MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Screening, Assessment and Treatment Initiation for SUD

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Disclosures

- Dr. Blevins receives salary support from NIDA research fellowship grant 5T32DA007294-22, but otherwise has no financial relationships to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

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Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Screen and assess for substance use disorders (SUD) and co-morbid disorders
    - Use brief and extended screening tools
    - Evaluate physical health as related to SUD
    - Evaluate mental health as related to SUD
  - Utilize Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategies and principles
  - Utilize motivational interviewing strategies
  - Describe continuum of care and models of SUD treatment
  - Apply ASAM criteria when referring to treatment
  - Integrate screening, assessment, and ASAM criteria for SUD treatment referrals.

Outline

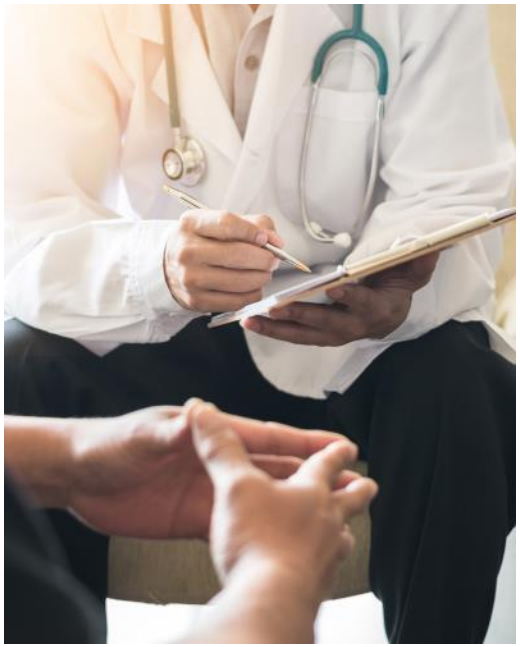
- Screening and Assessment for SUD
- Brief Intervention
- Referral to Treatment
- Continuum of Care Models
- ASAM Criteria
- Referral Resources

“I’m here for my work physical!” 😄

- 22 year old male, new patient, presents for employment physical for first job out of college. Everything is “great.” No complaints. No past medical/psychiatric history, or medications. He drinks “socially” and denies using drugs/tobacco.

- Further questioning reveals that he drinks on Friday and Saturday nights, typically 6 “mixed drinks” at the bar. He has never had any alcohol-related problems, including blackouts (except once in college). He also smokes a cannabis vaporizer pen 1-2 nights per week with friends. (He does not consider marijuana a “drug.”)

“I’m here for my work physical!” 😄



1. How would you approach discussing alcohol and cannabis use?
2. Which screening tool(s) would you use?
3. Does he need brief intervention or referral to treatment?
4. What is his current “stage of change”?
5. If he returns with increased alcohol use and a DUI, what should come next?

“I’m depressed and my belly hurts.” ☹

- 54 year old female presents for follow-up for hypertension treatment. She previously saw a different provider for 10 years in your clinic, and now her care is transferred to you after her doctor’s retirement. Per records, hypertension has been difficult to manage despite numerous medication trials. Previous doctor’s notes “regular drinker, needs AA” but no other details.

- Presents now for regular follow-up for hypertension, but with new complaint of feeling depressed and having abdominal pain.

- It becomes clear that abdominal pain is likely gastritis from alcohol.

- She admits that drinking has gotten “out of hand” and she “needs to go to AA.”

- First episode of depression lasted 3 months, started before alcohol problems, then during 2nd episode she began drinking more which allowed her to “numb” her emotions.

- Patient tried to cut back a few times, but her spouse is a “moderate” drinker who keeps alcohol in the house.

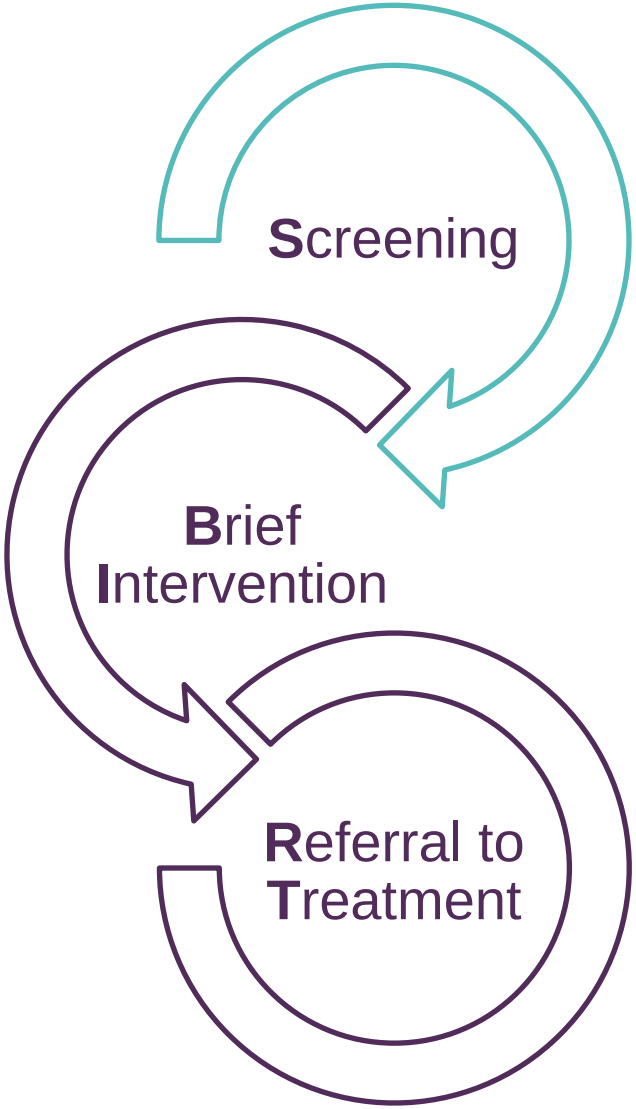
“I’m depressed and my belly hurts.” ☹

1. How would you screen/assess patient for an SUD?
2. Does patient need a brief intervention or a referral to treatment?
3. What is the patient’s current “stage of change”?
4. What strategies would you use?
5. According to ASAM Criteria, what would be the best place for her treatment?
6. What could you do to initiate treatment in the interim?

Screening and Assessment

- Screening tools
  - SBIRT using Motivational Interviewing (MI) techniques
  - Brief versus extended tools: CAGE, Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST), CRAFFT, NIDA Screen and Modified-ASSIST
  - NIAAA Rethinking Drinking℠
- Extended Substance Assessment & Diagnosis
  - Diagnostic and Statistical Manual (DSM)-5: 11 criteria in 4 categories
- Physical assessment
- Mental health assessment

SBIRT



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Alcohol and Drug Screening

- Used for illnesses with high prevalence.
- Used for early detection for better outcomes.
- Screening tests should have high sensitivity.
- The USPSTF recommends that clinicians screen adults aged **18 years or older** for **alcohol misuse** and provide persons engaged in risky or hazardous drinking with **brief behavioral counseling interventions** to reduce alcohol misuse.
- Positive screening does *not* result in substance use disorder (SUD) diagnosis, but indicates importance of further evaluation.
- Universal, quick, non-judgmental tools/methods
- Detect risky or problematic use

NIDA Quick Screen V1.0

In the past year, how often have you used the following?

