How to Effectively Assess Addicted Individuals

BLUFF
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Addictive Disease: Hiding in Plain Sight.

In medical school I could count the number of hours we spent learning about addiction on one hand. Now, 8 years into my internal medicine practice, I can confidently say that the majority of my patients suffer from some form of addiction. I wish I knew how to help them.

---Connor T. MD, Cleveland, Ohio

The lack of understanding among medical professionals regarding the nature and effects of addictive disease, including what constitutes professional treatment, has exposed tremendous gaps in our health care system. As a result, millions of men, women and adolescents with a life threatening illness fall through the gaping holes in our current clinical practice guidelines and never receive the treatment they need to save their lives. Yet, they do not suffer in isolation. Addiction has devastating effects on their families, their careers, their communities—and our nation.

INTRODUCTION

Remarkable advances in neuroscience and behavioral medicine have clearly identified addiction as a brain disease. At present, 23 million Americans ages 12 and older suffer from this disorder. This is nearly as much as the number of people with cardiovascular disease (27 million) or diabetes (26 million) and more than those with cancer (19 million). In addition, nearly 80 million American's use alcohol and other drugs to the degree that they are at great risk of hurting themselves via accidents, injuries and disease. Yet, less than 10% will receive any form of treatment. The suffering these individuals (and their families) endure is incalculable.

Substance Use Disorders (SUD) are also associated with debilitating diseases such as cancer, respiratory disease, cardiovascular disease, sexually transmitted diseases, depression, anxiety disorders, pregnancy complications, liver disease, ulcers and trauma. Not to mention the vast array of social consequences including violent crime, accidents, suicide, child neglect and abuse, family dysfunction, unplanned pregnancies and lost productivity. The cost of addiction and risky substance use for our nation exceeds $400 billion each year.

"Research shows that more than 20 percent of deaths in the U.S. are attributed to substance misuse, abuse and addiction."

Yet in spite of this data, there is an enormous deficit of clinicians with the experience and skills necessary to educate patients about risk factors, conduct screenings, diagnose or guide a patient toward evidenced based treatment. Worse, of those who are currently providing addiction services and treatment, most lack the skills, knowledge, or credentials necessary to effectively assess and manage addicted individuals.

CASE STUDY

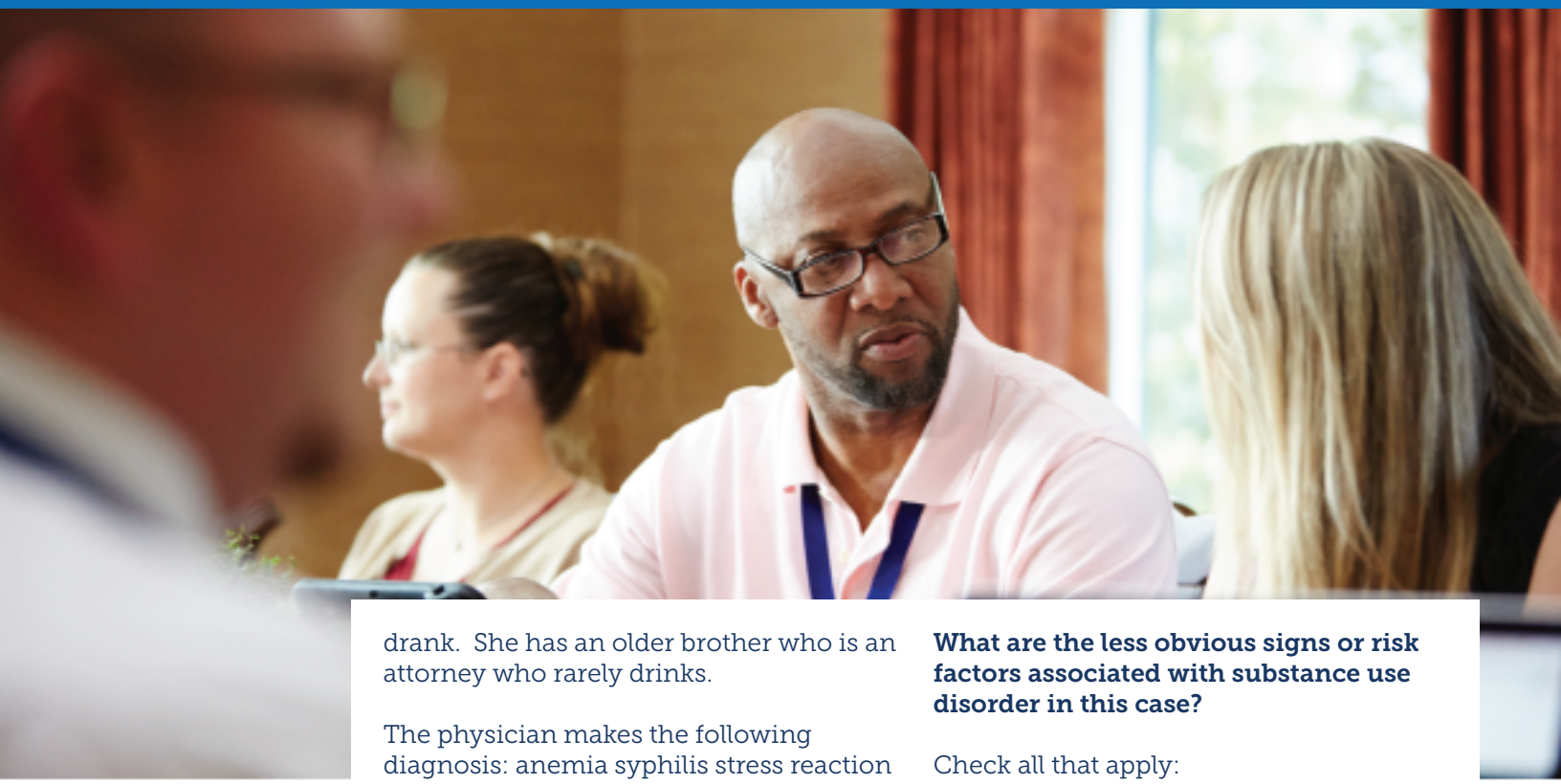
Michelle is a single, 28 year-old marketing representative who presents to her OB physician with a chief complaint of a vaginal soreness, swollen lymph nodes and a reddish brown rash.

