Understanding Substance Use Disorders and Co-Occurring Conditions: My Approach

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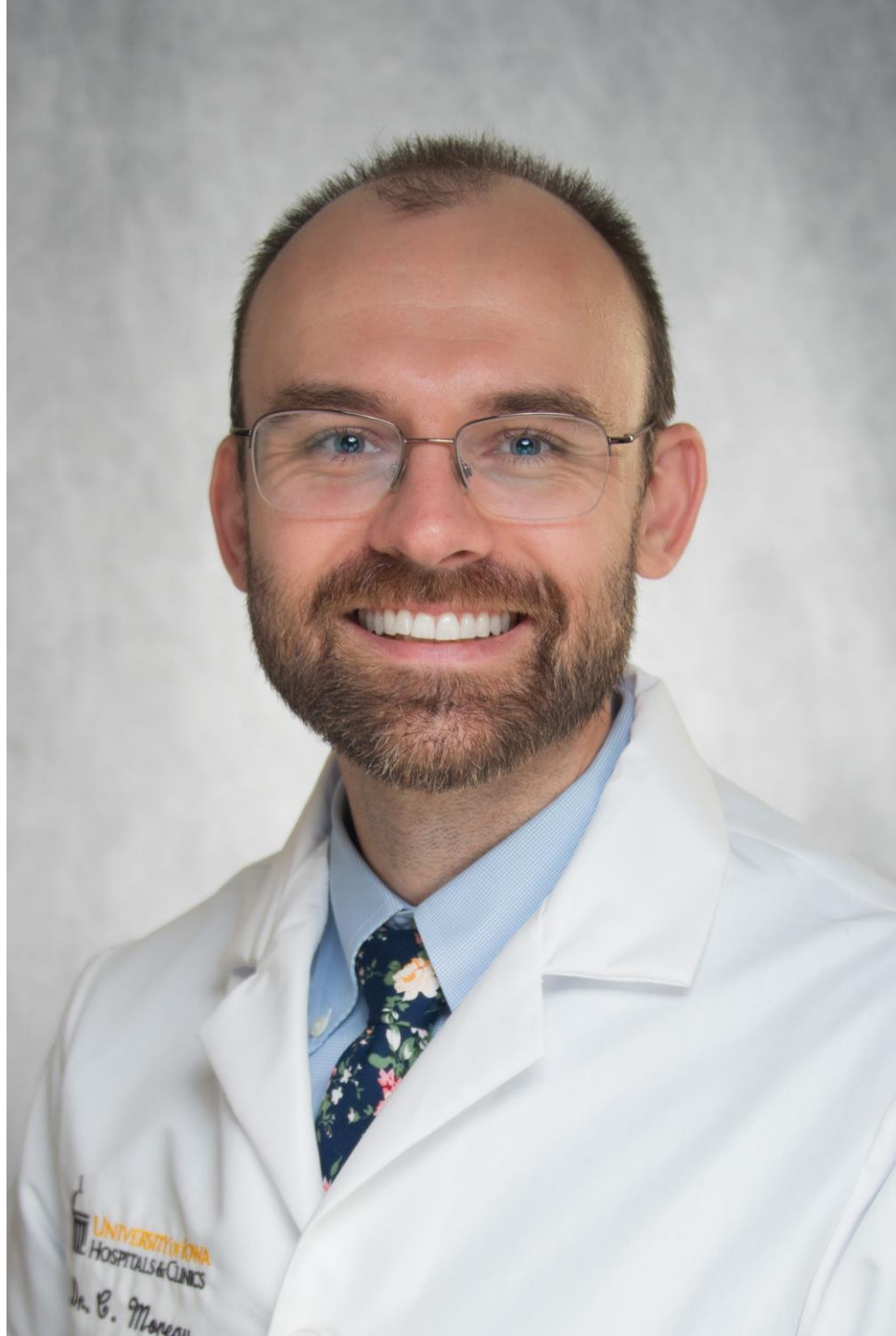
UI Healthcare

Disclosures

- None

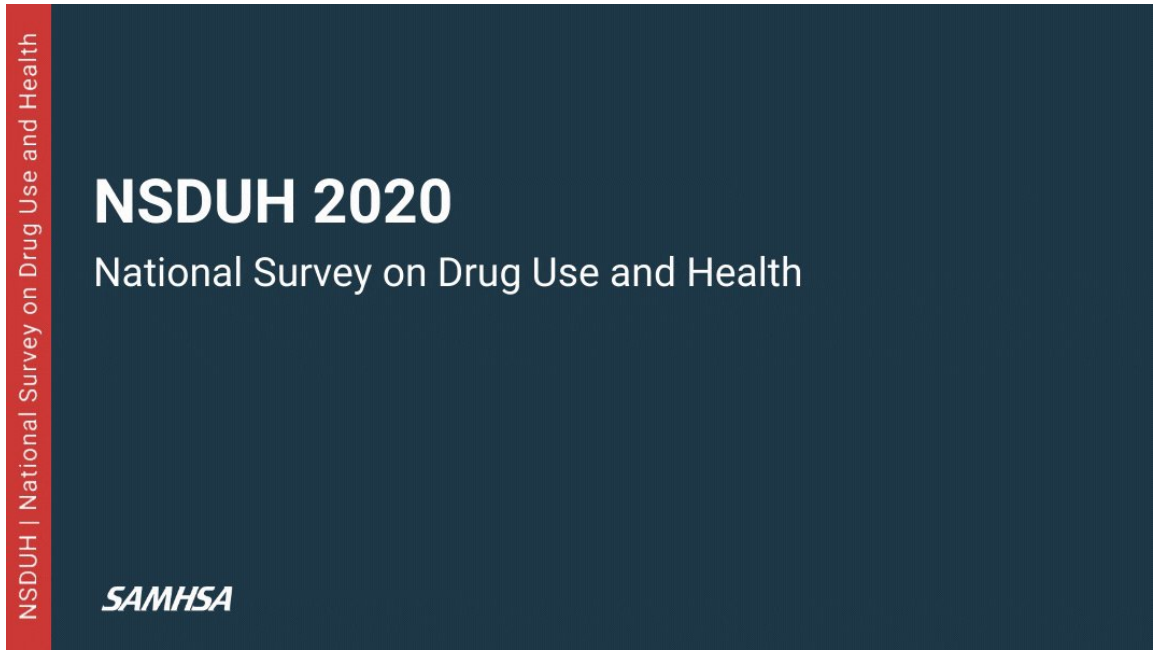
Who am I?

- White guy with glasses
- Not in recovery
- Former high school teacher
- Board Certified Psychiatry and Addiction Medicine Specialist
- Addiction Medicine Consult Service



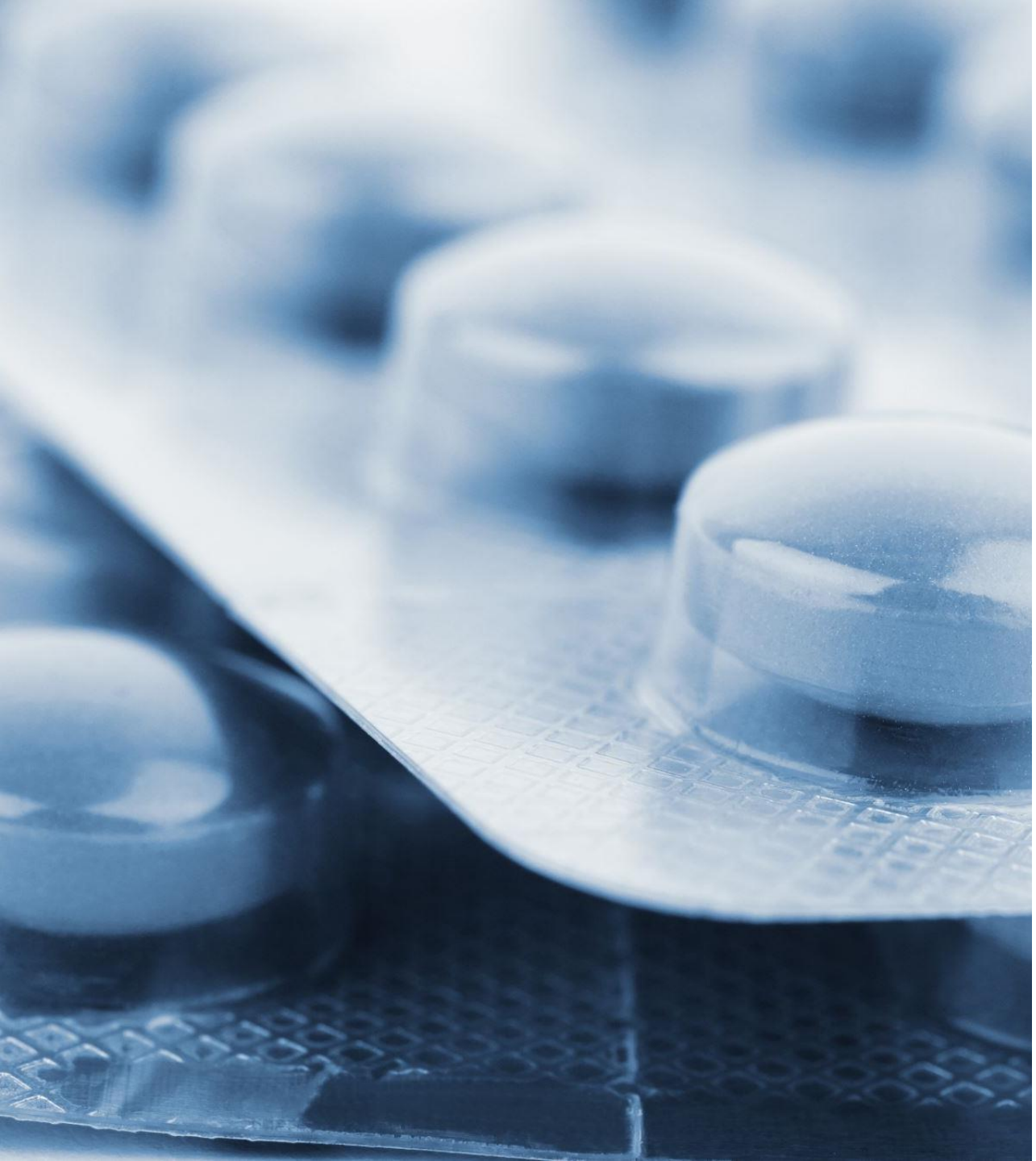
Our community uses drugs

- In 2022, 59.8% … used tobacco products, vaped nicotine, used alcohol, or used an illicit drug in the past month
- In 2021, 21.9 percent of the population used illicit drugs in the past year. The most used illicit drug was cannabis…



Many struggle with SUD

- 16.5 percent of the population met the applicable DSM-5 criteria for having a substance use disorder in the past year, including 29.5 million people who were classified as having an alcohol use disorder and 24 million people who were classified as having a drug use disorder.