- ***Alcohol***
  - ***For men, 5 or more drinks/day***
  - ***For women, 4 or more drinks/day***

- Tobacco products
- Prescription Drugs for Non-Medical Reasons
- Illegal Drugs

"**YES**" to any is a positive screen, followed by **NIDA-ASSIST**

Alcohol Screening

- **Positive Prescreen**
  - Past 30-days
    - Women >1 drink/day
    - Men >2 drinks/day
- Any:
  - Under 21
  - Pregnant
  - Medication interactions
    - E.g. Aspirin/NSAIDs/acetaminophen, Antibiotics, Anticonvulsants, Antihistamines, Anticoagulants, Antidiabetics, Barbiturates, Benzodiazepines, H2 antagonists, Immune modulators, Muscle relaxants, Opioids, Tricyclic antidepressants
  - Medical conditions
    - E.g. Cardiovascular (arrhythmia, hypertension, atherosclerosis), Pulmonary (apnea), Neurologic (seizures), Gastrointestinal (other causes of hepatitis/pancreatitis/ bleeding), Endocrine/Metabolic (diabetes, lipid disorders) Hematologic (clotting disorders)
  - Dangerous situations
    - E.g., driving, operating machinery

Reviewed in Weathermon, et al. 1999, Alcohol Res Health

Alcohol Screening

- AUDIT
  - Full AUDIT is 10 items.
  - AUDIT-C is first 3 questions of full AUDIT.
  - Detects risky drinking or active AUD.

- CAGE
  - 4 items.
  - Detects moderate/severe AUD, but may not detect risky drinking.

- **AUDIT-C is a better screening tool to detect risky or problematic drinking.**

Bradley KA, et al. J Gen Intern Med. 1998 Jun; 13(6): 379–389

Alcohol Screening: AUDIT

	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	Zero to two	Three or four	Five or six	Seven to nine	Ten or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Score items 1-10.

Add all scored items.

Positive Screen if: ≥ 8

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Alcohol Screening: AUDIT

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	0	1	2	3	4

Score items 1-10.

Add all scored items.

Positive Screen if: ≥ 8

- Questions 1-3 are sufficient for screening (AUDIT-C).
- Questions 4-10 can provide more detailed information.

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Alcohol Screening: AUDIT-C

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

a=0

b=1

c=2

d=3

e=4

Positive Screen if:

Men ≥ 4

Women ≥ 3

Alcohol Screening: Standard Drink

12 fl oz of **regular beer**	=	8-9 fl oz of **malt liquor** (shown in a 12-oz glass)	=	5 fl oz of **table wine**	=	3-4 fl oz of **fortified wine** (such as sherry or port; 3.5 oz shown)	=	2-3 fl oz of **cordial, liqueur, or aperitif** (2.5 oz shown)	=	1.5 fl oz of **brandy or cognac** (a single jigger or shot)	=	1.5 fl oz shot of 80-proof distilled spirits
about 5% alcohol		about 7% alcohol		about 12% alcohol		about 17% alcohol		about 24% alcohol		about 40% alcohol		40% alcohol

National Institute on Alcohol Abuse and Alcoholism

RETHINKING DRINKING℠
Alcohol & your health

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Alcohol Screening: CAGE

- Have you ever felt you needed to **CUT DOWN** on your drinking?
- Have people **ANNOYED** you by criticizing your drinking?
- Have you ever felt **GUILTY** about drinking?
- Have you ever felt you needed a drink first thing in the morning (**EYE-OPENER**) to steady your nerves or to get rid of a hangover?

Positive Screen if: 2+ YES

Alcohol Screening: NIAAA

Check your drinking pattern

See signs of a problem

Get tools to make a change

What's your pattern?

Answer these questions, then select "Click for feedback" to find out how your drinking pattern compares to those of other U.S. adults.

1. On **any day** in the past year, have you ever had

   For MEN: More than 4 "standard" drinks? ◉ yes ○ no

   For WOMEN: More than 3 "standard" drinks? ○ yes ○ no

2. Think about your **typical week:**

   On average, how many **days** per **week** do you drink alcohol? 5

   On a typical drinking day, how many **drinks** do you have? 5

CLICK FOR FEEDBACK

NIH National Institute on Alcohol Abuse and Alcoholism

RETHINKING DRINKING℠ *Alcohol & your health*

https://www.rethinkingdrinking.niaaa.nih.gov/

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Alcohol Screening: NIAAA

Feedback on your responses

The chart below shows where your drinking pattern fits based on a nationwide survey of 43,000 adults by the National Institutes of Health (NIH). Although the minimum legal drinking age in the United States is 21, this survey included people aged 18 or older.

U.S. drinking patterns—where do you fit?

Percent of U.S. adults with this pattern	Drinking pattern	
9%	Drink **more than *both*** the single-day limits ***and*** the weekly limits	«Your pattern» Highest risk
19%	Drink **more than *either*** the single-day limits ***or*** the weekly limits	Increased risk
37%	**Always** drink **within low-risk** limits	Low risk
35%	**Never** drink alcohol	**Never** drink alcohol

You drink more heavily than about 9 out of 10 U.S. adults, according to your responses. In a typical week, you have more than the men's low-risk limit of 14 drinks per week (your average is 25 drinks per week), and at times, you exceed the single-day limit of 4 drinks for men.

Your particular risk depends on how much, how quickly, and how often you drink. According to the NIH survey, about half of people in your drinking pattern group already have an alcohol use disorder, and the rest have an increased risk of developing these and other problems, especially liver disease.

You can reduce your risks. Research shows that people who stay within the low-risk limits have the lowest rates of alcohol-related problems. It's safest to quit, however, if you already have signs of a problem.

NIH National Institute on Alcohol Abuse and Alcoholism

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https://www.rethinkingdrinking.niaaa.nih.gov/

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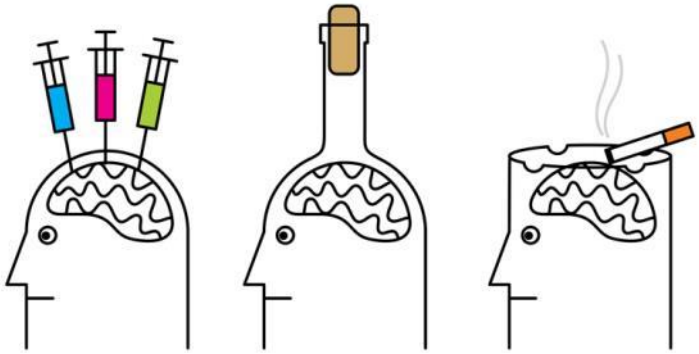
Drug Screening

- **Positive Screen** if past 30-day:
  - *Non-medical use* of medications (e.g., intoxicating effects, getting high, etc.)
  - *Use* of illicit drugs or tobacco
  - *Use* of other substances (solvents, gases, etc.) for intoxication



- ***DAST**:* 28-item and 10-item, gives "zone" of use, and "indicated action"

- ***CRAFFT***: 9-items, gives "probability" of SUD diagnosis for adolescents

NIDA Quick Screen V1.0

In the past year, how often have you used the following?

