

**NATIONAL HEALTH SERVICE CORPS EDUCATIONAL PROGRAM
FOR CLINICAL AND COMMUNITY ISSUES IN PRIMARY CARE**

SUBSTANCE ABUSE MODULE

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SUBTOPIC 1

SUBSTANCE ABUSE AND SUBSTANCE ADDICTION AS MEDICAL ILLNESSES

TIMELINE (60 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
10 min	Overview
20 min	Review of Case/Questions
15 min	Role-Play
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants, and physician assistant trainees.

By the end of this discussion, participants should:

1. Understand terms used in addiction medicine
2. Identify the signs and symptoms that suggest substance abuse
3. State the prevalence rate of substance abuse in the general population
4. Demonstrate the use of three screening questionnaires that are used in the diagnosis of patients with substance abuse and definitively diagnose addiction
5. Acquire a professional, non-judgmental approach to managing patients with substance abuse problems that is based on the medical model

SECTION 2 OVERVIEW

Not every health care worker will have the expertise or desire to assist addicted persons through the process of treatment and recovery. However, all persons with any responsibility for the care of patients should be aware of how common substance abuse is and of its health consequences. They should know how to diagnose substance abuse and how to refer affected persons for treatment if they will not carry out the treatment themselves.

It is important that all health care providers understand that addiction is a treatable chronic illness, not a hopeless problem or a result of moral weakness on the part of a patient. In fact, addiction is usually readily treatable, and millions of Americans are successfully recovering from addiction to substances. Treatment of addicted persons can be extremely rewarding. All of us have family and friends who are affected by addiction. We should approach our own patients with the same compassion and informed understanding that we would want for our affected friends and family.

The abuse of mood-altering chemicals can have a broad range of adverse physical and psychological effects, not only on users but on the people around them. For this reason, a systems approach is used to treat substance abuse. The user's family and other close acquaintances, such as employers or friends, are involved in treatment along with the user.

Disease Model of Alcoholism

Experts describe alcohol or other drug addiction as a disease in which an individual progresses from occasional abuse of a substance to dependence. Advocates of the disease model may theorize that some people have a genetic or hereditary susceptibility to drug dependency. This model suggests that addicted persons are genetically unsuited to moderate use of mood-altering substances, and that abstinence is the only appropriate goal for treatment.

Other experts view addiction as a disease because they see it as an attempt to self-medicate for depression or anxiety. Certainly substance abuse often coexists with and may mask other medical or psychiatric problems. Patients who present with both addiction and psychiatric disease are said to have a *dual diagnosis*. In many cases, however, the addiction disorder is primary, and once the addiction is successfully treated, the psychiatric disorder will spontaneously resolve.

Substance abuse also may be seen as a secondary problem resulting from primary problems of oppression, racism, economic deprivation, and hopelessness that are intrinsic to the society as a whole, rather than a random occurrence in an individual. A more conservative view of this position would be that we live in a drug-oriented society where children are taught to take or receive medicine early and throughout their lives, predisposing the population to addictive behavior. None of the various theories outlined here exclude the need for alcohol and other drug addiction treatment in an affected individual.

Definitions

Recognition of substance abuse requires a broad range of medical and psychosocial skills, as well as an understanding of some basic terms and definitions used in the assessment and management of substance abusers, as follows.

- *Substance abuse* is defined as using more than the socially or medically acceptable amount of a mood-altering substance. Any use of an illegal mood- or mind-altering substance—including alcohol use—by minors or operators of heavy machinery must be considered substance abuse.
- *Addiction* occurs when use or abuse of a mood-altering substance interferes with the user's normal life function, when the user is unable to control the use of the substance or when there is *chemical dependence*—physical or psychological dependence on a mood-altering substance. In the case of chemical dependence, adverse physical and psychologic signs occur when the mood-altering substances leave the body; these are termed *withdrawal syndromes*.

Epidemiology

The prevalence of substance abuse is difficult to determine, but a number of large epidemiologic surveys completed in the last few years give a good idea of the magnitude of the problem.

- About two-thirds of the adult population of the United States drinks alcohol, and about 1 in 10 drinkers is addicted to alcohol.
- About 1 in 20 high school students drinks on a daily basis, and approximately 2 million teenagers are involved in the use of illicit substances.
- Twenty percent of persons who see a physician have a current or previous problem with alcohol, and 25 percent of hospital inpatients have an alcohol problem.
- From 25 to 50 percent of emergency room visits are alcohol-related.
- At least 66 million Americans have used marijuana at some time, and 21 million have used cocaine at least once.
- It is estimated that there are about 12 million current marijuana users, about 8 million current cocaine users, and about 700,000 heroin users.
- In general, men are more likely than women to be addicted to substances, but women substance abusers tend to have more severe physical and psychological effects than men.
- There is a strong association between domestic violence and substance abuse.

Detection, Screening, and Diagnosis of Addiction

Alcohol or other drug abuse may present with physical symptoms such as hypertension, gastrointestinal symptoms, irritability, sexual dysfunction, injury, or seizures. Substance abusers may come to their health care providers with specific requests for anti-anxiety medication (used to relieve withdrawal symptoms or enhance the effects of alcohol), H2 blockers such as cimetidine or ranitidine (used to mask symptoms caused by alcohol abuse), or narcotics. Substance abuse (or dual diagnosis) should

always be considered in patients who present with psychiatric disorders such as depression, anxiety, or sleep disorders, or with non-specific social and family dysfunction.

Medical patients who are addicted (especially to alcohol) may have non-specific laboratory abnormalities such as abnormal liver function tests (especially gamma glutamyl transferase, GGT), anemia, or increased mean corpuscular volume (MCV). Many other laboratory tests may be abnormal as well, but they are non-specific. Positive urine tests for alcohol or other drugs prove only recent use, not abuse, and urine tests are primarily used for administrative purposes, rather than medical testing. There are exceptions. For example, urine drug screening frequently has medical utility in emergency settings or for psychiatric inpatients, and use of drug screens to monitor abstinence in treatment programs might have both therapeutic and administrative utility.

Substance abuse, particularly alcohol addiction, is so common that all patients seen in a medical office should be screened for it. Informal screening techniques, such as inquiries about how much a patient drinks, are much less effective than formal screening. The CAGE questionnaire (see Handouts section) has been extensively validated and is recognized as one of the most efficient and effective screening devices for alcohol dependence. It should be used to screen every adult patient in an office practice. The Michigan Alcoholism Screening Test (MAST) can be used to confirm more strongly the presence of addiction suspected on the basis of a positive CAGE screen (see Handouts section). The Drug Abuse Screening Test (DAST) is a similar test used to detect drug abuse (see Handouts section).

Addiction is a disease that can be diagnosed beyond any doubt. If there is any doubt for a given patient, the diagnostic criteria for substance abuse (see Handouts section) and substance dependence (see Handouts section) from *DSM III-Revised* can be used as objective, highly validated, widely accepted, diagnostic criteria.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

John Brown is a 40-year-old white male laboratory technician seen by you, a primary care provider at a health center in a small, predominately rural, community, for a scheduled follow-up of non-specific epigastric pain. The Brown family are long-time patients of yours, but you first saw Mr. Brown for this problem the previous month, at which time you performed a complete history and physical examination and prescribed a trial of cimetidine. Today, he gives a history of fatigue and insomnia, although he says the epigastric pain is better.

Upon questioning, Mr. Brown says that he is having trouble with his "nerves," and a lot of people are bothering him. Specifically, he mentions that he argued with his boss because he was late for work after a holiday weekend. Further, he says that his wife is nagging him because he doesn't give her enough attention, and she gets upset if he stops for a few beers on his way home from work. He comments that he feels stressed because he has to go to court next week to face a charge of driving under the influence (DUI).

You review the lab work drawn on the previous visit and notice some abnormal values on the complete blood count and serum chemistries. These abnormalities were also present on a hospital discharge summary after a motor vehicle accident. On a review of systems, Mr. Brown complains of early morning awakening, feelings of uselessness, and loss of interest in working with his home computer, which he used to enjoy enormously. On review of the laboratory work from his previous visit, you notice an elevated GGT and MCV.

1. What characteristics of this case are typical of patients seen in primary care settings?
2. What is the differential diagnosis of this presentation?
3. What clues suggest substance abuse in this case history?
4. What further information would you like to obtain to determine the correct diagnosis?
5. How should this further information be obtained?
6. Treatment will be considered in the next subtopic in this module. However, given the material in this subtopic and your own experience, how would you approach helping this patient?

SECTION 4 SUGGESTED ANSWERS

1. *What characteristics of this case are typical of patients seen in primary care settings?*

Mr. Brown is an excellent example of cases seen daily by primary care providers. There is something sufficiently wrong with the patient to motivate him to seek medical care, yet his symptoms are largely vague and undifferentiated. His symptoms are worrisome, yet the extent to which they are manifestations of serious health problems is uncertain, as is his diagnosis. The key cognitive tasks of primary health care are assessing patients with non-specific complaints, refining these complaints into medical problems and potential diagnoses, and establishing a treatment plan based on those diagnoses.

2. *What is the differential diagnosis of this presentation?*

The two main diagnostic considerations are major depressive disorder and alcoholism. The patient has symptoms consistent with both diagnoses. More broadly, the differential diagnosis could still include a large number of medical complaints causing fatigue, insomnia, and irritability (hyperthyroidism, toxic exposures, etc.), but the likelihood of these is diminished by the normal history and physical obtained at the previous visit. At this point, it is reasonable to consider the two most obvious differential diagnoses first, and if they cannot be substantiated to throw a wider net.

3. *What clues suggest substance abuse in this case history?*

The clues to substance abuse in the history include abdominal pain relieved by cimetidine, problems with "nerves" and irritability, being late to work after a holiday weekend, blaming problems on a "nagging" wife, stopping off for alcoholic beverages on the way home from work, non-specific abnormal blood tests, sleep disorder, and anhedonia (loss of interest in usual pursuits). Some clues, particularly sleep disorder, irritability, feeling useless, and anhedonia, are suggestive of major depressive disorder.

4. *What further information would you like to obtain to determine the correct diagnosis?*

It is important to complete an alcohol and other drug use history as soon as possible.

5. *How should this further information be obtained?*

It would be reasonable to start with the questions on the CAGE screening examination or even to proceed to a more structured interview like the MAST (see Handouts section). Screening

instruments for depression also would be very helpful. Important information might be gained from family members, assuming the patient is willing to let you speak with them.

If, after taking these steps, there is any question about the diagnosis, you can, by interviewing the patient and his family, eventually decide if he fits *DSM III-R* criteria for substance abuse, substance dependence (as described in the Handouts section), or depression. Further medical workup is probably not needed and would, like the cimetidine prescription, simply enable the patient to avoid facing his problem. If the patient becomes sober, his abnormal MCV and GGT should return to the normal range.

6. *Treatment will be considered in the next subtopic in this module. However, given the material in this subtopic and your own experience, how would you approach helping this patient?*

Even with all the information obtained above, some uncertainty about the diagnosis could still remain. Another consideration would be the presence of both depression and alcoholism. In any event, abstinence from alcohol would be the first step, since alcohol aggravates depression, and it would be inappropriate to start treatment for depression without stopping all alcohol. If the patient objects to the idea of giving up alcohol or is unable to do so, the diagnosis of alcoholism is more likely. These issues are pursued further in the next subtopic.

SECTION 5 ROLE-PLAY AND ADDITIONAL ACTIVITIES

Role-Play

Participants should play out the roles of Mr. Brown and the provider as the provider begins to make the diagnosis and explain it to Mr. Brown. It is important to establish an atmosphere of spontaneity and freedom for the role-play, so that participants can create realistic and effective scenarios. The group leader should act as a facilitator, ensuring that participants take the task seriously, and that others do not laugh at them.

About three or four minutes is plenty of time for a role-play. Afterward, it is important to interview the participants to see how they felt. For example, ask "Mr. Brown" which things the provider did that were helpful and which made him uncomfortable, and ask "the provider" similar questions.

Hand the scripts that follow to role-play participants before starting. Ideally, each participant should see only the script for his or her role.

Additional Activities

- The group leader may want to have a recovering substance abuse patient speak to the participants and give personal testimony regarding the insidious nature of the illness.
- It is strongly recommended to have participants attend a 12-step meeting.

Role-Play Instructions for the Part of Mr. Brown

Mr. Brown is a 40-year-old laboratory technician who has come to a medical office for help because of feelings of fatigue and depression. The case history reveals that you may have a problem with alcohol dependence, and for the purposes of this role-play, we will assume that you do. You should behave in a manner commonly seen in persons with alcohol addiction—attempt to minimize the problem but respond honestly to direct questions.

During the role-play, the provider will ask questions about your drinking behavior. You should respond honestly to direct questions if asked but exhibit some denial when asked less precise questions. For example, if you are asked if you have a drinking problem or if you drink too much alcohol, you should minimize the problem—"Oh, about the same as everybody else, I guess." However, if asked specifically what you drink (e.g., what form of alcohol, how much each day) you should answer directly—"I only drink beer, about six cans a night or so." If pressed, you might admit to occasional whiskey or more than six cans on some occasions. If asked specifically about having a drink in the morning or if you have ever tried to cut down on your drinking, you should admit that those things have happened.

Before you begin, take a moment to imagine what it would be like to be Mr. Brown. The key to understanding this role is to get the right mixture of denial tempered by a desire for help.

Since your experience is to feel criticized about your drinking, if the physician approaches the question of drinking, you become defensive. If, on the other hand, the physician impresses you with his sincere interest in you and in helping, then you become much more comfortable in sharing information about drinking.

Role-Play Instructions for the Provider

You will play the role of a health care provider seeing Mr. Brown, a 40-year-old laboratory technician, because of fatigue and symptoms of depression. The patient has typical symptoms of depression and has given several hints that he may abuse alcohol. He has said that his wife thinks he drinks too much, that he recently was arrested for DUI, and that he has been late to work after holiday weekends. In addition, persistent laboratory abnormalities are consistent with alcohol abuse.

Your goal is first to determine in a reliable, direct manner whether Mr. Brown might in fact have a problem with alcohol dependence and then, in a gentle but firm way, to get him to begin to see that he has a problem, and that you can offer help.

A reasonable way to proceed would be with the questions in the CAGE questionnaire, phrased in your own words. You could then use the laboratory evidence (after all, Mr. Brown is a laboratory technician) and other evidence to strengthen your point in a firm but supportive manner.