During the examination the patient states that she is tired this day because she has not been sleeping well and that work has been very stressful due to conflicts with her boss. She is also fearful about the rash, stating that she had unprotected sex with a man she met in a bar while celebrating a friend's birthday. Michelle further states that she was intoxicated that night and regrets her behavior. During the exam the doctor notes that Michelle has bruising on her right elbow and hip. Michelle was unaware of the bruising but stated that she had slipped on a wet sidewalk and fell the previous weekend. She also stated that she didn't think she was injured. Michelle denies that she is depressed but reveals that she often feels anxious, which she believes contributes to her poor sleep quality. The physical examination also reveals three cancerous lesions and enlarged lymph glands in the pelvic region. The physician orders blood chemistry, including a nontreponema antibody test, TSH & Thyroxine (for thyroid disease), urinalysis and a toxicology screen.

The toxicology report shows traces of alcohol and benzodiazepine. Blood chemistry reveals that she is anemic and the nontreponemal antibody test is positive for syphilis. All other tests are within normal range.

During the follow up visit Michelle expressed sorrow, shame and remorse. She further stated that she has been very stressed at her job and feels anxious and depressed several days per week. She reported that she had one glass of wine yesterday after work. She states the she has had trouble sleeping for several months and recently a sympathetic coworker gave her a few "Xanax" to help her unwind before bedtime.

When asked about alcohol consumption, Michelle reports that she occasionally drinks "a couple glasses of wine" with her friends after work but denies alcohol abuse or any alcohol related problems. Her maternal grandmother was an alcoholic but her mother and father never



drank. She has an older brother who is an attorney who rarely drinks.

The physician makes the following diagnosis: anemia syphilis stress reaction causing mixed disturbance dysthymic depression and insomnia.

Recommendations: The physician educates Michelle on safer sexual practice and gives her 24 condoms. She also educates her on how to get more iron from her diet to combat her anemia. She reminds Michelle that the recommended daily amount of alcohol for women is one alcoholic beverage (one 6 ounce glass of wine, one 12 ounce beer or 1.5 ounces of distilled 80 proof liquor) per day. She prescribes *Penicillin* for the syphilis, *Zoloft* for dysthymia and stress reaction and *Ambien* as needed for sleep. She advises Michelle to consider counseling to reduce her stress and anxiety and schedules a follow up visit in one month.

Without knowledge and clinical training regarding substance use disorder, this is a typical occurrence. The findings, diagnosis and recommendations are consistent with Michelle's presenting problem, symptoms, laboratory results and the information and history provided by the patient.

What are the less obvious signs or risk factors associated with substance use disorder in this case?