- Alcohol
  - For men, 5 or more drinks/day
  - For women, 4 or more drinks/day
- ***Tobacco products***
- ***Prescription Drugs for Non-Medical Reasons***
- ***Illegal Drugs***

"**YES**" to any is a positive screen, followed by **NIDA-ASSIST**

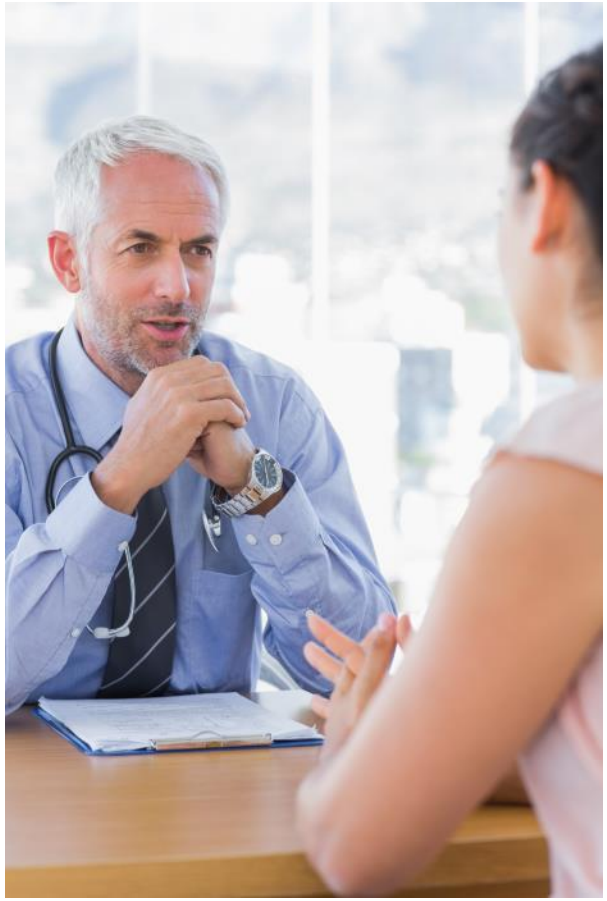
Drug Screening: NIDA-ASSIST

- **NIDA Modified ASSIST V2.0**
  1. Lifetime: which of the following substance have you ever used…?

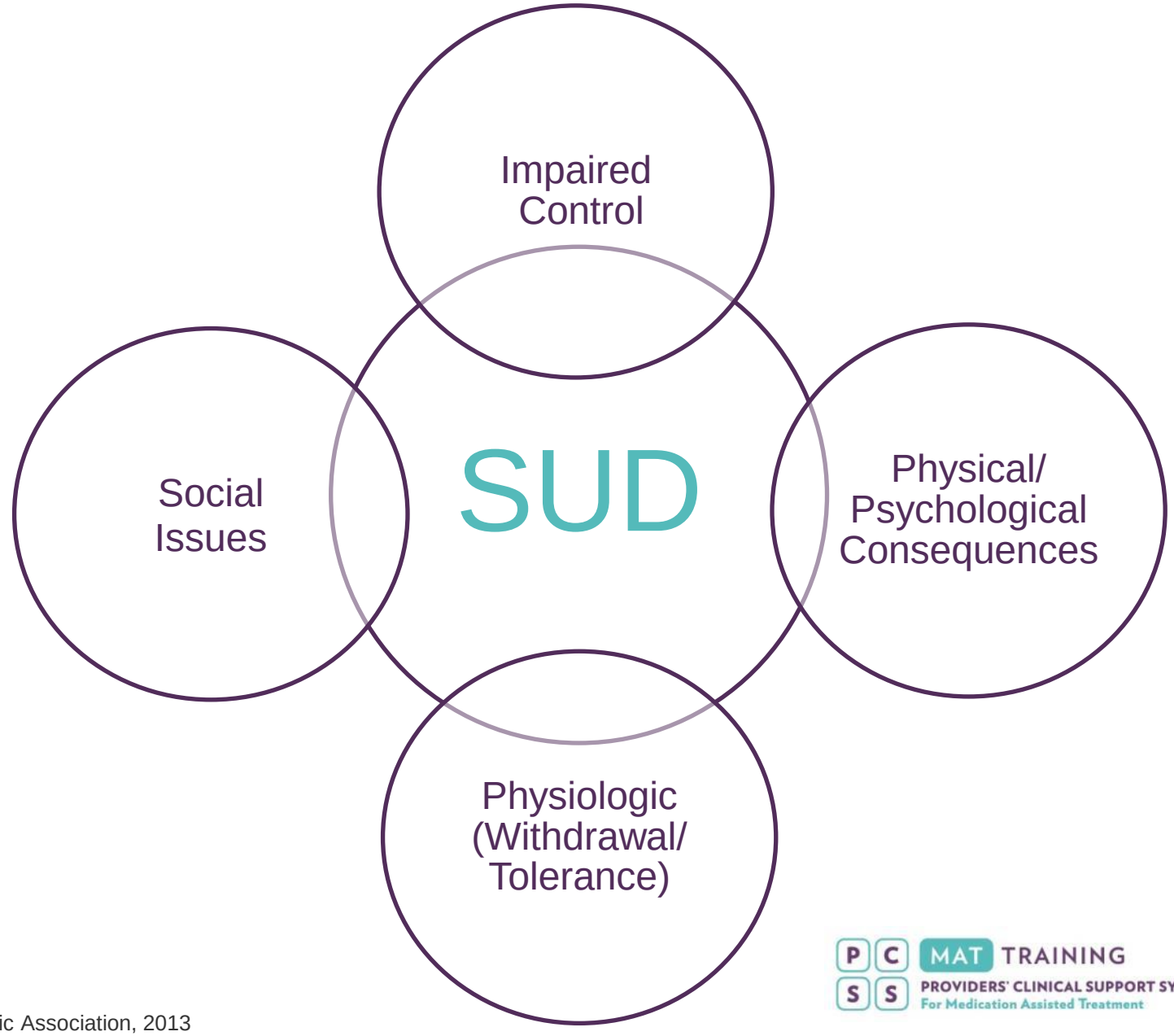
     *Questions 2-8 are asked about **each substance***
  2. Past 3 months: How often have you used the substances you mentioned?
  3. Past 3 months: How often have you had a strong desire or urge to use?
  4. Past 3 months: How often has your use led to health, social, legal, or financial problems?
  5. Past 3 months: How often have you failed to do what was normally expected because of your use?
  6. Has a friend or relative or anyone else ever expressed concern about your use?
  7. Have you ever tried and failed to control, cut down, or stop using?
  8. Have you ever used any drug by injection?
- Comprehensive, but more time investment
- Scoring is complex, but gives a **"level of risk"** per substance
- For complete assessment and scoring: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

Additional Assessment

1. Extended Substance Use Assessment
2. Physical Assessment
3. Mental Health Assessment



DSM-5 Diagnosis



American Psychiatric Association, 2013

Substance Use Assessment

- Drug of choice
- Last use
- Frequency of use
- Amount used regularly
- Route of administration
- Age of onset
- Periods of abstinence
- Other drugs used together or separately

- Past withdrawal symptoms
  - Severe: seizures, DTs
- Past treatment
- Past overdose
  - After prior detox?
  - After treatment?
- Past drug-related complications
- Prior treatment

Physical Assessment

- Vital signs
  - Temperature
  - Blood pressure
  - Heart rate
  - Respiratory rate
  - Weight/BMI
- Physical exam
  - ENT
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Neurologic
  - Skin
- Labs
  - Blood count
  - Metabolic panel
  - Liver function
  - Thyroid
  - Pregnancy
  - Urine drug screen
  - Urinalysis
  - HIV/HCV/HBV
  - STD Screening
- Electrocardiogram
- PPD / Chest X-ray

