

Quick Guide

For Clinicians

Based on TIP 24

A Guide to Substance Abuse Services for Primary Care Clinicians



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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Quick Guide

For Clinicians

Based on TIP 24
*A Guide to Substance
Abuse Services for Primary
Care Clinicians*

This Quick Guide is based almost entirely on information contained in TIP 24, published in 1997 and based on information updated through May 1996. No additional research has been conducted to update this topic since publication of the original TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *A Guide to Substance Abuse Services for Primary Care Clinicians*, Number 24 in the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration. This Quick Guide is based entirely on TIP 24 and is designed to meet the needs of the busy clinician for concise, easily accessed "how-to" information.

The Guide is divided into 10 sections (see ***Contents***). These sections will help readers quickly locate relevant material.

Clinicians can use the ***Resources*** on page 39 to keep updated with current information on the most recent developments in the field of substance abuse treatment.

For more information on the topics in this Quick Guide, readers are referred to TIP 24.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment.

TIP 24, A Guide to Substance Abuse Services for Primary Care Clinicians

- Addresses the concerns of readers who are primary care clinicians
- Includes extensive research
- Lists numerous resources for further information
- Provides a reference for substance abuse treatment for primary care clinicians

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

Alcohol-related disorders occur in up to 26 percent of general medicine clinic patients, a prevalence rate similar to those for such other chronic diseases as hypertension and diabetes.

Since substance abuse disorders are often chronic conditions that progress slowly, primary care clinicians are in an ideal position to screen for alcohol and drug problems. Studies have shown that primary care clinicians can help patients decrease alcohol consumption through office-based interventions that take only 10 or 15 minutes.

General Recommendations for Primary Care Clinicians

Screening

- 1) Periodically and routinely screen all patients for substance use disorders
- 2) Ask questions about substance abuse in the context of other lifestyle questions
- 3) Use the Alcohol Use Disorder Identification Test (AUDIT) to screen for alcohol problems among English-speaking, literate patients, or use the first three quantity/frequency questions from AUDIT, supplemented by the CAGE questionnaire
- 4) Use the CAGE-AID (CAGE Adapted to Include Drugs) to screen for drugs use among patients

- 5) Ask "Have you used street drugs more than five times in your life?" A positive answer suggests further screening and possibly assessment are needed
- 6) Ask high-risk patients about alcohol and drug use in combination
- 7) Ask pregnant women "Do you use street drugs?" If the answer is yes, advise abstinence
- 8) Use the CAGE, the AUDIT, or the Michigan Alcoholism Screening Test–Geriatric Version (MAST-G) to screen patients over 60
- 9) Screen adolescents for substance abuse every time they seek medical services

Brief Intervention

- 1) Perform a brief intervention with patients whose substance abuse problems are less severe
- 2) Include in the brief intervention feedback about screening results and risk of use, information about safe consumption limits and advice about change, assessment of patient's readiness to change, negotiated goals and strategies for change, and arrangements for followup visits

Assessment and Treatment

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

For more detailed information, see TIP 24, pp. xv–xvii.

WARNING SIGNS AND RISK FACTORS FOR ALCOHOL AND ILLICIT DRUG USE

It is important for primary care clinicians to know patients' drinking levels in order gauge their potential risk for developing problems.

Physical Signs: General

- Dental caries
- Swollen hands or feet
- Swollen parotid glands
- Leukoplakia in mouth
- Gingivitis
- Perforated septum
- Needle track marks
- Skin abscesses, burns on inside of lips
- Disrupted menstrual cycle

Physical Signs: Neurological

- Dilated or constricted pupils
- Slurred, incoherent, or too rapid speech
- Inability to focus (both visually and mentally)

- Unsteady gait
- "Nodding off"
- Blackouts or other periods of memory loss
- Insomnia or other sleep disturbances
- Withdrawal symptoms
- Agitation

