Addressing Substance Use Disorder and Opioid Use Disorder in Family Medicine and Primary Care

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Learning Objectives
By the end of this training, trainees will be able to:

1. Describe the state of substance use disorder (SUD) and opioid use disorder (OUD) in the United States and Pennsylvania;

2. Explain why it is important for primary care and family medicine physicians to play a role in patient care for individuals with harmful substance use;

3. Differentiate between the stages of addiction;

4. Recognize common signs of addiction and SUD/OUD; and

5. Identify the components of screening, brief intervention and referral to treatment (SBIRT) and motivational interviewing.

Substance and Opioid Use Disorders in Primary Care

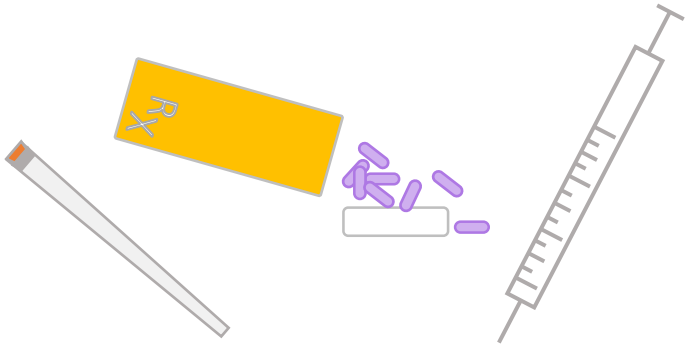
Primary care providers are an essential touch point for identifying individuals with SUD due to their ongoing relationships with their patients.[1]

About **80%** of the population visits a primary care provider each year.[1]

There is a high prevalence of SUD in the United states. In 2017...

15.1 million people had an alcohol use disorder.[2]

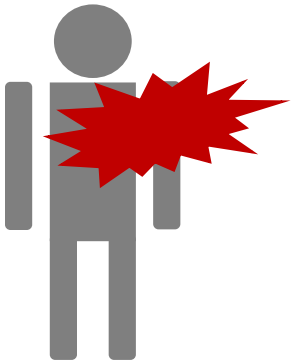
7.4 million people reported an illicit drug use disorder.[2]



SUDs continue to be **under reported and under treated**.

20% of family medicine patients **have an SUD**; however **SUD diagnoses** make up only **0.9%** of family medicine visits.[3,4]

But SUDs are associated with a number of other conditions.[5,6]

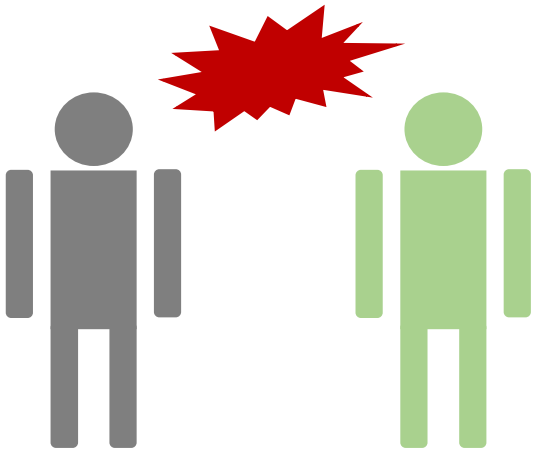


Physical Effects

- Cancer
- Hepatic disorders
- Infectious diseases
- Cardiovascular diseases
- Gastrointestinal disorders
- Lung Disease

Mental Effects

- Memory loss (can affect things like medication adherence)
- Depression
- Anxiety
- Irritability
- Mood swings



Social Effects

- Trouble maintaining healthy relationships
- Unemployment
- Criminal offenses
- Financial difficulties

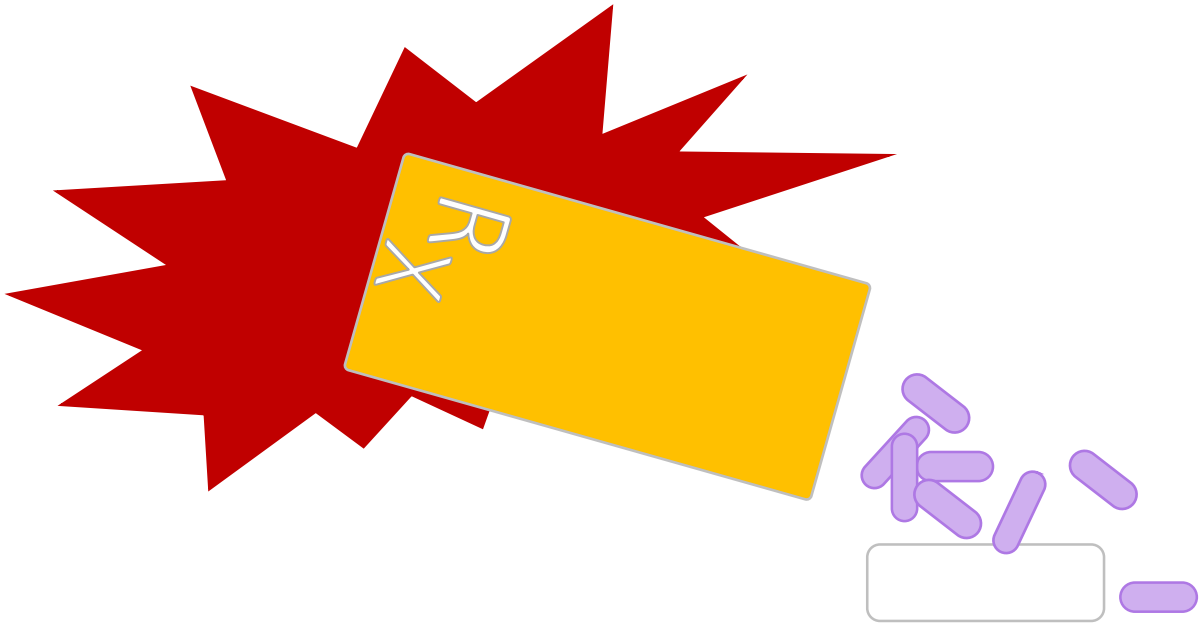
Thousands of Pennsylvanians do not receive treatment for their SUDs:

- In 2013-2014, **853,000** Pennsylvanians had alcohol or illicit drug dependence or misuse in the past year.[7]

- **95%** of those with alcohol dependence or misuse did not receive needed treatment.[7]
- **84%** of those with illicit drug dependence or misuse did not receive needed treatment.[7]

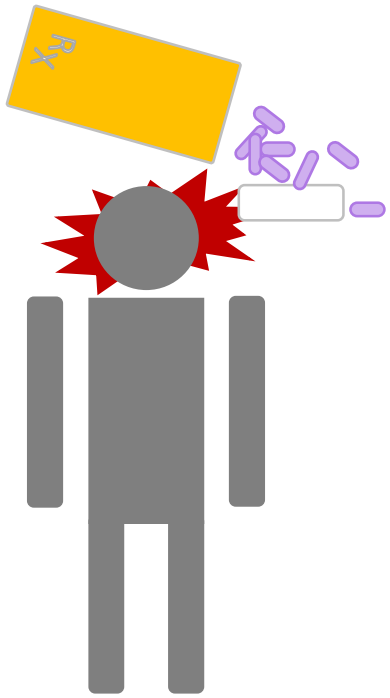
OUDs are the fastest growing form of SUD.[8]

There has been a **900%** increase in individuals seeking treatment for opioid pain reliever addiction from 1997 to 2011.[9]



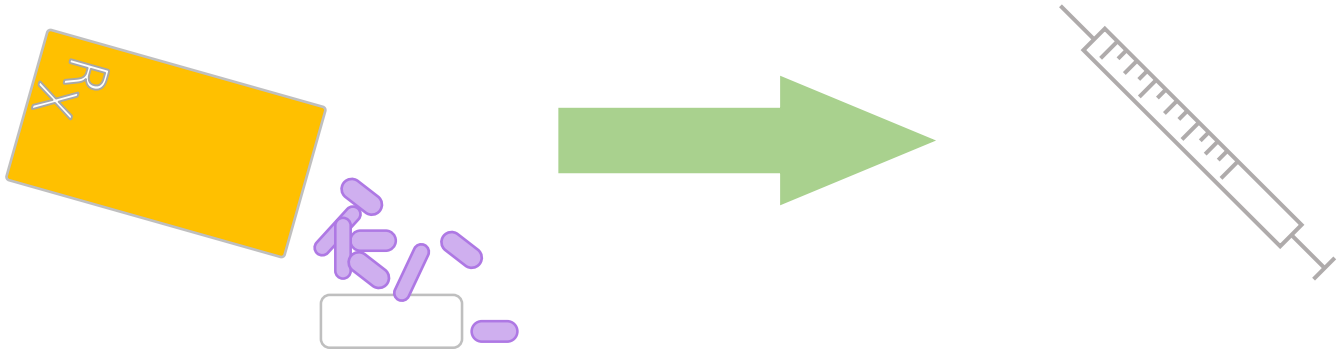
The use of pain medications can contribute to an increased risk for OUD.

About **22% of primary care** patients report persisting pain that lasts longer than six months and affects multiple life functions. Many of these patients are treated with opioid therapy.[10]



The prescription opioid problem contributes to the growing use of heroin.