Physical Assessment

Alcohol

- Cardiovascular
  - Cardiomyopathy
  - Hypertension
  - Arrhythmia
- Gastrointestinal
  - Cancers
  - Gastritis
  - Hepatitis/cirrhosis and associated stigmata
  - Pancreatitis
  - Anemia
- Hematologic
  - Thrombocytopenia

Opioids

- Respiratory
  - Apnea
- Infectious Disease
  - HIV
  - HCV/HBV
  - Injection site infection
  - Endocarditis
- Gastrointestinal
  - Constipation
- Reproductive
  - Amenorrhea (females)
  - Testicular atrophy (males)

Cannabis

- Cardiovascular
  - Tachycardia
- Gastrointestinal
  - Hyperemesis[1,2]
- Genitourinary
  - Testicular Cancer[3]

[1]Lacson et al, 2012; [2]Daling et al 2009, [3]Galli et al, 2011

Physical Assessment

Stimulants

- Cardiovascular
  - Ischemia/infarction
  - Hypertension
  - Aortic dissection
  - Vasculitis
  - Tachycardia
- Gastrointestinal
  - Mesenteric ischemia
- Musculoskeletal
  - Rhabdomyolysis
- Neurological
  - Seizures
  - Stroke

Tobacco

- Cardiovascular
  - Hypertension
  - Ischemia/ infarction
- Respiratory
  - COPD
  - Cancers
- Gastrointestinal
  - Cancers

Mental Health Assessment

- Mental status examination
  - Appearance, Attitude, Behavior (compulsions), Speech, Mood, Affect, Thought process, Thought content (obsessions, suicidal/homicidal ideation), Perceptual disturbances (hallucinations), Orientation, Insight, Judgment
- Cognitive examination
  - MMSE, MoCA
- Current physical/sexual abuse
- Evaluate for risk of harm to self, others, or inability to care for self
  - Current or recent ideation, plan, or intent
  - History of harm to self or others
  - Access to firearms or other lethal means
  - Inability to perform activities of daily living (ADLs)

Mental Health Assessment

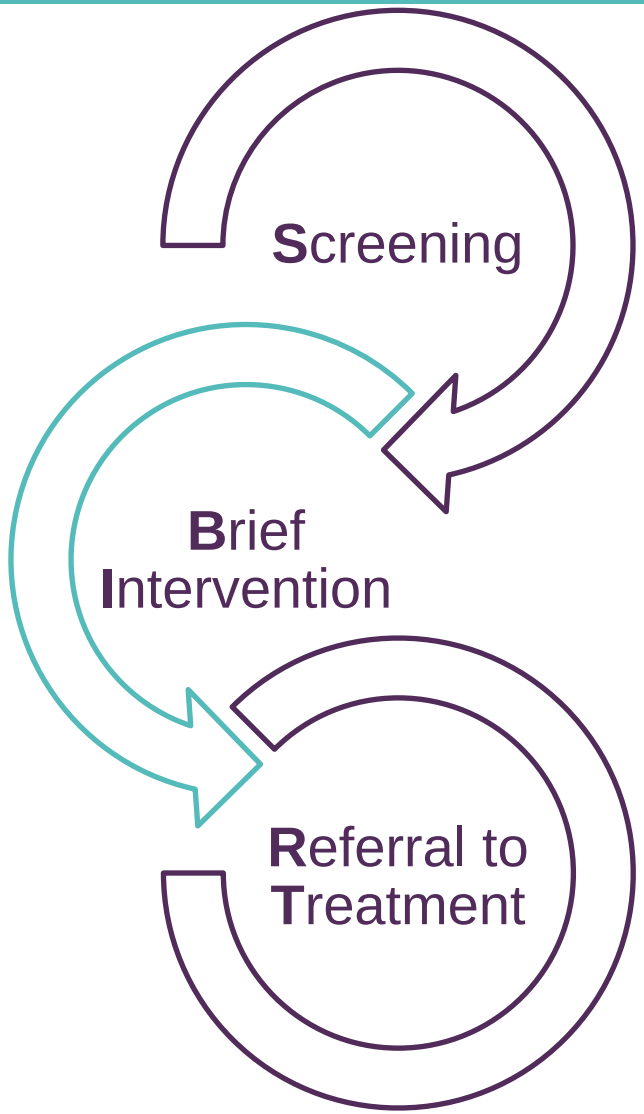
- SUDs have high rates of psychiatric co-morbidity
- Consider co-morbid psychiatric disorders
  - Major depressive disorder
  - Bipolar disorder
  - Anxiety disorders
  - Psychotic disorders
  - Attention-deficit hyperactivity disorder (ADD/ADHD)
  - Post-traumatic stress disorder (PTSD)
- Consider co-morbid personality disorder (PD)
  - Borderline PD
  - Antisocial PD
- Consider Substance-induced disorders and Substance withdrawal
  - Temporal relationship with substance use
  - Periods of abstinence may help clarify
  - Expected withdrawal signs/symptoms

Mental Health Assessment

- Treatment of SUD should be *concurrent with*, not subsequent to, treatment of psychiatric disorders, with evidence that this results in more improvement in both domains

Kelly, T. M., & Daley, D. C. (2013). Integrated Treatment of Substance Use and Psychiatric Disorders. *Social Work in Public Health*, *28*(0), 388–406. http://doi.org/10.1080/19371918.2013.774673

SBIRT



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SBIRT: BI vs. RT

Problematic Use

- Threatens health and safety
- Not “addiction”