Check all that apply:

- ☐ Bruising from a fall
- ☐ Bruising from a fall without knowledge of being injured
- ☐ Using a controlled substance (Xanax) that was not prescribed
- ☐ Positive toxicology screen for alcohol
- ☐ Her age
- ☐ Expressing remorse that she violated her personal morals while intoxicated
- ☐ Having a "few glasses of wine" after work with her friends
- ☐ Having risky and unprotected sex
- ☐ Sleep disturbances
- ☐ Vague symptoms of depression, stress and anxiety
- ☐ Family history of alcohol dependence
- ☐ Having an STD
- ☐ Stressful employment

Now, here's the real story:

Michelle has been drinking daily for over six years. She consumes four to six glasses of wine per evening during the workweek and approximately 50 % more on the weekends. She obtains benzodiazepines from friends and has stolen them from her grandmother's medicine cabinet on three occasions in the past two years. She has been late to work seven times in the past year and has received a written reprimand. She was arrested for a DUI eight months ago, but thanks to her brother, the charges were dismissed on a technicality.

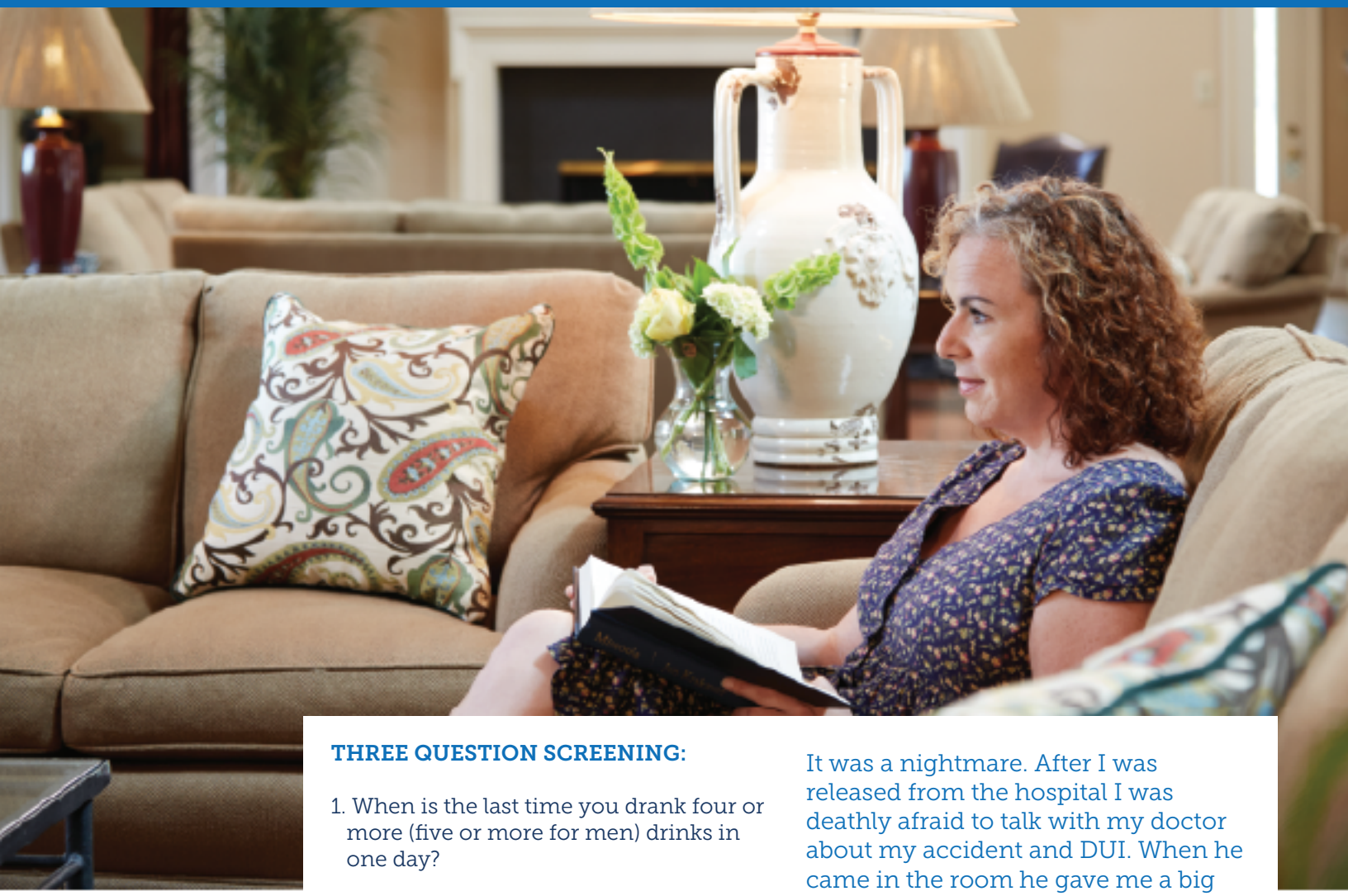
She has had high-risk, unprotected sex while intoxicated at least two dozen times with men she met at clubs. She has regular blackouts and feels deep remorse and shame for her sexual behavior. She has attempted to cut down on her drinking and not sleep with men she meets at clubs. Her friends have expressed their concern over her drinking and advised her to "slow down". Her parents and older brother are concerned about her drinking and fearful that something awful will happen. Michelle loves her family but has only minimal contact with them, although they live nearby.

