SCREENING FOR AND ELICITING A SUBSTANCE USE DISORDER HISTORY

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What is addiction?

Why do people get addicted?

What can we do about it?

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CONTINUUM OF DRUG AND ALCOHOL USE

- Drug and alcohol use exist on a continuum from non-problematic to problematic use
  - Not everyone who drinks is an alcoholic
  - Not everyone who uses drugs is an addict
  - Focus on the consequences and the harm involved, not just the drug(s) used

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ADDICTION FEATURES

- Loss of consistent control over use
- Continued use in the face of adverse consequences
- Compulsivity
- Craving
- Distortions in thinking (denial, minimization, rationalization)

- **Look for these features when taking a substance use history**

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WHAT IS ADDICTION?

Addiction is characterized by:

- Inability to consistently Abstain;
- Impairment in Behavioral control;
- Craving; or increased "hunger" for drugs or rewarding experiences;
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships; and
- A dysfunctional Emotional response.
- Addiction is a chronic, relapsing disease of the brain with multiple consequences.

https://www.asam.org/resources/definition-of-addiction

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"ADDICTION IS AN ONGOING [TORTURED] LOVE AFFAIR WITH SUBSTANCES."

- The addicted person is locked in the embrace of an abusive chemical lover. Usually when something painful happens as a result of drug use, the addicted person seeks to continue drug use believing that "next time it will be different."
- Like a person in an abusive relationship, the addict's brain denies the evidence of problems caused by drug use and longs for the time when the drug use appeared to be problem-free.
- As the addictive disease progresses, the addict is less motivated by the search for euphoria (positive reward) and more motivated by relief of distress (negative reward).
- **People with addiction believe that drugs are the SOLUTION to their problems, not the CAUSE of their problems.**

--Robert L. DuPont, M.D. Drugs, Crime and Race. Psychiatric Times February 2001

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VULNERABILITY TO ADDICTION

- 40 to 60% of the vulnerability for addiction is genetic
- Multifactorial
  - Drug self-administration
  - Alcohol intoxication responses
  - Alcohol withdrawal responses
  - Frontal theta oscillations
  - Interference with drug metabolism
  - And many others
- Earlier first use of drugs/ alcohol increases risk
- Environmental factors
  - Low socioeconomic class
  - Poor parental support
  - Within-peer group deviancy
  - Drug availability
  - Stress (including abuse and trauma)
  - Social isolation in adolescence
  - Social status
    - Subordinate lab animals more likely to self-administer cocaine
- Co-occurring psychiatric disorders
  - 30%(+) of people with psychiatric disorders have substance use disorders
  - More risk for suicidal symptoms and completed suicide
  - Increased risk for psychosis
  - Drug use/SUDs can lead to psychiatric disorders
  - Psychiatric disorders can lead to drug use/SUDs

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DEVELOPMENT OF ADDICTION

- Experimentation → euphoria / positive reinforcement (no negative consequences)
- Neuroadaptation → tolerance, increased use
- Increased use → withdrawal / negative reinforcement
- Loss of control (with negative consequences)

- An imbalance develops in the brain circuits that underlie reward and conditioning vs. those that underlie executive functioning (emotional control and decision-making)
  - **Too much "go", not enough "stop"**
- An increase of activity in the brain's anti-reward system

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THE MOST SUCCESSFUL PSYCHIATRIC TREATMENTS AFFECT THE MORE ADVANCED PARTS OF THE BRAIN—WHILE **ADDICTION** IS CONTROLLED BY PRIMITIVE, "REPTILIAN" AREAS OF THE BRAIN.

"Once you get into the reptile brain, you have as much luck [with standard treatments] as you do getting a crocodile to come when it's called."

--George Vaillant, M.D.

