a brief intervention. Even though they are unlikely to be very successful in cutting down their use or maintaining recovery for any length of time through informal self-help mechanisms, a brief intervention may help motivate them to accept the needed referral or come to terms with the diagnosis (Chafetz, 1961, 1968; Chafetz et al., 1962, 1964; Brown, 1992).

Brief intervention is not necessarily a one-time activity conducted only in response to an initial positive screen. Some patients may successfully reduce their consumption or abstain for some period of time, only to relapse or resume heavy and risky use at a later point in response to stress. Ongoing monitoring by the clinician, even if quite informal, is a logical part of the health care provider's responsibility for continuity of care and patient supervision (Institute of Medicine, 1990).

Critical Components of Brief Interventions

The Consensus Panel recommends that brief interventions include five components, although the individual needs of the patient should ultimately shape the clinician's response beyond this basic framework, and each case will follow its own course. For example, a patient who makes an office visit specifically to discuss a substance use problem (a rare occurrence) would be approached differently than a patient with a suspected substance use problem that is uncovered during a visit. The sequence and specific emphasis placed on these five key elements can be quite different for individual

patients, and other brief intervention models exist. However, the following are the most common components.

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 followup treatment.

Each of these steps is discussed in more detail in the following paragraphs, along with what could be considered a sixth step—referral for more in-depth assessment or to specialized treatment.

1. Give feedback about screening results, impairment, and risks while clarifying the findings

The clinician should report and interpret the findings (e.g., questionnaire answers, laboratory results, or observations from the examination) that have led to concern about the patient's substance use. Prompt feedback is one of the key elements commonly found in successful clinical trials of brief interventions (Bien et al., 1993). All results should be presented in a straightforward, nonjudgmental manner and framed in medical terms the patient can readily understand. Concerns about potential or actual health effects should be stressed (Fleming, 1995). Following are some sample scripts.

- "I notice from your answers to the CAGE questionnaire that your drinking has caused you some concern. You also state that you are consuming a six-pack every afternoon. Can you tell me more specifically what your concerns are?"
- "I'm concerned about your GGT levels. These indicate you may be drinking heavily and this could be causing some liver damage.

Just how much and how often are you drinking?"

- "Your urine screen shows the presence of cocaine (or heroin or cannabis). Could you tell me about your drug use?"
- "Your responses to our screening questionnaire and my physical examination indicate that you have some symptoms of alcohol dependence. I noticed that you have a slight tremor in your hand and you're reporting insomnia and occasional morning drinking as well as substantial drinking overall. Has this been a concern of yours too?"
- "I'm concerned about how your alcohol use is affecting your pregnancy. Your baby could suffer severe abnormalities as a direct result of your drinking."
- "I'm concerned that your alcohol use is related to many of the problems that we've been talking about."
- "At this level of consumption, you are at increased risk for some health problems as well as accidents."
- "You've said that you've been smoking pot for the past several years. You know about the trouble you could get into legally, but I'm concerned about your health."

In presenting positive screening results to a patient, the primary care clinician must avoid being adversarial and should pay careful attention to semantics. For example, the phrase "people for whom substance use is creating problems" is less off-putting than the pejorative labels of "alcoholic" or "addict." Neutral, nonstigmatizing language allows both clinician and patient to discuss substance use as potentially problematic with negative effects that can be confronted and addressed in much the same way that diabetes is.

Clinicians also must recognize that positive findings from the screening or initial assessment may trigger resistance or provoke feelings of guilt, shame, or anger. These negative reactions

can usually be counteracted if clinicians continue to focus on the relationship between the health complaint that originally prompted the patient's visit and substance use or on the negative consequences of the patient's alcohol- or drug-using behavior as revealed in the screening. To ease this discussion and gain as much information as possible, clinicians should

- Try to avoid arguments or discussions about how much others can drink without adverse consequences.
- Maintain the role of medical expert with important knowledge about potential negative health effects that must be conveyed to the patient.
- Be reassuring that alcohol and drug problems are not anyone's "fault" and can certainly be addressed.
- Remain tolerant of the range of patient reactions, including astonishment, embarrassment, hostility, and denial.

