SBIRT: Referral to Treatment and Follow-up Care

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SBIRT: REFERRAL TO TREATMENT AND FOLLOW-UP CARE

Goal:

The learner will improve care management and referral skills for treatment of substance use disorders. The learner will improve follow-up and reassessment skills for primary care patients who have received a brief intervention for substance-related issues as well as patients who have been referred for special treatment of substance use disorders.

After completing this activity participants will be able to:

- Follow-up with patients who have received brief interventions for substance use problems
- Determine the need to refer a patient for treatment of a substance use disorder
- Select the proper type of treatment for patients with substance use disorders
- Prepare the patient for a referral for substance use disorder through education, motivation, and follow-up
- Collaborate effectively with the specialist to ensure ongoing patient care after referral for substance use disorder

Professional Practice Gaps

Fewer primary care physicians make a referral after identifying a substance abuse problem[1–3] and many providers perceive communications from the other professional groups about patient substance use to be inadequate[4]. Additionally, primary care providers need to understand the different types of specialty treatment so that they can make appropriate referrals for their substance abuse patients[5,6].

INTRODUCTION

New Patient

The following case will be used throughout this module to illustrate and give you a chance to apply the concepts learned:

Patient: Mrs. Elise Capello

Age: 35 years old

Scenario: Ms. Capello has returned for blood pressure monitoring. She had missed an appointment to follow-up on a brief intervention for an alcohol use problem. The goal at that time was to reduce alcohol use to healthy limits. But in this office visit, we'll discover that, not only has she not reduced her alcohol use, she has instead increased her drinking and started misusing sedatives as well. Mrs. Capello had a brief intervention for her drinking over a year ago, but no follow-up. She now returns with a more severe problem with alcohol.

Referral

Referral to other treatment facilities may be the best course of treatment for some patients. More information is needed to determine if Mrs. Capello needs a referral.

Coordinated and comprehensive approaches to substance use disorder treatment are imperative when managing patients with substance use disorders. Multiple health-care providers or treatments, such as mental health counselors, social workers, self-help groups, and addiction treatment facilities may be involved.

POLL: I CURRENTLY HAVE A SYSTEM THAT REMINDS ME TO FOLLOW-UP WITH PATIENTS AFTER PROVIDING BRIEF INTERVENTIONS FOR SUBSTANCE USE PROBLEMS.

Choices

1. Yes, and it works
    - 26% (726 votes)
2. Yes, but it does not work well
    - 11% (296 votes)
3. No
    - 33% (922 votes)
4. Not currently or not yet practicing

- 30% (826 votes)

Total votes: 2770

FOLLOW-UP AFTER BRIEF INTERVENTIONS

Importance and Effectiveness

Follow-up is important, whether you manage a substance use problem through brief interventions or make a referral. Continued follow-up monitoring after a patient is referred for follow-up care and after a patient quits a substance or reduces substance use are also an important component of SBIRT.[5,7] Follow-up for the patient who was not motivated to quit is also important because interventions can have an additive effect over time. Follow-up calls can be performed by medical assistants or other staff.

Keeping the patient engaged with recommended changes is important. Engagement services, including direct outreach along with follow-up results in the patient being more likely to remain engaged throughout treatment[8]. Engagement can be achieved through:

- Carefully building a strong therapeutic alliance with the patient
- Using motivational strategies
- Acknowledging and being supportive in addressing individual patient barriers
- Reaching out through reminder phone calls or texts
- Being positive

Immediate

There are some immediate actions to be taken when following-up after brief intervention:

1. For the patient quitting or reducing the use of a substance on a particular date, a phone call immediately before that date as a reminder is ideal.
2. A call within several days after a patient quits/reduces use to check in on how it is going can help keep motivation on track.
3. Scheduling a clinic check-in within the first 2 weeks provides the opportunity for a more detailed update on withdrawal symptoms, effectiveness of any medication, side effects, etc.
4. In a hospital setting, make a referral for follow-up in primary care at discharge.

Long Term

Scheduling long-term follow-up after a brief intervention (for example, at 6 months) provides the opportunity for the following steps:

1. Screen for current substance use problems, including urine drug testing and other laboratory tests when appropriate.
2. Provide motivation, encouragement, and/or congratulations when appropriate for the situation.
3. Review the efficacy and side effects of any medications that were prescribed and are still being used. Discontinue their use if indicated.
4. Discuss relapse or continued use despite the brief intervention using a non-judgmental attitude. Consider whether the patient needs additional brief interventions, brief treatment (more intensive brief interventions) or a referral to a specialist/treatment center for more extensive treatment.

Keep in mind that as your referred patient progresses through a treatment plan, they will likely graduate to a lower level of care, and eventually, may need you to play a role in their follow-up care. Planning for this return in advance and reaching out to patients for a periodic check-in during their treatment can help facilitate their treatment continuing seamlessly and successfully.

BRIEF INTERVENTIONS TO PREVENT RELAPSE

It is important to continue to be supportive after brief interventions or referral in order to help prevent relapse for someone who quit using a substance in the past few years. This might include:

1. Congratulate them on any success.
2. Offer strong encouragement to remain abstinent (or reduction of substance use, if appropriate).
3. Ask open-ended questions regarding the following:
    - Benefits of quitting.
    - Describe their success (how long? resisted "temptations"?).
    - Any problems or concerns?
    - Remind them of the benefits of getting social support, such as attendance at 12-step meetings. For tobacco cessation, patients may also benefit from quitline counseling and should know about their local number or the national number 1-800-QUIT-NOW.

- Medication check. Ask if medication for quitting is still being used. Effectiveness? Side effects? Adjust as needed. Any withdrawal if it is not being used?
- Ask about negative mood or depression and address as needed.

CASE STUDY – MR. MARTIN

Mr. Martin, who was first introduced in the previous module, SBIRT: Brief Intervention and Other Treatments, and screened positively on the AUDIT for harmful or hazardous alcohol use and agreed to try to cut back on his drinking. He now returns for a 3-month followup.

Patient: Mr. Mike Martin

Age: 31 years old

Scenario: Three months ago, he reported that he used to smoke occasionally and currently drinks alcohol, but does not use illicit drugs or misuse prescription drugs. He tested positive for hazardous or harmful alcohol use on the AUDIT (score=16/40. 8 or more is positive). It has been three months since the previous appointment.

Provider: *[After a greeting] Last time you were here, when we discussed your alcohol use, you agreed to cut back on your drinking. How is that going?*

> **Mr. Martin:** *Yes, in fact, I cut back to no more than 2 drinks per day. Now I'm under that limit you mentioned last time, 14 drinks per week, right?*

Provider: *Yes, that is great to hear! What benefits have you noticed?*

> **Mr. Martin:** *I never get hangovers now, so it's a lot easier to wake up in the morning. I guess I'm saving money too.*

Provider: *I'm glad you are already experiencing benefits from cutting back. There are many more invisible benefits, too, in terms of improved health. I expect that cutting back even further would benefit you and your health even further. What concerns or problems do you have, such as temptations or pressure?*

> **Mr. Martin:** *It's getting hard for me to cut back any further. I just really look forward to a drink or two at the end of the day.*

Provider: *You've had a great start cutting back on your own. Getting involved in social support, such as attendance in a 12-step plan, could really benefit you to decrease your use even further. There is a medication I can prescribe that would help, too.*

SUPPORT GROUPS AND RECOVERY SUPPORT SERVICES

Supplementing Treatment with Support Groups

This discussion refers to support groups not run by licensed professionals and not qualifying as level I care, such as self-help groups run by peers. These groups can be an important way to gather additional social support, which is important for recovery.

Self-help groups, such as Alcoholics Anonymous, are interventions that supplement substance use treatment and are often free, easily accessible, and usually open to anyone who wants to come. Some members of these groups use them as an alternative to professional substance use treatment, but they also are often used in addition to professional treatment.

The **no-cost aspect** is especially important in the wake of managed care.[9] Self-help groups can vary in philosophy (e.g. secular vs. spiritual), so patients may require referral to more than one group before finding an appropriate fit.

The Range of Groups Available

12-step groups. The most famous 12-step group is Alcoholics Anonymous although there are such groups for many other addictions. It is a common misconception that 12-step self-help groups are only suitable for patients with religious beliefs. 12-step programs have been shown to be effective regardless of an individual's religious background.[10,11]

Other options. There are other networks of support groups available, such as *Life Ring*, *Rational Recovery*, *Women's Recovery*. These groups exist for alcohol, narcotics (broadly), cocaine, tobacco, prescription pills, and more. Many groups now also are available online.

Recovery Support Services

The Surgeon General's report, *Facing Addiction in America*, defines recovery support services as, "the collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use".[8] Further, these services help individuals in recovery to acquire resources that will help them stay in recovery, such as better jobs, education,

social opportunities, health, and general well-being. In addition to this support, ongoing monitoring and early re-introduction to treatment are often additional goals of these services. Recovery support services are found in various places including schools, health care systems, housing systems, and other community settings. Specific recovery support services include:

- Recovery Coaching: Helps individuals being discharged from treatment to connect with community services and resources as well as to overcome barriers or problems that might interfere with continued recovery.
- Recovery Housing: Provides a substance-free environment in which to recover as well as mutual support. Research on at least two such programs has shown improved long-term recovery rates
- Recovery Management: Follows a protocol to monitor individuals during recovery long term. May involve in-person checkups or telephone case monitoring.
- Recovery Community Centers: Often peer-led, recovery-focused. May provide any of the above recovery support services, 12-step meetings, education, social events, and access to resources that support recovery.