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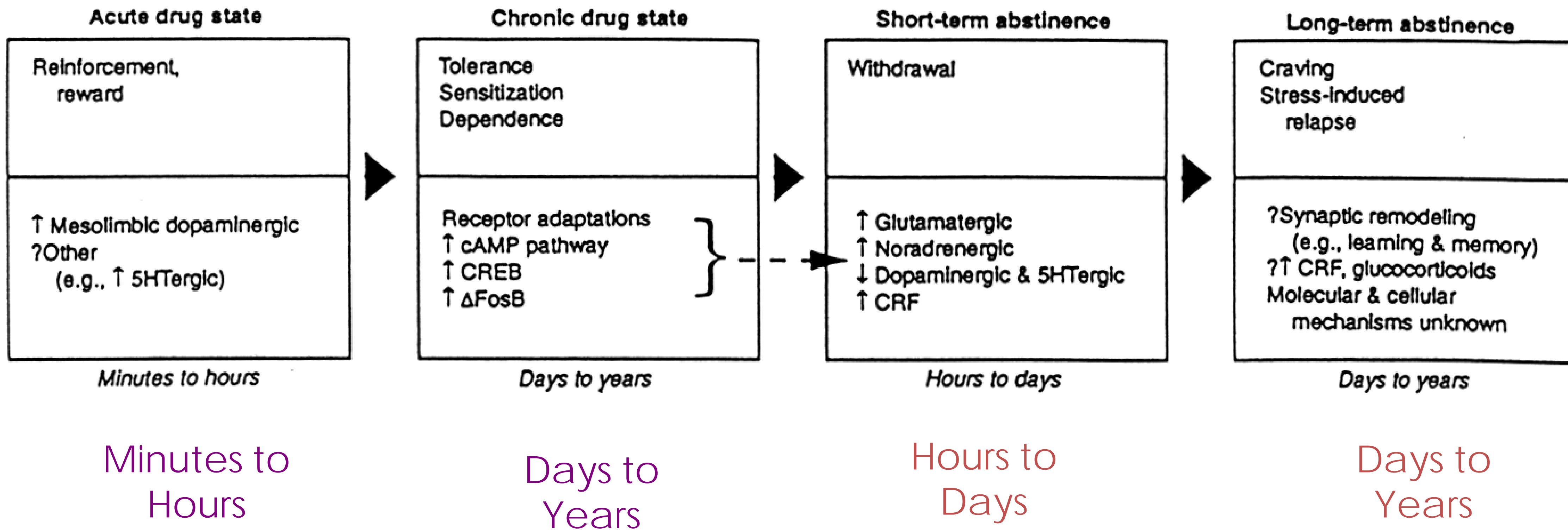
CHRONIC EFFECTS OF DRUG USE INCLUDE: NEURONAL ADAPTATION, TOLERANCE, DEPENDENCE AND WITHDRAWAL IF DRUG IS REMOVED



Minutes to Hours

Days to Years

Hours to Days

Days to Years

Drug Use

Drug Abstinence

E. J. Nestler and G. K. Aghajanian, 1997, Science, 278, p. 59.

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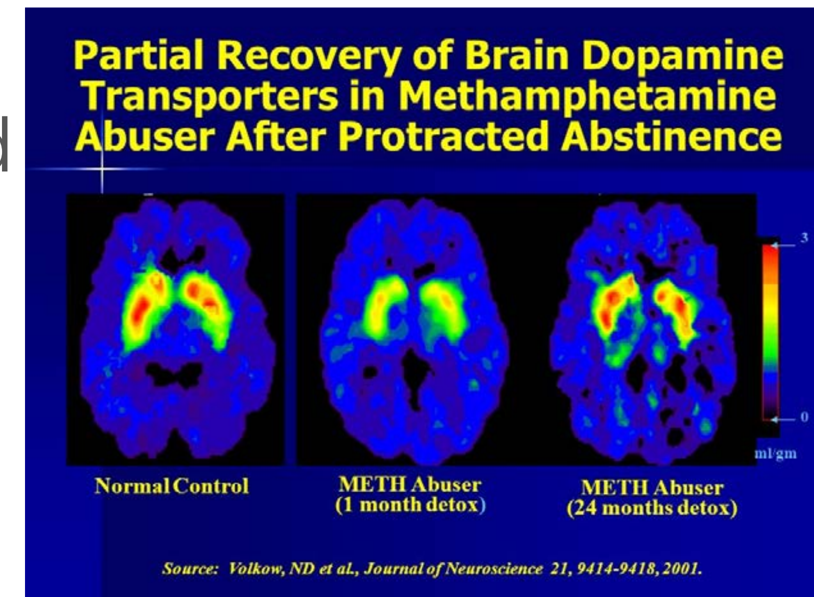
RECOVERY TAKES A LONG TIME

- There are persistent effects of drugs and alcohol on the brain
  - post acute withdrawal, clouded thinking, memory problems, emotional blunting, psychiatric symptoms, etc.
- It can take 24 months of abstinence from drugs for brain changes to partially recover.



Some drug and alcohol effects may be permanent.

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NEUROADAPTATIONS IN ADDICTION

- Neuroadaptations in brain reward, stress, habit formation, and executive function systems drive continued alcohol/drug intake despite negative consequences

Neuroadaptation	Result
Decreased dopamine and GABA in ventral striatum	Decreased reward
Enhancement of corticotrophin-releasing factor (CRF) in the extended amygdala	Increased negative emotional state
Blunting of HPA axis	Decreased response to stress
Engagement of dorsal striatum	Solidifies habitual behaviors
Prefrontal cortex damage/impairment	Poor inhibitory control and poor executive functioning, poor decision-making
Mesolimbic circuit (NAc, amygdala, hippocampus) adaptations	Enhanced saliency of drugs/drug stimuli, decreased sensitivity to natural reinforcers
Insula dysfunction	Impaired ability to evaluate internal states
Lateral habenula impairments	Compromised ability to process and learn from disappointment; disrupted mood

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TREATMENT OF ADDICTION--OVERVIEW

- Addiction is a chronic disease
- Detoxification alone is not treatment
- Long-term treatments are required, just like for other chronic diseases
  - e.g., diabetes, hypertension, asthma
- Discontinuation of treatment will likely result in relapse
- Relapse does not indicate failure of treatment
- Rates of relapse and recovery for addiction are equivalent to other medical diseases