2. Inform the patient about safe consumption limits and offer advice about change

Once screening results and health risks or concerns are conveyed, the primary care clinician needs to explain to the patient what acceptable and safe use levels are for the relevant substance. Most high-risk or heavy drinkers do not realize that their alcohol consumption patterns are not "normal" (Fleming, 1995). Acceptable levels for alcohol use can be stated as quantity/frequency indicators considered nonhazardous for most adults or given as population norms. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines *low-risk* drinking as "no more than two drinks per day" for men and "no more than one drink per day" for women, with never more than four drinks per occasion for men, three for women (National Institute on Alcohol Abuse and Alcoholism, 1995b, p. 1). It is crucial to note, however, that

safe consumption limits are only relevant for low-risk or at-risk drinkers—and not always for them. There are no safe levels for patients meeting the DSM-IV criteria for substance abuse or dependence or for others with specified medical conditions such as pregnancy, breast cancer, or peptic ulcer. Drinking or drug use is never acceptable for adolescents. Hence, abstinence may be the goal for many patients.

The concept of low-risk use does not apply to illegal drugs. While reducing consumption (e.g., smoking a decreasing number of marijuana cigarettes per week) may be a realistic intermediate step, abstinence from illegal drugs is always the ultimate goal.

Even with alcohol, the personal characteristics and behaviors of the patient must be taken into consideration in defining *low-risk* use. Body weight, age, and gender influence reactions to alcohol as do interactions with other prescription drugs and health conditions. Patients also should understand concepts of tolerance and metabolism rates. Even one or two drinks can be dangerous if consumed rapidly and on an empty stomach, especially by persons who do not drink regularly. Although States have established blood alcohol concentration levels beyond which driving is illegal, these are usually much higher than levels at which reaction times are slowed. Hence, low-risk use varies across substances and individuals.

Persuasive advice from the clinician has been described as the essence of the brief intervention (Edwards et al., 1977) and is the component found most often across 32 research studies of brief intervention (Samet et al., 1996; Bien et al., 1993). The health care provider should clearly state her own recommendations about consumption goals at this point, keeping these in the context of lifestyle issues and living habits (Kristenson et al., 1983; Chick et al., 1984). The more the advice can be integrated with health concerns and consequences of continued use,

the better the chance of success. Clinician authority in offering advice can be strongly motivating, even though the patient's responsibility and capability for complying needs to be encouraged too. Some sample comments follow.

- “Your blood pressure is high and your abdominal pain may be caused by gastritis or an ulcer. Until we can investigate further, I’d like you to stop drinking for at least 6 weeks to let your stomach heal. Do you think you can do this?”
- “Since I’m going to prescribe some pain medication for your shoulder that interacts with alcohol, I don’t want you to drink for the next several weeks. I’m also concerned that your regular consumption habits seem to be above safe levels for women. When you are finished with the medication, I suggest that you cut down to no more than one drink a day, especially since you’re also complaining about occasional insomnia. Let’s talk more about this when you come back in 2 weeks.”
- “Thank you for being honest with me about your marijuana use. One concern of mine is your asthma, because marijuana smoke does affect your lungs. Why don’t we work on a plan to help you quit.”
- “In reviewing your responses to our screening questionnaire, I notice that you are drinking a lot of beer on weekends. You don’t seem to be having any direct problems as a result, but I’m concerned that driving while intoxicated is not safe and you have a young family to consider. I’d like you to read this pamphlet and talk more about this when you come back next month to get your allergy shot. I hope you will think seriously about cutting back on the beers before you do have some problems.”
- “You say you’ve been taking ‘speed’ to stay awake during your second job, and I’m worried that you’re developing a

dependence on amphetamines. Let's talk about other, healthier ways to get you through your night job."

Primary care clinicians will not have time and are not expected to educate each patient about all possible hazards of alcohol and other drugs. Substance-specific pamphlets are useful at this stage of the brief intervention to reinforce and expand on what the clinician has said. (See Appendix D.) Some clinicians may train other office staff (e.g., nurses or health educators) to assist with providing relevant information or helping patients to develop specific strategies for change and to recognize risky situations and "triggers" that frequently lead to substance abuse.