8

ONGOING MONITORING AFTER FIRST BRIEF INTERVENTION

The National Council for Behavioral Health, in their SBIRT-related guide for medical settings recommends the following for monitoring patients after the initial brief intervention for identified substance use problems[5]:

- Repeat screening for substance use problems every 3 months to determine frequency and quantity of use. They suggest use of the AUDIT-C plus 2.
- Monitor symptoms of substance use.
- Monitor symptoms of substance use using the short alcohol or drug monitor questions described in the NCBH[5]. Regarding the past 2 weeks, ask:
    1. Were you bothered by how your drinking or drug use impacted your health, relationships, goals or life?
    2. Did you have trouble controlling your drinking, drink too much or spend too much time drinking/spend a lot of time using drugs?
    3. Was it difficult to get the thought of drinking out of your mind/Were drugs the only thing you could think about?
    4. Did you disappoint yourself or others due to drinking/drug use?

5. Have you had trouble getting things done due to drinking?/Did you feel your drug use was out of control?

Have the patient respond to the above with Never, Rarely, Sometimes, Often, or Almost Always.(Adapted from PROMIS[12,13])

- Monitor patient success with their goals related to their substance use and encourage self-monitoring and tracking of substance use and symptoms.
- Continue use of motivational interviewing to facilitate healthy changes.
- Adjust the treatment plan as needed for severity of substance use disorder or contributing problems.

BRIEF TREATMENT

When More Than Brief Intervention Is Needed

Patients who have a moderate to high risk for substance use problems, who have a moderate to severe substance use disorder, or who need but cannot obtain conventional treatment will likely need more intensive help than a brief intervention. Longer interventions, or those that take place over more than four clinical sessions, have been called *Brief Treatment* in contrast to *Brief Intervention*. A hospital setting or situation where a patient with a chronic condition requires regular clinic visits (e.g., pregnancy) may present the opportunity for brief treatment.

In some cases, a referral for treatment will not be possible due to a variety of reasons: rural location, transportation difficulties, or lack of patient interest. In these cases, spending a little extra time with the patient and utilizing at least one of the brief treatment tools presented can have a positive impact on patient outcomes. Counselors, who have more time to spend with patients, can review and utilize the following skills/techniques for brief treatment.

How Does Brief Treatment Differ From Brief Intervention?

The techniques used for brief treatment are the same as those already described for brief intervention, but applied more comprehensively. It includes more assessment, education, problem-solving, coping skills, and finding support and is spread over multiple structured and focused clinical sessions. A brief treatment would cover more topics than a brief intervention and would be more likely to include medication if

indicated. More intensive treatments may be more effective than brief interventions.[14,15]

Example of a Brief Treatment Schedule

- **Appointment 1:** Raise awareness of the problem, clearly recommend stopping and explain benefits, and assess quantity/frequency of use and readiness to quit. This might be all that is accomplished in a single, brief intervention.
- **Appointment 2:** Further assessment (including severity of dependence, personal consequences of use, and problem areas that would interfere with quitting) facilitate problem-solving and raise awareness of benefits of quitting.
- **Appointment 3:** Continue motivational interviewing as needed. If motivated, develop clear goals, assess commitment, and triage to the appropriate treatment setting. If quitting will be supervised in your clinic, schedule a date for quitting, develop a plan for quitting – identify changes needed in the environment, and find support
- **Appointment 4:** Prescribe medication if indicated and schedule a follow-up appointment
- **Appointment 5:** Follow-up in two weeks or less, assess medication effectiveness and side effects, and congratulate on any successes

For brief treatment to be effective, there has to be at least some commitment from the patient. A description of when referral is indicated instead of brief treatment is provided on the next page.

HELP THEM AVOID SOCIAL PRESSURE

In counseling and for clinicians who are able to have longer sessions with patients/clients*, discussing social pressure can benefit a patient's ability to maintain cessation and prevent relapse. The first step is to go through a typical week with the client to point out situations where they are likely to experience indirect social pressure (ie., being around people who are smoking) or direct social pressure (ie., being offered a cigarette).[16]

The following are ways the counselor can advise a client to avoid social pressure:

Advice	***Example***
Do small things to change your environment	Throw away any cigarettes you might have laying around at home
Anticipate and avoid social	Don't go to a restaurant with a bar

pressure	
Escape feelings of temptations	Have a plan to leave a party if you feel tempted to exceed your limit
Take a break from temptation	Leave a situation with social pressure for only a short time to regroup your thoughts
Distract yourself	Use something to distract yourself, such as chewing gum
Give yourself choices	Bringing your own non-alcoholic drinks to a party or get together
Seek support	Ask for encouragement from family and friends; Ask friends to avoid pressuring you
Bring support with you	Having someone else who is trying not to smoke or drink will give you someone to relate with
Call somebody	Call a friend or a support number to talk you through a situation

Coping skills can also be taught in counseling to turn down direct social pressure. One approach to learn coping skills is through role-play. The counselor and client will first discuss how to get through a conversation and then practice the refusal skills. The counselor and client can then summarize and reflect on how each of them felt after the role-play and complete further practice.

PRODUCTIVE THINKING & DECISION MAKING

Negative thoughts, sometimes called "stinking thinking" in drug and alcohol rehabilitation programs, and poor decision making leads to poor maintenance of abstinence and relapse in patients.[16] There are strategies for counselors to work with clients to recognize when they are having these thoughts and replace them with more productive thinking. This progress will also improve the decision making of the individual in dealing with cessation. The following steps illustrate how counseling session would help prevent a client from engaging in negative thoughts and poor decision making:

1. **Identify negative thinking:** Have the client think of examples in the past when they have subjected themselves to negative thinking regarding abstinence from drug, tobacco, or alcohol use. Provide an example, if necessary, of common maladaptive thoughts.

Provider: *Do you ever think in ways that might be preventing you from succeeding? I know some people will say to themselves something like, "I know I'm going to mess this up."*

1. **Identify Risky Decision Making:** Ask the client for previous examples where they may have exposed themselves to others who use substances or certain triggers that can cause relapse.

Provider: *Do you ever unexpectedly find yourself tempted to exceed the limits you've set for yourself?*

1. **Develop a Detailed Plan:** It is important to give the client a detailed, specific plan to work with when they recognize a thought or decision that may impact their abstinence.
    a. **Recognize the Risk:** The first step is to recognize the risky thought or decision as they are happening.
    b. **Challenge Thoughts and Decisions:** Through the recognition and awareness, the patient can be guided by a counselor on how to replace these thoughts with more productive thinking and decisions.
2. **Practice and Role-Play:** The client and counselor can practice these coping skills by filling out a worksheet of common negative thoughts and replace them with good thoughts. Another option is for the counselor and client to role-play certain risky situations for the client to gain experience and become more comfortable.

Provider: *Earlier you mentioned being in a situation where you thought you could go to the bar but drink water or tea instead of alcohol, and this didn't work out as you planned it. How can you change your thought process in a similar situation in the future?*

Patient: *I will remind myself of what happened last time. The next time probably won't be any different and I should avoid it altogether.*

Provider: *Will this thought process help you to make a safer decision?*

Patient: *Yes. It will help me to avoid the situation entirely.*

WHEN TO REFER PATIENTS TO SUBSTANCE USE TREATMENT

Patients with moderate to severe substance use disorders or severe risk for them should be referred to a specialist or a treatment center for substance use disorders in the following cases:

Case Severity/Complexity

Criteria to use in determining case severity include the following:

- A brief intervention is not adequate treatment, or has been tried and has not been sufficient.
- Patients with severe substance use disorder. Additionally, patients that have moderate to severe alcohol use disorder, are using prescription drugs non-medically or illicit drugs, or have severe tobacco use disorder.
- Patients have comorbid mental health disorders, low cognitive ability, or are on opioid therapy for chronic pain.
- Patients have multiple or complicated medical conditions
- Patients with a past history of substance use disorder
- Patients with polysubstance use disorder
- Pharmacological treatments for addiction are needed that are beyond the scope of your practice. This may include, for example, a patient who needs transfer from high-dose methadone maintenance or uses other high-dose opioids non-medically.

Other Patient Factors

Other factors that might require referral include the following patient factors:

- Patients lack motivation or commitment needed for brief treatment to be effective.
- Patient is non-compliant with your office policies or treatment protocol.
- Patients request a referral.

Practice Factors

Factors relating to a provider's practice that may require referral include:

- Having insufficient staff or other resources to provide brief treatment.
- Patient's needs are beyond your expertise.

PRACTICE TIP

Use Motivational Interviewing techniques to encourage the patient (or patient and parents, in the case of adolescents) to accept the referral.

SHARED DECISION MAKING AND ENGAGEMENT

Shared Decision Making

Shared decision-making, recommended for all patient care by the Institute of Medicine report, *Crossing the Quality Chasm* (2001), is especially important for patients with substance use disorder.[17] This should include deciding what treatment they obtain for their substance use disorder. Patients must have all information they need to make the decision in language they understand. Shared decision making also involves learning and respecting their priorities and involving them in setting goals.

Using a patient-centered approach, review outcomes of the patient's attempts to change their substance use previously including reasons they may have abandoned other treatments. Ask about their willingness to engage in treatment or a referral.

Engagement Strategies

Patients often express ambivalence or resistance to treatment at first and may continue to resist a referral.[18] Several principles are helpful in facilitating the patient being open to engaging in treatment:

- Emphasize that treatment is effective, more effective than no treatment.
- Consider previous treatment experience.
- Motivational interviewing is often an effective approach for patients expressing the full range of readiness to engage in treatment. This includes an emphasis on:
    - Building self-efficacy that they can change
    - Develop a therapeutic alliance
    - Strengthen coping skills
    - Use reinforcement
    - Build social support
- Emphasize that participation in treatment and community support are strong predictors of outcome.
- Promote active participation in mutual-help groups (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA))

- Recommend coordinated treatment of substance use problems with interventions for biopsychosocial problems. (Consider patient priorities in this.)
- Recommend the least restrictive setting possible for access, safety, and effectiveness.
- Make efforts to re-engage patients who drop out of treatment.
- Maintain use of Motivational Interviewing even if the patient is unwilling to engage in treatment, offering medical and psychiatric treatment as needed while looking for opportunities to facilitate further engagement of the patient in substance use treatment.