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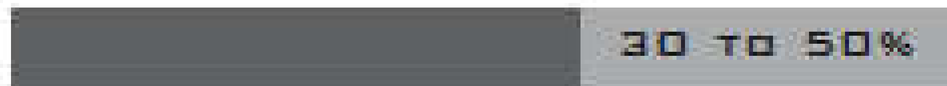
RELAPSE RATES FOR ADDICTION RESEMBLE THOSE OF OTHER CHRONIC DISEASES

Percentage of Patients Who Relapse

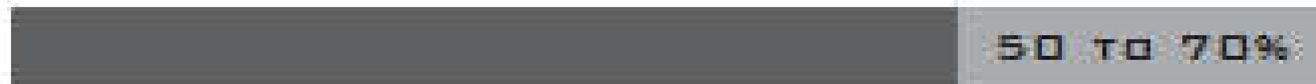
TYPE I DIABETES



DRUG ADDICTION

HYPERTENSION

ASTHMA



https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment

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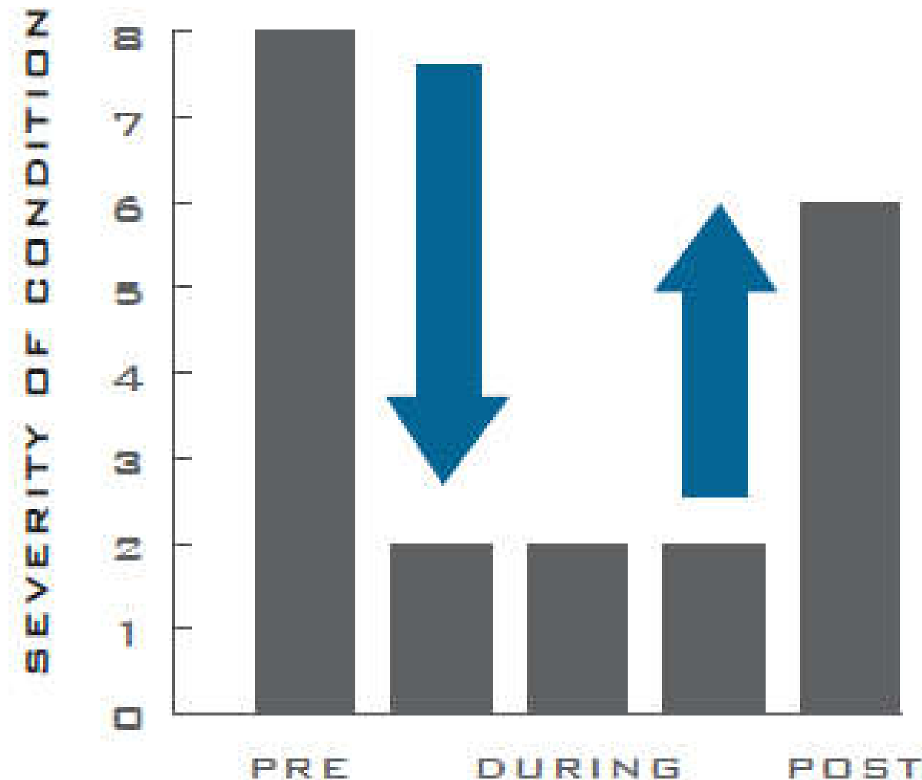
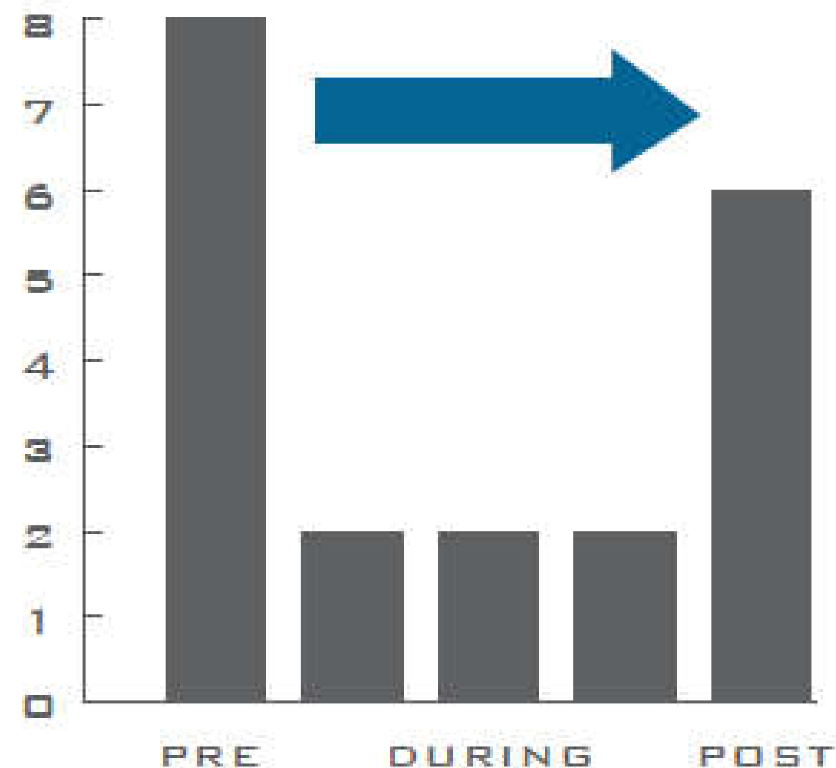
SUCCESSFUL TREATMENT FOR ADDICTION TYPICALLY REQUIRES CONTINUAL EVALUATION AND MODIFICATION, SIMILAR TO THE APPROACH TAKEN FOR OTHER CHRONIC DISEASES

WHY IS ADDICTION TREATMENT EVALUATED DIFFERENTLY?