- **50%-70%** of heroin users begin opioid use with prescription opioids.[11]
- Most heroin users are now older, white men and women living in non-urban areas who were **introduced to opioids with prescription drugs and use heroin as a cheaper, more accessible alternative.**[12]



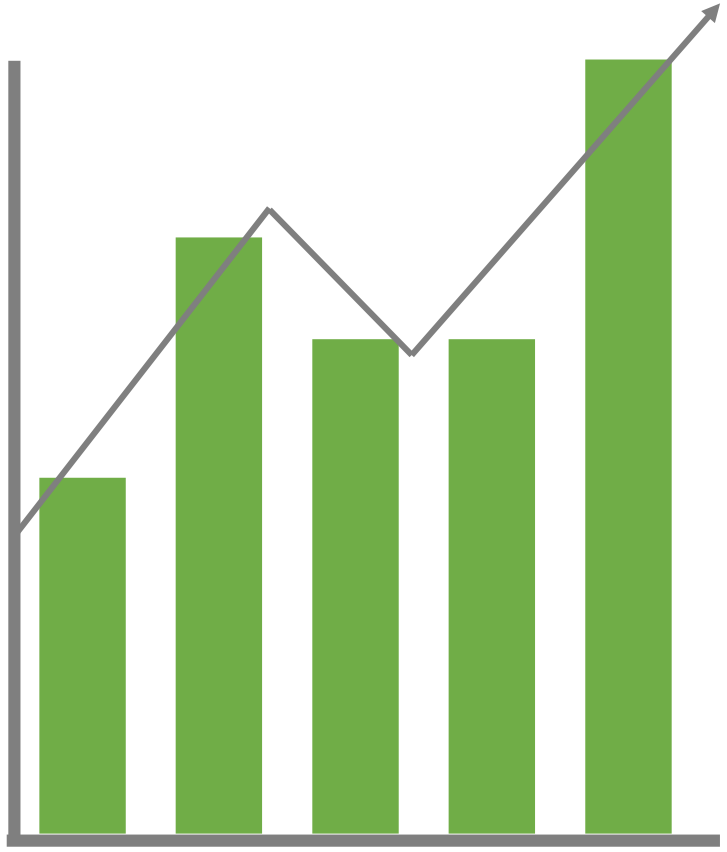
Even though most heroin users are older, opioid use is increasing among **younger individuals**.

- **50% of young heroin users** have previously misused prescription opioids.[11]

- Opioid first use is occurring at younger ages, and young individuals **(18-25 years old) have the highest rates of prescription opioid misuse.[13]**

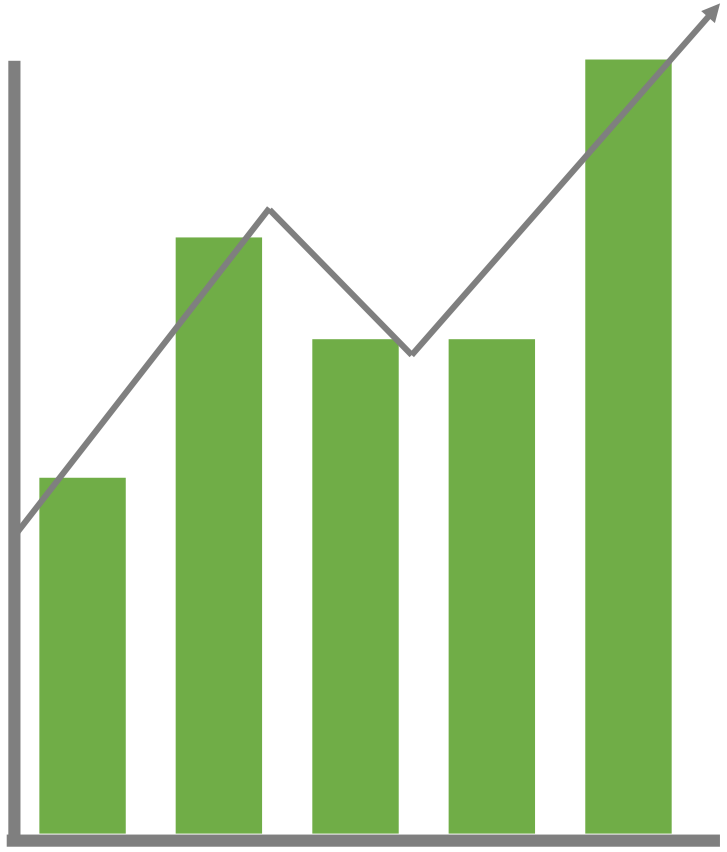
There are high rates of overdoses related to opioid use in PA.

- There are an average of **13.1 drug related overdose deaths per 100,000** people in Elk, Clearfield, and Jefferson counties.[14]



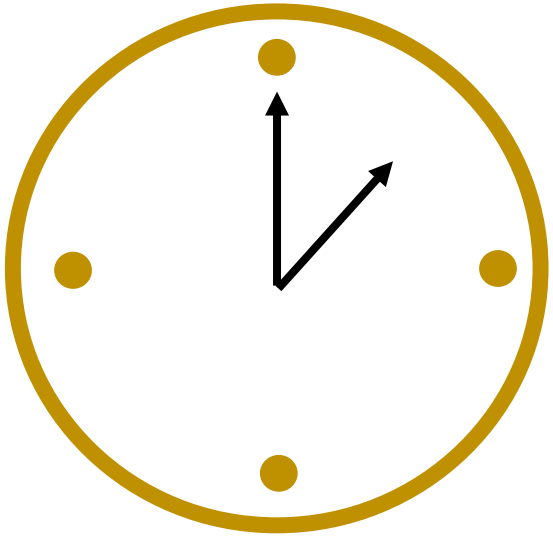
There are high rates of overdoses related to opioid use in Pennsylvania (cont'd).

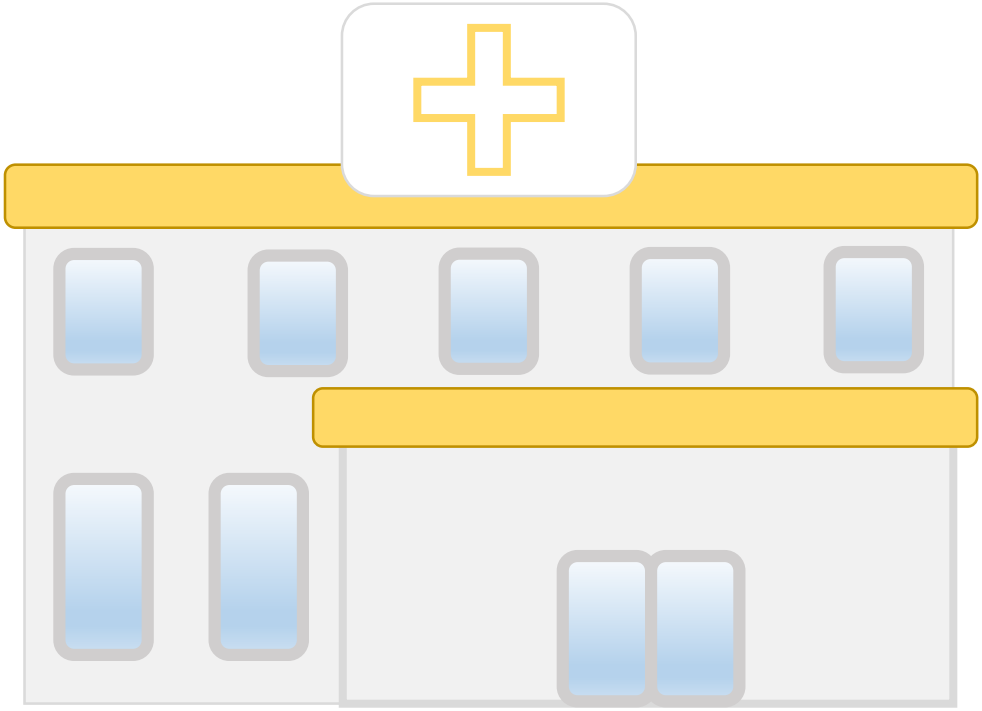
- Prescription opioids and heroin were most frequently reported as the cause of death, affecting mostly **white females and males aged 25-54.**[14]



It is important to think and treat SUD/OUD as a **chronic disease**.[15,16]

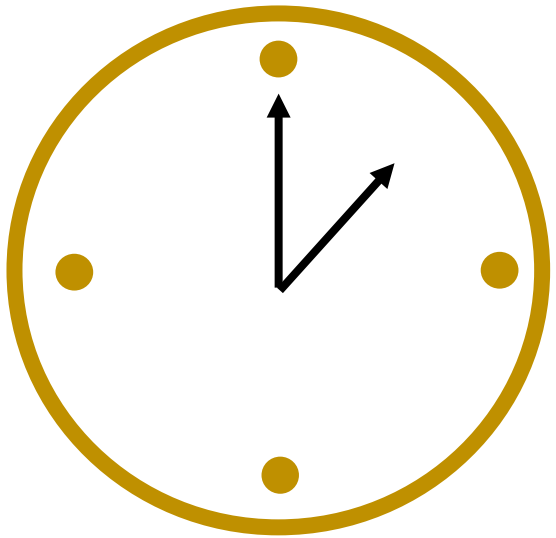
Like many chronic diseases, SUDs can be successfully treated.[15,16]





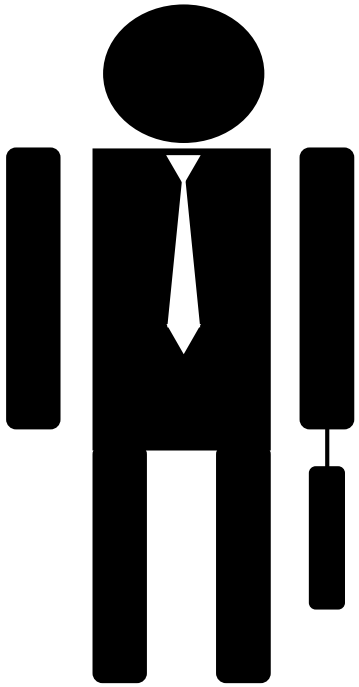
Individuals with SUDs are **more compliant** with treatment than individuals with other chronic diseases.[15]

- **40%-60%** of patients remain abstinent one year after discharge from treatment.[15]
- After five years, the recovery rate is **86%.**[16]
- Relapse rates for hypertension and asthma are **10%-70%.**[15]



Treatment has other **social benefits**.