Take a moment to imagine yourself in the role before you start. The most difficult part of your job is to get Mr. Brown to begin to see that he has a problem without behaving in a way that frightens him off or humiliates him.

SECTION 6 SUGGESTED READING

1. Blume S. *The Disease Concept of Alcoholism Today*. Johnson Institute Publications; 1992. 7205 Ohms Lane, Minneapolis, MN 55439-2159.
This booklet reviews the advantages and disadvantages of the disease concept of alcoholism, moral and social objections, and treatment implications.

US: 800-231-5165, MN only: 800-247-0484. 36 pages, \$2.50, Order #P128.
2. Institute of Medicine, National Academy of Sciences. *Prevention and Treatment of Alcohol Problems: Research Opportunities*. Publication IOM-89-13. National Academy Press, Washington, DC; 1989.
This two-volume publication contains a thorough examination of alcoholism issues and is particularly focused on research into drinking. The first volume addresses the progress and potential of prevention of alcohol problems. The second contains a history and appraisal of treatment methods and the costs and health consequences of drinking.

Available for \$34 by phone (202-334-3313) or mail (2101 Constitution Avenue, NW, Washington, DC 20418) through the publisher.
3. Mays JT, Spickard WA. Alcoholism: Early diagnosis and intervention. *Journal of General Internal Medicine*. 1987;2:420–427.
Through a review of the literature, summarizes the essential elements in making the diagnosis of alcoholism and the methods used to interrupt the progression of the disease.
4. Mooney AJ, Martin C. *Alcohol and Drug Abuse*. American Academy of Family Physician Home Study Self-Assessment Program, Kansas City, MO; 1988.
This volume contains a concise summary of the bare essentials a primary care provider needs to know about substance abuse.

5. National Institute on Alcoholism and Alcohol Abuse. *Seventh Special Report to the U.S. Congress on Alcohol and Health*. HHS/PHS/ADAMHA/NIAAA, Rockville, MD; 1990.

Describes advances in knowledge on the health consequences of alcohol abuse and alcoholism since publication of the Sixth Special Report in 1987. The following scientific areas are covered: epidemiology, genetics and the environment, neuroscience research, medical consequences, alcohol and pregnancy, adverse social consequences, diagnostic criteria and screening instruments, prevention, early and minimal intervention, and treatment.

Available at no charge by phone (301-468-2600) or mail (6000 Executive Boulevard, Suite 402, Rockville, MD 20852) through the National Clearinghouse on Alcohol and Drug Information (NCADI). 289 pages.

6. National Institute on Drug Abuse. *Third Triennial Report to Congress on Drug Abuse and Drug Abuse Research*. HHS/PHS/ADAMHA/NIDA, Rockville, MD; 1990.

Summarizes the extent of drug abuse in the United States, its health implications and recent advances in the prevention and treatment of drug dependency. The third report in this series, it emphasizes research developments in the last three years. The National Institute on Drug Abuse has called upon experts knowledgeable in epidemiology, prevention research, treatment research, drug abuse and psychiatric illness, AIDS and intravenous drug abuse, and research on specific drugs of abuse. Whenever possible, research findings have been summarized in nontechnical language.

Available at no charge by phone (301-468-2600) or mail (6000 Executive Boulevard, Suite 402, Rockville, MD 20852) through the National Clearinghouse on Alcohol and Drug Information (NCADI). 281 pages.

SECTION 7 AUDIOVISUAL RESOURCES

1. **I'll Quit Tomorrow (90 min).** This three-part video presents a clear and comprehensive introduction to the disease concept of alcoholism, enabling, the intervention process, treatment, and the hope and healing of recovery. The video shows how problem drinking affects a man, his family, his friends, and his employer.

Contact: Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000, MN only: 800-257-0070. Order #8024, \$995.

2. **An Introduction to Chemical Dependency.** Explores the complexity of chemical dependency and examines the interaction among culture, personality, and physiology. The audio album includes the following cassettes: Anxiety/Conflicts, Historical and Cultural Attitudes, Psychoactive Drugs, AA and the Self-Help Group Movement, Nature of Drug Dependency/Addiction to the Addicted, and Constitutional Factors in Chemical Dependency/The Pleasure Factor in Addiction.

Contact: Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000, MN only: 800-257-0070. Order #1521A, \$46.

3. **The Invisible Line (31 min).** 1987. This film witnesses the progression of a youth's substance abuse from drinking and experimentation with pot and pills to his fatal involvement with cocaine. It presents information on enabling, addiction, and overdose. Includes a leader's guide.

Contact: Gerald T. Rogers Productions, 5215 Old Orchard Road, Suite 410, Skokie, IL 60077. 800-227-9100. \$295.

4. **Medical Aspects of Mind Altering Drugs (28 min).** Illustrates the mental and physical effects of drugs on human physiology by combining dramatic vignettes with a discussion of important information regarding today's most abused drugs. This film groups mind-altering drugs into six major categories: marijuana, sedative hypnotics, narcotics, inhalants, hallucinogens, and stimulants. Some of the substances covered are alcohol, tranquilizers, heroin, Demerol, nitrates, PCP, LSD., cocaine, and crack. A study guide is available. Also available in Spanish.

Contact: FMS Productions, Inc., P.O. Box 5016, Carpinteria, CA 93014. 800-421-4609. \$425 (discounts sometimes apply).

SECTION 8 HANDOUTS/OVERHEADS

The CAGE Questionnaire

Have you ever felt a need to **C**ut down your drinking?

Have you ever felt **A**nnoyed by criticism of your drinking?

Have you had **G**uilty feelings about your drinking?

Do you ever take a morning **E**ye-opener?

From: Ewing J. Detecting alcoholism: The CAGE questionnaire. *JAMA*. 1984;252(14):1905–1907.
Copyright 1984, American Medical Association.

The Michigan Alcoholism Screening Test

1. Do you feel you are a normal drinker? (If patient denies any use of alcohol, check here.)
2. Have you ever awakened in the morning after drinking the night before and found you could not remember a part of the evening?
3. Does your spouse (or parent) ever worry or complain about your drinking?
4. Can you stop drinking without a struggle after one or two drinks?
5. Do you ever feel bad about your drinking?
6. Do friends or relatives think you are a normal drinker?
7. Do you ever try to limit your drinking to certain times of day or certain places?
8. Are you always able to stop drinking when you want to?
9. Have you ever attended a meeting of Alcoholics Anonymous to help with your drinking?
10. Have you gotten into fights when drinking?
11. Has drinking ever created problems with you and your spouse?
12. Has your spouse (or other family member) ever gone to anyone for help about your drinking?
13. Have you ever lost friends or girlfriends/boyfriends because of drinking?
14. Have you ever gotten into trouble at work because of drinking?
15. Have you ever lost a job because of drinking?
16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
17. Do you ever drink before noon?
18. Have you ever been told you have liver trouble? Cirrhosis?
19. Have you ever had delirium tremens, severe shaking, heard voices, or seen things that were not there after drinking?
20. Have you ever gone to anyone for help about your drinking?
21. Have you ever been in a hospital because of drinking?
22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital when drinking was part of the problem?
23. Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking played a part?
24. Have you ever been arrested, even for a few hours, because of drunk behavior?
25. Have you ever been arrested for drunk driving or driving after drinking?

A score of over five positive responses suggests the need for further evaluation about a possible alcohol abuse problem. Most clinicians, however, modify this test to fit their own practice and use it as both an informal screening instrument and educational tool for their patients.

Reprinted with permission from *Journal of Studies on Alcohol*, vol. 36, pp. 117–126, 1975. Copyright by Journal of Studies on Alcohol, Inc., Rutgers Center of Alcohol Studies, New Brunswick, NJ 08903.

The Drug Abuse Screening Test (DAST)

1. Have you used drugs other than those required for medical reasons?
2. Have you abused prescription drugs?
3. Do you abuse more than one drug at a time?
- 4.* Can you get through the week without using drugs (other than those required for medical reasons)?
- 5.* Are you always able to stop using drugs when you want to?
6. Do you abuse drugs on a continuous basis?
- 7.* Do you try to limit your drug use to certain situations?
8. Have you had "blackouts" or "flashbacks" as a result of drug use?
9. Do you ever feel bad about your drug abuse?
10. Does your spouse (or parents) ever complain about your involvement with drugs?
11. Do your friends or relatives know or suspect you abuse drugs?
12. Has drug abuse ever created problems between you and your spouse?
13. Has any family member ever sought help for problems related to your drug use?
14. Have you ever lost friends because of your use of drugs?
15. Have you ever neglected your family or missed work because of your use of drugs?
16. Have you ever been in trouble at work because of drug abuse?
17. Have you ever lost a job because of drug abuse?
18. Have you gotten into fights when under the influence of drugs?
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?
20. Have you ever been arrested for driving while under the influence of drugs?
21. Have you engaged in illegal activities to obtain drugs?
22. Have you ever been arrested for possession of illegal drugs?
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?
25. Have you ever gone to anyone for help for a drug problem?
26. Have you ever been in a hospital for medical problems related to your drug use?
27. Have you ever been involved in a treatment program specifically related to drug use?
28. Have you been treated as an outpatient for problems related to drug abuse?

*Items 4, 5, and 7 are scored in the "no" or false direction.

A score of greater than five requires further evaluation for substance abuse problems. Many clinicians will wish to modify the test for use in their practice as both a screening and an educational instrument.

Reprinted from *Addictive Behavior*, Volume 7(4), Skinner HA, The drug abuse screening test, 363-371, Copyright 1982, with kind permission from Pergamon Press Ltd., Headington Hill Hall, Oxford OX3 OBW, UK.

DSM III-Revised Criteria for Substance Abuse

- A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:
 - 1. Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance;
 - 2. Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated);
- B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a long period of time.
- C. Never met the criteria for Psychoactive Substance Dependence for this substance.

From: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. Third Edition, Revised*. Washington, DC: American Psychiatric Association; 1987.

DSM III-Revised Criteria for Substance Dependence

A. At least three of the following:

1. substance taken in larger amounts or over a longer period than the person intended;
2. persistent desire or one or more unsuccessful efforts to cut down or control substance use;
3. a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects;
4. frequent intoxication or withdrawal symptoms when expected to fulfill major obligations at work, school, or home (e.g., does not go to work because hung over, goes to work or school "high," intoxicated while taking care of his/her children) or when substance use is physically hazardous (e.g., drives when intoxicated);
5. important social, occupational, or recreational activities given up or reduced because of substance use;
6. continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking);
7. marked intolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount);

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP).

8. characteristic withdrawal symptoms (see specific withdrawal syndromes under "Psychoactive Substance-Induced Organic Mental Disorders");
9. substance often taken to relieve or avoid withdrawal symptoms.

- B. Some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

Criteria for Severity of Psychoactive Substance Dependence:

Mild

Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

Moderate

Symptoms or functional impairment between "mild" and "severe."

Severe

Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

In Partial Remission

During the past six months, some use of the substance and some symptoms of dependence,

In Full Remission

During the last six months, either no use or use with no symptoms of dependence.

From: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. Third Edition, Revised.* Washington, DC: American Psychiatric Association; 1987.

SUBTOPIC 2

INITIAL MANAGEMENT AND TREATMENT OF SUBSTANCE ABUSE: THE FAMILY SYSTEM MODEL

TIMELINE (60 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
15 min	Overview
15 min	Review of Case/Questions
15 min	Role-Play
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants, and physician assistant trainees.

By the end of this discussion, participants should:

1. Develop cognitive knowledge and behavioral skills that will assist them in the initial management of newly diagnosed patients with substance abuse and dependence
2. Enhance their sense of optimism in managing patients with newly diagnosed substance abuse and dependence
3. Understand the goal of chemical dependency treatment and be aware of treatment options

SECTION 2 OVERVIEW

Substance abuse and dependence are most usefully viewed as medical illnesses for which safe and effective treatment is available. The recommended approach to treatment is through the system of family, friends, employers, and others among whom the substance abuser lives.

The first step in dealing with a family affected by substance abuse is to help the members see how the problem is adversely affecting their functioning and health. The next step is to help each member see the ways in which he or she is denying the impact of substance, as illustrated by the story of the elephant in the living room (see Handouts section).

The person in the family who is the identified substance abuser may be ready to enter the process of treatment. If not, other family members can still be referred for treatment.

The classic treatment process consists of four phases: intervention, detoxification, inpatient treatment, and long-term outpatient follow-up. Not every substance abuser requires all four phases, and treatment plans must be individualized for each family.

Definitions

Understanding the following terms will help providers help patients to enter treatment.

Alcoholics Anonymous (AA) is a 12-step recovery program in use for more than 50 years that provides help and support for persons who are addicted to alcohol. *Narcotics Anonymous* and *Cocaine Anonymous* are similar 12-step programs that focus on helping persons who abuse narcotics or cocaine. All substance abuse treatment programs have patients work through one or more of AA's 12 steps while in treatment; this is sometimes called the *Hazelden model* of treatment.

The 12 steps of AA are included in this module (see Handouts section). The key to the process is the concept that once individuals have tried to stop on their own and failed, they can then recognize that they are unable to control their addiction by themselves and must turn to a higher power for help. The twelfth step involves helping other addicted persons through the recovery process. "The 12 Traditions of AA" (see Handouts section) is presented to supply participants with more information about the philosophy and approach used in this treatment model.

Adult children of alcoholics are defined as adults who were affected by the presence of alcoholism as they grew up. They have a characteristic pattern of behavior that includes marrying alcoholic spouses and passive-aggressive styles of interpersonal relationships. In the Hazelden model, these individuals may benefit enormously from 12-step treatment even though they may not themselves have chemical dependency.

Al-Anon is a 12-step recovery and support program for family members and friends of alcoholics, while *Al-Ateen* is a similar group for adolescent children of alcoholics.

Co-dependency is a pathologic pattern of behavior seen in persons who are in close relationship to an addicted person and who appear to derive some benefit from the addicted person's chemical dependence. Co-dependency and diagnostic criteria are further described in the Handouts section.

Enabling is anything done directly or indirectly that helps an addicted person continue in the progression of disease. For example, a co-dependent spouse might be said to enable an addicted person's drinking by supporting him or her financially or adapting family lifestyle to the substance abuser's needs. The enabling spouse is classically described as being serious and super-responsible on the outside but filled with hurt, anger, fear, and guilt on the inside. Another common example of enabling occurs when a doctor prescribes benzodiazepines or H2-blockers to an alcoholic on a chronic basis; these drugs can ease symptoms associated with alcoholism and may facilitate drinking.