BOTH REQUIRE ONGOING CARE





STAGE OF TREATMENT

https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment

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GOALS OF TREATMENT

- Safely withdraw a person from drugs
- Help the brain recover from effects of drugs
- Support a person's abstinence from alcohol and other addicting drugs
- Prevent relapse to use of alcohol and other addicting drugs
- Develop skills to prevent relapse
- Improve functioning
- Treat co-occurring medical, psychiatric problems
- Save lives

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MEDICALLY SUPERVISED WITHDRAWAL

- First, many people need medically supervised withdrawal or detoxification ("detox")
- Assures safety and stabilization
- **But "detox" is not treatment**
- Only gets the brain and body safely clear of the substance(s)
- Effects of drugs and alcohol on the brain persist long after withdrawal is over

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Screening for Substance Use Disorders

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CASA: MISSED OPPORTUNITY, 2000 NATIONAL SURVEY OF PRIMARY CARE PHYSICIANS AND PATIENTS ON SUBSTANCE ABUSE

- Less than one-third (32.1%) of primary care physicians carefully screen for substance abuse
- 94% of primary care physicians (excluding pediatricians) failed to include Substance Abuse among their top 5 diagnoses when presented with symptoms of early alcohol abuse
- 40.8% of pediatricians failed to diagnose drug abuse when presented with a classic description of an adolescent patient with symptoms of drug abuse
- Most patients (54.8%) agreed that physicians do not know how to detect addiction
- 54.5% of patients say that doctors prescribe drugs that could be dangerous to addicted individuals
- 29.5% of patients said their physician knew about their addiction and still prescribed psychoactive drugs such as sedatives or diazepam

https://www.cente

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INTEGRATE SCREENING INTO CLINICAL PRACTICE

- Part of routine examinations
- Before prescribing any medication that interacts with alcohol, tobacco, other drugs
- Before prescribing controlled substances
- In the emergency department or urgent care setting
- When seeing patients who are:
  - Pregnant, or trying to conceive
  - Likely to use or drink heavily (smokers, adolescents, young adults)
  - Have health problems that might be alcohol induced
  - Have a chronic illness not responding to treatment as expected

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SCREENING/INTERVIEWING RE: ALCOHOL/DRUG USE

- Focus on:
  - Distress about and consequences of alcohol/drug use
  - Feelings about alcohol/drug use
  - Efforts to control alcohol/drug use or compensate for effects
- Do not solely focus on alcohol/drug use behavior (how much, how often, etc.)
- Be prepared for patient's agitated counterattack
- It is a good thing to talk about alcohol/drug use
- It may be painful to talk about, but it is not harmful
- Watch out for your tactful impulses to withdraw from inquiry—keep going!

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HISTORICAL INDICATORS (RED FLAGS) SUBSTANCE USE DISORDERS

- Alcohol/drug-abusing partner
- Many emergency room contacts
- Many physician contacts
- Mood disorders
- Psychiatric treatment or hospitalizations
- Family history of alcoholism/addiction
- Family dissolution
- Child(ren) with:
  - neonatal abstinence syndrome
  - alcohol-related birth defects
  - low birth weight, failure to thrive
  - complex perinatal history & outcome
  - sudden infant death syndrome
- Placement of children outside the home

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BEHAVIORAL INDICATORS SUBSTANCE USE DISORDERS

- Domestic violence and conflicts
- Irritability, agitation, mood swings
- Intense daily drama, family chaos
- Child abuse/neglect
- Inappropriate behavior
- Depression, difficulty concentrating
- Suicide attempts
- Memory lapses, losses, or blackouts
- Vague personal or medical history
- Job problems, unemployment
- Trauma and accidents
- Driving while intoxicated
- Smell of alcohol on breath
- Intoxicated behavior or speech, staggering
- Missed appointments
- Depression, anxiety
- Insomnia

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FAMILY INDICATORS SUBSTANCE USE DISORDERS

- Denial of problems
- Domestic violence and conflicts
- Intense daily drama, family chaos
- Child abuse and/or neglect
- Alcohol/drug-abusing family member
- Financial problems
- Family dissolution
- Multiple moves, geographic cures
- Behavior in children:
  - Act out in school
  - Run away from home
  - Drop out of school
  - Act out sexually
  - Seek solace on the streets
  - Use drugs or alcohol