Most aren’t treated

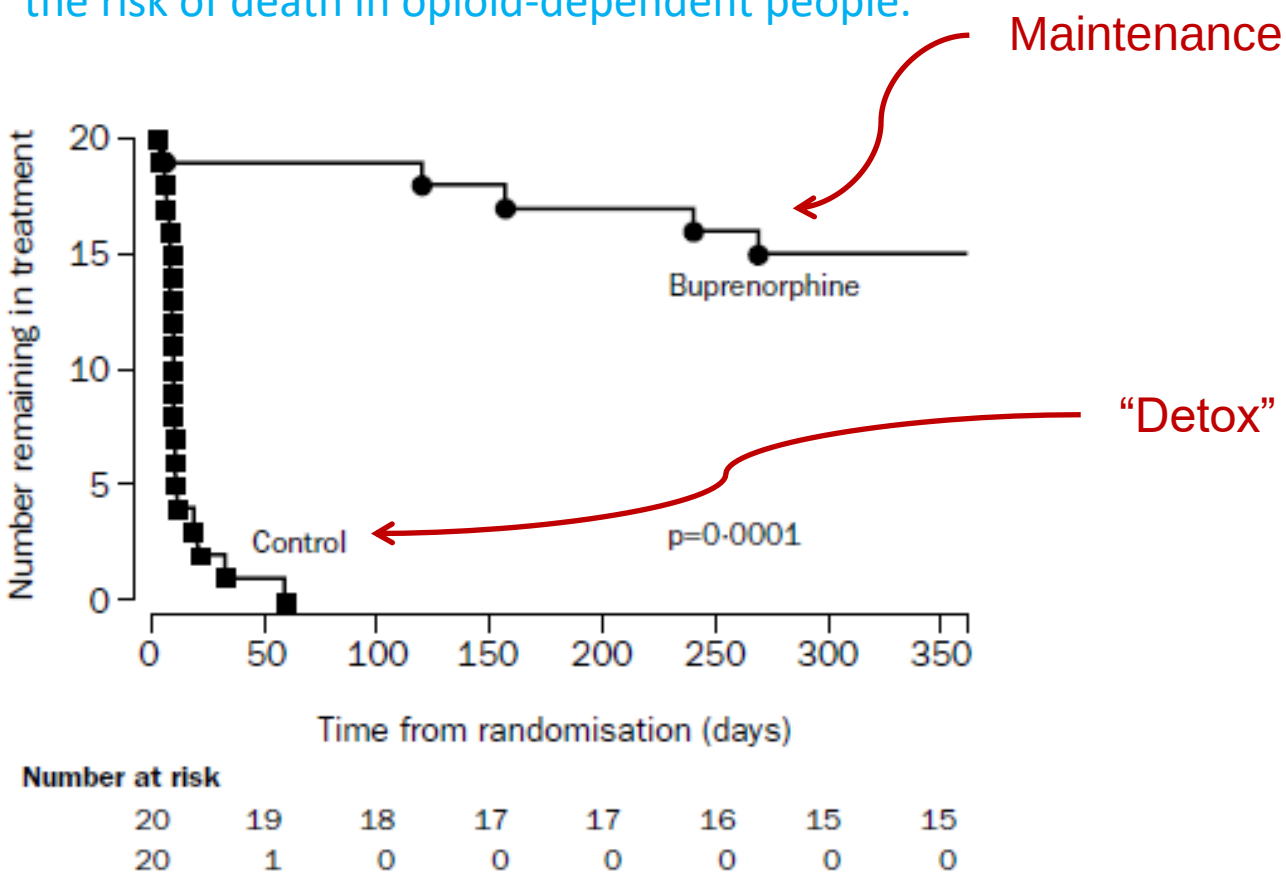
- In 2021, 94% of people with a substance use disorder did not receive any treatment. Nearly all (97.5%) people with a substance use disorder did not seek treatment or think they should get it.

Most people recover from SUD

- In 2022, 11.8% of the population perceived that they ever had a substance use problem. Among these adults, 71.0% considered themselves to be in recovery or to have recovered.
- REMINDER: Do NOT fall victim to fatalistic or reductionist thinking!
  - “They aren’t ready to change…”
  - “They will never change”
  - “They haven’t hit rock bottom yet…”

Treatment works!

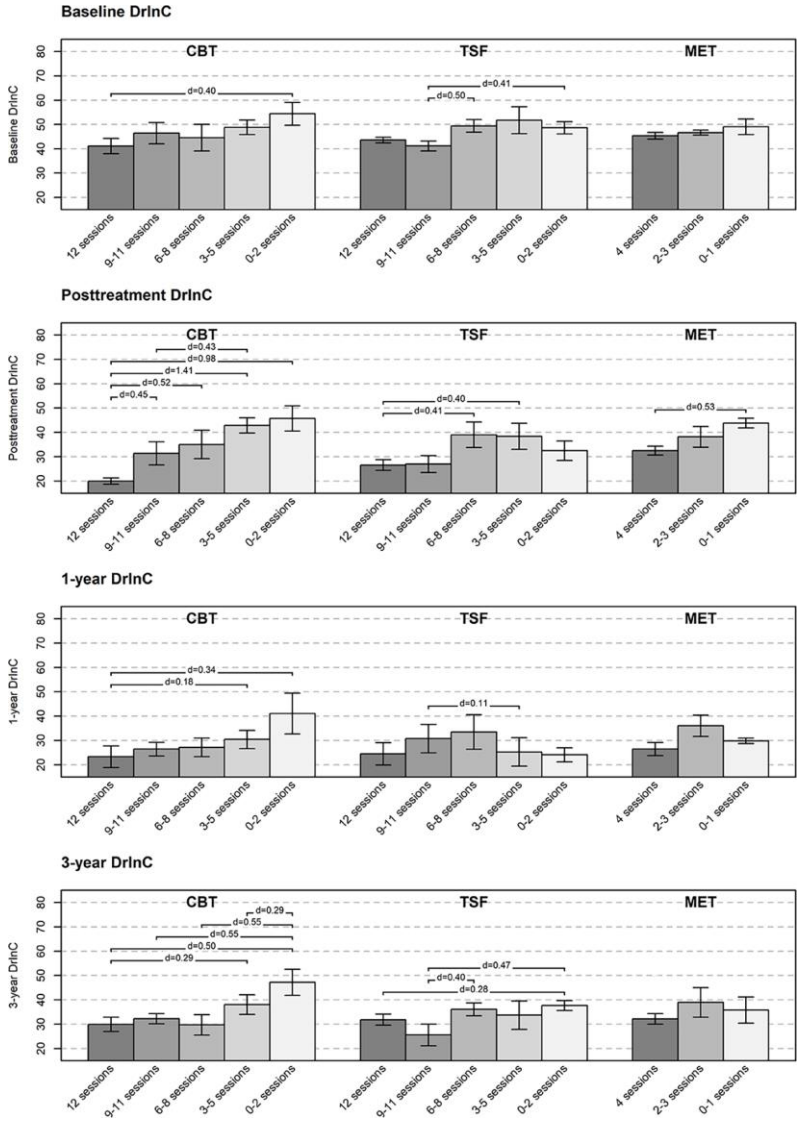
Increased exposure to opioid maintenance treatment reduces the risk of death in opioid-dependent people.