Psychiatric

- Depression
- Anxiety
- Low self-esteem
- Low tolerance for stress
- Other mental health disorders
- Feelings of desperation
- Feelings of loss of control over one's life
- Feelings of resentment

Behavioral

- Use of other substances
- Aggressive behavior in childhood
- Conduct disorders; antisocial personality
- Impulsiveness and risk taking
- Alienation and rebelliousness

- School-based academic or behavioral problems
- Involvement with criminal justice system
- Poor interpersonal relationships

Social and Sexual History

- Legal status (minor, in custody)
- Alcohol or drug use by friends
- Level of education
- Occupation/work history
- Sexual preference
- Number of sexual relationships
- Types of sexual activity engaged in
- Whether the patient practices safe sex

Family

- Use of drugs and alcohol by parents, siblings
- Inherited predisposition to alcohol or drug dependence
- Family dysfunction
- Family trauma
- Marital/cohabitation status
- Domestic violence and other abuse history

Demographic

- Male gender
- Inner city or rural residence combined with low-socioeconomic status
- Lack of employment opportunities

Low-Risk and At-Risk

Low-risk drinkers consume less than an average of one to two drinks per day, do not drink more than three or four drinks per occasion, and do not drink in high risk situations (i.e. while pregnant, driving a car, etc.).

At-risk drinkers occasionally exceed recommended guidelines for use. While they are at risk for alcohol related problems, they may never experience negative consequences as a result of their drinking and represent a prime target for preventive, educational efforts by primary care clinicians.

For more detailed information, see TIP 24, pp. 4–5, pp. 46–47.

SCREENING INSTRUMENTS

CAGE-AID

Asking the following questions of every adult routinely and periodically is a cost-effective way of screening for substance abuse and detecting possible problems at an early stage in their development

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

Scoring: Item responses on the CAGE are scored 0 for "no" and 1 for "yes" answers. Consider conducting a brief intervention (explained on page 22) with any patient who scores a one or higher.

Asking potentially sensitive questions about substance abuse in the context of other behavioral lifestyle questions appears to be less threatening to patients.

The AUDIT Questionnaire

The AUDIT is designed to be used as a brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history. Patients tend to answer it most accurately when

- The interviewer is friendly and nonthreatening
- The purpose of the questions is clearly related to a diagnosis of their health status
- The patient is alcohol- and drug-free at the time of the screening
- The information is considered confidential
- The questions are easy to understand

Health workers should try to establish these conditions before the AUDIT is given. Answers should be recorded carefully.

In addition to these general considerations, the following interviewing techniques should be used:

- Try to interview patients under the best possible circumstances
- Look for signs of alcohol or drug intoxication—patients who have alcohol on their breath or appear intoxicated may be unreliable respondents
- It is important to read the questions as written and in the order indicated

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

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

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

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

[Code number of standard drinks.*]

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

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

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

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

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

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

Procedures for scoring AUDIT

Question 1: Never = 0
Monthly or less = 1
Two to four times per month = 2
Two to three times per week = 3
Four or more times per week = 4

Question 2: 1 or 2 = 0
3 or 4 = 1
5 or 6 = 2
7 to 9 = 3
10 or more = 4

Questions 3–8: Never = 0
Less than monthly = 1
Monthly = 2
Weekly = 3
Daily or almost daily = 4

Questions 9–10: No = 0
Yes, but not in the last year = 2
Yes, during the last year = 4

The minimum score (for non-drinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

TWEAK Test

Use the TWEAK test to screen pregnant women.

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

Scoring: A 7-point scale is used to score the test. The "tolerance" question scores 2 points if a woman reports she can hold more than five drinks without falling asleep or passing out. A positive response to the "worry" question scores 2 points, and a positive response to the last three questions scores 1 point each. A total score of 2 or more indicates a woman is likely to be a risky drinker.

Screen all adults age 60 or older for alcohol and prescription drug abuse as part of their regular physical.