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MEDICAL INDICATORS SUBSTANCE USE DISORDERS

- Skin disease: erythema of hands, hair loss, gum disease, poor dental hygiene
- Ob-Gyn disease: erratic menses, infertility, spontaneous abortion, premature labor and delivery
- Intoxication, overdose and withdrawal
- Liver disease: hepatomegaly, hepatitis, cirrhosis
- Gastrointestinal disease: pancreatitis, gastritis, esophagitis, GI bleeding
- Poor nutritional status, loss of appetite
- Neurologic disorders: sensory impairment, neuropathy, myopathy, memory loss, dementia
- Cardiovascular Disease: hypertension, cardiomyopathy, mitral valve disease, edema, swelling
- Infectious disease: HIV, TB, STDs, abscesses, septicemia, bacteremia, cellulitis, pulmonary infections
- Hematologic disease: anemia, thrombocytopenia

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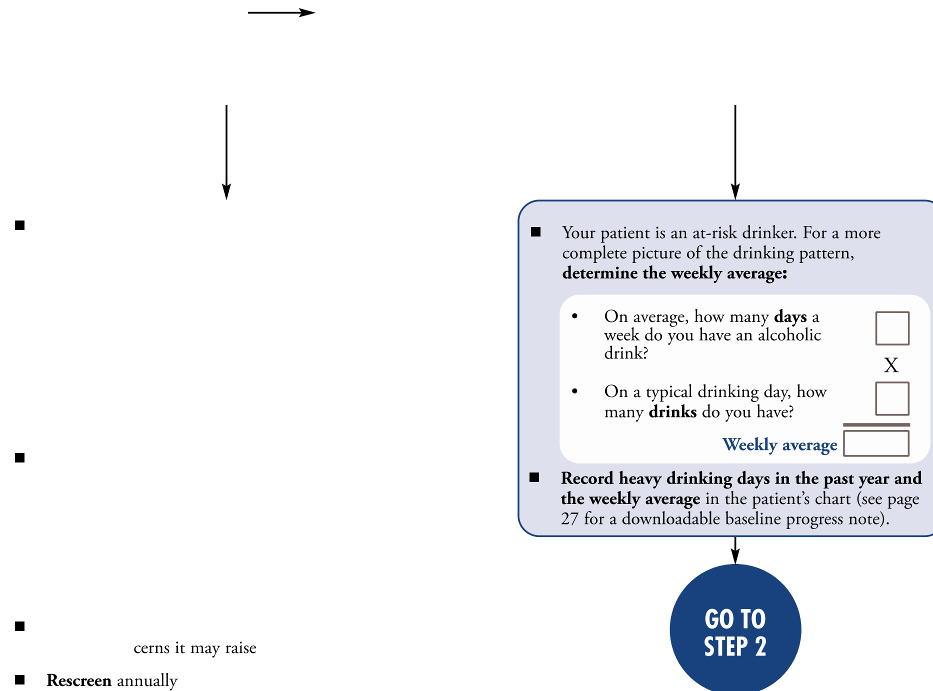
NIAAA FOUR STEPS FOR ALCOHOL SCREENING



ASK

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

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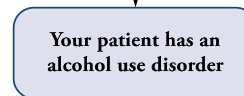
NIAAA FOUR STEPS FOR ALCOHOL SCREENING

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. The following list of symptoms is adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), Revised.* Sample assessment questions are available online at *www.niaaa.nih.gov/guide.*



ASSESS

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NIAAA FOUR STEPS FOR ALCOHOL SCREENING

HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (**no** abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

Is the patient ready to commit to change at this time?

Was the patient able to meet and sustain the drinking goal?

NO

YES

-
-
- **eturn** if unable to maintain adherence.
- **Rescreen** at least annually.

ADVISE AND ASSIST

FOLLOWUP; CONTINUE SUPPORT

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NIAAA FOUR STEPS FOR ALCOHOL SCREENING

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder. I strongly recommend that you quit drinking and I'm willing to help."
  - Relate to the patient's concerns and medical findings if present.
- **Negotiate a drinking goal:**
  - Abstaining is the safest course for most patients with alcohol use disorders.
  - Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down. (See Step 3 for At-Risk Drinking.)
- **Consider** referring for additional **evaluation by an addiction specialist,** especially if the patient is dependent. (See page 23 for tips on finding treatment resources.)
- **Consider** recommending a **mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly (see page 31).
  - prescribing a **medication** for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- **Arrange followup** appointments, including medication management support if needed (see page 17).

NO

YES

ching the drinking goal.

- **Address coexisting disorders**—medical and psychiatric—as needed.

ADVISE AND ASSIST

FOLLOWUP; CONTINUE SUPPORT

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SCREENING AND ASSESSMENT

- Examples of screening instruments:
  - CAGE, CAGE-AID
  - TWEAK, T-ACE
  - DAST-10
  - Michigan Alcohol Screening Test (MAST), MAST-Geriatric version
  - Alcohol Use Disorders Identification Test (AUDIT)
- Remember lower cut off points are needed for women on some screening tests

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CAGE-AID

- Have you ever felt the need to Cut down on your drinking or drug use?
- Have people Annoyed you by criticizing your drinking or drug use?
- Have you ever 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)

Ewing JA: JAMA 1984; 252:1905-07; Brown RL et al: Prev Med 27: 101-110.

