



INTERVIEWING FOR SUBSTANCE USE DISORDERS

*PAULA COOK MD AND MARCELA SMID MD
PROJECT ECHO*

“...In discussing substance use disorders, words can be powerful when used to inform, clarify, encourage, support, enlighten, and unify. On the other hand, stigmatizing words often discourage, isolate, misinform, shame, and embarrass...”

Excerpt from “Substance Use Disorders: A Guide to the Use of Language” published by CSAT and SAMHSA

Instead of

- Clean
- Addict
- Alcoholic
- Drug habit
- Dirty urine
- Relapse
- Replacement therapy

Use

- Remission or abstinent
- Person with SUD
- Person with AUD
- Substance use or D/O
- Negative
- Return to use
- MAT

- Barriers to addiction histories
 - Patient is guarded
 - Patient has poor insight into their addiction
 - Patient is selectively forthcoming
 - Patient has significant shame, doubt
 - Patient has had poor interactions with physicians in the past
 - Patient is intoxicated
 - Patient is in acute withdrawal

DIAGNOSTIC EVALUATION

Chief Complaint

Identifying Data

History of Present Illness

Substance Abuse Hx

Psychiatric Hx

Social Hx

Family Hx

Past Medical Hx

Medications

Allergies

ROS: medical and
psychiatric (SI/HI risk)

Objective

Vital Signs

Pertinent Physical Exam

Mental Status Exam

Mini-MSE

Urine Drug Testing

Other Labs

- Current level of intoxication, withdrawal
- Last use
- Recent use pattern
- All substances of abuse-list them off
- Amount used daily (average)
- Peak use
- Routes of use (IM, IV, SC, oral, intranasal, inhaled, rectal)
- Age at first use-helpful in taking a longitudinal hx
 - Early onset (before age 15 years) of substance use is associated with the subsequent development of substance-related disorders (Chen et al. 2005; Hingson et al. 2006).
- Longest period of abstinence

- Treatment hx:
 - Inpatient withdrawal management/detox
 - Withdrawal course? Complications?
 - Residential treatment
 - Time spent in the program
 - Graduation?
 - Sober period following completion?
 - Step-down care
 - IOP
 - Sober living
 - Medications for Addiction treatment

- Diagnostic Criteria
- Presence and level of intoxication
- Suicidal or homicidal ideation
- Physiologic dependence and withdrawal potential
- Level of addiction-associated morbidity by domain
 - Self-image
 - Close significant others
 - Social, financial
 - Legal, work/school
 - Physical
- Medical comorbid diagnoses
- Psychiatric comorbid diagnoses
- Prior treatment attempts and relapse patterns
- Readiness for behavior change

Open-ended questions: patient does the talking “tell me..”
“describe...”

Affirmations: sincere appraisal of self-efficacy, expresses empathy
“that must have been hard....” “you have made a lot of changes..”

Reflective listening: statement demonstrating understanding “it
sounds like you...” “you feel...”

Summarize: prepares for transition, promotes change talk “here is
what I heard, correct me...”

- Express empathy (reflective listening)
- Develop discrepancy (current behavior vs goals/values, patient elicited)
- Roll with resistance
- Support self-efficacy (patient chooses and carries out change)

WHICH OF THE FOLLOWING INTERVIEW QUESTIONS IS MOST LIKELY TO MAKE A PATIENT FEEL COMFORTABLE DURING AN INITIAL INTERVIEW?

- A. How long have you been addicted to cocaine?
- B. Why do you use cocaine?
- C. Is anyone else in your family addicted to cocaine?
- D. What brought you to see me today?
- E. Have you ever been to a hospital because of your cocaine use?

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- E. Have you ever been to a hospital because of your cocaine use?

Considerations:

Obstacles to obtaining an ACCURATE substance abuse history include the patient's **defenses**: denial, minimization, rationalization, projection, externalization. Asking **open-ended** questions may help circumvent these obstacles.

Avoid using labels such as "addicted;" and ask patients to describe their pattern of use without labeling it for them. Maintain a non-judgmental stance. Patients may have shame, denial.

"How were you feeling before you used cocaine?" vs. "Why do you use cocaine?"

- Addiction is complex but treatable and affects brain function and behavior
 - No single treatment is appropriate for everyone
 - Treatment needs to be readily available
 - Treatment needs to address all aspects of health needs
 - Treatment retention is crucial to success
 - Behavioral therapies are the most common approach
 - Medications may help many patients
 - Treatment plans should be continually assessed and modified according to progress
 - Co-occurring mental illness is common
- “Detox” is not treatment for chronic substance use disorders
- Treatment does not need to be voluntary to be effective
 - Treatment should include monitoring for relapse
 - Treatment should include targeted harm reduction counseling to reduce mortality and contraction of infectious diseases

The ASAM Principles of Addiction Medicine 5th Edition. Chapter 29

Botticelli M; Koh H. Changing the language of addiction. JAMA October 4,2016. Volume 316. Number 13.

The Psychiatric Interview by Daniel J. Carlat

Numerous MH screening forms from SAMHSA

Integration.samhsa.gov/clinical-practice/screening-tools

https://www.naabt.org/documents/NAABT_Language.pdf

Interviewing & Assessment of patients with Addiction. Patrick Bell SLC VAMC

Thank you!

Join our next session on October 10th

on

Alcohol use disorder



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