Number at risk

20	19	18	17	17	16	15	15
20	1	0	0	0	0	0	0

Figure 2: **Kaplan-Meier curve of cumulative retention in treatment**



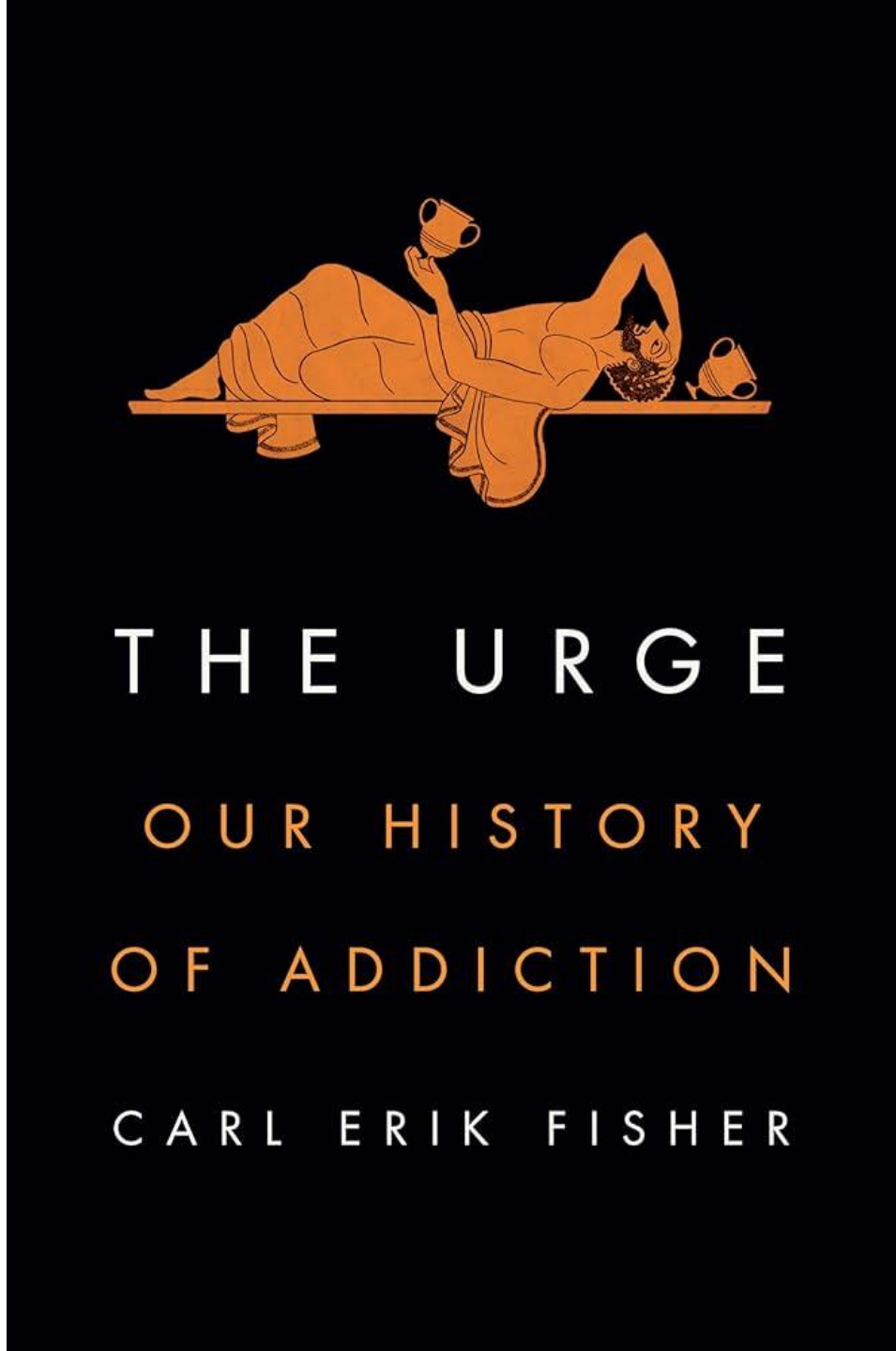
Psychosocial intervention and AA attendance are robustly associated with better AUD outcomes.

What is addiction?

“Not only is there no one biological cause, there is no one dominant cause of addiction, or even a set of causes that reliably explains why some people develop addiction.

The best we can say today is that all these variegated influences intersect in a complex and dynamic matrix, changing drastically from person to person, and even changing over the course of an individual’s lifetime.

It is not that addiction is a brain disease, or a social malady, or a universal response to suffering. It is all these things and none of them at the same time because each level has something to add but cannot possibly tell the whole story.”



Factors that influence addiction

- Medical, neuroscientific
- Psychological (thoughts, feelings)
- Social
- Trauma (personal, intergenerational)
- Legal
- Sex, gender, race
- Geographic
- Economic, advertising

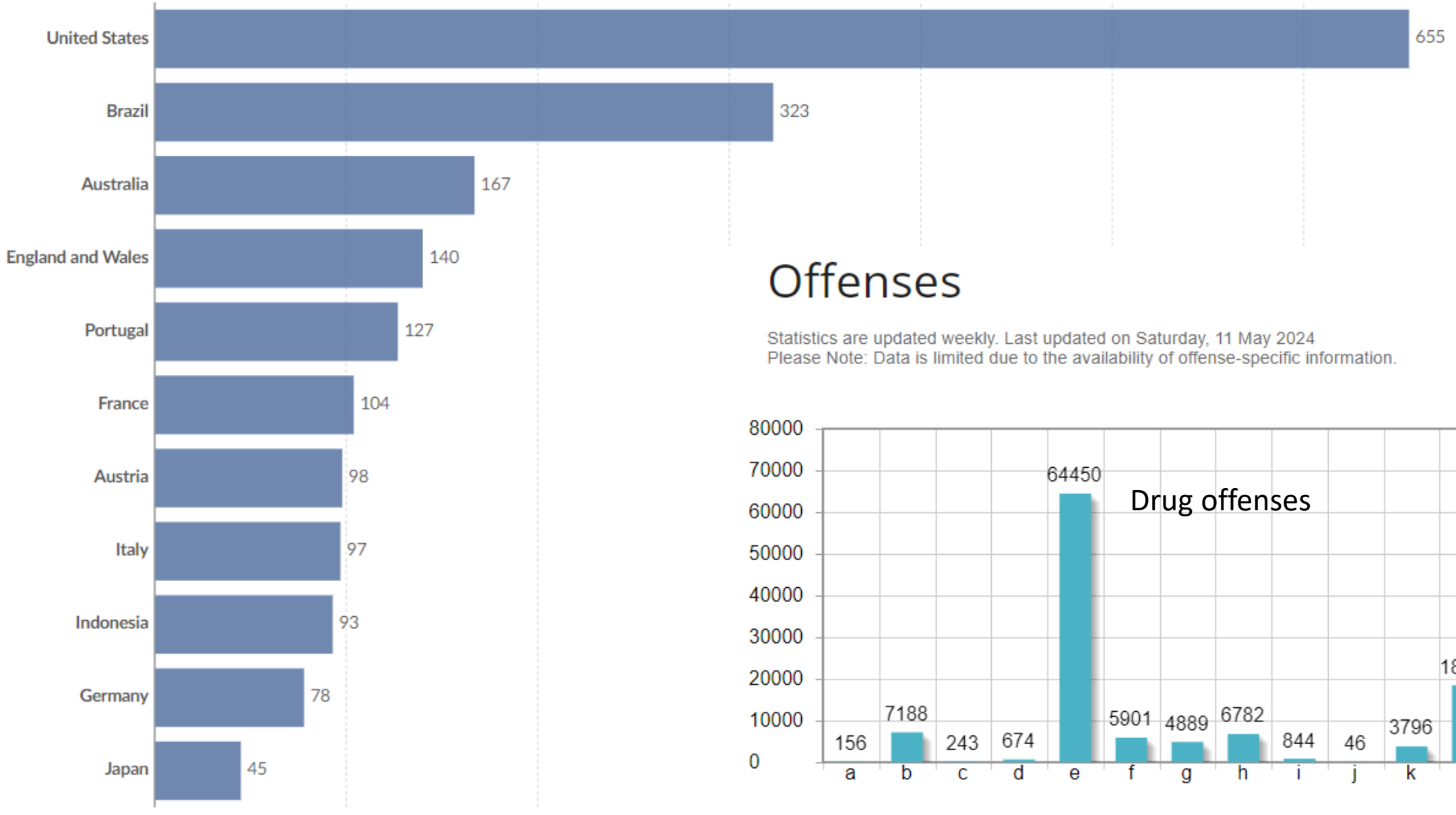
Prison population rate

Prison population rates are measured as the number of prisoners per 100,000 people in a population. Shown is data for 2018 or the latest available data before 2018.

Our World in Data

Table | Map | Chart

Edit countries and regions



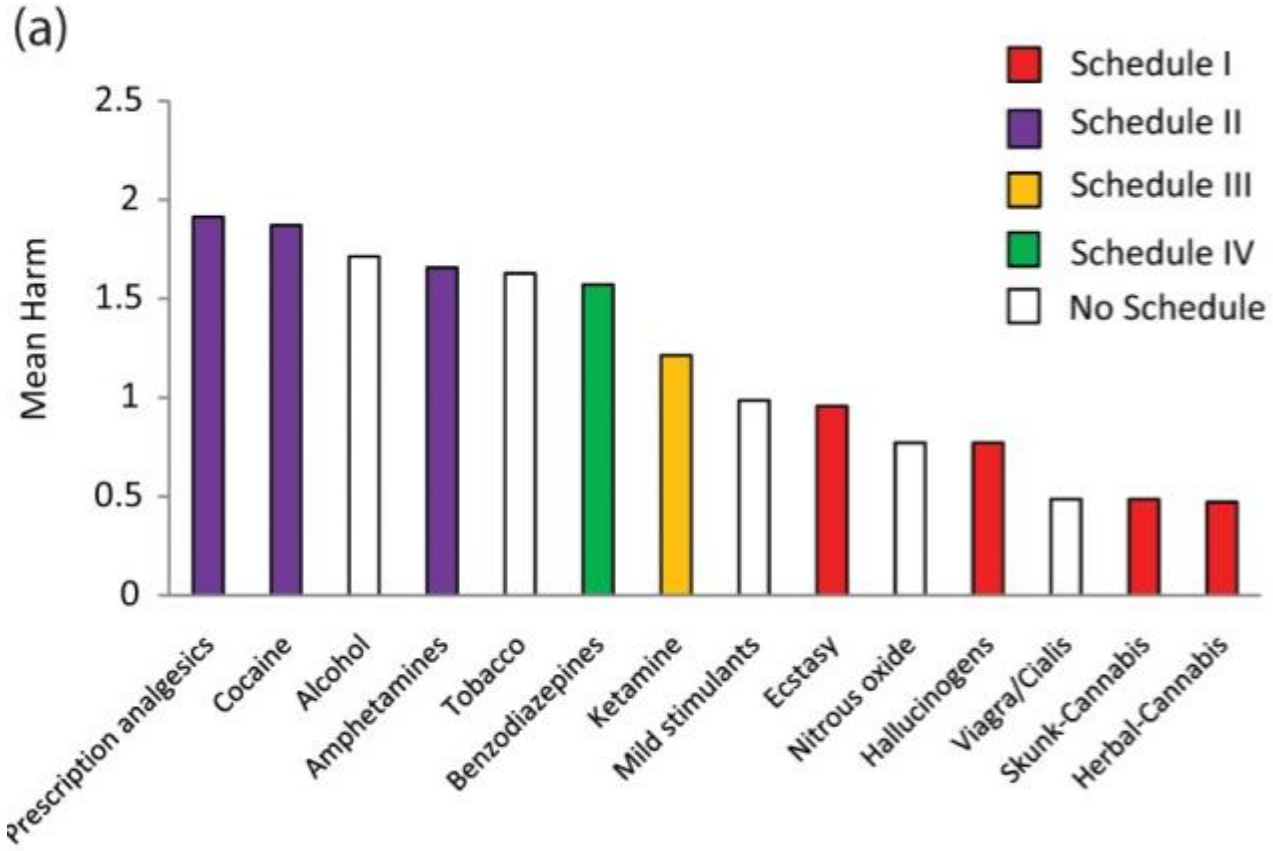
Offenses

Statistics are updated weekly. Last updated on Saturday, 11 May 2024
Please Note: Data is limited due to the availability of offense-specific information.