Michigan Alcoholism Screening Test–Geriatric Version (MAST-G)

The following are yes or no questions:

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?
2. When talking with others, do you ever underestimate how much you actually drink?
3. Does alcohol make you so sleepy that you often fall asleep in your chair?
4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
5. Does having a few drinks help decrease your shakiness or tremors?
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?
7. Do you have rules for yourself that you won't drink before a certain time of the day?
8. Have you lost interest in hobbies or activities you used to enjoy?

9. When you wake up in the morning, do you ever have trouble remembering part of the night before?
10. Does having a drink help you sleep?
11. Do you hide your alcohol bottles from family members?
12. After a social gathering, have you ever felt embarrassed because you drank too much?
13. Have you ever been concerned that drinking might be harmful to your health?
14. Do you like to end an evening with a nightcap?
15. Did you find your drinking increased after someone close to you died?
16. In general, would you prefer to have a few drinks at home rather than go out to a social event?
17. Are you drinking more now than in the past?
18. Do you usually take a drink to relax or calm your nerves?
19. Do you drink to take your mind off your problems?
20. Have you ever increased your drinking after experiencing a loss in your life?
21. Do you sometimes drive when you have had too much to drink?

22. Has a doctor or nurse ever said they were worried or concerned about your drinking?

23. Have you ever made rules to manage your drinking?

24. When you feel lonely does having a drink help?

Scoring: 5 or more "yes" responses are indicative of an alcohol problem.

Suggestions for Screening

All adolescents should be asked about alcohol and drug use, particularly marijuana.

Risk Factors for Adolescent Drug Use

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

Red Flags

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

- Involvement in serious delinquency or crimes
- HIV high-risk activities
- Serious psychological problems
- Pregnant women and women older than 60, as well as women who have experienced a major life transition, should be queried about their psychoactive prescription drug use and use of over-the-counter sleep aids.
- Clinicians will want to use the screening instrument that best meets the needs of their patient population.
- When treating patient populations at high risk for drug abuse, ask questions regarding alcohol and drug use at the same time.

For more detailed information, see TIP 24, pp. 12–21, pp. 116–119, p. 127.

FOLLOWING UP ON SCREENING

- All patients who undergo screening for alcohol or drug use should be told the results of the screen.
- Patients with positive results to a screen will need some type of followup. Assessment questions should cover severity of the suspected alcohol or drug involvement, the types and frequency of problems connected with the patient's use, and other special medical and psychiatric considerations.
- If a patient's response to a brief assessment suggests a diagnosis of substance abuse or dependence, the clinician should initiate a referral for an in-depth assessment.
- The clinician can initiate a brief, office-based therapeutic intervention in these situations:
 - Screening reveals only mild to moderate substance abuse problems
 - The patient appears to be at risk for experiencing negative consequences as a result of current patterns
 - Coexisting illness or conditions may be worsened by continued drinking or other medications
 - Patient refuses referral for further assessment or treatment

For more detailed information, see TIP 24, pp. 23–26

BRIEF INTERVENTION

Brief interventions as secondary prevention tools have the potential to help an estimated 15 to 20 million heavy drinkers in the U.S. by minimizing serious adverse consequences such as costly emergency room visits, domestic violence, or road accidents.

Selecting Appropriate Patients for Brief Intervention

In response to screening questionnaires patients can be categorized into one of three groups:

1. Patients who do not appear to have any alcohol- or drug-related problems. These patients require no further intervention.
2. Patients with positive but low scores on any screening tests or who occasionally use marijuana. These patients may be appropriate candidates for brief intervention.
3. Patients with several positive responses to screening questionnaires and suspicious drinking or drug use histories, symptoms of substance dependence, or current use of illicit drugs. These patients need further assessment.