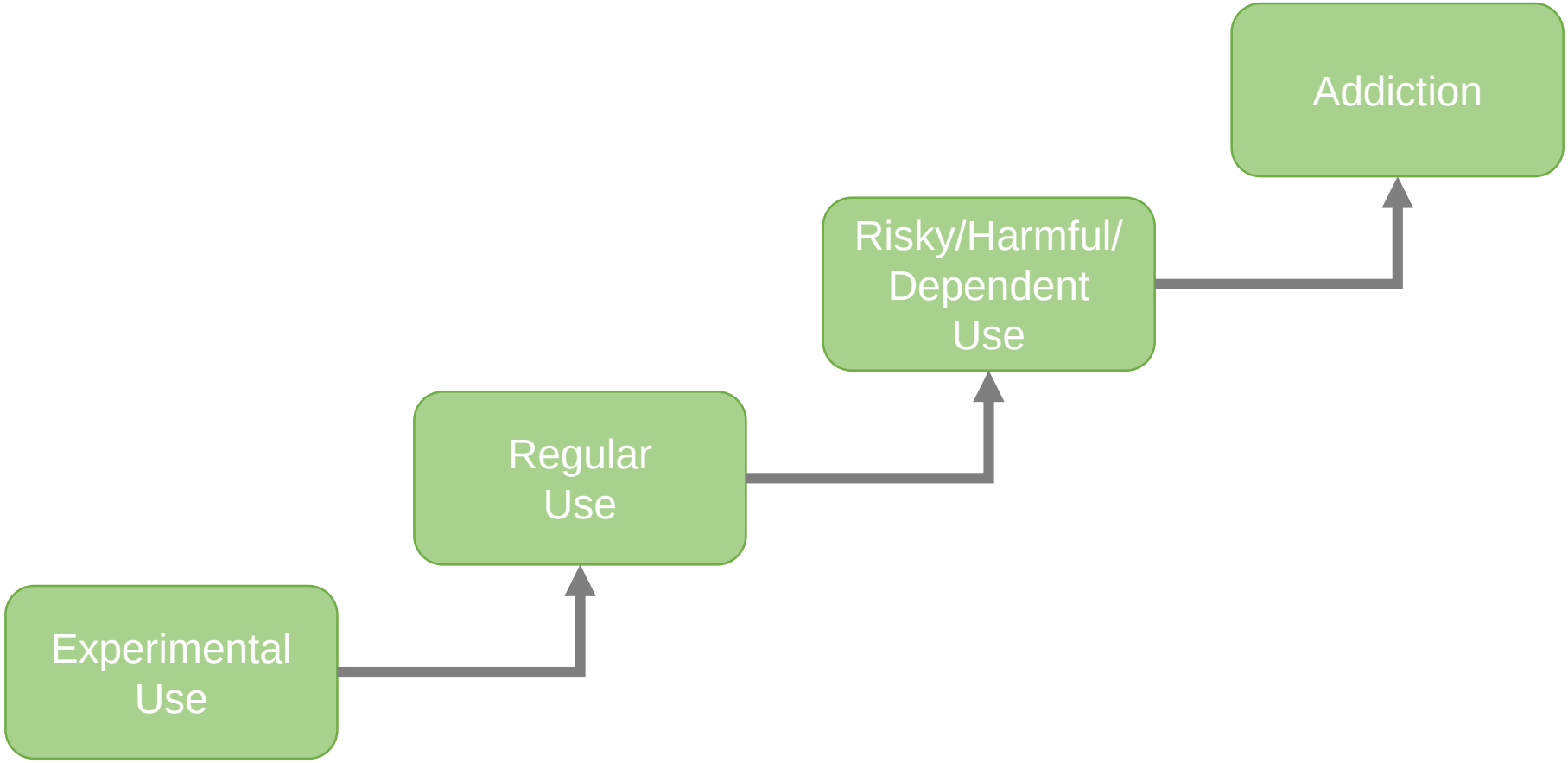
- Crime reduction of **40%-50%.**[17]
- Improvement in **employment rate by 40%.**[17]



Overview of Addiction

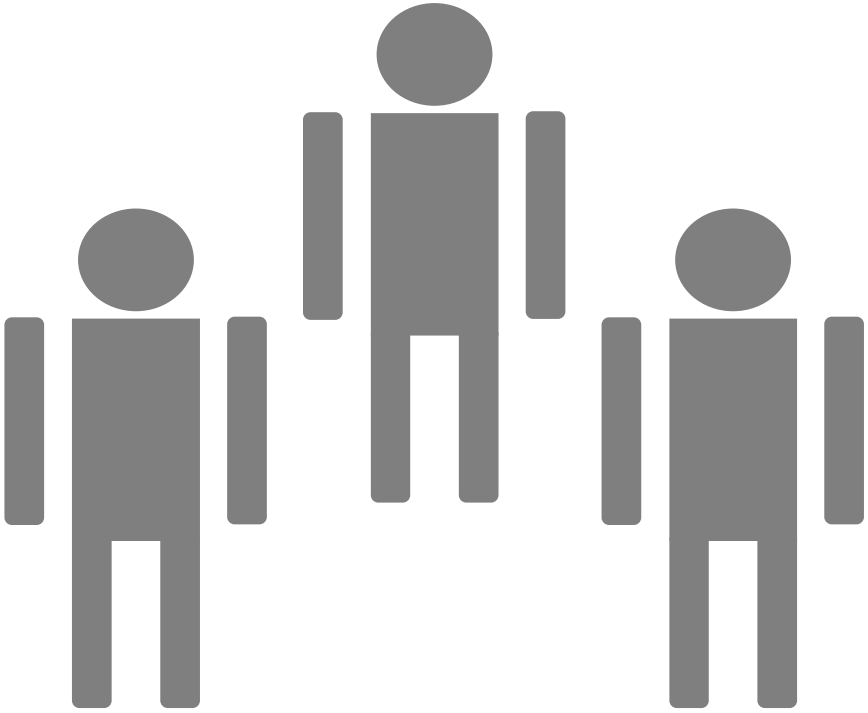
Next, we will review the **stages of drug use that lead to addiction.**

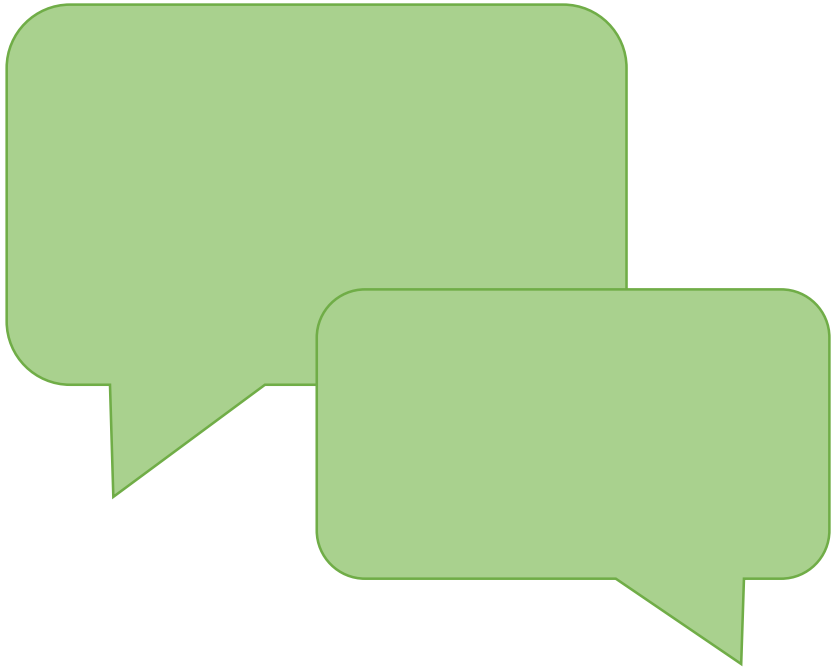
Addiction is the outcome of progressive drug use, each stage increases the individual's risk for harmful consequences.[18]



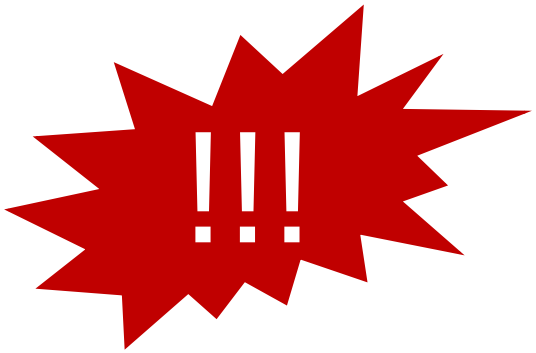
RAMP

The first stage of addiction is **initial or experimental use** categorized by recreational use influenced by peers.[18]

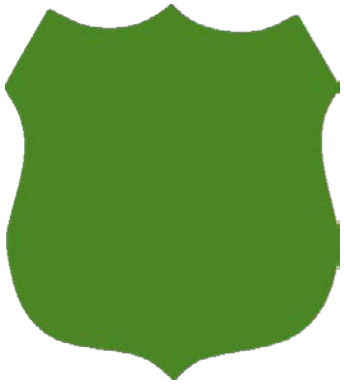




Initial use is influenced by **risk and protective factors**, which can be broken down into different life domains.[19]



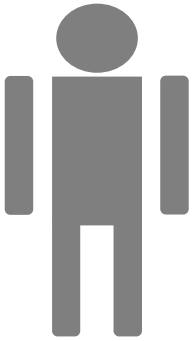
Risk Factors



Protective Factors

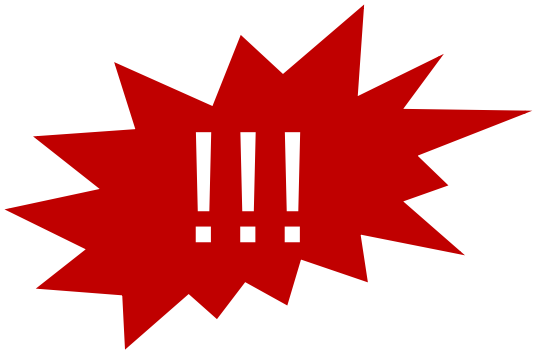
First, are **Individual** factors.[20]

Individual Factors



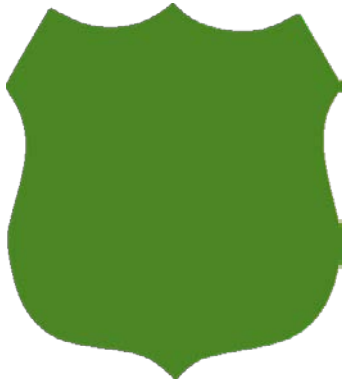
- Biological disposition
- Attitudes
- Values
- Knowledge
- Skills
- Problem behaviors

Risk Factors



- Genetic variability
- Low self-esteem
- Alienation
- Low involvement in recreational, social, and cultural activities