Denial is a form of self-deception in which addicted persons and their co-dependent others fail to perceive the progression and destructive nature of their substance abuse. Mr. Brown exhibits this behavior.

Detoxification is the process of withdrawal of drugs from the body of a chemically dependent person with or without medical supervision or the use of other drugs. While withdrawal from opiate addiction is popularly believed to be a serious problem, alcohol withdrawal is generally much more dangerous and difficult. Alcohol withdrawal syndrome is a potentially fatal disorder in which skilled medical care is essential.

Intervention is the process in which the addicted person and his or her family are motivated to take steps toward recovery from addiction. Some people may provide their own motivation and intervention; others may require an organized intervention from family, friends, or professionals. The steps in a planned intervention include identifying the individuals to be involved, writing up a plan and goals for the intervention, educating the interveners about addiction and the process of intervention, making arrangements for treatment, scheduling the intervention, and carrying through with the plan.

Recovery is the process of learning to live without the use of alcohol or other mood-altering drugs.

Relapse occurs when a recovering person returns to any mood-altering drug, including alcohol. Relapse may be preceded by a period of anxiety, irritation, or depression and may be accompanied by somatic symptoms.

Treatment is a planned systematic program to help a person who abuses a substance become

and remain abstinent and improve his or her quality of life.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

In this case, we will continue to follow Mr. Brown, a 40-year-old laboratory technician who was introduced in Subtopic 1. Mr. Brown presented to the office with epigastric pain and was found on an initial visit to have a normal physical but an elevated MCV and GGT on laboratory testing. On a subsequent visit, it began to appear that Mr. Brown might have an alcohol abuse problem. He gave a history of Monday morning absenteeism at work, stated that his wife by nagging him about his drinking was trying to deprive him of the only way he could relax, and gave a history of a recent arrest for driving under the influence. In addition, Mr. Brown gave a classic history for major depressive disorder, including vegetative signs and anhedonia. He was quite resistant when it was suggested that he might have an alcohol problem. Eventually, however, that visit ended with Mr. Brown agreeing to sit down and fill out the complete Michigan Alcohol Screening Test and to return for a longer visit later in the week with his wife.

Today, Mr. Brown is back, and his wife is with him. He continues to state that he is very depressed but not an alcoholic. He says he has been crying at times when he is alone and has even thought of suicide. His wife says she agrees that he is depressed but is convinced he has an alcohol problem. She reveals that her father and brother are alcoholic. She is frightened that their own children might become alcoholic and worries that Mr. Brown seems to have lost interest in them. Mrs. Brown says that Mr. Brown's supervisor at work is quite upset with him because of tardiness and inconsistency in his work.

1. What are your feelings (as the provider, patient, or spouse) during this interview? How should these feelings be handled in the interview by the provider?
2. How would you explain the progressive, insidious nature of Mr. Brown's illness to him?
3. How should you respond when he says substance abuse problems are considered moral issues in his family?
4. What are your limitations in dealing with Mr. Brown? What problems is he likely to present that will interfere with treatment? How can you proceed to help him?
5. Is Mr. Brown depressed? If so, how should this be treated?

SECTION 4 SUGGESTED ANSWERS

1. *What are your feelings (as the provider, patient, or spouse) during this interview? How should these feelings be handled in the interview by the provider?*

The provider may feel uneasy or anxious because of the attacks by Mr. Brown. The best way to handle these feelings is to use a professional demeanor and factual medical explanations. The provider may recognize that previously prescribing cimetidine to this patient (see Subtopic 1) might be interpreted as an enabling behavior. In this case, it is reasonable to ignore this concern. However, if the provider had been supplying the patient with benzodiazepines for some time, it might be necessary to state that the provider now sees that this course of action was well-intentioned but not helpful, and that it will not occur in the future.

Mr. Brown also will feel threatened and attacked, as indeed he is. It is up to the provider to present factual information about the disease model of substance abuse, as well as about Mr. Brown's history, symptoms, and lab results, in order to allay Mr. Brown's fears and let him become a partner in treatment.

Mrs. Brown may be having difficulty maintaining her composure. It is reasonable to allow her to display some pent-up emotions (as a child of an alcoholic family, she may find this difficult to do, and the opportunity should not be treated lightly). However, eventually she needs to be brought into the process of education and treatment and referred to Al-Anon and, if needed, for other individual counseling.

2. *How would you explain the progressive, insidious nature of Mr. Brown's illness to him?*

Emphasize the escalating problems Mr. Brown has had in the physical, mental, emotional, and spiritual aspects of his life. You might want to describe the progressive nature of the illness of addiction and ask if that picture fits him. You should use the abnormal laboratory tests to provide concrete evidence that his substance dependence is very real and is damaging him.

3. *How should you respond when he says substance abuse problems are considered moral issues in his family?*

You should acknowledge that some people still believe that chemical dependence is a moral issue but emphasize that the majority of professionals view it as a medical illness. Tell him that patients and their families have to be educated regarding the nature of chemical dependence and use your knowledge about the epidemiology of substance abuse to demystify the whole process. Throughout, emphasize that substance dependence and abuse are treatable disorders with excellent prognoses.

4. *What are your limitations in dealing with Mr. Brown? What problems is he likely to present that will interfere with treatment? How can you proceed to help him?*

Many providers may feel they are inadequately trained to help Mr. Brown and may experience a sense of helplessness in the face of his attempts to minimize his obvious and serious problem. However, it is clear that Mr. Brown's problem, which is interfering with his normal function at home and work, as well as with his health, is readily treatable.

Referral to a 12-step group for the patient and his family would be a good way to start educating the patient about his disease and the recovery process. Since he was willing to come in to talk to you with his wife, there is some indication he may be motivated.

If denial persists, it may be reasonable to stay in regular contact with this type of patient until he is motivated to get help. However, with this serious a substance abuse problem, even if the patient is not motivated, a formal intervention and referral for long-term treatment—possibly beginning with an inpatient stay—is certainly indicated. Again, objective evidence like abnormal laboratory tests can be used to emphasize the seriousness of substance abuse and motivate the patient to seek treatment.

5. *Is Mr. Brown depressed? If so, how should this be treated?*

This patient meets *DSM III-R* criteria for a major depressive disorder, and certainly he could be considered to have a dual diagnosis of alcoholism and major depression. Most experts would not recommend starting him on antidepressant medication at this point, because it is quite likely that his depression would clear after about a month of sobriety. However, the presence of the depression does make inpatient treatment in a unit prepared to deal with dual diagnosis a strong consideration. If, during inpatient treatment, his depression worsens instead of improving, medical treatment of depression could be instituted. If the depression were considered life-threatening (serious suicidal intent present) at any time, then immediate psychiatric consultation and medical therapy would be indicated.

SECTION 5 ROLE-PLAY

Participants play the roles of the provider, Mr. Brown, and Mrs. Brown in an office session that is a follow-up to an earlier visit with Mr. Brown alone. It is important to establish an atmosphere of spontaneity and freedom for the role-play, so that participants can create realistic and effective scenarios. The group leader should act as a facilitator, ensuring that participants take the task seriously, and that others do not laugh at them.

About three or four minutes is fine for a role-play. Afterward, it is important to interview the participants to see how they felt. For example, ask "Mr. Brown" and "Mrs. Brown" which things the provider did that were helpful and which made them uncomfortable. Ask the provider similar questions. In particular, it is useful to explore the way the provider felt in interviewing Mr. Brown about his problem.

Hand the following scripts to role-play participants before the starting. Ideally, each participant should see only the script for his or her part.

Script for Mr. Brown

You are playing Mr. Brown, a 40-year-old laboratory technician who has recently been seeing the provider because of problems of fatigue and depression. The provider is convinced you have a problem with alcohol abuse, and deep inside you know that this is true. However, it is not easy for you to admit this fact.

Both the provider and your wife will make statements suggesting that you have a "drinking problem." You should respond initially in a somewhat angry manner, for example, "Come off it, doc. I do drink, but I'm not an alcoholic. Why don't you just give me some help with my depression?" Your wife will vary between supporting you and trying to get you to admit you have a problem. You should display some anger toward her, such as, "Oh you just can't get over the fact your father was a drinker, and you see everyone who takes an innocent drink as being like him."

Your response continues to be defensive and angry unless the physician effectively combines direct expression of concern with irrefutable evidence of your problem and how it is hurting you.

Script for Mrs. Brown

You are playing the role of Mrs. Brown, a 38-year-old LPN married to a 40-year-old laboratory technician. For some time you have been worried that your husband is drinking too much. You are sure he is drinking more than a six-pack of beer a night. In addition, you notice that he has been moody and has not been paying attention to the children. Your father and your brother were both alcoholics, so you are well aware of the direction your husband is headed.

During the interview, you feel conflicted between a loyal desire to support your husband and your awareness that he needs help. Your comments in the interview should reflect this ambivalence and passivity to some extent. For example, you might volunteer your opinion that Mr. Brown drinks too much but retreat when he becomes angry.

Script for Provider

You will play the role of a health care provider seeing Mr. Brown, a 40-year-old laboratory technician, because of fatigue and symptoms of depression. He is in with his wife today for a follow-up after an earlier visit in which you confronted him with pretty convincing evidence that he abuses alcohol. Today you are interested in working with him and his wife to get them to agree to enter treatment.

Take a moment to imagine yourself in the role before you start. The most difficult part of your job is to get Mr. Brown to begin to see that he has a problem without behaving in a way that frightens him off or humiliates him. He may behave angrily during the interview, and his wife may be inconsistent in her behavior. You need to use the knowledge you have learned in this session to get them on the right track.

Success can best be accomplished with an intervention that includes:

- A direct verbal statement of interest and concern for both Mr. and Mrs. Brown (may need to be repeated)
- Restated evidence that Mr. Brown has an alcohol problem
- A clear statement that he will need to stop drinking and that you can arrange or provide help

SECTION 6 SUGGESTED READING

1. *Alcoholics Anonymous*. New York: Alcoholics Anonymous World Services; 1976.
Basic text describing the AA recovery program with personal histories.

Alcoholics Anonymous World Services, Inc., Box 459, Grand Central Station, New York, NY 10163. 212-870-3400. Publication B-1, \$5.
2. *Alcoholics Anonymous as a Resource for the Medical Profession*. New York: Alcoholics Anonymous.
Describes health professionals' approaches in referring problem drinkers to AA.

Alcoholics Anonymous World Services, Inc., Box 459, Grand Central Station, New York, NY 10163. 212-870-3400. Publication P-23, \$0.25.
3. Barnes HN, Aronson, MD (eds). *Alcoholism: A Guide for the Primary Care Physician*. New York: Springer-Verlag; 1987.
Provides concrete approaches to the detection, diagnosis, and treatment of alcoholism and its complications. Integrates basic research and wisdom gained through the authors' clinical experiences. Illustrates the interrelationship between the biological, psychological, social, and cultural issues that require a comprehensive approach to diagnosis and management. Addresses the physician's role in utilizing support services.
4. Cermak TL. *Diagnosing and Treating Co-Dependence*. Minneapolis, MN: Johnson Institute Publications; 1986.
Presents five clear diagnostic criteria, with examples, that correspond directly with accepted psychiatric/psychologic concepts. Describes ways of treating co-dependence that far exceed current approaches.

Johnson Institute Publications, 7205 Ohms Lane, Minneapolis, MN 55439-2159. US: 800-231-5165, MN only: 800-247-0484. 112 pages, Order #P100, \$8.95.

5. Lanier DC. Familial alcoholism. *J Family Practice*. 1984;18(3):417–422.
Reviews research to begin to define the familial risk factor for alcoholism and asserts that cases of familial alcoholism can be predicted and prevented. Proposes that family physicians address familial alcoholism before the appearance of symptoms and preferably before drinking decisions are made.
6. Mooney AJ, Martin C. *Alcohol and Drug Abuse*. American Academy of Family Physician Home Study Self-Assessment Program. Kansas City, MO; 1988.
Contains a concise summary of the bare essentials a primary care provider needs to know about substance abuse.

SECTION 7 AUDIOVISUAL RESOURCES

1. **Alcoholism and the Physician (80 min, Parts I–IV).** This video assists practitioners to deal with alcohol problems and alcohol use among their patients. It is divided into four sections: Attitudes, Early Diagnosis, Confirming the Diagnosis/Initiating Treatment, and The Physician's Role in Rehabilitation. Produced in cooperation with Dartmouth Medical School. Accompanying materials.

Contact: Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000 MN only: 800-257-0070. Order #9508H, \$525.

2. **Twelve Steps....The Video (35 min).** 1986. This video offers a general understanding of 12-step programs and encourages participation in support groups that utilize the approach in treating alcoholism, drug addiction, and other life-stressing problems.

Contact: Gerald T. Rogers Productions, 5215 Old Orchard Road, Suite 410, Skokie, IL 60077. 800-227-9100. \$29.95

SECTION 8 HANDOUTS/OVERHEADS

The Elephant in the Living Room

So there the dumb thing sits—it's called alcoholism, and it's the biggest thing in the house. Other people can entertain, other children can have friends sleep over. Your house is full of elephant!

So you flail at it, cry over it, push the tail end, pull the trunk end, and try to coax it to join the circus—but there the dumb thing sits.

Some of us spend so much time pushing and pulling our own private pachyderm around that we never really do anything else. Our children go on with their lives as best they can, and every now and then we leave off shoving long enough to throw a comment or criticism at them—but we run right back to our primary occupation.

Isn't that silly? You can't move an elephant! You can move out—or you can go on with your life the best way possible considering the irrefutable fact that there is an elephant in your living room. You can learn to live with it...roller skate around it...dust it...crochet a nose-cosy for it...paint it puce...rent space on it to the political candidate of your choice...But **STOP TRYING TO MOVE IT!**

...and smile. Your Higher Power loves you and gave you the whole world to be happy in—not just the little space around the you-know-what in your you-know-where.

The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our wills and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The Twelve Steps and Twelve Traditions are reprinted with permission of Alcoholics Anonymous World Services, Inc. Permission to reprint this material does not mean that AA is in any way affiliated with this program. AA is a program of recovery from alcoholism *only*—use of the Twelve Steps and Twelve Traditions in connection with programs and activities which are patterned after AA, but which address other problems, does not imply otherwise.