Without professional help, Michelle's life will continue its downward spiral until tragedy strikes. Partly due to her denial and minimizing her drinking, Michelle presents a formidable defense when queried or confronted about her drinking.

Her OB physician provided sound medical care based upon the results of her examination, objective testing and patient interview. She simply is not trained to identify or diagnose substance abuse disorder, particularly in a patient who is not forthcoming.

WHAT TO DO?

Many patients with substance use disorders visit their primary care physician with physical complaints, such as insomnia, fatigue, vague aches and pains, minor injuries, cardiac arrhythmia, headaches, being overly stressed, anxious or depressed. When other physical or psychological causes cannot be found, further evaluation is warranted. Recent research has shown that short screening tools are effective in identifying those at risk for a SUD and take only a few minutes to administer and score.



THREE QUESTION SCREENING:

1. When is the last time you drank four or more (five or more for men) drinks in one day?

☐ Never
☐ In the past three months
☐ More than three months ago

2. In the last year:
• Have you ever drunk alcohol or used drugs more than you meant to?

☐ **Yes** or ☐ **No**

3. Have you felt you wanted or needed to cut down on your drinking or drug use?

☐ **Yes** or ☐ **No**

The highlighted responses are associated with substance use disorder. All patients who screen positive for SUD should receive assessment and/ or brief intervention.

It was a nightmare. After I was released from the hospital I was deathly afraid to talk with my doctor about my accident and DUI. When he came in the room he gave me a big hug and told me how sorry he was that I had suffered so much. He didn't judge me at all. We talked about my drinking and he suggested that I contact a friend of his who was a specialist in addiction. I did just that, and now I have been sober for 10 months and the nightmare is over.

--Jamal, 33

Physicians can provide brief intervention for patients who they determine to be at risk. Research has shown that physician-driven interventions are effective in reducing alcohol and drug use, when used in the primary care setting, and for individuals with less severe pathology.

The Substance Abuse and Mental Health Administration (SAMSHA) recommends the following brief interventions:

1. Provide direct feedback to patients based on their histories, physical and behavioral warning signs, screening test results, and information on how these disorders affect their life.

2. Provide clear advice and education regarding recommendations on safe alcohol consumption limits, the negative effects of alcohol and drug use, and suggestions for lifestyle modification.

3. Establish a mutually consented plan of action that addresses SUDs, as appropriate, and includes specific goals for behavior change, behavioral or pharmaceutical treatments, referrals for further assessment and treatment when appropriate, and follow up plans, either in person or via the telephone.

The American Society of Addiction Medicine (ASAM) recommends that physicians adopt a disease management approach. Research shows that brief interventions by a medical provider are very effective in recovery engagement and relapse prevention. As with other chronic diseases, recovery from alcohol and other drug dependencies is marked by progress, exacerbation and is often complicated by co-morbidities.
A supportive and collaborative doctor-patient relationship is very helpful in the recovery process.

Comprehensive Assessment Includes:

- History of substance use and previous treatment
- Comorbidities which may affect treatment
- Family and social support for treatment
- Impact of home environment
- Housing, child care, employment and legal issues
- Readiness and willingness for treatment
- Need for tailored treatment (age, culture or gender specific)

When a diagnosis of SUD is made, referral to an addiction medicine specialist is recommended.

Addiction medicine physicians are certified by ASAM to evaluate and provide treatment services for individuals with SUD. To find an ASAM doctor in your area click the link below:

http://community.asam.org/search/default.asp?m=basic

In spite of our best efforts, most people with addictive disease hide their symptoms from medical professionals. Their denial and rigid alibi system serve to protect their use of intoxicants. This is not because they are inherently dishonest or bad people, rather these are simply the symptoms of their disease.

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