3. Assess the patient's readiness to change

The clinician must keep in mind the incremental nature of behavioral change and understand that many patients find such change difficult. A useful analogy is heart disease risk. A clinician may advise a patient to stop smoking, begin a regular exercise program, modify his diet, and lose 40 pounds to reduce the risk of heart disease, knowing, however, that incremental progress toward these goals is all that can be realistically expected. In making recommendations, the patient's readiness and willingness to change should also be taken into account. People with substance use disorders generally fall into one of five stages along a continuum that provides a useful framework for monitoring progress (Prochaska et al., 1992).

The stages are

1. Precontemplation—Not seeing the behavior as a problem or not wanting to change the behavior. This stage is sometimes characterized as "denial."
2. Contemplation—Beginning to understand that the behavior is causing difficulties in living or taking a toll on their health and happiness.

3. Preparation/Determination—Considering various options for change.
4. Action—Taking concrete steps to change the behavior in a specific way.
5. Maintenance—Avoiding relapse into the problem behavior.
6. Relapse—Slipping back into problematic use or abuse.

Most patients in primary care settings are in one of the first three stages and can be expected to express ambivalence or resistance to change, at least initially. A few patients may be taking concrete actions already or even experiencing a relapse (Marlatt et al., 1988; Miller and Rollnick, 1991; Prochaska, 1994).

There is not necessarily a correlation between severity of substance use and a patient's readiness to change. Life events such as marriage, divorce, death in the family, job change, or moving may put individuals at a greater risk for substance-associated problems and may also affect their readiness to change. For example, a study of trauma patients found that some associated their injury with their alcohol use (Longabaugh et al., 1995). Such an acknowledged association can be seen as an indication of readiness to change, and the clinician can help the patient move further along that continuum.

Patients' reactions to initial feedback about screening results or a recommended referral for further assessment or specialized treatment also offer strong clues regarding their readiness to change. Since only a few can be expected to offer immediate agreement, the primary care provider must be prepared for resistance and setbacks. If clinicians encounter resistance to the brief intervention from their patients, they should avoid the temptation to regard this as a challenge to their authority or to react in an authoritarian way. Studies show that the more confrontational or directive the clinician, the more resistant the patient is likely to be (Miller and Sovereign, 1989). Conversely, an empathic

and supportive attitude creates a safe environment that the patient will feel comfortable coming back to, even if goals are not successfully achieved. A clinician should not think of resistance as failure, because one of the goals of treatment is to move patients along the readiness-to-change continuum. Each discussion of the substance abuse problem will help the clinician understand a patient's readiness to change and may move a patient from contemplation toward action.

Developing a realistic sensitivity to the patient's location on this continuum can be key to a successful intervention. Samet and colleagues have developed a useful set of interview guidelines, summarized in Figure 3-1 below, to help the primary care clinician respond appropriately to patients in each of the six readiness-to-change stages (Samet et al., 1996).

4. Negotiate goals and strategies for change

If the patient indicates a readiness and willingness to change, it is time for the clinician and patient to explore the possibilities and work together to develop a realistic plan with goals the patient considers achievable. With alcohol, the clinician can first suggest that the patient reduce consumption to below unsafe or potentially hazardous levels. If the patient feels this is impossible, the clinician should ask, "What do you think you can do?" If a patient who is using illegal drugs or abusing prescription drugs does not feel ready yet to discontinue use, the clinician can suggest a tapering schedule. Ultimately, the patient must choose the goal: The clinician can only remind the patient that reducing or stopping alcohol use or abstaining from other drug use will help eliminate the health or social problems substance use is causing.

Following are some sample scripts:

- "Based on what we've been discussing, would you be willing to change your drinking habits (or drug use)?"
- "Can we set a specific date to reduce your alcohol use? Could you cut back, beginning this week?"
- "Since you agree to cut back on your drinking, you may find that this booklet offers some helpful advice about how to go about it."
- "Would you be willing to see a counselor to discuss your drug use further? Think of this referral as comparable to sending you to a cardiologist for a heart problem."

Patients will be more motivated to change if they are helping to set goals and develop strategies for change. Some studies have found self-help manuals to be a helpful adjunct for planning change (Chick et al., 1984; Heather et al., 1990). One study of brief interventions for problem drinkers concluded that women may prefer to use self-help instruction manuals because of their fear of social stigma (Sanchez-Craig et al., 1989). The clinician also can suggest readings or specific strategies (e.g., what to do instead of drinking or what reminders might be useful when consumption seems appealing). A patient can gather information and put his own problem in a context by attending an open 12-Step meeting.