VA/DoD Guidelines

The VA/Department of Defense has created a comprehensive guideline for treating substance use disorders, from screening through treatment options. Excellent clinician pocket guides that summarize much of what has been presented here on this subject and many further details are available free-of-charge in the Provider Summary, Screening, and Treatment, and Stabilization pocket guides available in the External Resources section.

QUIZ: SPECIALTY TREATMENT REFERRALS

Which of the following patients would you refer to substance use disorder treatment: Choose one

1. A patient who, despite multiple brief interventions, continues to use heroin
    - Feedback: Correct, but other choices are also correct. Heroin use is an indication for referral to substance use disorder treatment, however, the other choices are also indications for referral.
2. A patient who has an alcohol use disorder and also uses cocaine
    - Feedback: Correct, but other choices are also correct. Alcohol use disorder and use of cocaine are indications for referral to substance use disorder treatment, however, the other choices are also indications for referral.
3. A patient who suffers from depression and/or PTSD, comorbid with a substance use disorder
    - Feedback: Correct, but other choices are also correct. substance use disorders with PTSD and/or depression comorbidities are indications for referral to substance use disorder treatment, however, the other choices are also indications for referral.

4. All of the above
    - Feedback: Correct: All of these choices are indications for referral to substance use disorder treatment.

QUIZ: MRS. CAPELLO – CAGE-AID

Read the following case information and dialogue and answer the question at the bottom.

Patient: Mrs. Elise Capello

Age: 35 years old

Scenario: Mrs. Capello has returned for a check on her blood pressure. She skipped a follow-up appointment on a brief intervention that was provided for problem alcohol use at her last appointment. The goal at that time was to reduce alcohol use to healthy limits. A mild alcohol use problem was identified 6 months ago, which she blamed on the stress of a divorce. Mrs. Capello's previously elevated blood pressure was not elevated at this appointment. She had a brief intervention for excessive alcohol use a half year ago and did not return for a follow-up appointment. She is married and her husband and parents were supportive of her reducing alcohol use.

After attending to her blood pressure check, the provider next wants to follow up on her alcohol use, first requesting and obtaining Mrs. Capello's agreement to answer the CAGE-AID substance us screening questionnaire.

Provider: *(**C**ut Down) Last time we talked you felt you wanted to cut down on your drinking. How about now? Do you ever feel you should cut back on alcohol or drug use?*

> **Mrs. Capello:** *Yes, I still feel I should cut down on alcohol. I only take one sedative at a time, so I'm not too worried about that.*

Provider: *(**A**nnoyed) Have people annoyed you by criticizing your drinking or drug use?*

> **Mrs. Capello:** *Yes, my mother still criticizes my drinking.*

Provider: *(**G**uilty) Have you ever felt bad or guilty about your drinking or drug use?*

Mrs. Capello: *Yes, drinking alcohol.*

Provider: *(**E**ye Opener) Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?*

Mrs. Capello: *No, I recently started using sedatives instead.*

Question: What is the significance of Mrs. Capello's CAGE-AID responses?

Choose one

1. Probable alcohol use problem and possible misuse of sedatives, further evaluation is indicated to determine treatment needs.
    - Feedback: Correct. The score of 3 out of 4 (or possibly 4 out of 4 if you count her last response as positive) is obviously of concern. Even a score of 1 on the CAGE-AID indicates that more assessment is indicated.
2. This is enough information to determine her treatment needs.
    - Feedback: Incorrect. More assessment is needed, for example, regarding her frequency and quantity of drinking alcohol.

MRS. CAPELLO – ALCOHOL USE ASSESSMENT

Plan for Current Assessment

Mrs. Capello's current CAGE-AID results show a score of 3 out of a possible 4, which is higher than her last visit and so is discouraging. Her response to the last question on the CAGE-AID indicates possible sedative use, in addition to alcohol use. You use the following to guide further assessment of both her alcohol and sedative use:

- For the alcohol problem: Single Item Alcohol Screening Questionnaire (SIASQ),[19] followed by the rest of NIAAA's *Helping Patients Who Drink Too Much A Clinician's Guide*
- For the sedative use: NIDA-Modified ASSIST (To be conducted on a following page)

Assessment of the Extent of Mrs. Capello's Alcohol Use Problem

1. SIASQ:

You ask Mrs. Capello the number of heavy drinking days she has had in a year with the following results.

Provider: *How many times in the past year have you had 4 or more drinks in a day? (For a man, the question would ask about "5 or more drinks")*

Mrs. Capello: *Once or twice per week, so 50 to 100 in a year.*

Interpretation:

1 or more heavy drinking days in a year is a positive screen, making Mrs. Capello's response strongly positive. Because of this, further assessment as recommended by the NIAAA is continued as described on next page.

If there were no heavy drinking days, the next step would have been to advise her to drink no more than 3 drinks in a day and no more than 7 drinks in a week (the healthy drinking limit for women). For men, the healthy limit is no more than 4 drinks in a day and no more than 14 drinks in a week.

QUIZ: MRS. CAPELLO – NIAAA ASSESSMENT (CONTINUED)

Read the following case information and dialogue and answer the question at the bottom.

Patient: Mrs. Elise Capello

Age: 35 years old

Scenario: Because Mrs. Capello screened positively for heavy drinking, you ask the next NIAAA questions about typical number of drinks per week and number of drinks per day, which determine her weekly average drinking pattern:

Weekly Average Question 1: Days of Drinking per Week

Provider: *On average, how many days a week do you have an alcoholic drink?*

Mrs. Capello: *Probably every day.*

Weekly Average Question 2: Typical Number of Drinks Per Day

Provider: *On a typical drinking day, how many drinks do you have?*

Mrs. Capello: *It varies. Just a few drinks, like 2 to 3 drinks most days, but 4 to 5 on Friday and Saturday.*

Provider: *How many drinks before, during, or after dinner?*

Mrs. Capello: *Usually one before dinner, one that I finish with my dinner, and one after. On Friday or* Saturday, *it's more after dinner.*

To determine weekly average drinking pattern, you usually multiply the number of days per week times the typical number of drinks per day.

Question: Of the following, what is the best approximation of Mrs. Capello's weekly average for drinking?

Choose one

1. 17 drinks per week
    - Feedback: Incorrect. Her weekly average is 18 to 25 drinks per week. So 22 is the best estimate of the 4 choices offered. The recommended weekly limit: 7 for women/14 for men
2. 22 drinks per week
    - Feedback: Correct! Her weekly average is 18 to 25 drinks per week, so 22 is the best estimate of these four. The recommended weekly limit is 7 drinks for women/14 for men
3. 28 drinks per week
    - Feedback: Incorrect. Her weekly average is 18 to 25 drinks per week, so 22 is the best estimate of these four. The recommended weekly limit: 7 drinks for women/14 for men
4. 35 drinks per week
    - Feedback: Incorrect. Her weekly average is 18 to 25 drinks per week, so 22 is the best estimate of these four. The recommended weekly limit: 7 drinks for women/14 for men

MRS. CAPELLO: NIDA MODIFIED ASSIST

Assessment of Ms. Capello's Drug Use

The NIDA-Modified Assist assessment was selected after a positive CAGE-AID screening for drug use in addition to her alcohol use problem.

NIDA-Modified ASSIST Questions

1. In the past 3 months, how often have you used sedatives or sleeping pills?

Never	Once or Twice	Monthly	**Weekly**	Daily or Almost Daily

2. During the past 3 months, how often have you had a strong desire or urge to use this substance?

Never	**Once or Twice**	Monthly	Weekly	Daily or Almost Daily

3. During the past 3 months, how often has your use of this substance led to health, social, legal, or financial problems?

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

4. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of this substance?

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

5. Has a friend or relative or anyone else ever expressed concern about your use of this substance?

No, never	Yes, but not in the past 3 months	**Yes, in the past 3 months**

6. Have you ever tried and failed to control, cut down, or stop using this substance?

No,	Yes, but not in the past 3	Yes, in the past 3

never months months

Total score for sedatives & sleeping pills: **13/40 (Moderate Risk)**

Interpretation Mrs. Capello's NIDA Modified ASSIST score for illicit use or misuse of drugs is 13, which is in the *moderate risk* range.

Combining Mrs. Capello's Assessment Results

In summary, using either the CAGE-AID or the NIAAA guide's questions as screening tools would reveal that Mrs. Capello needed further assessment of her alcohol use. One or the other screening tools could have been used for this purpose. The NM ASSIST was then used to further assess the extent of her alcohol use problem and it was determined that she has moderate risk for alcohol use disorder. The criteria for Alcohol Use Disorder can be reviewed to determine whether she has this diagnosis and, if so, its severity.

MRS. CAPELLO – ASSESS FOR SUBSTANCE USE DISORDER

Assess for Alcohol Use Disorder

Continuing the interview, you ask Mrs. Capello questions recommended by the NIAAA guide (2007) regarding "maladaptive patterns of alcohol use, causing clinically significant impairment or distress." Each of the following questions aligns with a criterion from the DSM 5 for alcohol use disorder.[20] A positive response to any of the questions suggests that she fulfills the related criterion.

Provider: *In the past 12 months, has your drinking repeatedly caused or contributed to a risk of bodily harm? This could include drinking and driving, operating machinery, and swimming.*

Mrs. Capello: *No. I've been* mostly *careful, especially since we talked.*

Provider: *Has alcohol caused any relationship issues with your spouse, family, or friends?*

Mrs. Capello: *No, not much. They just want me to quit.*

Provider: *Has your alcohol use kept you from fulfilling your roles at home, school, or work?*

Mrs. Capello: *Um, no, not really.*

Provider: *Experienced cravings or a strong desire to use alcohol?*

Mrs. Capello: *Yes. That's why I kept drinking instead of cutting back.*

At this point, Mrs. Capello's cravings give her one positive response to the questions asked. Questioning is continued on the next page.