Brief intervention

is warranted

Addiction

- Chronic disease
- DSM-5 moderate/severe SUD

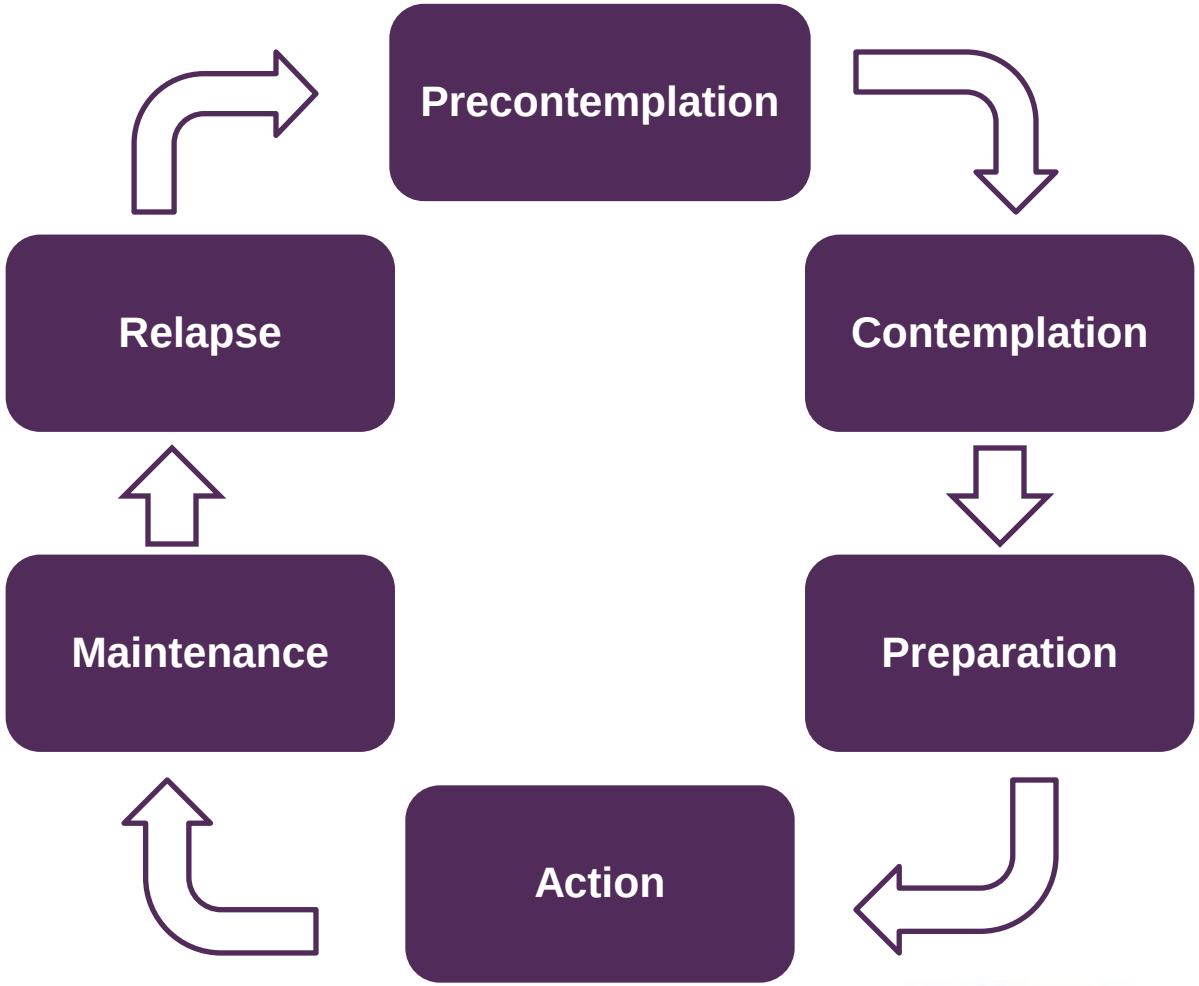
Referral to treatment

is required

Brief Intervention

- 5-10 minutes
- Educate patient, nonjudgmental
- Appeal to *patient's* goals and values
- Allow for patient contribution
- Allow for patient disagreement
- Encourage patient to problem solve
- Reflect to patient their commitment to change

Stages of Change



- Develop **comfortable** way to introduce the topic
- Establish **rapport** & ask **permission** to discuss
  - Nonjudgmental, empathic
- Frame discussion within **context of medicine**
- Emphasize medical consequences
- Consider **language**
  - “Recreational drug use” vs. “illegal drug use”
  - “Drug/alcohol use” vs. “ Drug/alcohol abuse”
- **Normalize**
  - “Routine questions”
- **Integrate** into preventive care

Open-ended

Affirm

Reflect

Summarize

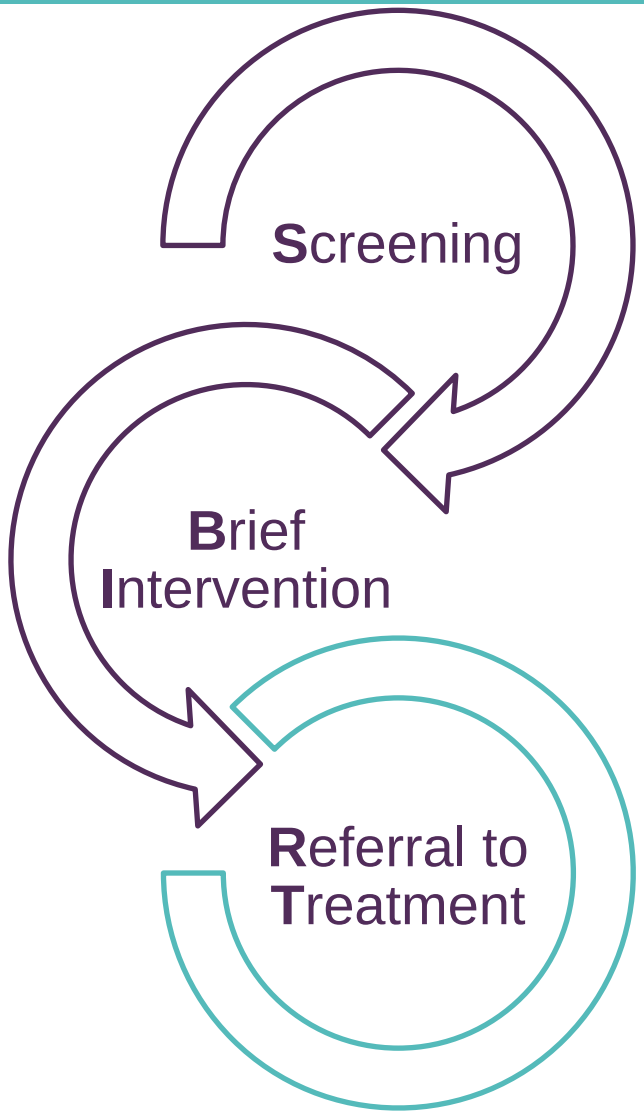
- Inquire about current patterns of substance use
- Determine patient **perception** of substance use
- Identify personal **values and goals**
- Discuss **impact** of substance use on goals
- Develop **discrepancy** between substance use and achieving goals
- Elicit the **need** and perceived **ability** to change

- Provide clear, specific, ***personalized*** **feedback**
- Include risks and consequences of use
- Express concern and recommend explicit changes
- Support patient **self-determination** and **autonomy**
- Tailor to patient's level of health literacy
- Emphasize **confidence** in ability to change
- Assure continued **support** throughout process
- Emphasize **strengths** & **past successes**
- **Validate** frustrations, but remain optimistic
- **Reflect** & **Summarize**
- **Prepare** patient for next steps

Engage → Motivate → **Plan**

- **Make goals** aligned with readiness to change
- Goals should be **attainable**, **measurable**, and **timely**
- Help **anticipate** potential challenges
- Change strategies as needed
- Avoid argumentation & defensiveness
- Recommend ideal, but **accept less if patient resists**
- **Follow-up** within 1 month
- **Reinforce, reassess,** and **update** plan
- **Acknowledge** efforts & experiences
- Offer continued support, despite progress
- Give self-help and guidance for social support