The clinician can also suggest that the patient keep track of consumption in a daily diary. Many substance users are unaware of the quantity they consume or deny actual patterns to themselves and others. Daily diaries to record actual consumption have been found to be more accurate than general recollections (Antti-Poika et al., 1988). Even patients who are not ready to change their behavior may be willing to keep a diary. A written contract is often a good idea too; sometimes patients forget what they agreed to do. Clinicians can fold the written contract into an information book for the patient and keep a copy for themselves.

Figure 3-1
Interview Approaches That Account for the Patient's Readiness
for Behavioral Change

Signs of Readiness	Interview Approaches
Precontemplation	<ul style="list-style-type: none"> ■ Express concern about the patient and substance use ■ State nonjudgmentally that substance use is a problem ■ Agree to disagree about the severity of the problem ■ Consider a trial of abstinence to clarify the issue ■ Suggest bringing a family member to an appointment ■ Explore the patient's perception of a substance use problem ■ Emphasize the importance of seeing the patient again
Contemplation	<ul style="list-style-type: none"> ■ Elicit positive and negative aspects of substance use ■ Ask about positive and negative aspects of past periods of abstinence ■ Summarize the patient's comments on substance use and abstinence ■ Make explicit discrepancies between values and actions ■ Consider a trial of abstinence
Determination	<ul style="list-style-type: none"> ■ Acknowledge the significance of the decision to seek treatment ■ Support self-efficacy ■ Affirm patient's ability to successfully seek treatment ■ Help the patient decide on appropriate, achievable action ■ Caution that the road ahead is tough but very important ■ Explain that relapse should not disrupt the patient-clinician relationship
Action	<ul style="list-style-type: none"> ■ Be a source of encouragement and support ■ Acknowledge the uncomfortable aspects of withdrawal ■ Reinforce the importance of remaining in recovery
Maintenance	<ul style="list-style-type: none"> ■ Anticipate difficulties as a means of relapse prevention ■ Recognize the patient's struggle ■ Support the patient's resolve ■ Reiterate that relapse should not disrupt the medical care relationship
Relapse	<ul style="list-style-type: none"> ■ Explore what can be learned from the relapse ■ Express concern and even disappointment about the relapse ■ Emphasize positive aspect of the effort to seek care ■ Support patient's self-efficacy so that recovery seems achievable

Source: Samet et al., 1996. Reproduced with permission from *Archives of Internal Medicine* 156:2287–2293, 1996. Copyright 1996, American Medical Association.

The goals of the intervention must reflect a patient's current situation and responsibilities in life. For example, abstinence should be a goal for a pregnant woman or one who is trying to conceive since alcohol or drug use in the first trimester—especially in the weeks immediately following conception—is especially dangerous to the fetus. On-the-job abstinence should be the goal for airline pilots, physicians and nurses, or school bus drivers; and nobody, of course, should drink and drive. Patients taking a variety of medications that interact harmfully with alcohol or other illicit drugs, including many over-the-counter preparations, should at least temporarily suspend drinking or other drug use. The effects of alcohol are particularly enhanced by sedatives, sleeping pills, anticonvulsants, antianxiety drugs, antidepressants, and some painkillers. Finally, patients with mental disorders such as schizophrenia or bipolar disorder should not consume alcohol or other drugs since use can prompt reemergence of symptoms and associated problems of medication compliance or reactions (see Appendix A for more on drug-drug and drug-alcohol interactions).

It is difficult to negotiate ways to address patients' substance use without understanding the larger context of their lives. Women are more likely than men to abuse prescribed sedative-hypnotics, and prescription drug abuse is a problem among elderly patients (Seale and Muramoto, 1993). The course of the brief intervention is also influenced by the patients' language and culture. Direct confrontation is anathema in some Native American and Asian cultures, and the clinician must adjust his or her approach accordingly. Health care providers have found an emphasis on health status the most persuasive tack with Appalachian substance users. Problem users in that culture can best explain—to themselves and their peers—their need to abstain on that basis. In short, each patient must be treated individually,

and the clinician's relationship with the patient is the best source of information about the patient.