MRS. CAPELLO – ASSESS FOR SUBSTANCE USE DISORDER (CONTINUED)

Assess for Alcohol Use Disorder

The provider continues the interview, asking Mrs. Capello questions based on the DSM 5 criteria for alcohol use disorder.[20]

Provider: *In the past 12 months, have you had difficulty being able to stick to drinking limits?*

Mrs. Capello: *Yes, I have been drinking more than the limits we talked about.*

Provider: *Has it been difficult for you to cut down or stop drinking alcohol?*

Mrs. Capello: *Yes. I probably could have tried harder, but it was difficult.*

Provider: *Have you felt the need to drink a lot more to get the same effect?*

Mrs. Capello: *Yes, maybe a little.*

Provider: *When you have to decrease or stop drinking, do you experience withdrawal symptoms?*

Mrs. Capello: *Yes, some. That's why it's so hard.*

Provider: *Have you found yourself drinking despite problems? These could include your social life, work problems, and any psychological and physical issues.*

> **Mrs. Capello:** *Not recurrent problems. Not really. I did miss work once or twice because of a hangover.*

Provider: *Have you spent a lot of time drinking, including preparing for or recovering from the effects of alcohol?*

> **Mrs. Capello:** *Not really. It doesn't take much time to drink, because I do it while I'm doing other things and we always have it in the house. I do look forward to a drink in the evening, though.*

Provider: *Have you found that you have spent less time on other, more important or pleasurable activities?*

> **Mrs. Capello:** *No. Drinking is actually part of my leisure time.*

Interpretation – Alcohol Use Disorder

The diagnosis in the DSM 5 (adopted in May 2013) became **Alcohol Use Disorder** - mild, moderate, or severe – according to how many diagnostic criteria are met. 2-3 is mild, 4-5 is moderate, and 6+ is severe.[20]

Having answered "Yes" to 5 of these questions, Mrs. Capello appears to have moderate alcohol use disorder.

Interpretation – Drug Use Disorder

The same criteria were reviewed for her use of sedatives and she does not meet criteria for a sedative use disorder, however, it is still a serious and important concern to address, and potentially dangerous interactions with her use of alcohol needs to be discussed.

QUIZ: MRS. CAPELLO – TREATMENT REFERRAL

Read the following case information and dialogue and answer the question at the bottom.

Patient: Mrs. Elise Capello

Age: 35 years old

Scenario: Mrs. Capello has returned for a check on her blood pressure.

She had a brief intervention for mildly excessive alcohol use a half year ago and did not return for a follow-up appointment. The goal at her last appointment was to reduce alcohol use to healthy limits. At that time, she blamed her alcohol use problem on the stress of a divorce. Her parents were supportive of her reducing alcohol use.

Today, Mrs. Capello's previously elevated blood pressure was not elevated. Mrs. Capello's responses to screening and assessment questions, followed by a review of the DSM-5 criteria revealed that she has alcohol use disorder and moderate risk of sedative use disorder, but does not meet criteria for a current diagnosis of sedative use disorder.

Question: With the provided information, which of the following is indicated for Mrs. Capello?

Choose one

1. Repeat brief intervention
    - Feedback: Incorrect. Mrs. Capello's current risk level is high from a combination of high volume of drinking as well as risky use of sedatives, possibly in an attempt to manage morning withdrawal. She appears to meet criteria for alcohol use disorder and so treatment is indicated. If she is not open to referral, repeating the brief intervention would be better than nothing, however.
2. Brief treatment
    - Feedback: Incorrect. Mrs. Capello needs a referral for substance use disorder but brief treatment would be better than nothing if she is not open to a referral.
3. Referral for substance abuse treatment
    - Feedback: Correct! Mrs. Capello's current risk level is high from a combination of high volume of drinking as well as risky use of sedatives, possibly in an attempt to manage morning withdrawal. She appears to have an alcohol use disorder. Treatment by a specialist is indicated because of the severity and complexity.
4. Not enough information is available at this point to be certain whether or not she needs referral for substance abuse treatment.

- Feedback: Incorrect. This isn't true – There is enough information that Mrs. Capello needs a referral for substance use disorder.

TREATMENT OPTIONS

Treatment should be tailored to meet the patient's needs. Primary care providers often refer patients to a trained substance use counselor or addiction specialist for this assessment,[21] however, a basic understanding of what treatments are available is still essential for the referring provider. Treatment can be looked at in terms of the following dimensions:

- **Levels of Treatment**

	DAST-10 Criteria
Level 0.5	Early intervention (SBIRT and some Brief Treatment)
Level I	Outpatient
Level II	Intensive Outpatient
Level III	Residential treatment
Level III-IV	Inpatient, medically monitored

- **Treatment for Specific Populations** e.g. women, teens, religious affiliations, language spoken
- **Treatment Dimensions**
  - **Dimension 1:** Withdrawal management
  - **Dimension 2:** Medical conditions
  - **Dimension 3:** Psychosocial conditions and complications

[22]

PRACTICE TIP

Remember that in patient-centered care, the patient should be informed of the treatment options and helped to understand them and to express needs and preferences.

SUBSTANCE USE COUNSELORS

What Do Substance Use Counselors Do?

Substance use counselors provide treatment at multiple levels from outpatient or Level I treatment through being part of the treatment team in residential or inpatient treatment (Levels III and IV). If a substance abuse problem is documented or strongly suspected, referral to a substance abuse counselor is indicated. Substance abuse counselors (also called rehabilitation counselors or chemical dependency counselors) are counselors who help people with drug and alcohol issues, as well as gambling and eating disorders. They are qualified to assess the patient further and triage the patient to the appropriate level of care if they need a different level, so they are a good place to start if a primary care provider is unclear of what a patient needs. Counselors may work with the individual, but may also work with affected family members, or with community outreach programs with the goal of preventing addiction and educating the public.

The substance abuse counselor helps the patient identify behaviors and patterns related to their addiction and develop healthy patterns of behaviors and coping mechanisms through a variety of mediums, including:

- One on One Counseling
- Group Counseling
- Family Therapy
- Career Counseling
- Community Service[23]

Their Qualifications

Depending on the state and occupational specialty, educational requirements may vary. A substance abuse counselor should be certified or licensed. Certification can usually be achieved through completion of a certificate course in drug and alcohol counseling but sometimes through a counseling degree program. Many states,

hospitals, and treatment centers require licensing or certification through a master's degree.

Additionally, some counselors may become certified with the general practice credential of National Certified Counselor by the National Board for Certified Counselors. There are a number of other counseling organizations which offer certification, as well.[23]

Their Practice Settings

Substance abuse counselors may be found at hospitals, outpatient clinics, and treatment centers. They may also visit halfway houses.

Frequency and Duration of Treatment

Counseling can be done on a daily or weekly basis or can be done on a drop-in basis. A counseling session may last one to two hours. Depending on the stage of treatment and the individual's needs, a patient may see the counselor up to several times per week.[23]

OUTPATIENT TREATMENTS

Outpatient treatments are provided by licensed individuals or programs that have the credentials to provide level I (Outpatient) or level II (Intensive Outpatient) treatment:

- **Outpatient Treatment (Level I Treatment)** – Less than 9 hours per week. This option is for patients who have minimal risk of severe withdrawal and works best for patients who have a support system in place, adequate living arrangements, transportation to treatment, motivated for consistent attendance or quitting smoking.[22]
- **Intensive Outpatient Treatment (Level II Treatment)** – A minimum of 9 hours per week. This is usually advised for early stages of treatment or transitioning from Residential treatment. This option is suitable for patients who have a support system in place but need some structure without full-time supervision. This option is for patients who have minimal risk of severe withdrawal, but also have emotional/behavioral conditions and complications and may have some resistance to treatment.[22]

Intensive treatments, in which the patient lives at home and participates in the program several days per week and several hours each day

- to -

Seeing a substance abuse counselor once per week (often used for *aftercare* after intensive care is completed).

A variety of locations are available, such as:

- a dedicated methadone clinic for detoxification from opioid addiction
- a private practice
- a primary care provider's office for detoxification from opioid addiction using buprenorphine
- community clinic with group counseling

Outpatient programs offer the advantage of lower cost and less disruption to the patient's life than inpatient treatment but lack the intense, limited, drug-free structure of inpatient treatments. They are appropriate for first time care of people who have mild to moderate substance use disorder.[8] Some outpatient clinics may provide psychosocial support and may provide medications when appropriate, but others refer the patient to a medical provider for medical management.

Partial hospitalization is a level of treatment intermediate between intensive outpatient and the residential and hospitalization treatments described on the next page. It is often used as a step-down program after these more intensive treatments and offers supervision during the day.
Note: 12-step programs, discussed under support groups, do not qualify as outpatient treatment or intensive outpatient treatment.

FYI

Resources such as the Substance Abuse Treatment Facility Locator allow you to do a detailed search for the level of treatment you are interested in, as well as search for a particular location and programs for special populations.

RESIDENTIAL OR INPATIENT TREATMENT

Drug rehabilitation programs provide a place where patients live in a drug-free environment where they can avoid the psychological, legal, financial, social, and physical ramifications of substance use disorders. The cost is typically higher than for outpatient treatments. Many insurers will pay for this level of care only if outpatient treatment has been tried and failed. If a patient refuses inpatient or residential treatment, a referral to intensive outpatient treatment should be considered.

- **Residential Treatment (Level III).** The level III residential treatment option is indicated for patients who lack motivation, social support, or supportive living situation, or who need monitored detoxification but do not need other medical or psychiatric management. Offers the advantages of 24-hour supervision and organized services. Clients who would otherwise qualify for lower levels of

treatment and have lower risk of withdrawal prefer residential treatment; for them, lower level residential treatment facilities are available.