Harms

- Survey data ->
- No correlation between schedule status/legality and reported harms

- “Among national estimates of the costs of illness for 33 diseases and conditions, alcohol ranked second, tobacco ranked sixth, and drug disorders ranked seventh”



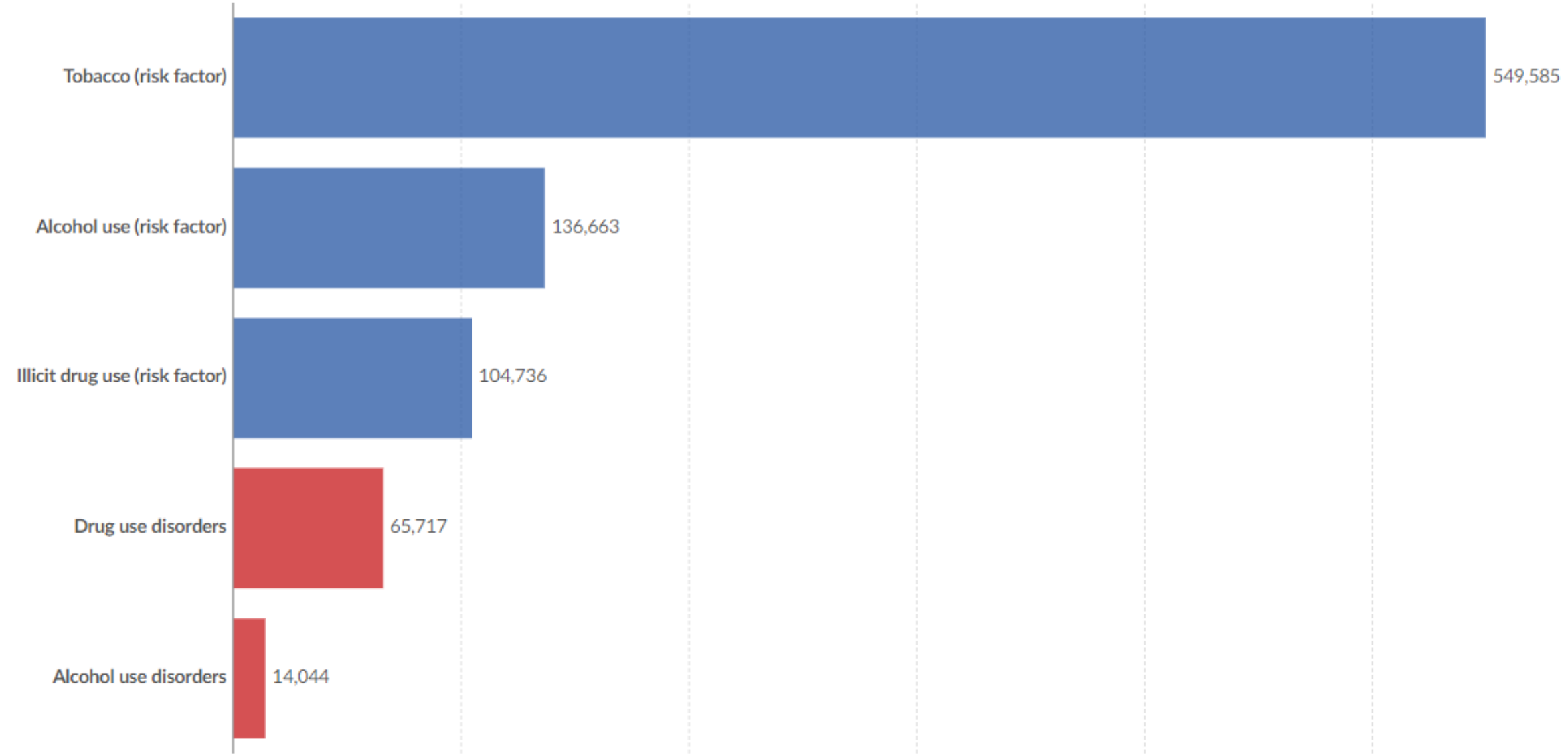
Deaths attributed to tobacco, alcohol and drugs, United States, 2019

In blue are shown the estimated annual number of deaths attributed to tobacco, alcohol and drugs. In red are shown the estimated annual number of deaths from drugs and alcohol. The difference between both is that they relate to indirect and direct causes of death, respectively.

Our World in Data

Table | Chart

Change country or region



Language Matters

- I’m not the PC police. The point is not to use anemic, unexpressive language.
- However, “Compared to those in the "substance use disorder" condition, those in the "substance abuser" condition agreed more with the notion that the character was personally culpable and that punitive measures should be taken.” (Kelly & Westerhoff, 2010)
- …‘marijuana’ or ‘marihuana,’ which have historical origins in early attempts by US federal law enforcement officials to demonize the compound, and to portray it as something used by ‘the other’ (i.e., Mexican immigrants or those of Mexican heritage now living in the US). Due to this history, ‘marijuana’ and ‘marihuana’ are not scientific terms. (Anthony et al, 2017)

Language Matters

- Try to use language the patient uses
  - For example, the term “alcoholic” can be an important identifier for some

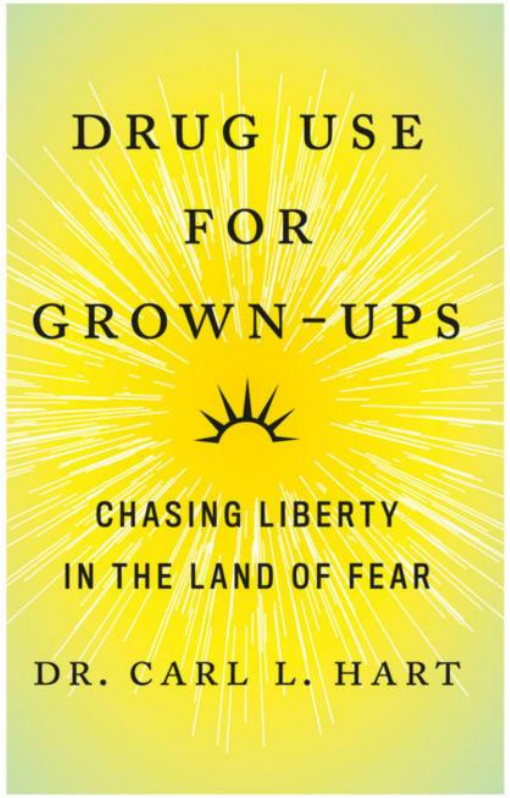
Avoid	Try
Abuse	Use, use disorder, chaotic use
Clean, dirty	Positive or negative for ___, using or not using
Addict, junkie, abuser, etc.	Person who uses ___
Marijuana	Cannabis, THC or CBD products
Relapse, Failure of treatment	Return to use
Former addict, reformed addict	Recovery

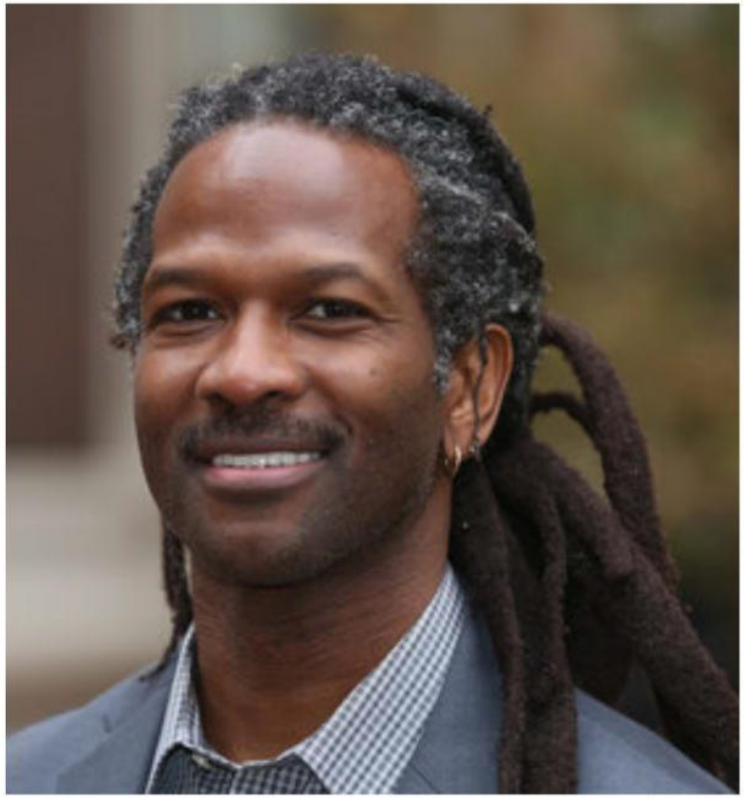
Before entering the room

- Mindful awareness
  - How am I feeling today? Deep breath.
  - What are my core beliefs regarding substance use and how do they influence my behavior?
- My Mantras of Respect and Humility
  - “The patient is the one who suffers.”
  - “I am a servant to my community.”
  - “Addiction is complex”
  - “People use drugs for good reasons.”
  - “What would Nancy Williams do?”

People Use Drugs for Good Reasons

- ≠ drug/alcohol use is an effective or mature coping strategy, or that it is safe or healthy
- It means we need to hear and take seriously peoples' stories, needs.