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AUDIT: ALCOHOL USE DISORDERS IDENTIFICATION TEST

- Alcohol Use Disorders Identification Test
  - Developed by World Health Organization
- 10 questions; total possible score of 40
- Score of 9 or more is hazardous consumption or alcoholism
- For women—use a cutoff score of 4 points or more
- Not as subject to ethnic and gender bias when used in primary care

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AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

AUDIT

PACIENTE: Debido a que el uso del alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Sus respuestas serán confidenciales, así que le agradecemos su honestidad.

Para cada pregunta en la tabla siguiente, marque una X en el cuadro que mejor describa su respuesta.

NOTA: En los Estados Unidos *una bebida* se refiere a cualquier bebida que contiene aproximadamente 14 gramos de etanol o alcohol puro. Las bebidas que siguen a continuación son de diferentes tamaños sin embargo su contenido de alcohol es el mismo. Es por eso que todas son consideradas *una bebida*:

Nota: Est

Publication No. 07-3769 **National Institute on Alcohol and Alcoholism** *www.niaaa.nih.gov/guide*

https://www.niaaa.nih.gov/guide#forms

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Eliciting a Substance Use Disorders History

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 1

Treatment History:

- Past treatment history: Outpatient, IOP, Residential, Detoxification, Medication treatment.
- Detoxification: DETAILS
- Outpatient/IOP: DETAILS
- Residential: DETAILS
- Medication treatment: Methadone maintenance, Buprenorphine maintenance, Naltrexone maintenance, other
- Longest time abstinent from all substances:

Past Consequences of Substance Use: Legal, Relationships, Health, Educational, Employment, etc.

Legal History: history of DUI's, other legal problems, incarcerations, probation, parole.

- DUI's:
- Past or current probation or parole:
- Past charges: possession of alcohol/drugs, public intoxication, etc.
- Past incarcerations:

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 2

Medical Risks and Complications:

Injection History: history of injecting drug use; sharing needles, works, other injecting tools.

Infectious Disease History:

- Past testing for HIV, Hepatitis C, other infectious diseases:
  - Wishes to be tested at this time?

Seizure History: history of seizures

Withdrawal History: hallucinations, medical complications, delirium tremens.

Overdose History: past hx of accidental overdose.

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 3

Alcohol: past or current use of alcohol

- First drink of alcohol was at age XXX.
- Recent use of alcohol: frequency, amounts
- Last drink on DATE at TIME, total AMOUNT on that day.
- Loss of control and consequences occurred at age XXX.
- Most ever consumed in one day AMOUNT.
- Symptoms: Morning drinking, Drinking more than intended, Inability to stop or cut down, Withdrawal, Tolerance
- Blackouts:
- Seizures:
- Past medication trials: acamprosate, naltrexone, depot naltrexone, disulfiram, topiramate, gabapentin, baclofen.

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 4

Tobacco/Nicotine: past or current use of tobacco/nicotine

- First use at age XXX.
- Smokes NUMBER cigarettes per day.
- Chewing tobacco:
- E-cigarette/vaping use:
- Does/does not want to quit smoking/using tobacco/nicotine at this time.
- Past medication trials: use of nicotine replacement therapies, bupropion, varenicline.

Opioids: past or current use of opioids

- First use of opioids age XXX.
- Problematic or non-medical use began age XXX.
- Last use of opioids occurred on DATE at TIME and used a total of AMOUNT that day.
- Drugs used (non-medically): Suboxone, methadone, heroin, fentanyl suckers/patches, morphine, Dilaudid, hydrocodone, oxycodone, codeine, tramadol, Opana.
- Route of use has been oral, intranasal, smoking, injecting.
- Most ever consumed in one day AMOUNT.
- Recent use: Over the two weeks prior to admission, has been using DRUG, AMOUNT, FREQUENCY.
- Past prescribed medication trials: buprenorphine-naloxone, methadone, naltrexone, depot naltrexone.

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FDA-APPROVED MEDICATIONS TO TREAT DRUG/ALCOHOL ADDICTION

Medication	Indication(s)
Disulfiram (Antabuse®)	Alcohol dependence
Nicotine replacement therapies	Nicotine dependence
Bupropion (Wellbutrin®, Zyban®)	Nicotine dependence
Varenicline (Chantix®)	Nicotine dependence
Naltrexone (ReVia®, Vivitrol®)	Alcohol dependence Opioid dependence
Acamprosate (Campral®)	Alcohol dependence
Methadone	Opioid dependence/withdrawal
Buprenorphine (Subutex®, others)	Opioid dependence/withdrawal
Buprenorphine-naloxone (Suboxone®, others)	Opioid dependence/withdrawal

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 5

Cocaine: past or current use of cocaine

- First use of cocaine at XXX years of age.
- Last use of cocaine occurred on DATE, TIME.
- Route of use has been oral, intranasal, smoking, IV, vaping.
- Most ever consumed in one day AMOUNT.

Stimulants: past or current use of stimulants

- Methamphetamine: First use at age XXX. Last use DATE. Route of use oral, intranasal, smoking, Injecting.
- MDMA: First use at age XXX. Total lifetime uses of MDMA: NUMBER. Last use DATE.
- Non-medical use of Prescription stimulants: First use at age XXX. Last use XXX. Route of use oral, intranasal, smoking, IV, vaping.
- Most ever consumed in one day AMOUNT.