The 12 Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends on AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

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Co-Dependency

1. My good feelings about who I am stem from being liked by you.
2. My good feelings about who I am stem from receiving approval from you.
3. Your struggle affects my serenity. My mental attention focuses on solving your problems or relieving your pain.
4. My mental attention is focused on pleasing you.
5. My mental attention is focused on protecting you.
6. My mental attention is focused on manipulating you (to do it my way).
7. My self-esteem is bolstered by relieving your pain.
8. My own interests and hobbies are put aside. My time is spent sharing your interest and hobbies.
9. Your clothing and personal appearance are dictated by my desires, as I feel you are a reflection of me.
10. Your behavior is dictated by my desires, as I feel you are a reflection of me.
11. I am not aware of how I feel. I am aware of how you feel.
12. I am not aware of what I want. I ask what you want. I am not aware—I assume.
13. The dreams I have for my future are linked to you.
14. My fear of rejection determines what I say or do.
15. My fear of your anger determines what I say or do.
16. I use giving as a way of feeling safe in our relationship.
17. My social circle diminishes as I involve myself with you.
18. I put my values aside in order to connect with you.
19. I value your opinion and way of doing things more than my own.
20. The quality of my life is in relation to the quality of yours.

Reprinted with permission from the Society of Teachers of Family Medicine. From: Antoinette Graham: Family and Children Issues. In: Fleming M, ed. *Substance Abuse Education for Family Physicians*. Kansas City, MO: Society of Teachers of Family Medicine; 1990.

Diagnostic Criteria for Co-Dependent Personality Disorder

- A. Continued investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences.
- B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.
- C. Anxiety and boundary distortions around intimacy and separation.
- D. Enmeshment in relationships with personality disordered, chemically dependent, other co-dependent, and/or impulse disordered individuals.
- E. Three or more of the following:
 - Excessive reliance on denial
 - Constriction of emotions (with or without dramatic outbursts)
 - Depression
 - Hypervigilance
 - Compulsions
 - Anxiety
 - Substance abuse
 - Has been (or is) the victim of recurrent physical or sexual abuse
 - Stress-related medical illness
 - Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help.

From: Cermak TL, M.D. *Diagnosing and Treating Co-Dependence*. Minneapolis: Johnson Institute; 1986.

SUBTOPIC 3

SOCIAL AND CULTURAL ISSUES INFLUENCING THE DIAGNOSIS AND TREATMENT OF SUBSTANCE ABUSE

TIMELINE (60 minutes)

5 min	Introduction to Objectives and Activities
15 min	Overview
15 min	Review of Cases/Questions
20 min	Role-Play
5 min	Additional Questions and Wrap Up

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants, and physician assistant trainees.

By the end of this discussion, participants should:

1. Understand the impact of sociocultural factors such as ethnicity, gender, and age on the prevalence, severity, and prognosis of substance abuse
2. Describe at least three characteristics that typify substance abusers from the following ethnic groups: African Americans, Latinos (Hispanics), Native Americans, and women
3. Identify cultural strengths that protect members of minority groups from substance abuse
4. Outline the components of a culturally sensitive interview as it applies to substance abuse
5. Understand important factors in substance abuse treatment that are specific to members of minority groups

SECTION 2 OVERVIEW

Numerous epidemiological studies have demonstrated that the prevalence, severity, and prognosis of substance abuse disorders vary across different ethnic, gender, and age groups in American society. While these findings can be of use to health care workers who deal with patients from one of these minorities, generalizations about minority groups should not be blindly applied to any individual patient who belongs or appears to belong to one of these groups.

In fact, except for gender, the definitions of these groups are extremely arbitrary, and studies of minority groups are often confounded by socioeconomic factors that may be more important than sociocultural ones. For example, is a 60-year-old person middle-aged or elderly? Can a middle-class physician who has a Hispanic surname but speaks only English and has lived in a Boston suburb her whole life be lumped into the same category as a recent illegal immigrant from El Salvador who speaks only Spanish and lives in inner-city Washington, DC? In spite of these difficulties, it is widely accepted that various ethnic groups do have varying patterns of substance abuse, and that the pattern of substance abuse for individuals may to some extent be determined (favorably or unfavorably) by the extent to which they identify themselves as belonging to one of these groups.

African Americans

Persons of African descent comprise 12 percent of the U.S. population. Compared to the overall population, persons of African descent in general are much less likely to use alcohol, but if they are from inner-city areas, they generally have higher rates of use of heroin, cocaine, and marijuana. With respect to alcohol, African American men have a decreased rate compared to the rest of the population for every age group but a relative increase during their thirties. They have 10 times the rate of cirrhosis seen in persons of European descent and are 10 times more likely to develop alcohol-related cancers such as esophageal, liver, and laryngeal cancer.

Lack of treatment facilities and economic opportunities contributes heavily to the disproportionate prevalence of these sequelae of end-stage alcohol addiction among African Americans. The greatly increased prevalence of tobacco addiction among African Americans compared to the overall population is also a factor in their increased death rates due to these diseases and other cancers.

Inner-city African Americans have a higher rate of intravenous drug abuse leading to HIV infection than any other ethnic group, and they have a greatly increased likelihood to be victims of drug-related homicide. Because many inner-city communities have between 25 and 50 percent of their young male population in the criminal justice system for drug-related crimes at any time, there is a concern that ethnic identification in some inner-city communities may lead to an acceptance of drug use, criminal activity, and incarceration as a normal part of the culture.

On the other hand, African American inner-city communities contain many positive protective factors, such as powerful church organizations, a strong family tradition, and a tradition of positive African

American role-models. These positive aspects of African American culture can be used as a focus for a very positive ethnic identification. This ethnic identification can be used among African American children in school to prevent substance abuse from developing and in treatment programs to maintain sobriety.

Asian Americans

Contrary to perceptions that Asian Americans are non-drinkers, alcohol use appears to be increasing among certain Asian American and Pacific Islander groups. Special driving under the influence (DUI) classes are now being held for Asian Americans. In Los Angeles, special Alcoholics Anonymous (AA) groups have been formed for those who speak Japanese, just as special AA groups have been formed for Hispanics.

The cultural diversity of Asian Americans, however, precludes generalization about their drinking behavior. In a survey conducted in Los Angeles, Japanese and Filipino respondents were twice as likely as Chinese respondents to report heavy drinking behaviors. Asian American substance abusers were less likely than white American substance abusers to seek treatment from state or mental health facilities, because Asian American families tend to keep substance abuse problems within the home.

In addition to increased alcohol use among Asian Americans, opium addiction has spread across the United States among Indochinese refugees. Although the total number of those addicted to opium is unknown, some estimates indicate as many as several thousand Asian Americans are addicted.

Hispanics

Although it is generally agreed that Hispanics (Latinos) comprise 6 percent of the U.S. population, this ethnic group is often defined extremely imprecisely, and it includes various groups of considerable diversity. For example, immigrants from Central America, South America, and Mexico may have widely varying religious and cultural norms.

Compared to the rest of Americans, Hispanic males have a significantly increased prevalence of alcohol abuse and a wider cultural acceptance of heavy drinking. Hispanic females are much less likely to abuse alcohol than women from the overall population. Some studies have shown that alcoholism among Hispanics is more common among higher income groups and among individuals who are more acculturated to the dominant society (that is, who identify less strongly with the Hispanic culture). Hispanics are more likely than the overall population to abuse illicit drugs and to use intravenous drugs leading to HIV infection. Inhalant abuse is common among Hispanic adolescents in some rural communities.

Strong family ties, the work ethic common to recent immigrants, and strong community organizations are among the positive influences that can protect Hispanics from substance abuse. On the other hand, some experts argue that the strong family commitment in some Hispanic cultures can lead to enabling

behavior in families, facilitating substance abuse in Hispanic males.

Native Americans

Native Americans comprise slightly less than 1 percent of the U.S. population. Like Hispanics, they have an extremely diverse culture with many different traditions and languages. Studies have shown that alcoholism is a major health problem for Native Americans, and that heavy drinking is very common, leading to an alcohol-related mortality rate about four times the national average. The prevalences of cirrhosis and fetal alcohol syndrome are strikingly increased among Native Americans compared to the overall population. Native American adolescents have a greatly increased rate of marijuana use and inhalant abuse compared to their peers of European descent. Many Native Americans live on reservations in isolated rural areas in which poverty and unemployment contribute significantly to substance abuse and other mental health problems.

Strengths in the Native American community include their traditional cultures, none of which advocate substance abuse, the extended family structure present in most Native American communities, and potentially the availability of special federally and tribally funded substance abuse treatment programs and other health programs.

Women

Women have only one-third the prevalence of alcoholism and other drug abuse of males. However, most experts agree that women who do abuse substances are more prone than male substance abusers to many of the associated ill effects, including those that affect health and socioeconomic status. For example, female alcoholics are much more likely to be physically abused than sober women, and they are four times more likely to be divorced than male alcoholics. Female alcoholics suffer more depression and other psychiatric disorders than male alcoholics, and they are generally underrepresented in treatment programs, partly because their responsibility for the care of families makes entering treatment difficult.

Inner-city women from African American and Latino communities are at increased risk for HIV infection because of their own addiction or involvement in sex for drugs or their involvement with drug-abusing partners who are HIV-positive. Because of this, the majority of HIV-infected children in the United States are from inner-city areas.

The women's movement can offer positive role-models and strong social support to women substance abusers and should be viewed as a resource. Women-to-women outreach programs and attention in treatment programs to key matters, such as child care and financial support of women caring for children, can greatly facilitate treatment and recruitment to treatment.

Seniors

Seniors comprise about 11 percent of the U.S. population. They have as little as one-tenth the prevalence of substance abuse seen in younger persons, but the diagnosis is frequently missed in older adults, and serious consequences like falls or declining function are often attributed to dementia or depression. About two-thirds of elderly alcoholics are "survivors"—their substance abuse began at an early age—while the remaining one-third have late-onset alcohol problems, perhaps as a response to the stress of retirement or death of a spouse.

Many seniors are socially isolated and depressed. Successful interventions must include social interventions as well as attention to alcohol and drug use (particularly prescription drug use). The use of community groups for the elderly, through church groups or national groups, such as the American Association of Retired Persons, Meals-on-Wheels, or day care for the elderly, can help break down isolation and therefore support decreased alcohol use.

Adolescents

Adolescence is a time of emotional turmoil characterized by risk-taking behavior and experimentation with different roles and potential lifestyles. Many adolescents may experiment with substances of abuse in the course of normal development. However, a number of adolescents become dependent on substances or establish life-long patterns of substance abuse; intervention in these patients can be of enormous benefit to them and to society.

Problems with self-esteem can develop in any adolescent, and for members of minority groups, these problems may be accentuated. For some minority groups, epidemics of substance abuse have led to deterioration of normal family structures, which in turn have led to increased poverty and other lifestyle problems that further complicate treatment.

There is good evidence that many health professionals are uncomfortable in dealing with adolescents and are poorly trained in adolescent health care. There is also evidence suggesting that adolescents are the only group in American society whose health status has consistently declined in recent years, probably because of cutbacks in government programs and the deterioration of family life in current American society and in some minority groups.

Dealing with adolescent substance abusers requires an unusual degree of sensitivity and judgment on the part of practitioners. Establishing a therapeutic alliance with adolescent substance abusers can be extremely difficult, as the substance abuse may be a direct response to adults in their lives who have betrayed and abused them, making all adults suspect.

The Culturally Sensitive Interview

As can be seen from the preceding descriptions, the dynamics and specific characteristics of substance use and abuse for members of particular subgroups can vary not only among but within subgroups.

This may seem to make the process of assessing and intervening with someone from another group a daunting task for the interviewer. However, it is not necessary to feel that one should know all the ins and outs of every group before asking questions in this important area. In fact, trying to seem like an expert on another person's culture can itself be a set up for trouble. The following suggestions will provide some general guidelines to the culturally sensitive interview.

1. Remember that the basics of good interpersonal communication apply in these situations as in any other. Ask questions nonjudgmentally, listen carefully to the individual's response, pay attention to both verbal and nonverbal cues, and provide feedback as to what was heard and what is being considered.
2. Use a medical context to set the stage for substance use related questions. For example, making a brief statement that you always ask about alcohol use in the setting of gastrointestinal distress, or that you always ask about alcohol or drug use in the setting of emotional distress, sexual dysfunction, or hypertension makes it harder for the person to interpret your questions as reflecting a cultural bias.
3. Avoid stereotyping: Substance abuse is common enough that all populations must be screened.
4. When possible, make a point to know the cultural and social norms for the ethnic group or groups with which you most commonly deal, including protective factors and factors making that group more vulnerable. For example, knowing that traditional Asian Americans and Native Americans prefer not to make direct eye contact, particularly with strangers, will help avoid misinterpreting this nonverbal behavior as avoidance or guilt. Knowing that churches are frequently powerful sources of support within the African American community will make it more likely that you can encourage use of that protective factor.
5. Treatment should include peer support groups from the appropriate cultural, ethnic, gender, or age group for the particular patient being treated, as well as mixed groups. For example, it is clear that gender-specific groups are an important component of comprehensive substance abuse treatment, particularly for women, and you should consider asking about that resource when referring a woman for treatment.
6. Early intervention programs tailored to particular minority groups—by ethnicity, gender, or age—may be particularly effective in prevention.

SECTION 3 CASE STUDIES/DISCUSSION QUESTIONS

Case 1

You are working in a community health center in a large city. A 15-year-old African American girl is brought in to see you by her grandmother because of a vaginal discharge. You ask the grandmother to leave so you can see the patient alone with your office nurse.

The girl is disheveled, sullen, and withdrawn, and she answers your questions in monosyllables. Her nose and lips appear to be irritated. From these signs, you suspect she may be a crack abuser. When questioned, the patient admits that she smokes crack at times. She also says "yes" when you ask if she has been sexually active but does not readily give further information in this area. You are concerned that your patient may have a more complicated problem than a vaginal discharge and wonder if there is some way you can intervene to get her life on a more productive track.

Case 2

You are working at an Indian Health Service Clinic on an isolated Indian reservation. A 15-year-old Native American girl is brought in to see you by her aunt because of a vaginal discharge. You ask the aunt to leave so you can see the patient alone with your office nurse.