Talking to people who use drugs (PWUD)

- Your approach matters
- The interview is dynamic

First Steps

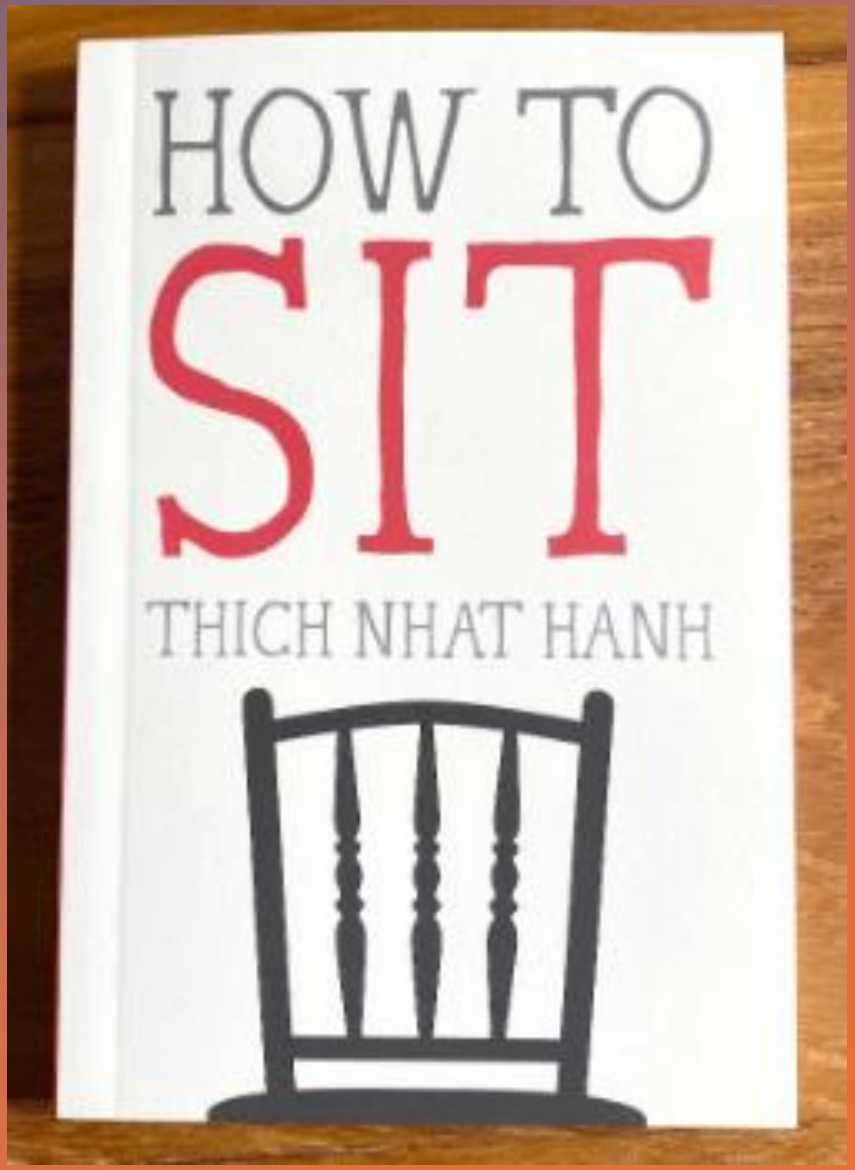
- Introductions
  - My name is ___ and I am with the Addiction Medicine team. I have a resident/student with me, ___. Is it all right if we have a chat with you?
- Sit Down

"At the end of the day people won't remember what you said or did, they will remember how you made them feel."

– Maya Angelou

How to Sit

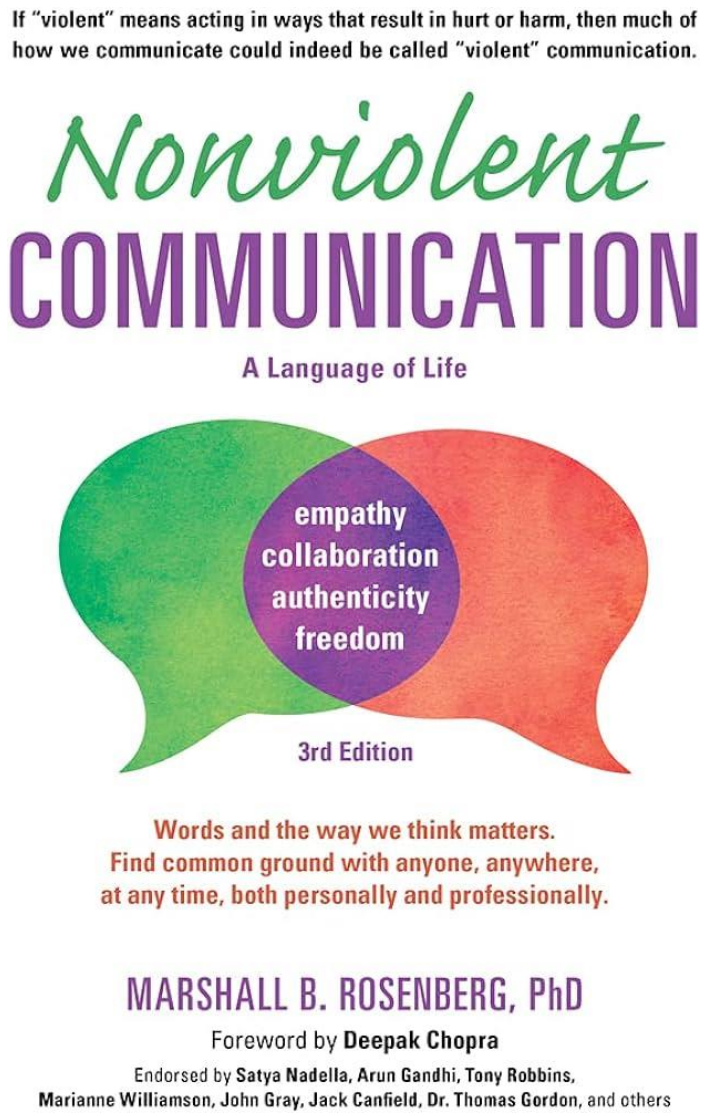
"The first thing to do is stop whatever else you are doing."



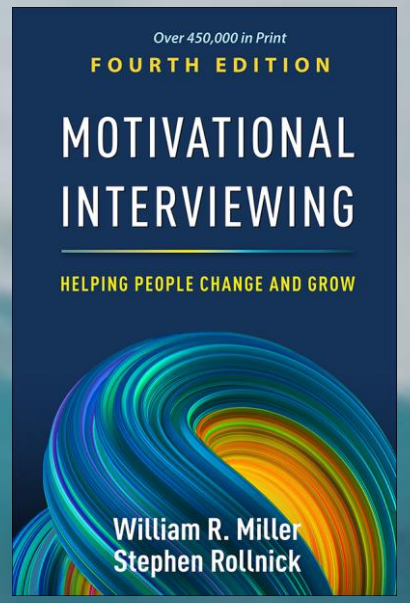
First Question

- How are you?
  - "What's alive in you?"
  - I value what matters to you
  - Not a platitude

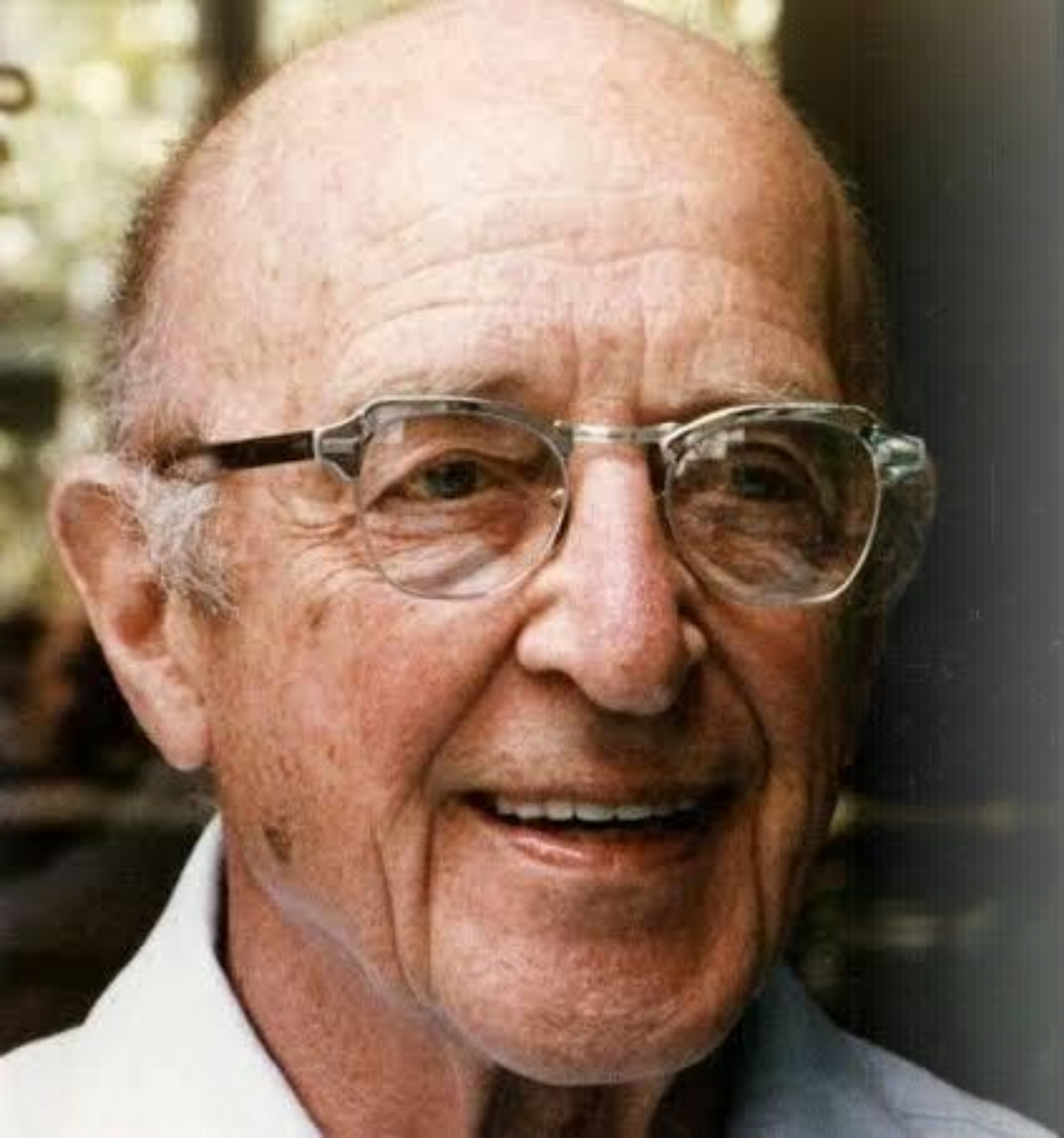
...then what?