5. Arrange for followup treatment

Once the patient and clinician have negotiated a plan of action to address the patient's substance abuse, they need to monitor progress. Any medical problem other than substance use (e.g., high blood pressure) should also be monitored, as should abnormal physical markers (e.g., elevated GGT levels). Patients need help in making progress, and whatever tools work should be used. It is encouraging for patients to see measurable changes, for example, in mean corpuscular volume and GGT levels.

Monitoring compliance is a trust issue. The clinician should express trust in the patient; then, if the patient is not honest about reporting substance use, the clinician must confront the patient and renegotiate the parameters of the relationship. Making honesty one of the ground rules works surprisingly well. The wish to preserve the trust of the clinician can be a part of what motivates patients to continue returning for followup monitoring. If a patient tries to deceive the clinician, the clinician should persist: "Your continued use of [alcohol or other relevant drug] is a problem. What do you think will help you stop using?"

Use of a collateral informant is another way to monitor compliance, but that can be problematic. Enlisting a patient's significant other to help monitor the patient's progress should be framed as a supportive rather than a policing effort. Before suggesting or agreeing to monitoring by a significant other, the clinician needs to be aware of marital and family dynamics, especially the potential for violence.

A clinician using urine samples, Breathalyzers™, and other toxicology tests may seem intrusive and suspicious to some patients, while others welcome the discipline imposed. The use of any form of objective monitoring beyond self-reports of substance abuse

consumption must be negotiated between the clinician and the patient. Biological monitoring, if implemented, should be viewed as an informative measure, not cause for punitive action. Repeated positive urine tests or elevated GGT levels simply mean that the informal strategy for reducing or eliminating substance use is not working and that alternative approaches should be considered. Clinicians must also remember that biological markers, by themselves, do not necessarily provide an accurate reflection of substance use. GGT levels may reflect liver damage caused by factors other than alcohol; positive urine screens may be triggered by other legal substances or reflect use before a patient agreed to stop using a particular drug. Laboratory tests work best in conjunction with open communication between the clinician and the patient.

The number of followup visits that should be scheduled will depend on the severity of the problem, the patient's response, and the clinician's available time. At least one researcher (Wallace et al., 1988) found that reduction of alcohol consumption correlated directly with the number of practitioner intervention sessions that were delivered, although the improvement in outcomes may have been due to self-selection bias, with more motivated patients changing their drinking habits and returning for more followup visits.

Finally, patients should be told exactly who will see their medical charts and what information about the screening and intervention will be recorded, particularly if the clinician is part of a health maintenance organization or sends bills to a third party insurance carrier. The complex issues involved in protecting the confidentiality of patients with substance abuse problems are discussed in more detail in Appendix B.

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 the 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.