SBIRT



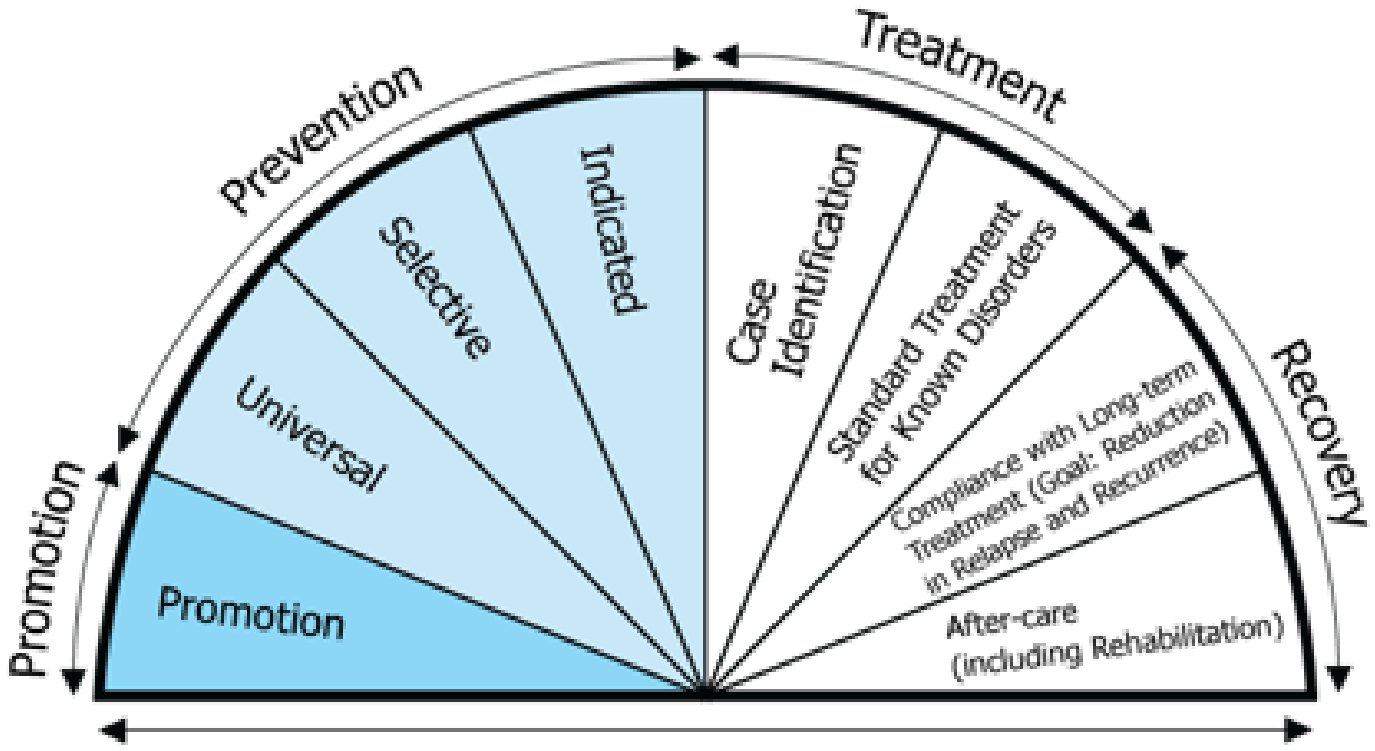
Referral to Treatment

- Evidence-based treatments and peer support
- Continuum of care models
- ASAM Placement Criteria
- Referral resources

Referral to Treatment

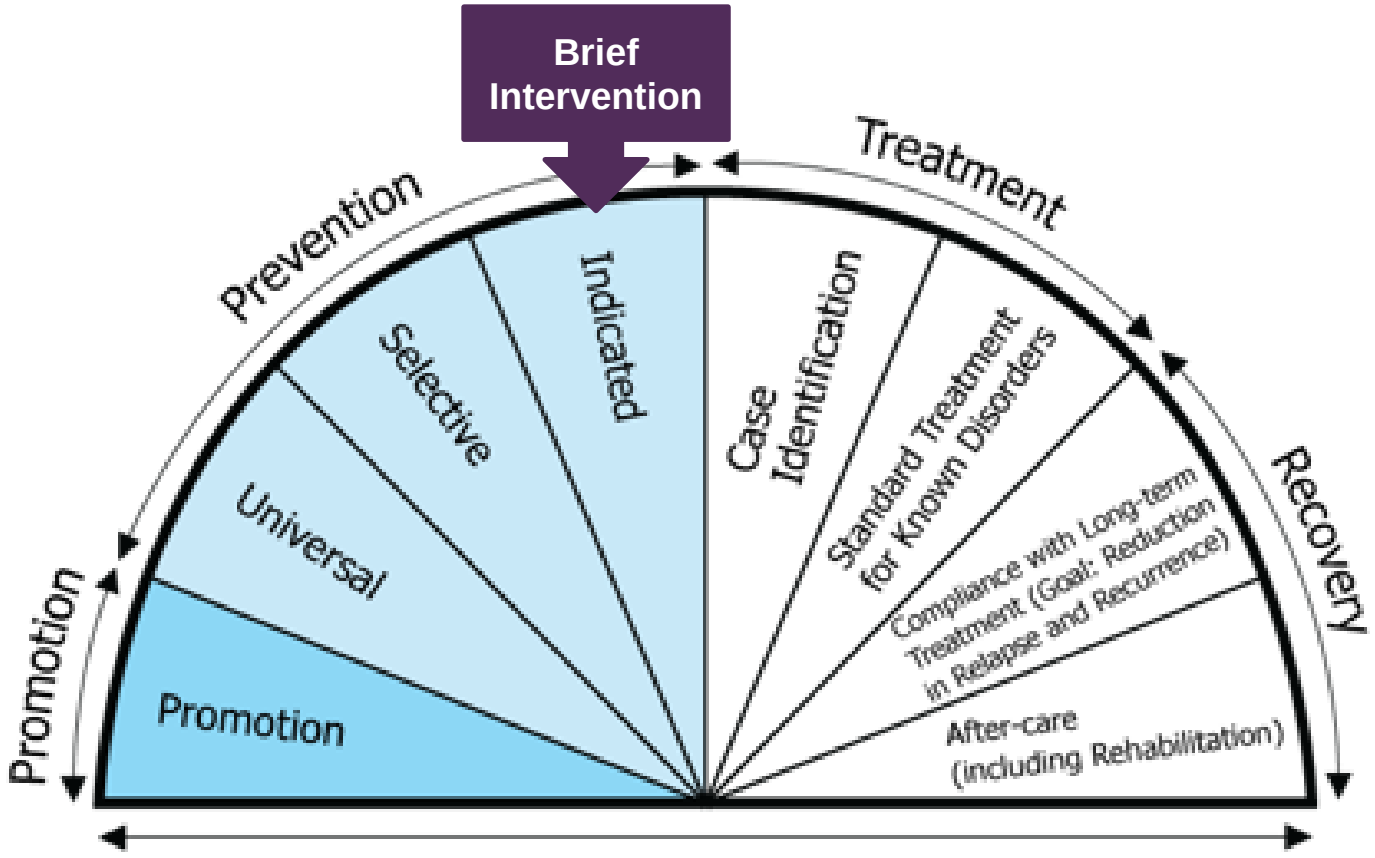
	FDA-Approved Medications	Psychosocial
Alcohol	Naltrexone (PO) Naltrexone ER (IM) Acamprosate Disulfiram Topiramate (off-label) Gabapentin (off-label)	Cognitive Behavioral Therapy Motivational Interviewing Motivational Enhancement Therapy Relapse Prevention Therapy Contingency management 12-Step Facilitation • Alcoholics Anonymous (AA) • Narcotics Anonymous (NA) • Marijuana Anonymous (MA) • Cocaine Anonymous (CA) • Crystal Meth Anonymous (CMA)
Opioids	Methadone Buprenorphine (sublingual film/tablet, subcutaneous injection, subdermal implant) Naltrexone ER (IM)	
Tobacco	Varenicline Bupropion Nicotine replacement therapy (patch, gum, nasal spray, inhaler, lozenges)	
Stimulants		
Cannabis		

Continuum of Care Models



SAMHSA: Prevention of Substance Abuse and Mental Illness
https://www.samhsa.gov/prevention.