Listen, engage, build “rapport”



- OARS
  - Open Ended Q's
  - Affirmations
  - **Reflections**
  - Summaries
- Validation

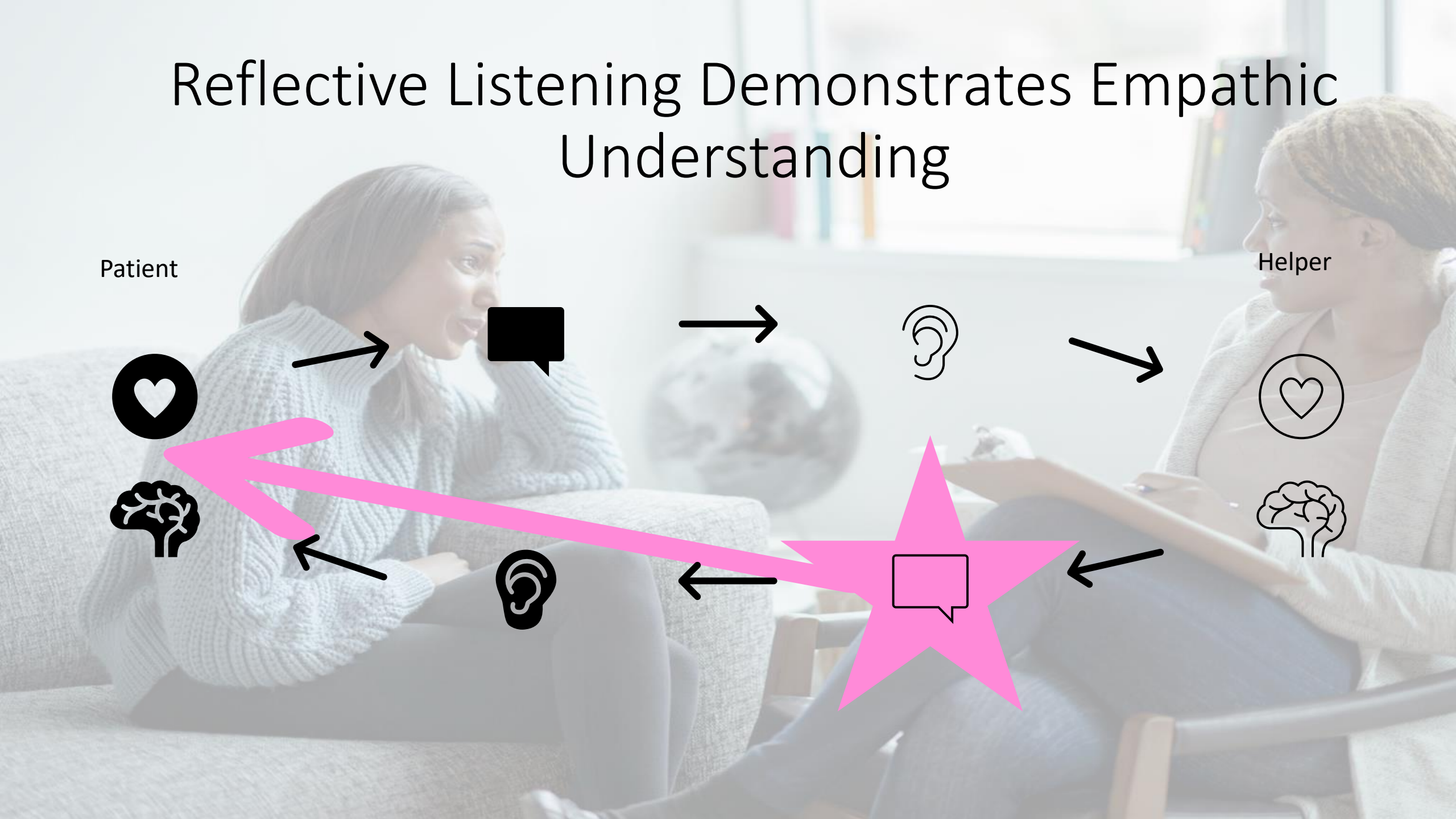


Listening

"It is astonishing how elements that seem insoluble become soluble when someone listens, how confusions that seem irremediable turn into relatively clear flowing streams when one is heard. I have deeply appreciated the times that I have experienced this sensitive, empathic, concentrated listening."

-Carl Rogers

Reflective Listening Demonstrates Empathic Understanding



Reflections

- A reflection is a guess about the meaning or feeling a patient is trying to convey/experiencing
- Statement, not question
- Keep ‘em short and sweet!
- Range from simple to deeper
  - Simple reflections mirror closely what the patient says and keep the conversation going
  - Deeper reflections get at meaning and feeling
- It OK to be wrong about our guess
  - Being wrong is an opportunity for clarification

Example Reflection

Helper: How are you?

Patient: Ha! (sarcastically) Are you kidding? Isn't it obvious? Jesus Christ! (scoffs, rolls over facing away from the helper) How can you even ask that question? For starters, I'm stuck in the hospital right now with this stupid thing in my arm (points to IV infusing antibiotics). Plus my hand (gestures to dressing on hand of a recently drained hand abscess) And that ain't even the worst of it.

Think of 3 reflections.

Examples

- You are upset that you are stuck in the hospital for now.
- You are frustrated.
- You are angry.
- You are stressed.
- Medical treatment is the least of your worries right now.
- Being stuck here sucks and it’s only the tip of the iceberg.

Practice Reflections

Helper: Tell me about your drinking.

Patient: Well, it didn't get bad until 2014. You see, my son had just… (pauses, face flushing). My son. He passed away that year. And then... I still can't talk about it. (Now holding back tears) And then my sister was diagnosed with cancer a few months later. And then my father died a few months after that. (Sobs).

Think of 3 reflections.

Simple Examples

- Your drinking got worse in 2014.
- Your drinking became heavier right after your son died.
- You were going through a lot in 2014.
- 2014 was a really tough year.

Deeper Examples

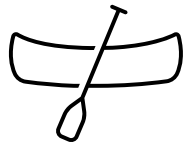
- You were in agony during all of that.
- You were really grieving during that time.
- Your drinking picked up during this really difficult time.
- You love your family more than anything.
- You were trying to cope with intense feelings of grief.
- Drinking was a way to numb these awful feelings of agony you were having.

If someone is disproportionally irritable…

- Consider withdrawal state
  - Celebrate! These are treatable, temporary. Tell the patient I am going to help and that I care.
    - Nicotine? Offer NRT
    - Alcohol? Offer benzodiazepines
    - Opioid withdrawal? Offer buprenorphine, clonidine, etc
- Consider trauma response
  - May be helpful to validate
    - "A lot of people who use drugs have had terrible, traumatic experiences with the healthcare system. I just want to recognize that. I'm not saying it is right. In fact, it is awful. And I will try my best not to re-open old wounds."
  - May be helpful to preface, explain philosophy, confidentially, professional boundaries
    - "I talk to folks about drugs and alcohol. My goal is always to listen and understand first. Then, if it makes sense, I look for ways that I might be helpful to you, to help you reach your goals. I'm not here to judge or tell you what to do. I'm not the police. I don't report to the police or to anyone. I do write what we discuss in your medical record but I don't share it with anyone without your permission, unless you tell me you plan to hurt yourself or someone else or that a child or dependent adult is in danger. Then I am required by law to help – and that means telling someone."

Starting to get the Use History

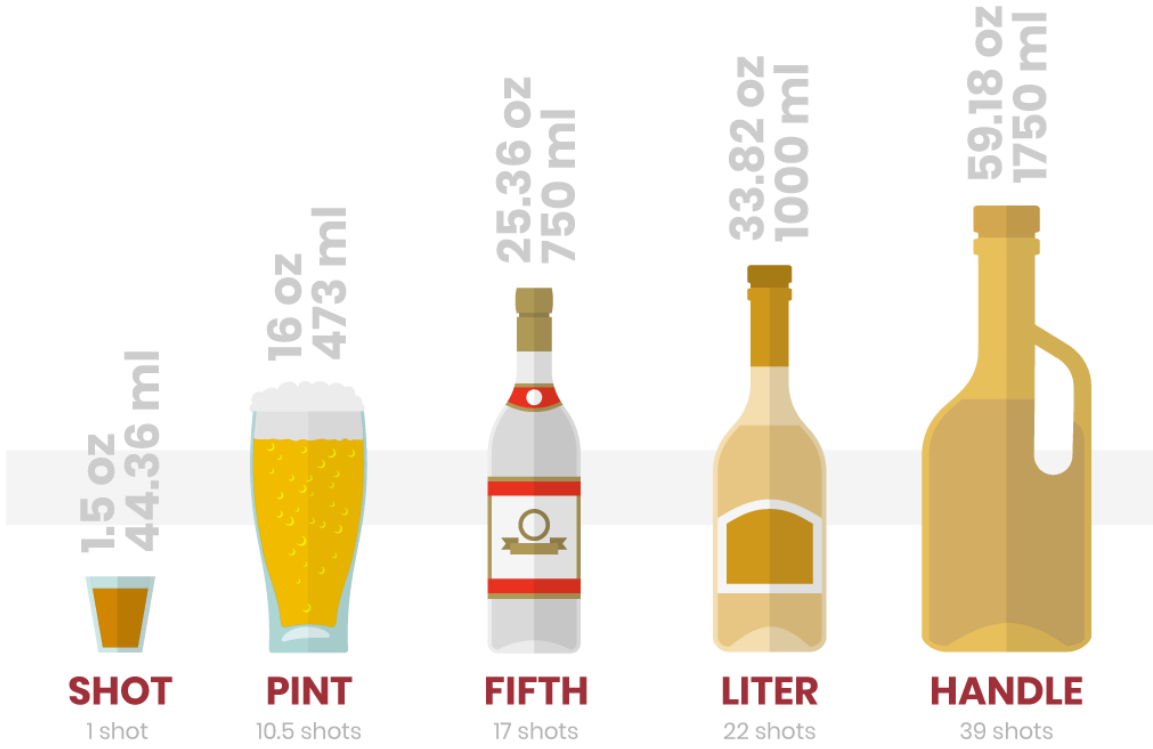
- Tell me about your alcohol/drug use.
- What does a typical day/week look like for you (in terms of use)?
- What drugs do you use?
  - Tell me about last week
  - What about in the past month?
  - What about in the past 6 months?