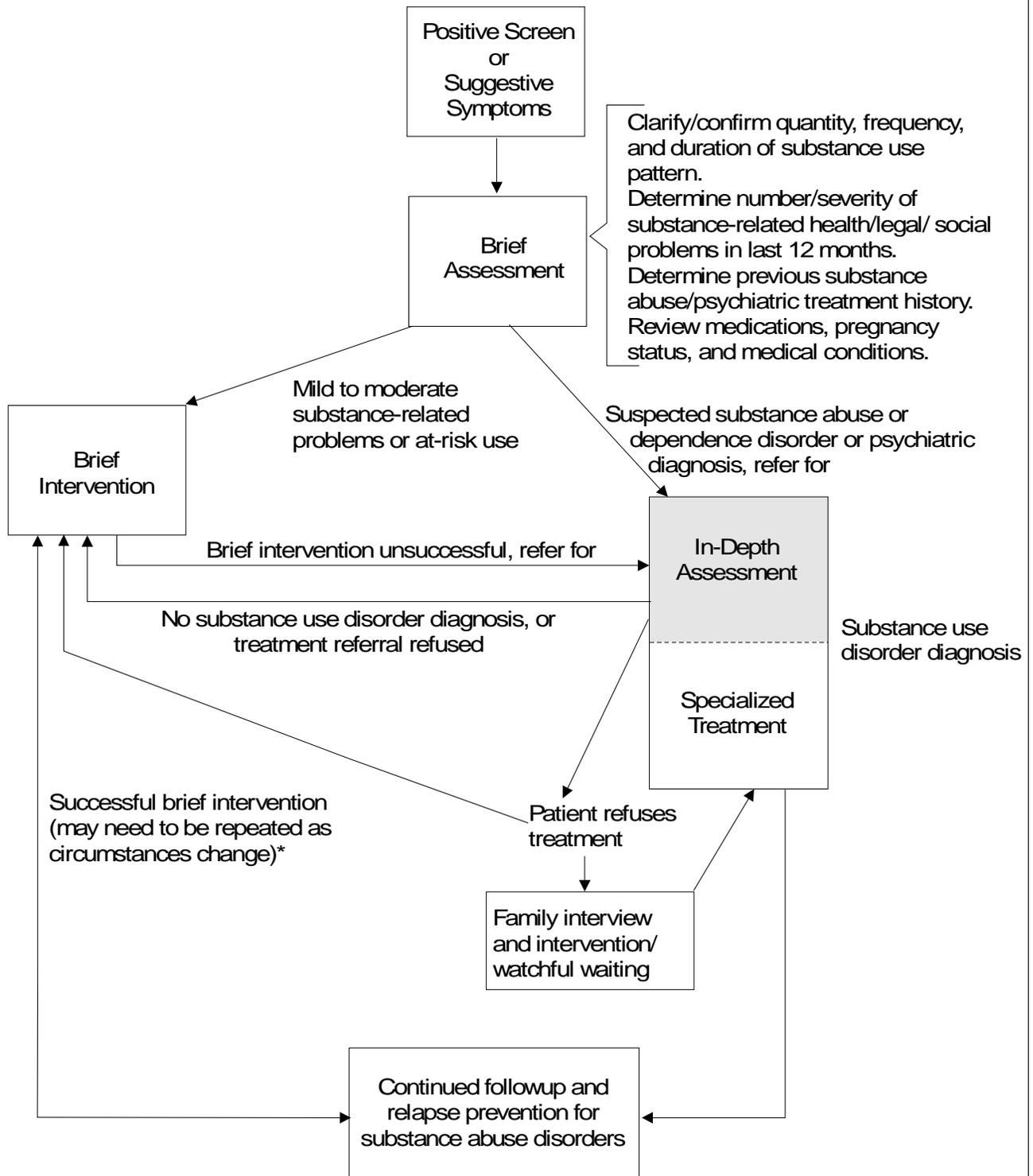
Also, even though abstinence may be the ultimate goal of an intervention, clinicians must be willing to accept limited, incremental goals. The concept of relative recovery can be useful. An individual may not regain perfect health but may improve. A brief intervention targeted at substance use is not the same as a single dose of medication that will resolve an infection. Rather, substance use disorders are chronic conditions that often need repeated interventions or treatments before progress is stabilized. Incremental steps toward improvement are necessary not only in patient behavior but also in the patient's attitude and readiness to change. Clinicians should not expect that patients with problems related to alcohol and other drug use will have any less difficulty than other patients in making significant lifestyle changes. Lack of success in following the advice given and the strategies undertaken in a brief intervention can be a learning and motivating experience, evidence to a patient that substance use may be a bigger problem than previously thought. The clinician can steer a patient toward such a revelation by saying something like, "You weren't able to cut down your alcohol use as you contracted to do. Does this make you think this is a bigger problem for you than you thought?" Failure to achieve the goals of an initial brief intervention may move the patient along the continuum of change.

A clinician cannot force a patient to undergo further assessment or accept a referral for specialized treatment even if the substance use disorder is severe. If the patient is only willing to accept a brief intervention, the clinician initially should try to work within this limitation, although some instruction should also be provided about the possibility of experiencing withdrawal symptoms.

Arrangements for more intensive and frequent followup will also be needed.

As stated above, brief intervention has several goals. If problem use persists after a brief intervention, those discussions between clinician and patient should serve as a springboard to a more in-depth assessment or specialized treatment.

Patient Flow Through Primary Care and Referral ASSESSMENT



*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.

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 their elements and objectives so that they can

- Initiate appropriate referrals
- Participate effectively as a member of the treatment team, if required
- Better fulfill the gatekeepers' monitoring responsibility with respect to patient progress
- Carry out needed case management functions as appropriate

Throughout this chapter, *assessment* will refer to in-depth assessment as distinct from the postscreening brief assessment discussed in Chapter 3.