The girl is disheveled, sullen, and withdrawn, and she answers your questions in monosyllables. Her nose and lips appear to be irritated, and her shoes are covered with drops of gold paint. From these signs, you suspect she may be an inhalant abuser. When questioned, however, the patient denies that she has ever "sniffed paint" and also denies being sexually active. You are concerned that your patient may have a more complicated problem than a vaginal discharge and wonder if there is some way you can intervene to get her life on a more productive track.

Note: An alternative to using the above cases would be to formulate beforehand, or ask the participants to formulate, a scenario involving an adolescent from a prominent ethnic or other cultural group frequently seen in local health care settings.

1. What initial feelings do these cases evoke in you?
2. What would you like to accomplish for these girls in the office visit? How about long-term treatment plans? How would cultural factors potentially affect the interaction?
3. Is it important to discuss these girls' problems with their parents? If so, can you do this without their permission? How would cultural factors affect this process?
4. In your state and practice setting, can you treat patients like this without parental permission,

assuming the girl consents? What can you do if she refuses treatment?

5. Describe the typical patient with a substance abuse problem in the facility in which you see patients.
6. Describe an agency in your community not related directly to substance abuse treatment that might be of help in treating substance abusers seen in your practice, including patients from minority and non-minority groups.

SECTION 4 SUGGESTED ANSWERS

1. *What initial feelings do these cases evoke in you?*

Participants who answer this question honestly may find that their view of this case is clouded by a number of ethnic and cultural stereotypes and misconceptions about African Americans, Native Americans, drug abusers, and adolescents. These attitudes may be revealed by participants in this case study. Racism, sexism, ageism, and other prejudices are present in all of us, including members of minority groups.

An important function of this case study is to get these issues out on the table and to try to raise the consciousness of all the participants. The group leader should create an atmosphere in which open discussion can occur and provide clarification using facts such as those presented in the Overview. On the other hand, the group leader cannot allow overtly hostile remarks addressed at any minority group to remain unchallenged.

2. *What would you like to accomplish for these girls in the office visit? How about long-term treatment plans? How would cultural factors potentially affect the interaction?*

There are some medical issues that could be of importance here, such as establishing whether or not the patient is pregnant, whether she has a sexually transmitted disease or HIV infection, and whether she wishes to initiate a method of birth control. However, the most important task to be accomplished during this visit is to establish a therapeutic alliance with the patient. To simply address her medical problems and send her home would be inappropriate. In fact, if time were short it would be better spent in establishing an alliance with the patient with a plan for a return visit later in the week to deal with the medical issues. Without some kind of intervention, the prognosis for either of these patients is extremely poor. Cultural factors could affect this interaction in a number of ways. The adolescent's natural reticence might be accentuated by cultural norms that emphasize not talking openly about problems or not talking to strangers or authority figures, and perceived risk might inhibit talking openly or answering honestly. On the other hand, strong extended family ties and the important role of grandparents, aunts, or uncles in both these cultures could provide valuable sources of information or support. Impediments can be minimized by a direct, empathetic approach, recognizing the limits of your knowledge of a specific culture, asking for clarification rather than interpreting blindly, and thoughtfully using access to family members.

3. *Is it important to discuss these girls' problems with their parents? If so, can you do this without their permission? How would cultural factors affect this process?*

As discussed in the Subtopic 2 of this module, substance abuse assessment and treatment should involve all members of a family, whenever possible. This principle must be balanced

against the need to have the patient trust that you will not betray any of his or her confidences. This commitment to confidentiality should be stated directly, rather than implied, and the need to speak with others framed as stemming from your concern for the patient. The best solution for the case at hand may be to get the patient's permission to talk with her grandmother or aunt, but only in her presence. Another solution is to have one member of your treatment team work with the patient and another with the family. The roles of caregivers may vary not only from family to family but by culture. The best approach is to not assume but to ask about guardianship roles and potential sources of support within the extended family or neighborhood.

4. *In your state and practice setting, can you treat patients like this without parental permission, assuming the girl consents? What can you do if she refuses treatment?*

The laws regarding treatment of minors vary from state to state. In many states, family planning, birth control, abortion services, and treatment of sexually transmitted diseases can all be performed without parental consent, while other forms of medical treatment cannot (except in emergencies). The best solution is to get the patient's permission to discuss her case with her parents or guardians in her presence.

5. *Describe the typical patient with a substance abuse problem in the facility in which you see patients.*

The answer obviously will vary from location to location. On an isolated Indian reservation in Wyoming, inhalant abuse (spray paint) involving an entire extended family might be extremely common. In Bronx, New York, a common encounter might involve an HIV-positive 28-year-old male intravenous drug abuser. In Dade County, Florida, a typical patient could be a wealthy elderly Jewish female with a mixed alcohol and sedative-hypnotic addiction or a young Cuban immigrant with a crack cocaine habit. Adolescents present a unique set of challenges. Each of these patients requires an approach tailored to the strengths and weaknesses of his or her own cultural and social background.

6. *Describe an agency in your community not related directly to substance abuse treatment that might be of help in treating substance abusers seen in your practice, including patients from minority and non-minority groups.*

As discussed in the Overview, such agencies might include church groups for African American populations, Native religious groups for Native Americans, women's support groups, and resources such as Meals-on-Wheels or adult day care for the elderly. Such groups may be available for adolescents through schools, churches, or community agencies.

SECTION 5 ROLE-PLAY AND ADDITIONAL ACTIVITIES

Role -Play

Participants play the parts of the health care provider and the adolescent with possible substance abuse issues. It is important to establish an atmosphere of spontaneity and freedom for the role-play, so that the participants can create realistic and effective scenarios. The group leader should act as a facilitator; setting roles, focusing discussion, and ensuring that participants take the task seriously.

About four or five minutes is plenty of time for a particular role-play. Focus the role-play on the skills needed to interview or intervene, such as asking substance abuse related questions, asking to talk with the grandmother or aunt, or intervening to get further help with identified problems. Afterward, it is important to interview the participants to see how they felt. For example, ask the group member who played the adolescent which things the provider did that were helpful and which made her uncomfortable, and ask the provider questions about the feelings the role-play invoked. If there were difficulties, explore how they could have been handled differently.

The issues that need to be addressed in the role-play include:

- Establishing a therapeutic alliance with an adolescent and a member of an ethnic group different from that of the provider to explore substance abuse related issues
- Providing guidelines with respect to how parents or extended families will be involved and/or told about what is going on

One participant should play the role of the health care provider and another the adolescent girl. Hand role-play participants the following scripts before starting. Ideally, participants should see only the script for his or her part.

Note: With slight modification, the scripts will work for the case on the Indian reservation as well.

Additional Activities

1. Recruit minority professionals or recovering persons to discuss special issues they have encountered in the health care system or in substance abuse treatment.
2. Have recovering persons discuss problems they have encountered with clinicians, employers, families, or other groups.

Script for Adolescent Girl

You are playing the part of a 15-year-old African American girl who is brought to the clinic by your grandmother because of a vaginal discharge. About a year ago, you began dating a high school dropout who used cocaine. Since that time, you have become a regular user of crack cocaine, have been skipping school yourself, and have had some activity selling sex in order to get money for drugs.

The health care provider (who you assume is a doctor) has asked your grandmother to leave and has brought a nurse into the room while talking to you. You are a little frightened by this maneuver and are uncertain what the doctor is up to.

The doctor asks you a number of questions about drug use and sexuality. You should answer the doctor's questions honestly but very briefly. Finally, the doctor may ask you about telling your grandmother about your sexual activity and drug use. You suspect she may know about it already but have never told her yourself. You are reluctant to do so because you fear she will be angry with you. However, you have had some frightening experiences on the street and have some interest in changing your life, so you are unsure what to do.

Since you are unhappy about your life, you will respond positively if the health provider:

- Attempts to establish rapport with you (get to know you)
- Discusses confidentiality and asks for your input
- Attempts to have you state your concerns

If he or she does not attempt each step, you should remain skeptical and aloof.

Script for Provider

You are a health care provider from an upper-middle class background who is seeing a 15-year-old African American girl who has just admitted to you that she uses crack cocaine. You are trying to think of some way you can be helpful to her. She was brought into the office by her grandmother, who seems to be an orderly and sympathetic person. Upon questioning the two together, you find that the girl lives with her grandmother and only rarely sees her mother, who herself is involved in substance abuse.

To have a successful encounter with this young woman from another culture you will need to:

- Establish rapport by finding out some things about her
- Discuss confidentiality
- Attempt to define what areas of concern she has that she would like to work on

You decide that it might be easier to help this girl if the grandmother were directly involved, but you recognize that if you simply tell the grandmother the information you have learned, the girl will feel you betrayed her confidence. You decide to try to encourage the girl to agree to tell the grandmother herself.

SECTION 6 SUGGESTED READING

1. Cheung YW. Ethnicity and alcohol/drug use revisited: a framework for future research. *Int J Addiction*. 1990–1991;25(5A–6A):581–605.
Describes selected studies on ethnicity and drug use in order to summarize major findings regarding ethnic and racial variations in drug use. Discusses the major methodological limitations of such studies. Elaborates on components of ethnicity that should be incorporated into future research.
2. Office of Minority Health, Public Health Service, Department of Health and Human Services. *Closing the Gap: Chemical Dependency and Minorities*.
Provides an overview of the differences in alcohol, tobacco, and illicit drug use among minority groups when compared to non-minority groups. Also discusses minorities' high death rates (including cancer related deaths) occurring as a result of substance abuse.

Available from Office of Minority Health Resource Center, P.O. Box 37337, Washington, DC 20013-7337. 800-444-MHRC.
3. Seale JP. Sociocultural issues influencing the diagnosis and treatment of substance abuse. In: Fleming M, ed. *Substance Abuse Education for Family Physicians*. Kansas City, MO: Society of Teachers of Family Medicine; 1990. 800-274-2237.
Increases awareness of sociocultural stereotypes. Describes the impact of ethnicity, gender, and age on the prevalence, severity, and prognosis of substance abuse disorders. Introduces a model for assessing sociocultural factors in patients with substance abuse disorders and for anticipating patients' special treatment needs.

Substance Abuse in Special Populations (including African American, Asian American, Latino, Native American, and elderly populations)

4. Beauvais F. An integrated model for prevention and treatment of drug abuse among American Indian youth. *J Addict Dis*. 1992;11(3):63–80.
Provides background and rates-of-use information. Presents a model that can guide both prevention and treatment efforts addressing drug abuse in Indian communities. Relates five variables: social structure, socialization factors, psychological variables, peer associations, and drug use.
5. Bell PB. *Chemical Dependency and the African American: Counseling Strategies and Community Issues*. 1990.
Reviews the impact alcohol and other drug abuse has on African American communities. Includes strategies for how professionals can effectively meet the special needs of African American clients. Offers fresh ideas for supporting the recovery

process and easing client transition into the community.

Available from Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000, MN only: 800-257-0070. Order #5305B, 66 pages, \$5.50.

6. Chi I, et al. Differences in Drinking Behavior Among Three Asian American Groups. *J Studies on Alcohol*. 50(1):15–23.

Illustrates differences in the drinking patterns of Asian American groups and clarifies determinants of drinking. Notes that availability, acculturation, and the development of new drinking styles may be as important as historical philosophies and old-world drinking behavior.

7. "The Fact Is..." series distributed by the National Clearinghouse for Alcohol and Drug Information.

Answers questions about alcohol and other drug use among different ethnic groups in the United States. Identifies organizations and resources that can help communities and families create or expand prevention programs. The series includes:

- *Alcohol and Other Drug Use Is a Special Concern for African American Families and Communities*. August 1990. 15 pages, Publication MS402.
- *Alcohol and Other Drug Problems Are a Major Concern in Native American Communities*. September 1989. 14 pages, Publication MS392.
- *Reaching Hispanic/Latino Audiences Requires Cultural Sensitivity*. September 1990. 12 pages, Publication MS406.
- *Hispanic Parents Can Help Their Children Avoid Alcohol Problems*. January 1989. 6 pages, Publication MS369.

To order, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. 800-729-6686.

8. Hoffman F. *Transcultural Adaptation of Alcoholics Anonymous to Serve Hispanic Populations*.

Describes adaptation of AA ideology and organization to serve Hispanics in Los Angeles. Discusses how differing economic and cultural constraints affect AA meeting formats, variations in male-female relationships, adaptation of machismo values to serve AA goals.

Available from Institute of Scientific Analysis, P.O. Box 26642, Los Angeles, CA 90026. 213-466-4138.

9. Kitano HHL, Lubben JE, Chi I. Predicting Japanese American drinking behavior. *Int J Addict*. 1988;23:417–428.

Potential reference groups (e.g., parents, friends, church groups, etc.) are often

significant in predicting whether and how much a Japanese American drinks. Significant gender differences in Japanese American drinking behavior are attributed to ascribed social roles.

10. Lamarine RJ. Alcohol abuse among Native Americans. *J Comm Health*. 1988;13(3):143–155. Examines how cultural and social orientations, socioeconomic conditions, "stake theory," failure to develop social sanctions regulating drunken deportment, passive-aggressive syndromes, and emotional repression contribute to Native American alcohol abuse. Emphasizes importance of enhancing self-esteem in young Native Americans before they establish firm concepts regarding self-worth.

11. Lawson GW. *Alcoholism and Substance Abuse in Special Populations*. Gaithersburg, MD: Aspen Publishers; 1989.
Examines the issues involved in the etiology, treatment, and prevention of alcoholism and other substance abuse among specific populations. Reviews demographic information, substance abuse rates, and kinds of substances abused. Emphasizes that substance abuse should be examined from physical, social, and psychological perspectives. Emphasizes role of family in treatment and prevention efforts. Addresses the special needs of adolescents and the causes, treatment, and prevention of alcoholism in women. Other chapters address substance abuse problems of the elderly, alcoholism in the black community, the Hispanic chemically dependent client, and treatment and prevention of alcoholism in the Native American family.

Aspen Publishers, Inc., 200 Orchard Ridge Drive, Gaithersburg, MD 20878. Customer Service: 800-234-1660

12. *Report of Secretary's Task Force on Black and Minority Health, Volume VII*. Washington, DC: Health Resources and Services Administration; 1985: pages 1–25, 40–51, 65–71.
Includes recommendations for department-wide activities to improve minority health status. The recommendations emphasize activities through which the Department of Health and Human Services might redirect its resources toward narrowing the disparity between minorities and non-minorities and suggest opportunities for cooperation with non-federal structures to bring about improvements in minority health. Volume VII specifically addresses chemical dependence.