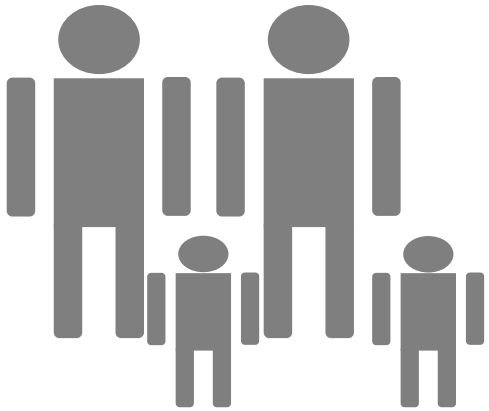
Protective Factors



- Negative attitudes toward substance use
- Sense of well-being
- Positive future plans
- Bonding to pro-social culture

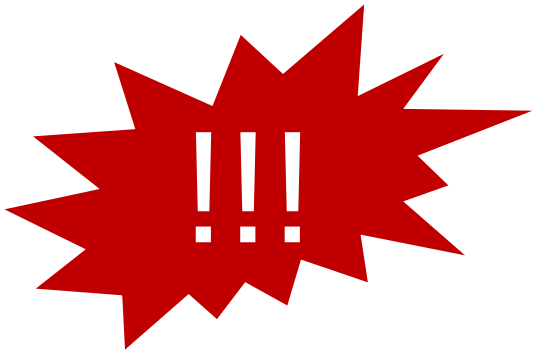
Next, there are **Family** factors.[20]

Family Factors



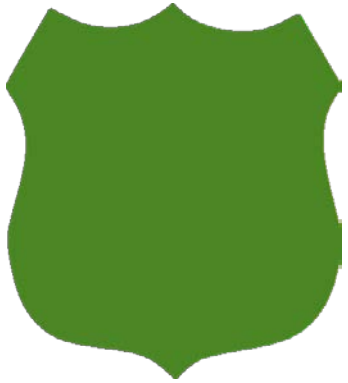
- Family function
- Family management
- Bonding

Risk Factors



- Family history of SUD
- Family conflict
- Abuse
- Loss of employment

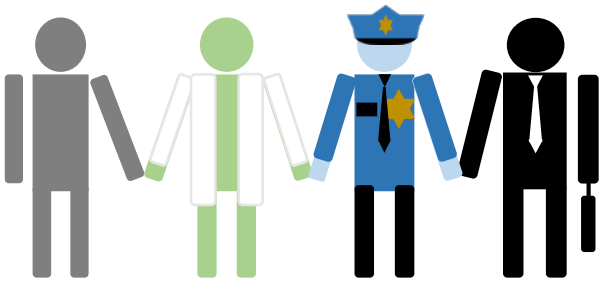
Protective Factors



- Close family relationships
- Shared family relationships
- Supportive family members

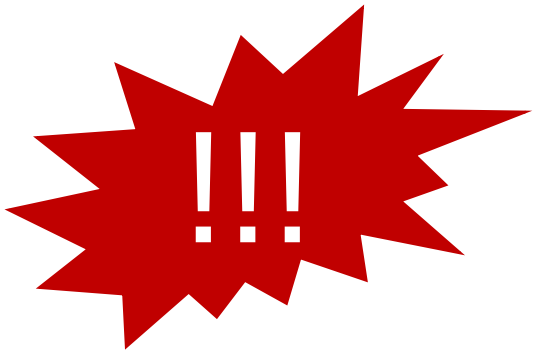
Finally, there are **Community** factors.[20]

Community Factors



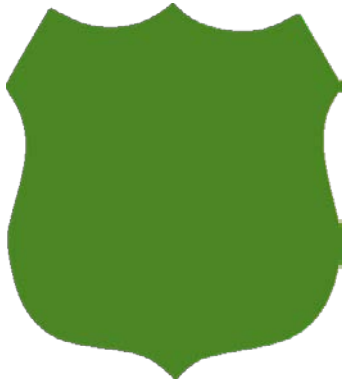
- Bonding
- Norms
- Resources
- Policy

Risk Factors



- Readily available drugs
- Lack of connection to community
- High unemployment
- Unclear norms or laws

Protective Factors

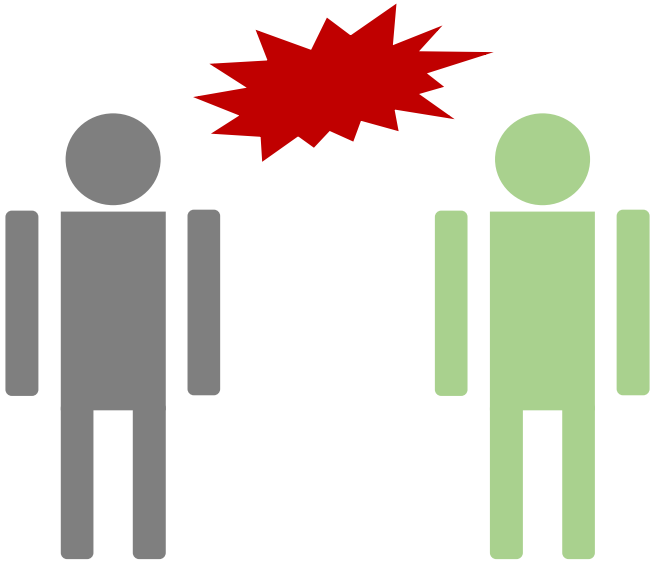


- Community resources are readily available
- Laws are clear and consistently enforced
- Norms discourage drug use

The next stage involves **regular use** in which the individual uses drugs to fix negative feelings.[18]

It is characterized by:

- Increased drug tolerance;
- Isolation from friends and family; and
- Increased friendships with other drug users.



After regular use, drug use becomes **risky and dependent**.[18]

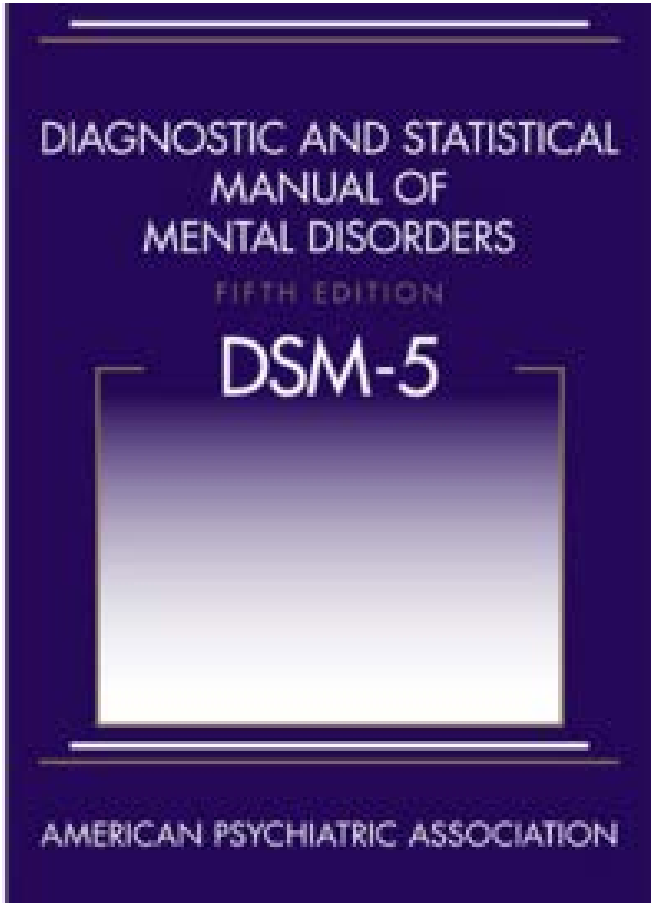
It is characterized by:

- Obvious behavior changes;
- Considering drugs to be more important than other interests; and
- Loss of motivation.

Lastly, in the addiction stage, one has **lost control over his/her drug use** and cannot engage in day-to-day life without drugs.[18]

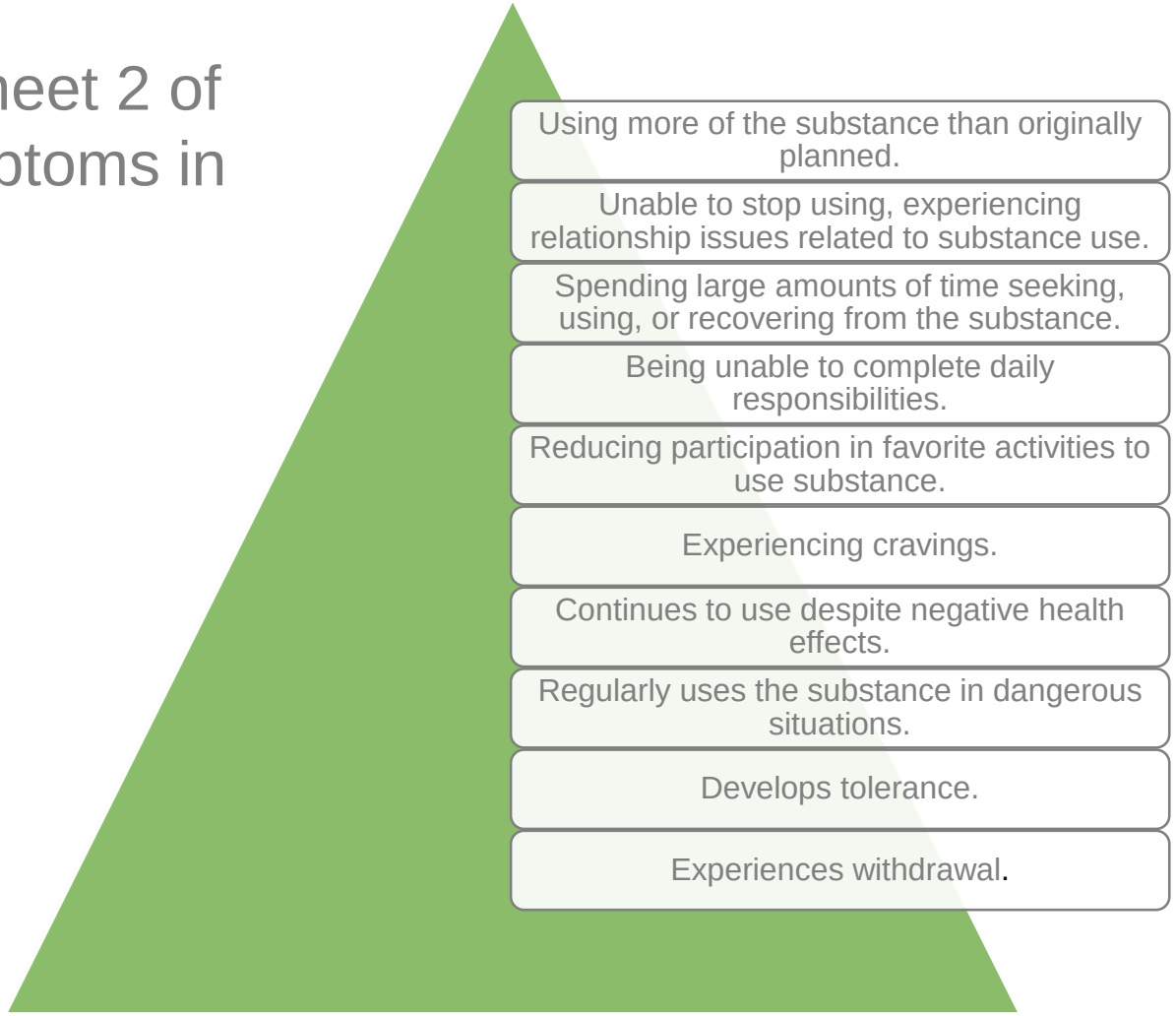
The individual:

- Denies problem; and
- Meets criteria for SUD in DSM-V.