Conducting Brief Interventions

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

- Give prompt feedback to the screening.
- Present results in a straightforward, nonjudgmental manner and in terms a patient can readily understand.
- Concerns about potential or actual health effects should be stressed. For example, "At this level of consumption, you are at increased risk for some health problems as well as accidents."
- Avoid being adversarial and pay attention to semantics. For example, the phrase "people for whom substance abuse is creating a problem" is less off-putting than the labels "alcoholic" or "addict."
- Remain tolerant of the range of patient reactions, including astonishment, embarrassment, hostility, and denial.
- Try to avoid arguments or discussions about how much others can drink without adverse consequences.
- Be reassuring that alcohol and drug problems are not anyone's "fault" and can certainly be addressed during visits.

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

- Explain what acceptable and safe use levels are for the relevant substance. Low-risk drinking is no more than two drinks per day for men and one drink per day for women.
- Patients should understand concepts of tolerance and metabolism.
- Abstinence from illegal drugs is always the ultimate goal. For example, "Thank you for being honest with me about your marijuana use. One concern of mine is your asthma, because marijuana smoke does affect your lungs. Why don't we work out a plan to help you quit?"
- Clearly state recommendations about consumption goals, keeping these in the context of lifestyle issues and living habits. For example, "In reviewing your response to our screening questionnaire, I notice that you are drinking a lot of beer on weekends. You don't seem to have any direct problems as a result, but I'm concerned that driving while intoxicated is not safe and you have a young family to consider."
- Clinician authority in offering advice can be strongly motivating.

3) Assess the patient's readiness to change

- A patient's reaction to initial feedback about screening results offers strong clues about readiness to change.
- People with substance abuse disorders generally fall into one of five stages along a continuum that provides a useful framework for monitoring progress:
 - 1) Precontemplation: Not seeing the behavior as a problem or not wanting to change the behavior.
 - 2) Contemplation: Beginning to understand that the behavior is causing difficulties in living or taking a toll on their health and happiness.
 - 3) Preparation/Determination: Considering various options for change.
 - 4) Action: Taking concrete steps to change the behavior in a specific way.
 - 5) Maintenance: Avoiding relapse into problem behavior.
- Be prepared for resistance and setbacks.
- Avoid the temptation to regard resistance as a challenge to authority or to react in an authoritarian way.
- Have an emphatic and supportive attitude and create an atmosphere that the patient will be

comfortable returning to even if goals are not successfully achieved.

4) Negotiate goals and strategies for change

- With alcohol, suggest that the client reduce consumption to below unsafe or potentially hazardous levels. For example, "Can we set a specific date to reduce your alcohol use? Could you cut back, beginning this week?"
- If a patient who is using illegal drugs does not feel ready to discontinue use, suggest a tapering schedule.
- The clinician can only remind the patient that reducing or stopping alcohol use or abstaining from other drug use will eliminate the health or social problems substance use is causing:
Ultimately the patient must choose the goal.
- Suggest that patients keep track of consumption in a daily diary to make them more aware of how much they consume. Even patients who are not ready to change their behavior may be willing to keep a diary.
- Patients will be more motivated to change if they are helping to set goals and develop strategies for change. Some studies have found that self-help manuals can be a helpful adjunct for planning change.

- A written contract is a good idea since sometimes patients forget what they agreed to do.

5) Arrange for followup treatment

- Monitor any health problems or abnormal physical markers.
- Express trust in the patient.
- Confront the patient if he or she is not honest about reporting substance use.
- The use of any form of objective monitoring beyond self-reports of substance abuse must be negotiated between the clinician and the patient.
- Tell patients exactly who will see their medical charts and what information about screening and intervention will be recorded.
- One researcher found that reduction of alcohol consumption correlated with the number of practitioner intervention sessions that were delivered.

Deciding to Refer for Further Assessment or Treatment

Clinicians should be prepared for the brief intervention to fail: The patient may not be able to achieve or maintain the mutually established goal of reducing or stopping use after one, or even several, tries. Clinicians cannot force a patient to

undergo further assessment. However, if problem use persists after a brief intervention, those discussions should serve as a springboard for a more in-depth assessment or specialized treatment.