Women and Substance Abuse

13. Blume S. Women and alcohol: a review. *JAMA*. 1986;256(11):1467–1470.
Summary of literature on the physiology, pathophysiology, patterns of heredity, drinking patterns, psychological factors, clinical factors, and diagnosis and treatment of alcoholism specific to women.

Adolescents and Substance Abuse

14. Hawkins JD, et al. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychol Bull.* 1992;112(1):64–105.
Calls for a risk-focused approach that identifies risk factors for drug abuse and methods by which risk factors have been effectively addressed, thereby identifying effective prevention strategies. The authors review risk and protective factors, assess a number of prevention approaches, and make recommendations for research and practice.
15. Strasburger VC. Sex, drugs and adolescent medicine. *Current Problems in Pediatrics.* 1992;22(2):59–65.
Provides an overview of issues confronted by adolescents. Includes 1990 drug use statistics. Emphasizes that the war on drugs has failed to adequately address the two most significant drugs used by adolescents—cigarettes and alcohol.

SECTION 7 AUDIOVISUAL RESOURCES

1. **Brother Earl's "Street Talk" (60 min).** 1988. This film approaches chemical dependency in a down-to-earth manner and describes addiction and its effect on behavior, performance, and judgment. Crucial basic concepts on addiction are discussed, including denial, rationalization, and loss of control. Includes a discussion guide.

Contact: Gerald T. Rogers Productions, Substance Abuse Catalog, 5215 Orchard Road, Suite 410, Skokie, IL 60077. 800-227-9100. \$165.

2. **Drugs in Black and White (40 min).** Through revealing interviews with Atlanta-area teenagers and their parents, examines how both African American and white teens have been harmed by false assumptions and stereotypes, reveals the truth about student drug use, and focuses on the importance of parental roles in discouraging drug use.

Contact: Coronet/MTI Film & Video, 108 Wilmot Road, Deerfield, IL 60015. 800-777-2400. Order #PK-6022M, video \$495, rental \$85.

3. **Marketing Booze to Blacks (17 min).** This video describes the health and social consequences of alcohol abuse in the African American community and discusses how advertising specifically aimed at this community affects use of alcohol and attitudes toward alcohol.

Contact: Institute on Black Chemical Abuse, 2616 Nicollet Avenue S., Minneapolis, MN 55408. 612-871-7878. Order #19003, \$125.

4. **A Thin Line: Recognizing Cultural Differences in Chemically Dependent Black Clients (30 min).** With the aid of short vignettes, this video gives a thorough introduction to some of the unique clinical needs of African Americans.

Contact: Institute on Black Chemical Abuse, 2616 Nicollet Avenue S., Minneapolis, MN 55408. 612-871-7878. Order #19000, \$325.

SUBTOPIC 4

THE IMPAIRED PROFESSIONAL

TIMELINE (60 minutes)

5 min	Introduction of Objectives and Activities
10 min	Overview
20 min	Review of Case/Questions
20 min	Role-Play
5 min	Wrap Up

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants, and physician assistant trainees.

By the end of this discussion, participants should:

1. Know the reasons why health care professionals are at high risk of developing chemical dependency
2. Recognize the signs indicating that a health professional may be abusing drugs or alcohol
3. Know how to use local, state, and national resources to help impaired health care professionals and their families
4. Know how to talk with a colleague you suspect of having problems with alcohol or other drugs

SECTION 2 OVERVIEW

Impairment of a health care professional is present when one or more problems cause that person to become dysfunctional in the quality of his or her patient care, educational activities, or other professional activities or private life. Impaired professionals commonly ignore their personal difficulties until those difficulties become completely disabling; even then, many impaired professionals deny them. This session focuses on impairment due to substance abuse, but psychiatric or other cognitive impairments (such as dementia) also occur. These psychiatric impairments may occur in conjunction with substance abuse.

The statement is often made that substance abuse and other forms of impairment are more common among health professionals (or one group of them) than among the general population. However, while health professionals do have easier access to substances that can lead to severe chemical dependence, epidemiologic studies indicate that they do not have an increased prevalence of substance abuse. The overall prevalence is about 6 percent for alcohol addiction and under 1 percent for drug abuse. These are consistent with percentages typically quoted for the general population.

Impaired professionals are in no way less intrinsically competent than their peers (in fact, they may be among the most respected in their profession), and numerous studies have shown that impaired health professionals given treatment have an excellent prognosis for return to a fully functional professional life. In fact, when intervention and follow up are through a coordinated impaired professional program, the prognosis is very optimistic, with up to 90 percent recovery in some studies. Nonetheless, because of health professionals' special role in society, impairment among them is of great concern.

Because of this sensitive role, the care of impaired health professionals is always complicated by medical-legal problems. For example, state licensing boards generally will restrict or suspend the licenses of substance-abusing physicians. However, state boards also will work to ensure that motivated clinicians who have been to treatment and are in monitored recovery can return to practice. Cases involving health professionals who are members of minority groups may require referral to culturally compatible treatment facilities and other special considerations. Very little has been written that specifically addresses the problems of female health professionals who are impaired; this is an area that is in need of further research.

Identification of Impaired Professionals

The signs that a professional is becoming impaired include:

- Deterioration of emotional stability (loss of enthusiasm, moodiness, inappropriate anger, inappropriate sexual behavior, etc.)
- Deterioration in performance (poor charting, erratic or bizarre work hours, errors on orders, missed meetings, and complaints from patients or family members)
- Deterioration in physical condition (looking tired or poorly groomed, appearing agitated or

depressed, smelling of alcohol during working hours, preoccupied with self-diagnosed health problems, etc.)

Assessment and Treatment of Impaired Professionals

When these signs are noted or brought to your attention as a friend, colleague, or supervisor, it is critical that they be taken seriously, and the person is assessed properly. Depending on the situation and the relationships involved, this may seem awkward, intrusive, or frightening. However, for the benefit of the clinician and his or her patients, it must be initiated. Sometimes this may mean meeting privately with the individual and expressing your concerns, other times it will be best to enlist the support of others, such as colleagues, supervisors, or family members, to confront the individual. Sometimes it will be best to report the observed behaviors to the state medical board's impaired professional program and allow them to initiate a confidential investigation. This final option may seem cowardly or punitive, but sometimes it is the most reasonable way to make sure matters are attended to and yet keep yourself out of the middle of a potentially emotionally volatile situation. Most states now have committees or individuals available to handle these investigations and potential interventions in an objective, supportive, nonpunitive manner.

When there is concern that substance use or abuse could be playing a part in the observed impairment (and it should be considered in almost any case, even when another cause seems to be apparent), the same kind of assessment is necessary as would be used with anyone (as described in detail in Subtopics 1 and 2). Questions should focus not only on quantity and frequency of alcohol or other drug use, but also on the individual's subjective sense of problematic use or loss of control (as identified, for example by the CAGE questions or AUDIT questionnaire), and any association between the drug use and problems in the individual's life (medical, emotional, interpersonal, professional, legal). Information may need to be candidly gathered from other significant individuals in the clinician's life (spouse, partners, supervisors), and the individual may need to be asked to submit to lab tests or urine drug screening. All these steps need to be handled empathetically and tactfully, and, depending on the level of concern and the individual's responsiveness, it may be necessary to involve a supervisor or the medical board.

When it is apparent or strongly suspected that a clinician does indeed have a substance abuse problem, it is critical to intervene and not let it slide by. If substance abuse is only suspected, the intervention may be to require a more thorough assessment by a substance abuse professional. When it is clear that there is a serious substance abuse or substance dependence problem, particularly when physical dependence and the risk for withdrawal is present, the person will need referral to an inpatient setting for detoxification, initial stabilization, and initiation of complete abstinence. Professional organizations such as impaired physician committees on the state and local level are key resources in arranging this treatment. Many health care professionals will prefer to be treated outside their own community. This treatment usually can be arranged through professional organizations, such as state licensing boards or state nursing or medical societies, that can arrange for admission to facilities that specialize in treating impaired professionals.

Some impaired professionals will have a dual diagnosis (psychiatric impairment and substance abuse), so that treatment will require attention to both (including psychotherapy and pharmacologic therapy when major mood disorders or other discrete psychiatric disorders are present). When impaired professionals have been through treatment, are recovering, and wish to re-enter professional life, they should have a close supervisory relationship with a colleague in the community, identified by the impaired professional program, who will stay in regular contact with them and perform regular urine drug and alcohol screens. These screens serve to protect both the professional and the community.

Finally, just as family members need to learn their role in supporting their loved one's recovery, it may be necessary for partners or other colleagues to learn their role in facilitating a safe return to practice.

It is important to note that the laws, resources, and procedures regarding professional impairment are different from state to state. It is best to contact the state board or professional organization for each particular profession to become better informed about your own particular situation.

Prevention

It is predictable that health professionals will face multiple stresses in their careers and personal lives, and impairment may be preventable through education and through procedures for handling problems when they occur. All health professional curricula should include elements that teach the principles of identifying high-risk substance use, as well as minimizing or adapting to the stresses that occur during training and practice. These curricular elements should include both didactic time and open-ended seminars. The material taught should include time management, self-awareness, stress reduction and financial management for professionals, as well as interpersonal skills for working with staff and colleagues.

Educational programs should also include self-help groups, well-being groups, retreats, and other structured time that gives attention to the personal development of trainees. Educational institutions should develop written procedures (see Handouts section) for ensuring that trainees who are impaired by substance abuse, psychiatric disease, or a combination of the two can become productive recovering professionals.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

You are a family physician working in a community health center in a rural state. You have taken a job moonlighting on weekends in the emergency room of a local hospital. It is midnight on a Saturday. The emergency room nurse informs you that one of the local family physicians, Bob Jones, a 35-year-old married male, is in to see you. He is complaining of severe back pain.

She says Dr. Jones has a good reputation but seems to have been under a lot of stress lately. You recall having met Dr. Jones on a previous moonlighting shift when he asked for your assistance with a procedure. You also have seen him at a distance at local medical events. Dr. Jones has seemed exhausted but was friendly and grateful for your help.

This evening you enter the room to see a disheveled white male grimacing in pain. If you had not known who he was, you would not have recognized him. There is an odor of alcohol in the room.

Your patient states that he needs a shot of Nubain, and then he can go home. You are unfamiliar with this medication but recall that it is a form of narcotic. You proceed to take a more detailed history, and within a few minutes Dr. Jones becomes increasingly disorganized, alternating between demanding a shot and telling inconsistent stories about his back pain and medical history.

You excuse yourself and call a friend and colleague who knows Dr. Jones better. She discloses in confidence that she has been increasingly concerned about her friend but is not sure what to do about it. She has noticed him to be increasingly erratic and moody, and she knows he is having trouble in his marriage.

1. What initial feelings does this case evoke in you?
2. What would you like to accomplish to help the impaired professional in the case? What immediate steps would you take? Would you prescribe the narcotic he is asking for?
3. How would you involve others in intervening with this clinician? What would be the role of professional organizations in your state that might be of help in treating impaired professionals?
4. Discuss ways in which your own organization (community health center clinic, training program, hospital, group practice, etc.) can organize a program to prevent professional impairment.

SECTION 4 SUGGESTED ANSWERS

1. *What initial feelings does this case evoke in you?*

This scenario may generate a range of very divergent feelings in the participants. Some may feel anger at the clinician for letting his personal problems get out of control and not only endangering patients but putting them in a potentially difficult situation. Others may feel anxiety or nervousness at the prospect of having to confront a colleague. Some may feel confused as to what to do in this situation, and many may feel hopeless at the prospect of sorting through and intervening in this complex situation.

This material may be difficult for participants who have a personal or familial problem with substance abuse or a mental health disorder. Other participants may have had encounters with impaired professionals or may be in working situations with colleagues, employees, or supervisors who are impaired. On the other hand, some participants may have intolerant attitudes toward impairment that must be addressed.

2. *What would you like to accomplish to help the impaired professional in the case? What immediate steps would you take? Would you prescribe the narcotic he is asking for?*

Dealing with an impaired professional is similar to dealing with any impaired person, although the professional role adds emotional aspects as well as legal and logistical problems that may not be present in other cases. The first step in this situation involves information gathering, identifying the nature of the problem so that an appropriate plan can be developed. This means asking direct, nonjudgmental questions about alcohol and other drug use (as outlined in the sections on screening and intervening); performing appropriate lab tests, including drug screens, if appropriate; and asking to talk to others who might have more information about the individual's behavior. These investigations are all empathetically placed in the context of needing to determine the reasons for the person's distress. The next step is to be straightforward in letting the impaired person know that you recognize a problem exists, and that you plan to be supportive.

During both these immediate steps, it is useful to consider involving other colleagues and/or the impaired professional organization within your state. This may seem awkward, but it can be very functional if done sensitively. It takes the concerned individual out of the difficult situation of confronting someone alone, adds the strength of numbers, and also sidesteps issues of impartiality. Finally, whatever treatment that is indicated will need to be monitored and enforced.

In the situation described, it is fairly clear not to give the individual the narcotic he is asking for. His behavior and the smell of alcohol make it clear that it would not be safe. However, the clinician did come in complaining of pain, and it should be addressed with non-narcotic or even

inpatient alternatives. This would include evaluation for the possibility of withdrawal.

3. *How would you involve others in intervening with this clinician? What would be the role of professional organizations in your state that might be of help in treating impaired professionals?*

All 50 state medical societies, along with that of the District of Columbia, as well as state nursing societies, state American Psychiatric Association chapters, and similar organizations, maintain committees to help impaired professionals and connect them with appropriate treatment. National organizations such as the American Medical Association attempt to maintain lists of local resources, but these become outdated quickly, and the best policy is to keep in touch with your own local organization. The American Medical Student Association (AMSA) can provide information about programs like the Committee for Assessment of Impaired Students (CAIS) and Aid for Impaired Medical Students (AIMS).

These programs typically have a process for anonymous or confidential reporting of concerns about potential impairment among colleagues or associates. Any report initiates a confidential investigation. Even though taking such a step elicits a number of emotions among peers, these organizations provide an excellent, nonpunitive resource.

SECTION 5 ROLE-PLAY AND ADDITIONAL ACTIVITIES

Role-Play

Participants should play the part of the emergency room physician and the drug-abusing physician. It is important to establish an atmosphere of spontaneity and freedom for the role-play, so that participants can create realistic and effective scenarios. The group leader should act as a facilitator, ensuring that participants take the task seriously and focusing and debriefing the role-play itself.