Assessment Parameters

Substance abuse assessment is the further investigation of patients (1) whose positive screening results indicate that substance abuse is likely and (2) whose responses to the questions in a brief assessment (see Chapter 3) suggest

that compulsion to use, impaired control, presence of other psychosocial problems, or absence of social support will render brief intervention ineffective (College of Family Physicians of Canada, 1994). Information gained through an assessment will clarify the type and extent of the problem and will help determine the appropriate treatment response.

Assessment

- Examines problems related to use (e.g., medical, behavioral, social, and financial)
- Provides data for a formal diagnosis of a possible problem
- Establishes the severity of an identified problem (i.e., mild, moderate, intermediate, or severe stage)
- Helps to determine appropriate level of care
- Guides treatment planning (e.g., whether specialized care is needed, components of an appropriate referral, and eligibility for services)
- Defines a baseline of the patient's status to which future conditions can be compared (National Institute on Alcohol Abuse and Alcoholism, 1995a)

If one thinks of screening as triage, then assessment is acquiring the information needed to direct a patient to appropriate treatment. At a minimum, patients must be assessed for

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications

3. Emotional/behavioral conditions (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
4. Treatment acceptance or resistance
5. Relapse potential or continued use potential
6. Recovery/living environment (American Society of Addiction Medicine, 1996, p. 6)

Assessing along these dimensions helps the assessor confirm that a substance abuse problem exists and recommend an appropriate level of care (see Chapter 5 for a discussion of substance abuse treatment systems and processes).

Through a combination of clinical interview, personal history-taking, and self-reports, supplemented by laboratory testing and collateral reports as appropriate, the assessment process identifies patients' health problems, interest in and readiness for treatment, and feasible treatment options. It also provides information on a patient's familial, educational, social, and vocational supports and deficits. Like screening, assessment may be a recurring event if clinical evidence indicates the need.

Who Should Assess?

Professional position is less important than specific training for performing accurate assessments. 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 (nurse practitioners and clinical nurse specialists) with experience in empathic motivational interviewing may perform intensive assessments after receiving training in

- The signs and symptoms of substance abuse

- The biopsychosocial effects of alcohol and other drugs and likely progression of the disease
- Common comorbid conditions and medical consequences of abuse
- The terms used in the classification system of the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994a), their interpretation, and their relationship to the findings that emerged during the assessment history
- The appropriate use, scoring, and interpretation of standardized assessment instruments

Understanding the Impact Of Culture and Gender

Clinicians performing in-depth assessments should also understand how patients' gender and cultural background bear on the characteristics and severity of the disease (Spector, 1996). For example, more males than females abuse alcohol and drugs, and older women are more likely than older men to abuse prescription drugs. Culture and gender also may influence patients' recognition of their problems (e.g., local cultural norms may condone or accept male drunkenness) and their reaction to the assessment process and recommended treatment interventions (e.g., substantial stigma may be associated with substance abuse treatment, especially for women and older patients of either sex). Assessors also should be aware of the influence of their own gender and cultural background on their response to patients with suspected substance abuse problems and on their interpretation of the information provided through the assessment process. While an understanding of "typical" patterns is useful in anticipating problem areas, experienced assessors resist the temptation to stereotype patients and subsume them within broad

categories based on language, ethnicity, age, education, and appearance. An oft-repeated anecdote illustrating the dangers of stereotyping concerns a well-dressed, middle-aged woman and her disheveled teenage son seen in an emergency room following a car accident. The young man was screened for substance abuse; the mother was not. Several hours after admission, the woman went into alcohol withdrawal.

When referring patients for assessment, primary care clinicians should consider whether a particular patient will relate more readily to a male or female assessor of similar cultural background or if a patient who speaks English as a second language will respond more easily to questions posed in his native tongue (Spector, 1996).

Knowledge of Comorbid Mental Disorders

The relationship between mental disorders and substance use disorders is variable and complicated. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that, in the general population, 4.7 to 13.7 percent of individuals between the ages of 15 and 54 may have both a mental disorder and a substance abuse or dependence problem (Substance Abuse and Mental Health Services Administration, 1995). Intoxication with a drug can produce psychiatric symptoms that subside with abstinence, but for those with a mental illness, substance use may mask, exacerbate, or be used to ameliorate psychiatric symptoms; precipitate psychological decompensation; or increase the frequency with which individuals require hospitalization. Because substance abuse disorders often manifest symptoms similar to those of mental health disorders, misdiagnosis may occur.