For more detailed information, see TIP 24, pp. 26–38.

ASSESSMENT

The first step to understanding local substance abuse treatment resources is to collect information about the specialized services in your area and have a contact person at each one.

In-depth substance abuse assessment requires specialized skills and consumes a substantial amount of time. However, even clinicians who will not perform substance abuse assessments should have a basic understanding of their elements and objectives so they can

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

What assessment does

- Examines problems related to use (e.g., medical, behavioral, social, and financial)
- Provides data for a formal diagnosis
- Establishes severity of an identified problem

- Helps to determine appropriate level of care
- Guides treatment planning

For more detailed information, see TIP 24, pp. 41–51.

GOALS AND EFFECTIVENESS OF TREATMENT

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

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

For most patients, the primary goal of treatment is attainment and maintenance of abstinence. However, until the patient accepts that abstinence is necessary, treatment programs try to minimize the effects of continuing use and abuse through

- Education
- Counseling
- Self-help groups that stress reducing risky behavior, building new relationships with drug-free friends, changing recreational activities and lifestyle patterns, substituting substances used with less risky ones, etc.

All the long-term studies find that "treatment works"—the majority of substance-dependent patients eventually stop compulsive use and have less frequent and severe relapse episodes.

Some important things to remember about alcohol and other drug treatment are

- No single approach is effective for all persons with alcohol problems
- Treatment of other life problems associated with drinking improves outcomes
- Therapists and patient (and problem) characteristics, treatment process, posttreatment adjustment factors and the interactions among these variables also determine outcomes
- Patients who significantly reduce alcohol consumption or become totally abstinent usually improve their functioning

The Role of the Primary Care Clinician Throughout Treatment

- Learn about treatment resources in the community that offer appropriate services
- Keep in touch with the specific treatment program where the patient is enrolled to ascertain

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The Role of the Primary Care Clinician Throughout Treatment

- Learn about treatment resources in the community that offer appropriate services
- Keep in touch with the specific treatment program where the patient is enrolled to ascertain

its quality and understand the approach and services offered

- Request formal reports regarding the treatment plan and progress indicators from the program on a periodic basis (with the patient's explicit permission)
- Clarify the clinician's role in continued care of the patient (e.g. treating specific medical conditions, writing prescriptions, and monitoring compliance through urine or other testing)

For more detailed information, see TIP 24, pp. 56–57, p. 70.

TREATMENT MODELS AND APPROACHES

The three historical orientations that still underlie different treatment models are

1. *A medical model*, emphasizing biological/genetic or physiological causes of addiction that require treatment by a physician utilizing pharmacotherapy to relieve symptoms.
2. *A psychological model*, focusing on an individual's maladaptive motivational learning or emotional dysfunction as the primary cause of substance abuse. The approach includes psychotherapy or behavioral therapy directed by a mental health professional.
3. *A sociocultural model*, stressing deficiencies in the social and cultural milieu or socialization process that can be ameliorated by changing the physical and social environment, particularly through involvement in self-help fellowships or spiritual activities and supportive networks. Treatment authority is often vested in persons who are in recovery themselves and whose experiential knowledge is valued.

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

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

1. *The Minnesota model of residential chemical dependency treatment* incorporates a biopsychosocial model for addiction that focuses on abstinence as the primary treatment goal and uses the Alcoholics Anonymous 12-Step program as a major tool for recovery and relapse prevention. This approach evolved from earlier precursors and initially required 28 to 30 days to complete. More recent models have shortened inpatient stays considerably and substituted intensive outpatient treatment followed by less intensive continuing care.
2. *Drug-free outpatient treatment* uses a variety of counseling and therapeutic techniques, skills training, and educational supports and little or no pharmacotherapy to address the specific needs of individuals moving from active substance abuse to abstinence. This is the least standardized treatment approach and varies considerably in both intensity, duration of care, and staffing patterns. Most of these programs see patients only once or twice weekly and use some combination of counseling strategies, social work, and 12-Step or self-help meetings.
3. *Methadone maintenance—or opioid substitution—treatment* specifically targets chronic hero-

in or opioid addicts who have not benefited from other treatment approaches. The methadone or other long-acting opioid, when administered in adequate doses, reduces drug craving, blocks euphoric effects from continued use of heroin or other illegal opioids, and eliminates the rapid mood swings associated with short-acting and usually injected heroin. The approach, which allows patients to function normally, focuses on rehabilitation and the development of a productive lifestyle.