Marijuana: past or current use of cannabis

- First use of marijuana at age XXX.
- Last use of marijuana XXX.
- Frequency of use.
- Most ever consumed in one day AMOUNT.
- Route of use oral, smoking, vaping.

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ELICITING A BRIEF SUBSTANCE USE DISORDERS HISTORY 6

Hallucinogens: past or current use of hallucinogens

- Hallucinogens used: TYPES.
- First use of TYPE at age XXX.
- Last use DATE.
- Most ever consumed in one day AMOUNT.
- Route of use: oral.

Inhalants: past or current use of inhalants

- Inhalants used: TYPES.
- First use of TYPE at age XXX.
- Last use DATE.
- Most ever consumed in one day AMOUNT.
- Route of use: inhaled.

Sedative Hypnotics/Benzodiazepines: past or current use of sedative-hypnotics/benzodiazepines.

- First use of sedatives/benzodiazepines at age XXX.
- Last use on DATE at TIME, total AMOUNT on that day.
- Most ever consumed in one day AMOUNT.
- Recent use? Over the two weeks prior to admission, has been using TYPES, AMOUNTS.
- Route of use oral, intranasal, injecting.

Other Drugs of Abuse: past or current use of synthetic cannabinoids, synthetic stimulants, anabolic steroids, kratom, GHB, etc.

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Eliciting a Detailed, Comprehensive Substance Use Disorders History

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 1

The **Attitude of the interviewer** should be matter-of-fact, non-judgmental, curious, respectful, interested, professional, and supportive.

• The **focus** should be on taking a good medical history that includes information on alcohol and other drug use throughout the person's life.

• Have the patient **describe his/her first use**--the situation, their age, amounts used, feelings, complications, results

- "How old were you when you first tried alcohol or any other drugs? Describe the experience to me."

• Begin with the **first psychoactive substance** used (licit or illicit). Be sure to include TOBACCO and CAFFEINE; beginning with these drugs can be less threatening than starting with alcohol or other drugs.

• **Ask about all psychoactive substances** in a non-judgmental way==ALCOHOL, CANNABIS, SEDATIVE-HYPNOTICS, STIMULANTS (including cocaine), OPIOIDS, HALLUCINOGENS, INHALANTS, and Others.

- What substances has the person ever used?
- When did they start each one?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 2

- Explore the **pattern of use** of each substance. ASK at least one more time about use of substances and categories of substances initially denied.
- **Evolution and progression of use over time**
  - Frequency of use, amount of drug, route(s) used, progression of symptoms, social context of use, attempts to cut down or control, taking larger amounts or over a longer period than intended, blackouts, shakes, withdrawal symptoms
  - **COMPULSIVITY** of use, **CRAVING**.
- **Tolerance**
  - The most of each substance the patient can consume in a 24 hour period now.
  - The most ever consumed in a 24 hour period.
  - Any increase or decrease in tolerance noted.
- **Withdrawal symptoms**
  - Describe withdrawal symptoms for any drug ever used, pattern, what relieves them (e.g., more of the drug and/or a cross-tolerant drug).
  - Any history of **withdrawal complications**(seizures, delirium tremens, hallucinosis)
  - What treatment was received for these past complications?
- **Attempts to be abstinent**
  - How many attempts at abstinence has the person made?
  - What happened (if anything, besides using) to end any abstinent periods?
  - What has been **the longest time free of all psychoactive substances** in the past year? The past 5 years? Lifetime?
  - Has the person switched substances over time?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 3

Cost/Consequences to the patient of drug use:

- What is the person's current social, occupational, etc. functioning?
- How does this compare to past functioning?
- What financial, familial, social, emotional, occupational, legal, medical, spiritual problems have occurred since the person has been using (GET SPECIFICS)?
- Has there been hazardous or impairing substance use?
- Has the person experienced legal problems, arrests, DUIs, multiple divorces, marital discord, bankruptcy, homelessness, fights, injuries, family violence, suicidal thoughts, etc. while using?
- Has the person had inadvertent overdoses (alcohol poisoning, opioid overdose, etc.? Did any require medical attention? How many times?
- Has there been **CONTINUING USE in the face of ADVERSE CONSEQUENCES**? Ask for examples of consequences.

CONTROL:

- Does the patient feel s/he has ever lost control over use, even one time?
- When did this first occur? What was the situation? What happened?
- Is there evidence for loss of consistent control over use?
- If the patient does not think control has ever been lost, do others (family/friends/employers) think differently?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 4

Recovery Environment/Support System:

- Is the person's overall recovery environment toxic or supportive?
- What has been the response of family, significant others, friends, employer, others?
- What is the existing problem as the spouse or significant other sees it?
- Have any of these people suggested that the patient may have an alcohol/drug problem? When did they first suggest this?
- What do others object to about the patient's drinking/drug use? What are their concerns/complaints?
- What is or has been patient's support system?
- Have supportive people been involved in Al-Anon or other support groups for families/friends? Are they supportive of the person getting help? Who has been alienated?
- Are most or all of friends/associates/family drinking/using "buddies"?
- Are alcohol or other drugs present or used in the house where the patient lives?
- Who is drinking or using in the patient's home?
- What addicting drugs are still at home now?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 5

Readiness to Change, Insight, Motivation:

- What is the patient's **understanding** of his/her problem?
- Does the patient know about, understand, or believe in the disease concept of addiction?
- What **Stage of Change** is the person in now: Precontemplation (don't think there is a problem), Contemplation (think there is a problem), Preparation (ready to do something about the problem), Action (doing something about the problem), Maintenance, Relapse? What stages has he/she passed through in the past?
- How responsive is s/he to motivational interviewing? What is s/he willing to do? Not ready to do?