Inadvertent bias may affect the assessment process when performed by addiction specialists who do not recognize or accept the role of

mental disorders in prompting or sustaining substance use or who have no experience with dually diagnosed patients. Conversely, some mental health practitioners dismiss substance abuse as merely symptomatic of underlying mental health disorders and do not acknowledge it as a problem requiring specific attention. While screening results, per se, do little to illuminate comorbid mental health disorders, information gleaned through a patient's history or inability to respond to brief intervention may suggest a mental health problem. If possible, primary care clinicians should refer patients to assessors who understand and are trained in mental health as well as substance abuse assessment and who are willing and able to expand the assessment process as needed to identify the multiple dimensions that may be contributing to a patient's problems (Institute of Medicine, 1990).

Whether referring for or conducting intensive assessments themselves, primary care clinicians also should be alert to the possibility of conflict of interest when assessors are linked to a program or practice providing substance abuse services. There may be financial incentives (e.g., fee-for-service arrangements) or ideological pressure to interpret assessment results in such a way as to steer patients to a particular program or treatment provider (Institute of Medicine, 1990). Aside from insisting on an independent assessment source, which may be impractical, clinicians have few options for ensuring objective assessments (Institute of Medicine, 1990). However, primary care providers who understand the purposes of assessment and are familiar with its components will be in a better position to identify and subsequently avoid biased assessors.

The Assessment Setting

Like screening, assessments must be conducted in private, and patients must be assured that the information they provide is confidential.

Patients often will not reveal information about drug or alcohol use because they fear that information will be shared with their family members or employers or be used against them by law enforcement agencies or health insurance organizations. Prior to conducting an assessment, assessors should review current legal protections with the patient and discuss the limitations that apply to sharing information. (See Appendix B for a detailed discussion of confidentiality as it pertains to substance abuse.)

Assessment Components

Assessment comprises a medical and psychological history along with family, social, sexual, and drug use histories and a physical examination. (The physical examination and the interviews to obtain histories may be split, with a primary care clinician performing the physical and a nonmedical substance abuse specialist conducting the interviews. When this occurs, close collaboration between the two providers is essential.) In its 1990 report, *Broadening the Base of Treatment for Alcohol Problems*, the Institute of Medicine recommended conducting “sequential” and “multidimensional” assessments for alcohol problems (Institute of Medicine, 1990). The Consensus Panel recommends the same approach when assessing for other drug-related problems. Essentially, *sequential* assessment entails separating “the process of assessment into a series of stages, each of which may or may not lead into the next stage” (Institute of Medicine, 1990, p. 249; Skinner, 1981) depending on the information obtained previously. In this model, a broad-based assessment is conducted first. If the information compiled suggests that other problems may be present, such as a psychiatric disorder, then a series of progressively more intense procedures would be initiated to confirm and characterize that finding. This approach not

only provides information needed for treatment planning, it saves both patient and assessor time. Moreover, by ensuring that “further information is necessary [it also] justifies its increased cost” (adapted from Skinner, 1981, in Institute of Medicine, 1990, p. 250).

A *multidimensional* approach to assessment ensures that the variety of factors that impinge on an individual’s substance abuse (level, pattern, and history of use; signs and symptoms of use; and consequences of use) are considered when evaluating individual patient problems and recommending treatment (Institute of Medicine, 1990). Detailed characterization not only helps assessors match patients to appropriate available services, it also provides information useful in anticipating relapse triggers and planning for relapse management (see Chapter 5).

A number of assessment instruments elicit similar information (see Appendix C), and specialized substance abuse treatment assessors may use one or more with patients. Administering an instrument can take from 90 minutes to 2 hours, depending on the instrument(s). Training is frequently required, and costs for purchase and required staff time can be substantial. While primary care clinicians trained or experienced in addiction medicine may use the instruments described in the appendix, many clinicians will not because they lack the time, training, and resources to do so. Based on members’ clinical experience, the Consensus Panel recommends that an assessment include at least the components presented in Figure 4-1.

The figure also includes additional questions on certain sensitive topics for situations in which primary care clinicians cannot refer for specialized assessment and require additional information in order to make a reasonable decision about the need for formal substance abuse treatment. In addition to the elements listed under the Mental Health History