4. *Therapeutic community residential treatment* is best suited to patients with a substance abuse dependence diagnosis who also have serious psychosocial adjustment problems and require resocialization in a highly structured setting. Treatment generally focuses on negative patterns of thinking and behavior that can be changed through reality-oriented individual and group therapy, and participation in a therapeutic milieu with hierarchical roles, privileges, and responsibilities. Tutorials, remedial and formal education, and daily work assignments in the communal setting or conventional jobs are usually required.

Pharmacotherapy

The use of medication to manage alcohol and drug abuse falls into four categories:

- ***Medications to manage withdrawal*** replaces the abused drug with another, safer drug. The latter can be gradually tapered until physiological homeostasis is restored.
- ***Medications to discourage substance use***, can precipitate an unpleasant reaction or diminish the euphoric effects of alcohol and other drugs.
- ***Agonist substitution therapy*** replaces an illicit drug with a prescribed medication. Opioid maintenance treatment, currently the only type of this therapy available, both prevents withdrawal symptoms from emerging and reduces craving among opioid-dependent patients.
- ***Medications to treat comorbid psychiatric conditions*** are used for persons with co-occurring mental health and substance abuse problems. Prescribing medications for these patients requires extreme caution, partly due to difficulties in making accurate differential diagnosis and due to the dangers of intentional or unintentional overdose.

For more information see TIP 24, pp. 81–97.

LEGAL ISSUES

Things to keep in mind when treating/screening patients:

- Though it is not required by law, doctors should ask patients' permission before any laboratory screens
- Laws regarding the extent of doctor-patient privilege vary from State to State
- All States permit health care professionals to disclose information if the patient consents in writing
- When documenting patient information, doctors should use neutral chart notations that do not identify issues as substance abuse related
- When doctors must communicate with a client's employer because a client is entering treatment, they should communicate in a way that does not indicate a patient is entering treatment for alcohol or other drugs

It is essential for primary care physicians to respect their patient's autonomy and rights to confidentiality if they are to be effective in screening and assessing patients for substance use disorders.

For more detailed information, see TIP 24, p. 69, p. 79, pp. 103–114.

PHONE AND INTERNET RESOURCES

Alcoholics Anonymous

(212) 870-3400

www.aa.org

Narcotics Anonymous

(818) 773-9999

www.na.org

SAMHSA's National Clearinghouse for Alcohol and
Drug Information

(800) 729-6686

(301) 468- 6433 fax

www.samhsa.gov

National Council on Alcoholism and Drug
Dependence, Inc. (NCADD)

(212) 206-6770

(212) 654-1690 fax

Hope Line: (800) 729-6686

www.ncadd.org

*For more detailed information, see TIP 24,
pp. 143–145.*

Ordering Information

TIP 24 *A Guide to Substance Abuse Services for Primary Care Clinicians*

TIP 24-Related Products

KAP Keys for Clinicians based on TIP 24



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Easy Ways to Obtain Free Copies of All TIP Products

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**
- 2 Visit CSAT's Website at **www.csat.samhsa.gov**



Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

TIP 3, *Screening and Assessment of Alcohol- and Other Drug Abusing Adolescents (1994)* **BKD108**

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders (1999)* **BKD306**

TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse (1999)* **BKD341**

TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment (1999)* **BKD342**

See the inside back cover for ordering information for all TIPs and related products.