Continuum of Care Models

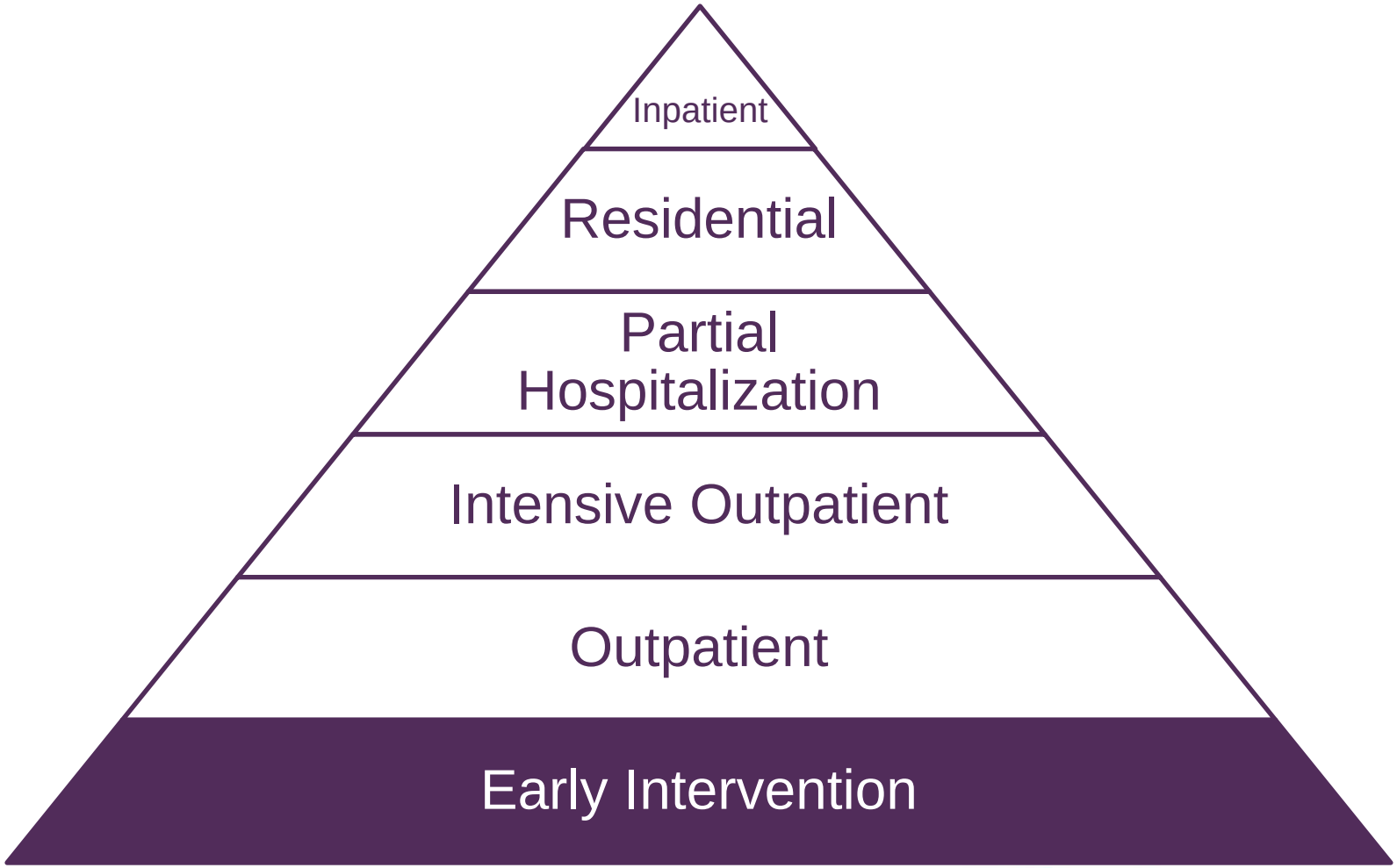


SAMHSA: Prevention of Substance Abuse and Mental Illness
https://www.samhsa.gov/prevention.

ASAM Criteria

- Guidelines for patient placement, transfer, or discharge for those with SUD and co-morbid medical or psychiatric conditions.
- Six dimensions of assessment
  1. Acute Intoxication/Withdrawal Potential
  2. Biomedical Conditions/Complication
  3. Emotional/Behavioral/Cognitive Complications
  4. Readiness to Change
  5. Relapse, Continued Use, or Continued Problem Potential
  6. Recovery/Living Environment

Continuum of Care Model



Inpatient

1. **Current intoxication, high risk of withdrawal**
2. **Co-morbid medical issues requiring attention**
3. **Co-morbid psychiatric issues requiring attention**
4. May have low readiness to change, but not necessary
5. May have high likelihood of continued use, but not necessary
6. May not have good recovery environment, but not necessary

Residential

1. No acute intoxication and low likelihood of withdrawal requiring treatment
2. Little to no active medical issues
3. No acute safety issues (suicidality, homicidality, inability to care for self), and some facilities may offer more psychiatric treatment than others
4. **Needs constant supervision to support change**
5. **Unable to stop using or remain abstinent**
6. **Unsupportive or dangerous recovery environment**

Partial Hospitalization

1. No acute intoxication and low withdrawal potential
2. May require medical supervision, but overall stable
3. May require psychiatric supervision or some attention
4. **Needs daily supervision to support change**
5. **High relapse risk**
6. **Less supportive environment, and requires more intense structure**

Intensive Outpatient

1. Low intoxication or withdrawal risk
2. Medical issues can be managed as outpatient
3. Mild psychiatric issues
4. Cooperative with discussions around change, but **needs more structure**
5. **Able to maintain abstinence, but needs closer monitoring**
6. **Less supportive environment, but structure helps**

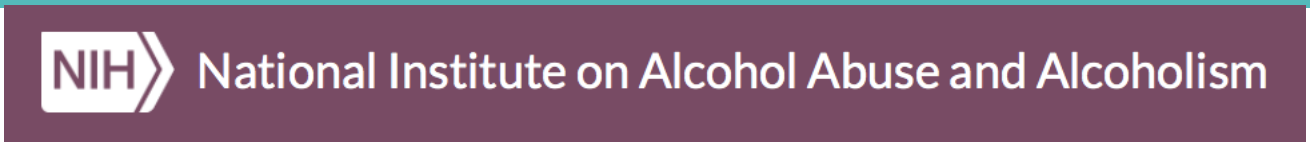
Outpatient

1. No intoxication or withdrawal risk requiring medical monitoring (i.e. seizure, delirium tremens, autonomic instability)
2. Medical issues can be managed as outpatient
3. Psychiatric issues can be managed as outpatient
4. Cooperative with discussions around change
5. Able to maintain abstinence
6. Supportive environment

Referral Resources: SAMHSA

- **National Helpline – 1-800-662-HELP**
  - 24/7/365, English/Spanish
  - Provides referrals to local treatment facilities, support groups, and community-based organizations
  - Order free publications & other information
- **Behavioral Health Treatment Services Locator**
  - https://findtreatment.samhsa.gov

Referral Resources: NIAAA



NIAAA ALCOHOL TREATMENT NAVIGATOR

Pointing the way to evidence-based care

- Provides education on diagnosis, treatment, costs, & insurance
- Information on quality care, how to find it, and how to make a choice
- Links to ABPN and ABAM provider locators
- https://alcoholtreatment.niaaa.nih.gov

“I’m here for my work physical!” 😄

- 22 year old male, new patient, presents for employment physical for first job out of college. Everything is “great.” No complaints. No past medical/psychiatric history, or medications. He **drinks “socially”** and denies using drugs/tobacco.

- Further questioning reveals that he drinks on Friday and Saturday nights, typically **6 “mixed drinks”** at the bar. He has never had any alcohol-related problems, including blackouts (except once in college). He also smokes a **cannabis** vaporizer pen 1-2 nights per week with friends. (He does not consider marijuana a “drug.”)