OARS! Open-ended questions

A detailed account

- Without sacrificing the relationship, get a detailed account
  - You should be able to imagine it in your mind
- Pearls
  - What is it that you buy? A fifth? A handle?
  - Of what? Fireball? Hawkeye vodka? Jack?
  - How long does a fifth last you?
  - How much money do you spend each week?
  - Are the tablets from a pharmacy/someone's prescription? Or from an unknown source?
- When did you last drink/use?



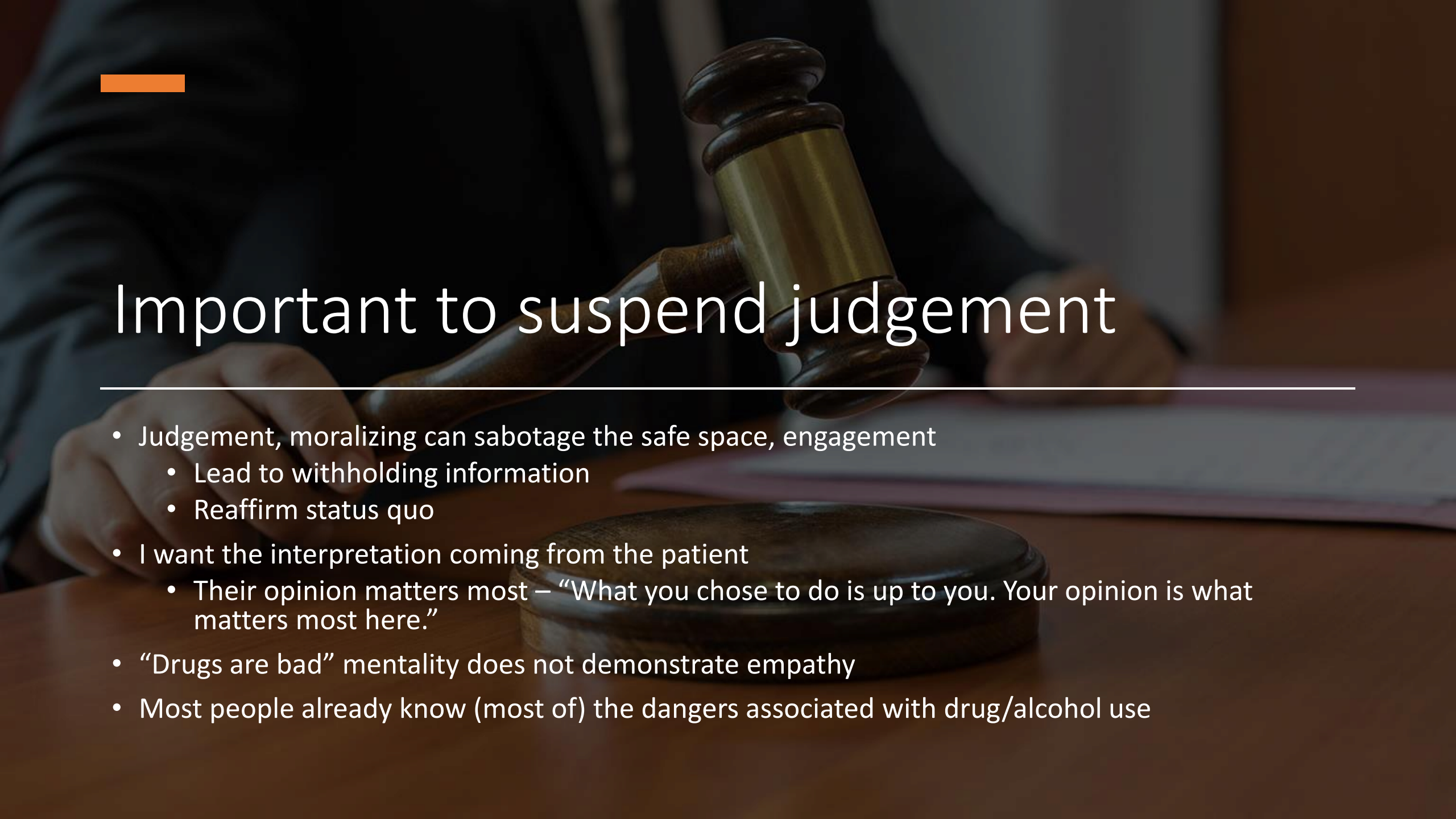
Route of administration

Route of Administration	Medical Sequela
Ingestion	Delayed onset, risk of excessive dosing
Insertion	Mucosal irritation, susceptibility to STI
Snorting/insufflation	Erosion of nasal mucosa, epistaxis, lung irritation, hepatitis
Smoking	End-stage lung complications: emphysema, bronchitis, cancer Oropharyngeal complications: burns, lacerations, cancer
Injection	Blood-borne illness (HIV, HCV), bacteremia/bacterial infections (cellulitis, abscess, thrombophlebitis, endocarditis, epidural abscess, septic joints)

Explore pros and cons

- Ask people what they like and don't like about their use.
- Then reflect/summarize
- On one hand… AND on the other hand…
- Highlight ambivalence in the patient's words
- Beware of the conjunction, 'but'.
  - 'And' acknowledges both sides as having merit
  - 'But' tends to dismiss everything that precedes it

OARS! Reflection/Summary Statement!



Important to suspend judgement

- Judgement, moralizing can sabotage the safe space, engagement
  - Lead to withholding information
  - Reaffirm status quo
- I want the interpretation coming from the patient
  - Their opinion matters most – “What you chose to do is up to you. Your opinion is what matters most here.”
- “Drugs are bad” mentality does not demonstrate empathy
- Most people already know (most of) the dangers associated with drug/alcohol use

Where are we so far…

- Sat down
- How are you?
- Detailed use history
- Important specific questions
  - If alcohol, history of seizures, DTs?
  - IVDU?
  - Last use
- Explored some pros and cons
- We are reflecting, validating, looking for values and reasons to change

Specifically ask about…

- Nicotine/tobacco
- Alcohol
- Cannabis
- Methamphetamine, cocaine (stimulants)
- Benzodiazepines (sedatives)
- Opioids
- Psychedelics/Hallucinogens/Dissociative/Party Drug
  - Psilocybin, LSD, mescaline, DMT, PCP, ketamine, MDMA
- Inhalants
- Steroids, kratom (supplements)

Screen/Diagnose Substance Use Disorder

2 or more within 12-month period:

1. Larger amounts or longer duration than intended
2. Persistent desire or unsuccessful attempt to cut down/control use
3. Significant time spent obtaining, using, or recovering
4. Craving/strong desire/urge to use
5. Failure to fulfill major roles (work, home, school)
6. Continued use despite ongoing social problems
7. Important activities reduced/aborted
8. Recurrent use in hazardous environments
9. Recurrent use despite physical/psychological problems
10. Tolerance
11. Withdrawal

Mild 2-3

Moderate 4-5

Severe 6 or 11

Abbreviated Method

1. Control
2. Consequences
3. Physiological
   - Cravings
   - Tolerance
   - Withdrawal

Social History

- What town do you live in?
- Who lives with you?
- How do you support yourself financially?
- Do you have access to a car, a phone?
- How far did you get in school? What was school like for you?
- Insurance carrier

Past Psychiatric / Treatment History

- Treatment History
  - How did this go? Did you finish the programs?
- Medication History (MAT)
  - When? For how long? How often were there missed doses?
- Psychiatric diagnoses, hospitalizations
- Suicide attempts

Medical/Surgical History

- Seizures
- TBI
- Chronic pain
- Heart, lung, liver, kidney disease
- Medical issues related to use?

Family History

- History of SUD
- History of Suicide, MH

Other important details

- Special scoring (COWS, CIWA)
- Vitals (Tachycardic? Hypertensive?)
- Labs (WBC, BUN, LFTs, UDS, BAL)
- Imaging (RUQ US, Abd CT)
- Mental Status Exam (Mood, SI?)
- Medications
- Review PMP - https://iowa.pmpaware.net
- Collateral
  - Best done separately
- Suicide Risk Assessment

COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-Ar) scale

Clinical Institute Withdrawal Assessment for Alcohol revised	
Symptoms	**Range of scores**
Nausea or vomiting	0 (no nausea, no vomiting) –7 (constant nausea and/or vomiting)
Tremor	0 (no tremor) – 7 (severe tremors, even with arms not extended)
Paroxysmal sweats	0 (no sweat visible) – 7 (drenching sweats)
Anxiety	0 (no anxiety, at ease) – 7 (acute panic states)
Agitation	0 (normal activity) – 7 (constantly trashes about)
Tactile disturbances	0 (none) – 7 (continuous hallucinations)
Auditory disturbances	0 (not present) – 7 (continuous hallucinations)
Visual disturbances	0 (not present) – 7 (continuous hallucinations)
Headache	0 (not present) – 7 (extremely severe)
Orientation/clouding of sensorium	0 (orientated, can do serial additions) – 4 (Disorientated for place and/or person)

My SUD Evaluation Template

- Introduction. Sit. How are you? Listen
- HPI:
  - Detailed use history
    - What substances? *Go through them individually.*
    - How much, how often? Last use? How do you use?
    - Withdrawal seizures/DTs, IVDU, OD? Sharing needles
    - Diagnose a SUD with DSM5 criteria
    - Screen for suicide
- Social Hx
  - Housing, income, transportation, access to internet, phone, support, legal, childhood
- Treatment/Psychiatric history
  - Past treatment for SUD, hospitalizations, RTPs, AA, SAs, firearms, medications?
  - Current providers
- Medical History
  - TBI, seizure, pain, organ failure?
  - HIV, HCV, STI testing?
- Family History of SUD, SA
- ROS
  - Intoxication, withdrawal symptoms
- Medications/Allergies
- Vitals, Labs, Imaging, Review PMP