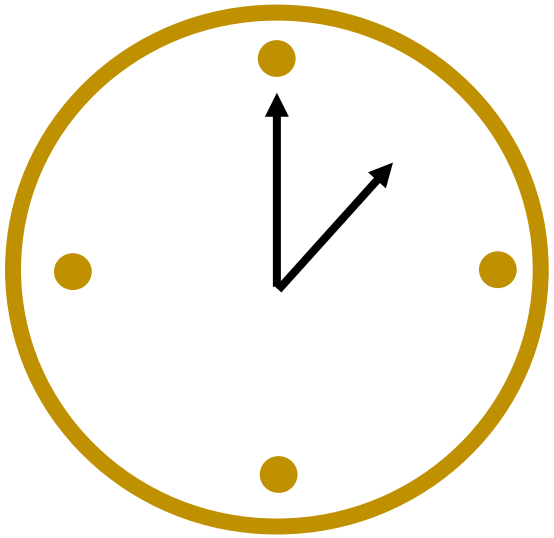
An individual enters the addiction stage when one meets the **DSM-V requirements** for SUD.[18,19]

The individual must meet 2 of the 11 signs and symptoms in the past two months.



Individuals may **relapse** in and out of addiction.

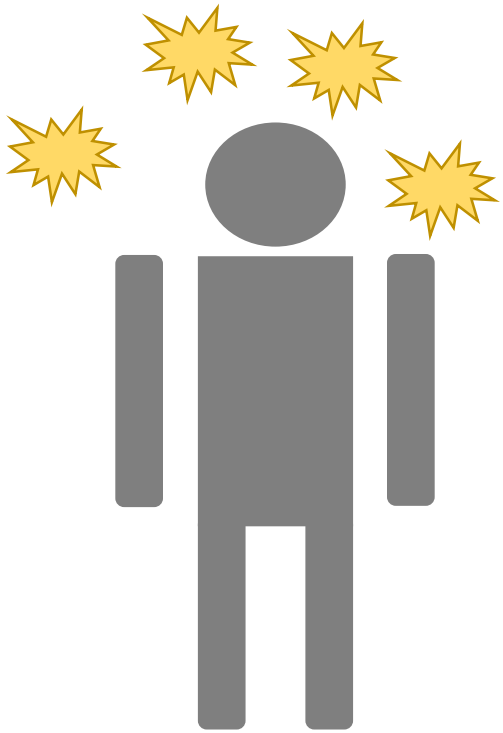
Relapse does not indicate failed treatment.[19] Relapse rates for SUD **(40%-60%)** are similar to relapse rates for other chronic diseases, such as diabetes **(30%-50%),** hypertension **(50%-70%)**, and asthma **(50-70%).**[15,21,22,23]



Biological Effects

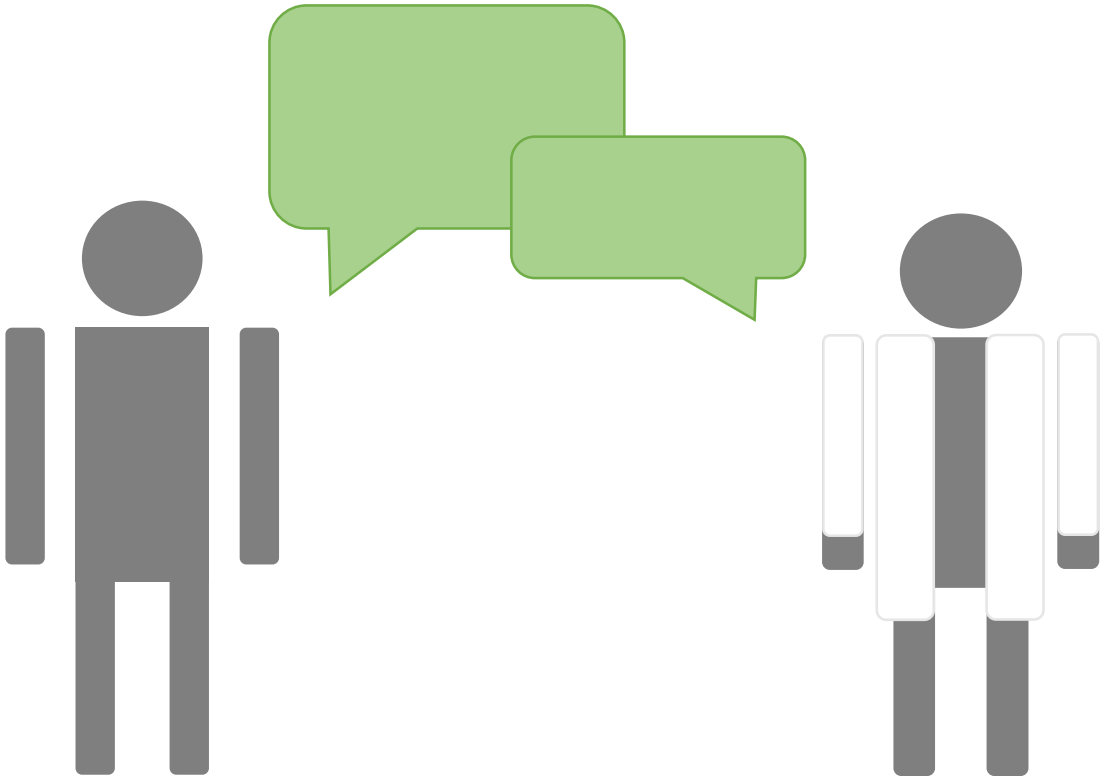
Throughout the addiction process, drugs influence one's **biological processes**.[24]

Almost all drugs **directly or indirectly affect the brain's reward system by flooding it with dopamine**. Overstimulation produces the euphoric effects sought by drug users and teach one to repeat the behavior.[24]



Recognizing Addiction

Substance misuse produces medical complaints, physical effects, and psychosocial effects that are **recognizable to providers**.[3]



Several common complaints are **red flags** for problem alcohol and drug use.[3]

- Frequent absence from school or work;
- History of frequent trauma or accidental injury;
- Depression or anxiety;
- Labile blood pressure or hypertension; and
- Gastrointestinal symptoms or weight changes.

There are many hallmark physical signs indicating problem alcohol and drug use.[3]

- Mild tremor;
- Alcohol odor on breath;
- Enlarged, tender liver;
- Nasal or conjunctival irritation;
- Labile blood pressure;
- Marijuana odor on clothing; and
- Signs of chronic obstructive pulmonary disease (COPD), Hepatitis B or C, or HIV infection.

Additionally, physicians can recognize **opioid use** using its common complaints, physical signs, and psychological signs.[25]

Complaints

- Dry mouth
- Constipation
- Sexual dysfunction
- Irregular menses
- Abscess
- Cellulitis

Physical Signs

- Needle marks or small scabs along veins
- Irritation in the nose lining
- Pupillary construction

Psychological Signs

- Mood swings
- Depression
- Anger
- Irritability
- Marital problems
- Missing school or work
- Poor school/work performance
- Financial problems
- Social isolation or loss of friends

Screening, Brief Intervention, and Referral to Treatment

Within family medicine practices, there are helpful tools to **identify and intervene** with patients with substance misuse or potential SUDs.[26]

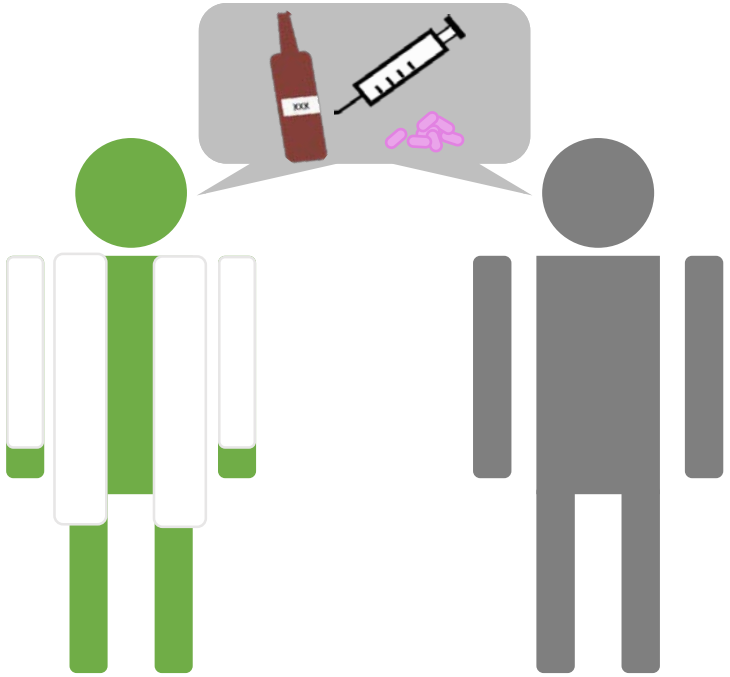
Screening

Brief

Intervention

Referral to

Treatment

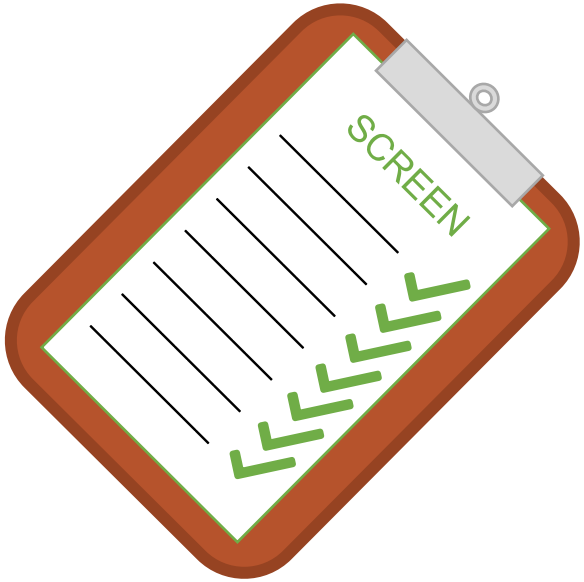


SBIRT (es-birt)