Relapse history:

- Has the patient ever been abstinent from ALL psychoactive drugs for an extended period of time? When? How long were they abstinent?
- What triggered or preceded relapses?
- What drug(s) did the person use when relapsing?
- What pattern of use developed after the relapses?
- How did the person's use patterns changes over time with each relapse?

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WHAT CAUSES RELAPSE?

- Stress
- Cues/triggers
- Exposure to drugs

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 6

Addction Treatment History:

- What have been the previous diagnoses?
- If ever treated for addiction:
  - What level(s) of service were received (detoxification, inpatient, residential, outpatient, sober living environment)?
  - What treatments were received (group, individual, family psychotherapy; relapse prevention; pharmacotherapy; education; cognitive-behavioral, etc.)?
  - Was the orientation of the treatment purely psychiatric, purely addiction, or integrated addiction/psychiatric treatment?
  - How long was treatment?
  - Did the patient complete recommended treatment? If not, why?
  - Has previous treatment been purely medical, e.g., brief medical detoxification, opioid maintenance therapy, or other medication therapy?
  - What medications for addiction has the patient taken? (disulfiram, varenicline, bupropion, naltrexone, depot naltrexone, acamprosate, buprenorphine/buprenorphine-naloxone, gabapentin, baclofen, topiramate, etc.)

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 7

- How long did the patient remain completely abstinent from ALL psychoactive drugs after each treatment?
- What was the most successful or beneficial treatment? Least successful/beneficial? What factors contributed to the success or benefit of treatments?
- Has the person had contact with 12 Step recovery groups such as AA/NA/CA/etc.?
- Ask them to describe their involvement in 12 Step recovery programs. How many meetings have they attended? Did they ever get a sponsor and work the steps? Do they have a current sponsor? How frequent is meeting attendance now?
- If involved in non-12 step support groups, which ones? Ask the person to describe their activities and involvement.

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 8

Psychiatric history:

- Has the patient ever had contact with psychiatrists or other mental health providers? What were previous psychiatric diagnoses?
- Has the person ever been in psychotherapy? If so, what kind and for how long?
- What medications have been prescribed and what was the response?
- List current and past psychotropic medications and clinical response.
- Were other treatments recommended? Was the person compliant? What has helped the most?
- What stressors and traumas have occurred throughout life? Was the patient ever physically, emotionally, and/or sexually abused, or traumatized in other ways? If so, what were the circumstances? Has the person ever received treatment for these problems?
- What symptoms of major psychiatric illness has the person had?
- Were symptoms present before, during, and/or after substance use?
- Ask other questions about DSM-5 Substance-Related and Addictive Disorders: Psychotic, Bipolar, Depressive, Anxiety, Obsessive-Compulsive and related, Sleep Disorders; Sexual Dysfunctions, Delirium, Neurocognitive Disorders, Substance Intoxication, Substance Withdrawal.

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 9

Family history:

- Which biological relatives have a history of alcoholism, "drinking problems," "drug problems" [include prescription drug addiction], cirrhosis (or other associated medical problems), depression, anxiety, sleep problems, attempted or completed suicide, psychiatric problems, overdoses, etc.?
- Have any family members been in recovery? If so, what worked for them?

Medical history:

- What medical problems does the patient have? Which ones are or could be related to alcohol/drug use? Has the patient ever had seizures, delirium tremens, cirrhosis, overdoses, other medical complications of addiction?
- What medications is the patient taking now, and for what reason?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 10

- Explore use of **addicting prescription drugs**, past and present.
  - What was the pattern of use of prescription drugs? More than prescribed, in combination with alcohol, etc.?
  - Has the person gone doctor-shopping?
  - "Lost" prescriptions to get new ones?
  - Forged or called in prescriptions for him/herself?
  - Stolen prescription pads?
  - Split prescriptions with others?
- Does the person have pain problems? What pain treatments have been tried or recommended?
  - Have opioid medications been prescribed? What is the level of pain now?
  - What non-addicting pain treatments have been tried--NSAIDS, Antidepressants (including Tricyclics), physical therapy, acupuncture, massage, trigger point injections, nerve blocks, etc.?

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ELICITING A SUBSTANCE USE DISORDERS HISTORY 11

- **Why now?**
- **Why** did the person seek treatment/help at this time?
- Is treatment coerced or voluntary?
- What are the **consequences** if the patient does not seek help/complete treatment?
- How does the patient feel about these consequences?

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Thank You!

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