Impression and Plan

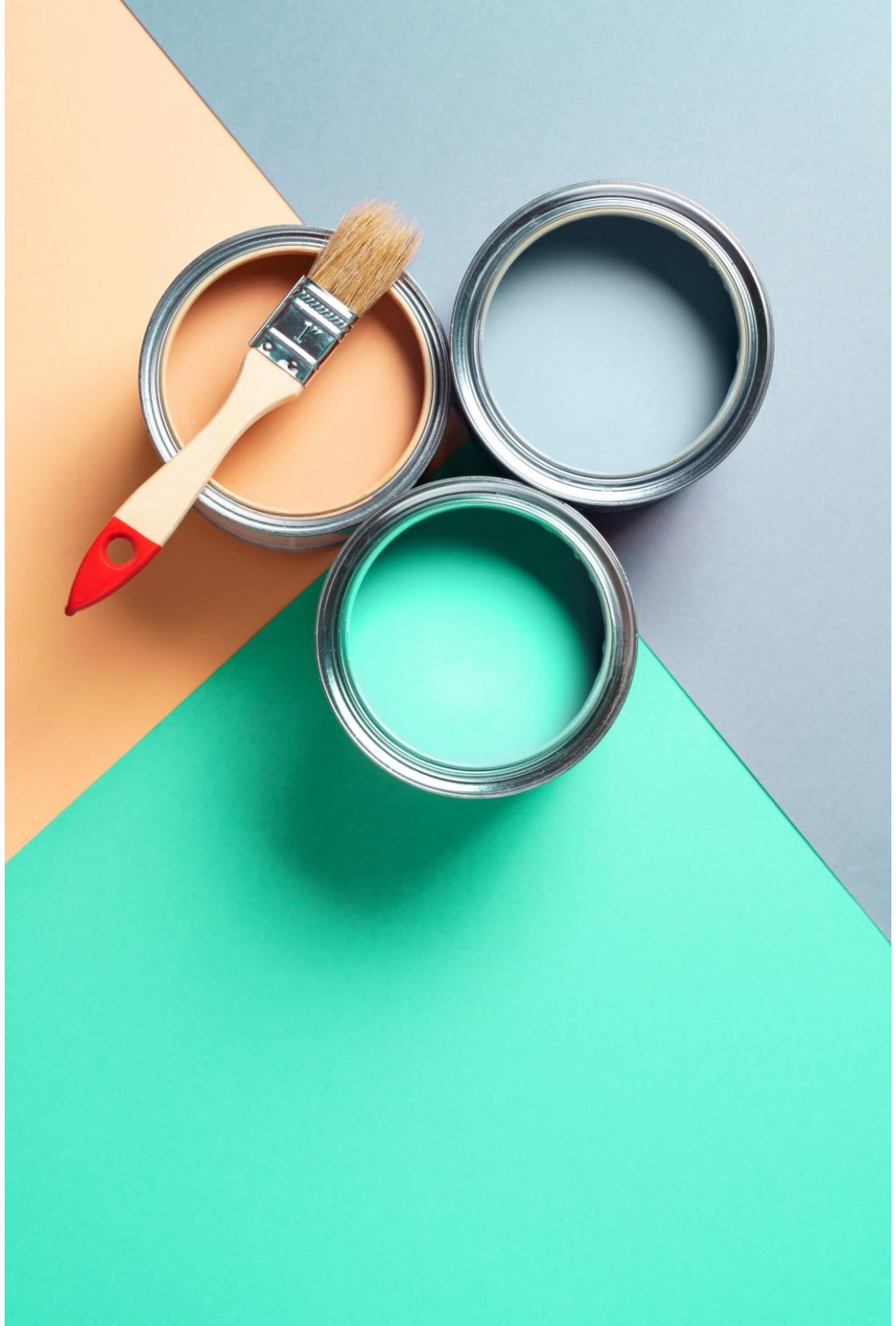
- Low Risk Use
- High Risk Use
  - Consider discussion about Harm Reduction
- Physiologic Dependence
  - ≠ use disorder
- Use Disorder

Heavy Alcohol Use:
•NIAAA defines heavy drinking as follows:

- For men, consuming >4 on any day or > 14 per week
- For women, consuming >3 on any day or >7 per week

My big buckets

- Use Disorder
  - Medications (MAT)
  - Formal Counseling/Psychotherapy
  - Community Resources
  - Harm Reduction
  - Follow Up



Providing Information: Ask-Provide-Ask

- Use with a clinical intent in mind
- Ask-Provide-Ask sandwich:
  - “Would it be all right if I told you about some things that worked for other people?”
  - [Provide info]
  - “What are your thoughts?”
- TIP: Activate prior knowledge
  - “Tell me what you already know about ___.”
- Prioritize, present clearly, small doses

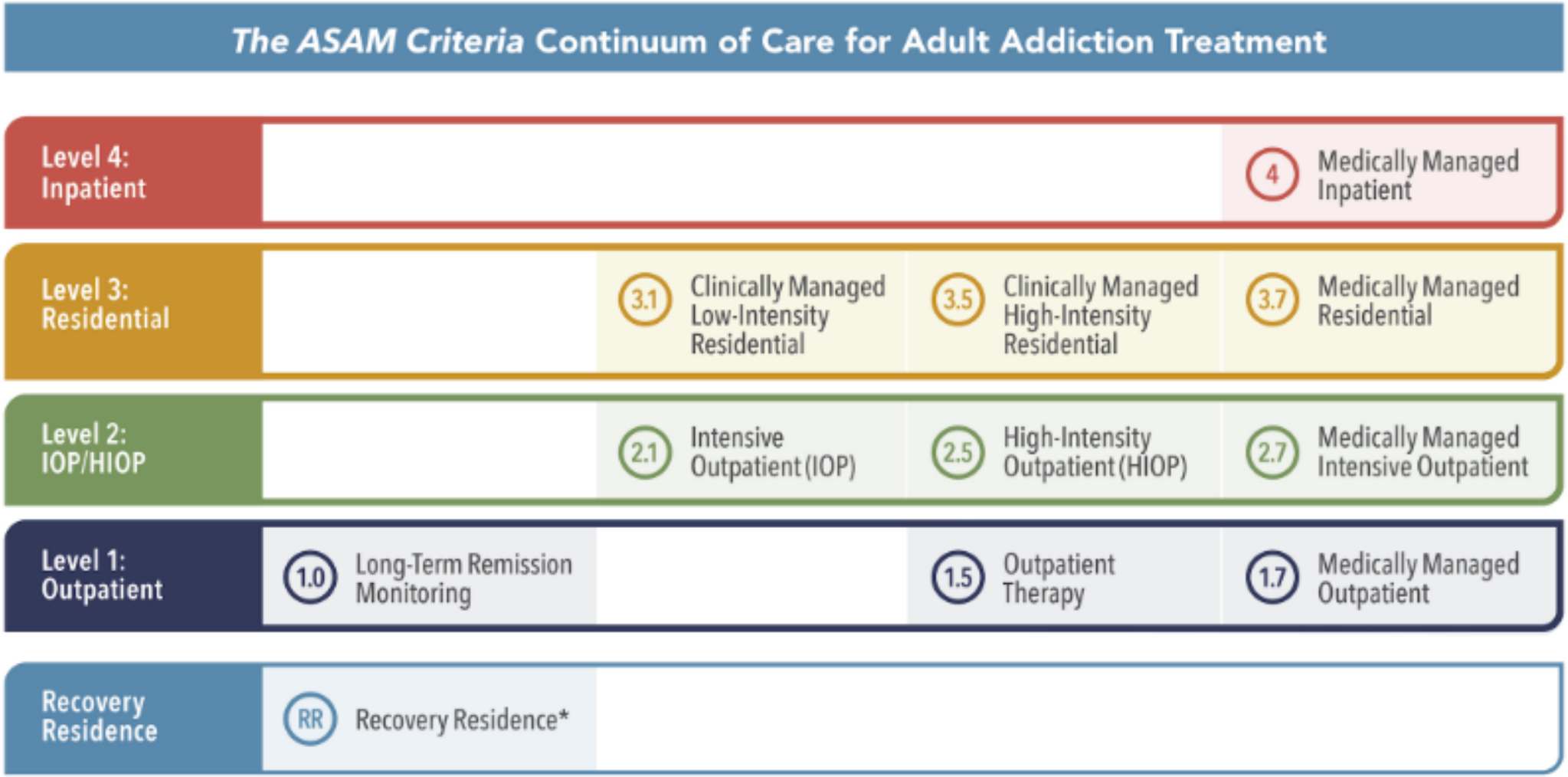
Medications for Addiction Treatment

- What attitudes/beliefs do you have about medication treatment?
  - “Just a crutch”
  - “Trading one addiction for another”

Alcohol	Nicotine	Opioids
Naltrexone	**Varenicline**	**Buprenorphine**
Acamprosate	Bupropion	Methadone
Disulfiram	Combined NRT	Naltrexone

- No FDA approved medications for methamphetamine, but we sometimes try mirtazapine or bupropion (or bupropion/naltrexone)

Level of Care/Formal Counseling



Findtreatment.gov

- Find
  - outpatient programs
  - residential programs
  - buprenorphine providers

Community Supports

- www.aa.org
- https://smartrecovery.org/
- https://recoverydharma.org/
- https://na.org/
- Al-anon.org
- https://www.crystalmeth.org/

Harm Reduction

- Naloxone
- Never use alone
- Don’t use and drive
- Needle exchange
- Fentanyl test kits

Examples of MI

https://www.youtube.com/watch?v=ATUZHIazbpU&t=1494s
– Bill Miller, “Soccer Mike”

https://www.youtube.com/watch?v=b8C1jQe0FZE&t=389s
– Coach Smith, “The Rounder”

https://www.youtube.com/watch?v=hHIdb6vuh-c
– Bill Miller “The Silent Man”

Thank you!