SBIRT is a **comprehensive and integrated public health approach** to the delivery of early interventions and treatment services through **universal screening** for persons with SUD and **those at risk of developing these disorders.**[26]

SBIRT identifies patients with **harmful or hazardous substance use** even if diagnostic criteria for SUD is not met.[26,27,28,29]

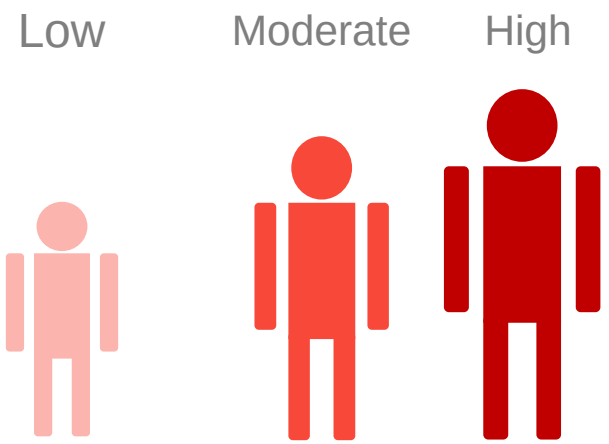
- **15%-20%** will meet the criteria for harmful substance use levels.
- Most will fall into a **low-risk** category.
- An individual's risk may **change at any time.**



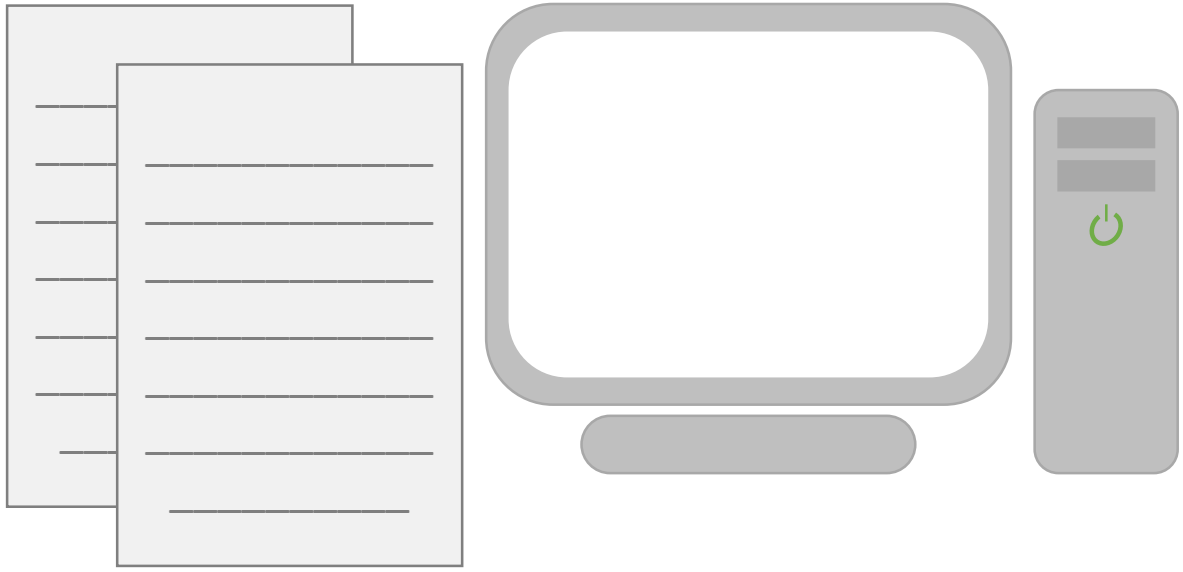
Screening

Universal use of **validated screening instruments** quickly assess a patient's level of substance use, consequences of substance use, and identifies the appropriate level of intervention.[30]

- Can be used for all people;
- Only takes a few minutes; and
- Determines an intervention appropriate for the individuals' level of risk.

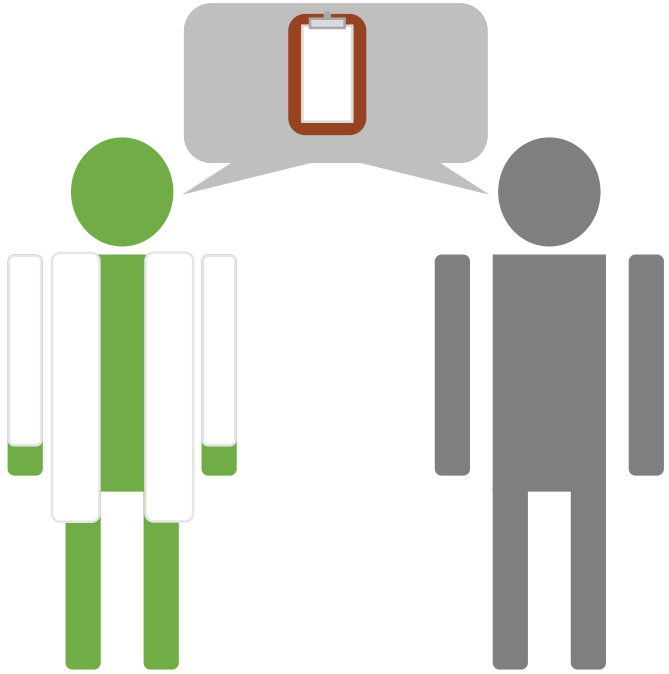


There are different types of screens used to identify SUDs: **initial and full screens**.



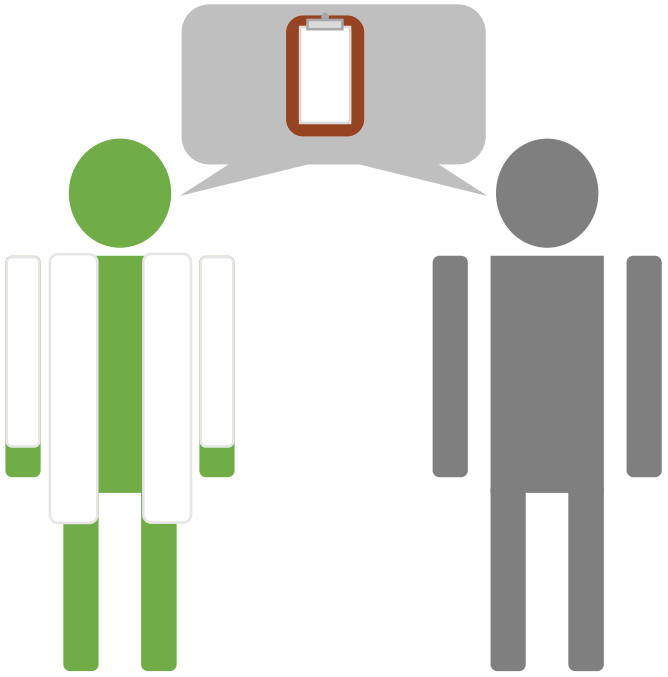
Initial screens are one-question screens that are completed by all patients.[31]

- **NIAA single-question screen** is a screening tool used to identify potential problematic alcohol use.[32]
- **NIDA quick screen** is a tool used to identify potentially problematic levels of illicit or prescription drug use.[33]



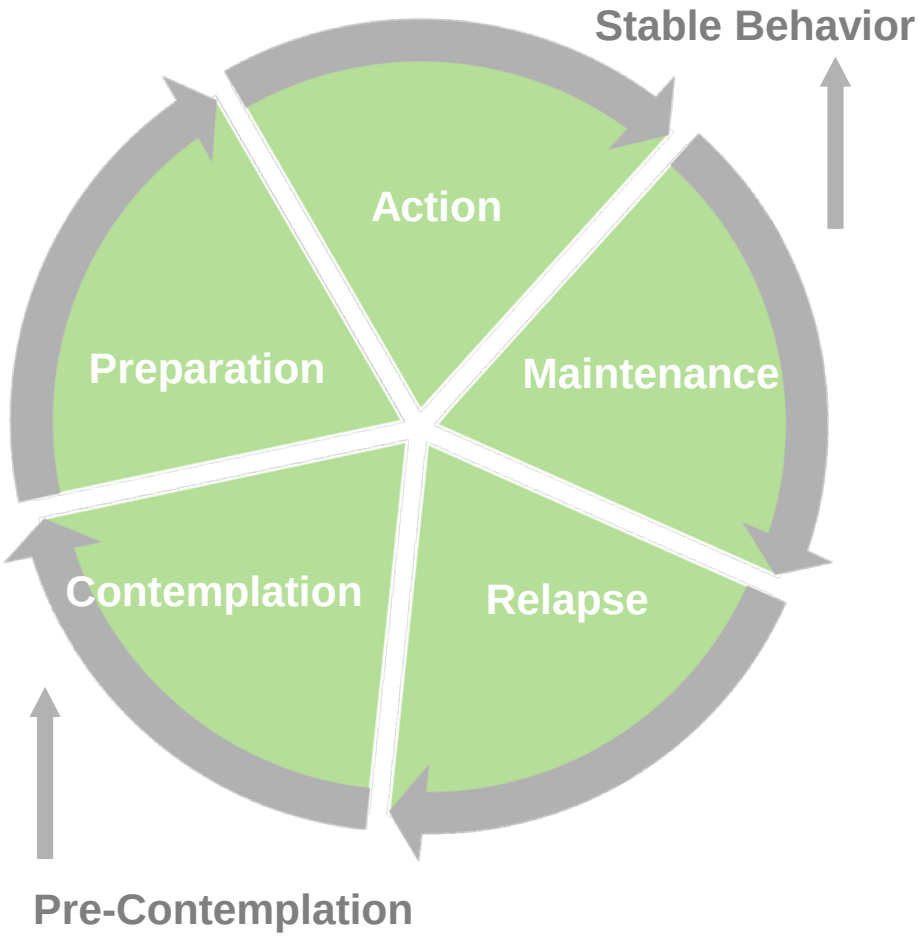
Full screens are completed by patients who screen positive in initial screens:

- **ASSIST** is a comprehensive screening tool that characterizes one's level of tobacco, alcohol, and drug use.[34]
- **AUDIT** is used to identify at-risk alcohol use only.[31]
- **DAST-10** is used to identify at-risk drug use only.[35]



Brief Intervention

Individuals will be in various **stages of change** and will vary in their readiness to commit to behavior changes related to their SUD.[36]



Pre-Contemplation: The patient is not aware of his/her behaviors as harmful or has not thought about changing.[36]

My drinking is normal.