“I’m here for my work physical!” 😄

1. **How would you approach discussing alcohol and cannabis use?**
    - Open-ended, nonjudgmental, patient-centered
2. **Which screening tool(s) would you use?**
    - AUDIT-C, NIAAA tool, DAST, NIDA-ASSIST
3. **Does he need brief intervention or referral to treatment?**
    - Brief intervention for “problematic” substance use

“I’m here for my work physical!” 😄

4. **What is his current “stage of change”?**
    - Precontemplation

5. **If he returns with increased alcohol use and a DUI, what should come next?**
    - Indicative of SUD diagnosis
    - Requires referral to treatment
    - Likely a good candidate for outpatient or intensive outpatient program

“I’m depressed and my belly hurts.” ☹

- 54 year old female presents for follow-up for **hypertension** treatment. She previously saw a different provider for 10 years in your clinic, and now her care is transferred to you after her doctor’s retirement. Per records, hypertension has been difficult to manage despite numerous medication trials. Previous doctor notes “regular drinker, needs AA” but no other details.
- Presents now for regular follow-up for hypertension, but with new complaint of feeling **depressed** and having **abdominal pain**.
- It becomes clear that abdominal pain is likely **gastritis** from alcohol.
- She admits that drinking has gotten **“out of hand”** and she **“needs to go to AA.”**
- First episode of depression lasted 3 months, started before alcohol problems, then during 2nd episode she began drinking more which allowed her to **“numb” her emotions**.
- Patient tried to cut back a few times, but her **spouse is a “moderate” drinker** who keeps alcohol in the house.

“I’m depressed and my belly hurts.” ☹

1. **How would you screen/assess her for an SUD?**
    - AUDIT for screen
    - DSM-5 criteria for SUD diagnosis
    - Medical: PE, Labs, ECG
    - Psychiatric: MSE, MMSE, Safety risk

2. **Does patient need a brief intervention or a referral to treatment?**
    - Referral to treatment

3. **What is the patient’s current “stage of change”?**
    - Contemplation

“I’m depressed and my belly hurts.” ☹

4. **What interview strategies would you use?**
   - Engage: Open-ended questions, Affirmations, Reflections, Summaries
   - Motivate: Personalized feedback, Focus on strengths, Validate frustrations
   - Plan: Make attainable goals, Anticipate challenges, Schedule follow-up

5. **According to ASAM Criteria, what would be the best place for her treatment?**
   - Inpatient → Residential

6. **What could you do to initiate treatment in the interim?**
   - Refer to 12-step, other peer support or self-help groups, and/or alcohol/drug counseling
   - Consider medication (naltrexone, acamprosate)
   - Consider depression evaluation and treatment (SSRI/SNRI)

Summary

- **Screening tools** of varying lengths are available to evaluate alcohol and drug use
- **Further assessment** of substance use, physical health, and mental health guides next steps
- **Brief interventions** (10-15 minutes) are effective when delivered appropriately, particularly for alcohol and tobacco users
- Appropriate **treatment referrals** depend on multiple medical, psychological, and psychosocial domains and can be guided by ASAM Criteria

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

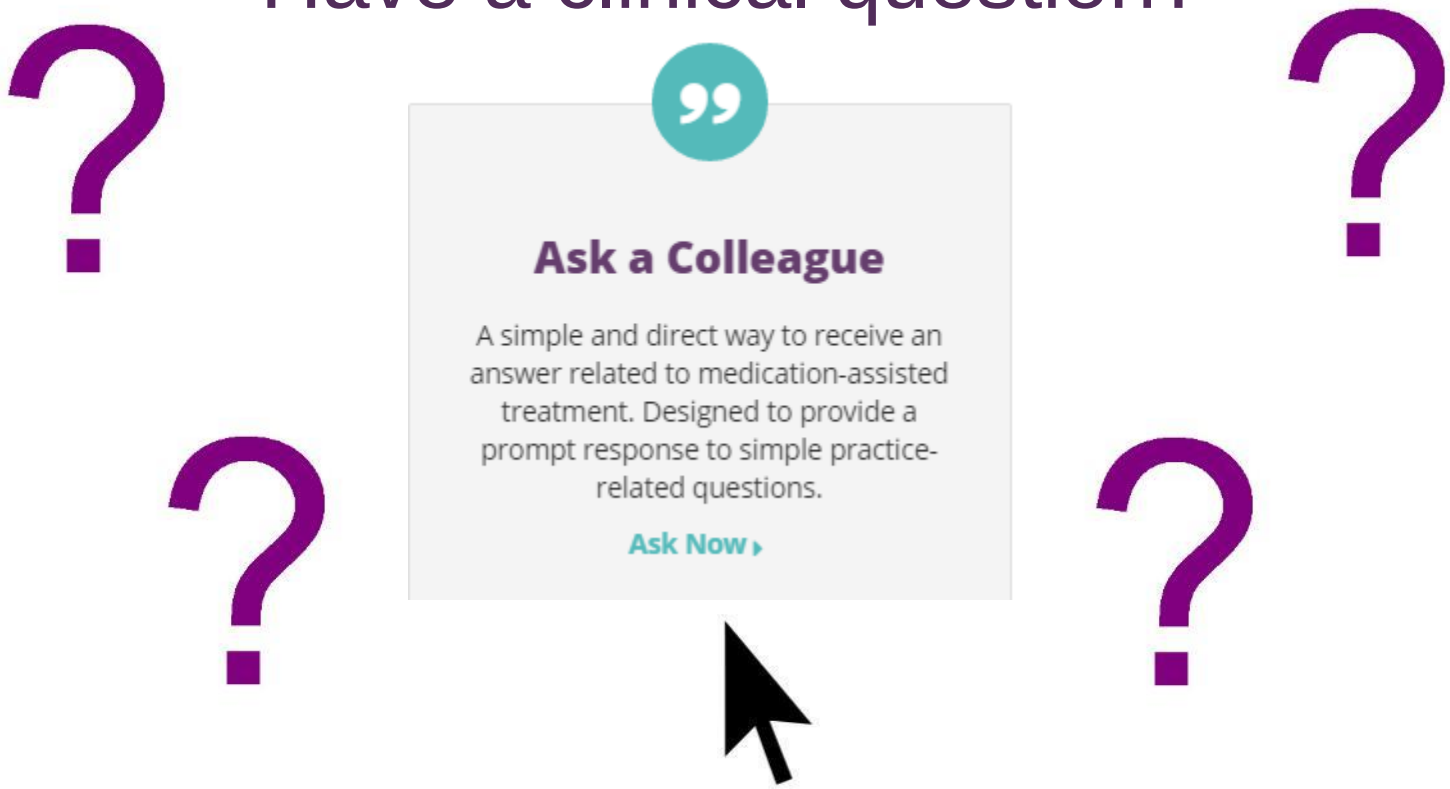
For more information visit:

pcssNOW.org/mentoring

PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PCSS Discussion Forum

Have a clinical question?



PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
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PCSS MAT TRAINING

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PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Neurology (AAN); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); American College of Physicians (ACP); American Dental Association (ADA); American Medical Association (AMA); American Osteopathic Academy of Addiction Medicine (AOAAM); American Psychiatric Association (APA); American Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); National Association of Drug Court Professionals (NADCP), and the Southeast Consortium for Substance Abuse Training (SECSAT).

For more information: www.pcssNOW.org

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