The participants should focus the role-play on either the information gathering or the feedback portions of the interaction, that is, questions and concerns specific to impairment and alcohol or other drug use.

About four or five minutes is plenty of time for a role-play. Afterward, it is important to interview the participants to see how they felt. For example, ask the clinicians which things the provider did that were helpful and which made them uncomfortable, and ask the provider which moments were most difficult and which felt more comfortable. If there are reservations or concerns, discuss other ways to approach the situation.

Hand the scripts that follow to role-play participants before starting. Ideally, participants should see only their own script.

Additional Activities

1. Have a recovering professional meet with the participants to discuss his or her own problems and recovery process. Professional impairment committees or their equivalent can provide individuals who can present on these issues in a thoughtful, balanced way. This can serve to make the issues more real and identifiable and also break down some reservations toward intervening.
2. Elicit concerns that participants have about any situation they or their colleagues are in, assuming that the environment is supportive and safe for such a discussion.

Role-Play Instructions for Drug-Abusing Physician

You have been assigned to play the part of Bob Jones, a family physician in a small city who abuses prescription narcotics. You have been getting into trouble more and more (unable to meet obligations, emotionally unstable, at odds with your wife over your erratic behavior) and are increasingly worried that someone will recognize that you are out of control. Nevertheless, you have run out of narcotics, have been drinking more to compensate, and you have decided to go to the emergency room to ask the emergency room physician for a shot of Nubain and hopefully a prescription.

The emergency room physician will confront you with his suspicions that you are a substance abuser. You should at first respond with denial. One approach is to medicalize the interview, trying to dazzle the emergency room physician with a set of diagnoses or with your knowledge of drugs. For example, you might claim to have ankylosing spondylitis one moment and a herniated nucleus pulposus the next, then talk about how Nubain is not really a narcotic but a narcotic antagonist, and so on.

If the emergency room physician is caring, non-defensive, assertive, and using factual information to keep you from denying, you should reward his or her efforts by agreeing that you might have a problem, agreeing to seek treatment, or at least agreeing to a referral for further evaluation.

Role-Play Instructions for Emergency Room Physician

You have been asked to play the part of a physician who is employed by a community health center and moonlights in a local community emergency room. It is midnight on a Saturday. You are working an emergency room shift, and Bob Jones, a local family physician, is in to see you as a patient.

Bob complains of low back pain and demands a shot of Nubain for pain relief. He has a strong odor of alcohol on his breath and appears disorganized and disheveled. His story changes from moment to moment.

You have been informed that others are concerned about Bob's behavior. His blood alcohol level is 200, and he has elevations in his liver function tests.

In order to succeed and intervene, you will need to communicate a combination of:

- Concern for his problem and the mental and physical pain he is undergoing
- Factual information that is consistent with a problem with alcohol and drugs

SECTION 6 SUGGESTED READING

1. Aach RD, Girard DE, et al. Alcohol and other substance abuse impairment among physicians in residency training. *Ann Intern Medicine*. 1992;116(3):245–254.
This position paper examines the extent of substance abuse among physicians in residency training. Outlines approaches to the problem and delineates responsibility of institutions and residency program directors.
2. Carter JH. Impaired black physicians: A methodology for detection and rehabilitation. *J National Medical Association*. 1989;81(6):663–667.
Discusses issues related to the problem of impairment in African American physicians, including institutional racism, and suggests a methodology for detection and rehabilitation.
3. Clark DC. Alcohol and drug use and mood disorders among medical students: Implication for physician impairment. *Quality Review Bulletin*. 1988;14(2):50–54.
Summarizes findings from a longitudinal study of medical students. These findings contribute to a better understanding of the prevalence of mood disorders and alcohol and drug abuse during the medical school and internship years. Suggests implications of these findings for efforts to improve health care delivery.
4. Council on Scientific Affairs. Results and implications of the AMA-APA Physician Mortality Project. *JAMA*. 1987;257(21):2949–2953.
Emphasizes that recognition of risk factors and warning signs might aid physician suicide prevention.
5. Krized CR. Addressing the problem of the impaired physician. *New Dir Mental Health Serv*. 1989;Spring(41):11–19.
This reference is concerned with legal and administrative issues.
6. Messner RL, Banonis BC, Van Horn FE. Chemical abuse in nurses: We must no longer enable, ignore, deny or excuse growing public and professional epidemic. *Advancing Clinical Care*. 1991;6(6):6–7.
Cites education (including awareness) as a crucial element in the prevention, early identification, and timely treatment of chemical abuse among nurses.

7. Schultz J. Physician and resident impairment. In: Fleming M (ed). *Substance Abuse Education for Family Physicians*. Kansas City, MO: Society of Teachers of Family Medicine; 1990. 800-274-2237.

Illustrates how medical professionals are at high risk to develop chemical dependency and discusses what to look for when a colleague is suspected of abusing drugs or alcohol. Addresses resources that may be helpful to physicians and their families.

SECTION 7 AUDIOVISUAL RESOURCES

1. **Alcoholism and the Physician (80 min, Parts I–IV).** This video assists practitioners to deal with alcohol problems and alcohol use among their patients. It is divided into four sections: Attitudes, Early Diagnosis, Confirming the Diagnosis/Initiating Treatment, and The Physician's Role in Rehabilitation. Produced in cooperation with Dartmouth Medical School. Accompanying materials.

Contact: Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000, MN only: 800-257-0070. Order #9508H, \$525.

2. **Intervention: How to Help Someone Who Doesn't Want Help (48 min).** Edited version of the live national teleconference featuring Vernon Johnson, D.D. Presents the basics of intervention through a description of an actual intervention.

Related publication: Johnson, VE. *Intervention: How to Help Someone Who Doesn't Want Help.*

Shows how chemical dependence affects those around the dependent. Provides a 30-point assessment questionnaire and teaches those concerned how they can intervene by effectively confronting the dependent person with reality.

Contact: Johnson Institute Videos. Johnson Institute, 7205 Ohms Lane, Minneapolis, MN 55439-2159. US: 800-231-5165, MN only: 800-247-0484. Video: Order #V406, \$495. Publication: 116 pages, Order #P140, \$8.95.

3. **Our Brother's Keeper (30 min).** Addresses the impaired physician issue. The sequences of alcoholism are, however, universal and can be applied to anyone. Accompanying materials.

Contact: Hazelden Educational Materials, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. US: 800-328-9000, MN only: 800-257-0070. Order #9507H, \$250.

SECTION 8 HANDOUTS/OVERHEADS

Policy for Impaired Residents

I. The Family Medicine Residency

1. Provides detailed educational goals and objectives that are used in the evaluation process
2. Provides written evaluation procedures based on measurable results
3. Encourages periodic informal evaluations while a resident is on a service so that the resident does not receive a negative post-rotation evaluation without prior awareness or opportunity to correct deficiencies
4. Conducts formal evaluations of a resident's progress at least every six months with the findings in writing and co-signed by the resident
5. Maintains in confidence but makes available to the resident her or his own recorded evaluations
6. Counsels residents found to have an academic deficiency and, if necessary, offers remedial education
7. Provides for resident representation in the policy-making and evaluation process
8. Has a written grievance procedure for residents
9. Specifies in the appropriate resident letter of understanding the resident's status, rights, duties, and privileges
10. Protects the resident, residency program, patients, and the profession by conducting evaluations that are honest and straightforward
11. Treats residents equally so that decisions are not considered arbitrary or capricious
12. In the case where deficiency could lead to dismissal, informs the resident in writing and counsels him or her on how to correct the deficiency
14. Applies fairness in the daily operation of the program
15. Provides each resident with a copy of the *AMA's Resident's Rights and Resources Handbook*
16. Does not and will not discriminate against or harass any resident or applicant for

residency because of race, color, creed, religion, national origin, sex, disability, age, marital status, or status with regard to public assistance

- II. In the case of a resident having academic difficulties or exhibiting behavior that is felt to be inconsistent with generally accepted standards for family practice residents, the following protocol will be followed:
1. For minor problems not serious enough to warrant suspension or discharge, a verbal warning will be given by the advisor or program director. The advisor or program director will inform the resident of the violation and discuss the action necessary to correct it. Written records will be kept of this in the resident's file.
 2. If a second problem occurs and is not in itself serious enough to warrant a suspension or discharge, a written warning will be issued. At this time, the advisor will consult with the program director to determine the appropriate action. The resident will then be called in for a meeting with the program director and advisor to discuss the situation and what action will be considered if the problem occurs again. A written record of the meeting will be prepared by the program director, a copy will be given to the resident, and a copy will be placed in the resident's file.
 3. The program director may remove disciplinary materials from a resident's file upon satisfactory resolution of the infraction.
 4. If a third problem develops, there may be a threat of adverse action (e.g., dismissal from the program, placement of the resident on probation). At this point, the residency program's due process guidelines will be in effect.
- III. The resident who has been advised of a possible adverse action has the right to the following due process considerations. To use the process, the resident must initiate the process within 30 days of the action and each succeeding step in the process.
1. Receive written notice of charges or deficiencies
 2. Be given an unbiased fact-finding departmental hearing
 3. Be provided adequate notice (at least two weeks) of a hearing so as to prepare a defense
 4. Have available for inspection all evidence to be used against him or her at a hearing
 5. Confront and cross-examine witnesses
 6. Have a representative of the resident's choice at the hearing

7. Call his or her own witness and introduce evidence
8. Have hearing proceedings recorded, kept confidential, and made available to the resident at his or her own expense
9. Base case determination only on the evidence recorded at a hearing
10. Have written findings and disposition of the case
11. Function as a resident during the case proceedings unless his or her continuation would jeopardize the well-being of the resident or others
12. The ultimate decision is made by the department head or his or her designee. If a resident is dissatisfied with the decision reached at the departmental hearing, the resident may appeal the decision to the medical director within 30 days of the issuance of the departmental decision.

From: Schultz J. Physician and resident impairment. In: Fleming M. editor: *Substance Abuse Education for Family Physicians*. Kansas City, MO: Society of Teachers of Family Medicine; 1990.

SUBTOPIC 5

A COMMUNITY-ORIENTED PRIMARY CARE APPROACH TO SUBSTANCE ABUSE

Developed by Elizabeth W. Markson, Ph.D., Associate Director, Gerontology Center, Boston University, Boston, Massachusetts, and James F. Calvert, Jr., M.D., Program Director, Cascades East AHEC Family Medicine Residency, Klamath Falls, Oregon

TIMELINE (50 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
30 min	Review of Case/Questions
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners/students, physician assistants/students.

By the end of this discussion, participants should:

1. Understand alcoholism among an aging population as a community public health issue
2. Give a rationale for community involvement in planning and developing a public health promotion/disease control program and describe at least one method of creating involvement
3. Identify sources of information that may be applied to a community-based needs assessment and give a rationale for using opinion data and survey data
4. Discuss options for intervention at various levels of social organization for seniors with substance abuse problems and talk about the need to choose options that are acceptable and can be implemented by the community

SECTION 2 OVERVIEW

In community-oriented primary care (COPC), the community is defined as the patient. COPC emphasizes involvement of health care providers with the community—that is, the people to be served. Four basic steps are necessary to incorporate COPC into a practice:

- Decide to be responsible for the health problems of a specific population
- Identify the health problem(s) and population to be targeted
- Reach out to the unserved or underserved population identified
- Include the community in study and solution to problems this population presents

Clinical methods of diagnosing illness in a specific patient are similar in some respects to COPC. Alcohol abuse in general and the specific needs of diverse groups, such as older alcoholics, are growing problems for communities that can be assessed using COPC. Although more common among younger people, alcohol abuse is estimated to be the second leading cause for psychiatric admissions of the elderly, a major factor in 15 to 20 percent of nursing home admissions, 5 to 15 percent of medical outpatient visits, and 10 percent of hospital admissions.

Older alcoholics may be divided into two groups:

- Those with long-term alcohol abuse problems who have grown old
- Those with emerging alcohol abuse problems aggravated by the stresses of aging, such as retirement, bereavement, and loneliness.

Because older adults are less likely to engage in criminal or antisocial behavior, they are less likely to be referred for treatment for alcohol abuse by the legal system and are more likely to seek medical or psychiatric attention for another reason. Elderly alcoholics who seek medical care rarely mention their alcoholism (because of denial), and primary care practitioners often either fail to recognize the problem or ignore it. Patients also tend to underreport their alcohol consumption even when questioned directly.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

You are a health care practitioner working at a community health center in a rural area. Although the local economy has historically been based on the lumber industry, the area has recently become a popular resort and retirement location because of its mountains, wilderness, and low cost of living. The area is economically mixed, with about a third of the population at or below the poverty level because of cyclical unemployment and layoffs in the resort and lumber industries. The remainder of the population is relatively well-off. Your health center provides comprehensive primary care, ranging from prenatal care and family planning to geriatric care.

Mrs. Charles, age 66, is one of your patients who presents at the after-hours clinic with a wrist injury. Although well-dressed, Mrs. Charles has applied her makeup poorly, and her hair appears uncombed. Her speech is slightly slurred, and her affect is depressed. She is not able to give a clear account of how she injured her wrist but believes she may have fallen in her living room. Upon examination, you find an obvious deformity of the right wrist. You also note that she smells strongly of alcohol. Upon questioning, however, she initially denies using alcohol and later modifies this to, "I just had one gin and tonic."

You arrange to admit her to the hospital for an orthopedic consultation for her wrist. The following day, after Mrs. Charles has been treated for a fractured wrist, she is noted to have symptoms of alcohol withdrawal. Upon discussion with Mrs. Charles, you learn that she was widowed shortly after she and her husband moved to the area. She misses her husband, has little to occupy her time (her children live in another state), and has made few new friends.

Since her husband's death, Mrs. Charles began drinking a gin and tonic alone at home around 4 p.m. to relieve her boredom, loneliness, and grief. She soon found that she needed increasingly larger amounts of alcohol to achieve the same effect. On some evenings she would black out in front of her television. You discuss detoxification with her, and she agrees to stay in the hospital. She is discharged successfully and decides to start a chapter of Alcoholics Anonymous at the local senior center.

You wonder how many other older adults in the area have untreated alcohol abuse problems. There are a large number of retirees who are relatively new to the area and may be isolated from old friends, family, and work patterns. Also, the growing number of older workers who have been displaced in the lumbering industry suggests that alcohol abuse may be an important issue for COPC. With Mrs. Charles, you decide to investigate.