I smoke pot everyday, and I'm fine.

Contemplation: The patient has thought about changing his/her behavior, but is ambivalent to change.[36]

I'm tired of always smelling like smoke.

I know that using cocaine is messing me up.

Preparation: The patient has begun to make plans for how to change the behavior.[36]

I think there is a hotline for people who are trying to stop using drugs.

Maybe I shouldn't walk by the store where I normally buy from.

Action: The patient is now actively working to change the behavior.[36]

I threw away all of my cigarettes and lighters.

I joined a peer-support group.

Maintenance: The patient has changed the behavior and is working to sustain the new behavior.[36]

It's been pretty amazing how much better I feel since I've stopped using.

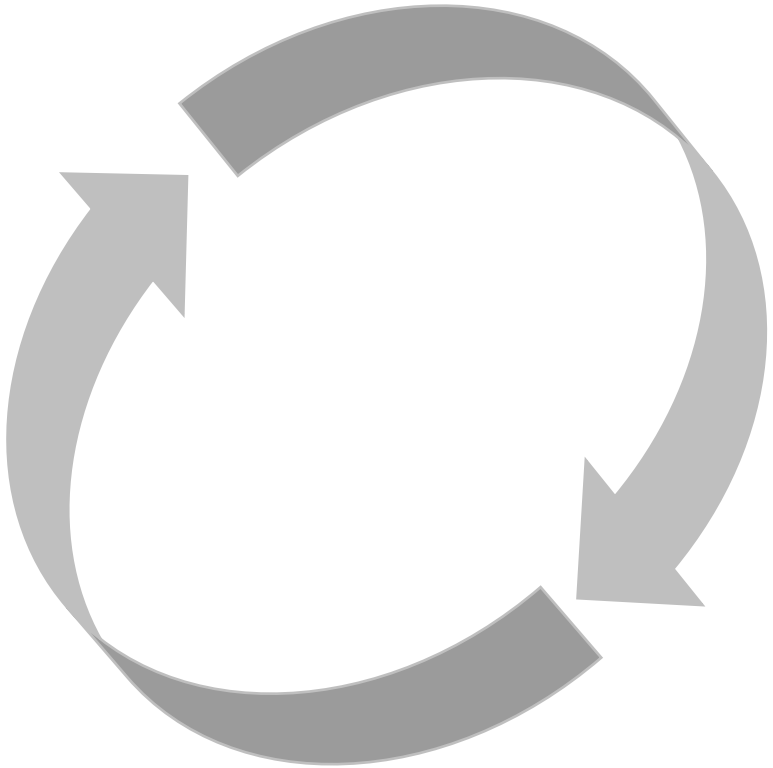
I haven't had more than two drinks in a sitting.

Relapse: The patient had maintained the changed behavior for a period, but has recently returned to the harmful behavior.[36]

I had a slip the other day.

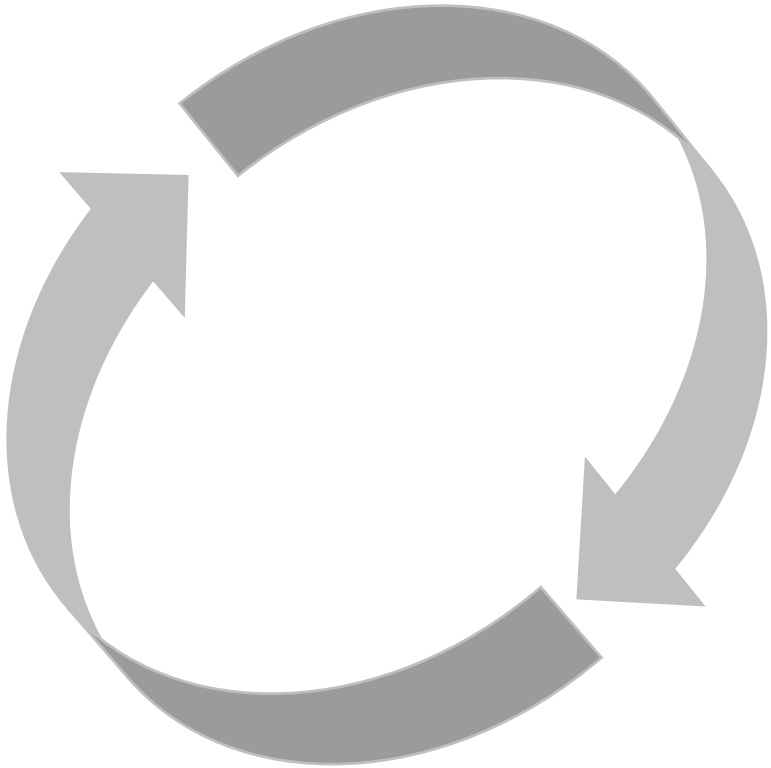
I want to get back into treatment.

For patients reluctant to change, **motivational interviewing** can be used to simplify patients' plans toward recovery, creating smaller, more manageable objectives that allow more immediate success towards change.[37]



There are four basic principles of motivational interviewing.[38]

- Expressing Empathy
- Developing Discrepancy
- Rolling with Resistance
- Developing Self-Efficacy



The skills utilized to conduct motivational interviewing can be remembered using the acronym **POLAR*S**.[37,39]

Permission

Open-Ended Questions

Listen

Affirmation

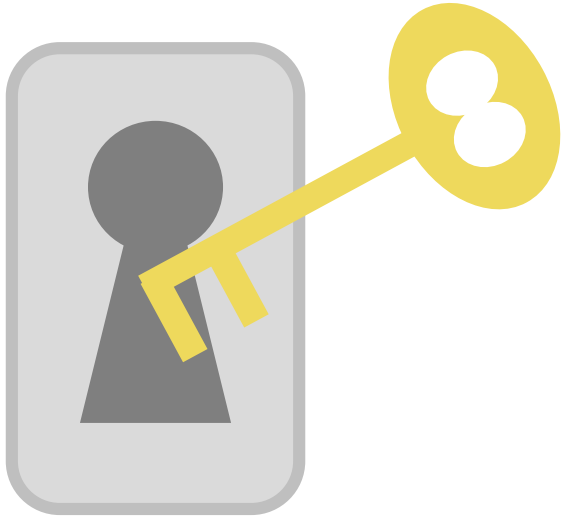
Roll with Ambivalence

Summarize

You want to begin the conversation by asking for **permission.**[37,39]

Asking for permission to discuss the screening results or your patient's drug and alcohol use:

- Respects his/her **autonomy;**
- Keeps the **focus** on the patient; and
- Minimizes patient **resistance**.



Examples of Permission

"Do you mind if I review the results of the screening you completed earlier?"

"Do you mind if we revisit your drinking habits today?"

"So, you came in today because you are experiencing some severe heartburn. Can I talk to you about what might be causing your heartburn?"

Avoid **“false permission”** questions.

“Can I ask you if you use drugs or alcohol?”

“Can I ask how you got this infection on your arm?”

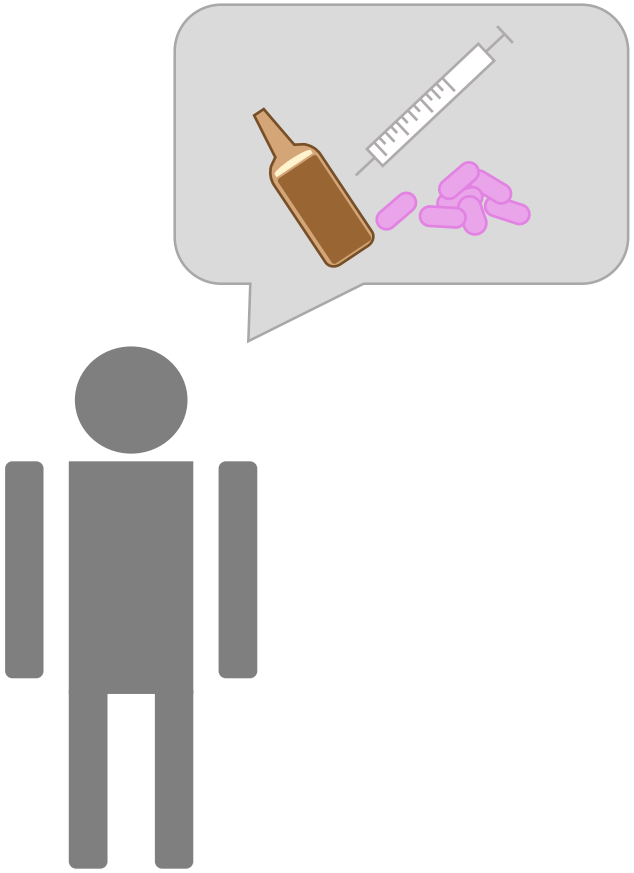
“Do you mind if I ask how many drinks you have in a week on average?”

Open-ended questions help you elicit information from the patient and keep the conversation moving. [37,39]

What kind of environment are you typically in when you use drugs?

Do you smoke when you are with your friends?

Think of your patient as the **expert** on his/her drug and alcohol use and you are trying to learn from that expertise.[37,39]



Examples of Open-Ended Questions

"What are some things that cause you stress and make you want to get high?"

"Can you think of some distractions for when you're craving a drink?"