- *Sub-type of residential treatment: Therapeutic Boarding Schools.* This option, which provides constant supervision and a highly structured environment, might be considered for an adolescent, who is still of school age. Teen treatment should be as close to home as possible to facilitate family involvement.

- **Inpatient Hospitalization (Level IV).** Medically monitored and managed inpatient care may be needed for patients needing medical and nursing care along with withdrawal management.[8] Patients having other medical conditions may need this high level of care. This option is indicated for patients who have:
  - Severe overdose or serious respiratory depression or coma
  - Severe withdrawal symptoms complicated by multiple drugs or history of delirium tremens
  - Acute or chronic general medical conditions that complicate withdrawal
  - Psychiatric comorbidity that could be dangerous to patient or others
  - A history of non-response to other, less intensive treatment

Note: Program-level descriptions are adapted from A Guide to Substance Abuse Services for Primary Care Clinicians.[6]

Treatment for Special Populations

Some treatment centers specialize in special populations. These may include treatment limited by gender, age, sexual preference, religious affiliation, stage of recovery, or languages spoken.

PRACTICE TIP

While it helps to estimate the appropriate level of care when making a referral, residential/inpatient treatments and outpatient treatment centers are all likely to do a formal assessment to determine the level of care needed.

POLL: WHICH OF THE FOLLOWING LEVELS OF TREATMENT IS LIKELY TO BE THE BEST LEVEL OF TREATMENT FOR MRS. CAPELLO INITIALLY?

1. Residential or inpatient or specialty treatment
   - 12% (319 votes)
2. Intensive outpatient specialty treatment

- 50% (1367 votes)

3. Outpatient treatment/Aftercare
    - 31% (854 votes)
4. Local support groups only
    - 2% (60 votes)
5. Try a brief intervention in primary care first and see if she responds
    - 6% (153 votes)

Total votes: 2753

MRS. CAPELLO – LEVEL OF TREATMENT DISCUSSION

The best option for Mrs. Capello is probably **outpatient treatment** that provides intensive treatments, in which the patient lives at home and participates in the program several days per week. A program that provides counseling and medical support would be ideal.

Outpatient treatment where she only meets with a counselor once per week is not likely to be enough support at first but is a good option for later in her treatment.

Residential treatment might be more than she needs. It is indicated for a patient who lacks motivation or social support or one who needs monitored detoxification but does not need other medical or psychiatric management. Mrs. Capello does have both social support and motivation.

ASAM PLACEMENT CRITERIA

More detailed criteria for placement are provided in the ASAM Criteria, which are used by trained providers to place patients. Even if you are referring patients to a substance use counselor or addiction specialist, for this detailed assessment, a familiarity with the criteria will help you explain your referral.

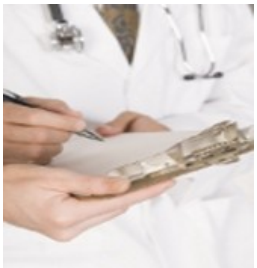
According to their **Patient Placement Criteria**, the following 6 patient dimensions should be considered when formulating a treatment plan:[22]

Dimension	***Things to Consider***

Acute Intoxication and/or Withdrawal Potential	Assess whether the patient is currently intoxicated, is at risk of precipitated withdrawal, or is currently in withdrawal.
Biomedical Conditions and Complications	Consider the patient's existing medical conditions and/or illnesses and how they might affect treatment.
Emotional, Behavioral, or Cognitive Conditions and Complications	Note the patient's psychiatric illnesses and psychological, behavioral, emotional, or cognitive problems, and determine if they are related to or are independent of the substance use disorder.
Readiness to Change	Assess the patient's readiness to change, and determine how willing he/she is to begin treatment.
Relapse, Continued Use, or Continued Problem Potential	Try to ascertain what the outcome will be if treatment is not successful, and consider if the patient can combat cravings and cues that might lead to relapse.
Recovery/Living Environment	Determine if the patient's home and work environments contribute to or detract from treatment efforts and what family and social support are available.

TREATMENT COMPONENTS

MEDICAL TREATMENT OF WITHDRAWAL AND COMORBIDITIES



The medical treatment components address the physical dependence and any other health effects from the substance use problem.

Inpatient/Outpatient Detoxification Treatment. Medications are typically used during early abstinence from the substance to ease withdrawal symptoms. The

medications used are selected in part based on the addictive substance. Some examples the most commonly used medications are the following:

- Tobacco – varenicline (brand name Chantix), bupropion (brand name Zyban), nicotine replacement (patch, lozenge, gum)
- Alcohol – acamprosate (generic available), disulfiram (brand name Antabuse), and naltrexone (brand names oral Depade and ReVia, injectable Vivitrol)
- Opioid addiction – methadone or buprenorphine. Also, naltrexone after detoxification.

PSYCHOSOCIAL TREATMENT

Substance abuse counseling component can take a number of approaches. The two most widely used are:

1. **Cognitive-Behavioral Approaches.** Cognitive-behavioral therapy is based on relating thoughts and behavior. The therapy helps the client to recognize and modify maladaptive thoughts that are contributing to the addictive behavior.[24] Stress management techniques may also be taught, such as meditation, exercise, and relaxation techniques.
2. **Group-Based Approaches.** Group therapy is frequently used in both inpatient and outpatient treatment.[6] Benefits unique to group-based treatments include witnessing others recover and reducing isolation. Multiple therapeutic approaches, including cognitive behavioral approaches, confrontation, and supportive therapies can be used with groups.

Other psychosocial factors that may be important to consider include whether or not there is a need for case management and whether family or friends should be involved.

ASAM PLACEMENT CRITERIA TABLE

The following is a table reviewing details of the ASAM placement criteria that were described earlier in this module under each level of care, as well as a few additional details. Providers who are responsible for triaging patients to the appropriate level of care, use these criteria. Familiarity with the basics of these criteria, even if you are not responsible for such triage, can be helpful in making an appropriate referral and with talking to patients.

	Brief Interventions	***Outpatient Treatment***	***Intensive Outpatient Treatment***	***Residential Treatment***	***Inpatient Hospitalization***
Dimension	**Level 0.5**	**Level I**	**Level II**	**Level III**	**Level III-IV**

Potential for Withdrawal or Intoxication	No risk of withdrawal	Minimal risk of severe withdrawal	Minimal risk of severe withdrawal	Up to a moderate risk of withdrawal	Moderate to severe risk of withdrawal
Medical	None or stable	None or stable	None or stable	No need for a possible need for medical monitoring	Needs monitoring and 24-hour medical care
Behavioral/ Psychiatric	None or stable	None or stable	Mild to moderate in severity; needs monitoring	No comorbidities to moderately severe comorbidities and/or inability to control impulses	Moderately severe to severe comorbidities requiring 24-hour psychiatric care
Readiness to Change	Has insight into how substance affects their goals	Cooperative but needs motivation and structured therapy to make positive changes	Moderate to significant degree of resistance; needs structure to make positive changes	Significant resistance; little to no insight; requires structure and motivating strategies	No insight, high degree of resistance and/ or poor impulse control
Relapse, Continued Use, or Continued Problem Potential	Requires skills to change current patterns	Can remain abstinent	Moderate to significant degree of automaticity; needs monitoring and support	May understand relapse but higher automaticity; requires structure and 24-hour monitoring	Cannot control use with dangerous consequences
Environment/ Support	Has social support and a supportive recovery environment	Has a supportive recovery environment	Has less of a supportive structure than what is needed to	Dangerous environment; higher structure needed to allow for recovery and	Dangerous recovery environment; needs structure to succeed in

	cope; needs additional patient coping		recovery structure

(Adapted from The ASAM Criteria[22])

QUIZ: TREATMENT SELECTION

Another patient, Mr. Williams, is a medically stable patient who experiences moderate withdrawal symptoms if he goes for more than 24 hours without alcohol. He has no other psychiatric problems but lacks a solid support system and is only intermittently motivated to recover. To which of the following treatment options would you refer Mr. Williams?
References:
Choose one

1. Inpatient Hospitalization
    - Feedback: Incorrect. This is a higher level of care than Mr. Williams needs. Mr. Williams can be treated in an intensive outpatient setting with ambulatory detoxification in coordination with his medical providers. He also needs an Intensive Outpatient setting to provide the additional support system and structure that he needs.
2. Residential Treatment
    - Feedback: Incorrect. This is probably more than Mr. Williams needs. He experiences only moderate withdrawal symptoms, is medically stable, and does not have any other psychiatric symptoms. Mr. Williams can be treated in an intensive outpatient setting with ambulatory detoxification in coordination with his medical providers. He also needs an Intensive Outpatient setting to provide the additional support system and structure that he needs.
3. Intensive Outpatient Treatment
    - Feedback: Correct, this is probably the best choice. With moderate but not severe withdrawal symptoms, Mr. Williams can be treated in an intensive outpatient setting with ambulatory detoxification in coordination with his medical providers. He also needs an Intensive Outpatient setting to provide the additional support system and structure that he needs.
4. Outpatient Treatment

- Feedback: Incorrect. This would not provide sufficient structure and support for Mr. Williams. Mr. Williams can be treated in an intensive outpatient setting with ambulatory detoxification in coordination with his medical providers. He also needs an Intensive Outpatient setting to provide the additional support system and structure that he needs.