1. What steps would you take to investigate and do something about suspected alcohol abuse among the older population?
2. Do you and the health center have a role in addressing the issue of elder alcohol abuse? What responsibility does the health center have to seniors in the area who do not use the health center?

3. How will you confirm your suspicion that both chronic and acute alcoholism are problems among seniors in the community? From whom would you obtain this information? What epidemiologic and other data might be useful in assessing the types of health care problems unique to an older alcoholic population?
4. With whom might you collaborate in setting goals for the intervention and implementing it? What barriers might you face in trying to set in motion different interventions?
5. What types of intervention programs could you try, and what would you like to learn to plan your intervention?

SECTION 4 SUGGESTED ANSWERS

1. *What steps would you take to investigate and do something about suspected alcohol abuse among the older population?*

COPC can enhance the quality of care within a practice and enhance professional satisfaction through collaboration with the community, but it requires a strong personal commitment. Your enlistment of Mrs. Charles as an active participant is an important first step in the process. The subsequent necessary steps, as outlined in the Overview, are:

- Identify the health problem(s) and population to be targeted
- Reach out to the unserved or underserved population identified
- Include the community in study and solution to problems this population presents

2. *Do you and the health center have a role in addressing the issue of elder alcohol abuse? What responsibility does the health center have to seniors in the area who do not use the health center?*

It is not unusual for a COPC project to be initiated based on a clinical impression that a health problem in the community is not being adequately addressed. In this case, the community health center has a definite role in addressing the issue of elder alcohol abuse.

A practitioner in a community-directed primary care practice must incorporate COPC into the health center. In many rural areas, a community health center may be the only health care provider available. In that event, the defined population to be served is all of the older members of the geographic area. If other health providers are practicing in the community, COPC should attempt to involve them in definition of the target groups and solutions to an identified problem.

3. *How will you confirm your suspicion that both chronic and acute alcoholism are problems among seniors in the community? From whom would you obtain this information? What epidemiologic and other data might be useful in assessing the types of health care problems unique to an older alcoholic population?*

The substance abuse problem Mrs. Charles presents is probably just the tip of the iceberg. Before launching a time-consuming intervention, you need to establish the existence of an older alcoholic group in the community and determine the extent of services they currently receive.

A first step will be to review charts of elderly CHC patients. Since seniors rarely present initially with complaints of alcoholism and often deny alcohol abuse, the chart data may need to be reviewed carefully for biomedical markers suggesting alcoholism. These include liver and

pancreatic disease, unexplained trauma, neurologic problems, and sleep disturbances. In some instances, however, such findings occur only in later stages of alcoholism and may not be useful for early detection.

You then will want to gather qualitative or quantitative opinion data on the perceived need for intervention from other sources in the community. Through focus groups, informal surveys, and interviews, you may gather qualitative data on community perceptions. Good sources of such opinions and information include senior center and meal site staff, any other health facilities or social agencies in the area, Alcoholics Anonymous, AlAnon, pharmacists, other health care providers, clergy, liquor stores and supermarkets selling wine or beer, long-term near-elderly, elderly and new elderly neighborhood residents, and police. Low-income seniors who may be *at risk* of alcohol abuse also should be included if possible.

Because the area is mixed socioeconomically, it is very important to incorporate members from each economic group in your data gathering. In the process of collecting opinion data, you begin to involve the community. The success of your health promotion or disease prevention program will depend on whether area residents perceive alcohol abuse as a public health problem and are willing to work to solve it. It is especially important to obtain information on what the community thinks about the scope and potential solutions to alcohol abuse.

Opinion data may be collected in various ways, including:

- Face-to-face interviews
- Telephone interviews
- Focus groups
- Simple written questionnaires

Questionnaires should be placed in strategic spots, such as waiting rooms, or administered to specific groups such as church or temple organizations, fraternal groups or lodges, neighborhood associations, etc. Mailed questionnaires may sensitize randomly selected or targeted residents of the area to the problem but will likely result in much lower response rates than those handed out at a meeting or administered by an individual. Motivation to complete a written questionnaire is greater when there is personal contact or explanation of its purpose.

Epidemiologic data include information already collected by others, as well as specific surveys made of the particular geographic area served. Health statistics for the city or county may give some information on reportable diseases associated with alcohol abuse. Local police stations may be able to provide information on drug and alcohol use but may have very little information specific to elders who do not come to the attention of the police.

More likely, however, information from specific studies of alcohol abuse in other locales will give a rough indication of prevalence. The actual prevalence of alcoholism in the general population of any age is unknown, as alcoholics tend to deny their illness until it has progressed. Estimates of the prevalence of alcohol abuse or heavy alcohol consumption among

older adults range from 1 to 5 percent in one study to 15 percent in others. Data also suggest that the prevalence of alcohol abuse among seniors seeking medical or psychiatric care is much higher than among the "well" elderly not seeking health care.

Systematic, well-designed surveys of the area, although time-consuming and costly, give more reliable and useful data about the specific community or neighborhood you are serving. Surveys have several advantages:

- They provide more precise information about the extent of the problem.
- They may provide important information about the etiology of the problem.
- They can be used as baseline data to assess the effectiveness of an intervention.

The disadvantages of surveys include:

- Length of time required to develop the methodology, do the survey, and analyze the results
- Expense for interviewers, consultants, and other personnel

It would be useful to involve older adults in the community in collection of qualitative as well as quantitative data. Their participation would not only reduce costs but increase commitment to solution of the problem. Student interns or graduate students from the nearest college or university may assist in gathering and analyzing information, and thus may also reduce costs.

4. *With whom might you collaborate in setting goals for the intervention and implementing it? What barriers might you face in trying to set in motion different interventions?*

Any intervention should involve multiple groups in identification, intervention design, and implementation and evaluation. The intervention chosen depends on the interests, abilities, and perspective of these groups, as well as the health providers serving them.

Because Mrs. Charles has already expressed a commitment, she would be an appropriate person to reach out to other retirees in the area who may have an abuse problem. You will also want to involve representatives from Alcoholics Anonymous, AlAnon, pharmacists, other health care providers, clergy, liquor store and supermarket managers selling wine or beer, long-term near-elderly, elderly and new elderly neighborhood residents, police, local town or county council, resort employees, currently employed and laid-off lumber executives and workers, trade unions, and agencies in the aging network. The aging network in most communities is made up of councils on aging, area agencies on aging, senior centers, and local chapters of voluntary organizations, such as Retired Senior Volunteer Professionals (RSVP) and American Association of Retired Persons (AARP).

You would also want to involve business and professional groups, such as the Rotary Club, Lions Club, and fraternal organizations (Elks, Moose, Eagles, Shriners, Masons, etc.). A

careful look at the number and composition of organizations representing various segments of the local population will help you include the broadest range of people possible and will increase your likelihood of success.

Also important are the potential barriers you may face. For example, retirees who have substantial savings and homes can easily mask their alcohol dependence by drinking undetected at home. Similarly, unemployed workers may have considerable leisure time during which drinking can occur. Traditional treatment programs have been aimed at younger people and have failed to meet the needs of the older alcoholic, who may hesitate, because of pride, to admit a problem. Moreover, in this case it seems likely that there are at least two groups of older substance abusers—natives of the area and new, more affluent retirees.

Area residents who have aged in place may feel threatened or angered by a growing, more affluent retiree population that can afford things they cannot. Conversely, retirees may view the long-term residents as "backwoods." Even merchants selling alcohol may regard a substance abuse program as a threat to business. Knowledge and community involvement are essential to overcome such barriers.

5. *What types of intervention programs could you try, and what would you like to learn to plan your intervention?*

Understanding why there are alcoholics in the community is crucial to developing a program to deal with alcohol abuse among people of any age. This particular rural area is undergoing two changes:

- Economic change because of growth of a resort industry, seasonal unemployment, and the decline of lumbering and layoffs of older workers
- Population change with influx of a retired older population, most of whom have no family, friendship, or work ties to long-term residents, but who share the stresses associated with unemployment and layoffs of an older work force.

Is there evidence that alcohol consumption has increased with economic and social change? Does alcohol consumption increase seasonally? If so, when? How do workers spend time when there is no work (is drinking to pass the time a norm)? What activities are available for retired older people? How many widowed, separated, or divorced seniors have no relatives or close friends in the area? Is there a local Alcoholics Anonymous or AlAnon group? If so, is its existence well-publicized and accessible to older people? Is there a need for an AA devoted to older people?

Based on a better understanding of elder substance abuse associated with stress, as well as the resources and skills in the area, interventions may be targeted at one or more levels of social organization. The first is the individual and health center level:

- Possible interventions include screening for alcohol abuse using a screening tool for psychosocial markers and evaluating older patients for biomedical markers, such as liver and pancreatic problems, trauma or falls, etc. One rapid, inexpensive, and reasonably effective psychosocial screening measure is the CAGE interview (see Handouts section).
- Other ideas include publicity programs to recognize the symptoms of alcohol abuse and to encourage screening and treatment at the health center, Alcoholics Anonymous, and AlAnon.

Interventions at the neighborhood and community level include:

- Locally based programs to increase job retraining options for laid-off workers who may be employable in the future
- Programs to provide additional activities, opportunities for informal get-togethers, appropriate physical activity, etc.
- Intervention programs to prevent increase in seniors' substance abuse, including support groups for the bereaved, "welcome wagon" visits, get-togethers to integrate new people into the community, and an emergency hot line for those who are concerned about their alcohol use

Finally, interventions at the broader community and society level include social and political action to increase volunteer and employment opportunities for local workers.

SECTION 5 SUGGESTED ACTIVITIES

1. Break the class into groups of two. Assign one participant in each group to play the role of a health care provider and the other an alcoholic older patient who has come to the center because of severe contusions sustained in a fall. The patient has just recently become a patient at the community health center after moving from a distant state.

Allow each role-play to take three to four minutes. Be prepared to set the scenario. The following trigger sentences might be used for the health care practitioner in three different role-plays:

- You say you are not sure how you fell. It appears to me that you have been drinking. How much were you drinking when you fell this time?
- I wonder how many of the injuries you sustained are due to the fact that you have obviously been drinking. Have you thought about joining AA?
- I am concerned about your falling, and I think we need to do something before you fall again or hurt yourself in some other way. Why don't we be open with each other and try to figure out what's going on in your life and what we should do?

Have each role-player discuss how he or she felt in the part played. The person playing the role of patient is often the best source of information about how an actual patient will behave in response to the provider's approach. Have the group discuss which approach might be most successful in dealing with an alcoholic elder patient and elicit suggestions for other approaches.

2. Role-play a community meeting. Assign one or more members to play the following roles: health center staff, liquor store owner, supermarket manager at a store selling wine and beer, bartender, police, older woman recently released from detox, newly relocated affluent widow or widower, unemployed older lumberjack.

Have the group discuss whether alcohol abuse among older people is an important issue for the community, how significant it is, what should be done, and what difficulties may be encountered. Ask them to discuss how these difficulties could be resolved. You may want to use the following trigger sentences for each role:

- **Liquor store owner**—We do a good business, but I never sell to somebody who's drunk.
- **Police**—We don't get a lot of calls from older people. Once in a while there's a problem when things get out of hand in the bars or for drunk driving.
- **Older detoxed woman**—I know a lot of women in this area must have the same problem I did but are afraid to let anyone know.
- **Bartender**—I don't get many of the new people in my bar. If they are drinking, they must be doing it somewhere else.
- **Unemployed older man**—Sure, we guys like to have a drink. There's not much else to do

when we're laid off.

- **Supermarket manager**—We're selling more specialty items now, imported beers and wines, than we used to.
- **New widowed resident**—It's hard to know what to do with yourself when you first move into a new area and don't know anybody.

SECTION 6 SUGGESTED READING

1. Barry PA. Alcoholism in the community-residing elderly. *Clinical Report on Aging*. 1987;1(1):6–12.
Presents material on alcohol use among community elderly and highlights issues in treatment and detection.
2. Gillanders WR, Buss TF, Gemmel D. Assessing the denominator problem in community-oriented primary care. *Fam Med*. 1991;23(4):275–278.
This study compares the demographics, health status, and medical care utilization of elderly community residents in general and the elderly patients of a family health center in Ohio.
3. Gold MR, Franks P. A community-oriented primary care project in a rural population: Reducing cardiovascular risk. *J Fam Pract*. 1990;30(6):639–644.
A COPC project was conducted in two towns in rural New York where there is a high level of cardiovascular mortality. Stresses the importance of engaging the support of the local and medical community in the project.
4. Klevens RM, Cashman SB, Margules A, Fulmer HS. Special contribution: Transforming a neighborhood health center into a community-oriented primary care practice. *Am J Prev Med*. 1992;8(1):62–65.
Residents of a COPC preventive medicine residency transform a health center into a COPC practice. Highlights specific environmental cleanliness projects as an example.
5. Kvale JN, Gillanders WR, Buss TF, Hofstetter CR, Gemmel D. Health and poverty among elderly persons: A community-oriented primary care survey. *J Am Board Fam Pract*. 1990;3(4):231–239.
The COPC approach provides a framework for assessing need and access to care for independent-living elderly persons.
6. O'Connor PJ, Wagner EH, Strogatz DS. Hypertension control in a rural community: An assessment of community-oriented primary care. *J Fam Pract*. 1990;30(4):420–424.
A survey was conducted and data analyzed to determine the effectiveness of a COPC approach for the detection, treatment, and control of hypertension.

SECTION 7 AUDIOVISUAL RESOURCE

1. **Alcoholism and Substance Abuse in Older Adults (120 min).** This video conference—one of nine in a series on different topics affecting the elderly—was produced by the Virginia Geriatric Education Center. Because of its length, instructors may wish to choose selected portions for group use.

Contact: Terra Nova Films, 9848 Winchester Avenue, Chicago, IL 60643. \$149. (Although this video is available only for purchase, substantial discounts are available if more than one video conference is purchased.)

SECTION 8 HANDOUTS/OVERHEADS

The CAGE Questionnaire

Have you ever felt a need to **C**ut down your drinking?

Have you ever felt **A**nnoyed by criticism of your drinking?

Have you had **G**uilty feelings about your drinking?

Do you ever take a morning **E**ye-opener?

From: Ewing J. Detecting alcoholism: The CAGE questionnaire. *JAMA*. 1984;252(14):1905–1907.
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