Listen reflectively to show your patient that you are engaged and understand what he/she is saying.[37,39]

- Use the patient's words;
- Think of each reflection as a summary of what is happening in the moment; and
- Offer reflections as statements to put patients at ease.

Examples of Reflective Listening

"I can definitely understand why your job is stressing you out."

"So, to make sure I understand, you want to go to treatment, but a main barrier is not having a car, is that correct?"

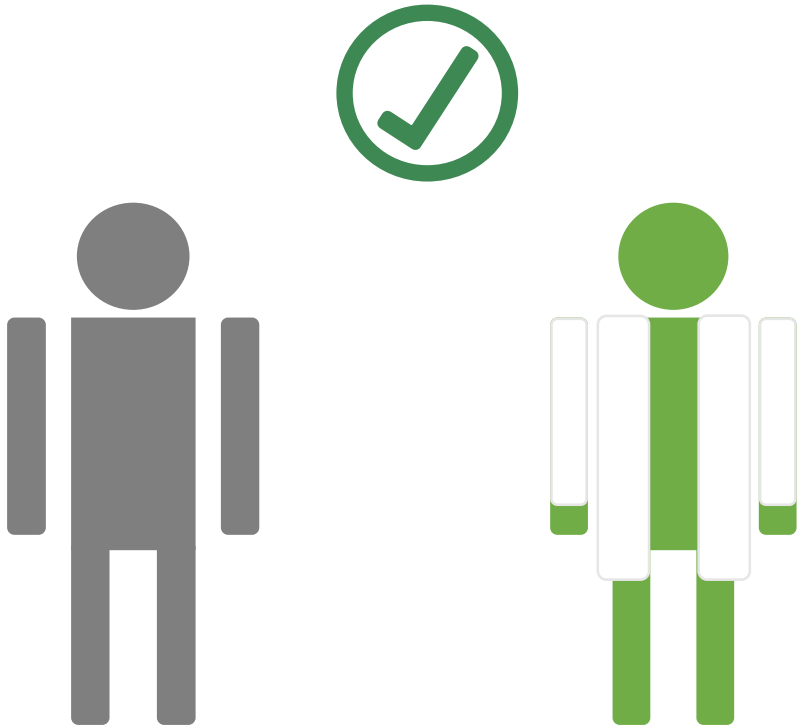
"I see that you are really frustrated about this."

Show that you are listening by paying attention to your **body language**.[37,39]

- Eye contact;
- Mirroring facial expressions;
- Leaning forward or to the side;
- Open and relaxed posture;
- Occasional note taking; and
- Avoiding fidgeting or distraction.

Affirmation can build trust and confidence in your patient.[37,39]

- Does not mean you are condoning your patient's substance use, but accepting his/her experience;
- Can help your patient see that change is possible; and
- Can help support positive behavior change.



Examples of Affirmation

"It is okay that you are not ready to stop using. Talking to someone was the first step. It shows that you are committed to stopping."

"It sounds like drinking is a big part of your social life, so I can understand why you're afraid about losing friends."

When seeing resistance or hesitancy, try to **Roll with Ambivalence**.[37,39]

I don't have a drinking problem.

I'm not ready to go to treatment.

Reflective listening is your go-to action when experiencing ambivalence or resistance.[37,39]

"It is okay if you are not ready to talk about this. Do you mind if I follow-up with you about this at our next appointment?"

Summarize your conversation at the end of the appointment in easy to understand terms.[37,39]

At this point, introduce **feasible options or next steps** with your patient.[37,39]

- Try to elicit options from your patient; and

> *"Are there other activities you and your friends enjoy that you can do instead of drinking?"*

- Always ask permission before giving advice or options.

> *"Do you mind if I give you some information on treatment options?"*

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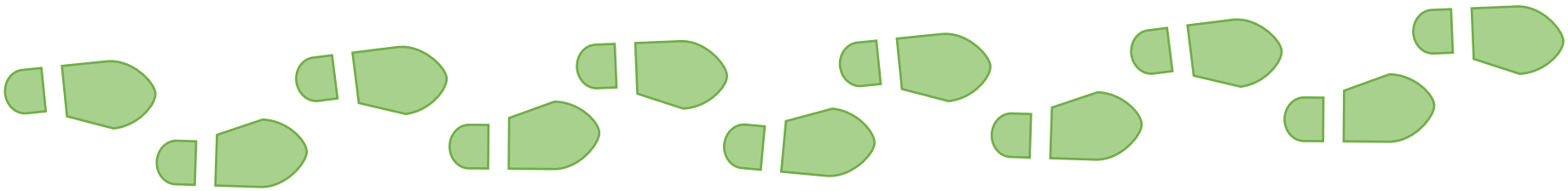
If you do offer options or set goals with your patient, make sure they are feasible and that your patient **is confident** in reaching them.[37,39]

"Do you think you would be able to join a peer support group by your next visit?"

"From 1 to 10, how ready are you to reduce your smoking from two packs a day to one pack a day?"



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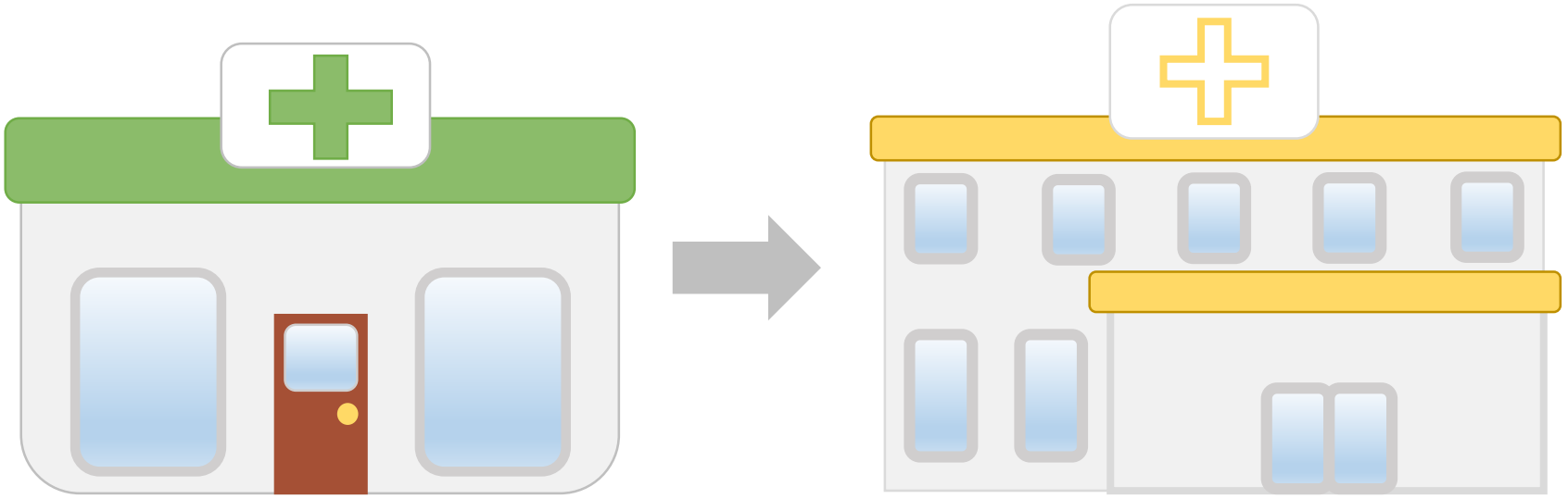
Examples of Summary

“I’m really glad we talked about your friends and beginning to build a support system. We agreed that by your next visit, you would talk to at least one friend about your drinking.”

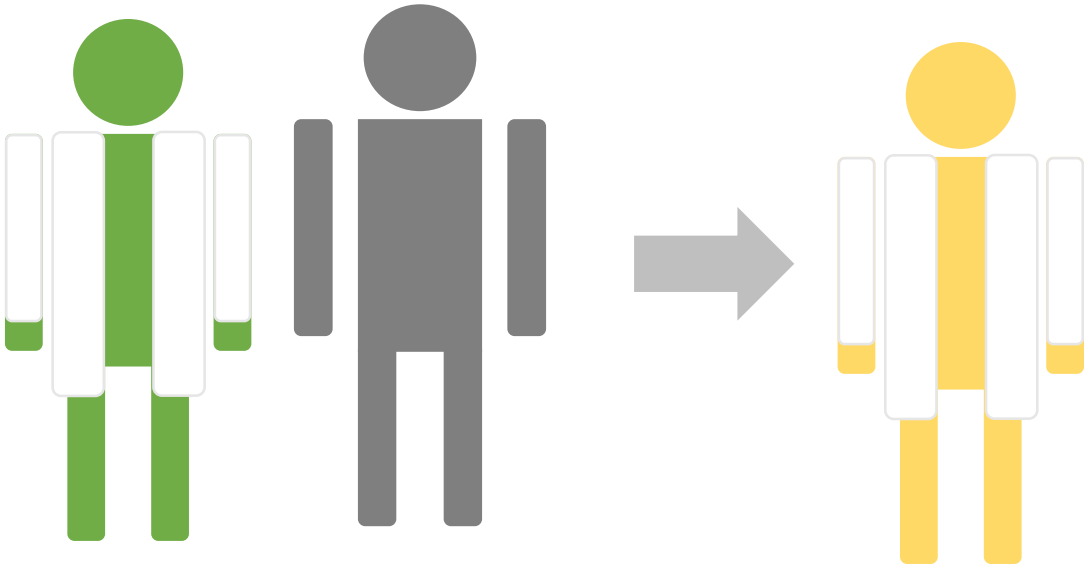
“So, we agreed that I would make a referral to help get you evaluated for further treatment. If they do not reach out to you, you will contact my office. Does that sound like a plan to you?”

Referral to Treatment

For patients with potential SUD, **referral for assessment and/or further treatment** may be needed.[40]



“Warm handoffs” are referrals to other providers or healthcare professionals that can better meet the patient’s needs.[40]



Resources within Pennsylvania and Nationally on SUD Intervention and Treatment

There are many resources available to providers seeking more information on treating patients with SUDs:

- PA Department of Health
- PA Department of Drug and Alcohol Programs
- Clearfield-Jefferson Drug and Alcohol Commission (Single County Authority/Center of Excellence)
- Pittsburgh SBIRT
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- National Institute on Drug Abuse (NIDA)
- PCSS-MAT
- PCSS-O

Thank you!

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