EVIDENCE-BASED COUNSELING FOR SUBSTANCE USE DISORDERS

Counseling is typically a part of any treatment program. A number of evidence-based treatment types have been shown to be effective for substance use disorders and may be a part of the treatment program to which you refer a patient. Alternatively, you may refer a patient who does not need that level of care directly for such counseling:

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is grounded in the theory that certain patterns of behavior and thoughts can contribute to the development and maintenance of substance use disorders.[8,25] Weekly individual sessions (usually lasting 12-24 weeks) teach patients to identify thought and behavior patterns through self-monitoring and to cope with them as they arise in order to decrease substance use.[8,25] CBT has been shown to increase the rate of long-term treatment success and improve mental health outcomes for those with co-occurring mental health disorders.[8,25]

Contingency Management and Community Reinforcement Approach

Contingency Management centers around tangible positive reinforcement for positive behavior change.[8,25] Positive behavior, such as participation in therapy sessions or having a negative urine drug test, is rewarded with vouchers that can be exchanged for desired objects, goods, or activities. Having a goal to work towards along with a tangible reward has been shown to be more effective than traditional treatment approaches in terms of longer abstinence and active engagement in treatment.

Community Reinforcement Approach (CRA) Plus Vouchers is an outpatient program that furthers the positive reinforcement approach by combining the voucher system with group therapy.[8,25] Group counseling sessions focus on how to reduce substance use and build support systems for long-term abstinence.[8,25]

Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) utilizes motivational interviewing techniques to support patients having uncertainty about ceasing substance use.[8,25] Patients develop awareness of how their actions and goals are misaligned, which

often increases the motivation to change their behaviors to meet their goals. MET uses empathy and support rather than confrontational tactics in order to promote change, which leads to self-efficacy in the patient and better long-term outcomes.

FURTHER EVIDENCE-BASED COUNSELING

Family Therapies

Family Therapies engage family members and friends to help support the patient's recovery and long-term abstinence. Different kinds of family therapies meet a variety of patient needs. Family Behavior Therapy (FBT) and Behavioral Couples Therapy (BCT) are most often used by adult patients.[8,25]

- **Family Behavior Therapy (FBT)** looks at not only the substance use but also surrounding family issues that may contribute, such as conflicts in the home or mental disorders in the family.[8,25] FBT helps the patient set goals, develop skills, eliminate or change factors that might prevent treatment success, and prepare both the patient and their social support system for treatment. Therapy can last up to 20 sessions.[8,25]
- **Behavioral Couples Therapy (BCT)** involves both the patient and their spouse. It includes the patient making a "daily sobriety contract" and the spouse supporting this commitment, giving the patient some accountability.[8,25] The couple also learns effective communication and how to become involved in positive social activities that are substance-free.[8,25]

Twelve-Step Facilitation Therapy

Twelve-Step Facilitation Therapy (TSF) uses individual therapy sessions to support becoming involved in a 12-step program.[8,25] It includes milestones of acceptance, surrender, and active involvement, similar to 12 step programs.

The Matrix Model

The Matrix Model combines multiple evidence-based practices (family and group therapy, relapse prevention, self-help, reduction of other risky behaviors, and drug education) in a coordinated, sequential approach.[8,25] The treatment centers around group therapy (3 times a week for 16 weeks) which promotes social support, individual counseling, cognitive behavior therapy, family education, and urine drug testing in order to achieve the patient's overall goal of abstinence.[8,25]

MEDICATION-ASSISTED TREATMENT

What is Medication-Assisted Treatment?

Individuals who are physically dependent may benefit from medication-assisted treatment in support of abstinence, and in some cases, detoxification. Medication-assisted treatment needs to be combined with psychosocial treatment in order to be effective. Medication-assisted treatment may be used at multiple treatment levels. The FDA has approved five medications for use in medication-assisted treatment (MAT) for alcohol and opioid use disorders:

- buprenorphine, with or without naloxone (opioid use disorder)
- methadone (opioid use disorder)
- naltrexone (alcohol and opioid use disorder)
- acamprosate (alcohol use disorder)
- disulfiram (alcohol use disorder)

Buprenorphine and Methadone. The first two medications, buprenorphine, and methadone can be used for the initial process of quitting opioids (first stage of treatment – detoxification) and help reduce the need for in-patient care at this stage.[26–28] Buprenorphine and methadone also help in managing the worst of the period of withdrawal from opioids by relieving withdrawal symptoms and psychological cravings. Buprenorphine and methadone work via the opioid receptors; the same ones responsible for problematic dependence on opioids.[29] They have weaker effects and/or have slower onset, so the individual does not feel "high" from taking them.

Naltrexone has a different mechanism, as it acts by blocking the receptors where opioids were having their effects (antagonist). By blocking the opioid receptors, the pleasant effects of opioids and alcohol are blocked.[8] Naltrexone is used to block alcohol cravings, but may not be effective at reducing opioid cravings.

Naltrexone is supplied as tablets to be taken daily or as an extended release injection.[8] The injection is more effective and can be given by an individual licensed and authorized to prescribe it by the state.

Acamprosate is used for alcohol maintenance.[8] It acts by normalizing the brain neurochemistry, reducing cravings.

Acamprosate is given as a delayed-release tablet, provided by prescription and is not a scheduled substance. It can be given by an individual licensed and authorized to prescribe it by the state

Disulfiram is used for alcohol maintenance.[8] It acts by creating metabolic products that cause a negative reaction and nausea, thus motivating the individual not to drink to avoid having this experience.

Disulfiram is given as a tablet and is not a scheduled substance.

These medications can be used to support long-term maintenance of being free from dependence on opioids (other than those being used in treatment) as they can be taken safely for years. Additionally, MAT has a higher rate of success than medication-free treatment. Whether or not medication-assisted treatment is chosen, however, psychosocial treatment is an important component of treatment and should be integrated into the overall treatment plan for your patients.

How Is the Treatment Chosen?

The provider and patient work together to select the best treatment considering:

- Whether the patient is open to taking a medication to assist with treatment, including an understanding of the physical dependence they will have on methadone or buprenorphine
- Efficacy, requirements/costs, side effects, and risks of each medication
- Patient preference among the choices
- Past experience with treatment

DUAL DIAGNOSIS

Co-Morbid Mental Health Problems and Substance Use Problems (Dual Diagnosis)

Comorbid mental health problems frequently are identified in conjunction with substance use disorders. This is often called "Dual Diagnosis." Inpatient settings are likely to manage dual diagnosis at the same time as the substance abuse treatment.

However, for patients with substance use problems that will be managed in primary care, such as a tobacco user or a person with mild to moderate alcohol abuse, referral for dual diagnosis is indicated. For example, an individual attempting to quit smoking or mild alcohol use disorder and who also suffers from anxiety or depression may benefit from counseling in addition to medical management of their substance problem.

Choosing which type of mental health professional for the referral depends upon multiple factors, such as:

- Need for medical management (psychiatry)

- Ability to pay/insurance coverage (a walk-in clinic is likely to cost less than a private therapist, for example).
- Areas of specialty (does the provider specialize in substance abuse issues?)

LOCATING ADDICTION AND SUBSTANCE USE COUNSELORS

Referral to Addiction Treatment

Treatment facility locations can be found online for resources such as employee assistance programs, behavioral health programs, local health departments, hospitals, and support group programs, such as 12 step programs. Some of the details that may be provided and that should be considered when selecting a treatment facility for a referral include the following:

- Type of treatment
- Patient age
- Location
- Hours
- Accessibility to public transportation
- Eligibility criteria
- Cost/insurance accepted
- Staff complement and qualifications
- Language proficiency
- Any religious orientation

If you need to compile a list yourself, the following resources are good first steps (see External Resources section):

- Substance Abuse Treatment Facility Locator – maintained by SAMHSA's Center for Substance Abuse Treatment
- AlcoholAnswers' Treatment Provider Locator – to find alcohol treatment specialists in your area
- American Society of Addiction Medicine Member Directory – Find ASAM certified providers in your area via their website.
- Support Groups – Keep a current list of various support groups meeting locations and times that can be given to the patient, such as 12 Step Groups. These can be obtained from local meeting sites or online.

Links to the above resources and more are provided in the External Resources section. Also, you can get referral information from employee assistance programs, local health departments, behavioral health program counselors, and local hospitals.

Treatment Locator Tools, such as the SAMHSA Locator Tool, can help you find addiction treatment providers in your area. Mentors are also available for consultation through NIDA's Physician Clinical Support System.

PRACTICE TIPS

Clinics and hospitals should maintain a list of local treatment providers where they can refer patients when a substance use problem is identified or suspected.

If you use the same local referral resource repeatedly, you will develop a positive working relationship, enhancing communication. You can visit the treatment source, personalizing the experience. This will also improve the likelihood of your patient coming back to your practice after treatment.

PATIENT EDUCATION AND MOTIVATION

Motivating the Patient to Follow Through:

1. **Schedule the appointment immediately.** If possible, schedule referral appointments to specialists and programs while the patient is in the office. Asking them to make the appointment themselves, in your presence, encourages the patient to start taking responsibility while at the same time provides support. Support the patient by providing the name and phone number, and a phone if necessary. Easing the patient's ability to request specialized treatment will increase their likelihood of following through with a referral.
2. **Provide encouragement.** It is important to encourage patients to comply with treatment, especially when referring them to other treatment facilities, in order to raise the likelihood that the patient will follow through with the intended treatment plan.
3. **Provide information about the treatment program.** Being informed about the prospective treatment program is likely to reduce a patient's anxiety about it. Let them know what to expect. For instance, among self-help group referrals,

providing both extensive information about the group and having contact information for a volunteer mentor available improves both attendance and treatment outcomes.[30]

4. **Follow up and repeat referrals as needed.** It is important to follow-up with the patient to make sure the referral was successful. The patient may require multiple referrals to find a treatment format with which they feel comfortable. For instance, comfort with a particular psychosocial approach may vary with psychiatric stability, polysubstance abuse, co-morbid medical disorders, age, and pregnancy status.

PRACTICE TIP

To ease a referred patient's anxiety about what to expect in a treatment program, provide some patient education materials about topics such as:

- Substance abuse treatment
- Information about how a particular treatment works
- What treatment entails
- Benefits of treatment and recovery

KEY POINTS

Help the patient follow through with a referral by:

- Making the appointment for them or having them make it while they are in your office
- Providing information about the program
- Providing encouragement
- Following-up to make sure the referral was successful

VIDEO: BRINGING UP THE NEED FOR REFERRAL BASED ON SCREENING RESULTS

Video: The video "SBIRT Brief Intervention for Preparation Stage, High-Risk Client".[31] which illustrates a patient having high risk for substance use problems in a fairly early stage of change, can be found here: https://www.youtube.com/watch?v=SfFF7jcm3t

The video shows a provider talking with a client who is in the high-risk category but only in the preparation stage, meaning he knows he has a problem but needs help finding treatment. He needs a referral for treatment. The provider completes the following steps:

1. Explains the significance of the patient's test results, and elicits his response to hearing these results, and responds with reflective listening.
2. Assesses and labels the patient's stage of change.
3. Explains to the patient that he needs treatment and offers to make a referral

TALKING TO PATIENTS ABOUT REFERRAL TO AN ADDICTION SPECIALIST

Talking Points

Some patients will resist discussing or deny having substance use problems. However, if you suspect substance use disorders and referral to addiction treatment is warranted, then you must discuss the issues with the patient. Explain to patients and their significant others that:

- Addiction is a treatable chronic disease
- You want to give them the best treatment and so you are referring them to a specialist much like you would for other chronic diseases
- When stabilized, patients may return to the primary care provider for on-going care, while the addiction specialist can continue to provide the addiction treatment

Skillful, empathetic interviewing is key. Sensitive approaches can reduce resistance.

Interview Techniques

- Use the "Ask-Tell-Ask" approach:
    1. **Ask** permission to discuss something with them
    2. **Tell** them your concerns
    3. **Ask** what they thought about what you said
- Explain that you need to discuss tobacco/alcohol/drug use because you are concerned about their health and explain why you are recommending a referral. Point out the direct relationship between their substance use and health/social consequences.

- Provide as much information as possible about the provider/clinic where you are referring the patient. If you speak with confidence and knowledge about the treatment center, patients are more likely to respond positively.
- Maintain the patient's privacy. Conduct the interview in private and do not bring up the substance use disorder or referral around others without the patient's permission.

Using "Warm" Techniques for Referral

A "warm hand-off" or "warm referral" is a referral strategy in which the primary care provider directly introduces the patient to the substance abuse treatment provider that they will be working with. This process can further help build rapport and trust between the primary care provider and patient, by establishing the presence of prior communications and relationships between the provider and treatment center.

Introducing patients personally, or via telephone, to their treatment provider can also increase the likelihood that appointments will be met by patients.[32]

MRS. CAPELLO TREATMENT REASONS

Question: Having decided to refer Mrs. Capello for intensive outpatient treatment, what might you say to bring up the topic or explain your reasons?
SUGGESTED ANSWER: See dialogue on next page for a suggested approach.

TALKING TO MRS. CAPELLO

The following dialogue is an example of how to give a patient a warm referral, which makes sure that she goes from the connection you have built up to a direct connection with another individual at the treating institution, with no intervening time period with a lack of support.

Provider: *With the severity of your alcohol use* disorder, *and use of sedatives complicating things, I feel it's time for specialty treatment. Can we talk about that possibility?*

Mrs. Capello: *I agree I'm addicted to alcohol, and I need help, but I just can't afford to be away from my job right now.*

Provider: *The intensive outpatient treatment fits your situation. I think you'll benefit from the support they provide. You may have to adjust your work schedule somewhat, but with the support you have from your family, that may work out. The important thing is to get the treatment you need.*

Mrs. Capello: *All right. I'm ready to do what is needed.*

Provider: *I know of a treatment facility close to your home that takes your insurance. I'd be happy to set up an appointment and introduce you to them to see if they are a good match for your needs. [Warm-Referral] How does that sound?*

Mrs. Capello: *I'd like to hear more about it.*

THE REFERRAL

Investigating potential treatment providers. Ask about:

- Services offered
- Philosophy toward treatment
- Insurance accepted or if there are publicly funded programs

Establishing an office protocol for referrals. Have a clear, standard, complete protocol in place for referral and make all staff aware of it. It should include the following:

- How the referral is made
- Who makes the referral call
- When and where in the appointment flow is the referral call made
- How the need for a referral is communicated to the person making the call
- If referral calls are delegated to staff, what training they must have
- What type of follow-up is needed with both the potential provider and patient, who will do it and when

Contacting potential treatment provider. When contacting a potential provider, there are multiple options:

- The provider or a staff member can make the initial call for the patient in the patient's presence.
- The provider may ask the patient to come into the provider's office, following the examination, to discuss the referral and make the referral call.

- To start the patient taking self-responsibility, the patient can be asked to make the phone call while still in the clinic.
- Alternatively, staff may be trained in working with the patient to contact the potential treatment provider. Training must include information on potential treatment providers, how to make the referral, and how to follow-up. The patient encounter record used to communicate with staff should clearly identify the need for the referral.

Making the call immediately takes advantage of the momentum of the motivational interviewing and provides the opportunity to support the patient.

Referral letter. Send a referral letter to the specialist before the patient's first visit.

Follow-up communications. Request that the treating party communicate with the referring provider after the patient's assessment, or if the patient misses the appointment. Follow-up with the patient to make sure that they follow through with the referral.[6]

MAKE A COMPLETE REFERRAL

Patients are not likely to follow up themselves if you just say, "You really should consider treatment."

QUIZ: MRS. CAPELLO – FOLLOW THROUGH

Read the following case information and dialogue and answer the question afterward.

Provider: *This program will treat you with a medication that will decrease your symptoms while you withdraw from alcohol, and they also will provide some counseling and some group support to help you through your recovery [Patient Education]. Do you have any questions?*

Mrs. Capello: *That's pretty clear, but I just don't know if it will help me or not.*

Provider: *I've seen this program work for many people like yourself. I encourage you to take this step now [Encouragement].*

Mrs. Capello: *Oh, all right...I suppose I'll do it.*

Provider: *I can call the treatment center to let you speak with a counselor and schedule an appointment right now [Warm-Referral]. Does that sound like something you'd be interested in?*

Mrs. Capello: *That would be nice. Thank you.*

Provider: *Great! After your first appointment, we'll call you to find out how it goes, because it's so important for you to take this step [Follow-up].*

Reimbursement: Mrs. Capello's counseling today took 25 minutes and so the provider filled out the billing information with a CPT code of 99408, which is *Alcohol and/or substance use disorder structured screening and brief intervention services; 15 to 30 minutes*. Before Mrs. Capello leaves, the provider reviews her paperwork to make sure it includes the permission necessary to communicate with a counseling therapist she has seen in the past.

Question: Which of the following communications can take place without specific patient permission?

Choose one

1. Her mental health status to the therapist.
    - Feedback: Incorrect. HIPAA laws provide privacy protection for her mental health status.
2. Her level of alcohol dependency to the therapist
    - Feedback: Incorrect. HIPAA laws provide privacy protection for her substance misuse.
3. Public health disclosures to public health officials and law enforcement officials under some specific circumstances.
    - Feedback: Correct! These two circumstances may be an exception to the privacy rule if 1) the public health information is anonymous and 2) for law officials there are certain life-threatening circumstances or certain other serious circumstances.
4. None of the above are situations in which Mrs. Capello's information can be given out without her written permission.
    - Feedback: This is almost correct, except that public health information may be disclosed to public health officials anonymously and information may be disclosed to law enforcement officials without written permission in certain life-threatening or other serious specific circumstances.

PRIVACY ISSUES

The Health Insurance Portability and Accountability Act (HIPAA)

In 1996, the first HIPAA regulations were enacted.[33] They were set forth to standardize electronic data communication, thereby improving healthcare efficiency. The *Standards For Privacy of Individually Identifiable Health Information*, referred to as the Privacy Rule, was added in 2003. It protects any identifiable health information about an individual, including:

- Photographs,
- Birth dates,
- Social security numbers
- Phone numbers

Following the requirements of this rule, health care providers must obtain patient authorization before disclosing "protected health information" (PHI), apart from the following exceptions:

- Disclosures required to public health officials and law enforcement officials (only in certain life-threatening circumstances and certain other serious circumstances).
- Disclosures to family or others involved in the patient's medical treatment *unless the patient specifically objects*
- Operations (eg., quality improvement, notification of appointments)
- Treatment
- Payment

Implications for Substance Use Programs

As patients are receiving treatment for substance abuse, they must share very personal information, which may make them wary. To alleviate this concern, federal regulations (Title 42, Section 290dd-3 and ee-3 of the U.S. Code) mandate strict confidentiality for information about patients being treated for substance use disorders. Disclosure of this information is prohibited without the written consent of the patient. The HIPAA laws also provide privacy protection for patients with psychiatric disorders, which are often comorbid with substance use disorders.[34]

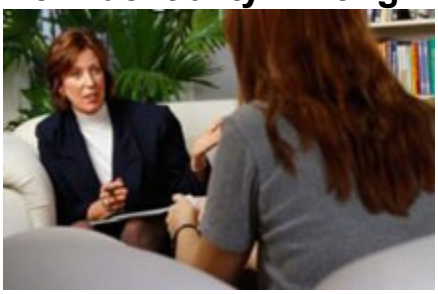
Privacy Issues in Multidisciplinary Care

Maintaining privacy while treating patients for substance use disorders can get complicated when coordinating care with multiple providers. Review SAMHSA's frequently asked questions document on *Applying the Substance Abuse*

Confidentiality Regulations to Health Information Exchange (HIE) for more on the topic.

PRIVACY CONSIDERATIONS WHEN TREATING ADOLESCENTS

Confidentiality Among Adolescents



Confidentiality is especially important when treating adolescents, as they are more likely, to be honest during medical treatment if they know their privacy will be respected. This assurance also makes them more likely to seek treatment in the first place. In addition, when adolescents are allowed their privacy when making health decisions, it helps them establish autonomy.[35]

Medical associations that support confidential health care for adolescents include the:

- American Medical Association,
- Society for Adolescent Medicine, and
- American Academy of Pediatrics.[36]

Obtaining consent from a minor is the same process as obtaining consent from an adult.[36] The safety of a minor outweighs his or her right to privacy[37] and it is your job to determine whether the minor is capable of providing informed consent or if parental involvement is required, as well as how that parental involvement might impact treatment.[36]

State Level

Most states protect the adolescent's confidentiality related to treatment for substance use disorders.[37] Because these laws can vary by location, you should become familiar with the laws of the state in which you practice.

PRACTICE TIP

Be sure to review current federal and laws regarding the treatment of adolescents.

FOLLOW-UP AFTER REFERRALS

Early Follow-Up

It is important to make sure the patient followed through on a referral. Some patients require a lot of support and multiple motivating interventions before they will get the treatment you recommend.

The treating facility is likely to provide a reminder phone call and possibly call if the patient misses an appointment. The referring provider's office can also support the patient by calling to ask whether they kept the referral appointment and how it went.

Many patients get discouraged after learning a treatment will not work for them, or if their insurance was not accepted. They may not even think to call and ask you for another referral. Also, be sure to ask about their progress at the next appointment. If the patient is not interested in another referral, use further brief interventions to encourage them to get treatment.

View a sample communication from the specialist back to the referring provider:

Example of a letter from a specialist back to the referring provider

Later Follow-Up

Re-assess patients who previously participated in treatment:

1. Review patient history and past treatment approaches, attempts, and outcome
2. Screen for current substance use problems
3. Test for drugs in bodily fluids and other laboratory tests when appropriate
4. Discuss relapse using non-judgmental attitude

FOLLOW-UP FOR MRS. CAPELLO

Here is an example of dialogue that could take place during a follow-up contact.

Provider: *(over the phone) Hi, Mrs. Capello, this is Anna from Dr. Green's office. We wanted to check on how your treatment at "Substance Use Disorder Treatment Center" is going.*

Mrs. Capello: *Thanks for calling. I had an interview and intake appointment. I start treatment next Tuesday.*

Provider: *That's great! You've made an important first step! We encourage you to keep going and give the full treatment program a chance to work. I'll see you at your next appointment [specify date].*

Mrs. Capello: *All right. Thanks for calling.*

COORDINATING CARE AFTER REFERRAL

Importance of Ongoing Communication with the Specialist

Primary care providers can act as the patient's medical home, coordinating care with specialists, as well as being a source for referrals. While it may take additional time, the benefits are worth the effort (for example, in terms of reduced problem drug interactions and fewer redundant treatment processes).[38]

After Referral

Steps to take after referral include:

- Become familiar with the addiction treatment plan.
- Establish an agreement between members of the treatment team that describes the care each will provide.
    - Develop common goals and a shared understanding of roles.
    - Prevent role confusion and conflict through clear, proactive communication.

    - Be clear about: Who is my patient? Who is our patient? Who is your patient?
- Develop a protocol for maintaining effective, ongoing, two-way communication.
- Check to make sure that follow-up messages are received from the specialist.
- Share the decision making. Disagreements on treatment need to be identified and openly discussed with a goal of consensus.[38]
- Continually share information with other healthcare providers throughout the patient's treatment.
- Conduct a periodic review of the co-management process.

After Treatment

It is difficult for substance abuse treatment providers to keep in touch with their clients after discharge, so primary care providers play an important role as part of a patient's aftercare program.

Primary care can support continued recovery by continuing to provide screening, assessment, support, and encouragement as well as referrals for return to treatment as needed.

VA/DOD Practice Pocket Guidelines

The VA/Department of Defense has created a comprehensive guideline for treating substance use disorders. Excellent clinician pocket guides that summarize much of what has been presented here on this subject and many further details are available free-of-charge in the Provider Summary, Screening, and Treatment, and Stabilization pocket guides available in the External Resources section.

MODULE SUMMARY

Here is a summary of **recommended** skills, organized by core competencies:

Provide patient-centered care

- Use the communication skills learned for brief interventions including using a patient-centered approach, for example, providing information, encouragement, and empathy.
- Help motivate the patient to follow through with a referral to treatment for substance use disorder by
    1. Scheduling the referral appointment for them while they are in your office
    2. Providing encouragement

3. Educating the patient about how the treatment program works and its benefits

- It is important to be familiar with how HIPAA relates to substance use issues and to know the applicable exceptions. Further restrictions are in place with respect to health information exchange systems.
- Some patients may benefit from an addiction treatment center that addresses the needs of special populations, such as centers that speak a particular language or that focus on specific age groups.
- Follow up after making a referral is essential in order to help keep patients motivated to follow-through, to learn the current status of the special treatment, and to learn whether a different referral is needed. Make repeat referrals as needed.

Work in interdisciplinary teams

- Consider the level of treatment the patient needs: residential or inpatient treatment, outpatient treatment, and/or local support groups.
- Referrals may be needed for both medical/detoxification and psychosocial needs. Counseling is typically included in treatment programs, but patients needing a lower level of care may be referred directly to substance use counseling.

Employ evidence-based practice

- Referral to specialty treatment is indicated for patients with severe or complicated substance use problems, high risk of substance use problems, or comorbidities when these are beyond your training level or the resources of your practice. Referral is also indicated when brief interventions (and brief treatment) have not been effective.
- Cognitive behavior therapy and group-based approaches are the most commonly used with the best evidence for effectiveness in treatment of substance use disorders.
- Comorbid mental health problems and substance use disorders are called "dual diagnosis" and increases the need for specialty referral. These patients need to have both their mental health and substance use disorders treated. Whether to refer patients with psychosocial issues for medical management (psychiatry) and/or counseling (psychologists, substance abuse counselor, licensed clinical social workers, etc.) should be considered.

- Make a referral in every instance that it is indicated, because patients do not tend to self-refer. If you do not make the referral, treatment is not likely to happen.
- Follow up through supportive phone calls and a scheduled appointment will likely increase the effectiveness of brief interventions and referrals.
- Send the patient's medical history and a letter of referral *before* the patient's first visit to the specialist.

EXTERNAL RESOURCES:

- Alcohol Answers Treatment Provider Locator

Provides a directory of alcohol treatment specialists.

- Alcoholics Anonymous Meeting Locator

Provides a directory of AA chapters.

- American Society of Addiction Medicine (ASAM) Member Directory

This is the American Society of Addiction Medicine's member directory which allows users to search by physician first name, last name, city, state, and specialty to find ASAM certified providers.

- Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange

Issues involved in applying the Substance Abuse Confidentiality Regulations to Health Information Exchange

- Celebrate Recovery

A faith-based recovery group with meetings available nationally.

- Life Ring Recovery Groups

LifeRing is a network of support groups for people who want to live free of alcohol and other addictive drugs. Supports treatment that is matched to the needs of the individual. Meetings work through positive social reinforcement.

- Narcotics Anonymous Meeting Locator

Based on area code, this website provides websites and locations for NA meetings.

- NIAAA Clinician's Guide: Helping Patients Who Drink Too Much

This Guide is written for primary care and mental health clinicians. It has been produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a component of the National Institutes of Health, with guidance from physicians, nurses, advanced practice nurses, physician assistants, and clinical researchers.

- NIDA Quick Screen – Online

The NIDA quick screen is an online screening tool for substance abuse filled out by the patient. Based on the patient's responses, it generates a substance involvement score that suggests the level of intervention needed. This is the short, online version of the longer screening tool, the NIDA Modified ASSIST.

- NM ASSIST

NM ASSIST Questionnaire

- Principles of Drug Addiction Treatment: A Research Based Guide

Includes answers to FAQs regarding drug addiction treatment.

- Rational Recovery

An addiction recovery support group network that is an alternative to 12-step programs.

- REFERRAL FORM

Referral form for sending information to specialists in substance abuse treatment.

- SAMHSA Substance Use Disorders

SAMHSA's breakdown on changes to substance-related addictive disorder diagnoses introduced by DSM-5.

- State Policies on Minors' Rights and Consent

Minors' Right to Consent to Health Care and to Make Other Important Decisions

- Substance Abuse Treatment Facility Locator

Searchable directory of drug and alcohol treatment programs. Includes more than 11,000 addiction treatment programs for marijuana, cocaine, heroin, and alcohol.

- Substance Use Disorders: A Guide to the Use of Language

A guide for using non-stigmatizing language when working with patients who have substance use disorders.

- Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians

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PEDIATRICS Vol. 128 No. 5 November 2011, pp. e1330-e1340
(doi:10.1542/peds.2011-1754)

- The ASAM Criteria

Described on the ASAM website as, "the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

- The ASAM National Practice Guideline

This document describes the 2015 ASAM assessment and pharmacological treatment options for patients with opioid use disorder.

- VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Screening and Treatment Pocket Card

A reference tool used to provide clinicians with screening and treatment resources for substance use disorder within active duty and veteran populations, including resources on brief interventions and pharmacological treatment.

- VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders Stabilization Pocket Card

A reference tool used to provide clinicians with stabilization resources for substance use disorder within active duty and veteran populations, including resources on pharmacological treatment and substance titration.

- VA/DoD Management of Substance Use Disorders

This Clinical Practice Guideline is intended to provide primary care clinicians and other healthcare providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with substance use disorders (SUD), leading to improved clinical outcomes. (From the website.)

- Women for Sobriety

Women For Sobriety, Inc. is a non-profit organization dedicated to helping women overcome alcoholism and other addictions (From their Website).

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